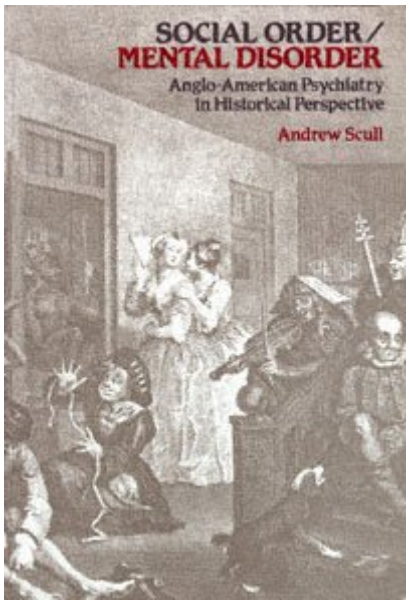

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Social Order / Mental Disorder

Anglo-American Psychiatry in Historical Perspective

Andrew Scull

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[Dedication]

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My intellectual and personal debts are still more numerous, so much so that it is perhaps invidious to mention particular individuals. Still, I cannot entirely forebear. William Bynum, Roy Porter, and the staff of the Wellcome Institute for the History of Medicine have provided me with a home away from home, stimulating intellectual company, and access to the unrivaled riches of their library during my insufficiently frequent stays in London. Lawrence Stone was enormously helpful and supportive during my year at the Center he directs, notwithstanding his strong intellectual disagreements with some of my work; and Charles Rosenberg, Gerald Grob, and David Rothman have been similarly gracious over the years. Finally, having elected to call myself a sociologist, I have been lucky enough, over the past ten years, to find myself a member of a department that takes history seriously, one that has not

held my burrowing around in the eighteenth and nineteenth centuries against me.

This volume is dedicated to my children, Anna and Andrew Edward, who have provided me with so much happiness and joy (not to mention distractions) over the years I have wrestled with a subject matter calculated to prompt the very opposite emotions.

Chapter One
Reflections on the Historical Sociology of Psychiatry

> The history of the victors, for the victors, and by the victors is not only indecent, but also bad history and bad sociology, for it makes us understand less the ways in which human societies operate and change.
> —TEODOR SHANIN,
>
> Foreword to The Agrarian Question and the Peasant Movement in Colombia
> by Leon Zamosc

> Madness constitutes a right, as it were, to treat people as vermin.
> —LORD SHAFTESBURY,
> Diaries, 5 September 1851

> "Well, in our country," said Alice, still panting a little, "you'd generally get somewhere else—if you ran very fast for a long time, as we've been doing."
> "A slow sort of country!" said the Queen. "Now, here, you see, it takes all the running you can do to keep in the same place."
> —LEWIS CARROLL,
> Through the Looking Glass

For more than a decade and a half now, I have been preoccupied with understanding social responses to madness in Britain and the United States. Some of my work, dealing with the analysis of the origins and implementation of contemporary mental health policies, seems to fall within the conventional boundaries of sociology as the mainstream of the American profession defines them (though this is largely the result of intellectual accident rather than design). For the most part, however, as the contents of this volume reveal, my interests have been heavily historical, a choice that has quite consciously reflected both my intellectual conviction that an adequate sociological understanding is necessarily a historically grounded understanding and, to be candid, the great pleasure I find in rummaging about in the past.

Intellectual choices, of course, are not made in a vacuum, flowing in substantial measure from a complex interaction between biography and circumstance of which we are seldom fully aware. In largely unintended ways, I suspect that my formal education at Balliol and Princeton contributed to my initial interest in psychiatric history. (One's acquisition of a certain intellectual capital and the natural tendency to work over the

years on a set of interrelated problems makes one's early decisions of more moment than is generally realized at the time, so that in retrospect I can hardly be surprised at my continuing fascination with this subject matter.)

Undergraduates at Oxford are not allowed to take a degree in sociology, a peculiar prejudice that has doubtless been reinforced in the present reactionary political climate, given the (not wholly mistaken) notion that there is something inherently subversive about the sustained intellectual analysis of social institutions. The immediate consequence of this policy in my case was that I acquired a rather broad education in philosophy and in a range of social sciences, rather than the narrow indoctrination into a particular academic discipline more characteristic of English university instruction. Because I have always relished the freedom to trespass across established disciplinary boundaries, I think that among sociology's prime attractions for me was my sense of the capaciousness of the

intellectual territory it sought to embrace.

This sense of the scope and ambition of the subject reflected the fact that the relatively small dose of sociology I had received at Oxford concentrated heavily on the work of Marx, Durkheim, and Weber, together with such atypical mid-twentieth-century sociologists as Barrington Moore and C. Wright Mills. Mainstream American sociology of the late 1960s, with its narrow, presentist bias, its crude scientism, and its preoccupation with method at the expense of substance, was infinitely less appealing. One might reasonably expect, therefore, that my passage into graduate school in the United States would have produced severe disillusionment. I was fortunate enough, however, to have chosen Princeton for my graduate training: fortunate in that, having cleared certain methodological and statistical hurdles, I (like the rest of my cohort there) was left almost entirely to my own devices, free to pursue my own intellectual whims and fancies.

While not without its hazards—virtually all my fellow students have disappeared without professional trace—this situation did have certain distinct advantages. In particular, when my reading of Foucault and Rothman had led me to an interest in matters psychiatric, no one was disposed to dissuade me from studying lunacy in the nineteenth century simply because the sociological audience for such work might prove vanishingly small. Soon I found myself fascinated by a whole set of interrelated questions about changing social responses to mental disturbance and the mentally disturbed and equally hooked on the pleasures of playing historical detective—a double addiction from which I have neither sought nor wished to escape.

There can be little question that, for many American sociologists, it must seem eccentric for one of their number to exhibit a persistent concern with such topics as eighteenth-century beliefs about madness, a law-

suit launched by an obscure and otherwise unmemorable middle-aged spinster in the late 1840s, the biography of a nineteenth-century alienist, the architecture of Victorian loony bins, and historiographic disputes about the interpretation of nineteenth-century lunacy reform. At the same time, only the most intellectually obtuse could avoid recognizing that a certified member of the sociological community is likely to be greeted with great wariness and suspicion by card-carrying professional historians, even if he somehow escapes being shot at by the border guards who so zealously patrol the artificial boundaries we have erected to distort the study of human society. Yet the intellectual rewards that can flow from resisting entrenched pressures to respect established disciplinary boundaries seem to me amply to justify a refusal to embrace conventional pieties about the territories that belong to the historian or to the sociologist.

One of the most pernicious, albeit widespread, views of the uneasy relationship between these two subspecies of *homo academicus,* while emphasizing that most historians and sociologists have better sense than to invade each other's ecological niche, suggests that when they do threaten to occupy the same social space, competition is reduced through a kind of division of intellectual labor. In the sociologist's version of this fairy tale, historians are portrayed as underlaborers for the queen of social sciences, engaged in the relentless pursuit of the particular without regard for its general theoretical significance, empiricists whose blind archival burrowings produce mounds of "facts," which then serve as the grist for the grander, *explanatory* science to ponder and process. As Joseph Gusfield puts it, "Historians tell stories without conclusions. [Historical] sociologists tell stories that are mostly conclusions."[1]

That this patronizing and, in my view, intellectually misguided set of claims has aroused considerable resentment in historical circles is scarcely surprising. Most historians, after all, quite rightly see themselves as engaged in the task of *explaining* and not simply reproducing the past and are disturbed at the crude and cavalier approach to the difficulties of reconstructing historical reality characteristic of most sociology of this sort. And, unfortunately but inevitably, there are plenty of examples of a "historical" sociology that eschews any but the most superficial acquaintance with the past and with the tools of the historian's trade, neglects (and even rejoices in an unconcern with) the difficulties and rewards of archival research, and blithely seeks either to cram the complexities of the past into a Procrustean bed of transhistorical "theory" or to reduce social reality to the banalities of lower mathematics, in the worst cases engaging in a little of both.

But if there are—all too often—ample grounds for the historian's suspicion of the sociological imagination, there is also good reason for regret that this should be so. The distinction between the idiographic and the nomothetic, valuable enough if it refers to a tension embedded in all attempts to grapple with social reality and to the *relative* emphasis on the particular or the general to be found in any specific piece of scholarship, threatens to be quite pernicious if it is reified and taken to refer to a real *opposition,* a binary choice between two mutually exclusive approaches to the study of human society. To the contrary, while generalization based on third- or fourthhand acquaintance with historical reality (and often a superficial and highly selective encounter at that) raises grave questions about the ontological status of the proffered accounts, a resolute emphasis on the uniqueness of events, if taken at face value, simply dissolves into solipsism. Any attempt at description and explanation necessitates a resort to abstraction from the endless particularities of the individual case, a reliance on generalization and the use of analogy, and an explicit or implicit comparison of one set of events with another.

One may quite reasonably object to the grandiosity of much sociological generalization and to the absence of concern among all too many of its practitioners with the constraints and disciplines imposed by the richness of the historical record. One may sensibly take issue with the tendency to value, in Gusfield's terms, the conclusions over the story, heedless of the epistemological difficulties—to say nothing of the empirical distortions and inaccuracies—that such a preference invites. But neither of these arguments confers exemption from the dilemma confronted by all practitioners of the historical and social disciplines: that the ceaseless flux of social reality can be ordered, however provisionally, only by means of reasoned thought and comparison. And this process must of necessity rely on principles of classification imposed upon rather than drawn from that reality.[2] Historians are as subject to this imperative as sociologists because, ultimately, the distinction between the two disciplines is by and large an artificial and unfortunate one, however, entrenched it has become over the years in institutional structures and no matter how skillfully it is now rationalized by the self-interests of academic guilds.

Undesirable as the separation of history and sociology may be, still it constitutes, as Durkheim would say, a social fact, with whose ramifications one must necessarily come to terms. Responding, as they must, to a variety of factors—pressures to maximize the perceived distinctiveness of one's discipline; the consolidation and entrenchment, through the specialization and professionalization of scholarship, of different criteria

for evaluating intellectual merit; and the parochialism of contemporary academic life, which tends to create powerful linkages between one's nominal disciplinary affiliation and the type of work that is encouraged and recognized as legitimate—it should come as no surprise that historians and sociologists are frequently so much at odds, even (perhaps especially) when cultivating the same territory. But such squabbles are nonetheless regrettable, the more so since neither side possesses a monopoly of virtue.

Justifiably, historians complain that many sociologists neglect the first requisites of historical understanding. But in their eagerness to point out the motes in the eyes of the sociologists, they are all too ready to overlook the beams in their own. For a sensitivity to questions of evidence and interence must be combined with theoretical sophistication and vision, and understanding the particular necessarily depends on an ability to place one's findings within a broadly comparative frame of reference. All too often historians shy away from making their theoretical assumptions and interpretive frameworks explicit and regard comparative statements with ill-concealed suspicion and distaste—as if attending to such matters might contaminate the attempt "to understand the past on its own terms." To the contrary, this evasion leaves one's criteria of selection and relevance underdeveloped and unself-conscious, hence unchallenged and ill thought through; and it constricts one's vision, distorting the sense of perspective so as to leave in obscurity aspects of historical reality that acquire meaning only when placed in a larger contextual frame. The extent to which my own contributions to the history of psychiatry are distinctive is, I like to think, a result of my attempt to marry the traditional concerns of the historian and the sociologist: a willingness to do my historical homework, coupled with a concern with implicit or explicit

comparison, with the more general significance of a given set of phenomena, and with issues that transcend the particularities of person and place.

Offering reflections on historical as well as contemporary issues, as I have done here and elsewhere, carries with it both risks and potential benefits. One's position on contemporary dilemmas may, of course, contaminate one's researches on the past, producing a narrow teleological history that abstracts both selectively and misleadingly from the record to provide a version of developments that neatly confirms one's current political prejudices. Gerald Grob and Jacques Quen have been bitterly critical of "revisionist" historians of psychiatry (most especially of David Rothman) on precisely these grounds, and their objections are not to be minimized, even though they apply with equal or greater force to those using them as a cudgel *pour épater les autres* . For whatever Rothman's deficiencies in this regard (an issue I discuss on occasion in other chapters), the much more common problem is precisely the reverse: the construction of versions of the past that serve (in ways generally obscured from

those offering such accounts) to legitimate the activities of psychiatrists in the present.

This problem is scarcely unexpected, given that, until recently, much psychiatric history has been written by amateur historians, and a peculiar group of amateurs at that—psychiatrists themselves. Occasionally, as in the case of Richard Hunter and Ida Macalpine, this situation has produced work that, notwithstanding its obvious partiality, has been of lasting value. In the more usual case, however, the resulting distortions have fatally compromised the accounts offered.[3] Nor have psychiatriststurned-historians been the only offenders in this regard, since the claims of the profession to rest its clinical practice on a scientific basis have led others to accord its activities a privileged ontological status, safe from even moderately searching critical scrutiny. Such "responsible" and sanitized history can expect a generally warm welcome, coinciding as it does with the received wisdom propagated by those whose claim to moral authority over the mad is sanctioned at once by law and by duly certified scientific expertise.

We know, of course, that history is always a matter of reconstruction through the filter of memory and that, to borrow Robert Castel's vivid phrase, all memory is built upon a foundation of forgetfulness (a forgetfulness, one must add, that is anything but random).[4] Furthermore, there is much in our societies' responses to madness, both past and present, that we are all too ready to consign to oblivion. Perhaps it is for this reason that one of the main functions of the history of psychiatry has traditionally been to provide a seemingly inexhaustible supply of images and exemplary tales documenting our passage from the barbarousness of the past into the enlightenment of the present: a movement from the dark period in which lunacy was not recognized as a condition requiring medical treatment, through a long struggle in which the steady application of rational-scientific principles produced irregular but unmistakable evidence of progress toward humane and effective treatments for those afflicted with mental alienation, to our present state of grace.

Within such a vision, we can persuade ourselves (as each generation before us has done) that we stand on the threshold of those discoveries that will finally banish the mysteries surrounding the etiology of madness, ushering in a Golden Age of understanding and practical treatment. It may well be, indeed, that it is precisely our repressed uncertain-

ties about the limits of our current understanding (compounded by the natural anxieties that must attend the daily confirmation of our relative impotence in the face of the more serious forms of alienation) that account for the tenacity and fervor with which so many cling to the myth of progress. To recover the horrors of a prescientific past is to bolster the assurance of escape from darkness into light, an assurance clung to the more desperately the less securely it is anchored in one's mundane experience.

In the last analysis, of course, one's view of the past is necessarily conditioned by the present in ways both large and small, perceived and unperceived. Conversely, to assert that an understanding of the past somehow contributes to a firmer grasp of contemporary realities is to endorse what is too often a banality bereft of any substantive content. Yet the very intractability of the dilemmas we confront in endeavoring to respond to unreason,

the peculiar and multiple interpenetrations of past and present that mark the psychiatric domain, the tendency (nowhere more evident and lamentable than here) for "progress" to mask repetitions at once both tragic and farcical, inescapably force historical echoes and parallels into our consciousness.

At the very least, for example, I would hope that those encountering our contemporary reformers and ideologues, who urge deinstitutionalization and praise the virtues of "community," may acquire a certain necessary skepticism from recalling how fervently their nineteenth-century counterparts once preached the gospel of retreat from the world and seclusion within the walls of the asylum.[5] Similarly, both those who urge liberty for the lunatic and those who on the contrary complain of patients "dying with their rights on" play out scripts with a long and checkered history.[6] And the metaphysical wager on a biologically reductionist account of mental disorder made by those who like to think of themselves as being on the cutting edge of modern psychiatry turns out to represent the latest twist on an oft-told tale—one whose full implications await a larger and more sustained analysis than has yet been provided.[7]

I began work on madness and its place in the social order in the early 1970s, the heyday of a romantic antipsychiatry that somehow attracted adherents ranging from the libertarian right to the self-consciously communitarian left. It would be disingenuous to pretend that this intellectual climate was somehow irrelevant to my own concerns and emphases.

For example, I largely concur with (and hope to develop in novel and defensible directions) the stress that this diverse literature places on the ways in which the recognition and response to mental disorder are inextricably culture-bound. Likewise, I have consistently argued that "madhouses, mad-doctors, and madmen" must necessarily be viewed in their sociological context, with much unavoidably remaining opaque and hidden from view till one penetrates the screens of ideology and makes sense of the impact of professional interests, changing social structures and relationships, and shifting forms of power. In my judgment, the usefulness of such claims is not to be demonstrated through abstract polemics, but through the examination and explication of concrete instances where these forces are at work.[8]

At the margin, what constitutes madness strikes me as fluctuating and ambiguous, indeed theoretically indeterminate, making its boundaries the subject of endless dispute and anxiety. Madness is, as Michael MacDonald has so felicitously put it, "the most solitary of afflictions to the people who experience it; but it is the most social of maladies to those who observe its effects,"[9] for its definitions, its boundaries, its meanings are but a distorted mirror image of the shifting social order. Moreover, those who claim the ability to decide for the rest of us where to draw the necessary moral and political lines continue to suffer from embarrassing intellectual vulnerabilities, to say nothing of an all-too-visible therapeutic impotence. My work, like that of the antipsychiatrists, is thus marked by a pronounced skepticism concerning psychiatry's self-proclaimed rationality and disinterested benevolence, a skepticism rooted in what is, on the whole, a dismal and depressing historical record.

On the other hand, I share with many of my fellow critics neither the perception that mental alienation is simply the product of arbitrary social labeling or scapegoating, a social construction *tout court,* nor the notion that psychiatry can be dismissed as merely a malevolent or cynical enterprise. I have never been comfortable with such romantic views of those incarcerated as crazy, which in my view elide and ignore the chronic demoralization and all-too-permanent incapacities that so frequently follow the descent into madness and grossly oversimplify their likely etiology. Nor do I find a simplistic portrait of psychiatrists as concentration camp guards or manufacturers of madness analytically helpful or substantively persuasive.[10] I have thus been increasingly troubled by the dis-

position shared by such disparate figures as Thomas Szasz and R. D. Laing, Thomas Scheft and Erving Goffman, and Michel Foucault and his epigones to play down the degree to which behavior recognized as mad was (and is) genuinely problematic—to say nothing of

their willingness either to ignore the enormity of the human suffering and the devastating character of the losses sustained by victims of this form of communicative breakdown or to lay the blame for whatever pathology they *do* acknowledge squarely and solely on the shoulders of a misguided or actively harmful profession. While I have argued elsewhere[11] that the sources of our current turn away from the asylum are not in the last analysis to be sought in an intellectual disenchantment with orthodox psychiatry and its works (indeed, I have contended that deinstitutionalization and the associated abandonment of the chronically insane has taken place with the active support and connivance of the mainstream of the profession), still the antipsychiatrists cannot escape their share of the responsibility for recent "reforms," if only for unwittingly providing an ideological figleaf with which to camouflage a policy of malign neglect.

The history and current state of both psychiatry and the objects of psychiatric attention are, of course, subjects of enormous complexity. And despite the increased attention they have attracted over the past decade and a half, our ignorance and uncertainties manifestly loom larger than those areas about which we can feel reasonably secure. Faced by such vast expanses of the unknown, the conventional historian seems to opt, on first instinct, for the narrowly circumscribed monograph, implicitly hoping that the accumulation of a whole series of these will ultimately, in Baconian fashion, provide the basis for the inductive con-

struction of a picture of the larger whole. I have my doubts. The more likely result of ceding the field to those "who keep their noses buried in dusty files in the Public Record Office—or County Record Offices or libraries"—while resolutely shying away from broader questions or a broader context is that, for lack of a larger perspective, history will be reduced to simply one damn thing after another, that those noses will be lifted from the dust "only to tell us that they find the detailed process of interaction between the various individuals involved too complex to yield any overall patterns."[12]

During the 1970s, however, many of those working on the history of psychiatry quite decisively avoided any such narrowness and constriction of vision. If anything, the dominant tendency was to move in the opposite direction. For one of the side effects of the enormous influence of Michel Foucault's *Madness and Civilization,* with its grandiose attempt to offer a reinterpretation of Western Europe's encounter with unreason from the waning of the Middle Ages to the advent of industrial capitalism, was to provoke a number of other wide-ranging surveys of portions of this territory. These were ambitious studies in their own right even if they lacked some of the rhetorical ostentation and temporal sweep of the original. Books like Klaus Doerner's *Madmen and the Bourgeoisie,* David Rothman's *The Discovery of the Asylum,* Robert Castel's *L'Ordre psychiatrique,* and my own *Museums of Madness* forced a wholesale reexamination of the transformation of social ideas and practices vis-à-vis the insane during the eighteenth and the first half of the nineteenth century. In the process, they fostered heated debates and reassessments and opened up an array of provocative questions demanding further research. If, in the ensuing decade, peregrinations through the dusty archives have been pursued with a new vigor, they have at the same time been undertaken in an infinitely richer theoretical and historiographic context and, more often than not, have been motivated by the desire to refine or refute some of the assertions made in these larger surveys of the terrain.

The first generation of these more detailed studies are now beginning to see the light of day, first as doctoral dissertations and, increasingly, as articles and monographs. Anne Digby has recently provided us with a searching reexamination of the history of the York Retreat—along with

its symbolic antithesis, Bethlem, one of the two most famous institutions in the history of Anglo-American psychiatry.[13] Nancy Tomes and Charlotte MacKenzie have written model studies of nineteenth-century institutions, in the United States and England, respectively,[14] which concentrated on an upper-class clientele. With their restricted and privileged patient population, these are asylums whose history is in many ways quite different from that of the public hospitals in which the bulk of the insane were confined. But precisely *because* of the character of those they served, their archives are unusually

rich and detailed, making possible, for instance, the reconstruction of the processes leading to commitment, the patients' families' views of mental disorder, and the daily routines of asylum existence in ways that the more voluminous but necessarily more superficial records of the public sector scarcely allow. Moreover, the examination of elite practice has, of course, its own special interest and significance, provided we remain constantly sensitive to the limitations on generalizing the findings.

Others have wrestled with institutions treating the opposite end of the social spectrum. In a splendid series of articles, John Walton has made use of the surviving records of the Lancaster County Asylum to explore how paupers were cast out of the community into the world of the asylum (and, more rarely, were brought back in); and he has exploited the opportunity offered by a more intensive examination of the history of an individual asylum to grasp the relationship of local developments to the broader national picture, as well as to question and, if necessary, to redraw, some portions of the larger portrait others have previously provided.[15] Ellen Dwyer has contributed a comparative study of the Utica State Hospital (original home of the *American Journal of Insanity*, now unfortunately renamed the *American Journal of Psychiatry*) and the Willard

State Hospital, a controversial institution set up to cope with New York State's overflow of chronic and incurable lunatics.[16] And focusing on a figure notable "not [for] his originality, but his very lack of it," Samuel Shortt has looked at the theory and practice of late-nineteenth-century psychiatry in a provincial Canadian asylum.[17]

Nor has the spate of new work been confined to the study of patients and institutions. The interaction between psychiatry and the law has always been the site of highly charged conflicts whose symbolic importance has far outweighed their apparent practical significance. While psychiatrists have repeatedly sought to remove their discourse to a plane where it would be accorded the objectivity of physical science, the legal system has exhibited persistent skepticism and doubts, remaining wedded to a commonsense schema wherein will or intention, the voluntary basis of action, assumed a central place; and, to the doctors' dismay, the law has periodically displayed considerable hesitations over the appropriate criteria and procedures for certifying someone as mad. Portions of this territory have now begun to receive close and epistemologically sophisticated attention.[18] In a very different vein, Nicholas Hervey has provided a meticulously researched examination of the most important nineteenth-century effort to regulate Victorian psychiatric practice and institutions, the English Lunacy Commission.[19] And, as I shall discuss at more length later in this chapter, a number of scholars have begun to examine the *content* of psychiatric theories and therapeutics in greater depth.

This voluminous outpouring of monographs has, quite naturally, presented us with a more nuanced and complex view of the history of madhouses, mad-doctors, and madmen (and even taught us something about

madwomen).[20] Almost without exception, though, the new work in the field remains marked by and in many ways deeply indebted to the earlier generation of revisionist studies. Mercifully, in consequence, we have been spared a return to a "public relations" history of psychiatry and have likewise not had to endure a revival of "historiographic nihilism or mindless empiricism."[21]

Recent scholarship hews to no consistent ideological line. That the socalled revisionist historians of psychiatry likewise did not constitute a unified counterorthodoxy scarcely requires demonstration. The historiographic essay that appears in Chapter 2 of this book was originally prepared for a conference on the meaning of nineteenth-century moral reform, at which David Rothman and I debated our sharply differing interpretations of the "discovery of the asylum."[22] Those who read even my half of the debate cannot harbor any illusions about the construction of a new revisionist consensus, even in an Anglo-American context, and the divisions between the Anglo-Saxons and the French are, if anything, still more marked.

In one sense, these divisions may seem odd, since all of us writing in the seventies and eighties owe multiple debts to the major figure of the French poststructuralist school, the

late Michel Foucault. On the purely mundane level, it was surely the reception accorded to Foucault's work, and the stature he came to occupy in both the academy and café society, that played a major role in rescuing madness from the clutches of drearily dull administrative historians and/or psychiatrists in their dotage, giving the whole topic the status of a serious intellectual subject and thus attracting us to it in the first place. More broadly, whatever else he may have suffered from, Foucault did not lack for intellectual daring, and most of the best recent work in the field for the past fifteen or twenty years can be seen as responding, at least in part, to the intellectual challenges he threw down.

But Foucault was a very peculiar academic animal, in some ways suggestive of an escapee from the bizarre bestiary of Borges' Chinese encyclopedia, whose categories he himself reproduces with such relish at the

beginning of *The Order of Things:* "(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."[23] Certainly he was not a historian in any ordinary sense of that term, and his work is marked by an audacious unconcern for the canons of historical scholarship and a cavalier way with evidence never likely to command universal assent. Nor is his philosophical baggage such as to guarantee widespread acceptance, at least outside those avant-garde intellectual circles wherein the sun is presumed to rise and set on the Left Bank of Paris. And his labyrinth of language, self-consciously obscure and opaque, "in which," he confesses, "I can lose [even] myself,"[24] is notoriously ambiguous and impenetrable. Perhaps it is not surprising, in these circumstances, that so many of the Anglo-American obeisances to Foucault involve ritual rather than substance and may be accompanied by complaints that his work is "too abstract, too angry, or too difficult to be of much use."[25] Yet besides these ritual acknowledgments (themselves a gesture of not inconsiderable significance), there are others who continue "to regard him as a historian and often extract historical details from him."[26]

In reaching any balanced assessment of *Madness and Civilization,* we need to bear in mind that Foucault himself later repudiated much of the analysis he had presented there. In part, this turnabout reflected a major shift in his general perspective, involving a heightened emphasis on the inextricable interconnections of power and knowledge (the "power-knowledge spiral") and a stress on the *productive* effects of power.[27] In-

stead of the *repressive* activities of a psychiatry concerned to stifle and conceal the ultimate affront to bourgeois sensibilities, Foucault and his followers developed a portrait of a far more thorough-going Orwellian nightmare: a system of control and regimentation ("the carceral archipelago") that operated insidiously and all but invisibly, reaching out to encompass the normal, to snare them within an ensemble of "benevolent" interventions and a discourse of personal fulfillment, and in the process serving to manage and manipulate a universe of ever more "docile bodies."[28] But Foucault also grew increasingly scornful of one of the central features of *Madness and Civilization,* the attempt "to reconstitute what madness might be, in the form in which it first presented itself to some primitive, fundamental, deaf, scarcely articulated experience"; and he forswore what he had there "come close to admitting[,] an anonymous and general subject of history."[29]

English-speaking readers, thanks to an interesting variation on Gresham's Law (the appearance of a bad translation precludes the issue of a good one) have access only to a truncated version of Foucault's original argument. For reasons that remain obscure, what appeared in English was the abbreviated text of the French paperback edition, an abridgment that omitted at least 40 percent of the original version, as well as the bulk of the footnotes and references. (Perhaps Foucault did not object too strenuously, since in this version the transitions between madness in the medieval, the classical, and the modern periods seem much more mysterious than in the original, thus according with his later emphasis on the impossibility of explaining epistemological transitions or ruptures.)

On one fundamental issue, whether the reforms of the moral treatment era constituted a rupture with the past, I think Foucault is more correct than not. Roy Porter, in particular,

[30] has recently sought to argue that, on the contrary, the activities of Samuel Tuke and Philippe Pinel exhibit fundamental continuities with earlier views and practices—a contention that, given historians' proclivity for emphasizing continuities

rather than drastic change, is likely to find a receptive audience. But, granted that Foucault's metaphysics leads him to adopt an overly schematic notion of a radical epistemological break with the past and that one can indeed uncover anticipations and adumbrations of moral treatment earlier in the eighteenth century, still I think he is right to insist on the importance of the *change* that moral treatment represents. My own reading of the evidence on this point is laid out in two related chapters in this book, one (Chapter 3) examining the shifting sense in which madness was seen as subject to domestication, the other (Chapter 4) focusing on the social roots of the altered perceptions that underlay the development of moral treatment.

Ironically, of course, in emphasizing the revolutionary character of moral treatment, Foucault appears to endorse one of the key tenets of the traditional triumphalist vision of psychiatric history. But for him, the revolution does not mark the liberation of the insane from their fetters of iron and shackles of superstition. On the contrary, it constitutes the imposition of an ever more thorough-going "moral uniformity and social denunciation"—the historical moment at which the medical gaze secures its domination over the mad, launching "that gigantic moral imprisonment which we are in the habit of calling, doubtless by antiphrasis, the liberation of the insane by Pinel and Tuke."[31]

Such ringing denunciations embody a rather complex set of assertions, some of which I think are defensible and correct, others quite dubious or wrong. To reduce moral treatment, for example, to a species of imprisonment, a more thorough-going form of repression, is to mask an important truth behind a screen of rhetorical excess. For moral treatment (like the larger reform it spawned) is Janus-faced: *pace* Foucault, it cannot be reduced to "the irruption of a bureaucratic rationalism into a preceding Golden Age of permissiveness towards insanity,"[32] and, from my perspective at least, there are good grounds for preferring the tactful manipulation and ambiguous "kindness" of Tuke and Pinel to the more directly brutal coercion, fear, and constraint that marked the methods of their predecessors; yet one must also recognize that in the not-so-long run, it was the other, less benevolent face of moral treatment that came to the fore. Its latent strengths as a mechanism for inducing conformity made possible the abandonment of the brutal and harsh methods of management that had previously been inextricably connected with the concentration of large numbers of lunatics in an institutional environment. And in placing far more effective and thorough-going means of control in the hands of the custodians while simultaneously re-

moving the necessity for the asylum's crudest features, the reality of that imprisonment and control simultaneously became far more difficult to perceive. So in a wider perspective, the major—if unintended—contribution of those who introduced the techniques of moral treatment was to make it possible, in a very practical sense, to manage and clothe with a veil of legitimacy the nineteenth- and twentieth-century museums for the collection and confinement of the mad.[33]

Similarly, the horrors of the nineteenth-century "loony bins" are real enough[34] so that there is no need to exaggerate their awfulness by conjuring up a contrast with the myth of a primal Arcady prior to the Fall produced by the advent of bourgeois reason. Yet it is precisely such a romantic counterimage that Foucault sees fit to invent, reaching back into the Continental equivalent of Merrie Olde England to draw a portrait of folly freed from pernicious social restraint. In medieval times, he informs us, "Les fous alors avaient une existence facilement errante. Les villes les chaissaient volontiers de leur enceinte; on les laissait courir dans des campagnes éloignées, quand on ne les confiait pas à un groupe de marchands et de pèlerins." More picturesquely still, the mad might find themselves on a perpetual voyage in search of their reason, on one of those ships of fools that supposedly haunted the medieval imagination. (Unlike all the other "vaisseaux romanesques ou satiriques," Foucault hastens to assure us, "le *Narrenschiff* est le seul qui ait en une existence réelle, car ils ont existe, ces bateaux qui d'une ville à l'autre menaient leur

cargaison insensée.")[35]

What can one say? As Erik Midelfort has pointed out, the ship of fools (like Foucault's other striking image of the medieval leprosaria, waiting across three centuries, "soliciting with new incantations a new incarnation of disease, another grimace of terror, renewed rites of purification and exclusion," till they were populated by the mad)[36] is simply a figment of the latter's overactive imagination: "Occasionally the mad were indeed sent away on boats. But nowhere can one find reference to real boats or

ships loaded with mad pilgrims in search of their reason."[37] Where the mad proved troublesome, they could expect to be beaten or locked up; otherwise they might roam or rot. Either way, the facile contrast between psychiatric oppression and an earlier almost anarchic toleration is surely illusory.

Foucault's history of madness allocates a central place to the classical age, the period, as he sees it, of the "Great Confinement." Beginning with the founding of the first *Hôpital Général* in Paris in 1657, the poor, the disabled, the deviant, and the morally disreputable—all those who displayed an incapacity for productive work—were swept up and confined. The mad formed only a tiny fraction of the total, yet Foucault's account portrays the whole episode as constituting a grand confrontation between "reason" and "unreason" that led to a profound shift in social sensibilities: "In the classical age, for the first time, madness was perceived through a condemnation of idleness and in a social immanence guaranteed by the community of labor. The community acquired an ethical power of segregation, which permitted it to eject, as into another world, all forms of social uselessness."[38] It was "the immorality of unreason" that prompted its segregation from public view, as an affront to bourgeois sensibilities.

Madness, it seems to me, is here accorded a much more significant place in comprehending the *ancien régime* 's resort to confinement than its quite marginal role actually warrants. Moreover, because he rejects any explanatory schema in which notions of central state power and the economic determination of action play a central role, Foucault neglects the instructive contrast between the Continental and English experiences in this period.[39] At the same time, he goes badly astray even in trying to account for the French policies, for, as Erik Midelfort points out, "the massive attempt to compel the poor to enter institutions originally set up on a voluntary basis ... has more to do with absolutism and centralization than with bourgeois inspiration."[40]

Developments elsewhere likewise emphasize the central importance of attending directly to the political realm. In Ireland, for example, the pe-

culiar quasi-administrative structure English imperialism imposed had far-reaching effects on the establishment and development of district asylums. Where the strength of localism in England ensured that lunacy reformers there faced a protracted and hard-fought battle to secure enactment of their schemes, in Ireland the conversion of a small governing group to the virtues of the asylum solution sufficed to secure the prompt passage of the necessary legislation, seemingly without much in the way of attention or debate. Subsequently, the authorities in Dublin Castle retained much greater powers over the size and operations of the system than were possessed by their counterparts in London, the lunacy commissioners. The United States presents a different pattern again, its federal structure leaving responsibility for coping with insanity to the individual states. As I analyze in Chapter 5, the continued intellectual dependence of the new republic on Europe profoundly influenced America's first experiments with the asylum; but thereafter the history of American psychiatry is indelibly marked by the dispersion of policy-making responsibility among the several states.[41]

If Foucault's analysis failed to present either a systematic discussion of politics or a serious dissection of economic structures, it also neglected to provide us with any coherent or persuasive account of how professional control over madness was secured by physicians. It is, he claims, "Tuke et Pinel [qui] ont overt l'asile à la connaissance médicale."[42] But Tuke was a layman, and the whole burden of his version of moral treatment constituted "a rather damning attack on the medical profession's capacity to deal

with mental illness."[43] Moral treatment, at least in its English guise, was a *threat* to preexisting medical involvement in the mad business, and, as I discuss later, it took a concerted effort on the part of interested medical men to put down the challenge it posed to their emerging hegemony. And though Pinel was an eminent physician, his experience convinced him that medicine was all but useless in madness, and he concluded that the success obtained in applying exclusively a moral regimen "gives great weight to the supposition, that, in a majority of instances, there is no organic lesion of the brain nor of the cranium."[44] Jan Goldstein's detailed reconstruction of the circumstances surrounding Pinel's

"discovery" of moral treatment has demonstrated quite conclusively "its non-esoteric, lay origins—which Pinel [himself] so proudly and defiantly proclaimed."[45] By his own account, his contribution was to convert this "charlatanistic" technique developed by the lay *concierges* who had dayto-day charge of the insane "into a respectable tenet of official medicine," a scientizing project he accomplished through philosophical specification of the mechanisms of both cause and cure and through the application of statistical methods to measure and confirm quantitatively "the efficacy of the treatment."[46]

In Pinel's eyes, "the lay *concierge*, as diligent, perceptive, and talented as he might be, was inalterably the intellectual inferior of the *médecinphilosophe* . The latter would take the rough-hewn commonsensical knowledge of the former and transform it into something refined, scientific, and esoteric; the elite professional confraternity, at one moment threatened with dissolution by Pinel, was thus fundamentally—and quickly—restored by him."[47] But not always securely. As Dowbiggin has shown,[48] in France, too, moral treatment's implied or explicit denigration of the value of medical treatment on occasion threatened the legitimacy of the physician's presence in the asylum, a problem that long persisted and then recurred, much to the discomfort of later generations of alienists. So the role of Pinel and Tuke in ushering in the Golden Age of psychiatry[49] is at the very least far more complicated and indirect than the reader of *Madness and Civilization* might surmise.

Chapter 6 represents an attempt on my part to examine these issues; it was, in fact, the first essay I published on matters psychiatric. Its focus only on events in the late eighteenth and nineteenth centuries is, I now feel, somewhat misleading. My subsequent researches into seventeenth-and eighteenth-century medical writings, some of which form the basis of the argument presented in Chapter 3 on the domestication of madness, made clear to me that I had underestimated the degree of interest in insanity some medical men displayed at that time. More generally, the passage from an eclectic fusion of the supernatural and the scientific—the religious, the magical, the social, the moral, and the medical—to a purely naturalistic and secular account is unquestionably more complex and convoluted than a narrow focus on nineteenth-century developments would lead one to believe. Michael MacDonald, for example, has plausibly argued, in his splendid *Mystical Bedlam*, [50] that a preference for natural causation and a "hankering after the bare Mechanical causes of things,"[51] which entailed a disposition to reject demonological and supernatural accounts of madness, grew ever more widespread among the English elite in the aftermath of the Restoration, in substantial measure as part of a conscious rejection of religious fanaticism and "enthusiasm."

At the same time, as MacDonald himself concedes, "ordinary men and women were reluctant to abandon beliefs that reinforced their view of the universe as a theatre of spiritual warfare between the forces of good and evil, and they continued to fear the power of Satan and malign spirits throughout the eighteenth century."[52] Thus (among other things) they remained disposed to see madness in more traditional terms. Furthermore, evidence that a large fraction of the English elite had come to embrace medical accounts of mental disorder during the course of the eighteenth century does not invalidate the claim that the ineffectiveness and scandals associated with medical treatment, in the context of the emergence of the lay vision of moral treatment, posed a potentially powerful threat to medical hegemony at the outset of the following century.[53] I continue to believe, in consequence, that the account I offer here of the cognitive and legal entrenchment of a

medical monopoly over the treatment of madness retains much of its force and relevance.

Recent work has begun to examine in more extended contexts the sig-

nificance of psychiatry's commitment to the somatic style, and this is likely to be a continuing focus of future research in the field. Reflecting the poverty of its cognitive accomplishments, its persistently dismal therapeutic capacities, and the social undesirability and disreputability of most of its clientele, psychiatry has enjoyed a perpetually marginal and unenviable position in the social division of labor—a profession always, so it seems, but a step away from a profound crisis of legitimacy.[54] Without question, its repeatedly successful defense of its tenuous social mandate has had multiple sources, many having little to do with its ideological presentation of self: the absence, for instance, of plausible rivals for its role; the continuing social utility of medical discourse as a rationalization for measures of intervention and control directed at the acute and persistent problems posed by the mad; and the real, if sharply circumscribed, impact of medical technology on the more florid manifestations of madness. Still, as a growing body of research repeatedly demonstrates, the organic metaphor, periodically reworked to bring psychiatric language into plausible correspondence with the reigning models of the somatic machine that characterize the medical mainstream, has been (as it continues to be) of quite central importance in establishing the psychiatrists' exclusive jurisdiction over the insane, their expertise as medical specialists, and popular acceptance (however grudging) of that expertise.

Stephen Jacyna, for example, has provided a detailed and searching examination of English psychiatric ideas in the mid-Victorian era,[55] pointing out the intimate connections between the rise of an aptly named "physiological psychology" and its polemical usefulness "to entrench and to enhance ... professional prerogatives." Reflex models of nervous function had come to dominate British neuroscience by the mid-nineteenth century, and over the next decade and a half it was in terms of reflex action that British alienists increasingly couched their explanations of insanity. But the construction of these connections masked a huge gap between scientific pretensions and reality. The use of reflex theory was crude and casual. What masqueraded as inferences from the latest developments in neurology was in fact simply the restatement of "old doctrines in a novel idiom." For beneath "the thin veneer of modernity" provided by the appropriation of the language of neuroscience there lurked a continuing attachment to a vascular, inflammatory etiology of insanity.[56]

In an important series of papers,[57] focusing on the last third of the nineteenth century, Ian Dowbiggin has similarly sought to connect French psychiatry's precarious social and scientific standing to the question of theory choice in the discipline. His discussion demonstrates how, in a very different sociopolitical and scientific setting, the theory of morbid heredity and degeneration "offered a loosely defined yet appealing cognitive model through which psychiatrists could terminate the theoretical conflicts dividing their profession and simultaneously counter their declining image, gain intellectual legitimacy through identification with the more fashionable biological sciences, and accommodate themselves to a general pessimism that characterized nineteenth-century French currents of thought."[58] Particularly salient in the French context was the persistent threat posed by clerical interest in the problems of insanity,[59] hence one powerful and culturally specific source of pressures to reemphasize the centrality of the body. But, more generally, the profession's therapeutic impotence, the psychiatrists' own growing despair, the massive overcrowding of French asylums, and the low esteem, even outright hostility, with which psychiatrists were greeted by the French public made them a beleaguered group desperate to hang on to the threads of respectability. Not just the persistent inability to discover cerebral lesions in autopsies performed on the insane, but also the developing rejection of the doctrine of pathological anatomy among members of the Paris School of Medicine forced alienists to modify the basis of their claim that madness was rooted in disorders of the soma. Yet their conviction remained unshakable that insanity was brain disease. It was a proposition, for them, not intelligibly subject to doubt, for to question it

was to challenge their claims to objectivity and to scientific status, the very basis of their privileged and authoritative role in the diagnosis and disposition of the lunatic.

But the persistent recourse to somatic theories of mental disorder has a much broader significance than its role in convincing political elites to legislate in favor of medical interests. As Roger Smith has rightly suggested, if we are to comprehend the "more subtle role played by belief as a cultural resource, and not just as a vehicle of professional advance-

ment," we must necessarily pay close attention to the detailed content of medical theories.[60] Much of the time, for example, psychiatry has derived, not only its mandate, but also its therapeutics from its metaphysical embrace of the body. Repeatedly, an emphasis on physical pathology has prompted the employment of physical treatments. Henry Maudsley articulated the logic of this position with characteristic bluntness: "That which ... has its foundation in a definite physical cause must have its cure in the production of a definite physical change."[61] The alternative could be speedily and scornfully dismissed. "No culture of the mind, however careful, no effort of will, however strong, will avail to prevent irregular and convulsive action when a certain degree of instability of nervous element has, from one cause or another, been produced in the spinal cells. It would be equally absurd to preach control to the spasms of chorea, or restraint to the convulsions of epilepsy, as to preach moderation to the east wind, or gentleness to the hurricane."[62]

As Michael Clark has brilliantly demonstrated,[63] in this fierce rejection of psychological approaches to mental disorder, Maudsley was entirely representative of his generation. Moreover, his convictions were firmly anchored in the "deep structures" of Victorian psychiatric theory, notwithstanding that somatic-pathological approaches to insanity (borrowing, by now, from the French emphasis on degeneration and morbid heredity), embodied a double failure: they yielded little in the way of increased *scientific understanding* of the etiology and pathology of insanity; and, equally, they possessed no clear-cut or decisive *therapeutic advantages* over "moral treatment" or other purely empirical nonmedical methods when it came to curing the insane.

Though we lack a full-fledged study of comparable scope and sophistication for the United States in the same period, it is apparent that not just institutional psychiatrists, but also such emerging specialisms as neu-

rology and gynecology, competitors with the more established professionals for patients on the borderland of insanity,[64] evinced a similarly thorough-going materialism.[65] Much of neurological therapeutics, for example, from the elaborate shiny machines for administering static electricity to S. Weir Mitchell's famous "rest cure" (which involved isolation from one's family, rest, diet, massage, and absence of all responsibility), to our eyes depended for its efficacy largely on its psychological impact on the patient. But while acknowledging that individual suggestibility sometimes played a part in a cure, the neurologists remained deeply antagonistic, not merely to psychological *explanations* of insanity, but to any sustained or systematic attention to mental therapeutics. Mitchell himself, though he accepted that there were some similarities between his rest cure and the activities of exponents of religiously based "mind cures," insisted that the fundamental impact of his approach derived from its contribution to building up the patient's "fat and blood."[66] And when George M. Beard had the temerity to suggest that "expectation is itself a curative force,"[67] he met with furious criticism from his colleagues, who denounced him for descending "to the level of all sorts of humbuggery."[68]

There is ample scope for further interrogation of these nineteenth-century materials, but the work done to date has already opened up a number of further lines of inquiry, exploration of which is only just beginning. In the first place, the twentieth century provides perhaps the most startling examples of the psychiatric profession's predilection for physical treatments, ranging from malarial mosquito therapy through metrazol-induced seizures, insulin comas, electroshock treatment, and surgical treatments for focal sepsis (not to mention several more exotic, if less widely canvassed, forms of therapy). The list extends, of course, to encompass direct surgical intervention on the organ most often held

to blame for the outbreak of madness, the brain, with lobotomy being one of only two psychiatric interventions held to warrant the award of the Nobel Prize in medicine!

One can easily comprehend why psychiatry might wish to envelop

these episodes in a veil of obscurity, but it is less clear why the rest of us should collaborate in this willful amnesia. For I suspect that their history can provide uniquely powerful insights into the interdependence of the intellectual and the social (a central theme of much of the best recent work in the field) and into the nature of the psychiatric enterprise as a whole. Strategically, too, the latest example of the fascination with facsimiles of more conventional medical therapeutics—the rise of psychopharmacology, associated particularly with the advent of the phenothiazines, the so-called major tranquilizers—appears to have been of quite major importance in the recapture of the commanding heights of psychiatric training programs by biological psychiatry[69] and in the interprofessional competition between psychiatry and the burgeoning numbers of lay psychotherapists, social workers, clinical psychologists, and the like. Its importance notwithstanding, we have as yet investigated only a small portion of this territory in any depth.[70]

Equally intriguing is the opposite line of investigation: how medical resistance to psychological approaches was, in different settings, at least partially overcome, permitting the development of dynamic psychiatry, particularly in its Freudian guise. Apart from the intrinsic interest that attaches to this question, it clearly has a vital and direct bearing on how and why twentieth-century psychiatry was able to expand and diversify the territory it was presumed competent to manage.

Not the least important factor was surely the continuing therapeutic and scientific barrenness of work based on pathological anatomy, and the growing recognition of this as the Victorian era drew to a close. Michael Clark has suggested that "it was an acute awareness of just how lowly, despised and vulnerable institutional psychiatry's existing social position was, and a desperate desire to escape its suffocating constraints

and frustrations, rather than any more vaunting ambition, which drove later-Victorian psychiatrists to broaden and diversify their territory."[71] And, within their own professional circles, Americans quite openly made a similar diagnosis: "Our therapeutics," C.G. Hill complained, in his 1907 Presidential Address to the American Medico-Psychological Association, "is simply a pile of rubbish."[72] Two years later, in his address to his fellow neurologists, Weir Mitchell echoed Hill's analysis: "Amid enormous gains in our art, we have sadly to confess the absolute standstill of the therapy of insanity and the relative failure, as concerns diagnosis, in mental maladies of even that most capable diagnostician, the postmortem surgeon."[73]

But this internal sense of crisis and malaise was clearly insufficient, by itself, to prompt more than public handwringing and lamentations. In the British context, both Elaine Showalter and Martin Stone have suggested that it was a powerful set of social pressures, "the exigencies of war and a mass epidemic of mental disorders"—shellshock among the troops—that constituted the necessary stimulus "to set the mechanism of psychiatric change in motion."[74] Unquestionably, World War I had similar effects in the United States. Here, however, the effects of wartime experience were to speed up a process that had already acquired considerable momentum in the earliest years of the new century. Once again, even with our present rather imperfect understanding of these changes, it seems clear that external developments were powerfully implicated in producing internal realignments of the profession. Most especially, the extraordinarily rapid proliferation of religiously based mental healing cults (of which Christian Science was the most notable) had prompted a growing "exodus of patients from the doctor's waiting room to the minister's study."[75] Faced by people voting with their feet for mental therapeutics, many physicians apparently concluded that patients must be saved from themselves, even if this meant that psychological medicine would have to abandon its traditional "antagonism to methods of treatment which appeal to other than physical means."[76]

At present, too, these are aspects of the evolving relationship between psychiatry and the larger social order that we can glimpse only in broad outline. If we are serious about grasping the unfolding effects of professional intervention in the lives of the mad and about understanding the complexities of the interrelationships between psychiatric power and knowledge, we obviously have a large agenda of research before us. The bulk of recent historical work in the field has concentrated on the eighteenth and nineteenth centuries,[77] and by contrast, our own century, even as it draws to a close, remains for the most part a dark continent in which merely a few prominent landmarks stand out. Only with respect to the last quarter century are things a little better, for this is a territory in which even an ahistorical sociology feels at home and about which it has had something to say.

Indeed, in some respects, sociology has been a *participant* in, rather than just an observer of, recent events. For the sociological critique of the mental hospital's pathologies, along with labeling theory's portrayal of stabilized mental disorder as ironically the *product* rather than the *object* of psychiatry's attentions, played a considerable role ideologically in underwriting the shift from institutional to community care and in prompting the constriction of the permissible grounds for certifying someone as so mad as to need confinement. At the birth of the asylum, reformers conjured up a mythological portrait of its virtues and its startling therapeutic effectiveness. Subsequently, alienists campaigned long and hard (albeit with at best limited success) to persuade the public of the need to adopt broad and easily satisfied commitment criteria: decision rules that would license swift commitment of incipient lunatics to their institutions, before minor eccentricities and mental imbalance passed over into permanent and chronic insanity. Our contemporary myths, embracing exactly the contrary set of assertions, have proved the more powerful since they can claim to constitute the findings of social "science."

One of the virtues of a historical perspective that extends beyond the ideas and events of the past quarter century is that it makes us properly

skeptical about claims of intellectual breakthroughs and the discovery of utopian solutions to the complex and extraordinarily recalcitrant problems we label mental illness. It also leaves us better placed to assess just how novel and original our current enthusiasms really are. Modern sociological critics of the "total institution" have remained blissfully innocent of the degree to which their findings reproduce observations first made a century and more ago.[78] And examination of nineteenth-century debates over what constituted adequate grounds for involuntary commitment to an asylum likewise disabuses us rather rapidly of the conceit that our generation has developed some privileged insight into the dangers of unchecked psychiatric authority over the commitment process.[79] If the social impact of such ideas and criticism turns out to vary sharply over time, it constitutes just one more reminder not only of the profound and inescapable mutual dependence of the social and the intellectual but also of the impossibility of gaining a proper understanding of one without knowledge of the other.

At various times during the past decade, I have been accused both of being viciously anti-institutional[80] and of wanting to reinstitutionalize the mad *en masse* .[81] While I take a certain sly pleasure in having simultaneously ruffled the feathers of the complacent souls who somehow continue to see mental hospitals as "the most blessed manifestation of true civilization"[82] and of the odd mixture of zealots and penny-pinching politicians who continue to call malign neglect "community *care*, " I must respectfully decline both labels. Like the late Peter Sedgwick, my knowledge of what went on in the old "loony bins" makes me want to shout "Never again!" to the prospect of a return to an unreconstructed psychiatric Victorianism.[83] But this must not blind us to the appalling deficiencies of yet another generation of mental health "reforms" or prevent us from recognizing that, as a last resort, sheltered care must remain an option for coping with a minority of the mentally disturbed. Over the past century and a half, we have swung wildly from viewing the asylum as the universal panacea for the defects of the community to seeing the com-

munity itself as a ubiquitous and uniformly desirable solution to the problem of what to do with the mentally defective. But, for all the rhetoric about community treatment, we remain as far as ever from solving the problems of "how to create the economic means of employment, the material apparatus of housing, the ethical structures of friendship and solidarity, for those who through various forms of mental disability cannot purchase these benefits as commodities in the marketplace."[84] Worse still, I fear the balance of political forces in Britain and the United States gives little prospect of major initiatives being undertaken to mitigate or eliminate the deficiencies of existing mental health policy.

Not just the present, but even the future for the chronically crazy strikes me as grimly unpromising. I wish it were otherwise. But, as Freud once taught us, reality, however harsh, is in the long run preferable to the childish consolations offered by a retreat into the realm of fantasy (appealing as the latter may sometimes seem).

Chapter Two
Humanitarianism or Control? Some Observations on the Historiography of Anglo-American Psychiatry

In my experience, large academic conferences are often stupifyingly boring affairs. In general, they appear to have little to do with matters of intellectual substance, providing instead a platform for the posturing and preening of academic narcissists and/or the opportunity for graduate student supplicants to sell themselves to prospective employers. Smaller gatherings, however, sometimes escape this fate, and the conference at which the [following paper was given proved to be one such occasion. In the winter of 1980, the Department of History at Rice University invited David Brion Davis, David Roberts, David Rothman, and me (they must have run out of Davids) to spend several days debating the origins and significance of nineteenth-century moral reform. Both the formal papers and some of the informal discussion were subsequently published as a special issue of *Rice University Studies* . Our disagreements were many, and over the three days, quarter was neither asked nor given. Still, the whole occasion proved to be a consistently stimulating and lively one, conducted on the friendliest of terms. For my part, I was grateful for the incentive to think systematically about the recent historiography of psychiatry and for the opportunity to debate some of the fundamental interpretive issues with David Rothman.

Pace the oddly obtuse readings of the more naive and indignant defenders of the liberal public relations theory of psychiatric history, there exists no unitary "revisionist" school of psychiatric historians. Certainly, Rothman and I had no difficulty uncovering some quite fundamental issues on which we disagreed, notwithstanding our shared skepticism about an earlier conventional "wisdom." Since this essay appeared, a number

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of others have sought to survey the historiography of Anglo-American psychiatry. I find the following particularly helpful and challenging: David Ingleby's "Mental Health and Social Order";[1] John Walton's "Casting out and Bringing back in Victorian England";[2] and Roy Porter, "Shutting People Up."[3] Joan Busfield's discussion in Part 1 of her *Managing Madness* provides a reasonably helpful overview.[4] Finally, Michael Ignatieff's "State, Civil Society and Total Institutions," while only tangentially concerned with matters psychiatric, still contains an interesting assessment of Rothman's work from a self-described "former, though unrepentant, member of the revisionist school";[5] and his "Total Institutions and the Working Classes" provides a more general survey of the territory.[6]

Humanitarianism or Control? Some Observations on the Historiography of Anglo-American Psychiatry

I

To judge by the increasingly strident tone of their mutual recriminations, historians of psychiatry have taken almost too much to heart J. H. Hexter's injunction that "in an academic generation a little overaddicted to *politesse,* it may be worth saying that violent destruction is not necessarily of itself worthless and futile. Even though it leaves doubts about the right road for London, it helps if someone rips up, however violently, a 'To London' sign on the Dover cliffs pointing south."[1] At times, the pro-

tagonists in the debate on the meaning of lunacy reform have given the impression of attempting to destroy, not just each other's work, but each other. On the one side, there have been accusations of attempts to "disguise contemporary social criticism and advocacy as history"[2] and of "destructively misleading" research marked by "errors, inconsistencies, unsupported assertions, and disparaging motivational assumptions" that, taken together, have produced "work that must be embarrassing to the professional historian."[3] And from the object of these assaults have come claims that their authors "rely on platitudes of historiography and straw men" and that the cries of villainy are a "stratagem to give novelty to findings that are now no longer novel."[4] Impelled by logic and evidence to swallow much of the revisionist case, even the opposition's "leading voice" apparently can do no better than resort to "shrillness" in an effort "to differentiate, in however marginal a fashion, his work from theirs. It is like putting a few touches of chrome on an automobile and saying that now a product differs from that of its competitors. Such a tactic may do well in the marketplace, but it has less relevance, one would hope, in the world of scholarship."[5]

Clearly, to venture into this fiercely contested territory is to take one's life (or at least scholarly reputation) into one's hands. Matters take a decided turn for the worse when one enters the combat zone with the conviction that it is not simply that neither side possesses a monopoly of virtue, but rather that both are wrong; for one is now without allies and susceptible to attack from either front or rear. And when the foolhardy intruder is a trespasser from an alien discipline, the risk is high that (like the fate of one who intervenes in a quarrel between husband and wife) the outcome will be an assault from both forces simultaneously. Thus, like the proverbial liberal, I suppose the best I can look forward to is matching lumps on each side of my head.

I I

I think it is only appropriate to begin by acknowledging that the debate on the interpretation of lunacy reform, and more especially the work of

some of those in the revisionist camp,[6] has been the occasion for a significant advance in the historiography of psychiatry. As those who are acquainted with the work of Albert Deutsch on the situation in America or of Kathleen Jones on that in England will be aware, the picture of lunacy reform as on the whole relatively simple and straightforward progress toward enlightenment is far from being merely a straw man, erected solely to exaggerate the novelty and significance of a less simplistic alternative. Rereading even some of the best and most scholarly of more specialized accounts from this era (for example, Norman Dain's[7]) is sufficient to remind us vividly of how deeply embedded "progressive" assumptions were in this period. And a glance at the treatment accorded lunacy reform in such more general surveys of Victorian social reform as David Roberts' *Victorian Origins of the British Welfare State* demonstrates how widespread their influence once was. For proponents of this viewpoint, the direction of the line of march and the sources of the impulse to march were essentially unproblematic:

> The obstacles to the improvement of asylums had been not vested interest but public ignorance and apathy. For centuries [*sic*] that apathy had remained unchallenged, but when nineteenth-century humanitarianism joined with a more scientific understanding of insanity it diminished. Yet neither humanitarianism nor science would have availed much had not government officials investigated the abuses and had not Commons [*sic*] placed asylums under the surveillance of government inspectors.[8]

Whatever the excesses and inadequacies of the various revisionist accounts of lunacy reform (to which I shall attend shortly), one must surely be grateful to them for liberating us from the narrowness and naïveté of a vision that reduced the whole process to a simplistic equation: humanitarianism + science + government inspection = the success of what David Roberts terms "the great nineteenth century movement for a more humane and intelligent treatment of the insane."[9]

We are now aware that such interpretations of social reform in general and lunacy reform in particular function more as intellectual strait-

jackets than as means to insight and understanding. In the present instance, the sources of the movement and the reasons for its success are infinitely more complex, the humanitarianism and the science indisputably more ambiguous, and the intelligence and humanity of the regimen in the public museums of the mad inescapably more dubious than any explanation of this sort allows.

In what follows, I shall begin by discussing in a little more detail the work of David Rothman and Gerald Grob. The former is clearly the best-known American exponent of the revisionist, or social control, approach to lunacy reform; the latter, the most tenacious and sophisticated defender of a modified form of the more traditional wisdom. I shall point to some of the serious reservations I have with the accounts offered by each of them; and I shall then attempt to sketch some elements of an alternative perspective on this example of nineteenth-century humanitarianism (though my account will have reference to England rather than to the United States).

I I I

Despite their sharp and serious disagreements on both the sources of lunacy reform and their overall assessment of the movement, there is a curious formal symmetry in the work of Rothman and Grob. Both place major emphasis in their respective accounts on the stated intentions and more or less acknowledged motivations of the lunacy reformers themselves. But strikingly and significantly, they employ the words of the asylum superintendents and their allies to reach almost diametrically opposed conclusions. As Johnson had earlier suggested was true of the history of schooling, it turns out that "on the basis of this sort of evidence the enterprise may be represented as a quasi-coercive and essentially self-protective response or as the genuine outgrowth of humanitarian Christian consciences."[10]

Out of the arguments of moral entrepreneurs like Horace Mann, Dorothea Dix, and Samuel Gridley Howe and from the reports and other published writings of the less widely known medical superintendents and overseers of the earliest asylums, Rothman constructs an account of the discovery of the asylum that emphasizes its sudden eruption onto the nineteenth-century scene and its uniquely American origins and that locates the source of this transformation of social practices in an "effort to ensure the cohesion of the community in new and changing circumstances."[11] The United States in the second quarter of the nine-

teenth century is portrayed as "a society that has slipped, for reasons that remain unclear, into a temporary state of disequilibrium," and the drive to institutionalize the deviant is itself seen as "a mysteriously diffuse movement toward equilibrium."[12] As Rothman himself puts it,

> The response in the Jacksonian period to the deviant and the dependent was first and foremost a vigorous attempt to promote the stability of the society at a moment when traditional ideas and practices appeared outmoded, constricted, and ineffective. . . . The asylum was to fulfill a dual purpose for its innovators. It would rehabilitate inmates and then, by virtue of its success, set an example of right action for the larger society. . . . The well-ordered asylum would exemplify the proper principles of social organization and thus ensure the safety of the republic and promote its glory.[13]

At the very outset of his analysis, Rothman rightly rejects a vulgar structural determinism that posits an automatic and inevitable linkage between urbanization/industrialization and the rise of the asylum. A few pages later, he insists that "institutions, whether social, political, or economic, cannot be understood apart from the society in which they flourished."[14] Admirable sentiments; and yet in the body of his work, there is never any serious and sustained or clearly articulated attempt to link ideas

and changing social practices with underlying structures. Worse, when his reliance on the ideological level of analysis falters, Rothman tends to resort to the same quasi-magical incantations and invocations of demographic and economic developments that he had earlier stigmatized.[15] Throughout, there is a lack of perception of the fundamental divisions of American society and of the shifting basis and nature of social conflict through time, a deficiency closely related to his failure "to inquire into the group or class interest that institutionalization served" and his inability to see social control as "more in the interest of one social group than another."[16] Instead, there is his constant resort to that curious explanatory variable, "an imaginary homogeneous group labelled 'the Americans.'"[17]

One might well argue that, given Rothman's characteristic analytic strategy, the larger social and political order *necessarily* remains opaque,

since it is generally perceived only dimly and indirectly through the mediation of the perceptions of society's individual members. To the extent that people's ideas are used to demonstrate the existence of the underlying structures and that their *perceptions* of disorder are not kept analytically distinct from the reality of disorder (and Rothman is persistently inclined "to use the reformers' claims of social upheaval as his primary evidence for the existence of disorder"[18]), any attempt to relate ideology and social structure threatens to dissolve into mere tautology. And at the level of the ideas themselves, there is a striking tendency to take the claims made at face value—a failure to perceive the degree to which the talk of looming disorder, the promotion of the institution's reformatory functions, and so forth, were rhetoric (albeit significant rhetoric) designed by a particular social group for particular polemical purposes.

For example, Rothman's analysis neglects the obvious question of "whether it was in the professional self-interest of such reformers to exaggerate the extent of the upheaval in order to help loosen state legislators' purse strings."[19] Was not the anxiety about the stability of the social order the anxiety of a specific stratum, the response of the bourgeois and professional classes to the corrosive effects of capitalism on such traditional precapitalist social restraints as religion and the family? And does not Rothman's approach ignore the still precarious social status of the psychiatric profession, its members' strivings to build a strong institutional base for their profession, and their direct attempt to do so through "the legitimation of the asylum and their own position in it"?[20]

An inadequate attempt to come to terms with the nature of the social and political order is something Rothman shares with that school of sociologists by whom he appears to have been most influenced and among whom he has certainly been most influential—those committed to the labeling, or societal reaction, theory of deviance. Once again, his work demonstrates how this narrowness of vision inevitably leads to an analysis that depicts social control as arbitrary. As Richard Fox has put it, "The social control perspective flattens out . . . vital structural developments by positing an abstract conflict between a group of controllers and their victims, and then by moralistically upbraiding the controllers and their alleged inclination to dominate."[21]

I V

It is, in part, the very weaknesses and excesses of the work of Rothman and other revisionists that have prompted the revival, albeit in a more sophisticated and seductive modern guise, of the traditional meliorist explanation. Gerald Grob, who has been the major figure in this movement, for the most part rests his critique of Rothman on quite other grounds than those I have just outlined. Yet, in the first instance, it is the implicit moral condemnation of the reformers and asylum superintendents that provokes some of his most severe strictures on Rothman's work. Like Jacques Quen, he seems extraordinarily concerned to rescue the reformers' reputation for humanitarianism and benevolence.

Much of Rothman's animus against the reformers (so Grob and Quen allege) derives

from his political stance vis-à-vis contemporary social policy in these areas, most notably a commitment to an explicitly antiinstitutional position. There is, I think, a measure of truth to this claim (and certainly Rothman's nostalgic evocation of a preinstitutional Golden Age, the Paradise Lost with the advent of the asylum, has been eagerly embraced by the deinstitutionalization ideologues). But there is a tendency here to refuse to see in their own eyes the motes they are so eager to point out in his. For their interpretations, and those of the other scholars in the field who receive their imprimatur,[22] are equally evidently grounded in a fundamental acceptance of a vision of history most congenial to (because supportive of) the powers that be and in a largely uncritical adherence to orthodox liberal pieties.

Grob's own thesis is more deeply embedded in his materials than Rothman's, and thus less immediately apparent to the casual reader—as perhaps befits one who lays such stress upon "understanding the past on its own terms." After all, the more open one is about one's interpretive framework, the more vulnerable one is to the charge that one's conclusions have been allowed to shape the selection of data, rather than the other way around. But this is not to say that in Grob's work the past in some mysterious way speaks for itself or that no organizing intelligence intervenes here. To the contrary, Grob's vision of social process and his metahistorical assumptions continuously affect both his selection and his presentation of materials. Theoretical models are not absent, merely underdeveloped and unself-conscious—and hence underscrutinized.

Grob is scornful of those who attribute the growth of the mental hospital to the attempt by dominant elites to restrain "deviant groups or largely lower-class elements, thereby ensuring some measure of social control (if not hegemony)."[23] As he views it, "A few saw reform as a con-

servative phenomenon in that it would diminish class rivalries and antagonisms and thereby preserve a fundamentally sound and moral social order. But many more were primarily concerned with uplifting the mass of suffering humanity and were not particularly aware of political or economic considerations."[24] In arguing for the contrary position, the social control theorists have confused "the by-product with the primary intention."[25] And they have persuaded others of the correctness of their position primarily by illegitimately attributing motives on the basis of the consequences of the reformers' actions.

The danger in this, as Grob sees it, is clear:

> It is, after all, extraordinarily difficult to infer motives from outcome without adopting a viewpoint that makes events the result of strictly rational, logical, or conscious behavior. Nor can we assume with any degree of confidence that undesirable consequences flowed from callous behavior or malevolent intentions, even though such elements were by no means absent.[26]

Yet even assuming that Grob has correctly judged which of these intentions were primary (and while the identification of human motivation is a peculiarly treacherous business, he presents no real arguments for this crucial assumption), and leaving aside the difficult issue of penetrating to unacknowledged but possibly powerful motives, he takes the content of their "benevolence" all too much for granted. And behind this there looms a still larger issue, to which I shall recur: "How far is it sufficient to comprehend [developments] in terms of the conscious purposes of contemporaries? Or should we not be concerned with the working out of unconscious function within some wider system of change?"[27]

If the origins of reform are here to be sought in benevolence (coupled with the pressures created by demographic change and the spread of new ideas about the treatment of mental disorder from France and England), what of its subsequent fate? Grob's answer is heavily conditioned by his view of nineteenth-century social policy as essentially incremental in character. Rather than being the result of conscious choices by legislators and officials, it represents the sum total of a series of unrelated

decisions.[28] Further, the absence of effective means of collecting and analyzing empirical data "often led to the adoption of policies that in the long run had results which

were quite at variance with the intentions of those involved in their formulation."[29] (Again, he sees this circumstance as rescuing "nineteenth-century legislators and administrators" from misplaced charges that they "were deficient in intelligence or malevolent in character."[30])

Within this overall framework, Grob then points to a number of more specific factors that he sees as linked to the collapse of the asylum's pretensions to cure.[31] The list is a long one: the growing size of the asylum; the influx of the lower classes, and particularly of the Irish and other ethnic groups; the consequent financial undernourishment of the system; the accumulation of chronic, incurable inmates; the difficulties associated with the "routinization of charisma," as one generation of asylum superintendents succeeded another; and the transformation of the mental hospitals into "strictly welfare institutions as far as their funding and reputation were concerned," thus solidifying "their custodial character."[32] All these developments, we are informed, "took place in several distinct stages and without any particular awareness of the eventual outcome."[33] In this sense, he sees them as once more affirming one of his central theses, the accidental and "nonmalevolent" character of reform.

At this point, therefore, even Grob is driven to concede that, looked at without rose-tinted spectacles, Victorian lunatic asylums in many ways present a dismal and depressing picture. And yet, if the *results* can scarcely be applauded, or must be damned with faint praise, the benevolent *intentions* remain. Apparently, the history of lunacy reform records the efforts of a largely well-intentioned group of men (and the occasional woman) whose endeavors mysteriously always produced accidental and unintended unpleasant consequences. However unattractive, the institutions they founded were not "inherently evil." On the contrary, "mental hospitals were not fundamentally dissimilar from most human institutions, the achievements of which usually fall far short of the hopes and aspirations of the individuals who founded and led them."[34]

But this simply will not do. In the first place, conceptualizations that operate through individuals' decisions or behavior are simply incapable of adequately reflecting social reality, both because "the policy or action of a collectivity [is in many instances] not attributable to particular individuals' decisions" and because the form of the organization (or social system) may itself generate systemic effects. In particular, the bias of the system is not sustained simply by a series of individually chosen acts, but also, most importantly, by "the socially structured and culturally patterned behavior of groups, and practices of institutions, which may indeed be manifested by individuals' inaction."[35]

With outcomes viewed as the product of benevolence combined with an endless series of incremental changes, no one of which was decisive and each of which is entitled to virtually equal explanatory weight, even the most flagrant examples of misery and inhumanity can be portrayed as largely accidental, and in any event as in no way calling into question the fundamental goodness and legitimacy of the social system within which they occurred. A neat reconciliation is thus effected between apparently contradictory phenomena, in such a fashion that the myth of the social system's basic humaneness is further strengthened and supported. Hence, I take it, the shrillness with which Grob insists upon the primary, the virtually unqualified, hegemony of benevolent motives. For it is precisely the benevolence of the intentions that rescues the whole enterprise of "reform" from the insinuations of the revisionists and other critics, leaving us to ponder the ironies of unintended consequences and historical accident—even while, as Ignatieff puts it, "maintaining the state's reputation as a moral agent."[36]

On any number of levels, therefore, the view of reform as the product of the "accidental," malevolent distortions of a Manichean world represents a denial of, or a failure to come to terms with, the multiple ways in

which structural factors constrain, prompt, and channel human activities in particular directions. On a deeper level, consequences that appear unintended and "accidental" considered from the viewpoint of the individual actor remain susceptible to investigation and explanation. Such explanation will always involve some abstraction from the complexities and particularities of individual events, and thus inevitably will do some

violence to the richness of the historical record.[37] But, as Lawrence Stone has pointed out, if we are to explain anything at all, we must inevitably risk generalization and the use of analogy; indeed, without them we cannot so much as describe what we have found.[38] To denounce such attempts as producing "oversimplification of complex social processes,"[39] to insist too resolutely on seeing events as "process"[40] or "one damn thing after another," is virtually to guarantee explanatory impotence—to reduce explanation to a banal mixture of individual intentions (which in the present context are for Grob almost universally "the best and most honorable of intentions"[41]) and inadvertent transformations (through a series of events, "many of which were unanticipated and unpredictable"[42]) that lead society in spite of itself in morally unfortunate directions."[43]

V

In some of my own work on lunacy reform, which looks at this movement in Victorian England and not in the United States, I have attempted to demonstrate that the genesis and subsequent development of specialized segregative techniques for handling the mad was neither fortuitous nor the product of the mere piling up of a series of incremental,

ad hoc decisions bereft of any underlying dynamic or logic. The activities of the lunacy reformers, and the outcome of their endeavors, must be seen as intimately linked to a whole series of historically specific and closely interrelated changes in English society's political, economic, and social structure and to the associated shifts in the intellectual and cultural horizons of the English bourgeoisie. I shall not attempt to recapitulate the whole of that analysis here. Instead, I shall look at just two of the many issues that require discussion (albeit two rather important ones) and try to indicate the general directions in which I think we need to go if we are to resolve them.

Let us begin by considering the "choice" of the asylum. Anyone claiming, as I would, that the adoption of the asylum as a response to madness was powerfully constrained by structural factors implies that the agents involved in the process could have acted otherwise only with extreme difficulty, if they could have done so at all. The assertion or denial of such an account thus rests upon a counterfactual claim that some specified agent or agents could or could not have acted (i.e., had or did not have the ability and opportunity to act) differently. Merely to state things in this form is to emphasize that, in all cases of this sort, empirical evidence must necessarily be indirect and lacking certainty. But that the "evidence must always be indirect and ultimately inconclusive"[44] is not to say that no empirical investigation is possible or that we cannot reach a balanced judgment on these matters. Rothman is quite clear on this issue. Unfortunately, I think he is also quite wrong. As he puts it, "There was nothing inevitable about the asylum form" and it was "not the only possible reaction to social problems."[45] On the most general level, much of the plausibility of these claims seems to derive from the essentially intentional account he offers of the origins of the asylum. The presumption must be that, absent the fear of disorder and the sense that institutions to "control abnormal behavior promised to be the first step in establishing a new system for stabilizing the community, for binding citizens together,"[46] the asylum would not have been built. But if an explanation on this basis is defective (as I have argued it is), no such presumption exists.

At this point, Rothman could fall back on two related and more specific counterarguments he presents to a structural account. First, there is his brief discussion and curt dismissal of the claim that the asylum was the "automatic and inevitable response of an industrial and urban society" to deviance.[47] He appears, at first sight, to be on strong ground

here, for not only is this "explanation" implausibly crude and mechanistic, but it fails to meet even the simplest of factual tests. The economic and demographic developments to which it refers came for the most part *after* the birth of the asylum in England[48] and still more unambiguously in America;[49] and the dissemination of the institutional approach bore no clear-cut relationship to whether a region was rural or urban.[50] But the support

this provides for Rothman's argument is illusory, for it rests upon the demonstrably false claim that the linkage to urbanization and industrialization is the only form a structural account of the origins of the asylum can take.

Rothman's second counterargument is in a sense derived from the first and appears downright curious, if only because on its face it seems so unhistorical. It consists essentially in the assertion that, since, "beginning about 1900, the asylum began to lose its centrality"[51] (a trend still more marked during the past two or three decades), its presence cannot have been structurally required in the nineteenth century. If the still more urbanized and industrialized twentieth century can abandon the institution, the nineteenth could have too, but for some failure of nerve, imagination, or whatever. Perhaps; but this argument will not suffice to show it. For the notion that American (or English) society in the twentieth century is just like its nineteenth-century predecessor (only more so) strains credibility. And if the nature of the beast has changed, who can be surprised if those changes permit/require changes in the characteristic shapes and forms of the social control apparatus?[52]

Considerable familiarity with lunacy reform in England and somewhat less acquaintance with it in America suggest to me that the very issue with which we began may be something of a red herring. For the notion of making a choice implies the perception and weighing of alternatives; and what is most remarkable when one examines the sources is that most reformers seem to have assumed from the outset that any changes they might introduce would retain the asylum as their basis. Even in England, where the reform movement proceeded largely by exposing abuses in existing madhouses, the question posed was not whether or not to employ the asylum to treat lunatics (the answer to that was usually taken to be self-evident), but rather how the asylum model could be modified so as to overcome the defects that had just been exposed.

It would be misleading to suggest that there was no opposition to the asylum. To the contrary, the reformers on both sides of the Atlantic

often met with considerable resistance when they sought to build a network of public asylums, usually on the grounds of cost, but also (and especially in England) because their schemes threatened to provide a precedent for increased central control over local administration. But such opposition was essentially negative. It was not linked to any alternative approach to the management of the mad, and hence its effect was to retard but not to deflect the movement to establish the asylum system.[53]

If one looks diligently enough, however, one can uncover a handful of figures whose opposition to the asylum rested on other, less limited grounds. In England in the period 1810–40, the crucial phase of the lunacy reform movement, there existed a small subterranean tradition that insistently criticized the asylum as a response to insanity. The critics we can identify were all medical men, and their claims amounted to a fundamental assault on the very concept of institutionalization. In the words of George Nesse Hill, a provincial surgeon, "Asylums stand opposed to all rational plans of speedy and permanent cure of insanity, and from their very nature are the most unfavorable situations in which . . . lunatics . . . can be placed."[54] The separation from the sane influences that surrounded mad people in the outside world exacerbated their problems, and the unfortunate inmates of asylums tended to feed off each other's delusions. The consequence, in the words of the well-known London medical writer John Reid, was that "many of the depots for the captivity of intellectual invalids may be regarded only as nurseries for and manufactories of madness; magazines or reservoirs of lunacy, from which is issued, from time to time, a sufficient supply for perpetuating and extending this formidable disease."[55]

In 1830, these ideas were revived and extended by John Conolly, previously the medical inspector of the madhouses in Warwickshire, then professor of medicine at the new University College, London, and later to become one of the most famous figures in nineteenth-century English psychiatry. While conceding that in some circumstances lunatic asylums were "unavoidable evils," he insisted that they were pernicious places from which all but the distinct minority of the insane who could not otherwise be cared for ought to be kept. For two-thirds of the inmates, "confinement is the very reverse of beneficial. It fixes and renders permanent what might have passed away. . . . I have seen numerous examples . . . in which it was evident that . . . a continued residence in the

asylum was gradually ruining body and mind."[56] The sanest among us would find it difficult

> to resist the horrible influences of the place;—a place in which a thousand fantasies, that are swept away almost as soon as formed in the healthy atmosphere of a diversified society, would assume shapes more distinct; a place in which the intellectual operations could not but become, from mere want of exercise, more and more inert; and the domination of wayward feelings more and more powerful. . . . [Patients] are subjected . . . to the very circumstances most likely to confuse or destroy the most rational and healthy mind.[57]

Indubitably, "the presence of a company of lunatics, their incoherent talk, their cries, their moans, their indescribable utterances of all imaginable fancies, or their ungovernable frolics and tumult, call have no salutary effect."[58] Quite the contrary, "the effect of living constantly among mad men or mad women is a loss of all sensibility and self-respect or care; or, not infrequently, a perverse pleasure in adding to the confusion and diversifying the eccentricity of those about them. . . . In both cases the disease grows inveterate."[59]

Such arguments raised the claim, one not unfamiliar to our own ears, that the defects of the asylum were inherent in its very constitution, and hence ineradicable. In the words of an anonymous fellow-critic, the institution itself was always and necessarily "an infected region" in which "healthy impressions" could not possibly be received.[60] The force, relevance, and importance of this critique are evident, even in my abbreviated presentation of it. Yet what is most striking is that, for all the impact these words had, they might as well have never been uttered. It is not just that they had no influence on social policy, or that they were met by counterarguments that seemed plausible at the time. Rather, their fate was to be greeted by silence, to be consigned to oblivion.[61]

One can suggest a number of reasons for this general lack of impact:

the critics' lack of numbers and organization; the conservatism induced by existing investments in the institutional approach; and the single-mindedness of the reformers, with their consequent lack of receptivity to alternatives to their chosen solution. But none of these seems sufficient, singly or in combination: a conclusion that is strengthened when one recalls that, during the 1870s and 1880s, bolstered by a half-century of evidence that made these claims seem prescient, they were revived on both sides of the Atlantic—in America by the newly emerging profession of neurology[62] and in England by such eminent medical psychologists as John Charles Bucknill, Lockhart Robertson, and Henry Maudsley [63] —with comparable lack of effect.

There is, I think, a deeper reason for the failure of the anti-institutional position to secure a hearing, and one that emphasizes just how deeply embedded in the structures of nineteenth-century society the shift to the asylum was. The most fundamental source of the critics' difficulty lies in a simple question: It was all very well to suggest that the cure in this instance was worse than the disease, but what was the alternative? Few of those concerned with the plight of the insane could contemplate with equanimity the prospect of leaving them in the sorts of conditions that commonly prevailed in the larger towns, where the squalor, disease, and misery endured by the *sane* members of the lower classes were quite sufficient to provoke expressions of disgust and horror in those of their betters who came into contact with them. (Most, of course, took pains not to.)[64]

After all,

> millions of English men, women, and children were virtually living in shit. The immediate question seems to have been whether they weren't drowning in it. . . . Large numbers of people lived in cellars, below the level of the street and below the water line. Thus generations of human beings, out of whose lives the wealth of England was produced, were compelled to live

in wealth's symbolic counterpart. And that substance which suffused their lives was also a virtual objectification of their social condition, their place in society: that was what they were.[65]

In the circumstances, those who sought to improve the lot of the pauper insane but who were doubtful of the merits of the asylum confronted a painful dilemma. They could scarcely dispute MacGill's claim that "the circumstances of the great body of mankind are of such a nature as to render every attempt at recovering insane persons in their own houses extremely difficult, and generally hopeless."[66] And if they balked at the idea of keeping lunatics in such surroundings, it was hard to see how they could avoid concluding that the asylum was better than the other option available, the workhouse.

What stood in the way of ameliorating the environment of the insane still at large? To improve the living conditions of lunatics living in the community would have entailed supplying relatively generous pension or welfare benefits to provide for their support, implying that the living standards of families with an insane member would have been raised above those of the working class generally. Moreover, under this system, the insane alone would have been beneficiaries of something approximating a modern social welfare system, while their sane brethren were subjected to the rigors of a Poor Law based on the principle of less eligibility. Quite apart from anything else, such an approach would clearly have been administratively unworkable, not least because of the labile nature of lunacy itself and the consequent ever-present danger that, given sufficient incentive, or rather desperation, the poorer classes would resort to feigning insanity.

In any event, suggestions of this sort would have had no political appeal whatsoever to England's governing classes. Among the latter, "there had developed by the 1830s a sense of precariousness about society. This was expressed in the form that there was a delicate balance between institutions and their operation, and the behavior of the labouring classes. There was a feeling that any concession to idleness might bring about a rapid and cumulative deterioration in the labourer's attitude towards work. This produced a growing sensitivity towards the Poor Law"[67] —

and towards anything else that, by lessening the dependence of the laboring classes on market forces, might weaken the social fabric of Victorian society.

By now, an abhorrence of outdoor relief had been etched deeply into the bourgeois consciousness. In part this reflected the ideological hegemony of classical liberalism. For the logical consequence of that doctrine's insistence on one's freedom to pursue self-interest and on one's unique responsibility for personal success or failure, when joined with its dogmatic certainty that intervention to alter market-derived outcomes could only be counterproductive, was to render the very notion of social protectionism anathema.

These obstacles, I suggest, presented a virtually insurmountable barrier to the development of a plausible, alternative, community-based response to the problem of insanity. Only the asylum plan offered the advantage of allowing scope for the exercise of humanitarian impulses while remaining consistent with the imperatives of the New Poor Law. Significantly, not one of the critics of the asylum was ever able to suggest even the basis of an alternative program (a *sine qua non* of their objections receiving serious consideration), and many of them ultimately conceded the futility of their opposition. Certain critics, while damning the asylum as "a prison" in which "the want of society, the absence of all amusement and employment, both of body and mind, must tend to *increase* rather than to relieve the morbid irritation of the brain,"[68] had from the outset blithely declared that such a solution was perfectly satisfactory for paupers.[69] (In this vision, only the rich were to be spared the asylum's horrors. Perhaps only their sensibilities were sufficiently refined to notice them.) Others, possibly lacking the capacity to engage in such flagrantly jesuitic reasoning, responded by gradually widening the definitions of those for whom the evils of the asylum were "unavoidable"—till, in John Conolly's case, he switched sides and became a leading and zealous advocate of county asylums for paupers.[70] In the last analysis, therefore, even its staunchest opponents were led to concede the asylum's inevitability.

V I

At the core of the reformers' approach to the asylum was a dual perception: positively, of the promise of cure; and negatively, of the revulsion

against cruelty and inhumanity. The conjunction of these two elements was a source of the greater part of the moral energy and commitment that sustained the drawn-out campaign for reform. Throughout the asylum's history, one source of the drive to institutionalize the insane has been anxiety, fear of the threat the mad posed to life, property, and the orderliness of social existence. In and of itself, however, fear provided only a weak argument for institutionalization, one that applied, at best, to a fraction of the insane. What was distinctive in many ways about the lunacy reform movement was not only its newfound conviction about the redemptive power of the institution, but also its insistence on extending the benefits of treatment to an ever-larger proportion of the mad. Certainly, in these connections we need to understand the relationship and appeal of lunacy reform to the Evangelicals, Quakers, and Benthamites in England, and to the Quakers, New England Unitarians, and those influenced by the Second Great Awakening in the United States. But we need to move beyond this to look for the broader sources of the profound shift in moral sensibilities that underlies and lends coherence to their activities—a humanitarian sensibility that finds expression in such diverse yet clearly related endeavors as controlling crime, relieving the poor and schooling the young, and that transformed slavery "from a problematical, but readily defensible institution, into a self-evidently evil and abominable one."[71]

This view implies that we must take the "humanitarianism" of the reformers very seriously indeed, and not dismiss it (as does Foucault) as "so much incidental music."[72] Of course, taking something seriously is not at all the same thing as taking it at face value or neglecting to subject it to further analysis. Reactions to traditional approaches to the management of the mad are sometimes taken to be self-evident. These approaches were cruel and brutal on their face, so that mere knowledge of or exposure to the conditions under which lunatics were kept was "naturally" sufficient to provoke horror and revulsion and to prompt vigorous and sustained efforts on the part of those endowed with the requisite temperament, intestinal fortitude, and religious sense of mission to rectify the treatment of the insane. In turn, once the general public were relieved of their ignorance and roused from their apathy by the efforts of these activists, reform straightforwardly followed.[73]

But, in the first instance, the claim of ignorance simply will not survive scrutiny. Broadsheets and other printed ephemera of the eighteenth

century often took as their subject the horrors of the madhouse.[74] Hogarth and his many imitators likewise contributed to making the image of the madhouse a staple of the popular imagination in this period, as did a whole literature of asylum exposés, running from Defoe through Cruden down to the gothic novels of the early nineteenth century and the commitment scares later in the century.[75] That madmen were chained, whipped, menaced, and half starved in asylums in the eighteenth century was well known at the time. Indeed, it could scarcely have been otherwise when, throughout the century, the inmates of Bethlem were exhibited before the impertinently curious sightseers at a mere penny a time, and when many a treatise on the management of the mad advocated such treatment. Even the king's mania prompted the use of intimidation, threats, shackles, and blows,[76] a fact of which his subjects were scarcely unaware.

Such practices, then, were not something of which people became conscious only after the turn of the century. Yet it was only then that protests began to be heard that such treatment was cruel and inhumane. Only then did practices that had formerly seemed entirely appropriate and that had been advocated by the most eminent physicians and cultured men of their day[77] lose their appearance of self-evidence. And the process was a gradual and halting one. Even major figures in the reform movement did not succeed at a stroke in freeing themselves from the past. Sir George Onesiphorus Paul, for example, the prime mover behind the original County Asylums Act (1808), continued to believe that chains and the inculcation of fear were the best means of managing madness; he repeatedly expressed his approbation, based on close personal inspections, of the regime

at the York Asylum.[78] Within less than a decade, other reformers excoriated "the institution at York under the excellent management of Dr Hunter"[79] as the epitome of all that was

wrong with previous approaches to the mad. Beyond the reformers' ranks, the old "backward" attitudes persisted even longer, prompting not only some of the opposition to the reformers' schemes, but also episodes of blank mutual incomprehension, as conditions that one side viewed as unexceptionable were viewed by the other with shock and outrage.[80]

I think we must accept, therefore, that in this period an authentic shift in moral consciousness took place, whose outcome was the development of a new sensibility vis-à-vis the treatment of the insane. We can define, too, some of the central dimensions of this change. There is the movement away from a view of madness as "the total suspension of every rational faculty,"[81] and from an outlook that stressed the need to subjugate the madman, to employ external discipline and constraint to break his will—indeed, a sharp break with a conception of the lunatic as an animal, a brute stripped of all remnants of its humanity. There is, instead, a new emphasis on the susceptibility of the insane to many of the same emotions and inducements as the rest of us; an insistence that "madmen are not . . . absolutely deprived of their reason"[82] and a belief that, through a suitable manipulation of inmate and environment, the qualities the lunatic lacks can and should be recreated or reawakened, so that he may once again be restored to the world, a sober, rational, "self-determining" citizen. Fundamentally, to put it another way, there is an abandonment of external coercion (which could never do more than force the crudest and least stable forms of outward conformity) for an approach that promises to produce the internalization of the necessary moral standards, by inducing the mad to collaborate in their own recapture by the forces of reason.

There remains, of course, the extraordinarily difficult task of defining what were, in David Brion Davis' words, "the material considerations which helped to shape the new moral consciousness and to define its historical effects."[83] But that is too large an issue on which to trespass within the confines of this chapter.[84] I suggest that an answer is not to be sought

in some more or less crude reductionism, which seeks to unmask the material or economic interest that produces and shapes the "humanitarian sensibility." Though such elements are undeniably by no means absent, we need rather to seek a broader comprehension of how the ways people look at the world are conditioned by the nature of their activity in it, and, more specifically, of the manifold linkages between the changes in conceptions of insanity and larger changes in the conditions of social existence.

Chapter Three
The Domestication of Madness

I was fortunate enough to spend much of 1982 in London, supported by a Guggenheim fellowship. Here, I was able to take advantage of the hospitality and unrivaled facilities of the Wellcome Institute for the History of Medicine and to spend many months exploring the English medical literature on madness. The timing of my stay was particularly advantageous, since it coincided with the launching of a year-long biweekly seminar on the history of psychiatry, organized by William Bynum and Roy Porter. This turned out to be a singularly well attended, consistently fascinating, and intellectually stimulating parade of performances, with the additional benefit that it rendered one's invisible college of fellow researchers temporarily visible and available for discussion and debate.

Just about the only price the Wellcome exacted in return for its largesse was a requirement that I deliver one of the seminar papers. William Bynum approached me quite early on in my stay, while I had my nose buried in eighteenth-century texts, and extracted my commitment, together with a title, one that I thought would not confine me unduly when I actually wrote something up. In fact, my choice of the term "domestication" came to seem prescient, for it captured what I have argued was a central shift in English views of madness from the eighteenth to the nineteenth century.

One of the most predictable, and, after a time, faintly alarming features of my months at the Wellcome was the regular arrival on my desk of a new essay by the prodigiously productive Porter. The paper that follows was originally framed as an attack on one of his bolder and more provocative pieces, an essay seeking to demolish the claim that the ad-

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vent of moral treatment at the close of the eighteenth century marked a distinct rupture or shift in English responses to insanity. In its published form,[1] the argument was toned down considerably, though it continues to offer an interpretation sharply at variance with that offered here. Obviously, Dr. Porter remains less than wholly persuaded by my arguments, and vice versa.

Most of the papers given in the Wellcome seminar series were subsequently revised and published as *The Anatomy of Madness,* [2] a third volume of which appeared in 1988. My own essay appeared in print rather more rapidly, in an issue of *Medical History* . Over the course of the year, however, I also completed work on a long-standing project on which I had been researching and reflecting for several years, a reassessment of the life and career of John Conolly, the most eminent English alienist of the early Victorian era. It was this paper (see Chapter 7) that ultimately appeared in the collection of seminar papers.

The Domestication of Madness

We use the term "domestic" and its cognates in at least two very different contexts. On the one hand, there is the contrast between the wild and the tame, the sense in which we refer to animals as "domesticated." And on the other hand, there is the reference to the private familial sphere, the environment of the home and one's intimate circle: domestic as contrasted with public life. In this paper I shall suggest that the changing social responses to madness from the end of the seventeenth to the early nineteenth century may be usefully looked at in terms of the metaphor of domestication, comprehending the transition from efforts to tame the wildly asocial to attempts to transform the company of the deranged into at least a facsimile of bourgeois family life.

During the early eighteenth century, most English medical writing on mental disorder

was concerned, not with the Bedlam mad,[1] but with the various manifestations of that Protean disorder, the grand "English malady,"[2] to which ladies and gentlemen of quality (but especially ladies of

[1] [2]

quality) displayed such a striking susceptibility. To be sure, there were some discussions of the seriously mad—furious or moping—to which I shall return shortly. But the main focus of concern was clearly the various "nervous" distempers—the spleen, hypochondria, the vapours, hysteria—to which the physicians' fashionable clientele, blessed with excessively refined sensibilities and exquisitely civilized temperaments (not to mention money), were apt to fall victim. Such speculations (and I use the word advisedly) as Thomas Willis and his epigoni ventured on the subject of lunacy itself reflected an intellectual fascination with the difficult problem of providing a rational explanation of the origins and characteristics of madness, coupled with a marked distaste for any close or continuing contact with those suffering from the disorder: a combination not unknown among later generations of academic psychiatrists, and one which led John Monro to remark with some asperity that "the person who is most conversant with such cases, provided he has but common sense enough to avoid metaphysical subtleties, will be enabled by his extensive knowledge and experience to excell those who have not the same opportunities of receiving information."[3]

And yet, while the utterances of a Willis, a Robinson, a Cullen on the etiology and treatment of insanity reflect a remarkably restricted clinical acquaintance with the condition, they do mirror quite well a broader cultural consensus about the meaning of madness and the nature of the response one should make to it. Moreover, it seems to me that the fundamental thrust of what they have to say undermines, or at the very least sharply limits, the validity of Michael MacDonald's recent claim that the eighteenth century was marked by a shift away from more traditional stereotypes of mad behavior, emphasizing irrational violence, furious raving, and incoherent bestiality.[4] And it likewise undercuts Roy Porter's attempts to play down the distinctiveness of the moral treatment introduced at the end of the eighteenth century and to suggest the essential continuity between the reformers' program and what had gone before.[5]

For whether one looks to theoretical medical texts, to works on the jurisprudence of insanity, to literary allusions, to popular pictorial representations, or to the practices of the despised madhouse keepers themselves, the dominant images are of whips and chains, depletion and degradation, the wreck of the intellect, and the loss of the mad person's very humanness; and madness's constant accompaniments are shit, straw, and stench. The traditional imagery is found in Shakespeare and in Elizabethan drama more generally:[6]

> Love is merely a madness; and, I tell you, deserves as well a dark house and a whip as madmen do; and the reason why they are not so punished and cured is, that the lunacy is so ordinary that the whippers are in love too.[7]

These notions find renewed expression in the more excremental outpourings of Jonathan Swift, who enjoins the madhouse keeper thus:

> Tie them keeper in a tether,
> Let them stare and stink together:
> Both are apt to be unruly,
> Lash them daily, lash them duly,
> Though 'tis hopeless to reclaim them,
> Scorpion Rods perhaps may tame them.[8]

This sense of madness as a condition that required taming, as one might domesticate and thus render predictable the behavior of a wild beast, runs through any number of eighteenth-century discussions of insanity. "Madmen," warned Thomas Willis, "are still strong and robust to a prodigy, so that they can break cords and chains, break down doors or walls, one easily overthrows many endeavouring to hold him."[9] More extraordinarily

yet, they "are almost never tired. . . . Madmen, what ever they bear or suffer are not hurt; but they bear cold, heat, watching, fasting, strokes, and wounds, without any sensible hurt; to wit because the spirits being strong and fixed, are neither daunted nor fly away."[10] By mid-century, Richard Mead had extended this set of immunities a step further: the mad, it appeared, were likewise immune to the ravages of bodily disease, a formulation that was to be repeated almost by rote into the nineteenth century.[11]

But such striking immunity to the infirmities to which human flesh is heir were purchased at a heavy price, for the descent into madness marked the divestment of "the rational Soul . . . of all its noble and dis-

tinguishing Endowments."[12] If, as Foucault[13] has argued, the madman's very animality protected him from all sickness and pathology, the bargain was nevertheless a poor one. The melancholy lunatic offered, said Nicholas Robinson, "the most gloomy Scene of Nature, that Mankind can possibly encounter, where nothing but Horror reigns; where the noble Endowments of the reasonable Soul are often disconcerted to a surprizing Degree, and this lordly creature then almost debas'd below the brutal Species of the animated Creation."[14] Still more clearly was the maniac reduced in status, losing "that Power by which we are distinguished from the brutal Class of the animated Creation: 'til at last upon a Level, or rather beneath the Condition of a mere Brute."[15]

"There is," said Mead, "no disease more to be dreaded than madness."[16] Such views were an eighteenth-century cliché,[17] yet, like many commonplaces, serve to reveal a great deal about contemporary beliefs. Dragged down to a state of brutish insensibility and incapacity, the lunatic occupied a wholly unenviable ontological status:[18] he became virtually a nonentity, one whose "Promises and Contracts" were "void and of no force" and whose behavior could never attain the dignity and status of human action. Such a creature, "deprived of his reason and understanding," could expect a miserable and humiliating career: "to attack his fellow creatures with fury like a wild beast; to be tied down, and even beat, to prevent his doing mischief to himself or others: or, on the contrary, to be sad and dejected, to be daily terrified with vain imaginations; to fancy hobgoblins haunting him; and after a life spent in continual anxiety, to be persuaded that his death will be the commencement of eternal punishment."[19]

Small wonder that the belief that madness was a state "even more deplorable than death itself"[20] enjoyed widespread assent. After all, it brought "the mighty reasoners of the earth, below even the insects that crawl upon it."[21] Nor, until the latter part of the century, was the gloom alleviated by any very confident claims from respectable quarters about

the possibility of cure. Quacks like Thomas Fallowes, whose M.D. was awarded by himself, might advertise their "incomparable oleum cephalicum" as a sure cure for frenzy.[22] Their orthodox competitors, however, were generally distinctly less sanguine. Willis, for example, held that "such being placed in Bedlam, or an hospital for Mad People, by the ordinary discipline of the place either at length returned to themselves or else they are kept from doing hurt to themselves or others."[23] And Richard Mead lamented "this unhappy circumstance, that the disorder is very difficult to be cured."[24] Even John Monro, the physician to Bedlam and a man whose name was virtually synonymous with the mad-doctoring trade, thought "madness . . . a distemper of such a nature that very little of real use can be said concerning it; the immediate causes will forever disappoint our search, and the cure of the disorder depends on *management* as much as medicine."[25]

The madman remained, then, emblematic of chaos and terror, of the dark, bestial possibilities that lurked within the human frame, waiting only upon the loss of "that governing principle, reason" to emerge in their full awfulness. Once encounter a man "deprived of that noble endowment," warned William Pargeter, "and see in how melancholy a posture he appears. He retains indeed the outward figure of the human species, but like the ruins of a once magnificent edifice, it only serves to remind us of his former dignity, and fill us with gloomy reflections with the loss of it. Within, all is confused and deranged, every look and expression testifies [to] internal anarchy and disorder."[26] Notwithstanding the more hopeful portrayal of milder forms of mental disarray embodied in the early

eighteenth-century textbooks on the spleen, the traditional view of Bedlam madness retained most of its old force and even its content. Toward the close of the century, mania still wore its earlier garb, finding expression in "a violent and inordinate desire to do mischief; fury, vociferation, impetuosity of temper, and indomitable turbulence and vehemence; an angry and wild staring look in the eyes, actions rashly attempted, and as suddenly relinquished, obstinacy, perverseness, immodesty," while its melancholic counterpart could be recognized "by sullenness, taciturnity, meditation, dreadful apprehensions, and despair."[27]

But still, under suitably controlled conditions, the varied beasts confined in "the wild abodes of secluded misery"[28] formed an entertaining display; an ever-varied menagerie from which an audience made up of both provincial bumpkins and urban sophisticates could derive almost endless amusement. From Ned Ward's *London Spy* to Henry Mackenzie's *Man of Feeling*, Bedlam offered, for a mere penny a time, the opportunity to view "the clamorous ravings, the furious gusts of outrageous action, the amazing exertion of muscular force, the proud and fanciful sallies of imagination"—if not perhaps "the excessive propensity to venereal intercourse"—that mad-doctors assured the public were the common currency of lunacy.[29] And by the thousands they came, as many as 100,000 in a good year, to what "was commonly regarded less as a hospital than as a kind of human zoo, with a fine, permanent exhibition of human curiosities."[30] All in all, an obvious setting for Hogarth to conclude his moral tract on the wages of sin (Figure l), and an inevitable occasion for one of those floods of tears that Mackenzie's *Man of Feeling* repeatedly inflicted on his readers. As they were brought within the gates,

> their conductor led them first to the dismal mansions of those who are in the most horrid state of incurable madness. The clanking of chains, the wildness of their cries, and the imprecations which some of them uttered, formed a scene inexpressibly shocking. Harley and his companions, especially the female part of them, begged their guide to return: he seemed surprised at their uneasiness and was with difficulty prevailed on to leave that part of the house without showing them some others, who as he expressed it in the phrase of those that keep wild beasts for show, were much better worth seeing than any they had passed, being ten times more fierce and unmanageable.[31]

A generation or two later, as professional conceptions of insanity began to change quite sharply, John Haslam complained that "to constitute madness, the minds of ignorant people expect a display of continued violence, and they are not satisfied that a person can be pronounced in that state, without they see him exhibit the pranks of a baboon, or hear him roar and bellow like a beast."[32] And his jibes were echoed by Thomas

[Full Size]

Figure 1.
Bedlam. Engraving by William Hogarth, 1735, retouched 1736. The final episode of *The Rake's Progress* , with madness presented as the wages of sin. (Courtesy of the Wellcome Trustees.)

Bakewell, who described with some disdain the public reaction when a convalescent madman escaped from his Staffordshire madhouse: "The alarm this has excited has been very like what might be expected, were lion, or royal tiger, to escape from a caravan; and the censure upon my conduct has been such as would be cast upon a keeper of wild beasts, on such a terrific event."[33] But their complaints have a somewhat disingenuous air, and not just because of medicine's long history of promoting and reinforcing such stereotypes. For even as they sought to dismiss such images as the product of ignorance and superstition, as eminent a physician as Charles Bell was displaying graphic evidence of their survival in the highest professional circles in his *Essays on the Anatomy of Ex* -

pression in Painting (Figure 2).[34] To his sketches themselves, he appended a vivid description of his effort to render madness as it appeared in nature, as "ferocity amid the utter wreck of the intellect . . . a most unpleasant and distressing subject of contemplation."[35] The essential requirement for the artist (to the neglect of which Bell attributed the romanticized images "we almost uniformly find given [to madmen] in painting") was "to learn the character of the human countenance when devoid of expression, and reduced to the state of lower animals; and as I have already hinted, study their expression, their timidity, their watchfulness, their state of excitement, and their ferociousness."[36]

Corresponding to these conceptions of the madman as beast were a set of therapeutic practices whose logic remained largely intact and unaltered over the course of more than a century. The madman's ferocity must be tamed by a mixture of discipline and depletion designed to put down "the raging of the Spirits and the lifting up of the Soul."[37] As Willis argued,

> To correct or allay the furies and exorbitancies of the Animal Spirits . . . requires threatenings, bonds, or strokes as well as *Physick* . For the *Madman* being placed in House convenient for the business, must be so handled both by the *Physician,* and also by the Servants that are prudent, that he may in some manner be kept in, either by warnings, chidings, or punishments inflicted on him, to his duty, or his behavior, or manners. And indeed for the curing of Mad people, there is nothing more effectual or necessary than their reverence or standing in awe of such as they think their Tormentors. For by this means, the Corporeal

> Soul being in some measure depressed and restrained, is compelled to remit its pride and fierceness; and so afterwards by degrees grows more mild, and returns in order; Wherefore, Furious Madmen are sooner, and more certainly cured by punishments and hard usage, in a strait room, than by *Physick* or Medicines. [38]

Not that the lunatics were to escape the more conventional weapons of the medical practitioner, for, unless they were numbered among those not furious but "more remissly Mad, [who] are healed often with flatteries, and with more gentle Physick,"[39] "Bloodletting, Vomits, or very strong Purges, and boldly and rashly given, are most often convenient [though for whom Willis does not say!]; which indeed appears manifest, because *Empericks* only with this kind of *Physick*, together with a more severe government and discipline do not seldom most happily cure Mad folks."[40] A misplaced caution and timidity were at all costs to be

[Full Size]

Figure 2.
Charles Bell's representation of "the madman," a portrait that purported to strip away the romanticized images prevalent among artists and to provide a faithful copy of nature. From: Sir Charles Bell, Essays on the *Anatomy of Expression in Painting* (London: Longman, 1806), 153.
(Courtesy of the Wellcome Trustees.)

avoided in favor of a vigorous trial of the full rigors of the Galenic therapeutics; for "it is Cruelty in the highest Degree, not to be bold in the Administration of Medicine" in such cases.[41] One must rather, said Robinson, have recourse to "a Course of Medicines of the

most violent Operation . . . to bring down the Spirit of the Stubborn Persons [and] to reduce their artificial Strength by compulsive Methods."[42]

Country clergymen, who dabbled in "physick" and found themselves consulted in the cure of the mad, were not always so convinced of the merits of coercing right thinking. Some indeed, like Southcomb, objected to "all those Means which tend to the giving of Pain and Uneasiness . . . such as *Blisters, Seatons, Cupping, Scarifying,* and all other Punishments of the Like kind," urging that such "tormenting Means" often "rendered a very *curable* Disease, either incurable or [were] the Occasion of protracting the Cure longer than otherwise the Nature of the Case would have required."[43]

For the most part, however, such pleas fell on deaf ears, at least as far as the medical profession was concerned. True, men like Richard Mead sometimes conceded that "it is not necessary to employ stripes or other rough treatment to bring [the outrageous] into order."[44] But the objection was not to beating as such, only to its being superfluous, since "all maniacal people are fearful and cowardly."[45] "Diversions" would often suffice for those afflicted with "sadness and fear"; but "melancholy very frequently changes, sooner or later, into maniacal madness," and then one must once more have recourse to "chiding and threatening" and to the various weapons in the physician's therapeutic armamentarium."[46]

Like his observation about the exemption of the mad from the ravages of other forms of disease, Mead's doctrine about the cowardliness of the insane was to prove widely influential,[47] eventually underpinning and giving legitimacy to some of the most characteristic late-eighteenth-century responses to madness. As Sir George Onesiphorus Paul put it, more than half a century later, mad-doctors had determined that their patients "possessed a cunning and instinctive penetration, which makes them apprehend consequences from acts, and indeed to fear them; for

they are universally cowardly. It is by keeping up this apprehension on their minds that they are so easily governed in numbers by the modern system of treating them."[48]

"To superficial observers," remarked William Pergeter, "the conduct of maniacs . . . appears extremely daring and courageous; but in reality they are exceedingly timorous and are found to be easily terrified."[49] (As we shall see, this perspective did not restrain the medical profession from exercising considerable ingenuity to foment that terror.) To accomplish the management that both Battie[50] and Monro[51] had urged as the key to the cure of the mad, the physician should ensure that his first visit was by surprise. But he must then "employ every moment of his time by mildness or menaces, as circumstances direct, to gain an ascendancy over them, and to obtain their favor and prepossession."[52] Much depended here on the mad-doctor's skill at managing his presentation of self, since "he may be obliged at one moment, according to the exigency of the case, to be placid and accommodating in his manners, and the next, angry and absolute."[53] Consequently, as Joseph Mason Cox noted,

> there are very few, whom nature has been so kind as to qualify for the practice; every man is not furnished with sufficient nerve, with the requisite features for the varied expression of countenance which may be necessary, with the degree of muscular powers, or stature, etc. [But all, at least, could recognize that] as the grand object in their moral management, is to make ourselves both feared and loved, nothing can so successfully tend to affect this as a system of kindness and mildness, address and firmness, the judicious allowance of indulgences, and the employment of irresistible control and coercion.[54]

Sometimes the coercion and control were quite straightforward. Bake-well, for example, relates an instance from his practice where "a maniac confined in a room over my own . . . bellowed like a wild beast, and shook his chain almost constantly for several days and nights. . . . I therefore got up, took a hand whip, and gave him a few smart stripes upon the shoulder. . . . He disturbed me no more."[55] Such techniques were generally expected to be efficacious since, as Falconer put it, "those who attend them . . . mostly find, that although generally irrational, they re-

tain a great consideration for personal safety, and that threats will often compel them

to speak and act rationally."[56]

But direct physical threats were not always necessary. "It is of great use in practice," said MacBride, "to bear in mind, that all mad people . . . can be awed even by the menacing look of a very expressive countenance; and when those who have charge of them once impress them with the notion of fear, they easily submit to anything that is required."[57] Indeed, "the eye" was perhaps the most dramatic technique that the late-eighteenth-century mad-doctor claimed to have at his disposal and was used most famously by Francis Willis in his treatment of George III.[58] Benjamin Rush even went so far as to claim that "there are keys in the eye, if I may be allowed the expression," that allowed the skilled practitioner to vary "its aspect from the highest degree of sternness, down to the mildest degree of benignity" and thus to secure minute changes in the patient's behavior.[59] And the growing clinical literature of the period is replete with case histories like this one, offered by William Pargeter.[60]

> The maniac was locked in a room, raving and exceeding turbulent. I took two men with me, and learning he had no offensive weapons, I planted them at the door with directions to be silent and keep out of sight, unless I should want their assistance. 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."[61]

One must realize, however, that the excitement of fear and the infliction of physical suffering were forms of treatment resting on a more elaborate theoretical basis than I have yet demonstrated. Madness was essentially defined, indeed constituted, by the preternatural force with which certain irrational ideas dominated the mind, heedless of the ordinary corrective processes provided by experience and persuasion. Mad people's loss of contact with our consensually defined reality, their spurning of common sense, reflected how deeply the chains of false impressions and associations were engraved upon their system. There were differences in degree between mania and melancholia: "The distinguishing character of [the latter] is an attachment of the mind to one object, concerning which the reason is defective, whilst in general it is perfect in what respects other subjects"; whereas mania entailed "an irrationality on all subjects."[62] And these differences argued for the use of a greater caution in handling the melancholic. But in both forms of the disorder, the thought processes were trapped in erroneous pathways—a language that reified and referred them to an underlying disorder of a (somewhat variously conceived) physical substratum of thought, from whose grip they must somehow be shaken loose.

The very tenacity with which maniacs adhered to their false and mistaken perceptions testified to the weight and strength with which these were impressed upon the brain, and by implication required and justified the extremity of the measures adopted to jolt the system back into sanity. Given that "*the mind when waking is always active and employed,* " it followed that "*we have no method of banishing one set or train of ideas, but by substituting another in its place* ."[63] And in view of the entrenched position occupied by the opposing ideas, one could only hope "to eradicate the false impressions by others still more violent."[64] Thus were intimidation and forceful persuasion embodied in a variety of physical treatments, which simuhaneously brought moral and physiological pressures to bear

on the patient and aimed to break "the chain of ideas which possessed the mind," even—what a splendid choice of words—if possible to "exterminate" them.[65]

Sometimes not just the insane *ideas* were exterminated. Throughout the century, classical sources were drawn on for inspiration, as the search went on for a suitable means of inducing the appropriate degree of terror. But there was a veritable paroxysm of inventiveness at the turn of the century, as the techniques of the Industrial Revolution were adapted to the task at hand. Elaborate systems of plumbing were developed to deliver forcible streams of cold water to the head of a suitably restrained maniac (Figure 3). The suggestion by Dutch physician Hermann Boerhaave that near-drowning be employed for its salutary effects gave birth to a variety of ingenious devices designed to

produce this effect: hidden trapdoors in corridors designed to plunge the unsuspecting lunatic into a "bath of surprise" as well as coffins with holes drilled in their lids, into which the patient could be fastened before being lowered under water. As Guislain put it, the two critical aims to be realized, in constructing such an apparatus, were to obtain complete mastery of the madman, and to avoid drowning him (in that order). Francis Willis' attempt to reconcile these imperatives struck him as imperfect, prompting him to offer an improved version of his own (Figure 4). As he describes it,

> It consists of a little Chinese temple, the interior of which comprises a moveable iron cage, of light-weight construction, which plunges down into the water descending in rails, of its own weight, by means of pulleys and ropes. To expose the madman to the action of this device, he is led into the interior of this cage: one servant shuts the door from the outside while the other releases a brake which, by this maneuver, causes the patient to sink down, shut up in the cage, under the water. Having produced the desired effect, one raises the machine again, as can be seen from the drawing attached.[66]

Generally, he continued gravely, the treatment could be applied only once to each lunatic, and, he warned, "Toute fois ce moyen sera plus ou moins dangereux."[67]

Some sought to improve instruments of restraint to ensure "all the tenderness and indulgence compatible with steady and effectual government."[68] Benjamin Rush, for example, who trained under William Cullen

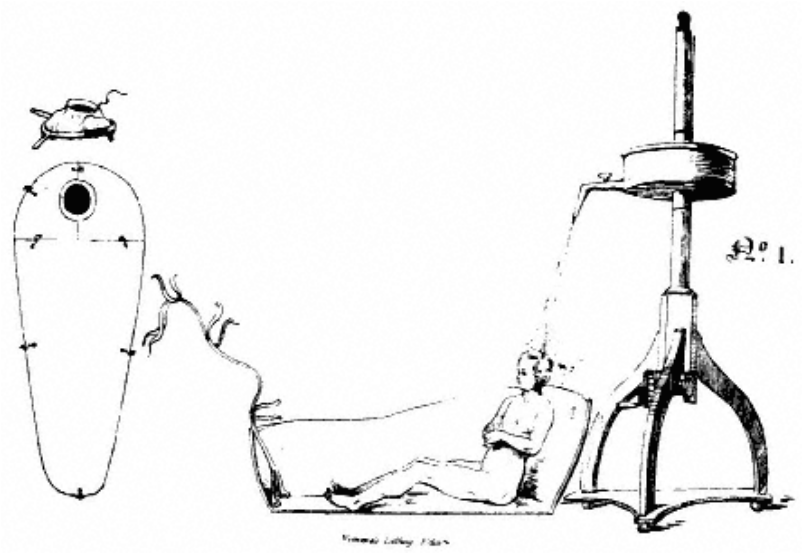

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Figure 3.
Immersion in cold water was an ancient nostrum for insanity. Aquatic shock treatment, otherwise euphemistically known as "hydrotherapy," here takes the form of the douche.
From: Alexander Morison, *Cases of Mental Disease*
(London: Longman and Highley, 1828).
(Courtesy of the Wellcome Trustees.)

at Edinburgh (like so many mad-doctors of the late eighteenth century), designed an elaborate "tranquillizing chair," whose good effects in coercing a measure of good behavior from his patients he was not slow to advertise.[69] There was even a debate of sorts between those who preferred "the strait waistcoat, with other improvements in modern practice," on the grounds that they "preclude[d] the necessity of coercion by corporal punishment,"[70] and those who preferred "metallic manacles on the wrist; the skin being less liable to be injured by the friction of polished metal

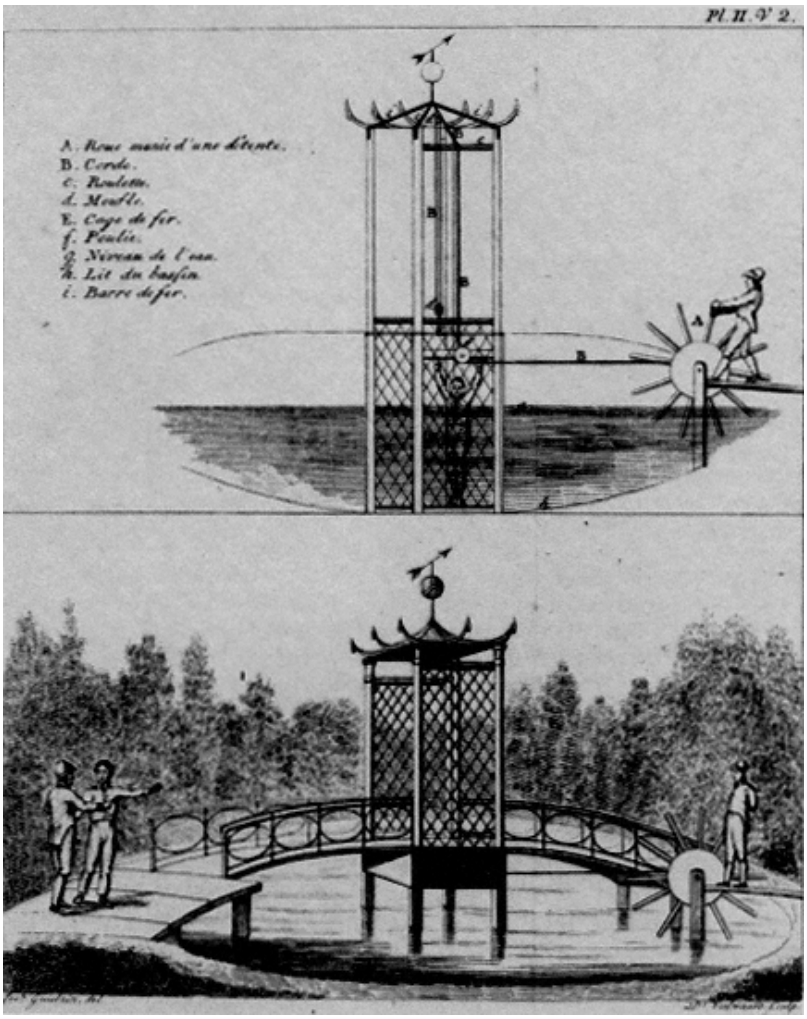

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Figure 4.
A far more elaborate device for the application of water to the cure of madness, Guislain's so-called Chinese Temple. From: J. Guislain, *Traité sur l'aliénation mentale et sur les hospices des aliénés* (Amsterdam: Hey, 1826), vol. 2, Pl. 2. (Courtesy of the Wellcome Trustees.)

than by that of linen or cotton."[71] Paul Slade Knight endorsed the latter opinion, though he cautioned that "the clinking of the chains should be, by all means, prevented, for I have known it to impress lunatics with the most gloomy apprehension."[72]

Perhaps the most famous contrivance of all at the time was Joseph Mason Cox's swinging device (Figure 5). The idea for it had come from Erasmus Darwin, who in turn had derived it from classical suggestions about the value of swinging as a therapy.[73] But Cox was the first to develop a working model, and his book describing its construction and use [74] rapidly went through three English editions, as well as appearing in an American and a German edition; his device was recommended by Knight as "a machine that should be easily accessible in every asylum for Lunatics."[75]

Like Rush's tranquillizer, the swing acted simultaneously on both physiological and mental levels, allowing the physician to exploit "the sympathy or reciprocity of action that subsists between mind and hotly." In the application of this sovereign remedy, each became "in its turn the agent, and the subject acted on, as when fear, terror, anger, and other passions, excited by the action of the swing, produce various alterations in the body, and where the revolving motion, occasioning fatigue, exhaustion, pallor, horripilatio, vertigo, etc. effect [*sic*] new associations and trains of thought."[76] The "mechanical apparatus" provided the operator with the inestimable advantage of being able to regulate

the whole process with extraordinary precision. One could, for example, vary its effects on the stomach so as to produce "either temporary or continued nausea, partial or full vomiting," and if necessary could secure "the most violent convulsions . . . the agitation and convulsion of every part of the animal frame."[77] Even the obstinate cases could not long resist its powers: if necessary it could be "employed in the dark, where,

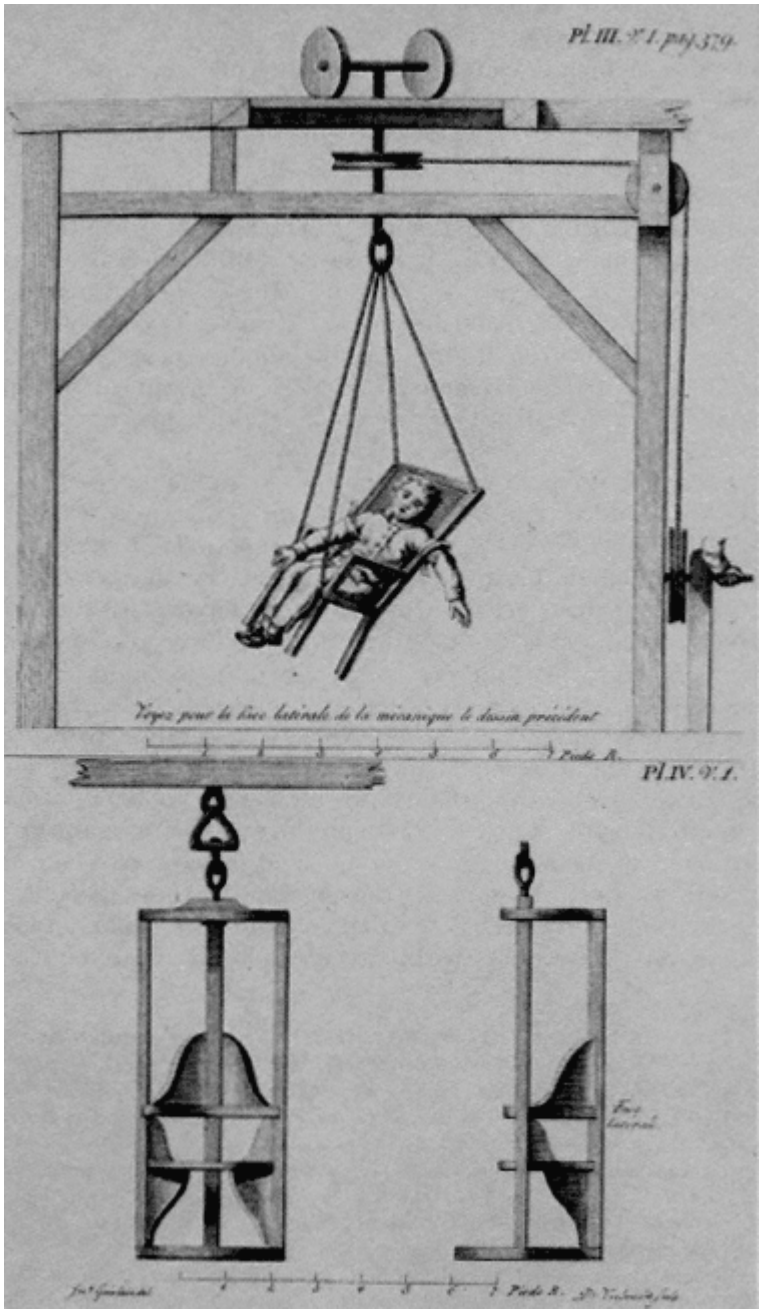

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Figure 5.
A rotary machine based on Cox's swing. A number of complicated variants on Cox's original design were developed in the early nineteenth century. This version was used in the Berlin Charite. From Guislain, *L'aliénation mentale* , vol. 1, Pl. 2.
(Courtesy of the Wellcome Trustees.)

from unusual noises, smells, or other powerful agents, acting forcibly on the senses, its efficacy might be amazingly increased."[78] And by "increasing the velocity of the swing, the motion be[ing] suddenly reversed every six or eight minutes, pausing occasionally, and stopping its circulation suddenly: the consequence is, an instant discharge of the contents of the stomach, bowels, and bladder, in quick succession."[79]

The consequent "very violent shock both to mind and body" exhibited a wholly salutary "tendency to excite fear or terror."[80] Hallaran subsequently carried the whole process to a higher pitch of perfection, designing a seat that "supports the cervical column better, and guards against the possibility of the head in the vertiginous state from hanging over the side [*sic*],"[81] and placed the seat in an improved version of the apparatus so that now four patients could be treated simultaneously at speeds of up to 100 revolutions a minute. Elaborate case histories documented its immense usefulness as an agent of moral repression, reducing the most violent and perverse to a meek obedience.

Yet notwithstanding all such encomiums, the half-life of the gyrating chair proved exceedingly brief. By 1828, George Man Burrows was complaining that, despite his personal conviction of the swing's therapeutic value, public sentiment was such that he dared not make use of it, fearing lest, given "the morbid sensitivity of modern pseudo-philanthropy," any accident attending its use would leave him "universally decried, his reputation blasted, and his family ruined."[82] The authorities in Berlin and Milan had already banned its use, and it rapidly disappeared from English asylums as well.

Its demise formed part of a wider rejection of traditional modes of managing the mad (as well as the rationales underlying them) that spread ever more widely in the first half of the nineteenth century. The mixture of incomprehension and moral outrage with which formerly respectable therapeutic techniques came to be viewed was captured most vividly by Charles Dickens, who spoke scathingly of the mad-doctors' "wildly extravagant, . . . monstrously cruel monomania," their bizarre insistence "that the most violent and certain means of driving a man mad, were the only hopeful means of restoring him to reason."[83] "What sane person," he asked, "seeing, on his entrance into any place, gyves and manacles (however highly polished) yawning for his ankles and wrists; swings dangling in the air, to spin him around like an impaled cockchafer; gags and

strait waistcoats ready at a moment's notice to muzzle and bind him; would be likely to retain the perfect command of his sense?"[84]

It was not just the outwardly visible apparatus of physical restraint and coercion that began to lose its legitimacy (a process that culminated in Gardiner Hill and Conolly's triumphant claims to have secured the total abolition of mechanical restraint).[85] Rather, the very attempt to *tame* madness was increasingly viewed as seriously misguided. Samuel Tuke commented that by means of terror, lunatics

> may be made to obey their keepers with the greatest promptitude, to rise, to sit, to stand, to walk, or to run at their pleasure; though only expressed by a look. Such an obedience, and even the appearance of affection, we not infrequently see in the poor animals who are exhibited to gratify our curiosity in natural history; but, who can avoid reflecting, in observing such spectacles, that the readiness with which the savage tiger obeys his master, is the result of treatment at which humanity would shudder?[86]

Within the new orthodoxy, attempts to *compel* patients to think and act reasonably were themselves stigmatized as unreasonable:[87] "Intimidation and coercion may make or modify the symptoms of insanity, but can seldom produce permanently good effects."[88]

The nineteenth-century domestication of madness proceeded in a wholly different direction, reducing rage and despair to at least a simulacrum of moderation, order, and lawfulness[89] and transforming the imagery of confinement from the "pigstyes"[90] in which, as Wynter put it, the mad had been "hung from their fetters and chains on the wall like vermin chained to a barn door,"[91] to the peaceful Potemkin villages that were Conolly's and W. A. F. Browne's vision of what asylums "are and ought to be."[92] Here

> calmness will come; hope will revive; satisfaction will prevail; . . . almost all disposition to meditate

> mischievous or fatal revenge, or self-destruction, will disappear; . . . cleanliness and decency will be maintained or restored; and despair itself will sometimes be found to give place to cheerfulness or secure tranquility. [This is the place] where humanity, if anywhere on earth, shall reign supreme.[93]

In the new iconography, madness was reined in amid the comforts of domesticity by the invisible yet infinitely potent fetters of the sufferer's own "desire for esteem," complemented by the benevolent authoritarianism of the asylum superintendent and the healthful influences of the new moral architecture.

A quasi-mythical scene recurs repeatedly: a maniac is brought to the asylum gates, frenzied, furious, exhibiting all the signs of dangerous and violent alienation, and in consequence laden with irons and chains. The alienist appears, and in the face of assurances from the man's captors that release will mean certain death for the bystanders, calmly orders that the bonds be discarded and leads the lamblike madman into dinner. "I treat them," said Thomas Bakewell, "exactly as I should do if they were not afflicted with that disease, and, in return, they almost uniformly behave as if nothing was the matter with them."[94]

"Language and actions" were once more to "become subordinate to a well-regulated will"[95] by inducing the madman to control himself. A person's madness was not to be reasoned with or refuted—a useless, even dangerous endeavor. Its content was ignored; its existence the lunatic had to be taught to suppress.[96]

Central to the new approach, as I argue at more length in Chapter 4, was the internalization of control,[97] a goal that necessarily entailed a move away from a regime of undifferentiated restraint and fear. It required instead the recognition of the lunatic's sensibility and the acknowledgment (in a highly limited and circumscribed sense) of his status as a moral subject. Contrary to previous practice, the madman must not be addressed "in a childish, or . . . domineering manner,"[98] for this approach threatened to subvert the effort to rouse his "moral feelings," and to use these as "a sort of moral discipline."[99] As Bakewell put it, "Certainly authority and order must be maintained, but these are better maintained by kindness, condescension, and indulgent attention, than by any severities whatever. Lunatics are not devoid of understanding, nor should they be treated as if they were; on the contrary, they should be treated as rational beings."[100]

They were also to be treated in an environment that was self-consciously domestic in a more conventional sense. There was a tireless insistence that the inmates of an asylum were a family, and that the discipline to which they were subject "naturally arises from the necessary regulations of the family."[101] And this fictional domesticity was tenaciously maintained (linguistically at least) even after the thirty patients of Tuke's Retreat had become the l,000 or more that swarmed into the burgeoning county asylum: Conolly moving among the hordes at Hanwell is described as "like a father among his children, speaking a word of comfort to one, cheering another, and exercising a kindly and humane influence over all."[102]

As this description suggests, the asylum regime in practice was no more than a grotesque caricature of the domestic circle: and the insis-

tence on the domestic imagery is the more ironic inasmuch as it coincides with the decisive removal of madness from family life.[103] But certainly insanity now assumed a more placid, less threatening garb, so much so that there were suggestions that "insanity has undergone a change, and that, whilst there is an increase in the number of cases of the disease, there is happily a marked diminution of its most formidable modification, furious mania."[104] Those running the asylums naturally preferred to see the change as an illustration of "the mildness and tractability of its forms under a humane and rational direction"[105] and to urge, with Conolly, that "mania, not exasperated by severity, and melancholia, not deepened by the want of all ordinary consolations, lose the exaggerated character in which they were formerly beheld."[106]

If cures swiftly proved beyond its reach in all but a small minority of cases, the asylum regime at least provided the public with symbolic demonstrations that the disturbing and dangerous manifestations of madness were firmly under control; that the disorderly could

be rendered tranquil and tractable. Tuke's famous image of the inmates of the Retreat calmly sipping tea and exchanging social pleasantries found its echo in the county asylum reports of the mid-century. At Hanwell on the occasion of the Matron's birthday, 200 patients

> assembled in Ward Number 10, the decoration of which had previously afforded amusing occupation to some of them. They drank tea in the Airing Court, and were afterwards allowed to amuse themselves by dancing in the galleries, a piano having been removed thither tot the purpose. It is impossible to image a more happy party. The utmost liveliness was combined with perfect good behavior. . . . Soon after eight o'clock they joined in singling the Evening Hymn, and returned, with perfect order, and many grateful expressions, to their respective wards.[107]

The mad could even be granted the consolation and the "indulgence of going to Chapel." Once again, they could be relied upon to preserve a perfect decorum. Indeed,

> so accustomed are the Patients to preserve their composure during the hour of service, that if, as sometimes happens, an Epileptic patient utters a loud scream, tails into a fit, and requires to be taken out by the keepers or nurses, very few of the Patients quit their seats; and those in the immediate neighbourhood of the person affected usually render what assistance they can, and then quietly resume their places.[108]

[Full Size]

Figure 6.
A view of the Men's Gallery, Bedlam, in 1860. From: *The Illustrated London News* 36 (March 3l, 1860): 308.
(Courtesy of the Wellcome Trustees.)

Soon the public no longer had to take such portraits on trust. As they had been allowed in to view the menagerie at Bedlam a century earlier, so they were now invited (albeit under more restricted and controlled conditions) to move across the boundary wall of the asylum that divided the mad from the sane (Figure 6). And once inside, the question that most frequently occurred was, where were all the mad people?[109] In Elaine Showalter's words, "Madness was no longer a gross and unmistakable inversion of appropriate conduct, but a collection of disquieting gestures and postures."[110] Even the forces of sexuality had been successfully brought under control.[111] Mid-Victorian asylums usually enforced a

[Full Size]

Figure 7.
A lunatics' ball at the Somerset County Asylum, with the superintendent, Robert Boyd, in the foreground. The "ballroom" is a converted kitchen. Reproduction of a lithograph by Katherine Drake (circa 1848). (Courtesy of the Wellcome Trustees.)

monastic segregation of the sexes. (The Lunacy Commissioners even complained when the "deadhouse" at the Cambridge County Asylum was shared by corpses of the opposite sex.[112]) But one exception to this policy was the lunatics' ball (Figure 7), a monthly (sometimes weekly) event in most asylums, and an event frequently used to display the asylum's achievements to outsiders:

> On the occasion of our visit there were about 200 patients present. . . . In a raised orchestra, five musicians, three of whom were lunatics, soon struck up a merry polka, and immediately the room was alive with dancers. . . . Had the men been differently dressed, it would have been impossible to have guessed that we were in the midst of a company of lunatics, the mere sweepings of the parish workhouses; but the prison uniform of sad coloured grey appeared like a jarring note amid the general harmony of the scene. . . . 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.[113]

Madness domesticated (in my second sense) was madness tamed, and more effectively than the eighteenth century could ever have imagined.

Chapter Four
Moral Treatment Reconsidered

Traditional histories of psychiatry saw in moral treatment the first of a series of "revolutions" that transformed social responses to the mentally ill, rescuing them from viciousness and neglect and ushering in a humane and rational response to the problems posed by mental disorder. The work of modern revisionists, from Foucault onwards, has on one level exhibited a fascinating convergence with these old-fashioned directionalist histories, accepting that moral treatment represents a decisive epistemological break in the history of Western responses to madness. But, of course, the revisionists have evaluated this rupture very differently and have sought to comprehend its origins and analyze its nature in very different ways.

The initial polemical excesses of Foucault's own reassessment, which simply stood the traditional interpretation on its head (urging that one see moral treatment as a "gigantic moral imprisonment"),[1] have been succeeded by a more complex and balanced view: a perspective that can recognize why one might reasonably prefer the manipulation and ambiguous "kindness" of Tuke and Pinel to the "coercion for the outward man, and rabid physicking for the inward man" that were for an earlier generation "the specifics for lunacy,"[2] but a perspective that is nevertheless aware of moral treatment's less benevolent aspects and its latent po-

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tential (all too soon realized) for deterioration into a repressive form of moral management.

The essay that follows represents my attempt, a decade ago, to grapple with a number of central and interrelated questions: How are we to make sense of traditional approaches to the mad, and in what do these consist? What, penetrating beneath the ideological accounts offered by the reformers themselves, are we to make of moral treatment? And, given the importance of the change it represents, how can we grasp its broader social roots and significance?

Since this paper appeared, Anne Digby has published a full-length study of the York Retreat, based on extensive and painstaking research in that institution's voluminous archives.[3] Her general assessment of the social origins, context, and significance of Tuke's version of moral treatment closely parallels (indeed is clearly indebted to) that offered here and in Chapter 3, though her subsequent analysis greatly broadens our understanding of the subsequent course of events at the Retreat and of the multiple ways in which the specifically Quaker character of the foundation influenced its unfolding history.

As I emphasize in what follows, even in an English context Tuke's was not an isolated achievement. Though it was the Retreat that made moral treatment famous in England, by the last years of the eighteenth century a number of madhouse proprietors were experimenting with generally similar approaches (just as, on the Continent, there were independent "discoveries" of the principles of moral treatment). Roy Porter, who has recently provided the first systematic synthesis of the history of madness in England from the late seventeenth to the early nineteenth century,[4] has cited the work of these other progenitors of moral treatment (among whom he numbers such figures as William Pargeter, John Ferriar, and Joseph Mason Cox) in support of a bold thesis: a rejection of the consensus (among traditionalist and revisionist alike) that "the eighteenth century was a disaster for the insane"[5] and a claim that Tuke's institution marked no radical switch in the handling of the mad, but rather exhibited substantial continuities with the practices of an earlier age.[6] Though I do not have the space to provide a detailed refutation here (and this is scarcely the occasion to do so), I think Porter is largely mistaken about

these matters.[7] Still, his book provides us with the most provocative and wide-ranging survey of Georgian madness we are likely to see for many years to come.

Moral Treatment Reconsidered

> What most sharply distinguishes a propagandistic from an ideological presentation and interpretation of the facts is . . . that its falsification and mystification of the truth are always conscious and intentional. Ideology, on the other hand, is mere deception—in essence self-deception—never simply lies and deceit. It obscures truth in order not so much to mislead others as to maintain and increase the self-confidence of those who express and benefit from such deceptions.
> —ARNOLD HAUSER,
> The Social History of Art

> The glory of the modern system [of asylum treatment] is repression by mildness and coaxing, and by solitary confinement.
> —JOHN THOMAS PERCEVAL,
> Letters to Sir James Graham upon the Reform of the Lunacy Law

Tuke and Moral Treatment

We are all familiar with that traditional version of psychiatric history that celebrates it as a not always continuous, but ultimately triumphal procession toward the rational and humane forms of treatment presently practiced. In such accounts, the introduction of moral treatment always occupies a central place of honor: the legendary decision by Pinel to strike the chains from the raving maniacs in the Bicêtre; and the less dramatic but equally significant endeavors of William Tuke to provide humane care for insane Quakers at the York Retreat. It is with moral treatment that I shall be concerned in this essay. I shall try to explicate some of the central dimensions of its English version and to explore some of

its broader social roots and significance. For I take it that one of the more important contributions that a sociologist can make to the history of psychiatry is to break down some of the parochialism that marks most treatments of the subject and to show some of its connections with larger social movements and processes.

Tuke's development of moral treatment was not, of course, an isolated achievement, even in England. A number of other practitioners in the "mad-business" were experimenting with essentially similar approaches by the end of the eighteenth century. John Ferriar of the Manchester Lunatic Asylum had become convinced that "the first salutary operation in the mind of a lunatic" lay in "creating a habit of self-restraint," a goal that might be reached by "the management of hope and apprehension ..., small favours, the show of confidence, and apparent distinction," rather than by coercion.[1] And to cite just one other example, Edward Long Fox,[2] from whose Bristol madhouse Tuke recruited Katherine Allen (the Retreat's first matron), independently developed a system of classification and mild management that allowed the elimination of most of the "barbarous" and "objectionable" features found in most contemporary asylums. But it was Tuke's version of moral treatment that attracted attention, first from a stream of visitors, both English and foreign, and then from those Parliamentarians and others who had taken up the cause of lunacy reform. So it is to his work that I wish to give most of my attention, while recognizing that it forms part of a much broader shift in the methods used to comprehend and cope with madness.

Traditional Approaches to Madness

From a number of perspectives, I think Tuke's admirers are quite right to stress that his approach marked a serious rupture with the past, rather than simply a refinement and improvement of existing techniques. They go astray, however, when they accept at face value the account that Tuke and his followers provide of their activities. The advent of moral treatment is both something more and something less than "the triumph of humanism and of therapy, a recognition that kindness, reason, and tactful manipulation were more effective in dealing with the inmates of asylums than were fear, brutal coercion and restraint, and medical therapy."[3] It will not do simply to assert that Tuke replaced *im* moral with moral therapy; or to attribute the reformers' achievements to their superior

moral sensibilities, while consigning their opponents to the status of moral lepers, people devoid of common decency and humanity.

On the contrary, the perception that the traditional ways of coping with lunatics in madhouses (even such tactics as the use of whips and chains to maintain a semblance of order) were inherently cruel and inhumane is by no means as simple and self-evident a judgment as both the reformers and later generations came to believe. The practices of the eighteenth-century madhouse keepers seem so transparently callous and brutal that we tend to take this judgment as unproblematic, as immediately given to any and all who have occasion to view such actions. But cruelty, like deviance, "is not a quality which lies in behavior itself, but in the interaction between the person who commits an act and those who respond to it."[4] Consequently, whether or not a set of practices is perceived as inhumane depends, in large part, on the world view of the person who is doing the perceiving. Practices from which we now recoil in horror were once advocated by the most eminent physicians and cultured men of their day. That the mad were chained and whipped in asylums in the eighteenth century was well known at the time. How could it be otherwise when, throughout the century, the doors of Bethlem were open to the public and the inmates exhibited to satisfy the impertinent curiosity of sightseers at a mere penny a time, and when standard treatises on the management of the mad advocated such treatment? Certainly, such practices were not something of which magistrates only became aware at the turn of the century. Yet it was only then that protests began to be heard that such treatment was cruel and inhumane.

To be sure, some of the treatment meted out to lunatics in private mad-houses was the natural product of an unregulated free market in madness—the consequence of the unchecked cupidity of the least scrupulous, of the incentives to half-starve and neglect pauper inmates, of the temptation to rely on force as the least troublesome form of control. But there is more to it than that. Even in situations where such factors were obviously inapplicable, lunatics were treated in ways that later generations were to condemn as barbaric and counterproductive and to find (as we do) virtually incomprehensible, almost by default attributing them to an underdeveloped moral sensibility, if not outright inhumanity.

The treatment of George III during his recurrent bouts of "mania" perhaps makes this point most dramatically and unambiguously. As Bynum has pointed out,

> A great deal was at stake with this patient, and there is every reason to believe that Francis Willis, his sons, and other assistants treated the king in a manner which (in Willis' considered opinion) would most likely result in

> the royal patient's recovery. Yet, as the Countess Harcourt described the situation, "The unhappy patient . . . was no longer treated as a human being. His body was immediately encased in a machine which left no liberty of motion. He was sometimes chained to a stake. He was frequently beaten and starved, and at best he was kept in subjection by menacing and violent language."[5]

Willis' approach was scarcely atypical. The eighteenth-century "trade in lunacy"[6] attracted a motley crew; but despite the heterogeneity of those engaged in the business, certain traditional approaches and techniques were widely employed—by medical and

nonmedical men alike. As with the king, intimidation, threats, and outright coercion were commonly used to cow and subdue the madman, whose condition was viewed as a "display of fury and violence to be subdued and conquered by stripes, chains, and lowering treatments."[7] Most madhouse keepers operated on the assumption that "fear [was] the most effectual principle by which to reduce the insane to orderly conduct,"[8] on the grounds that it was "a passion that diminishes excitement . . . particularly the angry and irascible excitement of maniacs."[9] As eminent a man as William Cullen argued that it was "necessary to employ a very constant impression of fear, . . . awe and dread"—emotions that should be aroused by "all restraints that may occasionally be proper . . . even by stripes and blows."[10] Together with a more elaborate and sophisticated intellectual rationalization of these procedures, medicine simply provided its practitioners with a wider variety of tools for "coercing patients into straight thinking and accepting reason . . . 'vomits, purges, . . . surprize baths, copious bleedings and meagre diets.'"[11]

Within a few years of the Retreat's practices obtaining national attention, such treatment (or at least its open avowal) had come to seem unthinkable. The fundamental basis of this whole approach—the subjugation of the mad, the breaking of the will by means of external discipline and constraint, the almost literal battle between reason and unreason—had lost its former appearance of self-evidence and, indeed, was now

seen as wholly inappropriate. I would suggest that a necessary condition for the emergence of such a changed perspective (and of the moral outrage that did so much to animate the lunacy reformers' activities) was a change in the cultural meaning of madness. And I think that such a change can indeed be shown to have occurred.

If, in seventeenth- and eighteenth-century practice, the madman in confinement was treated no better than a beast, that merely reflected his ontological status. For that was precisely what, according to the prevailing paradigm of insanity, he was. One of the most notable features of the prenineteenth-century literature on madness is

> its almost exclusive emphasis on disturbances of the *reason*, or the higher intellectual faculties of man. Insanity was conceived as a derangement of those very faculties which were widely assumed to be universal to man; as a matter of fact, we sometimes find in the literature the presumed absence in animals of any condition analogous to insanity taken as proof that man's highest psychological function results from some principle totally lacking in other animals, that is, the soul.[12]

But this conception implied that in losing his reason, the essence of his humanity, the madman had lost his claim to be treated as a human being.

Intellectually, such notions did no violence to the dominant world view of the period. Indeed, they could be seen as a confirmation of perhaps its critical organizing principle—the idea of the continuity and gradation of nature in what Arthur Lovejoy has termed "the Great Chain of Being."[13] The very idea of a chain, with no discontinuities or gaps, implied that no rigid barriers existed between one part of creation and another, that there always existed intermediate forms. The division between apes and men was a permeable, not an absolute, one in eighteenth-century conceptions of nature, as attested by the denial of the concept of common humanity to a slave; the ready identification of apes and savages (even extending to speculation on fertile copulation between blacks and apes); the portrayal of criminals in animalistic terms; and the assimilation of the mad to the ranks of brute creation. As Bynum puts it, such notions were "built into the analytic tools with which eighteenth century Europeans classified man."[14] And in the case of lunatics, the apparent insensitivity of the furious maniac to heat or cold, hunger or pain, his refusal to abide clothing, and so on, were simply taken as confirmation of the correctness of the basic explanatory schema.

If a sociologist may be permitted to cite literary evidence in support of his case, it may be noted that Ophelia, in her madness, is described as

> Divided from herself and her fair judgement,
> Without which we are pictures [i.e., no more than external facsimiles of human beings] or mere beasts.[15]

In a similar vein, Pascal informs us, "I can easily conceive of a man without hands, feet, head (for it is only experience which teaches us that the head is more necessary than the feet). But I cannot conceive of a man without thought; that would be a stone or a brute."[16] "Expert" opinion concurs. John Monro, the physician to Bethlem from 1751 to 1791 and one of the two most eminent mad-doctors of the mid-eighteenth century, speaks of madness as involving "a total suspension of every rational faculty";[17] just as Andrew Snape, almost half a century earlier, had lamented "those unhappy People, who are bereft of the dearest Light, the Light of Reason."[18] In a revealing passage, Shape then goes on to say:

> Distraction . . . divests the rational soul of all its noble and distinguishing Endowments, and sinks unhappy Man below the mute and senseless Part of Creation: even brutal Instinct being a surer and safer guide than disturb'd Reason, and every tame Species of Animals more sociable and less hurtful than humanity thus unmann'd.[19]

Eminent mad-doctors of the early nineteenth century continued to adhere to this position, arguing that "if the possession of reason be the proud attribute of man, its diseases must be ranked among our greatest afflictions, since they sink us from our preeminence to a level with the animal creatures."[20]

I suggest that the resort to fear, force, and coercion is a tactic entirely appropriate to the management of "brutes." Thus, when we look at the treatment of the insane prior to "reform," we must realize, as Foucault points out, that

> the negative fact that the madman is not treated like a "human being" has a very positive meaning. . . . For classicism, madness in its ultimate form is man in immediate relation to his animality. The day would come when from an evolutionary perspective this presence of animality in madness would be considered as the sign—indeed the very essence—of disease. In

> the classical period, on the contrary, it manifested the very fact that *the madman was not a sick man* . Animality in fact, protected the lunatic from whatever might be fragile, precarious, or sickly in man. . . . Unchained animality could be mastered only by *discipline* and *brutalizing* .[21]

The Rupture with the Past

It was this worldview that the nineteenth-century reformers and, indeed, society as a whole, were in the process of abandoning. Much of the reformers' revulsion on being exposed to conditions in contemporary madhouses derived from this changed perspective. For them, the lunatic was no longer an animal, stripped of all remnants of humanity.[22] On the contrary, he remained in essence a man; a man lacking in self-restraint and order, but a man for all that. Moreover, the qualities he lacked might and must be restored to him, so that he could once more function as a sober, rational citizen.

The beliefs that lie at the heart of the new approach to the insane—Tuke's moral treatment, as well as the much less well known equivalents developed by his contemporaries—differ so profoundly from those underlying traditional practices as to lend some credence to Michel Foucault's notion of a "rupture épistemologique." At the core of the eighteenth-century approach, as we have seen, was its view that the essence of madness was the absence, or the total perversion, of reason. "In the new system of moral treatment," by contrast, "madmen are not held to be absolutely deprived of their reason."[23] Tuke's whole system crucially depends upon "treating the patient as much in the manner of a rational being as the state of his mind will possibly allow"—a change so striking that it attracted much contemporary comment. In Sydney Smith's words, "It does not appear to them that because a man is mad upon one subject, that he is to be considered in a state of complete mental degradation, or insensible to feelings of gratitude."[24]

The emphasis on the lunatics' sensitivity to many of the same inducements and emotions to which other people were prone was associated, whether as cause or consequence, with other equally profound alterations in their treatment. What was seen as

perhaps the most striking,

both at the time and subsequently, was the emphasis on minimizing external, physical coercion—an emphasis that has had much to do with the interpretation of moral treatment as unproblematically kind and humane. William Cullen articulated the eighteenth-century consensus when he contended:

> Restraining the anger and violence of madmen is always necessary for preventing their hurting themselves or others; but this restraint is also to be considered as a remedy. Angry passions are always rendered more violent by the indulgence of the impetuous notions they produce; and even in madmen, the feeling of restraint will sometimes prevent the efforts which their passion would otherwise occasion. Restraint, therefore, is useful and ought to be complete.[25]

Tuke's dissent from this position was sharp and unequivocal: "Neither chains nor corporal punishment are tolerated, on any pretext, in this establishment."[26] Less objectionable forms of restraint might be necessary to prevent bodily injury, but they ought to be a last resort and must never be imposed solely for the convenience of the attendants. As a routine policy, those running an asylum ought "to endeavor to govern rather by the influence of esteem than of severity." The insistence upon "the superior efficacy . . . of a mild system of treatment," together with the elimination of "gyves, chains and manacles,"[27] had a profound effect on contemporary reformers, who saw Tuke's success at the Retreat as proof that the insane could be managed without what were now seen as harshness and cruelty.

Tuke's approach was not kindness for kindness' sake. From its architecture to its domestic arrangements, the Retreat was designed to encourage the individual's own efforts to reassert his powers of self-control. For instead of merely resting content with the outward control of those who were no longer quite human (which had been the dominant concern of traditional responses to the mad), moral treatment actively sought to *transform* the lunatic, to remodel him into something approximating the bourgeois ideal of the rational individual. From this viewpoint, the problem with external coercion was that it could force outward conformity, but never the necessary internalization of moral standards. The change in aim mandated a change in means. Granted, "it takes less trouble to fetter by means of cords, than by assiduities of sympathy or affection."[28] But "the natural tendency of such treatment is, to degrade the mind of the patient, and to make him indifferent to those moral feelings, which, under judicious direction and encouragement, are found capable, in no small degree, to strengthen the power of self-
[29]

restraint."[29] On purely *instrumental* grounds, then, "tenderness is better than torture, kindness more effectual than constraint. . . . Nothing has a more favourable and controlling influence over one who is disposed to or actually affected with melancholy or mania, than an exhibition of friendship or philanthropy."[30] Only thus could one hope to reeducate the patient to discipline himself. By acting as though "patients are capable of rational and honourable inducement" and by making use of the vital weapon of man's "*desire for esteem* " (which even lunatics were now seen as sharing), inmates could be induced to collaborate in their own recapture by the tortes of reason. "When properly cultivated," the desire to look well in others' eyes "leads many to struggle to conceal and overcome their morbid propensities: and, at least, materially assists them in confining their deviations within such bounds, as do not make them obnoxious to the family."[31]

The staff played a vital role in this process of reeducation: they must "treat the patients on the fundamental principles of . . . kindness and consideration."[32] Again, this was not because these were goods in themselves, but because

> whatever tends to promote the happiness of the patient, is found to increase his desire to restrain himself, by exciting the wish not to forfeit his enjoyments; and lessening the irritation of mind which too frequently accompanies mental derangement. . . . The comfort of the patients is therefore considered of the highest importance in a curative point of view.[33]

Here, too, lay the value of work, the other major cornerstone of moral treatment, since "of all the modes by which patients may be induced to restrain themselves, regular employment is perhaps the most generally efficacious."[34]

By all reasonable standards, the Retreat was an outstandingly successful experiment. It had demonstrated, to the reformers' satisfaction at least, that the supposedly continuous danger and frenzy to be anticipated from maniacs were the consequence of, rather than the occasion for, harsh and misguided methods of management and restraint; indeed, that this reputation was in large part the self-serving creation of the madhouse keepers. It apparently showed that the asylum could provide a comfortable and forgiving environment, where those who could not cope with the world could find respite; and where, in a familial atmosphere, they might be spared the neglect that would otherwise have been their lot. Perhaps even more impressive than this was that, despite a conservative outlook that classified as cured no one who had to be readmitred to an asylum, the statistics collected during the Retreat's first fifteen years of operation seemed to show that moral treatment could restore a large proportion of cases to sanity.

The Social Roots of the New Approach

But if one must grant the importance of the changing conceptions of insanity and its appropriate treatment as an intervening cause in the rise of the lunacy reform movement, one must also recognize that ideas and conceptions of human nature do not change in a vacuum. They arise from a concrete basis in actual social relations. Put slightly differently, the ways men look at the world are conditioned by their activity in it. The question we must therefore address—albeit briefly and somewhat speculatively—is what changes in the conditions of social existence prompted the changes we have just examined.

In a society still dominated by subsistence forms of agriculture, nature rather than man is the source of activity. Just as man's role in actively remaking the world is underdeveloped and scarcely perceived—favoring theological and supernatural rather than anthropocentric accounts of the physical and social environment—so too the possibilities for transforming man himself go largely unrecognized and the techniques for doing so remain strikingly primitive. In a world not humanly but divinely authored, "to attempt reform was not only to change men, but even more awesome, to change a universe responding to and reflecting God's will"—to embark on a course akin to sacrilege.[35] And where the rationalizing impact of the marketplace is still weak, structures of domination tend to remain *extensive* rather than intensive; that is, the quality and character of the work force are taken as fixed rather than as plastic and amenable to improvement through appropriate management and training.

But under the rationalization forced by competition, man's *active* role in the process presents itself ever more insistently to people's consciousness. This development is further accelerated by the rise of manufacturing—a form of human activity in which nature is relegated simply to a source of raw materials, to be worked on and transformed via active *human* intervention. More than that, economic competition and the factory system are the forcing house for a thoroughgoing transformation in the relation of man to man. For industrial capitalism demands "a reform of 'character' on the part of every single workman, since the previous character did not fit the new industrial system."[36] Entrepreneurs concerned to "make such machines of men as cannot err"[37] soon discover that physical threat and economic coercion will not suffice: men have to be taught to *internalize* the new attitudes and responses, to discipline them-

selves. Moreover, force under capitalism becomes an anachronism (perhaps even an anathema) save as a last resort. For one of the central achievements of the new economic system, one of its major advantages as a system of domination, is that it brings forth "a peculiar and mystifying . . . form of compulsion to labour for another that is purely economic and 'objective.'"[38]

The insistence on the importance of the internalization of norms, the conception of how this was to be done, and even the nature of the norms that were to be internalized—in all these respects we can now see how the emerging attitude toward the insane paralleled contemporaneous shifts in the treatment of other deviants and of the normal. The new attitude coincided with and formed part of what Peter Gay has dubbed "the recovery of nerve"[39] —a growing and quite novel sense that man is the master of his destiny and not the helpless victim of fate; and it had obvious links with the rise of "the materialist doctrine that people are the product of circumstance."[40] "Is it not evident," said James Burgh (and certainly it *was* to an ever-larger circle of his contemporaries), "that by management the human species may be moulded into any conceivable shape?"[41] The implication was that one might "organize the empirical world in such a way that man develops an experience of and assumes a habit of that which is truly human."[42]

This faith in the capacity for human improvement through social and environmental manipulation was translated in a variety of settings—factories, schools, prisons, asylums—into the development of a whole array of temporally coincident and structurally similar techniques of social discipline.[43] Originating among the upper and middle classes, for example, there emerged the notion that the education and upbringing of children ought no longer to consist in "the suppression of evil, or the breaking of the will."[44] With the growth of economic opportunity and social mobility, the old system of beating and intimidating the child to compel compliance came to be viewed as a blunt and unserviceable technique, for it

ill prepared one's offspring for the pressures of the marketplace. The child needed to be taught to be "his own slave driver," and with this end in view, "developing the child's sense of emulation and shame" was to be preferred to "physical punishment or chastisement."[45] John Locke, the theoretician of these changes, said:

> Beating is the worst, and therefore the last Means to be used in the Correction of Children. . . . The *Rewards* and *Punishments* ..., whereby we should keep Children in order *are* of quite another kind. . . . *Esteem* and *Disgrace* are, of all others, the most powerful Incentives to the Mind, when it is once brought to relish them. If you can once get into Children a Love of Credit and an Apprehension of Shame and Disgrace, you have put into them the true principle.[46]

The essential continuity of approach is equally manifest in the methods and assumptions of the early-nineteenth-century prison reformers. Crime had been seen as the product of innate and immemorial wickedness and sin. Now, however, the criminal was reassimilated to the ranks of a common humanity. As Fine puts it, "The prisoner was to be treated as a person, *who possessed a reason in common with all other persons,* in contrast to animals and objects. However hardened the prisoner was, beneath the surface of his or her criminality an irreduceable reason still remained."[47] In consequence, as lunatics were for Tuke, they were "defective mechanisms" that could be "remoulded" through their confinement in a penitentiary designed as "a machine for the social production of guilt."[48] And for such purposes (again the parallel with moral treat-

ment is clear) prison reformers plainly perceived that "gentle discipline is more efficacious than severity."[49]

The new practices, which had their origins in the wider transformation of English society, were shared, developed further, and given a somewhat different theoretical articulation in the context of the lunatic asylum. As in the wider world, so too in the lunatic asylum: one could no longer be content with the old emphasis on an externally imposed alien order, which ensured that madness was controlled, yet which could never produce self-restraint. Control must come from within, which meant that physical violence, now dysfunctional, became abhorrent.[50] The realization of the power that was latent in the ability to manipulate the environment and of the possibility of radically transforming the individual's "nature" was translated in the context of madness into a wholly new stress on the importance of cure. It represented a major structural support of the new ethic of rehabilitation. As the market made the individual "responsible" for his success or failure, so

the environment in the lunatic asylum was designed to create a synthetic link between action and consequences, such that the madman could not escape the recognition that he alone was responsible for the punishment he received. The insane were to be restored to reason by a system of rewards and punishment not essentially different from those used to teach a young child to obey the dictates of "civilized" morality. Just as those who formed the new industrial work force were to be taught the "rational" self-interest essential if the market system were to work, the lunatics, too, were to be made over in the image of bourgeois rationality: defective human mechanisms were to be repaired so that they could once more compete in the marketplace. And finally, just as hard work and self-discipline were the keys to the success of the urban bourgeoisie, from whose ranks Tuke came, so his moral treatment propounded these same qualities as the means of reclaiming the insane.

Chapter Five
The Discovery of the Asylum Revisited: Lunacy Reform in the New American Republic

With the hubris so characteristic of graduate students, I originally intended that my dissertation would be a comparative study of changing responses to mental disorder in nineteenth-century England and the United States. Reason subsequently prevailed (or rather, my supervising committee, swamped with 700 pages on England alone, declared themselves ready to surrender). By this time, I had a rather extensive acquaintance with the existing secondary literature on the United States and had begun to burrow about in a variety of archives, most notably those at the Northampton State Hospital in Massachusetts and at the Institute of Living (formerly the Hartford Retreat), located charmingly enough (though in blatant contradiction of its managers' feeble attempt at euphemism) on Asylum Avenue, at some small remove from the Connecticut State Capitol. In substantial measure, I set this work aside once I arrived at the University of Pennsylvania, first concentrating my energies on a new topic more readily seen as legitimate among my sociological colleagues, a study of the disenchantment with and abandonment of the mental hospital in the third quarter of the twentieth century;[1] and then, when the passage of time rendered the task slightly less unpalatable, pruning my examination of the social organization of insanity in nineteenth-century England to a more manageable (and publishable) size.[2]

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But I did not entirely lose touch with my earlier ambition to examine the parallel developments in the United States, and despite the competing distractions, I could not completely resist the temptation to nose around in the archives of the two very important pioneering American asylums that happened to be located in my new home town, the Frankford Retreat, and the psychiatric division of the Pennsylvania Hospital. A few years later, I was asked to present some general reflections on the historiography of Anglo-American psychiatry,[3] and in rereading David Rothman's influential *The Discovery of the Asylum,* was struck with how poorly his emphasis on the uniquely *American* character of the Jacksonian asylum accorded with the archival records I had examined. This finding seemed worth documenting with some care: hence the following chapter.

The Discovery of the Asylum Revisited: Lunacy Reform in the New American Republic

During the past fifteen years, with the possible exception of Michel Foucault's work, David Rothman's *Discovery of the Asylum* has attracted more attention than any other book on the history of our responses to insanity.[1] Like Foucault, Rothman has succeeded in reaching an audience far beyond the limited circle of historians who ordinarily concern themselves with social reform and administrative history. Indeed, he has even been widely read among sociologists, despite the well-known aversion of many of them to studying anything but contemporary America.

It is not difficult to suggest reasons for his success. At the very least, they include the following: the belated and welcome rupture with lingering Whiggish tendencies (still evident in many histories of psychiatry, though long since formally renounced in other areas of historical inquiry); the boldness and sweep of his argument, as well as his willingness (deriving in part from his acquaintance with the work of Goffman and others on

"total institutions")[2] to seek similarities and connections be-

tween the rise of the lunatic asylum and the adoption of segregative responses to other forms of deviance; the intrinsic appeal of his subject matter, given the newly fashionable interest in the poor and the powerless, in "history from below," bolstered in this instance by Rothman's claim that attention to these apparently peripheral concerns could shed new light upon so central an issue as the bases of social order and cohesion; and the resonance of his implicitly anti-institutional, antibureaucratic, antiexpert analysis, not just with the general intellectual climate of the 1970s, but (ironically enough) with the more particular ideology of a contemporary "reform" movement seeking the deinstitutionalization of the deviant.[3]

One further source of the book's popularity, I think, lies in its subliminal appeal to a certain sophisticated variant of cultural chauvinism. English historians have long treasured and nurtured the myth of "the peculiarities of the English,"[4] their American counterparts have been equally enamored of the image of "the city on the hill," the unique and special destiny of the American Republic. And, of course, the central element in Rothman's fundamentally idealist account of the rise of the asylum is his emphasis on the uniquely *American* properties of the new institutions and on their origins in a peculiarly Jacksonian mixture of angst about the stability of the social order and utopianism about the solutions available to meet the difficulty. As I have pointed out elsewhere, such an account is vulnerable to the overwhelming evidence that, so far from being a uniquely American phenomenon, the "discovery of the asylum" was well under way in Europe long before the Jacksonian era began. Furthermore, while Rothman's account persuasively *describes* the anxiety and the vision of perfectibility, it neither explains the emergence of these ideas nor analyzes the social location of those who espoused them.[5]

In this essay, however, I want to take this criticism a step further. For it is not just a comparative perspective on parallel developments in England, France, and elsewhere that undermines Rothman's argument. Rather, in his insistence on the domestic character of the changes he describes, he gives scant attention to evidence that the lines of influence were precisely the *reverse* of those he implies, to intimations that the first critical stages of the American lunacy reform movement involved a

heavy dependence on ideas and examples that were borrowed from abroad.[6]

In what follows, I shall examine the developments that led, between 1810 and 1824, to the construction of a number of lunatic asylums on the eastern seaboard of the United States. I shall suggest that while each of these so-called corporate asylums[7] had its idiosyncrasies, they all also exhibited striking similarities. I shall also suggest that these "family resemblances" mark them as a distinct departure in the history of American responses to insanity. I shall show that, taken together, these institutions had a profound impact on the movement to "reform" the treatment of lunatics in the United States, notwithstanding their eventual fate as asylums for the rich, precursors of the dual, class-based system that is still characteristic of our approach to mental disorder. And I shall demonstrate that the early history of these corporate asylums is marked at every turn by evidence of European inspiration and influence.

The new corporate asylums were not, of course, the first institutional provision made for lunatics in the United States. From its foundation in 1751, the Pennsylvania Hospital had made some provision for the distracted, first in the basement of the original building and later in a separate structure adjacent to the rest of the hospital.[8] Prompted largely by the urgings of two successive provincial governors, the Virginia burgesses had set up a "madhouse," modeled to some extent on London's Bethlem, in 1773.[9] And when a hospital for New York was first canvassed in 1769, its projectors urged that provision be made for maniacs as well as for medical and surgical cases. After its long-delayed opening in 179l, the maniacs were assigned to the basement; by 1803 a third story had to be added to accommodate them; and in 1808 they were moved to a separate building on the hospital grounds.[10] But each of these early institutions was little more than a "place of safekeeping" where the inmates could be "disabled from injuring themselves and others."[11] At best, those in charge hoped that "the wretched maniac, sequestered from

society,

might be made subject to such regimen and regulations, which if not always the means of recovery, would at least ensure safety, decency and order."[12] As this implies, these institutions were intended "to secure" rather than "cure,"[13] and the treatment that was given was dispensed haphazardly, consisting of the application of such standard medical therapies of the period as bleedings, purges, and emetics.

If these eighteenth-century institutions had looked to contemporary English developments for their models—to the growing number of voluntary hospitals of the period and to idealized accounts of the success of the regime at Bethlem—their nineteenth-century counterparts, too, looked across the Atlantic for inspiration, though with rather different results. Both England and France were by now in the throes of their own movements to reform the treatment of the insane, and it was to the work of Pinel and (to a much greater extent) of Tuke that the founders of the new corporate asylums looked for guidance. The means by which they obtained that guidance were sometimes more, sometimes less, direct, but the impact in each case was marked, and the outcome was an influential group of asylums that exemplified a radically different approach to the insane, [14] even while giving that approach some peculiarly American overtones.

The most direct lines of influence are found in the cases of the Friends' Asylum at Frankford and in the Bloomingdale Asylum in New York. The Friends' Asylum, as its name suggests, was, like its inspiration, a Quaker foundation. The prime mover in the enterprise was Thomas Scatter-good, who had visited the York Retreat during an extended religious sojourn in England between 1794 and 1800. Beginning at their meeting in the spring of 181l, the Philadelphia Friends began to debate the question of making "provision for such of our members as may be deprived of the use of their reason."[15] Even from three thousand miles away, Tuke's grandson Samuel played a direct role in the process, contributing an anonymous article, "Hints on the Treatment of Insane Persons," to the October 1811 issue of the Philadelphia *Eclectic Repertory and Analytic Review* . The Philadelphia Friends subsequently sponsored an American edition of Tuke's *Description of the Retreat,* which appeared only a matter of months after the original English printing. The latter "was circulated among Friends in Philadelphia and the adjoining districts of the Yearly

Meeting and served to stimulate the interest of Friends in collecting funds and in pushing forward the work to completion."[16] By 4 June 1813, the management committee had raised $24,092.50, having received "extensive approbation of the proposed institution" and contributions from a large number of individual subscribers as well as from more than twenty district Quaker Meetings.[17] The site selection and construction now proceeded alongside further fund-raising efforts, and in 1817 the asylum finally opened its doors to an exclusively Quaker clientele.[18]

The direct lines of communication between English and American Quakers played a similarly important role in the founding of the Bloomingdale Asylum in New York. Unlike Frankford, this was not a completely new foundation, but it resulted from a sharp change in the arrangements for dealing with the insane at an existing institution. As we have seen, the New York Hospital had begun by placing its lunatics in basement cells, but subsequently, it had moved them to a separate building on the hospital grounds, in an effort to diminish the deleterious impact on the remaining patients of the noise and confusion they created. This expedient proved to be little more than a palliative measure, as the accumulation of chronic cases, the lack of any systematic plan of treatment or management, the limited interest of the hospital's physicians in dealing with lunacy, and the absence of any unified authority over the insane department combined to create recurring difficulties for the hospital's governors.[19]

It was, therefore, with conditions ripe for change that, in April 1815,

Thomas Eddy set about converting his fellow members of the hospital board to the advantages of "a course of *moral* treatment for the lunatic patients, more extensive than had hitherto been practiced in this country, and similar to that pursued at 'The Retreat' near York, in England."[20] Highly active in many of the Quaker-inspired reforms of the period (he has been called "the American Howard" for his role in prison reform), Eddy had almost certainly learned of the new approach through the publications and appeals of his fellow Quakers who were on the asylum committee in Philadelphia. However, he also corresponded regularly with Lindley Murray, a member of the York Quaker Meeting and a close friend of the Tuke family.

Mention of his project to Murray brought forth a swift and detailed response from Samuel Tuke himself concerning the principles that should guide "the erection of an asylum for lunatics." Tuke's suggestions were published as a pamphlet in New York in 1815.[21] Eddy proposed both a new asylum on a separate site, a farm in the northern part of Manhattan Island, and an immediate attempt to apply the principles of moral treatment in the existing building[22] —proposals whose realization was made easier when the New York legislature voted an annual subvention of $10,000 to support the erection of more extensive accommodations for the insane.

The new Bloomingdale Asylum opened in 1821.[23] Like the Friends' Asylum at Frankford, it bore a pronounced physical resemblance to the York Retreat, which is perhaps not surprising in view of Tuke's emphasis on the contribution architecture could make to the patients' recovery.[24] All three institutions concurred on the primary qualification of a successful asylum superintendent: he should, in the words of the Bloomingdale

committee, be "reasonable, humane, moral and religious, possessing stability and dignity of character, mild and gentle, . . . resolute, . . . compassionate, [and] of just and sagacious observation."[25]

The omission of medical qualifications was neither accidental nor insignificant. Moral treatment, as I have pointed out elsewhere, had been developed at the York Retreat by laymen.[26] Following this precedent, both the Friends' and Bloomingdale Asylums placed this position of superintendent in lay hands.[27] At the New York Hospital, William Handy announced that medicine was "rarely given" and that "we do not believe in the specific power of any drug in curing madness." Reiterating Tuke's own conclusions in an American context, he denounced bloodletting, emetics, violent cathartics, setons, and blisters as generally useless and asserted that with the addition of warm baths, recovery "will be the most certainly accomplished by strict attention to a moral regimen."[28] The superintendent at Friends' Asylum made similar efforts to insist on the primacy of moral treatment but faced some opposition, for the resident physician continued to demand the frequent use of medicine.[29]

Boston had neglected to build a general hospital in the eighteenth century, possibly, as Leonard Eaton suggests, because the homogeneity of the elite there and the consequent lack of religious and social rivalry hampered the kind of competitive philanthropy that aided the establishment of the Pennsylvania and New York hospitals.[30] By 1810, however, some of the more ambitious young Boston physicians, perhaps resenting the provincial status quo to which the lack of such a hospital consigned them, were urging the establishment of a hospital and lunatic asylum.[31] The campaign quickly attracted the support of some of "the wealthiest and most respectable men of Boston." However, delayed somewhat by unsettled political conditions, the construction of the two institutions was

not completed until 1818.[32] Having learned from the experiences of New York and Philadelphia, the trustees of the new Massachusetts General Hospital had planned from the beginning to keep the hospital and lunatic asylum physically and administratively separate. Now they also sought to imitate the novel and supposedly more curative system of moral treatment. Accordingly, before taking up his appointment as the first superintendent of the asylum, Dr. Morrill Wyman was dispatched by the trustees to view and report back to them on conditions at the Philadelphia, New York, and Frankford asylums.[33]

At New York, he was conducted round by Thomas Eddy, who then presented him with a

copy of Tuke's *Description of the Retreat* .[34] His subsequent practice indicates that he became a convinced disciple. In his only separately published writing, a lecture delivered in 1830, Wyman suggested a very restricted role for conventional medical therapeutics because they were "seldom useful in relieving mental disease [and were] usually injurious and frequently fatal." The contrast with the value of Tuke's approach was stark: obviously, "without symptoms of organic disease, a judicious moral management is more successful." However, he went on, "moral treatment is indispensable even in cases arising from organic disease."[35]

The evidence we have about Wyman's practice at the McLean Hospital reinforces this portrait. Chains and straitjackets were absent; high qualifications were demanded of the attendants; patients ate at the superintendent's table, rowed on the Charles River, took country rides, and in some instances were allowed to visit the newly founded Boston Athenaeum. In the words of an English visitor, "To gain his confidence and imperceptibly lead him to the exercise of his disused energies and faculties . . . is all that the physician studies in the management of his patient."[36]

In their early years of operation, then, these three asylums tended to play down the importance of the medical armamentarium and to urge that moral treatment be employed widely in its place. In this respect, they differed sharply from the fourth corporate lunatic asylum that was built in this era, the Hartford Retreat. For here, from the outset,

medicine was accorded primacy, an approach that came to characterize American treatment of insanity during the remainder of the nineteenth century.[37]

This inversion of emphasis is scarcely surprising in view of the central place that was occupied by medical men in creating and running the Hartford Retreat. An asylum for the state had first been proposed before the Connecticut State Medical Society in 1812. At that time, little action was taken. But the project was revived again in 1820 by a group of Hartford physicians led by Eli Todd. In a speech before the local Hartford County Medical Society in December 1820, Todd articulated his conviction that "mental disorder is as definitely a manifestation of disease as is a fever or fracture. It is our duty as civilized men to attack this disease. Let us make diligent inquiry, find out how prevalent this disease is, and then establish an institution for its treatment and cure."[38] Within a year, the state medical society supported the asylum proposal and thereafter played a major role in bringing the plan to fruition. Society funds were made available to publicize the project and to print appeals for contributions; with the aid of local clergy, committees were formed throughout the state to collect donations; the public was repeatedly informed of the benefits and advantages of asylum treatment; and a state subvention was successfully sought.

Because Connecticut lacked the concentrations of wealth that were present in New York, Pennsylvania, and Massachusetts, fund-raising proved to be far more difficult there than it had been elsewhere,[39] and one may reasonably doubt that the Hartford Retreat would have been built at this time without the sustained initiative of the medical society—the more so since the state's wealthy inhabitants could clearly avail themselves of the new asylums in New York and Boston. The society's leaders were convinced that "no-one conversant with the records of our profession, can hesitate for a moment to believe that its interest would be greatly promoted by adopting the plan which we have suggested."[40] And in setting up the new institution, the society went to great lengths to ensure the dominance of the profession's interests.[41] The state charter that

was passed in 1822 provided that at least a quarter of the committee of trustees were to be physicians, as were all six of the official asylum visitors. Perhaps even more significantly, the power of appointing the superintendent rested with the state medical society, thereby cementing the profession's dominance.[42]

As the Very name of the institution indicates, those setting up the Hartford Retreat were heavily influenced by the recent developments in England and France. In his declining years, looking back on his role on the planning committee for the asylum, George Sumner commented, "We had no other guides than 'Pinel on Insanity' and 'Tuke's History of the

Retreat,' near York, in England."[43] The English institution was the most frequently mentioned in the fund-raising literature, the public being assured that, in accordance with Tuke's approach, "the inmates of this asylum will in all cases be treated with humanity, subjected to no unnecessary rigour of discipline, and controlled by no force unless their safety requires it. The chains and the scourge, which have too often been the implements of correction, must be abolished, and every attendant dismissed from the institution who resorts to violence in the performance of his ordinary duties."[44]

Shortly after the Hartford Retreat opened its doors in 1824, its new superintendent, Eli Todd, informed the public of the principles that guided his practice:

> These are to treat [the insane], in all cases, as far as possible, as rational beings. To allow them all the liberty and indulgence compatible with their own safety and that of others. To cherish in them sentiments of self-respect, To excite an ambition for the good will and esteem of others. To draw out the latent sparks of natural and social affection. To occupy their attention, to exercise their judgement and ingenuity, and to administer to their self-complacency by engaging them in useful employments, alternated with amusements. To withdraw, in most instances, their minds as much as possible from every former scene and every former companion, setting before them a new world and giving an entire change to the current of their recollections and ideas.[45]

The techniques, even the very wording, come directly from the *Description of the Retreat* .

But the Hartford Retreat was no mere copy of its namesake. Breaking sharply with his model, and criticizing the other American corporate asylums for failing to do so, Todd placed great stress on the value of medical treatment. The York Retreat had marked a distinct advance in the treatment of insanity: "Its managers appear, however, to have placed too little reliance upon the efficacy of medicine in the treatment of insanity, and hence their success is not equal to that of other asylums in which medicines are more freely employed."[46] And the managers of the McLean, Bloomingdale, and Friends' asylums had perpetuated the error, with the result that "their treatment is feeble [as] compared to the lofty conceptions of truly combined medical and moral management."[47] "The aid of medicine" was essential, since

> the mind and body are so connected that there can scarcely be a disease of either in which the other is not involved, and in which medical and moral treatment may not be advantageously combined. When mental derangement originates entirely in a diseased state of the body—medication constitutes the paramount, and moral treatment the subsidiary, means of cure. On the other hand, when bodily disease is merely the effect of mental derangement, then there is a complete inversion of the relative importance of these curative means. In most states of insanity, therefore, a judicious combination of both promises the most successful results.[48]

Gradually, practice at the other corporate asylums began to resemble that at Hartford. Stress was placed on the traditional medical therapeutics and was soon accompanied by the growing reliance on opium and morphine that became characteristic of American asylum practice. The McLean from the outset had a medical superintendent, albeit one skeptical of the value of medical as opposed to moral treatment of insanity.[49] But at Bloomingdale and the Friends' Asylum, the administrative structure was more fragmented and confused, and here the realignment in treatment philosophies was signaled and in large part produced by changes in the asylums' internal organization.

As we have seen, the latter asylums had initially opted for lay superintendents; but they also had a resident physician, a young man who prac-

ticed under the supervision of two or more visiting physicians.[50] The superintendent was "entrusted with the general control of the concerns of the Institution" and the supervision of the moral regimen; the medical men dealt with the strictly medical treatment.[51] At Bloomingdale, this system was abruptly abandoned in 1831, "the position of attending physician being dispensed with and the resident physician given immediate control of the moral and medical treatment of the patients." The lay superintendent, meanwhile, was reduced to the status of a steward.[52] At the Friends' Asylum, the changes

were more gradual and subtle: perhaps the Quaker managers here were less willing to abandon Tuke's original vision.

Symptomatic of growing medical ambition, the attending physicians' contribution to the *Annual Report* for 1830 for the first time moved beyond the compilation of routine statistics to a more elaborate discussion of the medical role in patient care. Two years later, the superintendent and his wife resigned, and the appointment of their replacements was accompanied by upheavals in the medical department, with "Dr. Robert Morton and Dr. Charles Evans, appointed attending physicians to the House."[53]

Like Eli Todd, Evans and Morton were convinced that moral and medical treatment were inextricably linked:

> Where a judicious system of medical treatment is steadily pursued [they commented] it exerts a strong influence on the other departments, which would not at first sight he obvious. . . . A course of moral treatment is almost a necessary consequence of a proper sense of the value of medical remedies. They, in fact, are parts of the same system. After what have been called medical means have been successfully resorted to, to remove obvious physical disease, moral treatment will then be found very efficient in restoring and strengthening the functions of the diseased organ.—And we believe that it is only by thus uniting them that full benefit can be derived front either.[54]

Subsequently, they sought a steadily larger role than the superintendent in the dispensing of the "moral" side of the treatment, a campaign bolstered by an insistence on insanity's somatic basis. In a complaint

seemingly intended as much for internal as for external consumption, they commented that "instead of regarding it, as it really is, strictly a morbid state of some of the physical organs, and the deranged manifestations of the mind merely the symptoms of that state, it has been too common to look upon it as an unintelligible malady of the immaterial existence itself; and the unhappy lunatic has been left . . . a victim to the idle and ignorant belief that his disease was immedicable."[55]

The success of their efforts can be measured in a series of changes in the asylum's rules. A new codification in 1840 for the first time included the provision that "it shall be their [the attending physicians'] duty to act in concert with the Superintendent in the moral treatment of the patients and promote their restoration with all the means in their power."[56] A decade later, this uneasy joint authority came to an end. In a further revision of the rules, it was laid down that "the Superintendent shall be a well-qualified Physician, and shall be the official head of the Institution. . . . He shall . . . direct such medical, moral and dietetic treatment, as may be best adapted to [the patients'] relief or comfort."[57]

Important as they were, administrative turbulence and realignments were not confined to these changes or, indeed, to these asylums. At none of the four corporate asylums were the founders familiar with the administrative problems associated with the organization and running of large institutions. It is thus not surprising that their first efforts in this sphere usually created unwieldy administrative structures. Thus the McLean was originally seriously understaffed[58] and placed trivial administrative tasks on the superintendent's shoulders—a situation mitigated somewhat only by the appointment in 1823 of a steward who was to assume some of these burdens.[59] Even the Hartford Retreat did not entirely escape these problems. Here, the superintendent from the outset had the aid of a steward, but even during Eli Todd's tenure (1824–33),

there were squabbles occasioned by the absence of clear lines of authority.[60] After his death, the problem became more acute, for his successor as superintendent, Silas Fuller, gave much of his attention to outside activities that were designed to augment his income. The lay steward and matron, who had previously served for four years under Todd and who claimed (correctly) to know more than Fuller about asylum treatment, sought to exploit this situation to expand their own roles. Ultimately, the managers only succeeded in restoring the *status quo ante* by obtaining the resignations of all three in 1840. Thereafter, Brigham (Fuller's replacement) quickly destroyed all remnants of divided authority and regained undisputed medical control of the institution.[61]

Thus after a period of experiment, all four institutions converged upon a standard system of authority relationships, one that gave allembracing hegemony to the medical superintendent. Moreover, in every institution, moral treatment came to be defined as the physicians' responsibility, and its administration was inextricably bound up with the employment of conventional medical therapeutics. Consequently, in these matters, as in so many others, these new institutions established the basic framework and ground rules within which subsequent asylums were to operate.

To an important extent, the rapid spread of the asylum idea in midcentury America rested on the well-publicized success of these early institutions. In their first fund-raising efforts, the asylums' founders had perforce to conduct an extensive campaign to convince the public of the superior merits of their chosen solution. Subsequently, in their printed annual reports and in more occasional addresses (often distributed in editions of 2,000 or more)[62] the asylum's officers initiated increasingly complex and extensive discussions of the nature of insanity and its proper treatment, all explicitly aimed at modifying public opinion on these matters.

The public was warned of the inconvenience and danger associated with leaving the mad at large. The threats to life and property, and the distress and hardship visited on families forced to cope with an insane member, meant that "the whole community is indirectly disturbed by the malady of the one."[63] There were more subtle and perhaps more serious dangers, including those of contagion: "When an individual becomes insane, unless he is removed from his family and associates, it is probable

that some of them will become the subjects of the same disorder."[64] Families and physicians alike should recognize that

> in private practice no disorder is more unmanageable. The patient suffers for the want of that steady course of discipline, which is equally remote from cruelty and indulgence—for the want of attendants, qualified for their task and faithful in its performance, and for want of that medical skill which is rarely possessed, by those whose attention is chiefly directed to other diseases. . . . A madman in his own house, has of all situations the worst. The same causes which produced his disorder continue to operate with their original force, and oppose every exertion which is made to mitigate its symptoms or arrest its progress.[65]

The obverse was true, of course, of the controlled environment of the asylum. The evil reputation the madhouse had long possessed in England was not unfamiliar to Americans, even if they possessed scarcely any domestic examples of the phenomenon.[66] The asylum authorities sought energetically to supplant it with the image of a humane institution that was carefully designed as a curative apparatus.[67] And they insisted repeatedly that "it is only in Lunatic Hospitals that the course of treatment indicated by an intelligent consideration of the different phases of insanity can be applied."[68]

Even before their asylums opened, committees announced confidently that, based on European experience, the new structures would markedly "*diminish the number of the insane* ."[69] Subsequent experience seemed to suggest that such claims had been overly modest. As little as three years after opening its doors, the superintendent of the Hartford Retreat informed the public that "during the last year there [have] been admitted twenty-three recent cases, of which twenty-one have recovered, a number equivalent to 91 3/10 per cent. The whole number of recent cases in the Institution during the year was twenty-eight, of which twenty-five have recovered—equal to 89 2/10 per cent"[70] —a result he attributed to the judicious combination of medical and moral treatment. Following the announcements of similar successes in 1830

and 1831,[71] he underlined the moral: "It is not an extravagant calculation that three fourths of these would have continued under the influence of mental derangement if no institution like the Retreat had been prepared for their reception."[72] As the "attending physician" at the Friends' Asylum, Charles Evans, had pointed out, the joint experience of the new asylums had demonstrated that, given early treatment, "this deplorable malady is equally with other diseases of the human system under the control of proper medical treatment, the proportion of cures being as great."[73]

There can be little doubt that the superintendents successfully communicated their message to "informed" opinion; or that the optimism they did so much to foster had much to do with the rapidity with which the asylum solution was to spread. Captain Basil Hall was only the first of a number of English travelers touring the United States to comment favorably on conditions in the new asylums and to extol their superintendents' extraordinary therapeutic success. That the praise was an isolated moment in the midst of a parade of sour and scornful comments on American manners and mores only increased the attention it received.[74] The result, as Pliny Earle pointed out, was that "the newspapers took it up and sent it throughout the land, and in this way, whatever a few physicians might have learned from the report itself, the people at large received the impression that insanity is largely curable."[75] By the mid1830s, the *North American Review* could inform its readers, with no little satisfaction, that "no fact relating to insanity appears better established than the general *certainty* of curing it in its early stage." The *Review* was able to cite in support of this claim not just such foreign authorities as Tuke and Dr. Francis Willis, Dr. George Man Burrows, and Dr. William Ellis, but also the "uniform testimony" provided by the experience of Bloomingdale and McLean asylums and the Hartford Retreat. Follow-

ing a review of that experience, the journal sounded a theme that was to be the leitmotiv of the American reform movement in the following decade: "We doubt not but that every State in the Union will, within a very few years, be supplied with at least one [asylum]. Interest will prompt the States to this, if feelings of benevolence do not; for it requires but slight observation to see, that the expense of supporting the insane poor will be much lessened by providing them with a good Asylum."[76] In the succinct words of the Pennsylvania Prison Discipline Society, *"The expense incurred in making a proper provision for this class of paupers is a very profitable investment."* [77]

Again and again in her crusade across the American continent in behalf of state asylums, Dorothea Dix was to draw upon such claims, coupling them with her own vivid (and sometimes imaginary) recital of the abuses to which the insane were exposed in the community. Repeatedly she informed state legislatures that "all experience shows that insanity reasonably treated is as certainly curable as a cold or a fever." She drew upon the elaborate statistics provided by her allies among the asylum superintendents (most notably Luther Bell of the McLean) to provide estimates to the penny of the money to be saved by "a combination of medical and moral treatment" in an asylum.[78] And always she succeeded in loosening the states' purse strings.

In the early years at least, the new state asylums continued to be beholden in a variety of ways to the preceding generation of *corporate* asylums. This indebtedness was true even of new corporate asylums built in the 1840s. For example, prior to his appointment in 1841 as the superintendent of the Pennsylvania Hospital's newly separate branch for the insane, Thomas Kirkbride had served a year in 1833 as resident physician at the Friends' Asylum at Frankford; and before assuming his new duties, he supplemented that experience with a tour of the Bloomingdale and McLean asylums and the Hartford Retreat, as well as the recently opened Worcester State Hospital.[79] And during the construction and or-

ganization of the Butler Hospital for the Insane in Rhode Island, the committee utilized Luther Bell of the McLean as its consultant.[80]

The two most influential state hospitals of this period, which set the pattern for similar institutions elsewhere, were the Worcester State Hospital in Massachusetts[81] and the Utica Asylum in New York. Again, both had close links to the corporate asylums. When Horace Mann sought, in the late 1820s, to secure a state asylum for Massachusetts, he frequently sought advice and support for his project from Eli Todd of the Hartford Retreat, and often visited that asylum himself to observe the new regime at first hand. Later, when the Worcester asylum was about to open, he tried unsuccessfully to induce Todd to become its first superintendent. When Todd refused, Mann accepted his suggestion that he appoint Samuel Woodward instead. (Woodward, an old friend of Todd's, had played one of the most active parts in securing the establishment of the Hartford Retreat, and he was intimately familiar with that asylum's operation.)[82]

Even the external appearance of the Worcester asylum—widely copied by other states—was modeled on an existing corporate asylum, this time the McLean.[83] There were important differences, however, emblematic of which was the use of brick in place of stone. As a consequence, Worcester's "cheap and flimsy style of construction presented a striking contrast to the finished massive features of the other. Being intended for the poorer classes, it was the first considerable example of very cheap construction, and one, unfortunately, which building committees have been too ready to imitate."[84]

Todd was at least as influential in New York. "When the New York Assembly first began to debate the advisability of a state hospital for the insane, several of its members visited the Connecticut Asylum."[85] Subsequently, both Todd and Amariah Brigham (who became superintendent at the Hartford Retreat in 1840) were consulted on the construction of the Utica Asylum. And in 1843, Brigham resigned his post at Hartford to take over the new state institution.[86]

The spread of state hospitals was to have important consequences for the corporate asylums as a whole, strengthening and intensifying some

preexisting tendencies and increasing the homogeneity of their patient populations. In their early years, as virtually the only specialized institutional provision for the insane, the private asylums (with the exception of the Friends' Asylum at Frankford)[87] had been under considerable pressure to make some space available for the poor. They responded with varying degrees of reluctance. At the McLean, in return for a contribution from the state to the initial fund-raising, the trustees had not only given the state the power to nominate four of their number, but had agreed to set aside thirty beds for the indigent insane. Two years before the asylum even opened, however, discreet lobbying had secured the repeal of this provision. In the short run, this created problems, especially since the poorer classes were, if anything, more anxious than the wealthy to obtain an asylum.[88] Accordingly, the trustees felt impelled to publish signed notices in the *Columbian Sentinel,* the *Commercial Gazette,* and the *Independent Chronicle* refuting the widespread belief that the asylum would accept only monied patients. These announcements were followed up, in 1817, with "an address to the public [devised] to obviate an impression that the Insane Hospital was designed exclusively for the wealthy."[89] Notwithstanding the repeated denials, the suspicions proved well founded. Two sizable bequests within the first few years of operation rendered the asylum independent of state support; and in response, the McLean became the first of the corporate institutions systematically to exclude the poor and thus to avoid "the odor of pauperism."[90]

At Bloomingdale and Hartford, the situation was somewhat different, and the exclusion of the poor came more slowly. With a much less generous endowment than the McLean, the Hartford Retreat perforce had to continue to rely on state subsidies. And in 1817, the governors of the New York Hospital had accepted an annual subsidy of $10,000 from the New York legislature, to remain in effect for thirty years.[91] Hence both, with some misgivings, took substantial numbers of poor patients. Bloomingdale's proportion of publicly supported patients grew from 17 percent in 1828 to 40 percent a decade later; while Hartford's share of the total jumped still more abruptly in 1842 and 1843, when the state legis-

lature granted both capital funds and an annual maintenance sum, provided that the asylum would make provision for pauper lunatics.

Eli Todd's fears that any such moves "would lower the character of the Institution" were amply borne outY.[92] Complaints were quickly voiced of "filthy, noisy or dangerous pauper lunatics" filling the asylum;[93] reported cure rates declined; and the quality of the physical plant began to deteriorate. Bloomingdale experienced a similar decline. By 1847, the superintendent reported that "the House is filled with a mass of chronic and incurable cases," and the trustees conceded that most "were listless and indifferent and wholly unoccupied."[94]

There was obviously an acute danger that both asylums would lose their well-to-do clientele. Of the two, Bloomingdale was able to respond to the situation more quickly.

Taking advantage of the opening of the Utica State Hospital in 1843 and the Kings County Lunatic Asylum in Flatbush in 1856, it no longer offered space for the pauper insane and ceased to accept state support in 1847.[95] Henceforth, it concentrated upon "the wealthy" and "indigent persons of superior respectability and personal refinement"—"families of clergymen, and other professional persons, . . . teachers and businessmen who have experienced reverses, . . . [and] dependent unmarried females."[96]

At Hartford, however, the managers remained hamstrung for a decade more by the failure of the Connecticut legislature to build a state facility. Their situation grew more desperate as the decline of state hospitals into warehouses for the unwanted intensified upper-class objections to any association with paupers. It was therefore with scarcely disguised relief that they greeted the legislature's decision in 1866 to build a state hospital at Middletown:

> It is evident [said John Butler, the superintendent] that different classes will require different styles of accommodation. The State should provide for its indigent insane, liberally and abundantly, all the needful means of treatment, but in a plain and rigidly economical way. Other classes of more abundant means will require, with an increased expenditure, a corresponding increase of conveniences and comforts, it may be of luxuries, that use has made essential. This common sense rule is adopted in other arrangements of our social life—our hotels, watering places, private dwellings and various personal expenditures.[97]

To compete successfully for a monied clientele required a substantial immediate expenditure to upgrade the physical facilities. Renovations began within weeks of the removal of the state patients, and at a cost of about $133,500, the managers secured a "beautiful homelike structure, resembling a country residence of a private gentleman more than a public building or a hospital."[98]

Ultimately, therefore, all the corporate asylums came to adhere to Luther Bell's dictum that "to the polished and cultivated it is due as much to separate them from the coarse and degraded, as to administer to them in other respects."[99] The asylums resembled one another in still a further respect: their decline from curative to custodial institutions. For all the extravagant expenditure of money—the opulent surroundings, the provision of French lessons, drawing classes, singing classes, theaters, and the like—they faced the same decline in curability as the "plain and rigidly economical" state asylums. No matter that "its scale of expenditure is faudrom six to eight times as costly" as the pauper institution; that "its sane population (physicians, attendants, nurses, etc.) is about half as numerous as the insane patients, while at [the state asylum] the sane are but one in thirty as compared with the insane." Inescapably, "like the State hospitals, and almost to the same extent, it has become the resort of incurable lunacy, and its noble endowments are bestowed, not so much for the cure or prevention as for the alleviation of this disease."[100]

In this study, I have shown that the influence of the corporate asylums upon American lunacy reform was pervasive. They played an important role in the conversion of the public to the merits of institutionalization as a response to the problems posed by the mentally disordered. It was through these institutions that Tuke's and Pinel's new "moral treatment of the insane" was most dramatically made known to an American audience. It was here that moral treatment was absorbed and became part of the therapeutic armamentarium of the medical profession. It was the apparent and widely publicized "success" of their programs that encouraged large-scale emulation and expansion of the asylum system. And even if they ultimately became resorts for the upper classes, distinctively different and self-consciously as remote as possible from the harsh realities of the state hospital system, this differentiation should not lead us to

slight their part in creating, and to some degree shaping, that system. For the earliest state hospitals, the corporate asylums provided not only a model to be copied, but a source of professional staff and advice once they opened. Lastly, given the extent to which the corporate asylums in turn drew upon European antecedents, parochial theories about the American discovery of the asylum must surely collapse.

Chapter Six
From Madness to Mental Illness: Medical Men as Moral Entrepreneurs

"From Madness to Mental Illness" was the first paper I published on matters psychiatric. (It was also, as a matter of fact—though in a somewhat different form—the first chapter I completed a couple of years earlier when writing my doctoral dissertation.) It appeared in print in early 1975, a few months after William Bynum had published "Rationales for Therapy in British Psychiatry, 1780–1835," in which he independently developed a closely related line of argument.[1] When these articles were written, serious historical research on English responses to insanity in the seventeenth and eighteenth centuries, with the important exceptions of Parry-Jones' work on English madhouses[2] and Hunter and MacAlpine's book on George III's madness[3] and their wide-ranging anthology of British "psychiatric" texts,[4] was still in its infancy. My discussion of the place of medicine in the treatment of the mad prior to the nineteenth-century events with which I was principally concerned was accordingly quite brief and limited, stressing only some of the special advantages that eighteenth-century doctors had in asserting jurisdiction over insanity and pointing out that by the latter part of George III's

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reign, theirs was clearty the dominant interpretation of madness in elite and educated circles. Subsequent work by Michael MacDonald[5] and Roy Porter[6] has given us a far richer and more nuanced portrait of developments from the late Tudor period to the dawn of the industrial age, presenting some particularly provocative arguments about the sources from which the upper classes adopted a naturalistic and medical perspective on mental disorder, while emphasizing the survival of more eclectic, even magical and supernatural notions among the masses even at the very end of period examined.

A year after "From Madness to Mental Illness" appeared, Roger Cooter published an excellent two-part article exploring the impact of phrenology on early-nineteenth-century medical thinking about madness.[7] Although I would quarrel with some of the further claims he makes about phrenology's importance, Cooter's central argument is surely well taken: Phrenology served as a vital theoretical mediation in the attempt to assimilate moral treatment into the medical armamentarium. Its doctrines provided a clear physiological explanation of the operations of the brain, one that permitted a parsimonious account of abnormal as well as normal mental functioning, while advancing a coherent rationale for the application of *both* medical and moral treatment in cases of insanity. His essay constitutes an important elaboration and refinement of my argument about the ways in which medicine succeeded in incorporating moral treatment into its recognized sphere of expertise.

It should be apparent that what follows deals with only one aspect of the rise of a self-conscious profession monopolizing the treatment of the mentally disordered. For England, we still lack a careful prosopographical study of the changing bases of recruitment to the mad-business, or any sustained analysis of the development of an organized profession. Two such attempts *have* been made, drawing on American materials,[8] and it

clearly would be extremely helpful to have a comparable analysis of the development of psychiatry in Victorian England. I continue to believe, however, that assumptions about the *somatic* basis of mental disturbance have played a quite crucial role in legitimizing medical claims to exclusive jurisdiction over the mad throughout the nineteenth and

twentieth centuries and have proved similarly crucial in the determination of therapeutic practices during this period. Indeed, I plan to make an examination of these issues the focus of my next book.[9]

From Madness to Mental Illness: Medical Men as Moral Entrepreneurs

> "When I use a word," Humpty Dumpty said, in a rather scornful tone, "it means just what I choose it to mean—neither more nor less."
> "The question is," said Alice, "whether you can make words mean so many different things."
> "The question is," said Humpty Dumpty, "which is to be master—that's all."
> —LEWIS CARROLL,
> Through the Looking Glass

This chapter seeks to provide a sociological account of one aspect of a highly significant redefinition of the moral boundaries of English society, a redefinition that saw the transformation of insanity from a vague, culturally defined phenomenon afflicting an unknown, but probably small, portion of the total population into a condition that could be authoritatively diagnosed, certified, and dealt with only by a group of legally recognized experts and that was now seen as one of the major forms of deviance in English society. Where in the eighteenth century only the most violent and destructive among those now labeled insane would have been segregated and confined apart from the rest of the community, by the mid-nineteenth century, with the achievement of lunacy "reform," the asylum was endorsed as the sole officially approved response to the problems posed by all forms of mental illness. In what

follows, I want to focus attention rather closely on one centrally important feature of this whole process: just how that segment of the medical profession we now call psychiatry captured control over insanity; or, to put it another way, how those known in the early nineteenth century as mad-doctors first acquired a monopolistic power to define and treat lunatics, I shall begin, though, with some general remarks on the sociological importance of the issues I shall be raising here.

In the first place, although the locus of responsibility for lunatics has shifted from the family and the local community to a group of trained professionals who, by reason of their expertise, claim to have a unique capacity for understanding and treating them, this change is by no means confined to the case of mental illness. The symbiotic relationship between psychiatry and insanity, with which I am here concerned, is merely a particularly important example (just how important I shall indicate in a moment) of a much more general trend in the social control practices of modern societies.[1] Elites in such societies over about the past century and a half have increasingly sought to rationalize and legitimize their control of all sorts of deviant and troublesome elements by consigning them to the ministrations of experts. No longer content to rely on vague cultural definitions of, and informal responses to, deviation, rational-bureaucratic Western societies have increasingly delegated this task to groups of people who claim, or are assumed to have, special competence in these areas. Within sociology, this reality is reflected in the current vogue of "labeling theory" and in the concern with the reactive effects of agents of social control on the problems they are supposed to solve.

The decisions these people take, and the kinds of activities they engage in, form one of the crucial ways in which deviance is now socially organized. Experts are the crucial filters in what Kai Erikson has called "the community screen."[2] In the process of sorting out certain kinds of behavior from the everyday flow of social existence, and assigning those held responsible for them to one or another of the socially recognized deviant statuses, it is their worldview that is the most widely accepted. Most of the time, it is their theories that are used, albeit in a bastardized, simplified form, by the other elements in what we might call the referral system, those involved in "blowing the whistle" on deviants. Moreover, the experts form the final and decisive part of the screening process. Through their power to legally label, they focus, define, and institutionally fix the deviant's status. In the last analysis, laymen generally de-

fer to the experts and regard their decisions as authoritative: "Their mandate is to define whether or not a problem exists and what the 'real' character of the problem is and how it should be managed."[3]

Among the most important of these groups of experts are psychiatrists. To a greater degree than some other experts specializing in the social control of deviance, they possess the attribute of professional autonomy.[4] They make the most vigorous claims to have an expertise resting on a scientific basis, and their ideology has proved so plausible that their view of deviance is an increasingly important one. At least since the end of World War II, we have been moving away from a punitive and toward what Kittrie has termed a "therapeutic" state; that is, one that enshrines the psychiatric worldview.[5] Just as "in the eighteenth and nineteenth centuries, a host of . . . phenomena—never before conceptualized in medical terms—were renamed or reclassified as mental illness,"[6] so over the last few decades most other forms of deviance are being assimilated into a quasi-medical model, being relabeled as illness and therefore "treated" rather than punished.[7] In such a situation, psychiatrists become perhaps the most strategically important of all experts to study, particularly since "the thrust of the expansion of the application of medical labels has been toward addressing (and controlling) the *serious* forms of deviance, leaving to the other institutions [law and religion] a residue of essentially trivial and narrowly defined technical offences."[8]

In what follows, I shall be concerned with how psychiatrists in England first gained control over that type of deviance that must be assumed to form their core area of competence, namely insanity. Given the particular questions I have in mind, I shall not here be concerned with the issue of whether mental illness really *is* illness, and all that en-

tails. After all, "consequential human behavior stems from the meanings that actors impute to their experience, not from the meanings that an 'objective' observer may impute."[9] As sociologists, we are interested in how actions are socially defined rather than with what their intrinsic qualities are. In this case, regardless of whether it is correct in some ultimate ontological sense to describe insanity as an illness, once it has been identified as such, people's responses to it are mediated by and through that socially constructed meaning; so we can legitimately ask how it was that that particular social meaning was arrived at and what its consequences are. As Freidson has argued for illness in general, we can choose to focus, not on whether certain persons are mentally sick or not, but on how their life is reorganized because they are called mentally sick.

Just as in the case of bodily illness, where a profession is granted the authority to label one person's discomfort an illness and another's not, so too with mental distress, the psychiatrists possess the ultimate power to assign one person to the status of being mentally ill and to refuse the designation to another. And it is contact with society's official experts in this area, rather than manifestations of specific behavioral or mental disturbance, that most firmly and legitimately affixes the label in the eyes of the laymen. While the situation obviously varies with the nature and degree of one's alienation, the social acceptance (or rather rejection) of someone as crazy often depends on his or her new status being professionally legitimized.[10] Psychiatrists' labels stick in a way lay ones don't, not least because they are backed by the police power of the state. The psychiatrist can "transform his judgement into social reality."[11]

Psychiatrists, and other social control experts for that matter, negotiate reality on behalf of the rest of society. Theirs is preeminently a moral enterprise, involved with the creation and application of social meanings to particular segments of everyday life. Just like physicians, they "may be said to be engaged in the creation of illness as a social state which a human being may assume."[12] Indeed, in view of the indefinite criteria employed to identify and define "mental illness," its status as a socially constructed reality is, if anything, plainer than in the case of somatic illness, and the latitude granted the expert correspondingly wide. When we look at how medicine first "captured" insanity, we are in essence examining the growth and transformation of the moral order of society.

Most psychiatric historians have been inclined to equate the shift from religious or

demonological "explanations" of insanity toward a concep-

tion of it as illness with the progress of science.[13] As ideology, an account of the establishment of a medical monopoly over the treatment of insanity in these simplistic terms has obvious value, creating a myth with powerful protective functions for the profession of psychiatry. As explanation, however, its adequacy is distinctly more dubious, inasmuch as it completely ignores the social processes necessarily involved in any such transformation of perspectives.[14] Its utility is further diminished when one recalls that, 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 earlynineteenth-century medicine that would have given the medical profession a rationally defensible claim to possess expertise vis-à-vis insanity. In what follows, then, I hope we can discount the naive "march of progress" school so popular among psychiatric historians and instead give our attention to the social processes involved.

For all intents and purposes, the insane in England were not really treated as a separate category or type of deviant much before the middle of the eighteenth century. They were simply part of the larger, more amorphous class of the poor and indigent, a category that also included vagrants and various minor criminal elements. They were a communal and family responsibility, and all save the most violent and unmanageable were kept in the community, rather than being segregated into separate receptacles that kept them apart from the rest of society. At this stage, medical interest in and concern with insanity were practically nonexistent. During the course of the eighteenth century, these old, informal mechanisms began to be abandoned. In their place, the response to all forms of deviance assumed an increasingly institutional form. Workhouses, almshouses, houses of industry and correction, all these institutions at first accommodated an essentially mixed, heterogeneous population of the troublesome and dependent and made little effort to classify inmates by age or sex or according to presumed differences in their underlying pathology.

The insane shared in this general trend, and there now emerged a number of institutions specifically concerned with dealing with them as a separate category, a process accelerated by the difficulty of handling them in one of the ordinary mixed institutions. Most of these early

madhouses were private speculations run for profit. Given the difficulties others experienced managing the insane and the lack of restrictions or legal checks on the actual conduct of the business, they were generally a very lucrative investment. And it was precisely at this stage that the medical profession first began to assert an interest in lunacy. A number of doctors trying to gain a share of the lucrative new business, and possibly also to improve the treatment of the insane, began opening madhouses of their own and/or became involved in efforts to set up charity hospitals for the care of lunatics.[15]

The English medical profession at this time was composed of three separate elements—physicians, surgeons, and apothecaries—each of whom catered to a different clientele. The physicians, the elite's doctors, generally possessed a medical degree and, in London at least, were members of the Royal College of Physicians. But an M.D. was no guarantee of more than a passing acquaintance with classical authors in the fields, with no assurance of clinical experience; and membership in the college depended more on social connections than medical skill. Surgeons had only recently severed their links with the barbers' trade; entry into their ranks was usually by apprenticeship, and their status was distinctly lower than that of the physicians. Apothecaries catered largely to the middle and lower classes; they too were recruited by apprenticeship and lacked any real control over licensing and entry; so that those calling themselves apothecaries might vary from semi-illiterate quacks to highly competent practitioners by the standards of the time.[16]

The doctors entering the mad-business were not drawn exclusively from any one of these three classes; nor, so far as one can judge, did they differ significantly from the rest of the profession in skill or respectability. While "doctors" with little claim to the title did enter the field, so too did well-known society physicians and those trained at some of the best medical schools of the time.[17] By no means was the mad-business a refuge of only the most disreputable elements of the medical profession. To the contrary, those drawn from the most educated and literate elements of the profession were among the most vigorous and effective partisans of medicine's claims in this area and contributed most to its growing dominance of the field.

The earliest lay proprietors of madhouses had often attempted to attract clients by claiming to provide cures as well as care.[18] This idea that expert intervention could provide a means of restoring the deranged to reason naturally proved an attractive one. However, it was a much more plausible claim when asserted by the medical proprietors of madhouses. To understand why this should be so, one need only recall certain basic characteristics of eighteenth-century medicine.

Unlike its modern successor, eighteenth-century medicine did not involve identifying specific disease entities and then prescribing specialized treatments for them. Rather, it possessed an arsenal of what were regarded as useful weapons against all types of bodily dysfunction. No English doctor went quite so far as the American, Benjamin Rush, who reduced all illnesses to one underlying pathology and prescribed a single remedy, depletion.[19] Nevertheless, adherents of almost every one of the eighteenth-century medical "systems" exhibited a touching faith in a number of cure-ails—such things as purges, vomits, bleedings, and various mysterious colored powders, whose secrets were known only to their compounders. These theories and their associated remedies were read-

ily adapted to incorporate the new disease of insanity; it was but a small leap to assert that these things would also cure lunatics.[20]

The doctors, then, had an advantage when it came to justifying their claims to cure insanity, because everybody "knew" that they possessed powerful remedies whose use demanded special training and expertise and whose "efficacy" against a wide range of complaints was generally acknowledged. They exploited this advantage to good effect. The appearance of a number of books on the medical treatment of insanity added weight to their claim, and such famous medical teachers as William Cullen began to incorporate materials on the subject into their lectures, so that some physicians could assert that they had specialized training in this area.[21] On this basis, therefore, doctors were gradually acquiring a dominant, though not a monopolistic, position in the mad-business by the end of the eighteenth century. Numerically, they might still be a minority, but the view of insanity as an illness was by now popular in elite circles, particularly after George III began to suffer from recurrent bouts of derangement.

As I have shown elsewhere, during the eighteenth and early nineteenth centuries, conditions in both medically and nonmedically run madhouses generally ranged from the bad to the appalling.[22] In part because of the lack of legal checks on entry into the business or on subsequent conduct of it, gross exploitation and maltreatment of patients

were common.[23] And it was a particular instance of this kind of maltreatment, involving the death under mysterious circumstances of an inmate of the York Asylum, that provoked the decision to set up the York Retreat. Here there emerged an alternative approach to the mentally disturbed that for a time threatened the growing dominance of medicine in this field.

William Tuke, the founder of the Retreat, was a layman with a considerable, and not entirely unmerited, distrust of the medical profession of his day.[24] His primary concern was with providing humane care for insane Quakers, though he also hoped, if possible, to cure them. Skeptical as he was of medicine's value, he possessed a sufficiently open mind to investigate its claims to have specific remedies for mental illness. With his encouragement, both the first visiting physician, Dr. Thomas Fowler, and his successors made a trial of all of the various medicines and techniques that members of the profession

had suggested.

The results must have been a disappointment, though perhaps not a surprise. In Samuel Tuke's words, "The experience of the Retreat . . . will not add much to the honour or extent of medical science. I regret . . . to relate the pharmaceutical means which have failed, rather than to record those which have succeeded."[25] Fowler found that

> the sanguine expectations, which he successively formed of the benefit to be derived from various pharmaceutical remedies, were, in great measure, as successively disappointed; and, although the proportion of cures, in the early part of the Institution, was respectable, yet the medical means were so imperfectly connected with the progress of recovery, that he could not avoid suspecting them, to be rather concomitants than causes. Further experiments and observations confirmed his suspicions, and led him

> to the painful conclusion (painful alike to our pride and our humanity), that medicine, as yet, possesses very inadequate means to relieve the most grievous of human diseases.[26]

Fowler's death in 1801 and the swift demise of his successor meant that the Retreat had three visiting physicians within its first five years of operation. Both of the others arrived convinced of medicine's applicability and value. Both were disillusioned: "They have had recourse to various means, suggested by either their own knowledge and ingenuity, or recommended by later writers; but their success has not been such, as to rescue this branch of their profession, from the charge, unjustly exhibited by some against the art of medicine in general, of its being chiefly conjectural."[27] Numerous trials had shown that all the suggestions that had been made, with the exception of warm baths for melancholics, were either useless or positively harmful.

Henceforth, the visiting physician confined his attention to treating cases of bodily illness, and it was the lay people in charge of the day-to-day running of the institution who began to develop the alternative response to insanity that became known as moral treatment.[28] One cannot readily summarize in a phrase or two what moral treatment consisted of, nor reduce it to a few standard formulas, for it was emphatically not a specific technique. Rather, it was a general, pragmatic approach aimed at minimizing external, physical coercion; and it has, therefore, usually been interpreted as unproblematically "kind" and "humane." Instead of merely resting content with controlling those who were no longer quite human, which had been the dominant concern of traditional responses to the mad, moral treatment actively sought to transform the lunatic, to remodel him or her into something approximating the bourgeois ideal of the rational individual; and as part of this process, an effort was made to create an environment that removed the artificial obstacles standing in the way of the "natural" tendencies toward recovery. Tuke was convinced that "there is much analogy between the judicious treatment of children and that of insane persons."[29] One should seek to reeducate the patients, teach them to reassert their powers of self-control.[30] This ap-

proach involved "treating the patient as much in the manner of a rational being, as the state of mind will possibly allow,"[31] rather than using motives of fear as a way of managing the patient. Far from harshness being necessary to avoid violent outbreaks among the inmates, it tended only to produce them.[32]

Treated less harshly and more nearly as rational human beings, the patients at the Retreat responded by acting less like the traditional stereotype of the raving maniac. Tuke's contention that "furious mania is almost unknown at the Retreat . . . and that all the patients wear clothes and are generally induced to adopt orderly habits"[33] agrees with the independent observations of visitors.[34] The refusal to use chains, the absence of physical abuse or coercion of patients, and the success in restoring them to a measure of dignity and self-respect, all contrasted sharply with the prevailing conditions in most madhouses of the period.[35] Perhaps even more spectacular were the changes thus effected: Despite a conservative outlook that classified no one as cured who had to be readmitted to an asylum, the statistics collected during the Retreat's first fifteen years of operation seemed

to show that moral treatment could restore a large proportion of cases to sanity. Of recent cases (those of less than a year's standing), twenty-one out of thirty-one diagnosed as mania had recovered; nineteen out of thirty cases of melancholia were restored; and four others were sufficiently improved that they no longer required confinement. Even among long-standing and apparently hopeless cases, a respectable number were discharged as cured.[36] Andrew Duncan was so impressed by his visit to the Retreat that he commented: "The fraternity denominated Quakers have demonstrated beyond contradiction the very great advantages resulting from a mode of treatment in cases on Insanity much more mild than was before introduced into any Lunatic Asylum at home or abroad. In the management of this institution, they have set an example which claims the imitation, and deserves the thanks, of every sect and every nation."[37]

These results were given considerable publicity through the efforts of a stream of visitors interested in lunacy reform and through Tuke's own writings.[38] However, though there were exceptions like Duncan, the initial response of most of the medical profession to the claims of moral treatment was one of hostility. In the face of the evidence, they simply tried to reassert the value of the traditional medical approach. Hill's book, perhaps the best-known work on the subject published at this time, assured its readers that "insanity is as generally curable as any of those violent Diseases most successfully treated by Medicine,"[39] and truculently asserted that "direct medical remedies can never be too early introduced or too readily applied."[40] Nisbet concurred: "The disease of insanity in all its shades and varieties, belongs, in point of treatment, to the department of the physician alone. . . . The medical treatment . . . is that part on which the whole success of the cure hangs."[41] And when the 1815 Select Committee asked Dr. John Weir, the official inspector of the conditions naval maniacs were kept under, for his opinion on the value of medical intervention, he qualified his answer only slightly: "In recent cases, and those unconnected with organic lesions of the brain, malformation of the skull, and hereditary disposition to insanity . . . medical treatment is of the utmost importance."[42] Nor should this reaction come as a surprise. After all, moral treatment challenged the traditional paradigm of what was suitable as a method of treating illness of any sort. Furthermore, the wholesale rejection of standard medical techniques naturally ran counter to the profession's deep intellectual and emotional investment in the value of its own theory and practice.

Those outside the profession, of course, lacked any such prior commitments and so were readier converts. In particular, those laymen who, for a number of years, had been agitating for lunacy reform on humanitarian grounds but who had previously lacked a viable alternative model to existing asylums eagerly seized on moral treatment. Since it was these lay people, primarily magistrates and upper middle-class philanthropists, who were the prime movers in the effort to reorganize the treatment of insanity through changes in the law, their conversion was a highly significant one.

Within two years of the publication of Tuke's *Description of the Retreat*, which brought the Retreat national attention, a series of revelations about the conditions in other madhouses further undermined medicine's claims to expertise or special competence in the treatment of insanity. Separate investigations of conditions at Bethlem and the York Asylum, hitherto regarded as among the leading institutions under medical control, uncovered evidence of systematic cruelty and maltreatment of patients,[43] reflected in extremely high mortality rates. This discovery in itself provided a highly unfavorable comparison with the layrun Retreat. Furthermore, the evidence of even the medical witnesses before the Select Committee provided support for William Tuke's contention that "in cases of mental derangement . . . very little can be done by way of medical treatment."[44]

The evidence given by Charles Best and Thomas Monro, physicians at York and Bethlem respectively, was particularly damaging. The Monro family had been physicians to Bethlem for almost a century, and prior to this Thomas Monro himself had been thought of as one of the foremost experts on the medical treatment of insanity. Like Best, though, the credibility of his testimony was colored by the committee's knowledge of conditions in his asylum, and he was treated as a hostile witness. Under close questioning by the

committee, the extent of his medical treatment was now revealed to the public: "In the months of May, June, July, Au-

gust and September, we generally administer medicines; we do not in the winter season, because the house is so excessively cold that it is not thought proper. . . . We apply generally bleeding, purging, and vomits; those are the general remedies we apply. . . . All the patients who require bleeding are generally bled on a particular day, and they are purged on a particular day."[45] Later in his testimony, Monro gave a few more details: all the patients under his care, except those manifestly too weak to survive such a heroic regime, "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."[46] Thereafter, of course, patients were kept chained to their beds at least four days out of every seven.

A committee convinced of the value of moral treatment's emphasis on treating every lunatic as an individual was in principle unlikely to approve of such indiscriminate mass medication. Under the even more hostile questioning he now faced, Monro was forced to make a still more damaging admission. "Do you think," he was asked, "it is within the scope of medical knowledge to discover any other efficacious means of treating Insane persons?" "With respect to the means used, I really do not depend a vast deal upon medicine; I do not think medicine is the sheet anchor; it is more by management that those patients are cured than by medicine. . . . *The disease is not cured by medicine, in my opinion. If I am obliged to make that public I must do so* ."[47] The only question that remained was why Monro continued to employ therapies he conceded were useless. He himself had already provided an answer to that: "That has been the practice invariably for years, long before my time; it was handed down to me by my father, and *I do not know any better practice* ."[48]

St. Luke's Hospital, London's other charity asylum, had not come in for the severe criticism directed at Bethlem. Nevertheless, when its physician, Dr. A. J. Sutherland, was called to give evidence, his answers were extremely circumspect, and he sought to be as noncontroversial as possible. While he felt that medicines for the stomach might be of some indirect benefit, he conceded that "moral treatment is of course more especially important in the treatment of mental disorder."[49] Similarly, when Dr. John Harness, a commissioner of the Transport Board, was asked "what was his opinion as to the utility of medical treatment of Insanity," he replied: "Although much may be effected by medical treatment, I have before stated that I am not sanguine in the expectation of a permanent advantage from it."[50]

Doctors at this time played another important role vis-à-vis the insane. Five commissioners selected from the members of the Royal College of Physicians were charged with annually inspecting metropolitan madhouses under the 1774 Act. Even conceding the defects of the act, as the reformers did, their record was hardly one to inspire confidence in a system of medical policing of asylums or in physicians' willingness to judge the work of their colleagues. According to Dr. Richard Powell, the secretary to the Royal College and himself a commissioner, the visits took no more than six days a year to perform. Often as many as six or eight madhouses were visited in a day. No attempt was made to check whether the numbers resident corresponded to those the commissioners had been notified of. The justification for medical visitation was primarily that no one else was competent to assess the medical treatment administered. Yet Powell conceded that, apart from cursory inquiries as to the condition of the patients, no effort was made to discover what medical treatment the patients received, let alone to find out how effective it was.

The most respectable medical figure to appear before the committee was Sir Henry Halford, who was already "indisputably at the head of London practice." A favorite of George III's, he was later physician to George IV and Victoria, and from 1820 to his death in 1844, president of the Royal College of Physicians.[51] As the official spokesman for the most prestigious branch of the medical profession and an influential figure in elite circles, he obviously presented his evidence with a view to making a strong case for the value of the medical approach and in an effort to rectify the damage done by Best's and Monro's

testimony. In practice, his evidence was too rambling and confused for that. Having begun by asserting that medical intervention was valuable, at least in the early stages of the disorder, he subsequently conceded that "our knowledge of insanity has not kept pace with our knowledge of other distem-

pers," a situation he blamed on "the habit we find established, of transferring patients under this malady, as soon as it has declared itself, to the care of persons who too frequently limit their attention to the mere personal security of their patients, without attempting to assist them by the resources of medicine." "The profession," he acknowledged, had "much to learn on the subject of mental derangement." By the end of his testimony, he had given the impression that medicine lacked reliable knowledge in this area and could offer little by way of effective therapy. In mitigation, he declared that "we want facts in the history of the disease" and coupled this asseveration with the vague hope that "if they are carefully recorded, under the observation of enlightened physicians, no doubt, they will sooner or later be collected in sufficient number, to admit of safe and useful inductions."[52] As a performance, this was scarcely calculated to convince the somewhat skeptical audience he faced. He had provided neither evidence nor plausible argument to refute the contention of those who favored moral treatment that "against mere insanity, unaccompanied by bodily derangement, [medicine] appears to be almost powerless."[53] Nor had he succeeded in erasing the unfavorable impression created by earlier medical testimony.

If Monro did not know of any better weapons to use against insanity than the traditional antiphlogistic system, the laymen who were acquainted at first hand with the results of moral treatment obviously thought that *they* did. Both their testimony before official inquiries and the pamphlets they were busily writing now took on a tone of considerable hostility to medicine's claims to jurisdiction in this area. When Edward Wakefield was asked, "In consequence of the observations you have made on the state and management of the Lunatic Establishments, and the manner of inspecting them, are you of the opinion that medical persons exclusively ought to be Inspectors and Controllers of Madhouses?" his response was:

> I think they are the most unfit of any class of persons. In the first place, *from every enquiry I have made, I am satisfied that medicine has little or no effect on the disease, and the only reason for their selection is the confidence which is placed in their being able to apply a remedy to the malady* . They are all persons interested more or less. It is extremely difficult in examining either the public Institutions or private houses, not to have strong impression upon your mind, that medical men derive a profit in some shape or form from those different establishments. . . . The rendering therefore, [of] any interested class of persons the Inspectors and Controllers, I hold to be mischievous in the greatest possible degree.[54]

Higgins, who had witnessed at first hand over many months the practices of one of the most famous medical "specialists" in the field, was, if anything, still more hostile. He pointed out that in the aftermath of Dr. Best's departure from the York Asylum and the establishment of an efficient system of lay visitation there, the number of deaths of patients fell from twenty a year to only four. Furthermore, thirty patients were almost at once found fit for discharge. In his caustic fashion he demanded to know "who after this will doubt the efficacy of my medicine—visitors and committees? I will warrant it superior even to Dr. Hunter's famous secret—*insane powders* —either green or grey—or his patent Brazil salts into the bargain."[55] Higgins was clearly angered by the efforts of the medical profession to explain away as legitimate medical techniques for "treating" insanity what he perceived as cruelty or to attribute to the progress of the condition itself what he saw as the consequences of neglect. In contemptuous tones, he commented:

> Amongst much medical nonsense, published by physicians interested to conceal their neglect, and the abuses of their establishments, it has been said, that persons afflicted with insanity are more liable than others to mortification of their extremities. Nothing of the kind was ever experienced at the institution of the Quakers. If the members of the royal and learned College of Physicians were chained, or shut up naked, on straw saturated with urine and excrement, with a scanty allowance of food, exposed to the indecency of a northern climate, in cells having windows unglazed, I have no doubt that they would soon

exhibit as strong a tendency to mortified extremities, as any of their patients.[56]

William Ellis, though himself medically qualified,[57] by now possessed firsthand acquaintance with Tuke's work at the Retreat and had absorbed much of the latter's skepticism about the activities of his fellow professionals. His *Letter* to Thomas Thompson, M.P. (a member of the Select Committee), contained a number of critical remarks directed at them. In particular, he alleged that "the management of the insane has been in too few hands; and many of those who have been engaged in it, finding it a very lucrative concern, have wished to involve it in great mystery, and, in order to prevent institutions for their cure from becoming more general, were desirous that it should be thought that there was some secret in the way of medicine for the cure, not easily to be found

out. Some medical men have gone so far as even to condescend to the greatest quackery in the treatment of insanity."[58] To the contrary, Ellis contended there were no medical specifics for the successful treatment of madness, and acceptance of the idea that care of the insane was best left to experts, medical or otherwise, was the surest guarantee of abuse. In his own proposals for reform, therefore, he advocated constant lay supervision of all asylums by local magistrates.[59]

The propagation of the notion that "very little dependence is to be placed on medicine alone for the cure of insanity"[60] posed a clear threat to the professional dominance of this field. Given that those most convinced of the truth of this proposition were also the prime movers in trying to obtain lunacy reform, the doctors interested in insanity were unable any longer to ignore or depreciate moral treatment. They had to find some way to accommodate it.

At first sight, moral treatment seemed to be an unpromising basis for any profession trying to assert special competence in the treatment of the insane. In Freidson's words, "One of the things that marks off professions from occupations is the professions' claims to schooling in knowledge of an especially esoteric, scientific, or abstract character that is markedly superior to the mere experience of suffering from the illness or having attempted pragmatically to heal a procession of sufferers from the illness."[61] Moral treatment had begun by rejecting existing "scientific" responses as worse than useless; and the remedies proposed in their place—warm baths and kindness—hardly provided much of a foundation for claims to possess the kinds of expertise and special skills that ordinarily form the basis for the grant of professional autonomy.

In practice, however, this feature of moral treatment proved an advantage to those bent on reasserting medicine's jurisdiction in this area. The very difficulty of erecting professional claims on such a flimsy basis largely precluded the emergence of an organized group of competitors—lay therapists. Moreover, Tuke had explicitly *not* sought to create or train a group of experts in moral treatment. To the contrary, he and his followers were deeply suspicious of any plan to hand the treatment of lunatics over to the experts. The essence of moral treatment was its emphasis on humanity, and humanity was not a quality monopolized by experts. Indeed, the grant of a measure of autonomy that accompanied the acceptance of someone as an expert threatened to remove the surest guarantee of humane treatment of the insane: searching inquiry and oversight by outsiders.

Interestingly enough, the earliest recruits to moral treatment were primarily those who were interested in the cause of lunacy reform, but who were unlikely, given their social status, to undertake themselves the task of administering an asylum—magistrates and upper-class philanthropists. The major exception to this generalization, William Ellis (who from 1814 on ran the Refuge, a private madhouse at Hull), was a doctor rather than just an expert on moral treatment. In the absence of any rival helping group, medicine set about assimilating moral treatment within its own sphere of competence.

Even while specifically denying medical claims to expertise in the area of insanity, the promoters of moral treatment had continued to employ a vocabulary laden with terms borrowed from medicine—"patient," "mental illness," "moral treatment," and so on. This failure to develop an alternative jargon itself made the reassertion of medical control somewhat easier, inasmuch as one of the most important connotations of the label

"illness," and its associated array of concepts, is the idea that the syndrome to which it is applied is essentially a medical one. Given the critical role of language in shaping the social construction of reality, to employ terms implying that something is a medical problem and yet to deny that doctors are those most competent to deal with it seems perverse.

The lack of a coherent, well-articulated theory as an alternative to the model of insanity had this further consequence: that the denial of the applicability of medicinal remedies implied a view of insanity as essentially irremediable ("incurable") or as remediable ("curable") only by accident or through the operation of spontaneous tendencies toward recovery. Tuke himself seems to have adhered to the latter view. Thus, in his efforts to secure the establishment of asylums for the insane poor, he urged that "though we can do but little by the aid of medicine towards the cure of insanity, it is surely not the less our duty to use every means in our power to alleviate the complaint, or at least place the poor sufferer in a situation where nature may take her own course, and not be obstructed in the relief which she herself would probably bring to him."[62] And his discussion of the Retreat's success in restoring patients to sanity concludes: "As we have not discovered any anti-maniacal specific, and profess to do little more than assist Nature, in the performance of her own cure, the term *recovered,* is adopted in preference to that of *cured* ."[63] Such modesty may well have been warranted; yet it was scarcely as appealing as the claim that one could actively influence the outcome in the desired direction.

All this meant that the challenge moral treatment posed to the medical dominance of insanity was not as clear-cut as it might have been. Furthermore, the medical profession possessed certain initial advantages as it sought to reassert its jurisdiction, advantages that could, however, have proved purely ephemeral. After all, there were, as yet, no legal barriers to the development of an organized rival group of therapists, and language is not immutable. The interested segments of the medical profession now moved to secure what they rightly perceived to be their imperiled position.

The potential consequences of taking Tuke seriously were most clearly articulated by Browne half a century later: "If therapeutical agents are cast aside or degraded from their legitimate rank, it will become the duty of the physician to give place to the divine or moralist, whose chosen mission it is to minister to the mind diseased; and of the heads of establishments like this [lunatic asylum] to depute their authority to the well-educated man of the world, who could, I feel assured, conduct an asylum fiscally, and as an intellectual boarding-house, a great deal better than any of us."[64] Earlier he had complained that "a want of power or inclination to discriminate between the inutility of medicine from its being inapplicable, and from its being injudiciously applied, had led to the adoption of the absurd opinion that the insane ought not to be committed to the charge of medical men. A manager of a large and excellent institution, entertaining this view, has declared the exhibition of medicine in insanity was useless, and that disease was to be cured by moral treatment only."[65]

The pernicious doctrine that traditional medical remedies were useless had spread dangerously far, even among those who continued to insist that doctors were the most qualified to treat lunatics. "We must confess," said Spurzheim, "that hitherto medical art has acquired very little merit in the cure of insanity; nature alone does almost everything."[66] When the *Quarterly Review* 's correspondent argued for medical control, he simultaneously made the dangerous concession that "the powers of medicine, merely upon mental hallucination are exceedingly circumscribed and feeble. . . . we want principles on which to form any satisfactory indications of treatment. . . . Almost the whole . . . of what may be called the strict medical treatment of madness must be regarded, at present, at least, as empirical, and the most extensive experience proves

that very little is to be done."[67] Casting about for justifications for his insistence on medicine's entitlement to preeminence, he found remarkably few. The administration of warm baths now became something that could only be done under careful professional supervision. After all, the use of such a powerful technique had to be guided by an expert assessment of the condition of the individual patient. Cathartics were somehow rescued

from the oblivion into which other medical remedies had been cast, once more with the caution that "the practice of purging" was by no means "of so simple and straight-forward a nature as might be at first sight conceived."[68] Conscious that these contentions might seem less than compelling, he resorted to the argument from experience: "Were it only an account of the frequent opportunities which more strictly medical practitioners have of witnessing aberrations of the intellect, from different sources, these would appear to be the fittest persons for the treatment of lunacy."[69]

The necessity for a more strenuous and convincing defense of professional prerogatives was clear. In the aftermath of the findings of the 1815–16 Select Committee, the reformers in the Commons attempted to devise a system of strict outside supervision and control of madhouse keepers, to ensure against the repetition of previous abuses. In 1816 and 1817, bills were introduced to set up a Board of Inspection of madhouses for each county, to be chosen annually from among the county magistrates. The proposal was revived in 1819, with the addition of a permanent Board of Inspection for the whole country, which was to visit all houses "at different and uncertain times."

All three of these bills would have empowered the boards of laymen to inquire into the treatment and management of patients, to direct discontinuance of practices they considered cruel or unnecessarily harsh, and to order the discharge of any patient they considered restored to sanity. If one follows Freidson in considering autonomy (the right to deny legitimacy to outside criticism of work and its performance) as the core characteristic of any profession, such proposals to introduce lay control and evaluation of expert performance must clearly be seen as of enormous strategic importance and as likely to provoke intense opposition from those threatened by such control. And that opposition was indeed forthcoming from doctors in the mad-business.

Burrows, in particular, was scathing in his criticisms of these bills. Somewhat disingenuously, he commented: "The provision of this [1817] Bill induces me to conclude that I certainly misinterpreted the import of many of the queries of the Members of the Committee of Inquiry; for I was led to think that a conviction had arisen out of the investigation, that all houses for the reception of insane persons ought to be under the superintendence of men of character and ability, and particularly of medical men."[70] Assuming that this was so (a large assumption, of course), it was simply absurd to allow the judgment of rank amateurs to override the mature judgment of a competent expert. If the legislature was convinced of the necessity of appointing commissioners to inspect madhouses, these ought, as in the past, to be medical men. One faced a situation in which "the most experienced will acknowledge the liability of being deceived, even where frequent opportunities of judging of the sanity of the mind have occurred. How then can those who are not only casual but unprofessional visitors pretend to decide on any particular case, or prescribe any alteration, or condemn any mode of treatment?"[71] It made no sense to ask a layman to pass judgment on the curative treatment of a patient, "for if any difference of opinion were to arise upon a question relative to the management or release of a patient, it were surely most proper that the medical opinion should prevail."[72] Furthermore, allowing "country gentlemen" to visit asylums, unaccompanied by medical men, in order to check for possible abuses, threatened the welfare of the patients in the most serious possible degree. The commotion their visits would cause, and the interference their ignorance might lead them to indulge in, would set at naught the asylum doctor's most skillful efforts to cure his patients. Consequently, the reformers could proceed with their plans only at "the hazard of great injury to the patients."[73]

In the Commons, the lunacy reformers, remaining unmoved by these arguments, managed to secure the passage of each of the bills they introduced. The House of Lords, however, proved more receptive and in each instance exercised its veto powers. Undoubtedly, in so doing they were not motivated simply by the desire to protect the prerogatives of the medical profession. A strong faction there was opposed to any effort to extend the scope of central government authority. Aristocratic families with a lunatic in the closet were determined to avoid publicity, and hence the provisions in the 1816 and 1817 bills for a central register of "single lunatics" provoked further opposition.[74] Furthermore,

the High Tories in the Upper House were disposed to reject on principle all type of "liberal" reform—their principal spokesman, Lord Eldon, the Lord Chancellor, once referred to "philanthropists" as "men pretending to humanity but brimful of intolerance, and swollen with malignity, which they all are." [75] ,

At the very least, however, the protests of the medical profession provided the Lords with a convenient ideological cloak for their opposition,

and while votes may actually have been swayed by other considerations, they were justified on these neutral, technical grounds. The Marquis of Landsdowne, who introduced the 1819 bill into the Lords, clearly foresaw the direction the debate would take and sought to reassure his audience that, while some systems of visitation and control by outsiders "might retard the cure of persons so affected," the insane would only benefit from the specific provisions of this bill.[76] Speaking against the bill, Eldon brushed this assuagement aside and reiterated the standard professional line: "It was of the utmost importance, with a view to the proper care of these unhappy individuals, and with a view to their recovery that they should be under the superintendance [*sic*] of men who had made this branch of medicine their peculiar study, and that the superintendence of physicians should not be interfered with." Yet this was precisely what the bill before them sought to do, and in consequence, "he conscientiously believed its regulations would tend to aggravate the malady with which the unfortunate persons were afflicted, or to retard their cure." One of the most objectionable features of the bill from his (and the medical profession's) perspective was that it "gave a number of penalties, half of which were to go to the informer, and *it was evident that the informer would be found amongst the attendants and servants in receptacles for lunatics, who would thus be made the judges of the conduct of the physicians,* and it would be impossible for the latter, under such circumstances, to resort to many of these means which their experience had taught them were most effectual for the cure of their unhappy patients."[77] Eldon had the authority of the best medical opinion behind him, when he asserted that "there could not be a more false humanity than an over-humanity with regard to persons afflicted with insanity," and in the division which followed, the bill was rejected 35 to 14.[78]

Temporarily, at least, the mad-doctors had successfully resisted efforts to restrict their professional autonomy, for with the rejection of the 1819 bill, the reform movement lost its momentum. Their victory was a fragile and uncertain one, however, so long as it rested on a marriage of convenience with political forces whose power was on the wane, and so long as they remained vulnerable to charges from moral-treatment enthusiasts that their expertise had no scientific or practical foundation. If they were to overcome their vulnerability, they had to develop a more sophisticated justification of their privileged position.

As part of this process, from about 1815 onwards, a veritable spate of books and articles purporting to be medical treatises on the treatment of

insanity began to appear.[79] Similarly, the claim that instruction in its treatment formed a part of the normal curriculum of medical training, which had been made by earlier generations of mad-doctors, was reinforced when Dr. (later Sir) Alexander Morison, a well-known society physician, began a course of lectures on the topic. These he repeated annually from 1823 to the late 1840s, while the published version simultaneously went through a number of editions. All this activity was probably

stimulated at least in part by the increased attention all members of the educated elite were giving to insanity, in the wake of two major parliamentary inquiries into the subject within the short space of eight years and in consequence of the revelations of the second of these about conditions in madhouses. But more importantly than that, it represented an effort to reassert the validity of the medical model of mental disturbance and to ensure a maximum of professional autonomy in the treatment of lunatics.

Dr. Francis Willis explicitly wrote his treatise to emphasize the medical nature of insanity, an endeavor rendered "the more necessary, because derangement has been considered by some to be merely and exclusively a mental disease, curable without the aid of medicine, by what are termed moral remedies; such as travelling and various kinds of amusements."[80] The language used by John and Thomas Mayo was even more revealing. Their announced purpose in publishing their *Remarks on Insanity* was "to vindicate the rights of [our] profession over Insanity, and to elucidate its medical treatment,"[81] two tasks that were obviously closely connected. For the mere existence of a large body of what purported to be technical literature passing on the fruits of scientific knowledge about the management of the insane gave impressive-seeming substance to the claim of expertise, regardless of its practical usefulness or merits. Complicated nosographies like that developed by Prichard bewildered and impressed the average layman; given such an array of diagnostic categories, recognition of the precise form of mental disease an individual lunatic was laboring under clearly became a matter for expert determination.

When medical ideas about insanity had to be presented to a lay audience, the availability of a large body of specialized knowledge was valuable in a different way. For it enabled writers who wanted to advance medicine's cause to circumvent the ordinary requirement that they produce evidence in support of their contentions. Nontechnical discussion of the medical treatment of insanity could be justified on the grounds of the general importance of making the public aware of the potential contribution medicine could make, but any pressures to move beyond vague generalities could now be resisted as being "more properly the province of journals exclusively devoted to technical science."[82] Such "purely professional" topics would "only be interesting to a comparatively small number of our readers,"[83] and would simply be above the heads of the majority of lay readers, since they lacked the requisite training.[84]

Morison's lectures were the most visible sign that members of the medical profession were in fact receiving training. It scarcely mattered that Morison himself had no practical experience that would have given him justification for claiming expertise in this area; or that his lectures were an unoriginal mélange of ideas uncritically assembled from existing works in the field.[85] Instruction in "a curriculum that includes some *special* theoretical contact (whether scientifically proven or not) may represent a declaration that there is a body of special knowledge and skill necessary for the occupation,"[86] which is not otherwise obtainable. Here, the availability of special education, regardless of its specific content or scientific validity, bolstered the medical profession's claims to expertise and esoteric knowledge.

The effort to press these claims proceeded on other fronts as well. The more respectable part of the medical profession used its prestige and ready access to elite circles to promote its cause. As part of this process, medical men running asylums made strenuous and eventually successful efforts to persuade their lay audience that they possessed a more common and/or intense commitment to a service orientation than did their nonmedically qualified competitors. At a time when madhouses were acquiring considerable disrepute, Nisbet took pains to emphasize that "out of thirty-three licenses for the metropolis, only three are in the hands of medical men. The chief part is in the hands of persons unacquainted with medicine, who take up this branch of medicine as a beneficial pursuit, and whose object is to make the most of it."$_{87}$ Similarly, Conolly urged the importance "of making medical men as familiar with disorders of the mind as with other disorders; and thus of rescuing lunatics from those whose interest it is to represent such maladies as more obscure, and more difficult to manage than they are."[88] Burrows' writings[89] and his evidence before the 1828 Select Committee
[87]

of the Honse of Lords likewise both reflected and promoted "the widespread view that lay proprietors were more likely to be corrupt and avaricious than their medically trained colleagues."[90] So that when the *Quarterly Review* informed its readers that "the superintendent of a mad-house ought to be a man of character and responsibility," it recommended in the same breath that "be should always be chosen from the medical

profession."[91]

The articles that appeared in the leading journals of the period either were themselves written by a physician[92] or presented an account of insanity sympathetic to the medical viewpoint.[93] The profession did not neglect the opportunity to show itself in a favorable light. Those, for instance, who relied on the *Edinburgh Review* 's summary for an account of the tradings of the 1815—16 Inquiry learned that "it is the decided opinion of *all* the most judicious and experienced witnesses examined before the Committee, that the proper employment of medicine, though neglected most deplorably in several public asylums, and in almost all the private establishments, has the best effect in cases of insanity."[94] Similarly, Burrows informed his readers that "from a perusal of the replies to the Questions put by the Committee, it is evident that insanity is greatly under the control of medicine—a fact that strictly accords with my own observations."[95]

The profession was able to use its representation in Parliament, as well as its position as one of the three ancient learned professions, to ensure that its views received due consideration. When there was a renewed inquiry into conditions in private madhouses, it could call on the services of eminently respectable society physicians like Sir Anthony Carlisle and Dr. John Bright to lend their authority to the contention that this was a medical problem. Medical certitication of insanity (for private patients only) had been required by the 1774 Madhouse Act as an additional security against improper confinement of the sane, and the doctors-now sought to clarify and extend their authority in this area, so as to develop an officially approved monopoly of the right to define (mental) health and illness.[96] Further efforts to get medicine's special competence vis-à-vis the insane recognized and written into the growing

volume of lunacy legislation based on the findings of the 1827 Select Committee was pending in the House of Lords, where a special committee sat to hear the views of the medical profession on the proposed changes. The testimony of men like E. L. Fox, W. Finch and W. T. Monro is indicative of considerable resentment of supervision and inspection by magistrates, particularly when efforts were made by these laymen to meddle with decisions that were properly the prerogative of the professional, such as when a patient was ready for discharge.[97] While legislation was pending, the Royal College of Physicians appointed a committee of its own to (as Parry-Jones delicately puts it) "enquire into the expediency of the provisions of the 1828 Bill."[98] And at the same time, a rash of pamphlets written by members of the medical profession appeared, urging that further inspection was "a useless inquisition into private concerns, destructive of all that privacy that is truly desirable for the patient" and that the proposal itself "betrays a want of confidence in their [mad-doctors'] moral and medical character."[99]

Some outside regulation and inspection of asylums was made inevitable by the continuing revelation in their absence of abuses and maltreatment of patients. Hence, the doctors sought to turn this into a system of professional self-regulation by obtaining a dominant role for medical practitioners. Under the 1828 Act, in the provinces only the medical visitor, and not the magistrates who accompanied him, received payment, while among the newly created metropolitan commissioners in lunacy, five out of fifteen were physicians. This representation was not achieved and maintained without a struggle. As late as 1842, Ashley expressed considerable skepticism about any requirement that commissioners, to inspect asylums, should be medically qualified, arguing that "although so far as health was concerned the opinion of a medical man was of the greatest importance, yet it having been once established that the insanity of a patient did not arise from the state of his bodily health, a man of common sense could give as good an opinion as any medical man he knew [respecting his treatment and the question of his sanity]."[100] Thomas Wakely, M.P., the editor of the leading medical periodical, the *Lancet,* defended his profession's prerogatives, terming insanity "a griev-

ous disease" and stigmatizing any proposal to have lunatic asylums inspected by lawyers alone as "an insult to the medical profession."[101] Such a proposal now formed a part of the Licensed Lunatics Asylums Bill, introduced to expand temporarily the jurisdiction of the metropolitan commissioners to allow them to inspect asylums throughout the

country, in preparation for a further national reform. When the bill came up again, Wakely renewed his attack: "He objected to the clause appointing barristers to the office of commissioners of lunatic asylums. What could be more absurd than to select members of the legal profession to sit in judgement on cases of mental derangement? Was not insanity invariably associated with bodily disease? The investigations in which the commissioners would be involved would be purely of a medical character, and therefore barristers, if they were appointed, would be incompetent to perform the duties which would devolve upon them."[102] "On the contrary," observed Lord Granville Somerset, "the commissioners were solely concerned with whether [the lunatic] was treated properly and with kindness," and this could as well be discovered by a lawyer as by a doctor.[103]

Both sides had their adherents in the debate that followed, and eventually some sentiment emerged for a compromise, whereby the commissioners would operate in pairs, one with legal and one with medical training. This was the solution eventually adopted, so that the number of metropolitan commissioners was expanded to include seven doctors—John Bright, Henry Herbert Southey, and John Robert Hume were joined by Thomas Turner, Thomas Waterfield, Francis Bisset Hawkins, and James Cowles Prichard.[104] Since the 1844 Commission Report formed the basis of the 1845 reforms, this expanded medical representation was of considerable importance. When the Report discussed the nature of insanity and its medical and moral treatment, the lay members of the commission deferred to the specialized knowledge of their medical colleagues, and thus these sections of the Report faithfully reflected the orthodox medical viewpoint. In turn, this official acknowledgment of medicine's legitimate interest in insanity (and Ashley was now one of the converted) helped shape the legislation and its subsequent implementation.

Simultaneously, the profession was active on the local level, where the magistrates who were engaged in setting up the new system of public asylums were an obvious target for these efforts. In some counties the magistrates were already convinced that insanity was a medical province and hence needed no prompting to place their asylum in the hands of the local doctor. At Nottingham, for instance, Reverend Becher, who was the man most responsible for getting the asylum built, was convinced that the management of insanity "is an art of itself,"[105] and madness a disease having its basis in organic lesions of the body that only doctors were competent to treat.[106] In consequence, an apothecary was placed in charge of the day-to-day management of the asylum, subject to the control of a visiting physician "who shall be entrusted with the medical treatment of the patients."[107] The magistrates at Hahwell and Wakefield followed a similar plan, except that here ultimate authority rested in "the hands of the Resident Physician."[108]

Elsewhere, however, asylum committees chose to place the daily control of the institution in the hands of a lay superintendent, or even tried to run it themselves. The Staffordshire magistrates chose a layman as their chief resident officer. At the Cornwall Asylum at Bodmin after the first appointment of a surgeon, James Duck, as superintendent proved unsatisfactory, he was replaced by a lay "Governor and Contractor."[109] The magistrates at Bedford initially also chose this latter plan. Among the candidates they considered to head their asylum were a former assistant keeper at St. Luke's and a house painter, who had some experience looking after a lunatic he had come across in the course of his business.[110] The magistrates had previously decided that, since the medical care needed by the lunatics was slight, and they "will not . . . require the same species of unremitting attention during the whole of the four and twenty hours as Patients in Hospitals do," that "Mr. Leach, our House Surgeon at the Infirmary who so ably discharges his duties there might from the Contiguity of the Establishments" be induced to attend to the occasional medical needs of the Asylum patients.[111] At a subsequent

meeting held on 27 April 1812, the house painter, William Pether, and his wife were appointed "the Governor and Matron of the Lunatic Asylum with a Salary of Sixty Guineas per Annum."[112]

Within less than a year, local physicians were seeking their first foothold in the new institution. A letter was received from a Dr. G. O. Yeats offering "to undertake the office of the Medical Superintendent and Physician of this Institution gratuitously."[113] He justified

the need for such assistance by pointing out that there were "a considerable number of lunatics whose diseases will require medical aid." Naturally enough, the offer was accepted.[114] A few more months went by before Yeats tried to convince the magistrates that medicine could be used not merely to cure the patients' physical ailments, but also to help restore them to sanity. In a second long letter to the managing committee, he argued that "however anxious the legislature has been strictly to confine the inmates of the house and to guard against the possibility of there being restored to the world unfit members of society, yet equal anxiety is expressed that every possible care should be taken by medical means for such restoration. . . . It is very desirable then, in order to render the Asylum, not only a place for incarceration, but one where every facility may be given for the amelioration of the condition and for the cure of the maladies of its unfortunate inmates, that the medical officer be given broader powers over the treatment of the patient."[115]

The process by which the physician invoked the privileges of his office to subordinate the lay superintendent to medical control, and eventually to squeeze him out altogether, had now begun. Three days later Pether received his new instructions: "It was ordered that the Governor in all matters relating to the Health and Distribution of the Patients with a view to their Convalescence or their Medical Treatment, do obey implicitly the instructions of the Physician."[116] In February of the following year, Yeats was obliged to submit his resignation as nonresident Medical Superintendent, as he was moving to London; but his colleague, Dr. Thackeray, offered to assume the position, once more gratuitously.[117]

During Thackeray's term in office, he and various other doctors made efforts to educate the magistrates to the fact that insanity was a disease just like any other disease physicians were called on to treat and that there ought therefore to be provision for a full-time resident medical officer to run the asylum. In 1815, he complained in a letter to the mag-

istrates of "the insufficiency of the present Medical Means to fulfill the benevolent designs of the Institution. Their asylum affords a solitary example in which a large and important medical establishment is conducted without the assistance of a Resident director in the character of House apothecary. The defect in its constitution by totally precluding the employment of all remedies requiring attention to their effects and by preventing the observation and accumulation of Facts for the advancement of the Science of medicine greatly limits its service as a Medical Institution."[118] Such a state of affairs was rendered the more deplorable because proper classification of the varieties of mental disease revealed that each major subtype was almost certainly the consequence of an underlying physical pathology—mania reflected a disorder of the brain, melancholia a dysfunction of the abdominal viscera, and nervousness a disturbed state of the nervous system.

Thackeray felt that "if there be any foundation for this classification of mental disease, great encouragement I think is held out in it for placing a Lunatic Asylum on the footing of a Medical Institution."[119] The magistrates clearly did not. Dr. Maclean, who had replaced Leech as House Surgeon at the Infirmary, continued to hold that post and to perform the duties of secretary and head apothecary at the infirmary, so that his attendance on the asylum patients was a distinctly part-time affair; and Thackeray still contributed his services on a voluntary, unpaid, visiting basis. On Maclean's resignation from his various posts in June 1823,[120] the governors ordered that his successor should perform these same duties, and in September a Mr. Harris accepted the appointment.[121]

Further efforts were now made to dislodge the layman, Pether, and to replace him with a resident medical officer. The large proportion of chronic derelicts among the asylum population here posed a problem for those advocating a greater role for medicine, since it was not clear what benefits, if any, the increased expenditure for a full-time medical officer would bring. Thackeray conceded the difficulty but sought to persuade the magistrates that it was a temporary state of affairs, the consequence of the failure to employ medical treatment while such cases were still curable, a mistake they should take care to avoid in the future. As he explained,

> The present state of the house in which there are but few subjects under medical treatment may perhaps have led to the idea that little occasion exists for the establishment of such a department. Were this state a *perma-*

nent condition of the house the conclusion would be just; but it should be regarded [as] wholly an *accidental* one, depending on the Infancy of the Institution. The asylum is at present filled chiefly with patients whose disorder from their *long* standing, discourage every hope of benefit from medical exertion. In the progress, however, of time *recent* cases of derangement will be continually presenting themselves, when much encouragement will be offered for the active interference of Art.[122]

For a while, the magistrates still proved recalcitrant. Thackeray and Harris submitted further memoranda in support of their position and obtained testimonials reinforcing their coutentions from other physicians who happened to visit the asylum. Finally, the magistrates bowed to the weight of professional opinion: "Dr. Thackeray and Mr. Harris having separately called the attention of the magistrates to the expediency of providing regular resident medical aid to the Institution and the Magistrates having noticed a similar suggestion centered in the visitors' journal by the Medical Superintendent of the Bicêtre of Paris and another foreigner and Dr. Thompson of the twenty-fifth of July last, and having taken the same into their consideration, resolved to recommend the subject to the next court of Quarter Sessions."[123] Pether's position swiftly became untenable, as he lost almost all his remaining authority. Finally, in 1828 he resigned his position as general manager, and was succeeded by Harris.[124] Paramount authority over all aspects of asylum administration now rested in medical hands.

The activities, both local and national, we have just been discussing all made use of, and owed much of their success to, the arguments developed in the medical literature of the period. For it was the contentions advanced here that convinced almost all the educated classes that insanity was indeed a disease and that its treatment ought therefore to be entrusted to doctors. Consequently, I now want to devote some time to a consideration of just what such arguments were.

Moral treatment lacked a well-developed ideological rationale for why it should work. Tuke had explicitly eschewed any desire to develop a theoretical account of the nature of mental disturbance and had refused to elaborate moral treatment into a rigid "scientific" therapy.[125] In the past, "the want of facts relative to this subject, and our disposition to

hasty generalization, have led to many conclusions equally unfriendly to the progress of knowledge, and the comfort of patients."[126] He therefore resisted efforts to achieve a premature systematization of knowledge and encouraged a pragmatic approach: "I have happily little occasion for theory, since my province is to relate, not only what ought to be done, but also what, in most instances, is actually performed."[127] He even refused to choose between a psychological and somatic etiology of insanity, arguing that "whatever theory we maintain in regard to the remote causes of insanity, we must consider moral treatment of very high importance."[128] If its origins lay in the mind, "applications made immediately to it are the most natural, and the most likely to be attended with success"; if they lay in the body, "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."[129]

Undoubtedly, though, the nature of the therapy he advanced, and the manner in which advocates of moral treatment persistently and explicitly denied the value of a medical approach, could, at the very least, be more readily reconciled with a mental rather than a somatic etiology of insanity. Francis Willis was not alone in accusing those favoring moral treatment of propagating the doctrine that "mental derangement must arise from causes, and be cured by remedies, that solely and exclusively operate on the mind."[130] Physicians stigmatized this as an "absurd opinion"[131] but were obviously afraid of the threat it posed to their position.

The single most effective response to an attack along these lines would have been to demonstrate that insanity was in fact caused by bio-physical variables. A somatic interpretation of insanity would place it beyond dispute within medicine's recognized sphere of competence and make plausible the assertion that it responded to medicine's conventional remedies for disease. The trouble was that the doctors could not

show the existence of the necessary physical lesions, and this inconvenient fact was already in the public domain.[132]

Unable to produce scientific evidence in support of their personal predilection tot a somatic interpretation,[133] the doctors invented an ingenious metaphysical argument that, dressed in the trappings of science, proved an equally satisfactory functional alternative. They began by postulating a Cartesian dualism between mind and body. The mind, which was an immortal, immaterial substance, identical with the Christian doc-

trine of the soul, was forced in this world to operate through the medium of a material instrument, namely the brain.[134] This was an apparently innocuous distinction, but once it had been conceded, the doctors had no trouble "proving" their case. For to argue that the mind was subject to disease, or even, in the case of outright idiotism, death, was to contradict the very foundation of Christianity, the belief in an immortal soul. On the other hand, adoption of a somatic viewpoint provided a wholly satisfactory resolution to the dilemma: "From the admission of this principle, derangement is no longer considered a disease of the understanding, but of the centre of the nervous system, upon the unimpaired condition of which the exercise of the understanding depends. The brain is at fault and not the mind."[135] The brain, as a material organ, was liable to irritation and inflammation, and it was this which produced insanity.[136] "But let this oppression [of the brain] be relieved, this irritation be removed, and the mind rises in its native strength, clear and calm, uninjured, immutable, immortal. In all cases where disorder of the mind is detectable, from the faintest peculiarity to the widest deviation

from health, it must and can only be traced directly or indirectly to the brain."[137]

The failure to *observe* physical lesions of the brain in most cases of insanity could now be explained in either of two ways, neither of which threatened the somatic interpretation. On the one hand, it might be that existing instruments and techniques were simply too crude to detect the very subtle changes involved.[138] On the other hand, it could be that insanity in its early stages was correlated only with functional changes in the brain, which only at a later stage, when the patient became chronic, passed over into structural ones.[139]

The intuitive appeal of this explanation to an audience of convinced Christians was enormous and suffered scarcely at all from its extrascientific character.[140] And by "proving" that insanity was a somatic complaint, it decisively reinforced medical claims to jurisdiction in this area. The obvious achievements of moral treatment could not be simply overlooked—they were too well established in the public mind for that. However, it could be, and was, just absorbed into the realm of ordinary medical techniques.

Moral treatment now became just one weapon among many (even if a

particularly valuable one) that the skillful physician used in his battle against mental illness. Texts like Prichard's included a chapter on moral treatment as a matter of course,[141] while those who rejected the conventional medical methods were accused of unnecessarily reducing their chances of curing their patients. In support of this position, certain maddoctors claimed to have cured a higher percentage of their patients than had the Retreat[142] and attributed this to their willingness to use both moral *and* medical means.[143] Others claimed to provide proof of the efficacy of medical means in certain cases, proof that took the form of citing instances of insanity known to the author where the patients had recovered at some time after the administration of traditional medical remedies.[144]

A number of doctors now proposed a truce. Extremists on both sides might argue for the unique value of a moral or a medical approach. But all reasonable men could see that a

judicious *combination* of these two therapies was likely to be more valuable than either taken by itself.[145] "To

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those acquainted with the workings of the malady and its peculiar characteristics," said Neville, "it will be easy to perceive the errors and partial views of such as profess to apply a medicinal agent only, as a specific, or those who advocate a course of moral treatment only for a cure. There is no doubt that a cooperation of medicinal and moral means is requisite to effect a thorough cure."[146] Now while from one perspective this attitude represented a concession, particularly when compared with earlier emphases on the exclusive value of medicine, the concession was a harmless one. For it left the physician, as the only person who could legitimately dispense the medical side of the treatment, firmly in control. Thus, Neville thought that moral and medical treatment could be carried out only "under the guidance of persons of sound protessional education, and mature experience of the disease,"[147] while Ellis commented: "From what has been said on the treatment of the insane in Lunatic Asylums, it

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will be obvious, that, according to my notions, no-one, except a medical man, and a benevolent one, ought to be entrusted with the management of them."[148]

And indeed, that was exactly what did happen. By the 1830s almost all the public mental hospitals had a resident medical director. Moreover, the magistrates' committees, which in several instances had been heavily involved in the day-to-day administration of asylums, increasingly left everything to the experts. The metropolitan commissioners, not entirely approvingly, commented in 1844 that the pattern at Bedford was being generally emulated, with "almost the entire control of the County Asylum being delegated to the Medical and General Superintendent."[149] Similarly, in the private sector, the more reputable private institutions acquired either a medical proprietor or a full-time resident medical superintendent.[150] Symptomatic of medicine's gains in this respect was the appointment of a resident physician to run the York Retreat, where moral treatment had originated and which, for the first forty-two years of its existence, had had a succession of lay superintendents.[151]

Finally, the asylum doctor solved the problem of restricting access to his clientele and transforming his dominance of the treatment of mental illness into a virtual monopoly, in a typically professional manner, by arranging "to have himself designated as the expert in such a way as to exclude all other claimants, his designation being official and bureaucratic insofar as it is formally established by law."[152] The Madhouse Act of 1828 introduced the first legal requirements with respect to medical attendance: each asylum had to make arrangements for a doctor to visit the patients at least once a week and for him to sign a Weekly Register.

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Where an asylum contained more than a hundred patients, it had to employ a medical superintendent. These requirements were stiffened by the 1845 Lunatics Act, which required, among other things, that all asylums keep a Medical Visitation Book and a record of the medical treatment of each patient in a Medical Case Book. And from 1846 on, the lunacy commissioners, who included a large contingent from the medical profession, manifested a steadily growing hostility to nonmedically run asylums. With the help of elite sponsorship, the asylum doctors were now able to drive competing lay people out of the same line of work and to subordinate those who stayed in the field to their authority. And their position controlling the only legitimate institutions for coping with the mentally ill gave them powerful leverage to discourage any future efforts to enter the field.[153]

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Chapter Seven
John Conolly: A Victorian Psychiatric Career

There is a venerable tradition of hagiography in the history of psychiatry (as in the histories of science and medicine). As psychiatric history has become less frequently the province of well-meaning amateurs, true consequence of their long-standing fixation on "great doctors and humanitarians" has been to make biographical studies a somewhat unfashionable, even disparaged form of inquiry. Prosopographical research, since it allows a measure of quantification and resolutely avoids focusing on the singular hero, has tot the most part been spared this stigma, and in the late 1970s it provided a vantage point from which a handful of doctoral students began to examine the early history of psychiatry.[1] Such studies can unquestionably teach us a great deal,[2] and it is a matter of regret that as yet their focus has been all but exclusively on American psychiatry.

Still, it would be foolish to think the only worthwhile form of biography is collective biography, or that a concentration on the individual precludes one from developing a greater understanding of larger themes

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and issues. Over the past few years, some of the most valuable contributions to our understanding of medical responses to madness have come from those who have refused to be put off by the general prejudice against a focus on the individual practitioner: Michael MacDonald's pioneering foray into the casebooks of the astrologist-cum-magician-cum-healer-cum-physician-cum-divine, Richard Napier, to illuminate the nature of seventeenth-century English views of madness and its treatment; Nancy Tomes' examination of the treatment of well-to-do American mental patients through an examination of the life and career of Thomas Story Kirkbride, superintendent of the psychiatric branch of the Pennsylvania Hospital; and Samuel Shortt's study of the largely unremarkable, but (for that very reason) probably representative late-nineteenthcentury Canadian alienist, Richard Bucke.[3]

John Conolly was anything but an unremarkable figure, and a study of him would clearly be mandatory for anyone fixated on the grand figures of nineteenth-century English psychiatry. But, paying due attention to the professional and social context of Conolly's life and career, one discovers that his biography teaches us a great deal about the larger issues associated with the emergence of a professionalized psychiatry in Victorian England. In my earliest researches for *Museums of Madness,* I necessarily devoted considerable time and attention to the surviving Hanwell records, not only because of the asylum's size and its metropolitan location, but also because of the great contemporary attention it drew as the inspiration for nonrestraint, the orthodoxy of nineteenthcentury English asylumdom. My interest in Conolly was still greater, because he occupied such a paradoxical role in the whole process of lunacy reform: the most formidable proselyte for the county asylum system in the 1840s, and yet a decade or so before, the most scathing critic of the emerging professional consensus about the necessity of the asylum in the treatment of mental disorder. How was one to account for such a puzzling transformation? The question fascinated me, and yet it was obviously tangential to the main thrust of the analysis I wanted to pursue in the hook. But over the next few years, I kept stumbling across additional materials that shed new light on the subject, while revealing that Conolly's career and intellectual development were even more convoluted than I had previously realized. Finally, when an extended stay in England allowed me to tie up some of the loose ends, I gave the project more sustained attention and was able to write up the following essay shortly after my return to San Diego.

John Conolly: A Victorian Psychiatric Career

We have in this asylum, Sir,
Some doctors of renown
With a plan of non-restraint
Which they seem to think their own.
All well-meaning men, Sir,
But troubled with a complaint
Called the monomania
Of total non-restraint.
—EPISTLE TO MR. EWART, M.P.,
by a Reverend Gentleman lately a patient in the Middlesex Asylum, 1841[1]

John Conolly's place in the pantheon of heroes of English psychiatric history seems secure. Contemporaries likened his achievement in introducing nonrestraint in the treatment of the insane paupers at Hanwell Lunatic Asylum to Howard's labors in the cause of penal reform and Clarkson's role in the abolition of slavery.[2] Lord Shaftesbury, for forty years the chairman of the English lunacy commissioners and chief spokesman for the lunacy reform movement, referred to Conolly's work as "the greatest triumph of skill and humanity" that the world had ever known.[3] And the doyens of late-nineteenth-century medicine were only marginally less hyperbolic: for Sir James Crichton-Browne, "no member of his profession—except Jenner and Lister—has done a tithe as much as he to ward off and alleviate human suffering."[4] "It is to Conolly," said Sir Benjamin Ward Richardson, "that we really owe the modern humane treatment of the insane as it exists today in all its beneficent ramifications. . . . The abolition of restraint . . . has placed us first among all the nations as physicians of medical disease."[5] These are judgments that historians have for the most part been content to echo,[6] crediting Conolly

with completing the work begun by Pinel and Tuke, by introducing "reforms which simultaneously gave freedom to the mentally ill and psychiatry to medicine."[7]

But Conolly's medical career is too long and varied to be reduced to a simple tale of his triumph as the author of "nonrestraint." Quite apart from any other considerations, the system he is popularly assumed to have initiated[8] was, as he periodically acknowledged, not his invention at all. Moreover, he was well into middle age before he became the resident physician at Hanwell, and he occupied that post for less than four years. A more extended look at his professional life provides valuable insight into some of the vicissitudes attending the choice of a medical career in Victorian England; and the sharp transformations that mark his thinking on psychiatric matters, closely paralleling the twists and turns of his own career, point up the intimate relationship that often exists between developments in disinterested medical "knowledge" and the varying social interests of those propounding it.

John Conolly was born at his grandmother's house in the small town of Market Rasen in Lincolnshire, in 1794. His father, "a younger son of a good Irish family . . . had been brought up to no profession; had no pursuits; [and] died young," leaving his wife with three young children to raise. The three boys were soon separated, and John, at the age of five, found himself boarded out, like "an inconvenient superfluity," with an elderly widow, a distant relative of the family, in the decaying borough of Hedon. Here he spent a "barren" and "wretched" boyhood, receiving a "dull, mechanical," and, as he later confessed, grossly inadequate education at the local grammar school. The descent from even a shabby gentility "to the commoner arrangements inseparable from school, and to a society of the lower kind, where nothing was tasteful, and nothing was beautiful, and nothing was cheerful"[9] made a profound impression on Conolly. The experience may well have contributed to the insistent concern he displayed in his later years that others acknowledge his gentlemanly status; and they certainly must have intensified the pressures engendered by the uncertain course that marked his professional and financial life until the age of

forty-five.

Conolly's mother had moved to Hull in 1803 and supported herself by opening a boarding school for "young ladies." Within a few years she

remarried, her new husband being a Mr. Stirling, an émigré Scot from Paris who taught languages; and in 1807, she brought her son John home to live with them. Despite the further decline in social status that these domestic arrangements implied, Conolly seems to have enjoyed the next five years. With his stepfather's encouragement, he became fluent in French, dabbled in Enlightenment philosophy, and obtained a rudimentary general and literary education. In 1812, at the age of eighteen, he procured a commission as an ensign in the Cambridgeshire militia and spent the closing years of the Napoleonic Wars in Scotland and Ireland. Apparently he found military life to his taste, tot Henry Maudsley reports enduring many conversations filled with "lively and pleasant recollections" of his service.[10] Napoleon's defeat and exile, however, foreclosed the possibility of a military career, and by 1816, Conolly had resigned his commission and returned to Hull.[11] With the death of his mother and stepfather he received a small inheritance, and in March of 1817, married Eliza Collins, daughter of the recently deceased Sir John Collins (himself the illegitimate son of the second Earl of Abermarle). Such an early marriage, with very little capital and no real prospects would by itself have struck most Victorians as foolhardy, and the couple quickly compounded their difficulties by the sort of financial ineptitude that Conolly was to exhibit throughout his life. After the marriage, they left immediately for France and spent an idyllic year in a cottage near Tours, on the banks of the Loire. At the end of this period, with the arrival of his first child and the rapid shrinking of his capital, it seems finally to have dawned on Conolly that he had to develop some stable source of income.

For those in early Victorian England who were without independent means but aspired to gentlemanly status, the choice of careers was meager indeed.[12] Anything connected with "trade" was out of the question, leaving only law, the Church, and perhaps medicine as ways of gaining a livelihood without irrevocable loss of caste. Medicine, in fact, was not an unambiguously acceptable choice: as Trollope observed (in the person of Miss Marable), "She would not absolutely say that a physician was not a gentleman, or even a surgeon; but she would not allow to physic the absolute privilege which, in her eyes, helonged to the law and the church."[13] Still, it was on medicine that Conolly settled (based in part on the advice of his older brother William, who was already medically qualified); and

like many an ill-connected and impecunious provincial, he elected to obtain his training in Scotland, first at Glasgow and then, for two years, at Edinburgh.

Possessed of a talent for making friends and for moving easily in society,[14] Conolly enjoyed a moderately successful student career, becoming one of the four annual presidents of the Royal Medical Society in his second year. He was strongly influenced by Dugald Stewart, the professor of moral philosophy,[15] and like a number of Edinburgh students of this period[16] he developed a special interest in the problem of insanity. Reflecting this, his M.D. dissertation of 1821 was devoted to a brief discussion of *De statu mentis in insania et melancholia* .[17]

He now had to earn his living and encountered immediately the dilemma of where to set up his practice. Lacking the means to buy into an established practice, and without any family ties he could call on to help obtain a clientele, Conolly faced an uphill battle.[18] His difficulties were further compounded by the fact that he already had a wife and child to support. And since his Scottish training left him without any institutional or personal linkages to the London hospitals and medical elites, he had perforce to begin his career in a provincial setting. Inevitably, this meant engaging in general practice in an isolated and highly competitive environment,[19] in which it generally took several years before one began to earn even a modest competence and where one was highly dependent

on somehow securing the approval and patronage of the well-to-do.[20] To make matters worse, medical men working in such settings were regarded with ill-concealed contempt by the professional elites of Edinburgh and London, reflecting their marginal status in the larger social world. They were, sniffed the *Edinburgh Medical and Surgical Journal*, "engaged in the trading, money-making parts of the profession, and not one in a hundred of them distinguished by anything like science or liberality of mind."[21]

Conolly's first efforts to make his way in this difficult environment met with abject failure. After a three-month stay in Lewes, he abandoned the attempt to build a practice there and removed his family to Chichester to try again. Here, however, he had to compete with another young practitioner, John Forbes.[22] Though the two were to become lifelong friends, there was insufficient work to support them both, and within a year it had become apparent that it was Conolly who would have to leave. Of the two, he was undoubtedly "the greater favourite in society, his courteous manner, his vivacity of character, and his general accomplishments, rendered him an agreeable companion."[23] But however enjoyable the local notables found his company, when they required professional medical services, they turned instead to Forbes. Conolly, as his son-in-law Henry Maudsley later remarked, was a poor "practical physician," with little talent or ability to inspire confidence in "the exact investigation of disease, or in its treatment; he had little faith in medicines, and hardly more faith in pathology, while the actual practice of his profession was not agreeable to him."[24]

Now blessed (or burdened) with a second child, his son Edward Tennyson, Conolly once more uprooted his family and moved, this time to

Stratford-upon-Avon, then a small town of some 4,000 inhabitants. Here he at last began to prosper, albeit in a very modest way. He was elected to the Town Council and twice served as mayor, the 80-pound salary serving as a useful supplement to his still slender professional income. He took a leading role in establishing a dispensary for the treatment of the sick poor and was active in civic affairs more generally, the well-worn path for a young practitioner trying to make his way.[25] Perhaps because of the interest he had developed in the subject while in Edinburgh, and no doubt because the honorarium attached supplemented his inadequate income, he also secured an appointment as "Inspecting Physician to the Lunatic Houses for the County of Warwick," a position that required only that he accompany two local justices of the peace on their annual inspection of the county's half-dozen madhouses.

In his best year at Stratford, though, Conolly's income is reported "not to have exceeded 400 pounds," an amount barely sufficient to maintain a suitable life-style for a professional man with a growing family.[26] Quite suddenly, however, the prospect arose of substituting the rewards of a London teaching and consulting practice for the dull routines of general practice in a provincial backwater. The founders of the new University of London had decided to include a medical school in the new foundation. Somewhat to his surprise, Conolly managed to obtain an appointment as professor of nature and treatment of diseases, helped in part by being previously known to Dr. George Birkbeck[27] and Lord Brougham,[28] two of the prime movers in the project. While the university had "sought to engage men of high standing,... it could offer but small emoluments and a precarious future" in its early years.[29] And accordingly, a number of the early appointments were of young or relatively unknown men.[30]

In general, however, "assured income and national visibility . . . went with status as full physician or surgeon at a hospital and as teacher at a

medical school" in London,[31] and Conolly undoubtedly thought that he was about to cross successfully the great divide that marked off the social and financial world of elite London physicians from the humble surroundings of the rest of the profession. He instantly wrote back accepting: "Gratified, as I cannot but be, by the confidence which has been placed in me, an untried person, I know that it only remains for me to justify it by my services."[32] Though the first scheduled teaching session was not to begin until October 1828, some fourteen months hence, he at once refused offers to write and edit for London

publishers on the grounds that "the attention and care required by the lectures of so inexperienced a teacher as I am . . . occupy almost every hour of my time."[33] And toward the end of 1827, he announced plans to travel to Paris for three months to obtain materials that would assist him in preparing his lectures.[34]

On 2 October, 1828, Conolly gave his inaugural lecture, the second at the new medical school.[35] It was apparently quite successful,[36] although largely given over to some rather platitudinous advice to his students. He informed them:

> I have watched with some interest, the fate and conduct of many of those who were pursuing their studies at the same time as myself. Of these, some were of course idle, and despised the secluded pursuits of the studious; I do not know *one* whose progress has been satisfactory: many of them, after trying various methods of dazzling the public, have sunk, already, into merited degradation. But I do not know one among the industrious, who has not attained a fair prospect of success; many of them have already acquired it; and some of them will doubtless be the improvers of their science in our own day, and remembered with honour when they are dead.[37]

Naturally enough, Conolly aspired to belong to the latter group. Nevertheless, his lecture's one departure from the expected was an announcement that "it is my intention to dwell somewhat more fully on Mental Disorders, or to speak more correctly, of disorders affecting the mani-

festations of the mind than has, I believe, been usual in lectures on the practice of medicine."[38] Conolly's attempts, over the next two years, to get permission to give students clinical instruction in mental disorders at a London asylum proved unavailing. After initially encouraging him, the University Council rejected the idea.[39] Thwarted in this direction, he decided instead to publish a book on the subject, not least because "I disapprove entirely of some part of the usual management of lunatics."[40]

An Inquiry Concerning the Indications of Insanity, published in 1830, is, in many respects, a rather conventional treatise, "investigating the mind's history, from its most perfect state, through all its modifications of strength and through all its varieties of disease, until it becomes affected with confirmed madness."[41] But Conolly broke sharply with contemporary orthodoxy over the key issue of how and where the lunatic ought to be treated. His book appeared in the midst of the early-nineteenth-century campaign for "reform" in the treatment of lunatics—a movement that took some thirty years to achieve its goals, and one whose proponents were absolutely convinced that asylum care was the only appropriate form of treatment for the insane. The heightened public attention to the problems posed by the mentally disturbed stimulated a large number of medical men to produce books and pamphlets on insanity, and running through this literature, and repeated with growing emphasis and conviction, was the assertion that all forms of madness required institutional care and treatment and that the sooner those displaying signs of mental imbalance were removed from domestic to asylum care, the greater their chances of ultimate recovery.[42]

From this almost universal consensus about "the improbability (I had almost said moral impossibility) of an insane person's regaining the use of his reason, except by removing him early to some Institution for that purpose,"[43] Conolly issued a lengthy and closely argued dissent. Seeking to offer "no opinions which have not received some confirmation from observation and experience,"[44] he asserted that the emphasis on the centrality of the asylum "originated in erroneous views of mental disorders, and has been perpetuated with such views."[45] Existing authorities ar-

gued that any and all forms of mental unsoundness warranted—indeed required—confinement. If this doctrine of "indiscriminate treatment, including deprivation of property and personal liberty," were to prevail, then, said Conolly,

> no man can be sure that he may not, with a full consciousness of his sufferings and wrongs, be one day treated as if all sense and feeling were in him destroyed and lost; torn from his family, from his home, from his innocent and eccentric pursuits, and condemned, for an indefinite period, to pass his melancholy days among the idiotic and the mad."[46]

"Restraint," as he saw it, was "seldom apportioned to the individual case, but is indiscriminate and excessive and uncertain in its termination."[47] (Later in Conolly's career, restraint was to acquire a narrower meaning, referring to the use of chains, straitjackets, and the like to impose physical controls on the insane, but here, significantly, it is used in the broad sense of removal from ordinary social life and confinement in an institution.) It was precisely the expert's task, not just to distinguish the mad from the sane, but "to point out those circumstances which, even in persons decidedly insane, can alone justify various degrees of restraint."[48] And the latter was clearly the more difficult accomplishment. At present, "certificates of insanity" were heedlessly and ignorantly . . . signed,"[49] with the result that "the crowd of most of our asylums is made up of odd but harmless individuals, not much more absurd than numbers who are at large."[50] Moreover,

> once confined, the very confinement is admitted as the strongest of all proofs that a man must be mad. . . . It matters not that the certificate is probably signed by those who know very little of madness or of the necessity of confinement; or by those who have not carefully examined the patient; a visitor hesitates to avow, in the face of such a document, what may be set down as a mere want of penetration in a matter wherein nobody seems in doubt but himself; or he may be tempted to affect to perceive those signs of madness that do not exist.[51]

Hence, the central importance of clinical instruction of medical students in the recognition and treatment of insanity. As the medical curriculum was presently constructed,

> during the term allotted to medical study, the student never sees a case of insanity, except by some rare accident. . . . The first occurrence, consequently, of a case of insanity, in his own practice, alarms him: he . . . has recourse to indiscriminate and, generally, to violent or unnecessary means; or gets rid of his anxiety and his patient together, by signing a certificate, which commits the unfortunate person to a mad house.[52]

Such an outcome might be avoided by teaching students not only how to solve the relatively simple problem of distinguishing those of unsound mind, but also how to decide "*whether or not the departure from sound mind be of such a nature to justify the confinement of the individual, and the imposition of restraint upon him, as regards the use or disposal of his property* ."[53]

The task was rendered the more urgent because asylum treatment was, as he saw it, more pernicious than beneficial. Perhaps a trifle disingenuously, Conolly announced that he had "no wish to exaggerate the disadvantages of lunatic asylums."[54] There were, after all, certain classes of patients for whom public asylums were "unavoidable evils."[55] "For a hopeless lunatic, a raving madman, for a melancholy wretch who seems neither to see nor to hear, or for an utter idiot, a lunatic asylum is a place which affords all the comforts of which unfortunate persons are capable."[56] But their regrettable necessity as places of last resort must not be allowed to obscure the fact that

> it is a tar different place for two-thirds of those who are confined there. . . . To all these patients confinement is the very reverse of beneficial. It fixes and renders permanent what might have passed away and ripens eccentricity or temporary excitement or depression, into actual insanity.[57]

The first principle of asylum treatment was the isolation of the mad from the sane. This sequestration from the world was alleged to be therapeutic, a notion Conolly scathingly attacked: "Whatever may be said, no one in his senses will believe, that a man whose mind is disordered is likely in any stage of his disorder to derive benefit from being surrounded by men whose mental faculties are obscured, whose passions and affections are perverted, and who present to him, in place of models of sound mind, in place of rational and kind associates, in place of reasonable and judicious conversation, every specimen of folly, of melancholy, and of extravagant madness."[58] People's mental and moral capacities varied markedly according to the circumstances in which they were placed, and their thoughts and actions were, in large degree, the product of an interaction between habits, situational pressures, and the influence and reactions of their associates. The capacity to control one's wayward passions and imagination and to avoid the perils of morbid introspection[59] was thus essentially dependent on social reinforcement and support. Granting these realities of

our mental life,

> who can fail to perceive that in such an unhappy situation [as asylum life provided] the most constant and vigorous assertion of his self-command would be required to resist the horrible influences of the place;—a place in which a thousand fantasies, that are swept away almost as soon as formed in the healthy atmosphere of our diversified society, would assume shapes more distinct; a place in which the intellectual operations could not but become, from mere want of exercise, more and more inert; and the domination of wayward feelings more and more powerful.[60]

Taking even "the most favourable case for the asylum," its effects were likely to be harmful.[61]

Of course, the men running such places sought to reject these charges. They claimed that the inmates of the asylums were not abandoned and subjected to a pernicious atmosphere of uncontrolled ravings and delusions, but were carefully monitored and controlled by a sane superintendent and judiciously coaxed and encouraged to resume an independent, self-governing existence. Conolly remained unconvinced:

> To say that persons in this state are not left, are not abandoned, is by no means satisfactory to those who have opportunities of knowing how little of the time of the superintendent is, or can be, commonly devoted to the professed objects of his care, and yet who, like children, demand constant watching and attention.[62]

Hence the "numerous examples" to be found "in which . . . a continued residence in the asylum was gradually ruining the body and the mind."[63]

To some extent, the antitherapeutic effects of the asylum derived from "the monotonous wretchedness of the unhappy patient's existence; debarred from home, from the sight of friends, from the society of their families; . . . shut out from even a hope of any change that *might* prove beneficial to them."[64] But criticisms of this sort suggested that a more enlightened and flexible administration, and the provision of more varied amusements and diversions, could obviate the difficulty. They could not. Superintendents, some of whom

> are men of great intelligence and humanity, . . . may point to the spaciousness of their grounds, to the variety of occupations and amusements prepared for their patients, to the excellence of their food and the convenience of their lodging; and urge that as little restraint is employed as is compatible with their safety: but the fault of the association of lunatics with each other, and the infrequency of any communication between the patient and persons of sound mind, mars the whole of the design.[65]

The defect was thus, as Conolly saw it, a structural one, and hence not removable by any conceivable reform. Confinement in an institution

acted like a self-fulfilling prophecy, intensifying and even creating the very behaviors that were its alleged justification:

> The effect of living constantly among mad men and women is a loss of all sensibility and self-respect or care; or not infrequently, a perverse pleasure in adding to the confusion and diversifying the eccentricity of those about them. . . . In both cases the disease grows inveterate. Paroxysms of violence alternate with tits of sullenness; both are considered further proofs of the hopelessness of the case.[66]

For whole classes of lunatics, therefore, asylum treatment was grossly inappropriate. Given that "so long as one lunatic associates with another, supposing the case is to be curable, so long must the chances of restoration to sanity be very materially diminished,"[67] recent and curable cases did not belong in an institution. This was particularly the case "during the mental weakness of their convalescence," when confinement exposed them to "the presence of a company of lunatics, their incoherent talk, their cries, their moans, their indescribable utterances of all imaginable fancies or their ungovernable frolics and tumult." These, said Conolly, "can have no salutary effect on a mind just reviving from long depression."[68] On the contrary, they were "the very

circumstances most likely to confuse or destroy [even] the most rational and healthy mind."[69]

> Another class of patients for whom a lunatic asylum is a most improper place consists of those who, in various periods of life become afflicted with various degrees of weakness of intellect. . . . But there is little or no extravagance of action, still less is there anything in the patient which would make his liberty dangerous, or, if he were properly attended to and watched, even inconvenient to others or himself.[70]

Such patients, along with the chronically insane, were subject to a more insidious but equally debilitating and damaging effect of confinement in an institution, the gradual atrophy of their social capacities: "After many hopeless years, such patients become so accustomed to the routine of the house, as to be mere children, and are content to remain there, as they commonly do, until they die."[71]

If social practices could be brought to reflect these realities, "the patients *out* of the asylum being the majority, and consisting of all whose circumstances would insure them proper attendance—better arrangements might be made for the smaller number of public asylums, or central houses of reception."[72] Such asylums must, first of all, he public, that is, state supported, for only by removing the distorting effects of the profit motive could one avoid the problems created by a system in which "the patients are transmitted, like stock-in-trade, from one member of a

family to another, and from one generation to another": a free trade in lunacy that attracts, besides a handful of "respectable, well-educated, and humane individuals," the "ignorant and ill-educated" and those "capable of no feeling but a desire for wealth."[73] Second, each asylum should become a center in which aspiring medical men could be taught to recognize and treat mental disorder.[74] The possession of such Clinically derived skills and knowledge—the fruit of the sort of arrangement he had unsuccessfully urged on the university—would give the average medical practitioner both the competence and the confidence to treat most cases of insanity on a domiciliary basis.

If Conolly hoped that the publication of *An Inquiry Concerning the Indications of Insanity* would serve to advance his reputation and enlarge his private practice, he was soon disabused. One reviewer, in the *Medical-Chirurigical Review*, did praise him for performing "a very important service to the profession, in calling their attention to the construction and properties of the mind," and for the superior "language and style" in which he expressed himself.[75] But for the most part, Conolly's suggestions were not even debated,[76] but simply ignored. For by now the overwhelming weight of opinion among both the profession itself and those laymen interested in lunacy reform was that in cases of insanity, asylum treatment was indispensable and could not be embarked upon too quickly for the patient's own good—a position Conolly himself was to embrace less than a decade later.

In the meantime, he was involved in a series of controversies at the medical school, that within six months, were to prompt his resignation. The early years of the university were stormy ones. The council, chosen from among the university's proprietors, exhibited a constant disposition to interfere with the conduct of the institution, threatening to send inspectors to check on the quality of lectures given, to exercise the power to censor the books used in teaching, and "to regulate minutely not only the number, length, and hours, but also the scope and content of the various courses."[77] In general, "it regarded the professors in the same light as any other of its employees, and all its employees with suspi-

cion."[78] The friction such conduct was sure to arouse was exacerbated by the activities of the warden, Leonard Horner, the salaried officer to whom the council had delegated day-to-day supervision of university affairs. For Horner, too, had an exalted view of his position, and his arrogant and autocratic manner, his constant petty interference and intrigue aroused widespread discontent among the professoriate—an antipathy strengthened by the fact that the warden, though paid four or five times as much as those he supervised, was an erstwhile linen manufacturer possessed of limited education and no

scholarly qualifications.[79]

The medical faculty considered that "a Hospital is absolutely necessary for the prosperity of the Medical School,"[80] since only by providing clinical instruction could they hope to compete effectively with rival London institutions for students. For a time it appeared that a suitable arrangement could be reached with the nearby London Fever Hospital, but when the council insisted on being given complete control, its intransigence led to the collapse of the negotiations. As a temporary, if inadequate, substitute, Conolly and his colleagues proposed the establishment of a university dispensary, which they would attend "without compensation . . . as a help to a rising school"[81] —a plan to which the parsimonious council quickly agreed.[82] But the dispensary soon became a new source of friction. It was to have a resident apothecary, and Conolly and his colleague Anthony Todd Thomson immediately expressed concern that the appointee be someone who aspired "solely to being efficient in that useful but still subordinate capacity."[83] Their concern to protect their status soon proved prescient, for Horner began to use John Hogg, who had secured the position, to check on the professors' performance of their duties. Conolly viewed such "very offensive" machinations as an intolerable affront to his dignity:

> You have constituted the Apothecary, who ought to be under the orders of the physicians and surgeons, a kind of spy over those physicians and

> surgeons, and have thereby completely subverted the discipline of the establishment. Among respectable men of my own rank in the medical profession, I find but one opinion concerning this matter; and that opinion makes it impossible for me to continue my attendance at the Dispensary. . . . The Council have no right to impose a degradation on me, and I cannot submit to it.[84]

Two months later, Horner informed him that "the Council considered it a part of the duty of the Professor of the Practice of Medicine to attend as Physician at the Dispensary."[85] But Conolly stood his ground: "No opinion of the Council, or of any body of men, can, or ever shall, induce me to act inconsistently to my character as a physician and a gentleman." Only a change in the lines of authority at the dispensary would induce him to return.[86] Eventually a meeting with the council itself led to the quarrel being patched up, though not until Conolly had incurred further slights from the warden.[87]

On other fronts, too, the relationship between the university and its professors grew strained. The proprietors wished to move to a system in which a professor's pay was directly proportional to the income he generated from his lectures. Initially, they had been forced to modify this plan in order to attract faculty to a new and untried enterprise, offering salary guarantees for the first three years of the university's existence. By the spring of 1830, however, financial difficulties were increasing as student numbers declined, and "the University was eating up its capital at a rate of 1,000 pounds a year."[88] Rumors began to circulate that the council was contemplating an early end to the system of guaranteed salaries. A number of professors, Conolly among them, responded by laying out an alternative plan to rescue the institution's finances. They insisted that "a salary should be secured for every professor in the event of his fees from pupils not attaining a certain amount," arguing that the institution was still too new for payment by results to work and that the failure to provide such a guarantee would inhibit the professors' study of their subjects, since such activities would be "unproductive of immediate pecuniary advantage."[89] Some professors' lectures fees amounted to less than 100 pounds, of which the university proposed to take a third, and yet "it is expected that the professor will subsist in the rank of a gentleman upon the balance." To balance the budget, they proposed tailoring

the length of courses to the convenience of students, since the university could not expect, "for many years to come, to draw any considerable number of students from the upper ranks [of society]";[90] and *reducing* fees so as to attract additional students who would otherwise attend the cheaper courses given by such places as the Royal Institution

and the London Institute. Finally, a great deal of money could be saved by abolishing the office of warden, with his salary of 1,200 pounds a year (a suggestion scarcely inclined to endear its authors to Horner). These proposals were leaked to the press and met by anonymous responses from the warden, a war of words that continued until 21 April 1830, when the *Sun* reported that with some lecture rooms all but empty, the proprietors had decided to reduce the salary guarantees to the least successful professors.[91]

This news must have been a considerable blow to Conolly, for his financial situation had been precarious since his arrival in London. On the same day that the new salary policy was announced, he wrote to Horner declining to repeat the summer session lectures he had given the year before, partly because the number of students was likely to be small, rendering the course unremunerative, and also because "I am under the necessity of employing some of the year in occupations unconnected, or not immediately connected, with my Professorship, which I could not possibly do if I were to lecture ten months out of twelve."[92] During the 1829–30 session, his university salary declined from 300 pounds to 272 pounds, 15 shillings, and before the year was out, he was forced to request an advance of "100 pounds on account" from the warden he detested,[93] a humiliation he was compelled to undergo twice more before he finally left London the following spring?.[94]

Conolly could scarcely have viewed the prospect of a further decline in his guaranteed salary with equanimity, for, notwithstanding all his laborious preparation and his personal charm, his lectures "were not great successes, if they were not in truth failures, [being] somewhat vague and diffuse, wanting in exact facts and practical information."[95] Here, as elsewhere, in the judgment of one of his friends, "the aid which Dr. Conolly rendered to the diffusion of knowledge was not special or professional."[96] Unfortunately, his efforts to augment his income from private practice were likewise unsuccessful. Conolly was blessed with consider-

able advantages that ought to have brought him patients: Lords Russell, Auckland, and Brougham provided aristocratic sponsorship; his university affiliation ought for once to have been an advantage; and he was amply provided with the necessary social graces.

> Though by nature passionate and impetuous, he had great command over his manner which was courteous in the extreme. Indeed he never failed to produce, by the suavity of his manner and the grace and ease of his address, the impression of great amiability, kindness, and unaffected simplicity; while his cheerful and vivacious disposition and his lively conversational powers rendered him an excellent social companion."[97]

He sought to capitalize on these advantages, following the well-worn path of the aspiring London practitioner. He joined the Medical and Chirurgical Society of London, and became an active member of the Society for the Diffusion of Useful Knowledge. He took the examination of the Royal College of Physicians and became a licentiate; and he secured election to the staff of the London Fever Hospital. Notwithstanding all his efforts, however, "practice did not come sufficiently quickly."[98] On a larger stage, he experienced a repetition of his failures at Lewes and Chichester, and almost certainly for the same reasons: his own deficiencies in the investigation of disease, his evident lack of faith in the medicine he prescribed, and his dislike of the tasks medical practice imposed, coupled with his settled disposition "to shrink from the disagreeable occasions of life, if it were possible, rather than encounter them with deliberate and settled resolution."[99]

Unlike the deficiencies of some of his colleagues, at least Conolly's failures were not the focus of public attention. Granville Sharp Pattison, the professor of anatomy, was not so fortunate. Having been one of Conolly's teachers at Glasgow, he had subsequently emigrated to the United States to an appointment at the University of Maryland. Apparently his tenure there was less than an overwhelming success (he was attacked in a pamphlet published in Philadelphia as "an adventurer with a tainted

reputation"),[100] but he succeeded in securing one of the first chairs at the University of London, Conolly providing a testimonial in his behalf. The appointment proved to be a mistake. He neglected his work or performed it incompetently, giving superficial and

perfunctory lectures when he bothered to attend. By contrast, J. R. Bennett, who had been appointed demonstrator in anatomy and had previously taught in Paris, "was a competent and popular teacher, and came to feel a contempt for Pattison as an anatomist which he was at no pains to conceal."[101] Conflict flared in the very first session and continued intermittently for more than two years. Pattison at first secured the support of many of his colleagues by alleging that Horner, whom they detested, was plotting his removal. But by the spring of 1830, student complaints about his performance grew more insistent, and the scandal surfaced in the medical press. A student memorial published in the *London Medical and Surgical Journal* "charge[d] him with *unusual ignorance* of old notions, and *total ignorance of* and *disgusting indifference* to new anatomical views and researches. . . . He is ignorant, or, if not ignorant, indolent, careless, and slovenly, and above all, indifferent to the interest of science."[102]

Conolly remained one of Pattison's staunchest supporters. He complained to the council that "the most heartless and iniquitous persecution has been carried on against the Professor of Anatomy . . . because his ruin would be convenient to the Warden's friends."[103] And for a few months, Pattison managed to cling to his position. But when the new session opened in October 1830, student discontent grew increasingly unmanageable. Pattison's classes were periodically boycotted and routinely disorderly. By February 1831, the students had opted for open rebellion, and "for over a month it was impossible to lecture. The scenes in the anatomy theatre reminded a contemporary reporter of Covent Garden during O. P. [Old Price] riots."[104] Conolly, too, began to lose control of some of his students, and on at least one occasion, nearly half of his class failed to attend his lecture.[105] Ultimately, the tumult subsided only after Horner abruptly relinquished his post and Pattison was forced to resign.[106] By then Conolly, too, had left the university.

Pattison was not the only colleague of doubtful competence whom Conolly sought to defend. His intervention on behalf of John Gordon Smith proved similarly unavailing, perhaps not surprisingly in view of its

maladroitness. Smith was a former army surgeon who had secured an appointment as professor of medical jurisprudence. A knowledge of forensic medicine conferred few obvious advantages on those seeking to practice medicine, and Smith's prospects of attracting a sufficient number of students to his classes were not aided by his rambling and disjointed lecture style. "Condensation . . . is not a virtue of Dr. Smith's," the *Morning Chronicle* commented on the occasion of his inaugural lecture,[107] and students voted with their feet not to listen to interminable stories of his wartime exploits. In early December 1830, while depressed and in his cups, he offered the council his resignation; then on sobering up, sought to withdraw it. Conolly's intervention can only have sealed his fate. He had been treating Smith, he informed the council, for a periodic "severe affection of the stomach" (most probably this was a side effect of Smith's heavy drinking). These episodes lasted for only a few days at a time, but

> on the decline of each attack, he is subject to a peculiar, but temporary, excitement of the nervous system which has once or twice, I believe, led to the interference of his friends. It was during one of these afflicting accessions that he lately conveyed to you his determination not to lecture in the University unless certain concessions were made to which he has ceased to attach any importance; and I know that he unfeignedly and extremely laments that he made such a communication to you.[108]

Lament he might, for the council, notwithstanding Conolly's warning that the loss of Smith's chair would be "an irretrievable, perhaps a ruinous calamity to him,"[109] gratefully accepted the opportunity to be rid of him. (Conolly, incidentally, proved a better prophet than advocate: within three years, Smith was dead, dying of alcoholism in a debtor's prison.)[110]

Conolly's manifold failures and disappointments make his resignation from the university not unexpected, but its manner and timing were nevertheless distinctly odd, lending weight to Maudsley's observation that he was "apt to do serious things in an impulsive way."[111] Only a few hours after sending a letter to the council begging it to ignore Smith's resignation, Conolly submitted his own. Bellot comments that "the reasons for Conolly's resignation are obscure,"[112] and Conolly himself, in requesting Horner "to lay my resignation before the Council," added: "I

have not troubled them with a useless detail of all my motives, but I am anxious that they should not think that I resigned from any want of interest in the university."[113] The penultimate paragraph of the same letter suggests that the council's refusal to heed his pleas on Smith's behalf may have constituted the final straw. ("I am sorry to have to trouble the Council with a second communication on the same day, but Dr. Smith is so deeply concerned in my doing so that I hope it will be excused"); and there are hints that some of his colleagues may have been glad to see him go ("I cannot doubt that Dr. Thompson and Mr. Amos will approve of what I have done in this matter");[114] but finally, Conolly is content to express no more than a veiled hope that his successor will have "a more favourable combination of circumstances than those in which I have endeavoured to perform [my duties]."[115]

Characteristically, his valedictory address given at the end of the academic year offers little substance at great length. He acknowledges that others may be puzzled by his decision:

> Retiring as I do, from a station, none of the prospective advantages of which have altogether escaped my attention—from a station which I was, four years ago, ambitious to obtain, and to which I felt it a great honour to be appointed—retiring, too, without the excuse of years, or any consciousness of a growing incapacity for exertion—I feel that a few words of explanation may be thought necessary, addressed to those who have interested themselves in my success.[116]

Many words but no explanation then follow. He grants that "it will be believed that powerful motives must exist which induce me to resign all these expectations, and when every previous hope has been sacrificed, to retire from a scene of public activity in which I might at least have continued without discredit." He then adds, "I think I could show that circumstances exist—have for some time existed—which so limit my usefulness here as to make it no less my duty, than it is my inclination, to withdraw from this institution." But the nature of those "circumstances" he glides over in silence, not wishing "to carry with me any unpleasant recollections."[117]

Whatever the precise reasons for his departure, the blow it constituted to his pride, to say nothing of his prospects, must have been staggering. Victorian medicine was marked by an enormous "division between the prestigious and influential men at the top of the profession

and the ordinary practitioners [beneath]."[118] Having once had hopes of belonging to the elite, Conolly now appeared to be thrust back, all but irretrievably, into the ranks of provincial obscurity. As one who later confessed "that he did not care for money, but that he very much liked the comfort and elegancies which money brings,"[119] the prospect was scarcely inviting.

Placing his furniture in storage (where it was to remain for eighteen months until he could afford to rent a house large enough to contain it), he gathered his wife and four children (a third daughter, Anne Caroline, had been born in 1830) and removed once more to Stratford. But the attempt to pick up the threads of his old practice was a failure, and within a few weeks he felt compelled to uproot them all again, and move to the nearby town of Warwick.[120] His one remaining tie to the metropolis was Thomas Coates, the secretary of the Society for the Diffusion of Useful Knowledge, now Horner's replacement at the university (though at a salary of 200 pounds rather than 1,200 pounds); and the correspondence between them gives us what little insight we have into Conolly's existence over the next seven years.

Conolly at first feigned optimism. While complaining that the demands of practice, being "unsettled as to house, and distracted at times with the noise of children," were interfering with his book on Ardent Spirits for the society, he boasted that "my practice [at Warwick] began at once, and the average thus far has equaled that of my best year before I left Warwickshire to be tormented 'for some sin' in the University." As for the future of "that Institution ..., much may be hoped from the timely (or untimely) death of some of the Council and Professors."[121] Two weeks later, the attractions of the provincial

backwater had begun to diminish. Conolly had begun a second book for the society, a popularization for the lower classes of medical ideas about cholera, only to discover that "this is a land when no books are to be borrowed or even stolen. The latest publication in the hands of any of my medical neighbours is a dissertation on the diseases which followed the Great Flood." Perforce he had to order three or four from London, "very unwillingly," because he could scarcely afford to purchase them. "Since these are for a piece on Cholera for the Society," he wondered whether "the publishers for the Society have the means of getting them more advantageously than I can do."[122] In the future, he assured Coates, his financial position

was bound to improve: "I really begin to think that at last I shall become a prosperous man, for I find myself getting Jewish." [123]

Such expectations were doomed to disappointment. In late December, he wrote an answer to Coates' "kind inquiry about my proceedings here. I think I am getting on so as to have a hope in time, of struggling through many difficulties."[124] But the difficulties were formidable. He finished the manuscript on cholera just before Christmas 1831,[125] but the small sum it earned him was swallowed up in the attempt to satisfy some of the creditors he had left behind in London: "After the 15th, Mr. Denies of 27 Princes Street Bank who is occasionally 'paying off' things for me will call to receive the fifty pounds—to save you any trouble." The companion volume on Ardent Spirits, first promised for December, then for January,[126] remained unwritten, though Conolly in each letter promised its imminent dispatch.[127] Meanwhile, he proposed that he write other titles for the society, only to have Coates decline them.[128]

By May of 1832, the burden of his past failures and the struggle to scratch an inadequate living from his practice began to show in his letters:

> I have been very busy lately, both in practice, and in lecturing to the Mechanics' Institution here, and in commemorating Shakespeare's birthday at Stratford. But I require constant task work to overcome a restlessness which what I suffered latterly in London has left in my brain and nervous system, which I sometimes fear will never leave me.[129]

And his protestations that, except for the Society for the Diffusion of Useful Knowledge, "I hardly regret having lost anything else that London contains"[130] sound increasingly hollow. After a long silence, he wrote plaintively to Coates, "Once upon a time there was a professor of my name, where is he now? May I flatter myself that you sometimes wonderingly ask that question?" If Coates were to visit him in Warwick, "you will find me a very rustic physician with some provincial fame, no doubt, but as my foolish friends say, buried." Revealingly, he continued, "I often wish I really were. . . . The London University has provided me for life with incurable care—but 'what's that'!—I have learned that resignation is the best philosophy."[131]

The "incurable care" was not to be vanquished so easily, however. Less than two years later, Conolly wrote to Coates again, begging for a

commission to write a series of popular treatises for working men on diseases of the chest, stomach, brain, and so on, to appear in the *Working Man's Companion* .

> It is but candid to say that I am in some degree driven to the idea of this industry by necessity. . . . I have long been trying[?] to extricate myself from the ruin [*sic*] which London brought me. . . . I am looking out for work. I am convinced I could prepare the little volumes of the Physician *one every three months* . Please think about it, and drop me a line soon—something I must set about and nothing takes my fancy more.[132]

But nothing came of this proposal, and in 1838, still drowning in debt,[133] Conolly embarked on a desperate attempt to escape from his provincial exile. "Not much encouraged thereto by his friends, who regarded such a step as the suicide of reputation and the confession of complete failure in life,"[134] he applied for the vacant position of superintendent of the Middlesex County Lunatic Asylum, at Hanwell. At least this offered the security of a salary of 500 pounds per annum, together with free room and board for

his family in the asylum; and he had, after all, a long-standing interest in the treatment of the insane, had written on insanity, and had served as inspector of the Warwickshire madhouses. To his dismay, however, his application was rejected, and in his stead the magistrates appointed J. R. Millingen, a retired army surgeon with no discernible background in the treatment of insanity.[135]

Conolly's humiliation was now complete. "The outlook into the future as black as ever, family cares increasing," he once more uprooted his household and moved to Birmingham, to see whether, in a different setting, his luck would change.[136] At forty-four, this latest failure appeared to have permanently dashed all the hopes he had once nurtured "of ob-

taining, through my exertions . . . , that reputation and those advantages of fortune, about which no reasonable man can, or ought to be indifferent."[137] His fixed disposition to refuse "to recognize or accept the painful necessities of life" meant that throughout his life, "troubles, shirked at the time, were gathered up in the future, so as to demand at last some convulsive act of energy, in order to disperse them."[138] But by this time, it must have seemed that even convulsive efforts would not suffice.

Ironically enough, Conolly was to be rescued from this depressing prospect by someone else's failures. The superintendency at Hanwell had originally fallen vacant when the Middlesex magistrates decided to experiment with a system of divided authority, allowing the superintendent to continue as the final arbiter of medical matters, but handing over administrative chores to a lay steward.[139] The arrangement proved unworkable, and exacerbated by Millingen's inexperience and quarrelsome disposition, conditions in the asylum degenerated until they verged upon anarchy. Finally the magistrates were forced to intervene, dismissing the steward, Mr. Hunt, and accepting Millingen's resignation.[140] This time Conolly's application was successful. Less than a year after his initial rejection, a few lines appeared in the *Times* announcing that "Dr. Conolly, late of [Warwick], is appointed to the very important office of Resident Physician at the Hanwell Lunatic Asylum, Middlesex."[141]

Quite unexpectedly, the stern critic of asylum treatment, a man apparently incapable of managing his own affairs with even a modest degree of success, turned out to be an able and effective administrator of what was already the largest and—because of its metropolitan location—the most visible English asylum. Within a few weeks, the magistrates cheerfully announced that a remarkable change for the better had already taken place in the discipline and order of the establishment.[142] Conolly had at last found something he could do well, and to his final days was to insist "that if his life were to come over again, he should like nothing better than to be at the head of a large public asylum, in order to superintend its administration."[143] All the doubts he had once expressed about the appropriateness of the asylum solution, all questions about the deleterious effects of institutional existence, were at once suppressed in his enthusiasm for his new task.

Thomas Bakewell, not many years before, had commented that "the

regular [medical] practitioner has little advantage either of reputation or [of] profit to expect from the treatment of [insanity]."[144] But whatever the general merits of this proposition, in Conolly's case it was emphatically disconfirmed. His achievements at Hanwell brought him, in rapid succession, national attention, royal notice and favor, election to a fellowship of the Royal College of Physicians, and ultimately recognition as "the most valuable consulting physician in mental disorders in Great Britain, and I suppose, in the world."[145] In Maudsley's words, "On the crest of the wave which he raised and rode he was carried to great fame and moderate prosperity."[146]

The first half of the nineteenth century witnessed a long struggle to "reform" the treatment of the mentally ill.[147] Indeed, Hanwell, like all other "County Asylums," was one product of this movement. It was the proud boast of the reformers that the adoption of their program, based on the new system of moral treatment pioneered by the Tukes at the York Retreat, did away with the cruelties previously visited upon the insane, and replaced them with a regime based on kindness and forbearance. Whips and chains, those traditional accoutrements of the madhouse, were, like the straw and stench that were their

inevitable accompaniment, to be banished from the modern asylum. The most sanguine hopes of the reformers had their limits, though. In Samuel Tuke's own words,

> With regard to . . . the necessity of coercion, I have no hesitation in saying, that it will diminish or increase, as the moral treatment of the patient is more or less judicious. We cannot, however, anticipate that the most enlightened and ingenious humanity, will ever be able entirely to supercede the necessity of personal restraint.[148]

Yet it was precisely this extraordinary feat that Conolly claimed to have accomplished. Beginning with his very first report of Hanwell, he boldly asserted "that the management of a large asylum is not only practicable without the application of bodily coercion to the patient, but that, after the total disuse of such a method of control, the whole character of

the asylum undergoes a gradual and beneficial change."[149] So far from being a regrettable necessity, or even a means of cure, restraint "was in fact creative of many of the outrages and disorders to repress which its application was commonly deemed indispensable;"[150] and to that extent "restraints and neglect, may be considered as synonymous."[151] In their place,

> we rely wholly upon constant superintendence, constant kindness, and firmness when required. . . . Insanity, thus treated, undergoes great, if not unexpected modifications; and the wards of lunatic asylums no longer illustrate the harrowing description of their former state. Mania, not exasperated by severity, and melancholia, not deepened by the want of all ordinary consolations, lose the exaggerated character in which they were formerly beheld.[152]

These were large and astonishing claims, and they were greeted in many quarters with skepticism, if not outright hostility. They were, sniffed "Medicus" in the correspondence columns of the *Times,* "a piece of contemptible quackery and a mere bait for the public ear."[153] Millingen seized the opportunity to denounce his successor: "Nothing can be more absurd, speculative, or peculative than the attempts of theoretic visionaries, or candidates for popular praise, to do away with all restraint. Desirable as such a management might be, it can never prevail without much danger to personal security, and a useless waste and dilapidation of property."[154] Others went further still and reiterated the traditional medical claim that restraint was a form of therapy. Dr. Samuel Hadwin, former house surgeon at the Lincoln Lunatic Asylum, wrote:

> Restraint forms the very basis and principle on which the sound treatment of lunatics is founded. The judicious and appropriate adaptation of the various modifications of this powerful means to the peculiarities of each case of insanity, comprises a large portion of the curative regimen of the scientific and rational practitioner; in his hands is a remedial agent of the first importance, and it appears to me that it is about as likely to be dispensed with, in the cure of mental diseases, as that the various articles of the materia medica will altogether be dispensed with in the cure of the bodily.[155]

But while many medical men viewed nonrestraint with extreme suspicion, the new system quickly attracted powerful support in other quarters. During the first month of 1840, the correspondence columns of the *Lancet* were opened impartially to both proponents and opponents of the new system, in an effort "to contribute, in any way, to the solution of a question of so much importance."[156] However, the strain of such uncharacteristic even-handedness eventually told on its editor, Thomas Wakley. Never one to abide by his own admonition to the disputants that "angry recrimination can do no good, and may do much evil,"[157] he soon switched to a fervent advocacy of the cause of reform, couched in his inimitable mixture of panegyric and vituperation.[158] More respectable opinion also rallied to Conolly's support. The venerable Samuel Tuke visited and bestowed his benediction ("Who can visit or contemplate the establishment of Hanwell, containing 800 insane persons, governed without any personal restraint, without gratitude or surprise?").[159] Lord Anthony Ashley Cooper, by now leader of the parliamentary forces seeking "lunacy reform," saw nonrestraint as the vindication and epitome of reform: He "could not speak too highly either of the system itself, or of the manner in which it was

carried out by the talented Superintendent, Dr. Conolly."[160] Meanwhile, the *Illustrated London News* brought Conolly's achievements to the notice of a still wider audience, extolling still another British contribution to the triumph of humanity.[161]

Perhaps the most important force in transforming Conolly into a national celebrity was, however, the *Times* . Beginning in late 1840, it devoted close and sympathetic attention to the progress of his experiment

for a period of some four years.[162] Commenting on the "very considerable opposition . . . the attempt to obtain so desirable an object" had stirred up, it noted that such resistance had also surfaced within the institution, "not simply on the part of several of the county magistrates, but even from many of the servants and officers of the asylum." Fortunately, "that humane gentleman," Dr. Conolly, had, with the staunch support of another faction among the magistrates, vanquished the peculiar notion that there was "more actual cruelty hidden under the show of humanity in the system of non-coercion than was openly displayed in muffs, strait-waistcoats, leg-locks, and coercion chairs," and had successfully brought to fruition "one of the greatest works that the dictates of the humane mind could suggest."[163] Three weeks later, a report on the celebration of "Old Year's Night" at Hanwell demonstrated for the paper's readers the happy effects of the salutary system of nonrestraint. The furies of madness were thoroughly domesticated, and "the utmost tranquility prevailed." Indeed, when the 400 patients assembled for the commencement of the merriment, "scarcely a word was to be heard and the effect produced was most striking and pleasing."[164] Soon afterwards, nonrestraint received the royal imprimatur: The Duke of Cambridge arrived and spent two and a half hours at "this admirable institution," lunched with Conolly (presumably not on ordinary asylum fare), and left proclaiming himself "highly delighted" with all he had seen.[165]

Basking in this unexpected praise of and attention to one of their pauper institutions, the Middlesex magistrates at once issued Conolly's first four annual reports bound together in a single new edition. Professional recognition of his achievement also grew apace. At the third annual meeting of the new Association of Medical Officers of Asylums and Hospitals for the Insane, Conolly was asked to take the chair.[166] In 1844,

he was elected a fellow of the Royal College of Physicians.[167] The 1844 Report of the Metropolitan Commissioners in Lunacy, it is true, exhibited rather more ambivalence about the value of nonrestraint,[168] but two years later, the new national Lunacy Commission had thrown aside such doubts, and nonrestraint became the ruling orthodoxy of British asylumdom.

Conolly had thus become, in the eyes of his admirers, "one of the most distinguished men of the age, and one whose name will pass down to posterity with those of the Howards, the Clarksons, the Father Mathews, and other great redressers of the wrongs, crimes, and miseries of mankind."[169] Oxford University awarded him an honorary D.C.L.; and his marble bust was executed by Benzoni.[170] In 1850, the Provincial Medical and Surgical Association feted Conolly at their annual meeting at Hull.[171] And two years later, with Lord Shaftesbury presiding,[172] Conolly's achievements were again celebrated, and he was presented with a gift of a three-quarter-length portrait by Sir John Watson Gordon, R.A., and an allegorical piece of silver plate standing two feet high and valued at 500 pounds, which illustrated mental patients with and without restraint, all surmounted by the god of healing.[173]

Such extraordinary praise and recognition suggest that Conolly's achievement had a symbolic significance for the Victorian bourgeoisie that extended far beyond its contribution to the welfare of the mad. Confronted by the threats of Chartism and a militant working class; surrounded by the all-but-inescapable evidence of the devastating impact of industrial capitalism on the social and physical landscape; and themselves the authors of a New Poor Law assailed by its critics (most memorably in Dickens' *Oliver Twist*) as the very embodiment of inhumanity and meanness of spirit, the Victorian governing classes could at least find a source of pride in the generous and kindly treatment now accorded to the mad. In a wholly practical way, the work of the lunacy reformers constituted a proof of their society's progressive and humane character. (Hence the curious claim made by Sir George

Paget, that the

Victorian asylum was "the most blessed manifestation of true civilization the world can present.")[174]

As the man who epitomized and had brought the new approach to perfection, John Conolly had thus richly earned his audience's applause. The paternal order he had established demonstrated that even the irrational and raving could be reduced to docility, and by moral suasion and self-sacrifice rather than force. Here, as he put it in the concluding lines of his panegyric on the new asylum,

> calmness will come; hope will revive; satisfaction will prevail. Some unmanageable tempers, some violent or sullen patients, there must always be; but much of the violence, much of the ill-humour, almost all the disposition to meditate mischievous or fatal revenge, or self-destruction will disappear. . . . Cleanliness and decency will be maintained or restored; and despair itself will sometimes be found to give place to cheerfulness or secure tranquility. [The asylum is the place] where humanity, if anywhere on earth, shall reign supreme.[175]

A Potemkin village characterized by an absence of conflict and strife, it constituted a veritable utopia wherein the lower orders of society could coexist in harmony and tranquility with their betters (personified by the figure of a superintendent devoted to their welfare and content to "sacrifice . . . the ordinary comforts and conventionalities of life" for their sake.[176]

In celebrating Conolly's accomplishment, Victorians were thus simultaneously affirming the moral validity of their social order itself; and his powerful friends, while acknowledging that he "no doubt received important assistance from fellow-labourers in the same field," now closed ranks around the proposition that "Dr. Conolly himself put an end to the use of all forms of mechanical restraint in our asylums."[177]

But such claims were, as Conolly himself periodically acknowledged,[178] at best a serious distortion. Nonrestraint was introduced, not by him, but by Robert Gardiner Hill, then a twenty-four-year-old house surgeon at

the provincial subscription asylum at Lincoln. Hill had announced the system in a public lecture to the Lincoln Mechanics Institute in 1838: "I wish to complete that which Pinel began. I assert then in plain and distinct terms, that in a properly constructed building, with a sufficient number of suitable attendants, restraint is never necessary, never justifiable, and always injurious, in all cases of lunacy whatever."[179] For almost two years before Conolly assumed his duties at Hanwell, Hill had demonstrated in practice the feasibility of such an approach. And it was, in fact, a visit to Lincoln that prompted Conolly to try the new system.[180]

Yet Hill's obvious claims as the originator of nonrestraint brought him little honor and scant reward of any other sort. Though bearing the brunt of the early assaults on the system as speculative and wildly misguided,[181] he was granted none of the subsequent recognition and social lionization so readily accorded to Conolly. On the contrary, machinations among the staff and governors at the Lincoln Asylum forced his resignation there,[182] and he found himself unable to obtain another asylum post. Ironically,—and this failure must have been especially galling—he was even rejected when he sought the position of medical officer under Conolly at Hanwell,[183] and so was forced by default to enter general practice.[184] Though a decade later he became the proprietor of a private licensed house, he never managed to obtain an appointment at another public asylum.

One can readily imagine the effects of this on someone as sensitive to questioning of his own merits as Hill was. Apparently the last straw was

when, in his presence, he heard Conolly praised as the author of his system at the 1850 meeting of the Provincial Medical and Surgical Association. Though Conolly graciously indicated that the merit was not his alone, but was shared with Dr. Charlesworth (the

visiting physician at Lincoln), and though Charlesworth then indicated that "the real honour belonged to Mr. Hill,"[185] he was not satisfied, not least, perhaps, because it was forcibly brought home to him how soon his claim to priority had been forgotten.[186]

Hill promptly sought to reassert his claims by writing to the medical press, only to be met by an attempt by his former enemies at Lincoln to claim the merit for Charlesworth.[187] And when Hill's supporters took up a collection for a testimonial to rival Conolly's, his opponents promptly erected a statue of Charlesworth, with a plaque on the base describing him as the originator of nonrestraint, on the Lincoln Asylum grounds.[188] More seriously, Hill fell afoul of Thomas Wakley's pen, and found himself traduced in the *Lancet* 's columns in the latter's typically unscrupulous fashion.[189]

Conolly's role in all of this was hardly innocent. With whatever motives, he consistently declined to give Hill his due. That he had borrowed

the idea of nonrestraint from Lincoln he could not deny; that the discovery was Hill's he sought constantly to obscure.[190] And when Hill in exasperation at length lashed out at his now deceased rival,[191] he succeeded only in alienating his audience and in further tarnishing his own reputation. His shrill and strident claims of priority, his wearisome marshaling of minutiae to prove his own originality,[192] were "not only boring, but repellent."[193] As he proved chronically unable to grasp, one who exhibited such boorish and ungentlemanly qualities could never hope to be accorded a place of honor in a profession desperate to dissociate itself from all that smacked of lower-class, tradesmanlike behavior.

The elegant and socially graceful Conolly inflicted no such handicaps on himself, displaying "a certain humility of manner, a degree of self-deprecation . . . which failed not to attract men; it was nonetheless captivating because it might seem the form in which a considerable dash of self-consciousness declared itself."[194] On the public stage that he had secured for himself at Hanwell, he took delight in the opportunity to display the liberal and paternalist instincts of the gentleman:

> His interest in the patients never seemed to flag. Even cases beyond all hope of recovery were still objects of his attention. He was always pleased to see them happy, and had a kind word for each. Simple things which vainer men with less wisdom would have disregarded or looked upon as too insignificant for their notice, arrested Dr. Conolly's attention, and supplied matter for remark and commendation—e.g., a face cleaner than usual, hair more carefully arranged, a neater cap, a new riband, clothes put on with greater neatness, and numerous little things of a like kind, enabled him to address his poor illiterate patients in gentle and loving accents, and thus woke up their feeble minds, caused sad faces to gleam with

> a smile, even though transient, and made his visits to the wards to be longed for and appreciated. Dr. Conolly rejoiced in acts of beneficence. To be poor and to be insane were conditions which at once endeared the sufferers to him; and when the insanity was removed, and when the patient left the asylum, he generally strove to obtain some pecuniary aid for her from the 'Adelaide Fund' (a fund originated for the relief of discharged patients), and supplemented this very often indeed with liberal donations from his own purse.[195]

Despite a patient population nearing a thousand, a "monstrous multitude of diseased humanity"[196] crammed into buildings originally designed for half that number, and notwithstanding a dismally low cure rate, Conolly's Hanwell was widely regarded as a splendid advertisement for the merits of reform and nonrestraint.[197] From time to time, he protested mildly that the asylum was too big[198] and objected to the Middle-sex magistrate's propensity to seek cheeseparing economies. But for the most part, he sought to exploit Hanwell's fame to persuade others of the advantages, indeed the necessity, of expanding the numbers of county asylums. Such endeavors acquired a new urgency in the wake of the passage of the 1845 Lunatic Asylums Act, for although public provision for the pauper insane was now made compulsory, magistrates in many parts of the country sought to delay or evade building asylums of their own. Accordingly, Conolly wrote a series of articles for the *Lancet* (republished the following year as a monograph)[199] extolling the humanity and economy of asylums devoted to the cure of the lunatic and urging their rapid

construction. Ironically enough, his own role at Hanwell was by this time much diminished and soon to end. His disengagement was not provoked by any disenchantment with administering an everlarger warehouse for the unwanted; or did it constitute a protest at the deficiencies of an overcrowded establishment later described as "a vast and straggling building, in which the characteristics of a prison, a selfadvertising charitable institution, and some ambitious piece of Poor Law architecture struggle for prominence."[200] Instead, it derived from administrative changes that threatened his own authority and status.

The Middlesex magistrates had long exhibited a much greater disposition to interfere in the daily running of "their" asylum then was to be found elsewhere. Their evident belief that nonmedical administration could affect significant economies had already led them to a proposed reorganization of Hanwell that had provoked their first superintendent, Sir William Ellis, to resign. And they were apparently not dissuaded by the fact that their subsequent experiment with a system of divided authority had dismally failed, forcing the resignation of the physician and the dismissal of the steward, and thus indirectly bringing about Conolly's appointment. For when the metropolitan commissioners in lunacy insisted that Hanwell's "extreme magnitude" required more extensive supervision, the justices once more developed a scheme to place daily administration in lay hands. Conolly did not wait for the plan's implementation—in later years, he spoke of "the absurdity—I could almost say the criminality,—of committing one of the most serious of human maladies to the charge of anyone uninstructed in medicine"[201] —but promptly offered his resignation.[202]

This time, as had not been the case with Ellis, a compromise was arranged. Anxious to retain the connection with Conolly that had brought them so much favorable publicity, the magistrates offered him the post of "visiting and consulting physician" at a reduced salary of 350 pounds, and he accepted. His duties now became "to give his attendance for two days a week, and for six hours at every attendance." At other times, medical matters were to be dealt with by the house surgeons who had formerly acted as his assistants.[203] Convinced that it was imperative to have a single resident officer exercising ultimate control over the asylum and its staff, and equally certain that medical men were fit neither by temperament nor by training to assume such a role, the magistrates announced the appointment of John Godwin, a retired army officer, to fill the position.[204]

Under the terms of the appointment, it was specified that "the Governor has the power of suspending not only the servants but even the Medical Officers and Matron of the Asylum. He has, also, the entire control over the classification, employment, amusements, instruction, and general management of the patients . . . subject only to the general control of the Visiting Justices."[205] His superiority was reflected in the higher salary paid him: while the two resident medical officers received 200 pounds each, the governor was paid 350 pounds a year. In view of the range and scope of affairs in which his lay judgment was supposedly given precedence, there was a disingenuousness about the claim that "in regulating his particular duties . . . the Visiting Justices have endeavoured to reconcile his position as their officer whom they will vest with paramount authority to enforce all their orders and regulations, with the distinct responsibility of the Medical Officers in all that concern the moral management as well as the strictly medical treatment of the Patients."[206] For, in practice, to concede the doctors' right to direct the moral treatment of the patients would involve taking away from the governor the very areas of supervision where his authority was supposed to be paramount; while to refuse to concede it was to reduce the asylum physicians to mere decorative appendages. Conflict was thus unavoidable, though the ensuing struggle reached a swift conclusion.

In August of 1844, just four months after his initial appointment, the justices cryptically announced, in two lines buried at the end of their report, that Godwin's resignation had been tendered and accepted.[207] In their next report, they indicated that "after the retirement of the late Governor, the Visiting Justices resolved to defer filling up the vacancy for awhile, and to entrust the management of the Asylum to the ability and experience of the principal [i.e., medical] officers until they could determine what course for its future government it would be most advisable to adopt."[208] Already, however, they

were noting "the progressive improvement in the order and discipline of the Establishment" since Godwin's departure.[209] Six months later, they conceded that under medical supervision, "good management and order prevail [and] that they have every reason to be satisfied with the way in which the Asylum continues to be conducted."[210]

The idea of employing a lay administrator to direct the asylum's affairs was now quietly buried; but the attempt to implement it had already served to all but sever Conolly's connection with Hanwell, after

less than four years on the job. "Mutual trust between himself and the Justices was lost. He felt that they preferred the opinion of others and that his authority and system were eroded."[211] He hung on to his visiting appointment until 1852, when he finally resigned, to the relief of the magistrates, to whom his departure now meant little more than saving the ratepayers some money.

Even before this final rupture, Conolly's situation was such that be was forced to seek some alternative means of earning his livelihood. At 500 pounds per annum, his salary as resident officer at Hanwell had scarcely been munificent, but at least he was also provided with room and board, a not inconsiderable benefit. His visiting appointment, however, entailed not just a reduced salary, but also the loss of this hidden subsidy. His new-found eminence ought presumably to have allowed him to escape the penury he had endured until middle age. But the difficulty was to know how to earn a living, given that there were no defined alternative careers for alienists, outside the burgeoning asylum system.

Almost fifty, Conolly had never possessed the qualities to succeed in single-handedly defining and developing a new form of specialist practice. Not until much later in the century, with the careers of men like his son-in-law, Henry Maudsley,[212] or Sir George Savage,[213] did the alternative of a practice based almost exclusively on the consulting room become possible. Conolly's fame did lead to his being called in as a consultant in difficult cases,[214] and he was also a frequently called expert witness in criminal cases where the insanity defense was raised.[215] But as in his ear-

lier efforts at private practice, he scarcely distinguished himself in these spheres. His forensic testimony in the Pate case, for example, prompted the *Morning Chronicle* to complain that "Dr. Conolly appears to have devoted his attention so exclusively to . . . mental disease that . . . he can apparently no longer distinguish where absolute madness begins and moral and legal responsibility ceases. There are very few of our fellow subjects, we suspect, who could get from Dr. Conolly a certificate of perfect sanity."[216]

Both lunacy inquisitions and criminal trials in which the insanity defense was invoked were highly charged occasions. While the latter were widely seen as a ruse to escape just punishment, a threat to the concept of responsibility and, thus, to the very foundation of criminal justice,[217] the former raised the specter of wrongful confinement of the sane in asylums, "a living death" that inspired periodic moral panics throughout the nineteenth century.[218] Large segments of the Victorian public seem to have questioned both the motives and the competence of alienists who claimed expertise in assessing madness, and Conolly's published opinions and his actions both helped feed these suspicions. Before entering upon a career as an asylum doctor, he had insisted that not every case of unsound mind required incarceration in an asylum. Rather, there was a need for a careful assessment of each case to determine "*whether or not the departure from sound mind be of a nature to justify the confinement of the individual*, "[219] and such inquiries were likely to disclose that "complete restraint is very rarely required."[220] A less discriminating approach posed a serious threat to individual freedom and peace of mind.[221]

Two decades later, these were almost precisely the fears his clear repudiation of his earlier views seemed calculated to arouse. In 1849, in the case of *Nottidge v. Ripley*, the lord chief baron of the Court of the Exchequer, Sir Frederick Pollock, declared that in his opinion, "no lunatic should be confined in an asylum unless dangerous to himself or oth-

ers."[222] Notwithstanding the fact that Conolly's own earlier opinions were the expressed authority for this decision,[223] he at once issued a lengthy remonstrance declaring Pollock's dictum "both mistaken and mischievous."[224] It transpired that he now believed that an extraordinary range of behaviors qualified one for the madhouse: "excessive eccentricity," "utter disregard of cleanliness and decency," "perversions of the moral feelings and passions," a disposition "to give away sums of money which they cannot afford to lose," indeed all cases where people's "being at large is inconsistent with the comfort of society and their own welfare."[225] Particularly in the young, incipient madness took on protean forms, and its cure required active and early intervention. Suitable cases for treatment included

> young men, whose grossness of habits, immoderate love of drink, disregard of honesty, or general irregularity of conduct, bring disgrace and wretchedness on their relatives; and whose unsound state of mind, unless met by prompt and proper treatment, precedes the utter subversion of reason;—young women of ungovernable temper, subject, in fact, to paroxysms of real insanity; and at other times sullen, wayward, malicious, defying all domestic control; or who want that restraint over the passions without which the female character is lost. For these also such protection, seclusion, and order, and systematic treatment as can only be afforded in an asylum, are often indispensable. Without early attention and more careful superintendence than can be exercised at home, or in any private family, [many] will become ungovernably mad, and remain so for life.[226]

Conolly's eagerness to consign the morally perverse and socially inadequate to the asylum was widely shared by his colleagues,[227] but seen in other quarters as a dangerous blurring of immorality and insanity.[228] In addition, many of the public were inclined to believe that alienists' willingness to define others as mad on such slender pretext reflected their financial interests in expanding their pool of patients. Conolly's actions in the Ruck case served only to reinforce these suspicions. Ruck was an alcoholic whose wife had secured his commitment to a private asylum on

certificates issued by Conolly and Dr. Richard Barnett. Enforced abstinence brought about a rapid recovery, but several months passed before Ruck, at a cost of 1,100 pounds, secured an inquisition in lunacy, at which a jury found him sane by majority vote. He then sued Conolly and others for false imprisonment. At the trial that followed, Conolly was forced to make a series of damaging admissions. He had issued his certificate of Ruck's lunacy after a joint examination with Barnett, a clear violation of the law; and, more seriously, he had received a fee from Moorcroft House, where he was the consulting physician, for referring Ruck. The jury was obviously not impressed with Conolly's disingenuous defense: "I know the act says that a certificate should not be signed by any medical man connected with the establishment. I do not consider myself connected with the establishment, as I only send male patients to it"![229] As a result, he laced a swingeing judgment against him for 500 pounds' damages.

Subsequently, too, his transparent rationalizations and the convenient congruence between his beliefs and his self-interest were savagely burlesqued in Charles Reade's scandalous best-seller, *Hard Cash*, where Conolly appears in thinly disguised form as the bumbling Dr. Wycherly.[230] Wycherly, in the sardonic words of Reade's hero, Alfred Hardie, "is the very soul of humanity," in whose asylum there are "no tortures, no handcuffs, nor leg-locks, no brutality."[231] But his "vast benevolence of manner"[232] and the "oleaginous periphrasis" of his conversation concealed a second-rate mind "blinded by self interest" and apt to perceive insanity wherever he looked.[233] In Reade's savage caricature, Conolly/Wycherly's pretensions to gentlemanly status are mocked, and his vaunted psychological acumen exposed as a pious fraud. "Bland and bald," this psychocerebral expert was "a voluminous writer on certain medical subjects . . . a man of large reading and the tact to make it subserve his interests,"[234] a task in which he was greatly aided by his settled disposition "to found facts on theories instead of theories on facts."[235] As "a collector of mad people . . . whose turn of mind, cooperating with his instincts, led him to put down any man a lunatic, whose intellect was manifestly superior to his own,"[236] he is easily duped into diagnosing a sane man as lunatic, and thereafter persists stubbornly in his opinion till the unfortunate inmate is willing to grant that "Hamlet was mad."[237] In the climactic courtroom

scene that brings the melodrama to a close, Reade puts Wycherly on the witness stand and gives him for his lines Conolly's most damaging admissions in the Ruck case. Wycherly, like his alter ego, tries to bluster his way through by protesting that counsel's questions are an affront to his professional dignity—but to no avail. Question:

> "Is it consistent with your dignity to tell us whether the keepers of private asylums pay you a commission for all the patients you consign to durance vile by your certificates?" Dr. Wycherly fenced with the question, but the remorseless Colt only kept him longer under torture, and dragged out of him that he received fifteen per cent from the asylum keepers for every patient he wrote insane; and that he had an income of eight hundred pounds a year from that source alone.[238]

Along with his sometimes embarrassing forays into the courtroom, and his moderately rewarding practice as a consultant,[239] Conolly was forced to turn to the private "trade in lunacy" as an additional source of income. His private residence, Lawn House, only a stone's throw from Hanwell,[240] was adapted to take a handful of female patients.[241] Subse-

quently, he acquired an interest in another small asylum at Wood End and opened a third house, Hayes Park, in partnership with his brother, William;[242] and in 1853 he became consulting physician to Moorcroft House Asylum from which he received both a salary and a percentage of the patients' fees.[243]

"A man," said Conolly a few years later, "must live by his profession, and a physician who devotes himself to mental disorders has to deal with a very small portion of the population, and he generally adds to his consulting practice, the plan of having a place where the treatment of patients can be conducted entirely under his own observation."[244] There can be no doubt, however, that trading in lunacy was at first distasteful to him. He had long argued that "every lunatic asylum should be the property of the State, and should be controlled by public officers,"[245] and during his time at Hanwell had become the leading spokesman for the new county asylums. Moreover, with its obvious overtones of "trade" and its long-established unsavory reputation (to which the writings of reformers like himself had in no small measure contributed), the business of running a private asylum was widely regarded as one of the most *déclassé* forms of medical practice; potentially lucrative, to be sure, but abhorrent to those of gentlemanly sensibilities.

But however repugnant, it was unavoidable. Conolly's income at Hanwell had been "barely sufficient to maintain his family," even with accommodation and food provided. Thrown back entirely on his own resources, he compounded his difficulties by being once more "very liberal-minded in practice and otherwise, and gave little attention to financial matters."[246] More seriously, however, his household remained a large, even a growing burden. His eldest daughter soon married a missionary stationed in China; but Sophia Jane did not marry until 1852, at the age of twenty-six,[247] and Anne Caroline not until 1866, at the age of thirty-five.[248]

Much the greatest source of concern, though, was his son, Edward Tennyson, who far exceeded even his father's youthful fecklessness and displayed a remarkable inability to find any settled pursuit. When he was eighteen, his father's connections had secured him a position as parttime secretary to the Society for the Diffusion of Useful Knowledge. But in 1846, with the disbanding of the society, this came to an end, and the elder Conolly's appeal to Lord Brougham for another patronage ap-

pointment for his son met with no response.[249] Five months later, Edward himself renewed the petition, asking specifically for an appointment with the new Railways Commission.[250] Spurned, he was not discouraged. Three years later, he sought Brougham's assistance to obtain a position as "a Poor Law Inspector," urging his experience as "one of the Guardians of the Poor for Brentford Union, [undertaken] in the absence of any more remunerative employment," as a qualification for the job.[251] He was no more successful on this occasion, and since he had now reached his late twenties, it seems at last to have occurred to him that further efforts of his own were required. An

attempt to practice as a barrister brought no improvement: "Prospects of . . . business are anything but encouraging, and I am every year more desirous of doing something profitable in the world." The upshot was still another appeal to Brougham: "I venture to apply to your lordship to know whether there is likely to be any appointment connected with new Charities Commission which I have any chance of obtaining."[252] There was not.

Now married, Edward still remained almost entirely dependent on his father's largesse, a burden that was further augmented with the arrival of the first of a series of children. At thirty-three, he had "been four years at the bar; . . . had hardly any practice," and decided to renew his entrearies: "My Lord, I have been so often troublesome with applications that I am ashamed to make another." Nevertheless, he did not let a little embarrassment stand in his way, this time seeking the vacant post of secretary to the Lunacy Commission.[253] But even the Conolly name could not secure this appointment or a similar post with the Scottish Lunacy Commission, for which he applied some two years later.[254] As late as 1864, his father still did not know what was to become of him: "Past forty—seven or eight children [*sic*]—no present means of educating them, nor of emigration where they might prosper, no friends whom he has continued to see—no prospects at the Bar, etc., etc."[255] (In 1865, however, a year before his father's death, he finally adopted the favorite strategy for failed scions of the Victorian middle classes, and emigrated to New Zealand, where he became a Supreme Court judge.)[256]

Faced with these demands on his income, it is not surprising that John Conolly had to swallow his pride and seek financial reward where he

could find it. But just as he had earlier turned from a skeptic about asylum treatment into an advocate of a greatly expanded asylum system, so he now publicly defended the private institutions he once anathematized. Repudiating his prior stance on domestic treatment, he contended that "the management essential to recovery is impracticable in [the lunatic's] own house, or in any private family."[257] Yet out of the strong desire to conceal the presence of insanity, the wealthy attempted to resort to these expedients, with the result that "the whole house becomes a kind of asylum, but without the advantages of an asylum."[258] The consequences were necessarily antitherapeutic: "The alarm and even the affection of surrounding friends lead to hurtful concessions and indulgences, and to the withdrawal of all wholesome control; until the bodily disorder present in the first stages is increased, and the mind is much more irritated, thus making eventual recovery more difficult, and often altogether doubtful or impossible."[259] Still less enviable was the situation of those placed "in detached residences, where no other patient is received." Gloom, solitude, and neglect, both physical and moral, were their lot, "such, indeed, as to make the position of lunatics of wealthy families inferior to that of the lunatic pauper."[260] Private asylums had once been notorious for similar abuse and neglect. But their current proprietors were, with few exceptions, men "of high character and education"; and the institutions themselves "are now so well conducted as to present every advantage adapted to the richer patients, and to secure all the care and comfort which the poorer patient enjoys in our admirable county asylums"; with the result that the patient's reception into the asylum "is usually followed by an immediate alleviation of his malady, and

he becomes at once surrounded by every circumstance and means favourable to cure."[261]

This Panglossian portrait was far from universally admired. Sir John Charles Buckhill dismissed private asylums as "institutions for private imprisonment";[262] and the success of Charles Reade's *Hard Cash*, a story centering upon the improper confinement of its hero in a series of private madhouses, suggests that Bucknill's opinion reflected a widespread public suspicion.[263] But Conolly's views certainly corresponded closely with the official mythology of the Victorian asylum system and were fitting for one who now ranked as the doyen of his profession.

The publication of his defense of private asylums represented Conolly's last significant public activity. By 1860, he lived "in an elegant retirement" at Lawn House,[264] consulting occasionally in difficult cases, but for the most part concentrating upon *A Study of Hamlet*, an essay designed to show that the prince was indeed mad.[265] His health steadily

worsened until, on 4 March 1866, he suffered a massive stroke. By the following day, he was dead. "His name," as the *Journal of Mental Science* puts it, "liveth forevermore."[266]

Not only did John Conolly play a central role in the success of the Victorian lunacy reform movement, but the vicissitudes of his individual biography nicely illustrate some of the general sociological features that attended the constitution of Victorian alienism as a specialism.[267] His widely publicized work at Hanwell contributed significantly to the crea-

tion of a marketplace for the alienists' services and helped legitimize medical monopolization of the treatment of lunacy. Both ideologically and practically, his activities consolidated the Victorian commitment to institutional "solutions" to the problems posed by the deviant and the dependent. Furthermore, notwithstanding his skepticism about the value of most medical remedies for madness, and his own overt reliance on and preference for moral suasion and management in the treatment of his charges, he was most insistent on the crucial importance of medical control over the treatment of the insane. Any alternative to this professional monopoly he stigmatized as fatally misguided, almost "criminal." In this judgment he echoed and lent the considerable weight of his prestige to the opinions of his colleagues.[268]

As was generally true of Victorian alienists, it was his prerogatives as a professional that Conolly defended most fiercely against outside threats. Thus it was a proposal to limit the authority of the medical superintendent, not such critical issues as the unwieldy size and organized monotony of the Victorian asylum, that provoked his resignation from Hanwell—though size and routine undoubtedly contributed the more powerfully to the transformation of the ideal of curative institutions into the reality of museums for the collection of the unwanted.[269] So far from acquiescing in the dilution of his authority, Conolly was among the first to insist that, for the alienist, everything that occurred within the institution was relevant to cure, and in consequence nothing could be safely delegated into lay hands. This claim, as I have pointed out elsewhere,[270] was widely shared in the profession at this time, reflecting the importance of monopolistic control of asylum administration as support for an otherwise shaky professional authority. Hence the urgency with which alienists sought to persuade their employers that they alone should have

authority over the most minute details of day-to-day activity in this "special apparatus for the cure of lunacy."[271]

As we have seen, Conolly's major concern, in the course of his writings on insanity, was with the administrative aspects of the treatment of insanity, and over the course of his career he evinced a declining interest in contributing to the scientific understanding of the condition itself. Almost certainly, this hierarchy of concerns accounts for a good measure of the hostility that lurked just beneath the surface of Henry Maudsley's strikingly ambivalent "Memoir" of his late father-in-law.[272] The markedly different—almost diametrically opposed—priorities of these two men (probably the leading figures of their respective generations of British alienists), in turn, mirror the sharp alteration of the context within which the profession operated in the two periods: the movement from what came to be seen as the naive optimism of the first half of the century, that medicine possessed the means to diagnose and successfully treat insanity, to the deepening pessimism of late Victorian psychiatry, with its sense that insanity was all but incurable, the product of defective heredity and Morelian degeneration. For those adhering to the latter orthodoxy, the issue of improving the treatment of the insane naturally lost some of its urgency, to be replaced by the need to explain (or explain away) the profession's apparent therapeutic impotence.

But even Conolly's own position underwent dramatic internal evolution in the course of his career. In his earliest writings on insanity, the product of a period in which he was very much the outside critic of existing practices, he assailed the indiscriminate confinement of the insane, urged the elimination of the private, profit-making "madhouses," and touted the merits of domiciliary care. A decade later, on his appointment as superintendent of one of the largest of the existing county asylums, he became one of the most important and effective proselytes of the expansion of the asylum system, and before long was railing

against those who wanted to confine asylum admissions to lunatics dangerous to themselves or others. Toward the close of his career, during a period in which he had become one of the leading private specialists in the treatment of insanity, he exhibited yet another volte-face, using the occasion of his second presidential address to the Medico-Psychological Association to issue a lengthy defense of the social utility—indeed indispensability—of the private asylum system.

It is possible, if one is charitably inclined, to view the evolution of his views as the product of greater experience and maturity. The inex-

perienced observer of his earlier years was disposed to promote impractical, if superficially attractive, visionary schemes of nonasylum treatment. Later acquaintance with the realities of treating insanity and the therapeutic possibilities of asylum treatment forced him to revise his ideas, as did his subsequent experience of running a private asylum. Equally, of course, one may opt for a cynical interpretation of his intellectual "progress." As Conolly himself remarked, early in his career, "When men's interests depend upon an opinion, it is too much to expect that opinion always to be cautiously formed, or even in all cases honestly given."[273] The close correspondence between the evolution of his ideas and the unfolding of his career is too marked to escape comment. And even in the nineteenth century, there were those who saw the parallels as more than coincidental. Sir John Charles Buckhill, whose own intellectual development was in precisely the opposite direction to Conolly's—from an enthusiastic advocate to a scathing critic of the asylum system, both public and private[274] —was convinced that Conolly's judgment had been subverted by self-interest. Praising the positions Conolly had adopted in *An Inquiry Concerning the Indications of Insanity* ("Nothing which Dr. Conolly ever wrote does more credit to his head and heart than these opinions"), he noted with sorrow his later repudiation of them. One could only regret that "advancing years and personal interests had made him indulgent to the evils he had denounced."[275]

The less moralistically inclined may prefer to adopt a rather different perspective on the internal evolution of Conolly's ideas. It is instructive to note how difficult it is for modern readers to portray his intellectual journey as "progress." For our generation has learned to view the asylum as an almost unmitigated disaster, a fatally mistaken approach to the problems of managing the mad, and one that cannot be too swiftly consigned to the dustbin of history. Viewed from this perspective, Conolly's changing views appear to mark an almost perverse shift from enlightenment to error. It is to his earliest work that our contemporaries turn, when they count him the author "of principles of treatment that have scarcely been improved in all the succeeding epochs of vanguard practice."[276] But for the Victorians, it was precisely this early critique of the asylum and advocacy of domiciliary care that was anomalous; and the

abandonment of such aberrant opinions in favor of an elaborate defense of asylum treatment required no special explanation: it simply represented an acknowledgment of the findings of modern medical science. Here, as elsewhere, we observe how slippery the concept of "scientific knowledge" is in the human sciences, and how profoundly dependent the content of that "knowledge" is on the nature of the larger social order.

Chapter Eight
Moral Architecture: The Victorian Lunatic Asylum

The following paper was originally commissioned by Anthony King for a collection of interdisciplii development of the built environment. Sociologists, anthropologists, historians, even architects "much greater emphasis on an historical understanding of the economic, functional, and cultural social conditions within which particular types of built form have evolved."[1] Drawing in part on volume was to explore what buildings and the social organization of space could teach us about and to trace the reverse connections, in an attempt to decipher how changes in society at large configuration of buildings and spatial environments.

The asylum lends itself particularly well to analysis of this sort. As the example of Bethlem confinement of a small number of lunatics had long historical roots in England (even though "the Foucault makes so much was scarcely part of the English historical experience). But Bethlem wa until the eighteenth century was there any noticeable increase in the number of private establish confining the mad;[2] and the development of a large and elabo-

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rate network of state-run asylums and the routine consignment of the lunatic to the tender were very much a creation of the Victorian age.

One must realize, too, that these buildings directly embodied a particular and peculiar set madness; radically transformed what it meant to be labeled mad (even affecting who was susce acquired a transhistorical symbolic resonance of very substantial proportions. For the nineteenth historically unprecedented and very distinctive sense, a purpose-built structure—an example of form of "moral architecture." In the rehabilitation of the insane, as in the reform of the criminal were seen as quite central to any serious effort to remoralize the dangerous and defective. And mammoth structures built in response to the reformers' utopian visions remained, even after as degenerated into mere holding pens, grotesque parodies of the regenerative vision they had orig

Moral Architecture: The Victorian Lunatic Asylum

> Were we to draw our opinions on the treatment of insanity from the construction of the buildings destined to the re conclude that the great principle adopted in recovering the faculties of the mind was to immure the demented in gl that these were the means best adapted for restoring the wandering intellect, correcting its illusions, or quickening lost social affections were to be corrected or removed by coldness or monotony.[1]

Scattered widely across the English landscape, sometimes surrounded now by urban and suburb incongruously in-

stalled in the midst of sylvan countryside, are to be found one of the most notable architec nineteenth century, the Victorian "loony bins." Huge, ramshackle, decaying structures, once hail manifestation of true civilization the world can present,"[2] they now apparently exist on borrowe institutions" merely awaiting the setting of "the torch to the funeral pyre."[3] Not that they go ur contrary, mental hospital admission rates have seldom been higher. But the number of patients falls remorselessly, as the mentally disturbed are processed and discharged at an ever more rap mounting attack on their therapeutic failings and harmful effects on those they treat, the asylum

"community-based" alternatives.

Still, the association between mental disorder and these grim relics of Victorian humanitari
our minds. For almost two centuries, madness and the built form within which it has been conta
synonymous. The link will not easily be obliterated. Nor, I suspect, will the buildings themselves
the social forces that lay behind the emergence of asylums as the dominant response to madnes
factors that led to the transformation of these institutions into museums for the collection of the

Capitalism and the Transformation of Society

The rise of the asylum forms part of a much larger transformation in social control styles and pr
roughly between the mid-eighteenth and mid-nineteenth centuries. Prior to this, the control of d
essentially communal and family affair. The amorphous class of the morally disreputable, the inc
such elements as vagrants, minor criminals, the insane, and the physically handicapped—was m
ways. Characteristically, little effort was made to segregate such "problem populations" into sep
keep them apart from the rest of society. Instead, they were dealt with in a variety of ways that
community. Most of the time, families were held liable to provide for their own, if necessary with
or a more permanent subsidy from the community. Lunatics were generally treated no differentl

deviants:[4] only a few of the most violent or troublesome cases might find themselves cor
cell or as part of the heterogeneous population of the local gaol.

By the mid-nineteenth century, however, virtually no aspect of this traditional response re
century or so, a remarkable change in social practices and a highly significant redefinition of the
society had taken place. Insanity had been transformed from a vague, culturally defined phenon
probably small, proportion of the population into a condition that could be authoritatively diagno
by a group of legally recognized experts and that was now seen as one of the major forms of de
and of critical importance for my present concerns, whereas in the eighteenth century only the r
among those now labeled insane would have been segregated and confined apart from the rest
achievement of what is conventionally called "lunacy reform," the asylum was endorsed as the s
the problems posed by mental illness. Throughout the length and breadth of the country, huge s
built or were in the process of being built to accommodate the legions of the mad.

What had happened to bring about these profound changes? It is frequently suggested tha
modes of handling deviance represents no more than a quasi-automatic response to the realities
society. Supposedly, the sheer scale of the problems associated with the advent of the Industria
adaptive capacity of a community and householdbased relief system, prompting the resort to th
practice, however, not only is this account excessively mechanistic, but, in addition, no clear-cut
rise of asylums and the growth of large cities. The drive to institutionalize the lunatic begins too
the problems created by urbanization; and at a very early stage in the process rural areas exhib
asylum solution.

Instead, as I have argued at greater length elsewhere,[5] the main driving force behind the
madness (and to other forms of deviance, come to that) can much more plausibly be asserted to
effects of the advent of a mature capitalist market economy and the associated ever more thoro
existence. While the urban conditions created by

industrialization initially had an impact that was quite limited in geographical scope, the m
restrictions. Rather, it had increasingly subversive effects on the whole traditional rural and urba
as I shall suggest later, in turn prompted the abandonment of long-established techniques for co
troublesome.

Quite obviously, of course, the origins of capitalism in England lie much further back in tim
century. One may trace commercialized production back at least as far as the fifteenth century,
by some definitions a single national market economy.[6] But for all the importance of these earl
incontrovertible that, until the latter part of the eighteenth century, the market continued to exe
economy" and had only a limited impact on English social structure.[7] This situation, in turn, all
into the eighteenth century, of a relatively unchanging agriculture and a social order that exhibit
the past. The mass of workers were not yet fully proletarianized; and notions of the just price ar

and at times inhibited market determination of wages and prices.[8] Put another way, thou capitalism was present, it operated only within strict limits.[9]

Beginning in the late eighteenth century, however, capitalism broke the social bonds that h There occurred a massive reorganization of society as a whole along market principles—a develo "the running of society as an adjunct to the market."[10] The old social order was undermined an shifts took place in the relationships between superordinate and subordinate classes: changes w from a paternalistic social order dominated by rank, order, and degree to a society based on cla transformation are too many and complex to go into here,[12] particularly since my

present concern is rather with the social impact of the process than with its origins. Turnin first place, the rationalization of production increasingly forced the closing off of all alternatives providing for subsistence. And wage earners, whether agricultural laborers or industrial workers, make adequate provision for periods of economic depression. Yet employers increasingly convin the workers only wages, and that once these had been paid, the employees had no further claim worse, one of the most notable features of the economy in this period was its tendency to oscilla boom and slump. Thus, for the lower classes, family members unable to contribute to their own drain on resources. Such dependent groups as the aged and children became a much greater bu insane.

These changes in structures, perceptions, and outlook provided a direct source of bourgeoi traditional, noninstitutional response to the indigent. There were others, however. Most notably, structure associated with the transition to an industrial economy led to a sizable rise in the prop of poor relief—at precisely the time when the growing power of the bourgeoisie and their increas cultural life was reducing the inclination to tolerate this. In the circumstances, the upper classes laxly administered household relief *promoted* poverty rather than relieved it (a position for whic support in the writings of Malthus and others).[14] In its place, they were increasingly attracted t system. For, in theory at least, workhouses and the like enabled a close and continuing watch to They could be used to punish idleness. Moreover, their quasi-military authority structure seeme work habits among those resisting the monotony, routine, and regularity of industrialized labor. would function as "a mill to grind rogues honest and idle men industrious":[15] and in this way th rendered efficient and economical.

If the general receptivity of the English ruling class to institutional responses to indigence structural transformations of the society, what in turn accounts for the tendency not merely to i and categorize the previously amorphous class of the indigent, the troublesome, and the morall for our present concerns, how and why was insanity differentiated in this way? The establishme more especially, a market in labor, provided the initial incentive to distinguish far more carefully categories of deviance. If nothing else, under these conditions, stress had to be laid for the first distinguishing between the able-bodied and non-able-bodied poor. For a labor market was a bas and to provide aid to the able-bodied threatened to undermine that market in a radical fashion a Adam Smith pointed out,[17] relief to the able-bodied interfered with labor mobility; it created co and region and another; and it had a wholly pernicious effect on labor discipline and productivity ought to be the stimulus to the capable, who must therefore be distinguished from the helpless. thus increases in direct relationship to the rise of the wage labor system.

One can see the primitive beginnings of this process even in the Elizabethan Poor Law of 1 the able but workless, the aged and impotent, and children. But until much later than this, the b would be termed the unemployed, the unemployable, and the employed remained much more fl to realize.[18] Moreover, while the Tudors and Stuarts did not scruple to invoke harsh legal penal their efforts were inspired at least as much by the need to defuse the political threat posed by a more directly economic considerations.[19]

As economic considerations grow in importance, so does the pressure to separate the able work. At first the compulsion to work came through threats of judicial punishment, but gradually favor of one best summed up by the Quaker pamphleteer, John Beliefs: "The Sluggard shall be work shall not eat."[20] The superiority of the whip-

lash of hunger over legal compulsion was clear. Not least, it appeared as a purely economi compulsion, a suprahuman law of nature. As that well-known humanitarian Thomas Robert Malt govern and punish for us, it is a very miserable ambition to wish to snatch the rod from her han odium of the executioner."[21]

In this way, then, the functional requirements of a market system promoted a relatively si between two broad classes of the indigent. Workhouses and the like were to be an important pra theoretical separation, and thereby of rendering the whole system efficient and economical. Not their founders, however, workhouses quickly became filled with the decaying, the decrepit, and unintended consequence of this concentration of the deviant in an institutional environment was handling at least some of them—most notably those who could not or would not abide by the ru

Among the most important of these were the acutely disturbed and refractory insane. The gathered together in an institution were quite different from those they had posed when scattere order and discipline of the whole establishment were jeopardized by the presence of people who punishment, could not be persuaded or induced to conform. Hence the adoption of an institution populations greatly increased the pressures and incentives to differentiate among them. Under t complaints from both administrators and inmates of workhouses, gaols, and hospitals, efforts w

Initially, this situation provided simply an opportunity for speculation and profit for those w human misery. Those involved with "the disposal of lunatics" increasingly placed them with indiv dwelling houses which gradually acquired the description of 'mad' houses."[22] Large as some ma the "trade in lunacy" often was, few of these places were purpose-built. The resulting structural together with the lack of restraints on entry into or conduct of the business, undoubtedly had so widespread reliance on chains, manacles, and physical coercion to manage patients. Their impor be exaggerated, however. Alongside the profit-making madhouses, and in addition to

the ancient establishment of Bethlem (which had been rebuilt in 1676),[23] the eighteenth a number of charity asylums supported by public subscription. And though these institutions wer contain lunatics, here, too, madness was considered "a display of fury and violence to be subdue chains, and lowering treatments."[24]

"Lunacy Reform"

Beginning in the early years of the new century, however, a movement began to replace the pri accommodate in statesupported asylums those lunatics still housed in gaols, in poor-law institut closets. Particularly in its early stages, lunacy reform formed part of a much broader movement characteristic of the late eighteenth and early nineteenth centuries. Borrowing both personnel[25] movements, it was at first a somewhat confused and ill-defined enterprise. Those involved in it s concern to protect society from the disorder threatened by the raving; a desire to simplify life fo administering the local poorhouses and gaols; and an equally unfocused and unsystematic feelir deserved to be treated in a more "humane" fashion. But they possessed no clear ideological visi existing arrangements. This lack of clarity was evident both in

the first parliamentary inquiry the reformers instituted into the treatment of the insane, wh insufficient institutional provision to complain about and bestowed considerable praise on precise asylums the reformers were shortly to criticize so vehemently;[26] and in the vague, weak permi reformers then secured. Counties were henceforth allowed (although not required) to provide as expense; but even the reformers appeared to have little conception at this point of why the asyl institution it should be.[27]

Within less than a decade, they possessed answers to both questions. A hitherto obscure p York Retreat, attracted national attention and provided the reformers with both a model to be co superiority of properly run asylums as a treatment setting.[28] Sharply departing from traditional insisted upon "the superior efficacy . . . of a mild system of treatment." External, physical coerci blatant forms—"gyves, chains, and manacles"—done away with entirely. In its place came an en much in the manner of a rational being as the state of mind will possibly allow" and on carefully

inmates to collaborate in their own recapture by the forces of reason[29] (see Figure 8).

[Full Size]

Figure 8.
The original building of the York Retreat, opened in 1796. The domestic a
of this establishment reminded one early visitor of "une grande ferme rust
early nineteenth century, the institution (at first, with only thirty patients
model for lunacy reformers. From: D. H. Tuke, *Reform in the Treatme*
Insane (London: Churchill, 1892), 18.
(Courtesy of the Wellcome Trustees.)

From most perspectives, the Retreat was an outstandingly successful experiment. It had d
satisfaction at least, that the supposedly continuous danger and frenzy to be anticipated from m
rather than the occasion for harsh and misguided methods of management and restraint; indeed
measure the self-serving creation of the madhouse keepers. It apparently showed that the asylu
and forgiving environment that not only spared the insane the neglect that would otherwise hav
role in restoring a substantial proportion of them to sanity.

Now that the reformers had before them a practical realization of their own half-formulated
conditions in most existing madhouses became one of fierce moral outrage. Since the free trade
opportunities and incentives for keepers to maltreat the mad (or so they now concluded), only a
rigorously inspected asylums would allow the extension of the benefits of moral treatment to all
therefore, the reformers were seeking legislation to secure these ends.

Any such measures, however, threatened a transformation in political relationships whose
the narrow sphere of lunacy reform. If enacted, it would have set the precedent for a notable ex
machinery at the disposal of the state. Opposition to such a concentration of power at the natior
widespread and well entrenched at both the structural and the ideological levels,[30] so that it to
lunacy reformers to secure legislative enactment of their plans. (Indeed, they succeeded only af
administration had been confronted and dealt a decisive defeat, not over the marginal issue of t
the critically important issue of Poor Law reform.) In the interim, the reformers devoted themse
opinion, through the periodic exposure of the evils necessarily attendant upon the continued ope
system and through the development of a steadily more elaborate ideological account of the virt
run asylums.

Though it was further developed and refined by the newly emerging class of professional "
ideology drew heavily on the York Retreat for inspiration.[31] It was insistently proclaimed that ir
insanity, the requisite "means and advantages can rarely, if ever, be united in the private habita
part, this superiority simply reflected the much greater experience of asylum personnel with the
disturbance, which allowed them to handle the insane more easily and skillfully, in situations wh

and misdirected interventions of relatives only aggravated the condition. But, beyond this, private dwelling is illadapted to the wants and requirements of such an unfortunate being." Expe charged with curing lunatics of "the improbability (I had almost said moral impossibility) of an ir

person's regaining the use of his reason, except by . . . a mode of treatment . . . which ca Building constructed for the purpose."[33] The very physical structure, as this implied, was "a spe lunacy"[34] quite as important as any drugs or other remedies in the alienist's armamentarium. I leading American member of the fraternity,

> An Asylum or more properly a Hospital for the insane, may justly be considered an architectural contrivance as pec its designs, as is any edifice for manufacturing purposes to meet its specific end. It is emphatically an instrument c

Designing the Purpose-Built Asylum

Many aspects of the asylum's physical structure and siting contributed to its value as a therapeu and his followers placed a wholly new emphasis on the importance of classification as a means c Segregation of inmates by other than social class was largely ignored in the eighteenth century. Bethlem in 1788, for example, he discovered that "the patients communicate with one another f house, so that there is no separation of the calm and the quiet from the noisy and turbulent, ex their cells."[37]

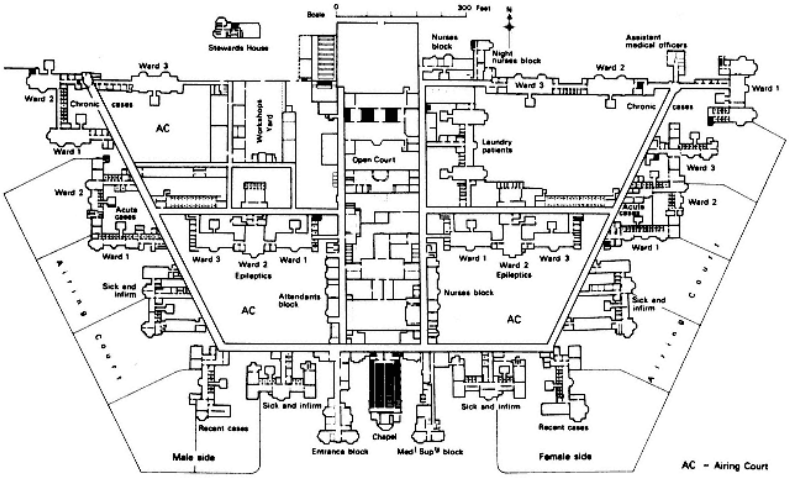
By contrast, in the reform institutions, separation was a key management device, the tech discarding of cruder, more obvious ways of inducing a measure of conformity from the asylum's arranged into classes, as much as may be, according to the degree in which they approach to ra asylum authorities had a powerful weapon at their disposal with which to prevail upon the patier

restraint: "[The insane] quickly perceive, or if not, they are informed on the first occasion, great measure on their conduct."[39] If a patient misbehaved, he was simply demoted to a level dealt with and to a degree allowed," but where the available social amenities were sharply curta willingness to control his disagreeable propensities was he allowed to obtain his former privilege that their grant was purely conditional and subject to revocation. As Goffman has pointed out, "' the outside) is a very model of what psychologists might call a learning situation—all hinged on in."[40] The importance of this approach as a mechanism for controlling the uncontrollable is perh employment of architecture to permit classification, long after its use for the other purposes the abandoned. (See Figure 9.)

For beyond the utility of physical barriers to enforce moral divisions in the patient populati important for the reformers in countless other ways. Their ideal institution was to be a home, wh treated as individuals, where the mind was constantly stimulated and encouraged to return to it calibrated treatment could be administered only in an institution of manageable size. The Retrea patients, though later expansion almost doubled that number. For the new pauper asylums to be felt that these standards could be relaxed, though not by much. "It is evident," said Sir William

> that for the patients to have all the care they require, there should never be more than can, with comfort, be atter many as ought to be in any one house; where they are beyond that the individual cases cease to excite the attenti case, not one half the good can be expected to result.[41]

Others thought that the number might be raised to 200, or even 250, but all the major aut rise beyond this point.[42]



[Full Size]

Figure 9.
Ground floor plan of the Claybury County Asylum at Woodford, Essex, begun in 1887. The a
patients. In addition to its four "curative" asylums (of which this was one), Middlesex also
incurables at Caterham and Leavesden (see Figures 13 and 14), each taking approximatel
hospital and prison, the architecture of the asylum developed in association with the s
organizing the inmates. Based on drawings from *The Builder* , 23 November 1889, a
Hospitals and Asylums of the World (London: Churchill, 1893), 1

The building itself should emphasize as little as possible the idea of imprisonment or confir
the patients could enjoy the benefits of fresh, bracing country air, and where there was an exter
surrounding countryside to divert the mind from its morbid fantasies. The insane were very sens
though "some have been disposed to contemn as superfluous the attention paid to the lesser fe
great reason to believe it has been of considerable advantage."[43] It was thus not an extravaga
that emphasized cheerfulness by being aesthetically pleasing. The architect could help secure th
apparently insignificant details: for example, by substituting iron for wooden frames in the sash
maintained without the need for iron bars.[44] Similarly, patients ought to be able to change roo
a change of scenery, and provision ought always to be made for extensive grounds to be attache
would allow scope for recreation and harmless diversions, the kinds of mental and physical stim
tendency of insanity to degenerate into outright fatuity.

"Monasteries of the Mad"

Such utopian reveries bore little relationship to reality. During the first twenty years after the pa
Asylums Act of 1808, the ten asylums built were all of moderate size, averaging 115 inmates ea
built for 110 patients [Figure 10] is typical of the asylums built in this period.) Thereafter, howe
inexorably grew ever larger. By the mid-1840s, the average size was in the region of 300 inmat
contained over 600 inmates; and the Middlesex Asylum at Hanwell as many as a thousand.[45] T
magistrates exhibited a profound skepticism about the reformers' arguments in favor of small in
of providing for a horde of derelict paupers, they opted for the concrete economies of scale over
curative institutions would allegedly produce.

Subsequent events only stiffened their resolve. Over the last half of the nineteenth century
increased dramatically, multiplying more than five times, from 20,809 in 1844 to

[Full Size]

Figure 10.
Cheshire County Asylum, built in 1828. Accommodating 110 patients, the asylum already loc
supposed inspiration, the York Retreat. Within a generation, such small-scale asylums had
(Courtesy of the Wellcome Trustees.)

117,200 in 1904, while the population merely doubled. In part this massive increase reflec
doctors to cure more than a fraction of those they treated, with the consequent accumulation of
the very existence and expansion of the asylum system created an increased demand for its ow
"humanitarian" and "scientific" alternative of treatment in a specialized institution operated stea
community tolerance, encouraging the abandonment of the struggle to cope with the troubleson
experts and their public to take a more expansive view of what constituted madness. In Andrew

> The very imposing appearance of these establishments acts as an advertisement to draw patients towards them. I
> we all know how speedily it becomes filled up with lumber. The county asylum is the mental lumber room of the su
> too willing, in their poverty, to place away the human encumbrance of the family in a palatial building at county ex

Even the experts in the magistrates' employ, the asylum superintendents, conceded that a
this enormous mass of lunatics—drawn overwhelmingly from the lower classes—was susceptible
estimating that fewer than eight in a hundred of their charges would recover,[47] a prophecy tha
The doctors were disposed to blame this low cure rate not on the bankruptcy of their own therap
failure of their patients to seek treatment soon enough following the onset of insanity, coupled w
employers' parsimony. But such complaints, while useful for bolstering the alienists' sagging mo
the authorities' actions.

If magistrates were unwilling to spend "extravagant" sums of money on pauper lunatics, th
for *incurable* pauper lunatics. Propelled by the overriding desire to economize, local justices alm
practice of tacking wing after wing, story upon story, building next to building, in a haphazard a
strove to keep pace with the demand for accommodation for more and more lunatics. In the wea

asylum administrator, "Once christen the disease insanity, and the cost of treatment shrinl
than that of living in health."[50] Remorselessly, the size of the average asylum grew, climbing to
beds by 1900. By the last quarter of the nineteenth century, asylums such as the one at Claybu
county asylum for Middlesex, were almost commonplace. Accommodating upwards of 2,000 pati
these places were "more like towns than houses" and partook "rather of the nature of industrial
but they sufficed to "herd lunatics together . . . where they can be more easily visited and accou

Despite their failure to live up to their original promise, asylums remained a convenient pla
people. The community was used by now to disposing of the derelict and troublesome in an insti
it, "they are for the most part harmless because they are kept out of harm's way."[53] In other r
provided its own rationale. Why else were lunatics locked up in the first place, unless it was unsa

the public was convinced (not without supporting "evidence" supplied by the asylum docto
the necessary places of detention of troops of violent madness, too dangerous to be allowed out
now seen as an essential guarantor of the social order, as well as an important symbolic remind
nonconformity. Reflecting these related demands for "economy, . . . safe custody, and physical
produced a "bald and monotonous architecture, which has scarcely recognized more than physic

Homogeneous in these respects, asylum design did vary in others. In particular, it is possil
architectural types, though some institutions took on intermediate forms. In the first place, som
termed "irregular or conglomerate" in construction—that is, they were largely a hodgepodge of
exhibiting little or no unity of style and often composed of

buildings of widely varying age. A number of asylums of this sort were housed in buildings
was the case at the Suffolk County Asylum, for example. Originally a conversion of an existing w
additions and further remodeling, it was still being used to house over 500 patients at the end o
asylums were originally purpose-built to a more or less symmetrical design and only gradually a
appearance. Typical of these last was the Gloucester County Asylum, which by 1890 had grown
inmates. As its superintendent confessed, "In order to defer as long as possible the evil day of b
of queer, fantastic additions have been made to the original building, until it now resembles notl
warren."[56]

Certainly the most frequently used asylum design, in England at least, was the corridor typ
asylums consisted of a series of corridors with wards and other rooms opening off them, connec
angles to one another, or in echelon. Usually, as at Hanwell (Figure 11), these corridors doubled
patients were consigned on being expelled from their sleeping quarters. While some asylums ha
corridors, others had rooms on both, adding to the problems of securing sufficient ventilation an
12), built on the latter plan, "the wards were tunnel-like and dark at the centre, ill-heated, spars
with lavatories opening directly into the gallery, and deficient wash and bath facilities."[57] Here,
this plan, the central portion of the building contained the main entrance and administrative dep
hall for exercise in wet weather.[58] Regarded on its completion as the most modern asylum in E
designed for more than 1,000 patients. In consequence, its wards and passages taken together
Subsequently, it grew still more enormous: within a decade and a half it had expanded to contai
Contemporaries remarked that the exterior was "almost palatial" in character.

> Its facade, of nearly one third of a mile, is broken at intervals by Italian campaniles and cupolas, and the whole as
> to expect an interior of commensurable pretensions. He no sooner

[Full Size]

Figure 11.

Twelfth Night entertainments at Hanwell Lunatic Asylum. The illustrat
designed to display the achievements of lunacy reform to the public at
group in the right foreground is the Asylum Committee and its guests. B
stretches the cavernous corridor that, save on this festive occasion (a
party), served as a day room for male patients.
(From the *Illustrated London News* 12 [1848]: 27.)

> crosses the threshold, however, than the scene changes. As he passes along the corridor, which runs from end to
> with the gloom; the little light admitted by the loopholed windows is absorbed by the inky ashphalte paving, and c
> ceiling gives a stifling feeling and a sense of detention as in a prison. The staircases scarcely equal those of a work
> coat of paint, or whitewash, does not even conceal the rugged surface of the brickwork. In the wards a similar stat
> interest they possess nothing.[60]

"Long, narrow, gloomy and comfortless," each room contained as many as eight inmates. A
dayrooms the inmates escaped only for brief periods into "airing courts [which], although in som
uninviting and prison-like."[61] The consequences of this situation were recorded even in the rep
the whole asylum enterprise, the lunacy commissioners. Such structures were characterized by

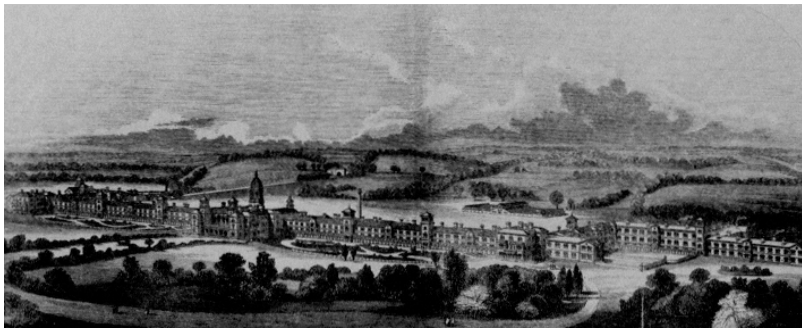


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Figure 12.
Colney Hatch Lunatic Asylum, opened in 1851. The original building, with its facade of a third of
patients on the corridor plan, the second main type of asylum design and the most freque
century England.
According to one report, its interior was characterized by "long cold corridors, huge wards, and a
Wood engraving by Laing. (Courtesy of the Wellcome Trustees

> the utter absence of any means for engaging the attention of the Patients, interesting them in any occupations or a
> sufficient variety of exercise outdoors. Besides a large number crouching on the floors, many were in or upon their
> and some as if they had merely sought relief there from the noise and monotony of the galleries.[62]

Finally, in the late 1860s, a third basic building type made its appearance—the so-called pa
This was characterized by the replication of uniform blocks in two parallel rows, each housing be
row for male patients and the other for females. Between the buildings assigned to each sex wa
containing the administration, accommodation for the superintendent and staff, and that critical
Victorian asylum, the chapel, in which the inmates could be brought the consolations of organize
this type, those at Caterham and Leavesden, were identical institutions explicitly designed to sip
decrepit cases from the existing metropolitan asylums. Scarcely any of these "patients" were ex
(less than 1 percent in an average year). Here, then, the drive for economy reached its apotheo
than 2,000 inmates accommodated in huge, barnlike dormitories, two to a building, of eighty be
reveals (Figure 14), even at the outset each dormitory was partitioned once only, into two group
room for passage between them; and subsequently, they were to he "adapted" to cram in still m
barren, featureless room, the inmates' only change of scene was to be removed *en masse* to the

feet long by 36 feet wide and 14 feet high—"home" for some 160 human beings.[63]

Everything was now "well arranged for the storage (we use the word advisedly) of imbecile asylum's pretensions to provide cure in the post-1845 era had been matched by the decay and features of moral treatment—those elements that were supposed to distinguish the asylum from more apparent than in the physical appearance of these institutions. The cheerful and pleasing a formulations of moral treatment was to have played such a vital role in creating and sustaining t atmosphere so essential to success, had come to be considered an "unnecessary cost," so that t offered mute testimony that the

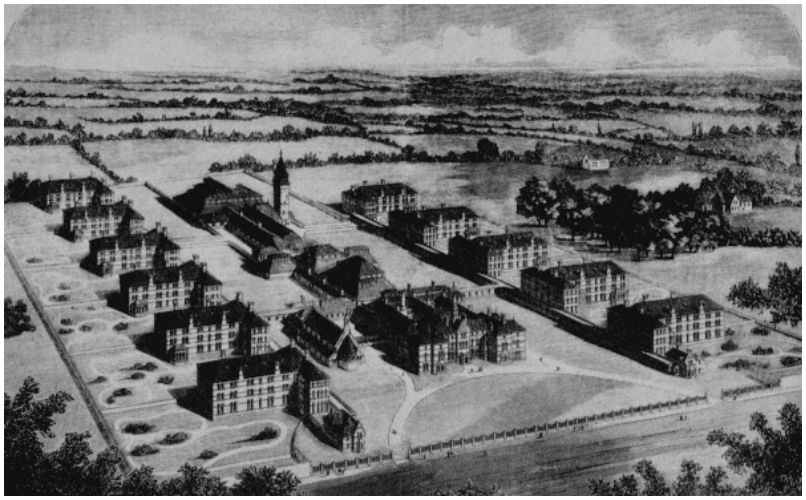

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Figure 13.
Design for asylums at Leavesden Woodside, near Watford, and at Caterham, near Croy shows a typical example of the pavilion asylum, the third basic type developed in the l provide efficient storage for pauper lunatics. The emphasis on a healthy environment i well as social distance from the town, is well illustrated in this drawing. From: *The Bu*

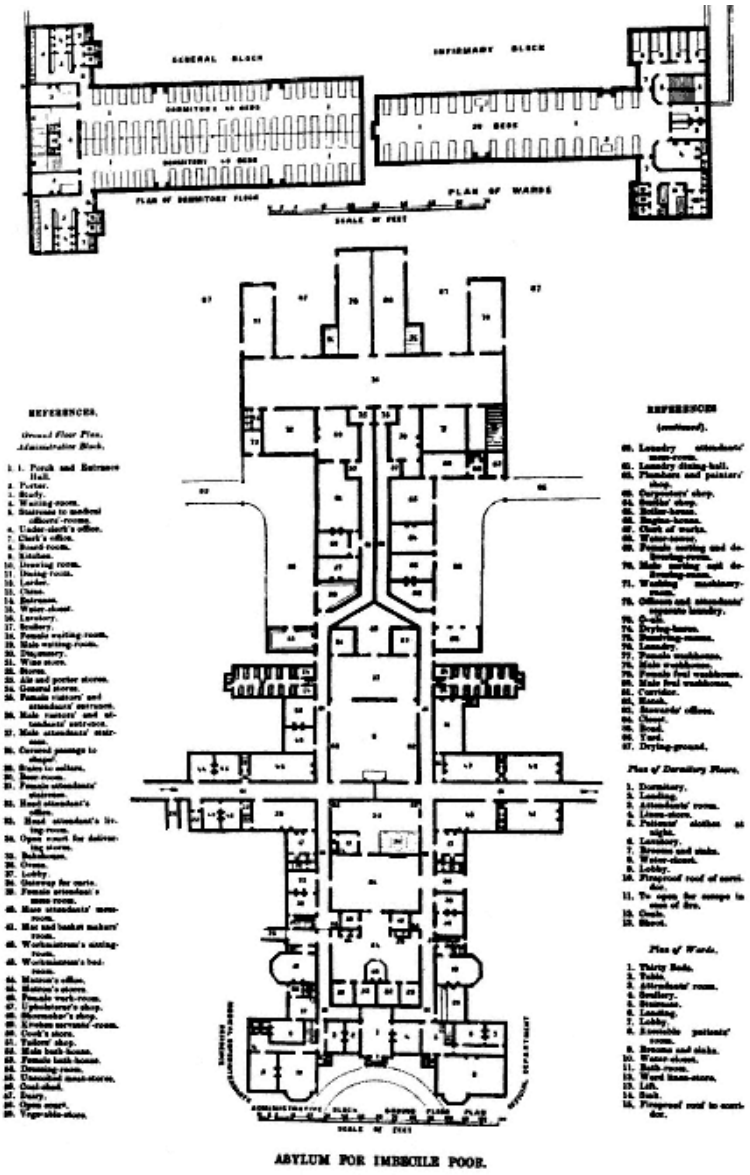

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Figure 14.
Floor plan of the general, infirmary, and administrative blocks of the asyl
chronic insane at Caterham and Leavesden, 1868. Note the spacing of the
dormitories. For lack of room, the patients' clothes were stored outside ea
at night. From: *The Builder* , 25 July 1868, 550.

asylum was now "a mere refuge or house of detention for a mass of hopeless and incurabl
thus confronting those who looked back on the work of the reformers in the early part of the cer
complaints and aims of the reformers, in the days when there were few county and borough asy
respect to the very evils these institutions were designed to remedy that they are themselves cc

Chapter Nine
Was Insanity Increasing?

In a Maudsley lecture delivered to the Royal College of Psychiatrists in late 1982, Edward Hare contended that the incidence of serious mental disorder had increased sharply over the course of the nineteenth century. He argued that this rise in the number of mad folk accounted for the abrupt development of medical interest in lunacy at the beginning of the century and for the rapid publication of a series of early-nineteenth-century medical treatises on insanity. Moreover, in a wholly "straightforward" way, and without resort to the complications introduced by sociologists, the existence of this "epidemic" provided "a medical explanation of the asylum era." In his view, one could take the argument a step further: the madness that fueled all these changes was what the psychiatric profession now calls schizophrenia; and the transformation of "schizophrenia" in this era from a rare to an all-too-common disorder reflects its probable etiology, as a virulent viral infection laying waste the susceptible members of society.

Dr. Hare's contention is not the first attempt at psychiatric reductionism, nor is it likely to be the last. An earlier flirtation with an infectious etiology for the major psychoses (this time of a bacteriological rather than a viral sort) was attended with some rather bizarre and untoward consequences for those deemed victims of toxicity.[1] One trusts that its latest incarnation will not be greeted so ingenuously and uncritically.

Portions of Chapter 9 appeared in the *British Journal of Psychiatry,* Volume 144, 1984, pp. 432–36, and are reprinted by permission.

I cannot pretend to possess Dr. Hare's talent for diagnosis at a distance (indeed, for diagnosis *tout court*); and I concede that the ingenuity of his explanation, its ability to reduce surface complexities to the simplicity of a single underlying somatic cause, would do credit to a professor at the Grand Academy of Lagado.[2] But I confess that in the last analysis I find his account a trifle speculative, requiring perhaps too large a leap of faith for one of my agnostic disposition. Accordingly, in what follows, I offer the sketch of a rather different version of events, one that leaves but a minute place for the microbes, even though it insists (with Dr. Hare) that insanity was indeed increasing over the course of the nineteenth century.

Was Insanity Increasing?

> Upon reflection, one quickly comes to recognize that Society must protect not only the life, but also the property and honor of individuals, as well as public order. Hence the number of the insane that can, on various counts, be prejudicial to public safety is singularly increased.
> —J. FALRET,
> Des aliénés dangereux et des asiles spéciaux pour aliénés

One of the central paradoxes of the Victorian reforms in the treatment of the mentally ill was the curious fact that the "scientific" discovery of mental illness and the adoption of a more rational approach based on this discovery—an approach that aimed at treating and curing lunatics, rather than neglecting them or incarcerating them in a gaol or workhouse—were associated with an explosive growth in the number of insane people. Edward Hare's recent Maudsley Lecture raises again the interesting question of whether or not this surge reflects a true increase in the incidence of mental illness in nineteenth-century England. As he correctly notes, the aggregate data collected at the time do not allow a "decisive answer," but I am pleased that his reassessment of the probabilities led him to endorse my prior conclusion that its incidence was indeed increasing.[1]

Hare does dispute, however, the explanation I offered of this increase, which attributed much of it to the development of a more expansive view of madness. Instead of an expansion of the boundaries of what constituted mental illness, he argues that the growth in numbers reflects

a real rise in the most serious forms of mental disorder, more specifically, "a slow epidemic of schizophrenia."[2] The dispute between us is not purely an academic debate (in the bad sense of that term) since Hare argues that the adoption of his explanation provides some "speculative" support for "a medical explanation of the asylum era" and for a viral etiology of schizophrenia.[3] I should therefore like to point to some of the evidence that seems instead to favor my own hypothesis, recognizing (as does Hare) that in this matter we can at best obtain an approximation of the truth, given the data with which we have to work.

At least prior to the adoption of the third edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association in 1980, the research evidence demonstrates that even twentieth-century psychiatric diagnoses lacked reliability and validity. Diagnosis remained dependent on clinical supposition and consensus, with the consequence that "the reliability of diagnoses of mental disorders, including those considered most severe, measured by independent rater agreement, often failed to rise over 50 per cent."[4] Everything we know of the practice of nineteenth-century psychiatrists suggests an even stronger reliance on clinical experience to legitimize and certify the authenticity of the individual practitioners' decisions. Certainly, many of the leading men in the field devoted a good deal of their energies to the elaboration of complex nosologies, encompassing a plethora of subtypes and varieties of insanity, but as Henry Monro noted, those who tried to rely on these categories in their practice were soon obliged to abandon the attempt in despair:

> All who have charge of asylums must well know how very different the clear and distinct classification of books is from that medley of symptoms which is presented by real cases. . . . It is useless to attempt to paint pictures with more vivid colours than nature presents, and worse than useless if practical men (or rather, I would say, men obliged to practice) receive these pictures as true representatives.[5]

Notwithstanding all efforts to alleviate the situation, and with the exception of extreme cases of violent mania or complete dementia, alienists were forced to confess that "the task of declaring this to be reason and that insanity is exceedingly embarrassing and, to a great degree, arbitrary. . . . No palpable distinction exists, no line of demarcation can be traced between the sane and the insane."[6] Thus, "the practitioner's own mind must be the criterion by which he infers the insanity of any other person."[7]

"Such emphasis," as Freidson has noted, "is directly contrary to the emphasis of science on shared knowledge, collected and tested on the basis of methods meant to overcome the deficiencies of the individual experience. And its efficacy and reliability are suspect."[8] In this instance, beyond the initial hard core of easily recognizable behavioral and/or mental disturbance, the boundary between the pathological and the normal was left extraordinarily vague and indeterminate. Hence the frequent and embarrassing disputes between alienists over individual cases in the courts.[9] In the circumstances, the assumption that identifying who is and who is not mentally ill was an activity governed by some uniform, objective, and unchanging standard will not survive critical scrutiny.

As Hare notes, I have suggested that asylum doctors' professional self-interest provided one set of motives for the adoption of an expansionary view of madness.[10] But other forces also prompted them to behave in this fashion. On humanitarian grounds, for example, since doctors were convinced that asylums were benevolent and therapeutic institutions and that laymen were incompetent to cope with, and liable to maltreat, the mentally ill, they were impelled to seek out still more cases rather than reject any that were proffered. Moreover, professional "imperialism" provides only one—and to my mind by no means that most important—reason to suspect an ever-wider practical application of the term "mental illness." The asylum provided a convenient and culturally legitimate

alternative to coping with "intolerable" individuals within the family, offering, if its proponents were to be believed, a level of care and possibilities of cure far beyond what even the most dedicated family could hope to provide in its midst. So far from being blamed, families were encouraged to place their mentally unbalanced relatives where they could receive professional care and treatment at the earliest pos-

sible moment. The attraction was obviously greatest for those with fewer resources for coping with the dependent and economically unproductive. Significantly, the statistics demonstrate that by far the largest portion of the increase in insanity occurred among those drawn from the lowest socioeconomic classes.

Contemporary observers frequently commented on the dynamics of this process: the superintendent of the Northampton General Lunatic Asylum noted in his 1858 report that "persons in humble life soon become wearied of the presence of their insane relatives and regardless of their age desire relief. Persons above this class more readily tolerate infirmity and command time and attention. The occasion may never occur in the one case, which is urgent in the other. Hence an Asylum to the poor and needy is the only refuge. To a man of many friends it is the last resort."[11] In the words of another asylum superintendent, "Poverty, truly, is the great evil: it has no friends able to help. Persons in middle society do not put away their aged relatives because of their infirmities, and I think it was not always the custom for worn out paupers to be sent to the asylum. . . . It is one more of the ways in which, at this day, the apparent increase of insanity is sustained. It is not a real increase, since the aged have ever been subject to this sort of unsoundness."[12]

Moreover, the level of disordered behavior or dependency that a family could not or would not put up with was not fixed and immutable, but likely to vary over time, with individual circumstances and with the gradual growth of the perception that there existed alternatives to the retention of the disturbed and troublesome within a domestic setting. (Such a pattern is, however, much more difficult to reconcile to the hypothesis of a viral-induced epidemic of schizophrenia.) Finally, as Maudsley himself suggested, the central government contributed significantly to the process by enacting legislation "whereby the government said in effect, to parish officials, 'We will pay you a premium of four shillings a head on every pauper whom you can by hook or crook make out to be a lunatic and send into an asylum' [thus putting] a direct premium on the manufacture of lunacy."[13]

Hare makes much of the fact that recovery rates declined over time in Victorian asylums, arguing that "milder" cases should have been more

likely to recover. It is, however, not at all clear why we should accept this argument. First, there is no obvious warrant for the claim that Victorian psychiatry was more successful in treating milder cases (unless one tautologically assumes an identity between "milder" and "more treatable"). Indeed, "mild" mental symptoms often coexisted with chronic and incurable underlying disease states. Bucknill, for example, while superintendent at the Devon County Asylum, found that

> patients have been admitted suffering from heart disease, aneurism, and cancer, with scarcely a greater amount of melancholy than might be expected to take place in many sane persons at the near and certain prospect of death. Some have been received in the last stages of consumption, with that amount of cerebral excitement so common in this disorder; others have been received in the delirium or stupor of typhus; while in several cases the mental condition was totally unknown after admission and must have been unknown before, since an advanced condition of bodily disease prevented speech, and the expression of intelligence or emotion, either normal or morbid.[14]

Such catalogues of decrepit and all but moribund admissions were anything but exceptional;[15] and in the light of evidence of this sort, Hare's contention that the admission of milder cases "should have decreased" the asylum death rate[16] does not seem particularly plausible.

Second, there are other, at least equally plausible ways of accounting for the decline in cure rates. Many Victorian critics of the asylum system, including Maudsley himself, thought that there was a clear connection between increasing size and decreasing therapeutic efficacy. As John Arlidge put it,

> In a colossal refuge for the insane, a person 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 invariable routine; a triumph of skill adapted to show how such unpromising materials 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. In all cases admitting of recovery, or of material amelioration, a gigantic asylum is a gigantic evil, and figuratively speaking, a manufactory of chronic insanity.[17]

Modern research on "institutionalism"[18] surely lends considerable credence to this hypothesis. And we know that the average size of English

county asylums rose remorselessly through the course of the nineteenth century, from just over a hundred patients in 1827 to almost a thousand by the end of the century, paralleling the development of a steadily more hopeless and "institutional" environment. Increasingly, within such mammoth institutions, "the classification generally made is for the purpose of shelving cases; that is to say, practically it has that effect. . . . In consequence of the treatment not being personal, but simply a treatment in classes, there is a tendency to make whole classes sink down into a sort of chronic state. . . . I think they come under a sort of routine discipline which ends in their passing into a state of dementia."[19]

Almost certainly, then, increasing size and the associated changes in the treatment of the inmate population had negative effects on cure rates. In turn, this situation provoked a steadily more pessimistic assessment of the prognosis for insanity among alienists themselves, forced to account for the falling rate of cures despite the advances of medical science. As explanations of mental illness were ever more frequently couched in terms of structural brain disease, defective heredity, and Morelian degeneration, so there emerged an entrenched expectation that most cases of mental illness would prove to be incurable. Expectations of this sort, through their effects on staff morale and the quality of care provided (to say nothing of the negative placebo effect), became a relentlessly self-fulfilling prophecy, further diminishing the underlying recovery rate while providing tautological "proof" of their essential accuracy. I suggest it is this combination of factors, rather than "the admission of less favourable cases,"[20] that accounts for the dismal therapeutic results of asylum care in the late nineteenth century—though for obvious reasons this was a conclusion that both the psychiatric profession and the lunacy commissioners were reluctant even to consider.

Beyond this, a good deal of contemporary testimony supports my suggestion that the boundaries of what constituted committable madness expanded during the 1800s. A wide range of nineteenth-century observers commented on how much laxer the standards were for judging a poor person to be insane, and how much readier both local poor-law authorities and lower-class families were to commit decrepit and troublesome people to the asylum, individuals who, had they come from the middle and upper classes, would never have been diagnosed as insane.

In the words of William Ley, superintendent of the Littlemore Asylum, "Orders for the admission of Paupers into the County Asylum are given more freely than would be thought right as regards the imputation of Lunacy, towards persons equally debilitated in body and mind who have the means of providing their own care."[21] Over time, this tendency grew more marked. Just over twenty years later, John Joseph Henley, the general inspector of the Local Government Board, informed a Select Committee of the House of Commons that in his inspectors' experience, "there is a disposition among all classes now not to bear with the troubles that may arise in their own houses. If a person is troublesome from senile dementia, dirty in his habits, they will not bear it now. Persons are more easily removed to an asylum than they were a few years ago."[22] Workhouse authorities, too, according to the medical inspector of the London workhouses, routinely used asylums to "relieve their wards of many old people who are suffering from nothing else than the natural failing of old age" as well as to rid themselves of troublesome people in general.[23]

As a result, Mortimer Granville noted, "it is impossible not to recognise the presence of a considerable number of 'patients' in these asylums who are not lunatic. They may be

weak, dirty, troublesome, but they are certainly no[t] . . . affected with mental disease."[24] Those who had been acquainted with the county asylum system from its very earliest years could not help but notice the change in the implicit definition of mental illness, the enormous and striking difference "between the inmates of the old madhouses and the modern asylum—the former containing only obvious and dangerous cases of lunacy, the latter containing great numbers of quiet and harmless patients whose insanity is often difficult to determine."[25] At least for these well-placed observers, there could be no question but that

> the law providing that madmen, dangerous to themselves and others, shall be secluded in madhouses for absolutely needful care and protection, has been extended in its application to large classes of persons who would never have been considered lunatics when this legislation was entered upon. Since 1845, medical science has discovered whole new realms of lunacy, and the nicer touch of a finikin civilization has shrunk from the contact of imperfect fellow creatures, and thus the manifold receptacles of lunacy are filled to overflow with a population more nearly resembling that which is still at large.[26]

Hare argues that mild cases could not have provided the reservoir from which the increased asylum population was drawn, because such cases would not have seemed sufficiently urgent to warrant the construction of so many beds. But the definition of "urgent" in this case is obviously a matter of complex social construction, not something engraved in stone. I see no reason to doubt that those committing patients in 1880 were convinced that their reasons for doing so were urgent and compelling—though one may reasonably question whether the same justifications would have seemed equally compelling some thirty or forty years earlier.[27] Nor should it surprise us that what constituted adequate grounds for commitment should shift over time in this fashion. After all, the past quarter of a century has witnessed a move in just the reverse direction, toward a much more restricted view of the appropriate criteria for involuntary commitment.[28]

Conclusion

Ultimately, of course, the most satisfactory way of deciding between the rival hypotheses offered by Hare and myself would be to look at a random sampling of admissions over time, to see whether the increase occurs among mild or severe cases. Unfortunately, there must be serious doubt about whether the quality of the surviving records is adequate for this purpose. Case records for upper-class asylums were extensive, as in

the Ticehurst Asylum casebooks now at the Wellcome Institute. But, as Hare notes, almost none of the increase in the incidence of mental illness occurred among private patients, so that for our present purposes, these materials are unlikely to be very helpful. On the other hand, precisely because the county asylums were so overcrowded, and were filled with paupers, their individual case records are generally too skimpy to be useful for answering this question.

I would suggest, however, that the class-specific pattern of the increase in insanity does pose certain difficulties (though I grant these are not necessarily of an insuperable sort) for Hare's argument. Somehow, the slow epidemic of schizophrenia was a *class-specific* epidemic, so that on top of the highly speculative claim that it had a viral origin, one must add the further hypothesis that the upper classes—whether for constitutional or environmental reasons—were mysteriously immune to its ravages.

It may well be that we shall have to be satisfied with an assessment of the general plausibility of each argument and with the extent to which it makes sense of the wide variety of data and observations that *have* survived. However, since Hare felt free to draw on comparative data to buttress his case, perhaps I may be allowed to do the same. Examining the growth of French psychiatry in the nineteenth century, Robert Castel argues that theoretical developments made possible a similar expansion of the boundaries of madness there. Particularly as alienists began to ground their decisions in predictions about patients' likely behavior in the future, they created a substantial area of indeterminacy. As

he puts it, "By abandoning reference to real behavior in favor of surmises concerning future behavior, psychiatry begins to arrogate to itself a margin of interpretation (and thus of intervention) whose bounds are no longer discernible."[29] Ian Dowbiggin has demonstrated that this theoretical possibility proceeded to have a substantial practical effect: "By citing heredity and degeneracy, alienists were able to extend the boundaries of mental pathology to encompass marginally deviant affective symptoms and make a plausible case for the reality of partial insanity. Hereditarianism had the 'halo' effect . . . of convincing juries, magistrates, and the public that psychiatry was authorized to expand conventional medical taxa into areas of behavior previously managed by religion and law."[30]

Samuel Shortt's monograph on Richard Bucke and the London Provincial Asylum in Ontario suggests that a similar broadening of the basis for committing people as mad was characteristic of late-nineteenth-

century Canada. Reviewing the data on Ontario admissions in the last quarter of the century, he documents, for example, the disproportionate admission of the elderly, generally suffering from "'senile decay,' a term signifying not threatening behavior but confusion and forgetfulness of varying severity."[31] And overall, he concludes that "a major reason for admission was the inability or unwillingness of friends, family, or community to cope in alternative fashion with harmless but chronically disorderly and unproductive behavior."[32]

Of still more direct relevance, the one careful study we possess of the composition of asylum populations at the turn of the century is Richard Fox's examination of legal commitments in California between 1906 and 1929. Using a random sample of commitments from San Francisco in this period, Fox demonstrates that

> two thirds of those committed were odd, peculiar, or simply immoral individuals who displayed no symptoms indicating serious disability, or violent or destructive tendencies. The reported behavior of this 66 per cent included primarily nervous and depressive symptoms and a wide variety of fears, beliefs, perceptions and delusions. In these cases the examiners noted that behaviors which they and various witnesses deemed inappropriate, but failed to indicate any reason why the individual, for his own protection or that of the community, had to be detained.[33]

It goes almost without saying that this finding accords very well with my hypothesis and provides little or no support for Hare's.

Chapter Ten
Progressive Dreams, Progressive Nightmares: Social Control in Twentieth-Century America

At the Rice University conference mentioned in the introduction to Chapter 2, David Rothman and I spent a good deal of time outside the formal conference session discussing his new book, *Conscience and Convenience: The Asylum and Its Alternatives in Progressive America,* which was then just a few weeks from publication. Not long after my return to southern California, the *Stanford University Law Review* invited me to write a review essay dealing with the issues raised in Rothman's book. Delighted to have an excuse to write something on developments in the early twentieth century, and eager to continue the debate Professor Rothman and I had begun in Houston, I agreed to do so. Coincidentally, when I had nearly completed work on the essay, David Brion Davis, who had spoken at the same conference, published his own assessment of the book in the *New York Review of Books* .[1] Readers may care to compare our respective commentaries.

By the time *Conscience and Convenience* appeared, Rothman had almost completed his evolution from being simply a historian to being a historian *and* a public activist. His subsequent analysis of the horrors of institutional provision for the mentally retarded in contemporary New York, *The Willowbrook Wars,* was at once a piece of social *reportage* and a polemic against segregative and institutionally based responses to mental disorder and deficiency.[2] As such, it provided further ammunition for

those critics who charged that Rothman's historical analysis had from the outset been dictated by a commitment to a particular political agenda. Rothman's own account of the intellectual origins of *The Discovery of the Asylum* casts considerable doubt on these claims, contending that his acquaintance with the advocates of deinstitutionalization, and adoption of their cause, came only after the writing of his book and its adoption by activists as an ideological weapon in their campaign against state hospitals.[3] If true (and I suspect that it is), this version of events suggests that, ironically enough, some of his critics are guilty of the same sin they so vociferously accuse him of: deducing original intentions from subsequent events.

Gerald Grob has been perhaps the sternest of these critics. The first volume of Grob's examination of post-colonial American mental health policy appeared just two years after *The Discovery of the Asylum* and is discussed in Chapter 2. The second of a planned trilogy appeared in 1983.[4]

Like its precursor, whose strengths and weaknesses it largely shares, Grob's *Mental Illness and American Society* is based on prodigious research into a wide variety of both printed and manuscript sources and provides a far more thorough and wide-ranging account of the period it covers than his rival's. The period surveyed was a bleak one for American psychiatry, and the thrust of Grob's narrative constitutes a damning critique of mental health policy and mental health professionals in the period. In his portrait, the behavior of the psychiatric profession is largely dictated by its desire to preserve its monopoly and autonomy. It offered no therapies that were demonstrably effective, and its concept of mental disease rested for the most part on little more than a vague faith in future progress. Moreover, seeking new, extra-institutional markets for its wares, the profession began an implicit abandonment of the chronically crazy, the bulk of those nominally in need of its services. Within state systems increasingly preoccupied with cost containment, the existing monasteries of the mad grew ever larger, a development that reflected the silting up of the "hospitals" with the senile and decrepit.

Grob successfully demonstrates that the profession's status concerns prompted a persistent attempt to rationalize caretaking behavior in medical terms; an ambivalent and eventually hostile relationship with potential competitors (social workers, psychologists); an insistence by many on the biological bases of mental disorder, coupled with a penchant to make use of ill-tested, often dangerous, and generally worthless somatic treatments; and a cavalier dismissal of all criticism by outsiders (in the words of one eminent psychiatrist, "'laymanization' was synon-

ymous with 'ignorization'"). The impact of his analysis is weakened, however, by its embedment in a mass of dreary administrative-cuminstitutional history and by Grob's wearisome insistence (familiar to readers of his earlier book) that those in charge always acted with the best of motives, making untoward consequences at worst the result of inadvertence. Such a Panglossian view of the world has, in my judgment, a profoundly distorting impact on his vision. Rather than lamenting the "agonizing dilemma" facing psychiatrists who claimed expertise but were unable to cure, one ought surely to sympathize with the patients, subjected to agonizing treatments by those concerned overwhelmingly with protecting their shaky scientific legitimacy and privileged social status. [5] Still, for those interested in the twentieth-century history of American psychiatry, both Grob and Rothman are required, if not always very lively, reading.

Progressive Dreams, Progressive Nightmares: Social Control in Twentieth Century America

One of the most notable features of recent historical literature about society's responses to its misfits—the criminal, the delinquent, and the mentally disturbed—has been the emerging sign of its break with the biases and distortions of Whig historiography. A new generation of historians, abandoning the prejudice that crime and craziness are somehow unworthy of serious scholarly attention, has begun to cast a more critical and jaundiced gaze upon the traditional portrait of society's ever more rational and benevolent response to the mad and the bad. If one leaves aside the idiosyncratic intellectual pyrotechnics of Michel Foucault [1] —who attempts a peculiar marriage of history and French structuralism in a style evocative of James Joyce at his most obscure—the most widely

read and influential revisionist has certainly been Columbia historian David J. Rothman.

Rothman's controversial *The Discovery of the Asylum* [2] pioneered the new approach nearly a decade ago. His bold and sweeping interpretation of the origins and achievements of America's first penitentiaries, juvenile reformatories, and mental hospitals during the Jacksonian era attracted widespread attention,[3] sparking a fierce debate that prompted others to undertake research on the history of social control. Most of this work has shared with *The Discovery of the Asylum* a concern with the origins and impact of major transformations in social control structures rather than focusing on the more mundane aspects of institutionalized repression.[4]

In reentering the fray, Rothman maintains this tradition. His new book, *Conscience and Convenience: The Asylum and Its Alternatives in Progressive America,* [5] is a sequel to his earlier study that deliberately leaves unexamined the years from the Civil War to the end of the nineteenth century: For Rothman, the Progressive era—1900–1920—marks the second "major divide" in American society "in attitudes and practices toward the deviant, creating new ideas and procedures to combat crime, delinquency, and mental illness."[6] The changes, in their way as revolutionary as those of the Jacksonian era, mark a distinct shift in approach that survived, largely intact, into the mid- 1960s, only then to falter in the face of the "post-Progressive—indeed, anti-Progressive"[7] —upheaval. Later in this essay, I shall argue that Rothman's approach is in certain important respects mistaken and shall examine his cautious endorsement of the current anti-Progressive revolution. I shall begin, however, by discussing the value as well as the limitations of his more concrete analysis.

That analysis begins with a brief sketch of the parlous state to which prisons and

asylums had degenerated by the last decades of the nineteenth century. Even within a small compass, the recital is vivid and convincing enough. Prisons were at once lax and brutal, relying heavily on intimidation and torture to secure a measure of order. Those who ran afoul of the authorities might find themselves suspended from a cord

bound round their thumbs, left to dangle till the blood ran from their mouths and the physician supervising the business ordered them cut down. Or they might be strapped into a coffinlike box with holes drilled in the lid, which, when slowly filled with water, produced the impression (and sometimes the reality) of slow drowning. Asylums were mere storage bins for human refuse, filled with chronic "patients" who seldom returned to the outside world. Here, the insane, if not the victims of violent assault by attendants or fellow inmates, passively rotted away, often spending their days restrained by camisoles and straitjackets and their nights locked into covered cribs.

During the last third of the nineteenth century, knowledge of such conditions produced a measure of criticism. The strongest complaints came from members of the newly emerging profession of neurology, who urged that the asylum's inherent deficiencies were so far-reaching as to require that it be used only as a last resort. But neither this nor any other proposal for fundamental change received serious consideration. Remarkably, society as a whole remained confident of the basic appropriateness of institutional control.[8]

In some quarters, the modest cost of incarceration was sufficient motive for perpetuating places that conveniently got rid of the inconvenient. But even those of more tender conscience could rationalize continued support of the existing system out of fear that the alternative to institutions was a still worse catalogue of horrors, or, more positively, out of a desperate collective illusion that prisons and asylums might still somehow rehabilitate and cure, a willed suspension of disbelief when confronted with claims like those of the Elmira Reformatory to reform "more than 80 percent of those who are sent there."[9]

All at once, however, such justifications lost their persuasiveness. With quite "incredible speed,"[10] there developed a crisis of institutional legitimacy that the Progressives "solved" by an equally rapid spasm of reform. They introduced strikingly similar "open-ended, informal, and highly flexible policies" and programs based on a heightened ideological concern to break with the "rigid, inflexible, and machine-like" qualities of inherited approaches.[11] Within Progressive social thought, a variety of explanations for what causes deviance competed for attention: environmental, psychological, and genetic. Yet underlying each is an almost uni-

versal convergence on the need for a discretionary response to the individual case, coupled with blithe self-confidence in the Progressives' own capacity to design effective forms of treatment. Central, too, is a naive and dangerous faith in the benevolence of the state and its agents—a faith that prompted the new generation of reformers to promote program after program widening the scope of state action.

To individualize the response to the criminal, Progressives sought to widen the range of treatments while granting the authorities greater freedom to match diagnosis to therapy. (Use of the medical metaphor grew apace, for it legitimized official discretion and the emphasis on individual variability.) They started by making probation a more and more popular courtroom disposition.[12] For more serious offenders came parole and the indeterminate sentence, innovations by means of which "the prisoner becomes the arbiter of his own fate. He carries the key to the prison in his own pocket."[13] In addition, the prison's internal routines were adapted to permit a more flexible response to the individual offender. By the early 1920s, almost half the state prison population were serving indeterminate sentences, and more than half the prisoners released were on parole.[14]

In the sphere of juvenile justice, change came with similar speed. The juvenile court emerged in Chicago at the turn of the century, quickly spread nationwide, and "revolutionized social policy toward the delinquent"[15] by abandoning punishment for rehabilitation to help the individual child and thereby contribute to the welfare of society. Redirecting the wayward required not a response to a single delinquent act, but a global

reformation of character, using techniques expertly tailored to the requirements of the individual case. And if this meant abandoning procedural safeguards and granting extraordinary latitude to intervene, Progressive reformers were willing, indeed eager, to do so.

They were likewise eager to break away from overreliance on a single solution to the problems posed by mental disorder. Instead of a monolithic asylum system, they proposed a network of psychopathic hospitals providing expert diagnosis and intensive treatment for recent curable cases; a massive effort to provide outpatient clinics and aftercare services for those discharged from the hospitals; financial aid, augmented by psychological support and counseling; and a new emphasis on *preventing* the outbreak of mental disorder through public education in mental hygiene. Central to most of these services was a new group of professionals, the social workers.

By far the best and most convincing part of Rothman's book is his analysis of the unholy alliance between reformist conscience and administrative convenience that supported Progressive innovations. He argues that the symbiotic relationship of these two elements accounts for both the rapid shift in public policy and the persistence of the new programs even when, measured by the reformers' own criteria, they proved to be abject failures.

On one side stood a rather shadowy and ill-defined assortment of benevolent and philanthropic men and women, disinterested "moral entrepreneurs"[16] whose impulse to do good was matched by an entirely misplaced confidence that they had discovered the "civic medicine"[17] with which to cure crime, delinquency, and insanity. These altruistic crusaders "marched under a very appealing banner, asking citizens not to do less for fear of harm, but to do more, confident of favorable results."[18] Theirs were the ideological formulations so essential to promoting change, along with the rhetoric that provided a veneer of legitimacy for the Progressive reforms. But their proselytizing succeeded only because some curious allies stood on the other side: The administrators of the very programs being attacked were eager for quite different reasons to embrace the reformers' proposals.

In welcoming this conversion of the heathen, the reformers "were never deeply disturbed by the fact that administrative convenience had become so well served in their programs."[19] This passivity was, as Rothman sees it, an error with appalling consequences: The professionals who oversaw the implementation of the reforms proceeded to make sure that the new programs served primarily their bureaucratic self-interests. If the reformers were blind to the uses to which their stress on "discretionary responses to each case"[20] were put, the administrators clearly were not. Thus, the introduction of probation and the indeterminate sentence multiplied the inducements to "cop a plea," and plea bargaining enabled judges and prosecutors to shorten trials, ease crowded court calendars, and raise the conviction rate, as well as insulate both their own and police conduct from further judicial scrutiny and review. Prison wardens welcomed the combination of parole and the indeterminate sentence with open arms, for with it the "reformers had delivered into their hands a disciplinary mechanism far more potent than the lash, and not insignificantly, far more legitimate."[21] The reformers might be con-

vinced that they had placed the inmate's "destiny . . . largely in his own hands,"[22] but the wardens (and their prisoners) knew better. And although these changes apparently diminished judicial authority by transferring sentencing power to an executive and administrative body, judges gained, too. The indeterminate sentence gave them "added freedom to dispense justice as they saw fit."[23] And with the parole board as a buffer and whipping boy, judges could escape political criticism for prisoner recidivism.

Elsewhere, whether one looks to programs for the delinquent or for the mentally ill, Progressive innovations fared no better. In every setting, the reveries of reformist conscience were transmuted under the pressures of administrative convenience into harsh caricatures of themselves. They served merely to advance the self-interest of the caretaker-professionals, or, as with social work, virtually to create the profession that perpetuated them.

Progressive reformers, though not unaware of the bastardization of their programs, resisted acknowledging how far the process had gone. Recognizing that their achievements were only partial and flawed, they sought consolation in the belief that they had prevented the perpetuation of barbarism—to them, the stark and singular alternative to a leap aboard their bandwagon. Their very commitment to the idea of progress and their own self-appointed role as its agents effectively blocked any alternative perception, and left them convinced that present horrors were at least less awful than those of the past. Finally, if all else failed, such horrors could always be attributed to improper implementation of Progressive programs, reflecting "not faulty conceptualization but inadequate funding."[24]

But Rothman is determined to deny the progressives and their present-day apologists even this limited miserable measure of consolation. For him, their whole enterprise was unworkable from the outset, resting as it did on the fatally mistaken assumption that institutions "could coexist with, and even sponsor, non-institutional programs."[25] This was a lesson the reformers simply would not learn, remaining heedless of their limitations and of the need to reconsider the premises of their programs in the wake of failure. "One searches in vain," as Rothman puts it, "for any thorough reappraisal of the Progressive ideology or any coherent effort to review reform postulates in the light of their marginal relationship to actual practices."[26] In one of those cruel ironies with which the history of social control abounds, the consequence was that their ever-so-benevolently intended "reforms" only gave a further twist to the vicious logic of the existing system. Because they blithely substituted good inten-

tions for knowledge and continued to give a cloak of humanity and legitimacy to the Frankensteinian monster that emerged from their blueprints, the Progressives must bear a large measure of responsibility for the nightmares they created.

Historians of social reform have traditionally taken ideology very seriously. Indeed, they have been all too prone simply to reproduce it. Their work presents an elaborate morality play that, couched in the reformers' own rhetoric, attends earnestly to expressed intentions and scarcely at all to results. By forcing a sustained examination of the neglected gaps between rhetoric and reality, Rothman has done as much as anyone to debunk these pious myths and to invalidate the general approach on which they rest. Yet, despite the very different conclusions he reaches about the nature and outcome of reform, he ultimately shares earlier historians' convictions about the centrality of ideology in historical explanation.

The account he offers of the Jacksonian discovery of the asylum in his earlier book[27] is an essentially intentionalist one, in which the new institutions emerge out of the reformers' fears for the stability of the social order and their sense that asylums to "control abnormal behavior promised to be the first step in establishing a new system for stabilizing the community, for binding citizens together."[28] When he turns to examine the invention of probation, parole, outpatient care, and the juvenile court in the Progressive era, again his primary emphasis is on "the rhetoric of the reformers—for it is here that one will find the strongest clues to the origins of the changes and sources of their success, their legitimation if you will."[29] Rothman is remarkably adept at capturing the hopes and fears of the reformers and at revealing nuances in their thought that have escaped earlier observers. At least in *Conscience and Convenience,* his examination of the fit between reformist conscience and administrative convenience moves beyond a fixation with ideas and goes some distance toward explaining why these ideas found a wider audience and were enacted so swiftly. To a significant extent, however, he remains trapped within the limitations of a fundamentally idealist worldview, and to that degree his explanations are necessarily flawed and incomplete.

The Discovery of the Asylum begins with the admonition that "institutions, whether social, political, or economic, cannot be understood apart from the society in which they flourished. The sturdy walls of the asylum were intended to isolate the inmates, not the historian."[30] But both here and in *Conscience and Convenience,* Rothman's admirable methodological

prescription has a scarcely discernible impact on his own analysis. In neither book does the larger social environment that both spawned and shaped reform receive the attention it warrants. Ideas remain free-floating, and change remains the product of "the power of the rhetoric"[31] the reformers invent; both remain stubbornly unanchored in underlying transformations of social structures and practices. Beyond the occasional feeble gesture—a quasi-magical invocation of economic and demographic change or passing reference to immigration, the ghetto, and the settlement house (but scarcely a mention of class or race)—little dispels the illusion that the entire outcome rests on the rhetorical skills of a collection of moral entrepreneurs, allied with the bureaucratic self-interest of institutional administrators.

The crucial causal variable in *The Discovery of the Asylum* is allegedly a peculiarly American anxiety about the stability of the social order.[32] In the book's sequel, the reform program centers on the virtues of flexibility, discretion, and the expertly tailored response to the individual case. In neither instance are matters pursued much further. It is as though such items as anxiety and optimism constituted primitive logical terms not susceptible of further examination or investigation; as though, in this instance at least, analysis must stop at the level of the reformers' presentation of self. But of course they are not and it cannot. One wants to know, for example, which segments of Jacksonian society felt anxious, about what, and why. One wonders to what extent all the talk of looming disorder and the promotion of the institutions' reformatory functions can be understood as the rhetoric of a particular social group, who employed it for particular polemical purposes: Similarly with the Progressives' positivism: their naive sense that the facts would speak for themselves; their belief that everything was adjustable, that there were no irreconcilable conflicts of interest; and their abandonment of laissez-faire for a new ideology of expertly guided state intervention to correct the imbalances and imperfections of the social system. These should mark the starting point of the search for understanding, not its culmination.

The two books share a further defect, an odd and perverse ethnocentrism. Rothman's insistence on viewing the invention of the penitentiary and the asylum as a uniquely American phenomenon was one of the bolder features of his earlier work. It is also an idea that has been subjected to withering criticism and must now be recognized as simply untenable.[33] Yet, in David Brion Davis' words, the analysis in *Conscience and*

Convenience continues to exhibit an "almost defiant indifference to European influences and parallels"[34] and to proceed as though American developments can be examined in a vacuum. Other than the dearth of research on the European materials, it is difficult to understand why Rothman persists in this stance. But certainly the lapse is unfortunate, for a comparative perspective often points up the shallowness and inadequacy of solipsistic cultural "explanations" and may help uncover some of the underlying structural sources of social change.

By choosing to emphasize ideology so heavily, Rothman is led to misconstrue, and to overestimate, the significance of Progressive reforms. As we have seen,[35] he presents the changes introduced in this period as if they were of revolutionary importance—a major shift that ranks, along with the discovery of the asylum and its contemporary demise, as one of the three major watersheds in the history of social control in America. At the level of rhetoric, such a judgment is perhaps defensible. Semantically, the transformations made in the Progressive era mark a sharp break with the past. Their emphasis on procedural informality and discretion and on a highly differentiated response to the individual case is combined with savage criticism of the very different practices inherited from the nineteenth century. But even at the outset, doubts arise. For although the distinctions between Progressive *rhetoric* and Jacksonian *practice* seem clear enough, the differences are not well marked when one's point of comparison is what the early-nineteenth-century reformers *claimed* to be doing. For example, their program for rescuing the mad from maltreatment leaned heavily upon a set of principles largely borrowed from abroad, known collectively as "moral treatment," that broke with a prior emphasis on indiscriminate mass medication and insisted on a flexible, noncoercive approach to curing the mad, carefully tailored to the individual case and dispensed by an asylum administrator armed with wide discretionary powers.[36]

If the Progressives were not quite as distinctive ideologically as Rothman implies, their practice was even less so. Though he resolutely avoids confronting the implications of his

findings, Rothman himself presents a remarkable array of evidence that demonstrates that most of the Progressive reformers' sound and fury in reality signified nothing: "therapeutic innovations had little effect on prison routines" and "change never moved beyond the superficial."[37]

Reform on occasion did not even penetrate skin deep, as with the changeover from striped convict uniforms to more ordinary dress. Even when some new amenities were allowed—more exercise, more frequent visitors—the fundamental realities of prison life remained unaltered. The Progressive reformers' dream, "that they could transform a nightmarish prison, dedicated to punishment, into a community that would at once prepare the inmate for release and serve as a testing ground for society,"[38] echoed the reveries of their Jacksonian counterparts. Reality once again proved brutally recalcitrant.

Nor did alternative, noninstitutional programs fare much better. Probation was scarcely more than a sham in all but densely populated areas.[39] And even there, "the actual results were pitiful."[40] Conditions in the system "not only made the fulfillment of case work principles well nigh impossible, [they] also prevented probation from carrying out a meaningful police function."[41]

Examination of the juvenile justice system also reveals a litany of failure. Again and again, Rothman returns to the token quality of the Progressive emphasis on individualization, psychiatric guidance, and intervention, and to the persistence within institutions' walls of quasi-military routines not essentially different from those that characterized the Jacksonian asylum system. All of the reformers' brave words about breaking with the ugliness and failures of the past had little practical effect.[42] At best, "the rhetoric of treatment provided only the external trappings. Inside, incapacitation and deterrence ruled, as befit a holding operation." [43]

Finally, the gap between the Progressives' ambitions and prosaic reality was nowhere greater than in the sphere of mental health.[44] Only a handful of the network of psychopathic hospitals the reformers had envisaged were actually built. And, rather than serving as the core of intensive treatment and mental hygiene programs, they became little more than handmaidens to the traditional asylum system—"diagnostic centers" that were but "a first stop on the road to the state hospital,"[45] for they made no sustained effort to treat or cure, but simply smoothed away

obstacles to easy commitment. "The effort to extend the reach of treatment and the principles of prevention into the community"[46] was likewise a dismal failure. Forced to compete for the same funds as the long-established state hospitals, while threatening to deprive them of the very patients whose labor contributed most to their low operating costs, such programs never had much chance of success. They were all but killed off by opposition from patients' families and from the community at large. Asylums endured, "and [their] needs shaped the outcome of all reform ventures."[47]

From many perspectives, then, the transformations of the Progressive era were little more than another episode in the saga of reform by word magic. Houses of refuge now became training schools or industrial schools; prisons were renamed reformatories or correctional institutes; asylums turned into mental hospitals. Euphemisms abounded, papering over the degree to which "reform" left the underlying nineteenth-century structures largely untouched.

In developing his critique of the reformers' failures, Rothman unwittingly undermines his own claims for the revolutionary significance of Progressive reform. Not that the ideological changes he analyzes are without significance; the greater emphasis placed on medical and therapeutic rhetoric did indeed help legitimize a policy of ever greater intervention. And probation and parole were important innovations, however far they departed from the reformers' intentions, and however halfhearted their implementation. Probation in particular "expanded the scope of state action and state surveillance," and though its potential for coercion "was never realized" fully, probation "did have serious consequences for civil liberties."[48] Such innovations widened the net and subjected new segments of the population to the risks of arbitrary state action; but they supplemented,

rather than revolutionized, existing arrangements.

Rothman believes that one can learn from history; his work is self-consciously intended to speak to an audience far beyond those specializing in the social history of Jacksonian and Progressive America. It is "the enterprise of reform"[49] as a whole that he seeks to illuminate, and his goal "is to inform both history and social policy, to analyze a revolution in practice that has an immediate relevance to present concerns."[50] Judging by the extraordinary attention his work has attracted, he has certainly succeeded in reaching that wider audience. But what of the lessons he seeks to teach?

On one point Rothman is adamant: Notwithstanding the failures and disappointments of past attempts at reform, he will have no truck with pessimism, with those who argue that the whole enterprise is "at best

foolhardy, at worst deceptive."[51] He is particularly eager to distinguish his position from that of Foucault, with whom he has often been lumped as a "revisionist" or "social control" historian. Unlike Foucault, he cannot accept the portrait of an inevitable and progressive intensification of discipline in an ever more rationalized capitalist society. On the contrary, to Rothman, the history of reform is of a process in which "choices were made, decisions reached; and to appreciate the dynamic is to be able to recognize the opportunity to affect it. . . . There is much more room for maneuver than a Foucault could ever imagine or allow."[52]

The insistence that "men make their own history"[53] is a welcome and necessary corrective to the narrow structural determinism now in vogue in certain historical circles,[54] but only so long as one remembers the other half of Marx's famous aphorism: that "they do not make it just as they please; they do not make it under circumstances chosen by themselves" but as conditioned by and in the context of a particular historical inheritance and set of structural possibilities.[55] As I have already suggested, Rothman is all too inclined to neglect structural factors. Precisely because he accords such a critical role to ideology, he readily assumes that had the reformers' zeal about eliminating the horrors of the Jacksonian asylum been more thoroughgoing, instead of falling into the egregious error of strengthening the segregative institutions he finds so loathsome, they would have destroyed them.

I think he is mistaken in this assumption. Institutional structures are far less malleable than the conceptual edifices constructed by intellectuals, even though the latter can prove resistant enough to modification and change. Notwithstanding Rothman's criticism of the Progressives for remaining wedded to the foolish notion that "the appropriate task was to reform incarceration, not to launch a fundamental attack upon it,"[56] it is not at all clear how they could have done otherwise.[57] And it is even less clear that, had they concluded that more radical change was essential, they could possibly have secured the enactment of their program. Rothman's reproaches here rest on arguments that are not properly spelled out, let alone explored through systematic empirical analysis.

Mutatis mutandis, the same can be said of his somewhat cautious endorsement of the anti-Progressive reforms advanced by contemporary men of conscience. Despite his insistence on learning from the past, Rothman is remarkably coy about suggesting a "platform for reform."[58] Or perhaps it is rather that any program he could suggest would be a negative one, whose central theme would be the need to avoid the hubris that bedevils reformers. Like sociologists before him,[59] Rothman has perceived that punishment and therapy are ultimately irreconcilable, and that in any attempt to combine them, the winner is predestined: "When treatment and coercion [meet], coercion [wins]."[60] He has also grasped, though the point is not as novel as he implies, that institutional control systems necessarily rest on hierarchical levels of coercion.[61] Still, he elegantly demonstrates that the problem is "not that we cannot here or there run one decent institution; [but] rather, that the decency of any one place rests ultimately . . . upon the presence of a still more coercive back-up."[62]

What distinguishes us from the Progressives, apparently, is not our greater knowledge of how to do good. Rather, it is our recognition that we *lack* such knowledge, and our

realization of the harm that can result should we attempt to substitute good intentions for it. Anti-Progressives have learned—partly from Rothman's prior work—the "limits of benevolence"[63] and the dangers of expanding the boundaries of discretionary state action.

Thus, on Rothman's account, the current wave of reform—the attempt to decarcerate prisoners and patients[64] —is again to be explained by changes at the level of ideas: our recognition that institutions for the deviant are irredeemably nasty, counterproductive places; our willingness to abandon the chimera of combining reformation and punishment; our sense of the need to restrict the scope of state power. Unlike the case of the Progressives, our quarrel with the principle of incarceration is a fundamental one, and our programs of community corrections and community-based treatment of the mentally ill are replacements for, not supplements of, old institutions.

This is not the place to argue in detail that Rothman's explanation of the genesis of contemporary reforms is fundamentally mistaken.[65] It is curious, however, that Rothman should be so willing to take contemporary reform movements at their own estimation and, like the Progressives before him, be so convinced of the horrors of past practices as to be certain beyond doubt that change *must* be for the better. Nor does he seriously appear to entertain the possibility that new forms of administrative convenience may play a crucial role in the success of contemporary men of conscience.

Yet, calls for retrenchment and cutbacks have an obvious attraction for state managers in periods of acute fiscal crisis, the more so if reductions in expenditures can simultaneously be portrayed as a splendid humanitarian gesture. Who can be surprised, therefore, that the new generation of reformers has met with such a friendly reception? For the mentally ill, at least, states have been only too willing to grant the negative right to be left alone, to be free from the obvious coercion that involuntary hospitalization represents. Neglect, after all, is cheaper than care, even at the minimal level traditionally provided by our state hospitals. Unfortunately, though, "there is no primal Arcady into which the mental patient can slip away from modern institutions of care and intervention. If he slips anywhere away from it at all, it will be into the gutter or the graveyard" or, perhaps worse, into the hands of the burgeoning class of entrepreneurs and professionals speculating in this form of human misery.[66] Benevolence here is limited indeed![67]

Since nonintervention in the penal context would clearly raise serious social and political problems,[68] it is scarcely surprising that, for criminals and delinquents, community disapproval of *alternatives* to incarceration has proven as solid as it was in the Progressive era. In this setting, the reformers' conscience has once again been no match for the occupational interests of correctional and prison employees and administrators, or for public demands, partly instrumental and partly symbolic, for sterner measures to stop increasing crime. Despite rhetorical claims to the contrary, "the major results of the new movement towards 'community' and 'diversion' have been to increase the *amount* of intervention directed at many groups of deviants in the system and, probably, to increase rather than decrease the total *number* who get into the system in the first place. In other words: 'alternatives' become not alternatives at all, but new programs that supplement the existing system or else expand it by attracting new populations."[69]

In the very first pages of *Conscience and Convenience*, Rothman confronts the question of whether Progressive innovations were better than the procedures that they replaced. To his credit, he provides a forthright answer: no, they were not. "Progressive innovations may well have done less to upgrade dismal conditions than they did to create nightmares of their own."[70]

Plus ça change, plus c'est la même chose?

Chapter Eleven
Dazeland

The forces of sex and madness have historically been linked together in a multitude of ways. Notoriously, psychodynamic theories of mental disturbance, particularly those of a Freudian provenance, have accorded pride of place to sexuality in accounting for the etiology of mental disturbance. The more organically inclined, not to be outdone, have provided their own accounts of the linkage, ranging from neurological portraits of females as possessed of nervous systems of greater refinement and delicacy (and hence more susceptible to breakdown) to gynecological theorizing about peculiarly intimate ties between a woman's brain and her reproductive organs.[1] Correspondingly, one encounters insistent claims that there exist differential diagnostic practices and criteria for men and women, along with evidence that treatment itself may vary sharply by gender.[2] *Social Research* recently devoted an entire issue to a

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series of essays examining some of these interrelationships in historical and comparative perspective.[3] And Elaine Showalter has given more sustained and systematic attention to this whole range of issues, through an examination of English psychiatric practices over the past two centuries.[4]

The London Review of Books asked that I write an essay-review of Professor Showalter's book, and what follows is an expanded version of that piece. As I hope my discussion makes clear, no one should harbor any illusions that either folk beliefs about madness or psychiatric theorizing and practice are somehow gender-neutral. To the contrary, both our stereotypical images of madness and professional explanations and treatments for mental disorder are clearly saturated with overt and subliminal sexual references and assumptions.

It follows that there is an obvious temptation to place the psychiatric enterprise in a critical double-bind over this issue. I have in mind here the simultaneous assertion that women are disproportionately victimized by a male-defined double standard of mental health, which unwarrantably assigns them to the highly stigmatizing status of the psychiatric patient (most especially if they behave in ways that challenge masculine stereotypes of female propriety); and that the oppressions, constrictions, and limitations of the female role in a patriarchical society are so damaging and stressful as to drive a disproportionate share of women mad. For feminists, embracing a pair of such ideologically attractive positions makes it easy to view the psychiatric arena as simply another and particularly lurid set of illustrations of the baneful effects of the patriarchical oppression of women.

But, as always, there is a price to be paid for the polemical pleasure of "having one's cake in the form of stress theory as well as eating it in the substance of labelling or antipsychiatry theory."[5] It obviously would make little sense to claim that the same people are *driven* mad by intolerable social pressures and also are inappropriately and improperly *labelled* mad by those bent on repressing rebellion and nonconformity. One can rescue both assertions by claiming that they apply to different subgroups within the overall population of the mentally disordered, and anecdotal evidence can certainly be found to demonstrate that neither category is empirically empty. But anecdote does not suffice to establish significance. Indeed, it is necessarily silent on the crucial issue of the degree to which women's presence among the ranks of the mentally disturbed can be attributed to each of these processes, as opposed to whatever it is that accounts for the alienation of men. In the absence of firm

evidence on this point, and given the broadly equal representation of men and women among the ranks of the mentally disordered, one must be circumspect about claims that "women, by definition . . . are viewed as psychiatrically impaired"[6] and that mental illness is "the female malady."

Dazeland

> In the first place, an insane woman is no more a member of the body-politic than a criminal; second, her death is always a relief to her dearest friends; third, even in the case of her recovery from her mental disease, she is liable to transmit the taint of insanity to her children's children for many generations.
> —WILLIAM GOODELL,
> "Clinical Notes on the Extirpation of the Ovaries for Insanity," Transactions of the Medical Society of the State of Pennsylvania 13 (1881)

Most recent work on the history of psychiatry has tended to focus on the history of institutions, of ideas, and of the psychiatric profession itself, and to ignore those for whom this vast infrastructure has (at least ostensibly) been erected. It is a historiography, as David Ingleby wittily puts it, "like the histories of colonial wars[: it tells] us more about the relations between the imperial powers than about the 'third world' of the mental patients themselves."[1] Elaine Showalter's *The Female Malady* [2] is thus doubly valuable, as an exploration of popular and professional discourse about the relationships between women and madness and as an analysis of how the profession of psychiatry has treated somewhat more than half of those who fall within its territory.

On examination, in the psychiatric domain, as in the more conventionally defined Third World, the position and treatment of women consistently turn out to be even less enviable than those endured by men. Can this justify, though, a move to label madness the female malady?[3] Not in any straightforward statistical fashion, contrary to what Showalter sometimes implies. One may plausibly contend that, for much of the past two or three centuries, women have outnumbered men in the ranks of the mentally disturbed. Still, for the most part, this imbalance has not been in such gross disproportion that one could sensibly call the disorder

a preeminently feminine one; and there have even been occasions when men have constituted a substantial majority of those officially identified as mad.

For example, against the fact that nearly two-thirds of those who consulted the seventeenth-century astrological physician Richard Napier for treatment of their mopish or melancholic moods were women,[4] one must set the observation that, as best one can judge from the admittedly defective data, men greatly outnumbered women among the inmates of eighteenth and early-nineteenth-century madhouses.[5] It was only after the middle of the nineteenth century, when the madhouses of the Gothic novelists had supposedly been transformed into the domestic retreats favored by the Victorian lunacy reformers, that women began gradually to outnumber men among those legally designated as mad—first among the pauper residuum who contributed the bulk of the rapid rise in the ranks of mad folk, and not till the end of the century among their genteel and affluent cousins. Nor, among the institutionalized insane, did the imbalance ever amount to more than a few percent, itself quite possibly attributable to the greater longevity of the "weaker" sex and to the disposition of the asylum authorities to keep female lunatics institutionalized longer than their male counterparts. And from the late 1960s to the present, men have formed the clear majority of mental hospital populations in the United States,[6] while the best modern research can find no consistent differences by sex in the prevalence of psychotic symptoms or in rates of schizophrenic breakdown.[7]

Taking a more expansive view of what constitutes mental illness, the idea that women are more frequently troubled in mind is perhaps more supportable. If women were only marginally overrepresented among the "Bedlam mad," the rise of a nonasylum psychiatry, ministering to the neurotic, the neurasthenic, and the hysteric, quickly found itself catering

to a more heavily female clientele. On the late-nineteenth-century borderlands of insanity,[8] women were disproportionately represented among the clientele of rest homes, water cure establishments, mesmeric salons, and the mind cures of the Christian Scientists. And in the pres-

ent, women are consistently found to be more prone to neurosis and manic-depressive symptoms and are much more likely to be taking psychoactive drugs.

Yet these figures, too, demand to be treated with some caution. For alongside the greater reported frequency of symptoms of mental illness among women and their more extensive utilization of psychiatric facilities, one must note that an identical pattern holds for physical illness and the use of nonpsychiatric physicians and hospital services. Puzzlingly, women consistently exhibit higher rates of morbidity and lower rates of mortality than men of comparable age and social circumstances.[9]

Still, if the statistical evidence is at best rather ambiguous, the assertion that our culture somehow equates madness and the female of the species is not without foundation; and our organized responses to these maladies repeatedly turn out to be influenced, in ways both gross and subtle, by questions of sexuality and gender. One welcomes, then, an attempt to explore what is distinctive about the female experience of madness. Drawing on an extraordinary array of sources (literary and pictorial representations of the mad, in painting, photography, and film; asylum records; the recollections of ex-patients; the words and practices of their physicians; and the private papers of eminent women who did *not* become psychiatric casualties—materials that provide eloquent testimony about the tensions and tribulations faced even by exceptionally talented, privileged, and apparently successful women trapped within the confines of a patriarchal social order), Showalter's book constructs a compelling (if at times overdrawn) portrait of the contributions of psychiatry to the wrongs of women.

Our images of madness, she argues, are overwhelmingly female: "Women, within our dualistic systems of language and representation, are typically situated on the side of irrationality, silence, nature, and body, while men are situated on the side of reason, discourse, culture, and mind."[10] Romantic portraits of Crazy Jane, a poor servant girl seduced and abandoned by her lover;[11] *Lucia di Lammermoor* and a picture

of female sexuality as insane violence against men;[12] Bertha Mason and Gothic madness, violent and hideous animality kept caged in Mr. Rochester's attic lest a "clothed hyena" be let loose upon the world:[13] in novels, in drama, in poetry, in painting, in popular ballads, in opera, it is women who stand as emblems and exemplars of irrationality.

Moreover, there has been much traffic between these cultural images and psychiatric ideologies. Notwithstanding the nearly equal propensity of the two sexes to go mad, Victorian alienists developed different explanations of why men and women became deranged, elaborate accounts of women's greater vulnerability to insanity, and even speculations about their tendency to experience madness in peculiarly feminine ways. In keeping with their professional preference for somatic accounts of the etiology of mental imbalance,[14] mad-doctors increasingly emphasized the biological and ignored or were indifferent to the social and the psychological sources of their patients' distress. Indeed, in reductionist fashion, woman's "natural" place in society—her capacities, her roles, her behavior—was held to be ineluctably derived from and controlled by the existence and functioning of her reproductive organs.[15] As an organism dominated by her uterus and ovaries, and hence by crisis and periodicity, a woman necessarily possessed greater capacities for affection and aptitude for child rearing, a preference for the domestic hearth, and a "natural" purity and moral sensibility; but she was also inescapably a creature in whom the emotional predominated over the rational, someone whose physiological equipment was of surpassing delicacy and fragility, at any moment liable to give way under the strains of modern life or the unavoidably perilous passage through puberty, pregnancy, par-

turition, lactation, menstruation, and the menopause. The constriction of women's lives, their legal powerlessness, and their economic marginality, which were the central features of existing social relations between the sexes, thus received the sanction of science. And confronting such weak and fragile vessels, "Victorian psychiatry defined its task with respect to women as the preservation of brain stability in the face of almost overwhelming physical odds."[16]

Theories of a differential, gender-based etiology for mental disturbance corresponded, in some important respects, to differential expectations and treatments for men and women. The early Victorian period saw the creation of a whole new network of public asylums, coupled with a system of national inspection of receptacles for the mad by the lunacy commissioners.[17] Such changes reflected a revulsion against earlier methods of managing the mad and an astonishing (and in the event sadly misplaced) optimism about the therapeutic effects of the new system of moral management. In institutions containing several hundred, even a thousand or more, inmates, alienists struggled to produce a simulacrum of the domestic scene, in the process revealing and reproducing "structures of class and gender that were 'moral,' that is, 'normal,' by their own standards."[18] Classification was quite central to the production of a docile and harmonious community (essential, in the words of the Scottish alienist, W. A. F. Browne, if one were "to inspire that respect for order and tranquility which is the basis of all sanity and serenity of mind");[19] and rigid segregation of the sexes was quite central to their classificatory schemes.[20] The lunacy commissioners even objected to the mingling of male and female corpses in the deadhouse at the Cambridgeshire County Asylum![21]

Kept constantly separated from their male counterparts, save at the carefully stage-managed asylum balls that were a weekly demonstration of the powers of moral management over the sexual passions, women endured an even more passive and circumscribed existence than could

be found on the men's wards. The idle monotony of their daily round was relieved only by work at quintessentially feminine tasks: the cleaning, laundry, and sewing that were vital to the upkeep of these ever-larger museums of madness. And their improvement was measured, as often as not, by their ability to manage their dress and their appearance. In a striking analysis of the work of Hugh Diamond, the pioneer of psychiatric photography in England,[22] Showalter points out how it allows us to *see* the moral management of female insanity; how the supposedly objective lens of the photographer instead reveals, in the choice, the posing, the staging of its subjects, the imposition of cultural stereotypes of femininity and female insanity, a capturing of the madwoman in the straitjacket of her keeper's gaze. In image after image, "women were given props that symbolized, often with pathetic futility, the asylum superintendent's hope of making them conform to Victorian ideals of feminine decorum."[23] Humanitarianism had, as its hidden face, new forms of paternalistic domination.

As the hopes of the asylums' founders dimmed, and their institutions silted up with the chronically crazy, "the waifs and strays, the weak and wayward of our race,"[24] so cracks began to appear in the facade they presented to the world, providing glimpses of a moribund system, overcrowded, inefficient, ever more demoralized. Showalter adopts Veida Skultans' term, "psychiatric Darwinism,"[25] to describe the parallel evolution of medical theories of insanity, towards a grim determinism that emphasized madness as the product of a process of mental and physical degeneration. In the words of Henry Maudsley, the dominant figure of *fin-de-siècle* English psychiatry, the madman "is the necessary organic consequent of certain organic antecedents: and it is impossible he should escape the tyranny of his organization."[26] The physical signs of physiological decay were written particularly plainly on the bodies of women, and given the hopelessness of curative efforts and the vital significance of healthy offspring for the future of the race, prospective husbands were urged to inspect the merchandise carefully, searching for "physical signs . . . which betray degeneracy of stock . . . any malformations of the head, face, mouth, teeth and ears. Outward defects and deformities are the visible signs of inward and invisible faults which will have their influence in breeding."[27]

Such rigid somaticism coincided with a barely disguised contempt for the mad and appeared to leave but little scope for expert intervention. In response, the leading alienists sought to widen the scope of their authority, to move outside the asylum walls, and to obtain a mandate to patrol the mental frontiers of society on the lookout for "incipient lunatics" whose disorders, hidden from less trained eyes, threatened future trouble and a further dangerous dilution of the quality of the breeding population. It was these shadowy inhabitants of what Mortimer Granville dubbed Mazeland, Dazeland, and Driftland[28] who now drew the attention of the most eminent mental specialists of the day—provided, of course, that their families possessed sufficient resources to pay for such expert attention. And in most instances, these mental cripples and invalids turned out to be women. Some were diagnosed as neurasthenics or anorexic (a condition recognized for the first time in 1873); but the most common diagnosis was unquestionably hysteria.

In two central chapters, Showalter examines the relationship between hysteria and women's lives and the nature of the psychiatric response to this protean, puzzling, infuriating, recalcitrant condition—a syndrome the prominent American neurologist Silas Weir Mitchell preferred to call "mysteria."[29] With its associations with capricious physical symptoms and emotional lability, here was a disorder that epitomized feminine fickleness. Its very name associated it with female sexuality, and English alienists characteristically attributed it to some combination of sexual inhibition, enforced passivity, and thwarted maternal drives, allied to faulty heredity and the biological crises of the female reproductive system and exacerbated by any attempt to transgress the "natural" limits on women's participation in society.[30] Too much education was a particularly dangerous thing.[31] Adolescent girls needed all their mental and physical energies to negotiate the treacherous shoals of puberty. Add mental strain, and one could expect, warned Maudsley, "the degeneration of the reproductive capacity, beginning with the atrophy of the breasts and ending with a total loss of 'pelvic power' "—not to mention the prospect of epilepsy, chorea, or mental breakdown.[32]

Showalter rightly notes the persistent blindness of even the most sym-

pathetic male physicians to the connections between psychosomatic disorders and constricted and powerless lives, "women's intellectual frustration, lack of mobility, or needs for autonomy and control."[33] In the impassioned words of Florence Nightingale:

> To have no food for our heads, no food for our hearts, no food for our activity, is that nothing? If we have no food for the body, how we do cry out, how all the world hears of it, how all the newspapers talk of it, with a paragraph headed in great capital letters, DEATH FROM STARVATION! But suppose one were to put a paragraph in the "Times," *Death of Thought from Starvation,* or *Death of Moral Activity from Starvation,* how people would stare, how they would laugh and wonder! One would think we had no heads or hearts, by the indifference of the public towards them. Our bodies are the only things of consequence.[34]

But if hysteria was hidden protest, a rebellion against the stifling demands of a patriarchal social order, it was a feeble and ineffectual form of resistance. The secondary gains—"the sympathy of the family, the attention of the physician"—were quite incommensurate with the far more extensive primary losses, "the costs in powerlessness and silence."[35] In the words of the French feminist theorist Helene Cixous, "Silence: silence is the mark of hysteria. The great hysterics have lost speech . . . their tongues are cut off and what talks isn't heard because it's the body that talks and man doesn't hear the body."[36]

Nor was this the only price paid by the female hysteric. For English psychiatrists "found their hysterical patients personally and morally repulsive,"[37] and their treatment of them was suitably ruthless, uncompromising, even brutal. Viewing their patients as a cowardly, histrionic, deceitful, and morally wretched lot, many responded in kind, advising "observant neglect" or even active intimidation, blackmail, and threats. "Ridicule," noted F. C. Skey, "is a powerful weapon . . . but there is no emotion equal to fear and the threat of personal chastisement."[38] And for some, threats might give way to action: stopping the patient's breathing, pouring water on her head, slapping her with wet towels, exercising pressure "on some tender area." All too frequently to no avail. In the understanding and treatment

of hysteria, as with psychosis, English psychiatry found itself at an impasse. Elsewhere, first through Charcot's work, and then in Freud and

Breuer's *Studies on Hysteria*, there were experiments with a more psychologically oriented approach. In picturing hysterical symptoms as the product of unconscious conflicts beyond the individual's control, in beginning to take "women's words and women's lives seriously,"[39] Showalter sees psychoanalysis as potentially a major advance, but one whose promise soon dissolved as Freud's increasing theoretical rigidity and obsessive "insistence on the sexual origins of hysteria blinded him to the social factors contributing to it."[40] In any event, Freud's ideas met with a particularly hostile response from many English psychiatrists, notwithstanding, in Leonard Woolf's words, the "desperately meagre . . . primitive and chaotic" state of English medical knowledge of insanity on the eve of the Great War.[41]

The final, and in some ways the least successful section of *The English Malady*, deals with developments from World War I through the demise of Laingian antipsychiatry in the late 1970s, a period Showalter labels the era of psychiatric modernism. Her analysis opens promisingly enough, with a harrowing comparison of the treatment of shellshock by Lewis Yealland and by W. H. R. Rivers. The epidemic of war neurosis among the British troops was a wholly unexpected development. First interpreted as quite literally the product of the physical or chemical effects of a shell bursting at close range and assumed to have a physical cause,[42] it gradually came to be seen as the product of emotional disturbance, a male form of hysterical conversion. In effect, as Showalter puts it, "when all signs of physical fear were judged as weakness and where alternatives to combat—pacifism, conscientious objection, desertion, even suicide—were viewed as unmanly, men were silenced and immobilized and forced, like women, to express their conflicts through the body."[43]

Men's unconscious resistance provoked some of the same negative reactions as greeted their hysterical sisters—made harsher by the "unmanliness" of those who failed to fight. Many took a harshly moralistic view of the emotionally incapacitated, suggesting that shell-shock cases should be court-martialed and shot for malingering or cowardice. Yealland's "disciplinary therapy" gave barely disguised expression to these feelings, stressing "quick cures, shaming, and physical re-education,

which often involved the infliction of pain,"[44] and extending to the use of cigarette burns, "hot plates" thrust into the mouth, and the application of painful electrical shocks to the neck and throat. But war neurosis was four times more common among officers than among enlisted men, and for the most part, there was reluctance to treat gentlemen in such overtly harsh and brutal ways. Instead, the treatment of officers brought the first breach in English psychiatry's commitment to organicism. Siegfried Sassoon's "Soldier's Declaration," for example, a forthright denunciation of the war, could have brought him a court-martial and imprisonment. Instead, he was diagnosed as neurasthenic and shipped off to be "treated" by W. H. R. Rivers at Craiglockhart Military Hospital. Here, as Showalter points out, the treatment was kindly and gentle, and the surroundings luxurious (though in the outcome, Sassoon's political protest was invalidated by redefining it as a nervous breakdown, and he was manipulated into resuming his role at the front as "an officer and a gentleman").

The world fit for heroes now saw a bifurcated psychiatry: psychotherapy (usually some variant of psychoanalysis) for well-to-do outpatients; and a renewed commitment to organicism for the multitudes who continued to be packed off to the asylum. Psychoanalysis, notwithstanding its sizable cohort of female therapists, "hardened into a discourse that devalued women."[45] Meanwhile, in a veritable paroxysm of inventiveness, asylum psychiatry experimented with malarial therapy, metrazol-induced seizures, insulin comas, electroshock treatment, lobotomies, and finally ataraxic drugs, most notably Largactil, the "mighty drug" that was to be our culture's magic potion against the ravages of schizophrenia.[46] A number of these therapies, Showalter argues, reduced patients treated with them to a state of passivity and dependence that constitute extremes of typical female experiences; and incomplete evidence suggests that women were

disproportionately the beneficiaries of lobotomies and shock treatments.

Both here and in the parallel discussion of literary representations of female madness, much of what Showalter has to say is apt and insightful. But there are also passages that strike me as too glib and simplistic, passages that violate her insistence earlier in the book that one must not romanticize madness. It may be that women's autobiographical novels "transform the experiences of shock, psychosurgery, and chemotherapy into symbolic episodes of punishment for intellectual ambition, domestic

defiance, and sexual autonomy,"[47] but this is surely too crude and self-serving a portrait to accept at face value. Or to take another example, to assert that "during the postwar period, the female malady, no longer linked to hysteria, assumed a new clinical form: schizophrenia"[48] is to damage one's own case by engaging in polemical excess. Though Showalter briefly acknowledges that the incidence of schizophrenia is "about equal in women and men,"[49] the whole thrust of the discussion that follows is to emphasize the "parallels" between "schizophrenic symptoms of passivity, depersonalization, disembodiment, and fragmentation" and "the social situation of women;"[50] to present, apparently approvingly, accounts of "schizophrenia as a protest against the feminine mystique" and portraits of "mental institutions as environments in which deviants from conventional feminine roles were forced to conform."[51]

By now, the antipsychiatric follies of R. D. Laing and his epigones are rather thoroughly discredited. The intellectual vapidity of Laing's later work, the transparent hucksterism and political opportunism he paraded as his star began to set, and the disastrous track record of Laingian therapy have all combined to make him a yesterday's man. But it is with Laing that Showalter brings her story to a conclusion. As she points out, feminists had once seen in his notion of "ontological insecurity" and in his analysis of the effects of the double bind on female adolescents "important new ways of conceptualizing the relationship between madness and femininity."[52] But having reviewed the whole sorry episode, down to the dotty view of schizophrenia as religious vision and spiritual quest, and the pathetic story of Mary Barnes, she concedes that "in retrospect, it seems clear that despite vivid representations of women's suffering, antipsychiatry had no coherent analysis to offer women"[53] —or, one might add, members of the opposite sex either. (Unless, of course, one sees David Cooper's advocacy of "bed therapy," that is, sex with David Cooper, as a contribution to the cure of schizophrenia in women.)[54]

In a brief epilogue, Showalter suggests, with considerable rhetorical flourish but without sustained argument or elaboration, that hopes for the future must now be invested in the new feminist therapy movement. Perhaps—though for those of us who are skeptical, it would help if she had spelled out just who these therapists are, what their therapeutic innovations have been, and why one should accept that their activities have radically transformed the prospects for coping with, even curing, the deranged. For my part, I fear that the miseries of madness (female *and* male), and the horrors that have been perpetrated in the name of its treatment, will not be so readily or rapidly vanquished.

Chapter Twelve
The Theory and Practice of Civil Commitment

The past two decades have witnessed a significant extension of the involvement of lawyers and the legal system in matters psychiatric. Much of this activity has had a sharply adversarial edge, with mental health lawyers (many of them public-interest attorneys schooled in the civil rights movement) attacking the procedures and practices of organized psychiatry and on occasion impugning psychiatrists' claims to expert status and authority.[1] Efforts have been made to bestow both the "right to treatment" and "the right to refuse treatment" on the psychiatrically unfortunate, prompting fierce objections from psychiatrists that their clinical authority is being improperly infringed upon, to their patients' (not to mention their profession's) detriment.

Whatever the validity of these protests, it should now be apparent that the judicial system is not the most promising arena of action for those committed to psychiatric reform. In the late Peter Sedgwick's words, "If the resources of court action really did represent the high road of hope for the average institutionalised psychiatric patient, one might imagine

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that the United States would by now possess the finest mental-health system that legal and libertarian reason could invent."[2] To the contrary, the manifest deficiencies of contemporary American mental health policies, particularly with regard to the chronically mentally disordered, are now a staple item in the popular media, both printed and electronic. This situation is unsurprising, since civil libertarian interventions are necessarily reactive, and the law at best a crude instrument for formulating social policy, particularly when the courts attempt to intrude on quintessentially political decision-making about the allocation of funds among competing programs and priorities.

One of the major contemporary arenas of conflict between law and psychiatry has been over civil-commitment laws and procedures. From the late 1960s onwards, states generally began to circumscribe the formal criteria that justified the involuntary commitment of the mentally disordered, many of the states following the model provided by California's Lanterman-Petris-Short Act of 1967.[3] More recently, one can find evidence of a backlash against such changes. Increasingly, it seems, we are being urged to reconsider our new-found reluctance to countenance the involuntary confinement of the mentally disordered—a stance reflecting "disillusionment and frustration with commitment statutes that have made it increasingly difficult to provide treatment to psychotic patients who are not imminently dangerous, and . . . increasing demands [by an aroused public] for more extensive involuntary hospitalization."[4]

Carol Warren's *The Court of Last Resort* contains the most extended and systematic attempt we have to examine *empirically* the impact of the Lanterman-Petris-Short Act. When the *University of Michigan Law Review* asked me to write an essay on the issues raised by her study, I welcomed the opportunity to do so, not least because it seemed to me that the contemporary debates uncannily echoed arguments first rehearsed at a much earlier stage in the evolution of the psychiatric profession. To highlight the value of a historical perspective on our contemporary dilemmas, I elected to frame the discussion that follows around a mid-nineteenth century lawsuit brought by an obscure middle-aged lady enraptured by the teachings of a now-forgotten sectarian preacher—a decision that I hope gives some substance to the old saw concerning the value of historical inquiry in understanding the roots of our contemporary dilemmas.

The Theory and Practice of Civil Commitment

On a sweltering day in London, towards the end of June 1849, a curious throng of spectators jammed into a special sitting of the Court of the Exchequer to hear the lord chief baron, Sir Frederick Pollock, and a special jury decide the case of *Nottidge v. Ripley and another* .[1] For three days, the court remained "crowded to suffocation," while a still larger audience followed the proceedings at a distance, devouring successive installments of the real-life soap opera at breakfast, in the blow-by-blow account provided in the legal columns of the *Times* . At the conclusion of the trial, after a brief retirement, the jury found for the plaintiff, awarding her fifty pounds and costs.

The object of this unwonted celebrity, Miss Louisa Nottidge, was a quiet and retiring "maiden lady . . . at the meridian of life," and her suit was an action for damages against her brother and brother-in-law for wrongful confinement in a madhouse.[2] As the trial testimony revealed, shortly after her father's death, in May 1844, Louisa and three of her unmarried sisters (all rather advanced in years) had become enamored of the doctrines of an obscure and tiny religious cult, the Lampeter Brethren, and of the preaching of the sect's leader, a defrocked Anglican curate named Prince. Within a matter of months, they had left their maternal home to follow Prince, taking with them their private fortunes—amounting to some 6,000 pounds each. Three of the ladies promptly married, in the same ceremony, much younger (and penniless) members of the religious commune, not troubling to take the usual Victorian precaution of protecting their property through prenuptial settlements. Louisa, apparently unable to find even so unsatisfactory a suitor, nevertheless joined her sisters in Agapemone, or the Abode of Love, the country house the sect now occupied in Somerset.

Here she lived for six weeks with the other fifty or sixty members of the commune, "dazzled by its luxury, charmed with its games and pastimes, and sustained by glorious assurances of judgment being past, and heaven to come;" till at length her mother learned of her whereabouts.

Convinced that her daughter "was not a free agent," that her mind was deranged, and that her continued presence in this den of sin and iniquity was "endangering her happiness in this and her welfare in a future life," Mrs. Nottidge determined to rescue her from such "a low, degrading, and disgusting association." Accordingly, she dispatched her son and son-in-law to Somerset. Gaining access to the house by stealth, they first tried to persuade Louisa to come with them to visit her sick mother. When she declined, however, they seized her, "dragged her out of the house, notwithstanding her struggles and screams, and forced her into a carriage without either bonnet, or shawl, or shoes . . . and then off they drove as fast as the horses could put their feet to the ground."[3] Two medical men were readily found to certify that her reckless disregard of her reputation and property, and her peculiar religious beliefs—or delusions, as they were now held to be—constituted clear evidence of insanity, and she was promptly carted off to Dr. Stillwell's madhouse, Moorcroft House.

The spectators at the trial listened to this gothic tale with rapt attention, occasionally mixed with gales of laughter when revelations of the goings-on at the Abode of Love provided a measure of comic relief. Miss Nottidge had remained under confinement for some fourteen months, still insisting that Prince was "God manifest in the flesh," that the day of judgment had come, and that she had been rendered immortal and should shortly "be taken up to heaven in the twinkling of an eye"—and still diagnosed by the asylum superintendent and by the lunacy commissioners, the official inspectors of all asylums, as a religious monomaniac. Then she managed to escape. She was rapidly recaptured and brought back to the asylum, but not before she had succeeded in alerting her co-religionists to her whereabouts. After a protracted struggle, they secured her release (at which point, she promptly returned to Agapemone and handed over all her assets to Prince).

The medical witnesses at the trial were uniformly convinced that Louisa Nottidge had been and still was deranged, and thus in need of protection and treatment in an institution. The lay audience was not persuaded. As the *Times* put it in its editorial on the case: "We must not stretch a harmless hallucination into legal insanity. . . . The shades and gradations of error and folly are so insensibly blended that we could not incarcerate and coerce such an [*sic*] one without danger to others."[4] And in summing up the evidence for the jury, the Lord Chief Baron all but directed a verdict for the plaintiff: "It is my opinion that you ought to

liberate every person who is not dangerous to himself or others . . . and I desire to impress that opinion with as much force as I can."[5]

Periodic moral panics over the issue of the improper commitment of the sane to asylums were endemic in the nineteenth century in both England and the United States, and attempts like Pollock's to limit the criteria justifying involuntary commitment to the narrowest possible compass reflect one possible response to these spasms of anxiety.[6] But alienists fiercely resisted attempts to constrict the definition of madness within such narrow confines, and for the most part they succeeded. In the *Nottidge* case, the Lord Chief Baron's dictum drew forth an impassioned critique from John Conolly, the leading authority of his generation in matters psychiatric.[7]

Notwithstanding its "apparent conformity . . . to the liberty of the subject, and to the dictates of humanity,"[8] argued Conolly, the attempt to restrict the asylum population to lunatics who were a danger to themselves or others was thoroughly mistaken and mischievous:

> If the liberty of an insane person is inconsistent with the safety of his property or the property of others; or with his preservation from disgraceful scenes and exposures; or with the tranquility of his family, or his neighbours, or society;—if his sensuality, his disregard of cleanliness and decency, make him offensive in private and public, dishonouring and injuring his children and his name;—if his excessive eccentricity or extreme feebleness of mind subject him to continual imposition, and to ridicule, abuse, and persecution in the streets, and to frequent accidents at home and abroad ;—his protection and that of society demands that he should be kept in a quiet and secluded residence, guarded by watchful attendants and not exposed to the public.[9]

Similar are the cases of young women "of ungovernable temper, . . . sullen, wayward, malicious, defying all domestic control; or who want that restraint over the passions without which the female character is lost";[10] and young men "whose grossness of habits, immoderate love of drink, disregard of honesty, or general irregularity of conduct, bring disgrace and wretchedness on their relatives. . . . People of this kind may not endanger their lives or those of others, but their being at large is inconsistent with the comfort of society, and their own welfare."[11] "To forbid the placing of such persons in asylums because they are not dan-

gerous . . . would be to forbid their being protected and cured,"[12] and furthermore would "bring affliction on a thousand families, and even throw society into confusion."[13] The case of Louise Nottidge was of exactly this sort: "It belonged to a class in which the patient is unequal, from feebleness and unsoundness of mind, to take care of herself or her property."[14] Confinement preserved "her money . . . from legalized robbery, and her person from the possibility of legalized prostitution."[15] Consequently, "those who exult in her liberation from the salutary control of an asylum are exulting over her ruin."[16]

It is clear that over the next century and more, while perhaps shrinking from endorsing the full measure of Conolly's attempt to equate insanity with any deviation from conventional social and moral standards, the civil commitment codes of all Anglo-American jurisdictions by and large embraced the claims made by psychiatrists to be the arbiters of the boundary between sanity and insanity. These laws accepted the need for a broad standard for commitability, based on the state's paternalistic interest in securing protection and treatment for the loosely defined class of the mentally unbalanced. Sir Frederick Pollock's attempt to narrow the criteria for individual commitment, although symptomatic of a widespread distrust of psychiatrists' character and competence,[17] had only a limited

impact on the development of mental health law.

Beginning in the late 1960s, however, in the context of a virtual explosion of law and litigation in the United States relating to the mental health system, there has been a marked trend away from traditional commitment codes, with their typically loose standards and protections and broad grants of discretionary authority.[18] One of the earliest and most influential manifestations of this trend was the passage of a new commitment law in California, widely known as the Lanterman-Petris-Short Act (LPS).[19] Under LPS, the emphasis in involuntary commitment decisions shifted away from a *parens patriae* concern with "protecting" those unable to care for themselves, toward a much greater stress on the issue of danger to others and on procedural rights. Commitment for anything more than an emergency seventy-two-hour period could be achieved in only two ways: (1) through a conservatorship subject to mandatory yearly judicial review and jury trial for those persons found to be

"gravely disabled"—that is, on the basis of clear and convincing evidence, mentally unable to provide for their "basic personal needs for food, clothing, or shelter"; or (2) through commitments lasting no more than ninety days for persons who are mentally ill and who, as evidenced by recent overt acts, attempts, or threats of violence, are found to be "imminently dangerous." Such ninety-day commitments can be renewed only if it is shown that the patient, while confined, again acted violently. Under either standard of commitment, the person alleged to be mentally ill has the right to be notified of all proceedings against him or her and to be present at all hearings; and the right to be represented by an attorney during all judicial review proceedings.[20] Thus, the California commitment law in a number of crucial respects now corresponds quite closely to the standard articulated in *Nottidge v. Ripley;* indeed, from some points of view, it is even stricter.

Carol Warren's book, *The Court of Last Resort,* [21] presents a wide-ranging analysis of court administration of this new mental health law. The book's particular focus is an empirical examination of judicial decision-making about whether to release or retain those involuntarily committed under LPS, based on extensive firsthand research and observation in "Metropolitan Court" (a pseudonym for a Los Angeles mental health court). Though she attempts to place her findings in a broader sociological context, to see courtroom decisions as to some degree conditioned by large-scale economic, political, and historical forces, the results of this effort are rather thin and insubstantial.[22] The book's real strength lies in its documentation of the gap between the formal wording of the statute and the practical application of the law and in its contribution to the current debate about the appropriate standards for involuntary commitment.

The Metropolitan Court Routine

Theoretically, LPS sets up an adversarial system in the courtroom, designed (on an analogy with an idealized portrait of the criminal justice system) to protect the patient's rights. Lawyers seeking commitment confront other lawyers representing those alleged to be in need of confine-

ment, and psychiatric personnel face questioning and cross-examination about the grounds for their conclusions. In practice, however, as Warren demonstrates in a variety of contexts, the norm is rather one of cooperation and mutual accommodation among a group of actors who routinely play out the same roles day after day, and who have all developed a working consensus around a "commonsense" model of madness.[23] The practical effect of a common culture and a set of shared organizational imperatives is a recognition that "we all work together here"[24] and a conviction that such a state of affairs is both natural and desirable. Thus, though courtroom procedures are dominated by elaborate rituals designed "to demonstrate compliance with procedural rules as well as with substantive law,"[25] public defenders "generally refrained from vigorous advocacy of their clients' legal rights under LPS."[26] Instead, they chose to work "together with the other participants in

the hearing to come to what all could agree was the 'right decision' for the individual and for society."[27]

Notwithstanding an apparent conflict between "the medical and legal frames of reference," the practical convergence on "an underlying commonsense and a taken-for-granted perspective on mental illness" smoothed the way for an easy and tension-free collaboration. Just as "attorneys view their clients as crazy and therefore refrain from standing firmly in the way of their involuntary incarceration,"[28] so too the psychiatrists—mostly state hospital personnel who appear regularly in the same courtroom—adapt readily to "legal practices" and to the existence of "a stable release rate."[29] The judge, meanwhile, justifies "the smooth, rapid, and routine method of processing" in the courtroom, and

> the lack of an adversary approach to justice in mental health law on the grounds that the role of the defense attorney [is] to be 'a reflection of the client's personality' rather than a vigorous advocate. If the client [is] crazy, then this should not be concealed by the defense attorney.[30]

As Warren notes, this emphasis on assembly line justice closely corresponds with the pattern that obtains in the criminal courts—on whose allegedly "adversarial" procedures the reformers who wrote LPS modeled the new law.[31]

Where outside intervention in the system threatens this pattern of mutual accommodation, the main actors in the carefully staged drama move quickly to minimize its impact. Thus, in the face of the challenge

posed by potentially disruptive higher court rulings, the judge, district attorneys, public defenders, and mental health counselors—"members of the organization cooperating as a whole—embarked on a search for a legal way to evade the problems attendant upon [implementation]"—as one participant put it, "'tinkering with' the new precedent until it 'came out right.'"[32] A more frequent source of disturbance was the arrival of a "new, aggressive, advocate defense attorney," full of idealism, intent on implementing the letter of the law and defending the "rights" of his clientele.[33] Such callow youths were quickly disabused, and most "would learn the ropes, and would become socialized to the way things are done."[34] The occasional nonconformist aroused anger and then protective action: Mr. William Simmons, for example, refused to "settle down." Instead,

> he persuaded a number of his conservatee clients to ask for jury trials, thus tying up Department 2 for days on end. He also spent hours studying and arguing on habeas corpus hearings, committing what was probably the most egregious organizational faux pas, talking at length to clientele. Unlike his predecessors, Mr. Simmons did not modify this behavior over time, let alone cease and desist. After a few weeks, the judge became angry. . . . Bill Simmons was fired from his job after about three months; when I asked another public defender why, he replied, "Oh, that guy—because he was stupid."[35]

As this example suggests, while the formal requirements of the law do, to a limited extent, constrain decision-making, they are far from determining outcomes. For instance, "long-term commitment based on the need for care and treatment, the standard overturned by LPS, has been restored through the use of conservatorships."[36] Patients admitted on an emergency seventy-two-hour hold as "dangerous" are subsequently relabeled as "gravely disabled,"[37] in part because of the difficulty of demonstrating dangerousness. Indeed, the LPS provision allowing a ninetyday commitment on grounds of danger to others "is almost never used in California."[38] Moreover,

> grave disability standards dealt less with food, clothing, shelter, and finances—functioning within the community—than with functioning inside the family and the mental health system. This suggests that considerations of individual rights and the protection of society are displaced in this court by considerations of the relief of family tensions and the smooth functioning of the mental health system.[39]

Perhaps even more ironic, conservatorship hearings under LPS take even less time than the five-minute average prior to the act, "the statistic

which had prompted legislative interest in involuntary civil commitment in the first place."[40]

In the courtrooms Warren studied, therefore, "decision making is particularistic, situational, and arbitrary rather than universal and fair; medical theories posture as proven facts, and organizational needs take precedence over legal and psychiatric requirements."[41] And there is every reason to believe that this is not an atypical pattern. At the very least, this situation should caution us to be wary of becoming caught up in abstract debates on the issue of civil commitment and to be skeptical about the practical impact of any given set of "reform" proposals. Still, of course, it scarcely renders irrelevant the question of what in principle constitutes appropriate grounds for involuntary commitment, and Warren's book devotes considerable space to precisely this issue.

The Debate over Abolition

At one extreme, in recent years a small but vocal minority has urged that compulsory commitment is never justified, so that "the goal [of mental health policy] should be nothing less than the abolition of involuntary hospitalization."[42] Such proposals have attracted a considerable following among the legal community, though their most visible and tireless proponent has been the renegade psychiatrist, Thomas Szasz, for whom "involuntary mental hospitalization is like slavery. Refining the standards for commitment is like prettifying the slave plantations. The problem is not how to improve commitment, but how to abolish it."[43] The antithesis to this position, from one perspective, is the extraordinary array of behaviors and conditions John Conolly urged us to accept as justifications for involuntary commitment in his *Remonstrance* over the *Nottidge v. Ripley* case[44] —except that few would now defend such a stance, at least in public. Realistically speaking, therefore, the alternative to abolitionism turns out to be a much more limited, eclectic, and qualified defense of compulsory commitment, which presses for involuntary hospitalization as preferable, on balance, to the likely alternatives.

In *The Court of Last Resort,* these two competing positions are defended with considerable zeal by Stephen Morse,[45] a lawyer and psychol-

ogist, and Jack Zusman,[46] a psychiatrist, with Warren joining in to argue for the retention of certain forms of involuntary commitment. Morse's arguments for the abolitionist position closely resemble those previously developed by Szasz,[47] and rest upon a shared commitment to the overriding importance of what they both term "liberty"[48] —though it should be noted at the outset that Morse's brief is less overtly polemical and consciously eschews the vituperative tone, name-calling, and attribution of base motives to one's opponents in which Szasz seems to revel. As one would expect from a skilled attorney, the abolitionist position is persuasively made, with logic and force that threaten to demolish the opposition's more cautious eclecticism. By contrast, Zusman and Warren's uneasy compromises among competing values, and rueful confessions of both the psychiatrists' limitations and the dangers inherent in the exercise of *parens patriae* powers, give their arguments a necessarily more vulnerable and compromised appearance.[49] And yet, I shall suggest that in the final analysis, it is precisely the moral absolutism of Morse's position that is its decisive weakness, rendering "it impotent to calculate the complex relations between means and ends, risks and benefits which hold in real life."[50]

Morse notes that "the deprivation of liberty authorized by involuntary commitment laws is among the most serious restrictions on individual freedom the state may impose," and that, unlike incarceration for criminal acts, "it may be imposed on the basis of predictions, without the prior occurrence of legally relevant behavior such as dangerous acts."[51] He begins his assault on this practice by denying the validity of the widespread belief in our culture that the irrational behavior of the mentally ill is compelled, while the behavior of "normal" people is freely chosen. Recent social scientific research has indeed cast some doubt on this belief, as a blanket contention, demonstrating that in some contexts, in certain restricted ways, psychotics can exercise a measure of control over their

behavior.[52] Indeed, from the early nineteenth century to the present, control of inmate behavior within the mental hospital has perforce rested on precisely this presumption "that it made some sort of sense to hold the lunatic responsible for his actions, and that by doing so his behaviour could be manipulated."[53] Morse seizes on this evidence. The mentally ill, he contends, "often . . . have as much control over their behavior as normal persons do"; and "we cannot be sure that the person was incapable, as opposed to *unwilling,* to behave rationally or to control him or herself."[54] Moreover, "the assertion that the irrationality or other behavior of mentally disordered persons is compelled . . . is a belief that rests on commonsense intuitions and not on scientific evidence."[55]

But these are disingenuous arguments. "Often" is a very long way from always, and few observers would dispute that much psychotic behavior remains uninterpretable in any ordinary sense as intentional behavior. Indeed, we cannot be *sure* that a madman's actions were uncontrollable, but it may well be more sensible (i.e., in accordance with the preponderance of the evidence) to act on that presumption than to assume that he *was* capable of control and treat him accordingly. And of course the claim that action is either free or determined ultimately rests on commonsense intuitions and not on science: How could it be otherwise when (as Morse himself concedes but a few moments later) "empirical evidence cannot definitely prove or disprove that *anyone* has or lacks free will"?[56] But what Morse neglects to note is that we may have very good grounds indeed for this commonsense presumption.[57]

Moreover, were we to adopt Morse's position, we would be committed to holding "nearly all persons, including crazy persons, responsible for their behavior."[58] Necessarily, then, we would have no grounds for objecting if substantial numbers of discharged mental patients were to end up in prison. To his credit, Morse does not try to duck this issue: instead, he meets it head on, asserting that this result is "more respectful of the dignity and autonomy of crazy persons" than the alternative of confining them in a mental hospital.[59] One cannot help admiring his audacity, even as one is dismayed by the Orwellian use of language. Fortunately, despite

the advent of 1984, we do not all (yet) inhabit a Humpty-Dumpty world in which "a word . . . means just what I choose it to mean—neither more nor less."[60] And until we do, it is unlikely that many of us will view consigning someone to jail as anything but a singularly odd way of respecting his dignity and autonomy.[61] Of equal importance, while Morse may not balk at the prospect of sending the mentally ill to prison, a commonlaw system of justice built around the concept of criminal responsibility almost certainly will.[62] Zusman is thus assuredly correct when he points out that "to eliminate state control as a preventive measure and allow the mentally ill to be accountable for any law-breaking and mistakes, is completely unacceptable without a massive shift in law and public opinion." On the other hand, it is equally plain that "complete disregard of rule breaking by the mentally disordered—that is, freedom to do whatever they please without any consequences—is a politically unacceptable alternative."[63]

Morse's second argument against involuntary commitment is that the mental health system "is unlikely to identify accurately those persons who should arguably be committed."[64] He is on much stronger ground here. The tendency of psychiatrists to overpredict dangerousness is pervasive and (given the structural pressures operating on them) both unsurprising and unlikely to change.[65] Thus, legitimizing commitment on the basis of dangerousness necessarily involves accepting that a high proportion of those preventively detained would not in fact have behaved violently: the most authoritative review suggests that inaccurate predictions will range as high as 60 or 70 percent.[66] Unquestionably, such statistics should give anyone pause. Whether they should also lead us entirely to abandon "dangerousness" as a ground for involuntary commitment is, however, more debatable. There is the obvious objection about the political possibility (or rather impossibility) of such a move.[67] But quite apart from these purely practical concerns, the question remains as to whether we *ought* to wait until the predicted harm occurs (if indeed it does) before we attempt to intervene. For those who share, with Morse, an absolute and overriding commitment to "liberty"—conceived of as a

presocial attribute of atomized individuals—no dilemma exists.[68] By contrast, if liberty is seen as a vital, but not always controlling value, and as an inextricably social phenomenon,[69] decision-making becomes much more complex, with no ready-made and all-embracing solution. One is forced to recognize, for example, that the social costs (including the costs to the liberty of a sizable number of other people)[70] imposed by the continued presence in society of a seriously disruptive and potentially violent crazy person (to use Morse's terminology) may be so great as to justify commitment, even if more than half the time the threat of violence remains merely a threat. The choices here are obviously very difficult; but I suspect that the best pragmatic resolution is to follow Monahan and Wexler's[71] suggestion and require an inverse relation between the probability and the seriousness of the harm, so that the greater the harm predicted, the lower the probability of its occurrence needs to be to justify involuntary commitment.

What of those "who are mentally unable to fend for themselves"[72] and who need to be confined for their own good? Morse denies that such cases exist:

> Of course, there are cases of disordered persons that *seem* to cry out for intervention: the delusional person who seems on the verge of a violent outburst or who appears to be destroying the fabric of his or her family; or the terribly disorganized person whose life is apparently in jeopardy because the person seems unable to cope with minimal food, shelter, clothing, or medical needs; or the person in the throes of a manic episode who appears to be jeopardizing a career or reputation; or, perhaps most compellingly, the person on the verge of suicide who appears clearly to be making a mistake in judgment about his or her own helplessness and the hopelessness of his or her life situation.[73]

Not to worry, they only *seem* that way: Morse has "an intuitive hunch" that "even the craziest person has substantial control over his or her be-

havior"; and if that does not seem sufficiently persuasive, he reminds us that crazy persons, like the rest of us, possess "an inalienable right to liberty."[74]

Doubtless, the inalienable right to liberty must have been a great comfort to the severely impaired 89-year-old woman whom Warren observed, slowly starving to death in her home, wandering around a room with "barely a sign of habitation . . . bumping into things and alternately mumbling softly and shouting phrases from fragments of a past life."[75] Or to a Mrs. Simmons, of whom counsel testified:

> She was found on the floor of her apartment, where she had not gotten up for three months. She was malnourished. Maggots had eaten away part of her leg. She cannot be moved from the hospital until her leg is healed and she gains some weight. A neighbor had fed her on the floor for three months. She was lying in her own feces for three months.[76]

In the future, if such persons "really" disliked their situations, why then, they could always exercise the "autonomy" Professor Morse had so sedulously and kindly preserved for them when he blocked their involuntary commitment.

On the whole, I think we ought to prefer the commonsense view that one of the things people like this *lack* is autonomy, even if, as Morse is quick to remind us, such perceptions rest on "little more than an intuitive hunch."[77] Indeed, since the contrary view seems more than a trifle perverse, one wonders what can have led intelligent and thoughtful persons to adopt it. In part, the answer seems to lie in a continuing attachment to the Szaszian position that mental illness is simply a "myth."[78] As Warren points out, sociology made its own distinctive contribution to this belief that "mental illness was merely a matter of labeling of undesired behaviors and persons,"[79] and Morse, like others skeptical of psychiatry's pretentions, seems to have adopted substantial portions of this analysis. Hence his preference for "crazy" rather than "mentally ill," "because it is more descriptive and carries fewer connotations about disease processes that beg important questions about self-control";[80] and his penchant for minimizing the distinctiveness of the psychotic and the claims to expertise of their custodians, the psychiatrists.

For almost a quarter of a century, an intense and often acrimonious debate has raged about the medical model and the appropriate concep-

tualization of mental disorder, with no agreement yet in sight.[81] But whatever the final outcome of the controversy, it surely cannot alter the social reality that there exist a substantial number of people—be they victims of endogenous disease processes or of "problems in living"—who lack basic social capacities and who manifest extreme helplessness and dependency. Moreover, while I share the assessment that on balance the data at our disposal "suggest that expert psychiatric knowledge is a well-managed 'appearance of objectivity' rather than a set of 'objective facts,'"[82] I would suggest that this provides an argument for lessening the role of doubtfully "expert" testimony in the commitment process, not for abolishing commitment altogether.[83] Nor do I think that the evidence supports Morse's attempts to play down the damage associated with psychosis, an essential prop for his contention that commitment is "a simple, although unfair, answer to interpersonal, family, and comparatively *mild* social problems."[84] In this connection, it is surely significant (though of course in no sense conclusive) that Carol Warren, who began her observations in "Metropolitan Court" sharing this assumption "as an article of faith (although I saw it then as sober scientific reasoning, not belief),"[85] found herself compelled by what she experienced to recognize the existential reality of "mental disorder . . . independent of labeling"[86] and the necessity for compulsory hospitalization.

Care, Treatment, and Liberty

Morse is certainly correct, however, to worry about the potentially repressive consequences of allowing people to be confined "for their own good." As Conolly's remarks on the *Nottidge* case demonstrate,[87] the range of behaviors that might render one subject to such intervention (in the eyes of at least some psychiatrists) has in the past been extraor-

dinarily wide: adolescent rebelliousness, harmless eccentricity, violation of conventional standards of morality or of sexual propriety, extreme carelessness with one's money or property.[88] It is this extravagance, I suspect, that has prompted the claim that "psychiatric opinions are essentially political judgments."[89] Yet the fact that "benevolent" concern for the welfare of others has served to legitimize egregious violations of some people's freedom does not invalidate the claim that there are occasions when we may indeed be justified in intervening in others' lives "for their own good."

It may be objected, however, that mental hospitals "rarely cure, nor do they decrease the stigma."[90] Worse, "even in 'advanced' states that supposedly maintain the best services" all too often one encounters "revelations of . . . inadequate and sometimes inhumane care and treatment."[91] Again, there is a good deal of truth to both claims, though once more I shall suggest that this does not compel us to embrace Morse's chosen alternative of abolishing involuntary confinement.

The critique of the mental hospital's structural deficiencies has a very long history.[92] In the late nineteenth century, for example, neurologists—then in the process of constituting themselves as a medical specialty—provoked a bitter internecine conflict with institutional psychiatry by urging the asylum's total unsuitability for the treatment of mental disorders.[93] A long series of exposés by muckraking journalists provided further ammunition for the mental hospital's critics.[94] And, most notably of all, a mass of social scientific research in the 1950s and 1960s was devoted to the elaborate documentation of the irredeemable deficiencies of what Erving Goffman dubbed "total institutions."[95]

Such apparently objective findings have been widely disseminated, serving as one of the major ideological supports for the movement to deinstitutionalize the mental hospital population.[96] In the process, mental hospitals have been stigmatized as inevitably providing a disabling, counterproductive environment, one that exacerbates any preexisting pathology through an "organizational tyranny [calculated to produce] the thwarting of human possibilities."[97] Unquestionably, the historical record demonstrates that most mental hospitals have more closely resembled warehouses for the storage of the unwanted than institutions providing treatment and cures.[98] But this is a far cry from the

more extravagant claims made by Goffman and his epigones. It is these more extreme "findings" that Morse and others rely on when they urge us to abolish involuntary hospitalization altogether; and yet the research purporting to document these effects is so methodologically flawed and empirically inadequate[99] that one must seriously question the wisdom of depending on it.

Of at least equal significance in the present context, those social scientists who have criticized the mental hospital have almost entirely neglected to consider what the alternatives to it are, preferring to make the bland (and untested) assumption that "the worst home is better than the best mental hospital."[100] In practice, this has proved to be a tragically mistaken belief. A growing volume of research[101] has demonstrated that community "care" for the chronically crazy is in fact community neglect

and that "the effective meaning of liberty for the involuntarily committed is social marginality, deprivation, and despair."[102] So far from being the grand reform of mental health care its ideologues have proclaimed, the practical implementation of community treatment has created "a system which, daily and quietly, harms and kills the sick."[103]

At least Morse recognizes that the problem exists: "The condition of many 'deinstitutionalized' ex-patients in the community is a national disgrace."[104] But he immediately seeks to evade its implications:

> One should not compare the all-too-questionable benefits of hospitalization to complete or near-complete neglect in the community. The only fair comparison is to community living and treatment where society meets its moral obligations rather than cynically avoiding them.[105]

I find this an astonishing claim. Such a comparison is "fair" only in the sense that it supports the argument Morse is advancing—but at the unacceptable price of leaving behind the social realities we must confront. Discharged mental patients do not live in a society that "meets its moral obligations." The alternatives they (and we) must face are inadequate and underfunded mental hospitals or a grossly underdeveloped and often nonexistent system of community care. Here the choices are tougher and the answers less clear-cut than those Morse provides us with; but they have the distinct merit of being the real ones. And when we confront them, I think we must conclude, as Warren does, that for a substantial proportion of the chronically crazy,

> care in a profit-making institution at a cost of $14.50 a day seems more treacherous and less human than care in a state institution at $31 a day. And the confines of the state hospital, for the dispossessed, seem to threaten effective liberty less vitally than the sidewalks, streets, and cheap hotels of the completely homeless.[106]

To suggest that the mental hospital is sometimes a defensible—indeed preferable—solution to the problems posed by mental disorder, and to argue that compulsory commitment is also an option we should retain, is not to deny the need to place a sharp check on psychiatric enthusiasms, since these are no less capable of leading us astray. Indeed, when we debate the merits and demerits of compulsory commitment, we ought constantly to bear in mind that "the real scandal of contemporary public psychiatry is not the particular section of the mental-health statutes under which patients get into hospitals, but the alternatives offered to these supremely weak members of society by our present social arrangements both inside and outside the mental institution."[107]

Chapter Thirteen
The Asylum as Community or the Community as Asylum: Paradoxes and Contradictions of Mental Health Care

For several years after I first became interested in the study of madness, the primary focus of my researches was the nineteenth century. Yet my first book dealt with a far more sociologically respectable topic, contemporary mental health policy in the United States and Britain.[1] In substantial measure, this shift occurred because the first publishers I approached were reluctant to publish the somewhat bloated manuscript that constituted my Ph.D. dissertation; and because I lacked sufficient distance from what I had written (not to mention enthusiasm for the task) to take on the job of pruning and reworking it into publishable form. Consequently, I decided to set that manuscript aside temporarily, and to begin work on a new project.

Having tried in *Museums of Madness* to unravel the *origins* of the commitment to the asylum solution, I now found myself urged by friends and colleagues to scrutinize its contemporary demise. I must confess to a certain initial skepticism about claims that so durable an institution was swiftly and certainly en route to the historical scrapheap, but the subject certainly seemed worthy of further investigation. Moreover, I already sensed that there might be some interesting parallels to be explored between contemporary assaults on the therapeutic legitimacy of the mental hospital and a hitherto neglected, almost subterranean strand of criticism of lunacy reform and its products, which had appeared and per-

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sisted even at the height of Victorian optimism and complacency about the value of the asylum solution.

Very early on in my new researches, I was struck by the further parallels between the millennial expectations of the asylum's founders and the equally extravagant claims of the devotees of community care. It is difficult even a decade or two later to recapture the naive optimism of the late 1960s and early 1970s, for we live now in an era filled with denunciations of "the wholesale neglect of the mentally ill, especially the chronic patient and the deinstitutionalized":[2] a period in which we are bombarded with exposés of scandals in the board and care and the nursing home industries, and urged to reconsider our reluctance to countenance the involuntary confinement of street people. But twenty years ago, the optimistic illusion that we had uncovered a solution to the endless difficulties associated with chronic mental disorder had not yet melted away. To the contrary, the emptying of asylums was then hailed as unambiguous evidence of social progress, part of a third "psychiatric revolution"[3] that would finally liberate mental patients from the shackles of the past.

I completed work on *Decarceration* in late 1975. The book offered, unfashionably, a much bleaker assessment of the realities of deinstitutionalization, together with an account of the origins of this far-reaching change in social control styles and practices that was sharply critical of the then conventional pieties others offered on the subject. Since then, historical materials have once more absorbed the bulk of my attentions. From time to time, however, I have been drawn back to the study of contemporary realities. On one such occasion, half a dozen years ago, I wrote a piece comparing the nineteenth-century asylum as an idealized manufactured community with our idealization of twentieth-century "communities" as asylums for those afflicted with mental disorders. What follows is a revision of that essay, expanded to incorporate some discussion of developments in the 1980s.

The Asylum as Community or the Community as Asylum: Paradoxes and Contradictions of Mental Health Care

> As we see wing after wing spreading, and story after story ascending, in every asylum throughout the country, we are reminded of the overgrown monastic system, which entangled so many interests and seemed so powerful that it could defy all change, but for that very reason toppled and fell by its own weight, never to be renewed. Asylum life may not come to so sudden an end, but the longer its present unnatural and oppressive system is maintained, the greater will be the revolution when it at last arrives.
> —ANDREW WYNTER,
> The Borderlands of Insanity

> Some Persons of a Desponding Spirit are in Great Concern about that vast Number of poor People, who are Aged, Diseased, or Maimed; and I have been desired to employ my Thoughts what Course may be taken, to ease the Nation of so grievous an Incumbrance. . . . I am not in the least Pain on that Matter; because it is very well known, that they are every Day dying and rotting, by Cold and Famine, and Filth and Vermine, as fast as can reasonably be expected.
> —JONATHAN SWIFT,
> A Modest Proposal For Preventing the Children of Poor People in Ireland from Being a Burden to Their Parents or Country

Paradoxical as it may seem, any discussion of "community care" for the mentally ill must begin by paying serious attention to the mental hospital. The current generation of mental health reformers has shown a remarkable tendency to seize on statistics about reductions in the mental hospital census as a direct measure of the success of their endeavors. Moreover, their reiterated emphasis on the horrors endemic and inextricably part of the Victorian bins to which earlier generations consigned the mentally disturbed has helped to legitimize the notion that any change (though preferably a drastic change) must represent an improvement over what has gone before and to deflect attention away from "the demise of state responsibility for the seriously mentally ill and the current crisis of abandonment."[1]

Though the prehistory of the asylum can be traced back to medieval religious foundations (the most widely known example in the English-

speaking world being the monastic foundation of Bethlehem, or Bedlam),[2] its use as a major instrument of public policy has far less ancient roots. It is instead, the private, profit-making madhouses of eighteenthcentury England[3] and, to a far greater degree, the publicly funded county asylums and state hospitals of nineteenth-century England and the United States[4] that mark the advent of an approach to mental illness based on the physical and symbolic segregation of "lunatics"—their isolation in ever larger specialized and purpose-built institutions designed to contain and treat them. It is one of the ironies with which the history of psychiatry abounds that the emergence of the state-sponsored asylum system was itself the outcome of a vigorous campaign for reform; and that, as with the current drive to return the mentally ill to the community, their segregation in these places was urged as being vital on both humanitarian and therapeutic grounds.

During the first half of the nineteenth century, the weight of informed opinion on both sides of the Atlantic embraced an extreme therapeutic optimism. Those who led the crusade to establish state-supported mental hospitals—people like Dorothea Dix in the United States and Lord Shaftesbury in England—saw themselves as rescuing the mad from maltreatment, neglect, and inhumanity, and ushering in a golden age of kindness, scientifically guided treatment, and cure. In this respect, their self-portrait is indistinguishable from their present-day successors. But for Dix and Shaftesbury, the certain recipe for neglect and abuse was to leave the mentally disturbed to the mercies of the community. More often than not, the troublesome qualities of the insane would ensure their confinement in some nonspecialized environment—the gaol, the workhouse, or the private madhouse—whose structural deficiencies (to say nothing of the qualities of those in

charge of those places) made harsh treatment all but inescapable. Even those not abandoned by their families were the unfortunate prey of ignorance, if not callous unconcern. The ministrations of the most devoted relatives, however well meaning, were all too likely to be misconceived, and thus to exacerbate rather than mitigate the underlying problem. Beyond this, "relatives and dependents" were "timid, unskilled, and frequently objects of irrita-

tion,"[5] and the home was precisely the environment that had nurtured the disturbance in the first place.[6]

By contrast, the asylum was portrayed as a technical, objective response to the patient's condition, an environment that provided the best possible conditions for recovery. While relieving the community of the turmoil and disorder at least latently present in madness, it provided those suffering from the condition with a sanctuary, respite from a world with which they could no longer cope. Here they would find a home where they would be known and treated as individuals, while their minds were constantly stimulated and encouraged to return to their natural state. Even the architecture and physical setting of the building could make a vital contribution to its success, by avoiding all impressions of confinement, emphasizing cheerfulness, offering an aesthetically pleasing design, and allowing a maximum of organizational flexibility.[7] Coupled with an expertly chosen and carefully supervised staff, this milieu would secure kindly, dedicated and Unremitting care, carefully adapted to the needs and progress of the individual case.

On the one hand, therefore, nineteenth-century reformers promoted a vision of the asylum as providing a forgiving environment in which humane care on a large scale was possible and in and through which a very substantial proportion of "lunatics" could be restored to sanity. The converse of this portrait, however, was an elaborate and prolonged campaign to impress others with the gross unsuitability of the family and community as arenas for the treatment of the insane, and with the need to insulate the insane from the pressures of the world. Repeatedly, the reformers used their speeches and memorials to contrast the horrors of these alternative dispositions with idealized portraits of the asylum's beneficence. Harnessing the combined forces of humanity and science, they had protected future generations of the insane from the trials endured by poor Mary Jones, a Welsh lunatic whose family had kept her

> on a foul pallet of chaff or straw . . . in a dark and offensive room over a blacksmith's forge. . . . Here she had been confined for a period of fifteen years and upward. She was seated in a bent and crouching posture on her bed of nauseous and disgusting filth. Near to her person was a cup emptied from time to time into a chamber utensil. This last vessel contained a quantity of feculent matter, the accumulation of several days. By her side were the remnants of some food of which she had partaken. . . . The stag-

> nant and suffocating atmosphere, and the nauseous effluvia which infected it, were all but intolerable.[8]

Yet if the mentally disordered in the latter half of the nineteenth century were no longer subjected to confinement of this sort, the change in their situation was hardly one the reformers had envisaged. The small, intimate institution devoted to the cure and humane care of its inmates proved to be a chimera of its planners' imaginations. By the last third of the nineteenth century, public asylums on both sides of the Atlantic had become mammoth institutions, huge custodial warehouses in which the conditions of the patients' existence departed further and further from those in the outside world, for their return to which their incarceration was still ostensibly preparing them. Even gross statistics serve as an accurate indicator of the basic character of these places. The average size of county asylums in England was little short of a thousand patients by the end of the century, and, as in the United States, there were several "hospitals of patients and employees of three thousand, four thousand, and even higher."[9] Necessarily in such vast lunatic colonies, "all transactions, moral as well as economic, must be done wholesale," as their sheer "number renders the inmates mere automatons, acted on in this or that fashion

according to the rules governing the great machine."[10]

Thus, for active cruelty the reformers had succeeded in substituting the "monstrous evils" of "idle monotony." In what typically became "a mere house of perpetual detention," there was an "utter absence of any means of engaging the attention of the patients, interesting them in any occupations or amusements or affording them a sufficient variety of exercise outdoors."[11] Consequently, those who bothered to examine the inside of the asylum would find "patients in the prime of life sitting or lying about, moping idly and listlessly in the debilitating atmosphere of the wards, and sinking gradually into a torpor, like that of living corpses." Men and women "who have lost even the memory of hope, sit in rows, too dull to know despair, watched by attendants; silent, grewsome [*sic*] machines which eat and sleep, sleep and eat."[12]

In the face of the growing crisis of institutional legitimacy to which these conditions ultimately gave rise, the early twentieth century witnessed a further round of reform, one designed to reinvigorate the asylum and restore it to its original curative function. David Rothman[13] has recently dissected the American period of this second generation of reforms, those of the so-called progressive era, and shown how vast the gap between rhetoric and reality remained, how little, in fact, was changed, despite the ostensibly new emphasis on flexibility, discretion, and the carefully adapted treatment of the individual case. Indeed, the failure of this episode to produce more than cosmetic "improvements," such as the relabeling of asylums as mental hospitals, had already been documented indirectly by that explosion of sociological studies of the mental hospital as "total institution" that marked the 1950s and 1960s. (Since that body of research plays an important, yet controversial, role in the community care movement, I shall discuss it at more length shortly.)

More vividly, and for a wider audience, the same basic message was periodically reiterated in journalistic exposés of the deficiencies of the mental hospitals. Perhaps best-known of the latter genre, certainly in the United States, was Albert Deutsch's *The Shame of the States* . Although Deutsch was certainly no foe of institutional psychiatry, here the wheel seems once more to come full circle, with descriptions of the inmate circumstances bearing an almost eerie resemblance to the ones the original generation of reformers had proffered as irrefutable evidence of the need for an asylum system. At Byberry, for example, "the male incontinent ward was like a scene out of Dante's Inferno. Three hundred nude men stood, squatted, and sprawled in this bare room, amid shrieks, groans, and unearthly laughter. Winter or summer, these creatures were never given any clothing at all. Some lay about on the bare floor in their own excreta. The filth-covered walls were rotting away."[14] Scenes he had witnessed elsewhere reminded him, as they did other observers, of nothing so much as the death camps they had recently viewed at Dachau, Belsen, and Buchenwald.[15]

What is remarkable as one looks back on this 200-year "history of reform without change"[16] is how consistently those in charge of the system, indeed society as a whole, sought to deflect attention away from the horrors of the present by resurrecting the tales of the barbarities of the past. Indeed, it is perhaps not too much to claim that one of the main ideological tasks of the history of psychiatry has been to manufacture reas-

surance of this sort, supplying us with a seemingly inexhaustible store of exemplary tales to document the inhumanities of earlier generations and the heroic struggles through which we arrived at our present (relative) state of grace and enlightenment.

The first generation of reformers seized on this splendid collective defense mechanism almost as soon as their visions began to turn sour. As early as 1845, surrounded by clear signs of the collapse of the very things they had previously urged as indispensable to the whole enterprise, they sought solace in the thought that "the worse asylum that can at this day by possibility be conceived, will still afford great protection" to the poor lunatic, when compared to his or her fate if left to the tender mercies of the community.[17] Later in the century, defenders of the asylum system subtly shifted their ground: the standard of comparison by which the "success" of the asylums was to be judged was not the goals that the reformers had set for themselves, but rather the worst conditions the mad had been

found in prior to the enactment of protective legislation.[18] And given such a starting point, it was naturally all but impossible *not* to find evidence of improvement, no matter how dismal the reality one confronted.

Ironically enough, in the most recent variant of this by-now-hallowed ploy the negative referent is not the squalor and viciousness of the period before the work of Pinel and Tuke liberated the mad from their chains and secured for them the blessings of treatment in the mental hospital. Nor is it some dark episode in the asylum's history when, notwithstanding the existence of policy based on the best and most honorable intentions, things went temporarily and inexplicably wrong. Rather, the new target of reformist energy, the evil crying out for abolition, is the mental hospital itself. Instead of basking in their role as "the most blessed manifestation of true civilization the world can present,"[19] even the most up-to-date institutions find themselves denounced as harmful and antitherapeutic, and their destruction is urged as "one of the greatest humanitarian reforms and the greatest financial economy ever achieved."[20] Thus, over the past quarter of a century in what must surely rank as an extraordinary reversal of effort, the energy and resources once devoted to giving the illusion of reality to the chimera of the hu-

mane and curative asylum have instead been employed in the elaboration and documentation of its irredeemable flaws and deficiencies. From the late 1950s through the mid-1970s a veritable flood of social scientific research elucidated the baneful effect of confinement in an institution. The most famous and influential of these studies was undoubtedly Erving Goffman's *Asylums,* [21] though that work in many ways was simply the most rhetorically persuasive presentation of a widespread scholarly consensus.

Studies of institutions as diverse as research hospitals Closely associated with major medical schools,[22] expensive, exclusive, and well-staffed private facilities,[23] and undermanned and underfinanced state hospitals[24] all revealed a depressingly familiar picture. Apparently, "life in such a community tended inexorably to attenuation of the spirit, a shrinking of capacity, and slowing of the rhythms of interaction, a kind of atrophy."[25] In the light of this research, it now appeared that, so far from sheltering the disturbed and helping to restore them to sanity, the mental hospital performed "a disabling, custodial function."[26] Moreover, this conclusion appeared to be the more plausible in the light of the striking convergences among those working in such widely different settings, for as Belknap put it, the very "similarity of these problems strongly suggests that many of the serious problems of the state hospital are inherent in the nature of mental institutionalization rather than simply in the financial difficulties of the state hospitals."[27]

Echoing one of the central themes of this work, major American psychiatrists, particularly those in university settings, began to express fears that "the patients are infantile . . . because we infantilize them."[28] Instead of being a positive influence, mental hospitals threatened to amplify and even produce disturbance. Such ideas also acquired widespread currency on the other side of the Atlantic, where the work of

men like Duncan McMillan and T. P. Rees, British pioneers of the concept of the open hospital, was held to provide unambiguous support for the notion "that much of the aggressive, disturbed, suicidal, and regressive behavior of the mentally ill is not necessarily or inherently a part of the illness as such but is very largely an artificial by-product of the way of life imposed on them [by hospitalization]."[29] Another British psychiatrist, Russell Barton, even ventured to give this iatrogenic phenomenon the status of a new psychiatric label of its own—"institutional neurosis."[30]

Seen in the context of this general intellectual climate, many of the details of Goffman's arguments in *Asylums* are not in the least original. The importance of his essays lay rather in the skill with which he deployed and then extended conventional wisdom and in the adroitness with which he made use of limited evidence of often dubious validity to advance some extremely general claims. Though the reader is hard-put to recall the fact, Goffman's primary data source is a relatively brief period of field observation in a single hospital, St. Elizabeth's in Washington, D.C., a data base that in other hands would have produced still another ethnography of a particular institution. In this case, however, the

outcome is a general delineation of an organizational type to which *all* mental hospitals belong—along with prisons, monasteries, military schools, old-age homes, and concentration camps. Replete with vivid "references to mortifications that disrupt, defile, assault, or contaminate the self,"[31] Goffman's account of these "total institutions" provides a powerful indictment of such places as engines of degradation and oppression, a finely rendered "symbolic presentation of organizational tyranny, and a closed universe symbolizing the thwarting of human possibilities."[32]

Oddly enough, given his interactionist sensibilities, the central feature of the portrait Goffman sketches is an inevitable and powerful structural determinism. By its very nature, the mental hospital (not unlike Dickens' Marshalsea) manufactures the human materials that justify its existence. The crucial factor in forming mental patients is their institution rather than their illness. And their reactions and adjustments, pathological as they might seem to an outsider, are the product of the ill effects of their environment (with all its peculiar routines and deprivations) rather than the natural outcome of an unfolding intra-individual pathology.

As I suggested earlier, there are serious weaknesses in the evidentiary base on which these extraordinary far-reaching claims rest. There is, for

example, not even a token attempt in Goffman's work to confront the issue of what explains inmates' presence in the mental hospital in the first place. We are instead supposed to rest content with an unsubstantiated claim that they are the victims of "contingencies," somehow "betrayed" into the institution by their nearest and dearest (for reasons that remain entirely obscure). The "blame" for their situation, then, lies not at all in their own conduct or mental state, but rather in a conspiracy of others to secure their exclusion from society. Likewise, questions of the social location of madness and of the kind of existence to which hospitalization is an alternative are simply passed over in silence. And perhaps most notably of all, there is not even an attempt to generate valid and reliable evidence essential to any credible assessment of the respective contribution of intrapsychic and environmental influences to what he calls the "moral career of the mental patient." As Craig McEwen puts it, "Goffman's analysis has persuaded readers as much by its literary power as by the weight of its evidence"; indeed it relies for its persuasiveness on our willingness to take "literary metaphor as established fact."[33]

Yet there is no shortage of people (and policymakers) willing to make precisely that leap of faith. In the process, the chilling equation of the mental hospital and the concentration camp, originally the hyperbole of muckraking journalists, has now acquired the mantle of academic respectability. Ideologically, this is a development of profound significance, for it has effectively legitimized "community treatment," not by a careful demonstration of its merits (which would require systematic attention to its practical implementation), but by rendering the alternative simply unthinkable. Who, in the circumstances, would even attempt to dispute the claim that "the worst home is better than the best mental hospital"?[34]

It was this climate of opinion that over more than two decades, from the mid-1950s onward, allowed the portrayal of the simple decline in mental hospital censuses and in length of stay in the hospitals as an unambiguous reform and improvement. Measured in this crude yet easily quantifiable way, the "success" of community care in both England and America is easily shown, though the speed and extent of the changes has varied between the two societies. From the earliest years of the statefunded mental hospital system in the nineteenth century a pattern was established in both societies of consistent and almost uninterrupted increase in in-patient population. This remorseless increase was such that in the United States during the first half of the twentieth century, "the public mental hospital population had quadrupled . . . , whereas the gen-

eral population had only doubled."[35] In England, the timing of the rise was somewhat different, with the most spectacular increases coming in the last half of the nineteenth century, but even here the hospital census all but tripled between 1890 and 1950.

This pattern of uninterrupted growth was abruptly reversed in the mid-1950s. First in

England, then in the United States, the in-patient census began to fall. As Table 1 shows, the population of English mental hospitals had decreased from little short of 150,000 in 1954 to some 75,000 in 1980. In the United States, the decline began two years later, and from a maximum of approximately 560,000 had fallen to only 171,500 some twenty years later, and to 132,000 by 1980 (Table 2). Allowing for population growth, of course, the break with historical trends was even more dramatic than these data would indicate. In the United States, for example, had the size of the hospital population relative to the total population remained constant (and historically the tendency was for it to rise faster than the general population), by 1975 the mental hospitals would have contained some three-quarters of a million people.

As comparison of Tables 1 and 2 reveals, once the in-patient census began to decline, it did so each and every year in both countries. This common experience is the more remarkable given that both societies were also experiencing a simuhaneous and sharp increase in *admissions* to mental hospitals. Between 1955 and 1968, admissions to mental hospitals in England and Wales rose from 78,586 per year to 170,527; and although admissions dipped to 169,864 in 1970, this was still more than twice the number admitted in 1955. The rise in admissions has been equally steady and of similar magnitude in the United States. Whereas approximately 185,000 were admitted to mental hospitals in 1956, by 1970 the figure was 393,000 (although, once more, there was a slight decline after this). Statistically speaking, therefore, the decline in mental hospital populations reflects a policy of greatly accelerated discharge. In the United States, for example, whereas, in 1950, the average stay in a state mental hospital was over twenty years, by 1975, it was no more than seven months.

Still, if deinstitutionalization has shared certain features in the two societies, even the gross statistics in Tables 1 and 2 suggest that there have also been important divergences. In both England and the United States, during the first ten years of declines in their hospital populations the dips were consistent but relatively small. But while the English in-patient population continued a mostly steady 2 or 3 percent per annum de-

TABLE 1 Resident Population of Mental Hospitals in England and Wales, 1951–80

Year	*Number Resident*	*Year*	*Number Resident* *
1951	143,200	1966	121,600
1952	144,600	1967	118,600
1953	146,600	1968	116,400
1954	148,100	1969	105,600
1955	146,900	1970	103,300
1956	145,600	1971	103,000
1957	143,200	1972	100,000
1958	142,800	1973	94,000
1959	139,100	1974	90,000
1960	136,200	1975	87,000
1961	135,400	1976	83,800
1962	133,800	1977	80,800
1963	127,600	1978	78,200
1964	126,500	1979	76,500
1965	123,600	1980	75,200

SOURCES: Figures for 1951–60 from E. M. Brooke, "Factors in the Demand for Psychiatric Beds," *The Lancet*, 8 December 1962, 1211 (by permission). Figures for 1961–70 supplied by the Department of Health and Social Security (DHSS). Figures for 1971–80 from DHSS, *Health and Personal Social Services Statistics for England* (London: HMSO, 1982).

Note: All figures are rounded.
* Figures for 1971–80 are for average daily number of in-patients, rather than for total patients resident as of 31 December.

crease, its American counterpart began to decline much more rapidly. The major source of the difference lies in the treatment of the senile and the mentally ill elderly. In England, persons over 65 do not constitute a disproportionate fraction of those discharged from mental hospitals.[36] Beginning in the latter 1960s, however, the contrary is true in the United States. Between 1969 and 1974 alone, the number of patients over 65 in state and county mental hospitals nationwide fell by 56 percent, from 135,322 to 59,685.[37] In individual states, the decline was steeper yet. In 1968, a memorandum from the New York state commissioner of mental hygiene ordered the implementation of more restrictive admissions of the elderly, leading to a fall in hospital cases from 78,020 to 34,000 by

TABLE 2 Resident Population in State and County Mental Hospitals in the United States, 1950–80

Year	*Number Resident*	*Year*	*Number Resident*
1950	512,500	1966	452,100
1951	520,300	1967	426,000
1952	532,000	1968	400,700
1953	545,000	1969	370,000
1954	554,000	1970	339,000
1955	558,000	1971	309,000
1956	551,400	1972	276,000
1957	548,000	1973	255,000
1958	545,200	1974	215,600
1959	541,900	1975	191,400
1960	535,000	1976	171,500
1961	527,500	1977	159,500
1962	515,600	1978	153,500
1963	504,600	1979	140,400
1964	409,400	1980	132,200
1965	475,200		

SOURCES: National Institute of Mental Health (NIMH), *Trends in Resident Patients, State and County Mental Hospitals, 1950–1968* (Washington, D.C.: Department of Health, Education, and Welfare, 1972); idem, "Provisional Patient Movement and Administrative Data State and County Mental Hospital Inpatient Services," Mental Health Statistical Note, no. 114 (Washington, D.C.: Department of Health, Education, and Welfare, 1975); Biometry Branch, NIMH.

Note: All figures are rounded.

1973, a decrease of 64 percent in five years. As Table 3 (page 320) shows, other states were even more "successful" than this.

As I shall discuss at greater length later, this pattern of accelerated discharge both reflects and depends on some broad differences in the practical implementation of deinstitutionalization in England and the United States. I have pointed out that one major ideological defense of the decanting of patients from mental hospitals has been the essentially negative one that life in a state-run "total institution" was so irredeemably awful that the mere absence of its detorming, dehumanizing pressures must be an improvement. Some of the deinstitutionalization's supporters have been content with this claim to be guided by a belated recognition of "the limits of benevolence"[38] and have argued that this round of reform rests on a prudent recognition of the need to concentrate on avoiding harm rather than doing good.[39] In most quarters, however, the movement back to the

community has involved the invocation

of millennial claims not very different from those that accompanied its predecessors in the history of psychiatric reform. In Paul Rock's apt phrase, most of the advocates of community treatment have sought to picture the community as a kind of "secular Lourdes providing inexpensive redemption"[40] to the lame, the halt, the morally unfit, and the mentally maimed.

Gliding silently over the reality of the increasingly segmented, isolated, and atomized existence characteristic of late capitalist societies, those active in promoting the community approach to serious forms of mental disorder argued that the very locus of treatment could prove therapeutic. By not segregating the mentally ill from the rest of us, the community approach would help to keep them integrated with their neighbors, and even where those linkages had already been strained or fractured, would more readily permit a reestablishment of social ties with "normal" society. Instead of the passive and dependent behavior nourished by institutional existence, community care would restore independence and initiative. Possibly with some assistance from an outpatient clinic located at a general hospital or, in the United States, from one of the new community mental health centers, patients would find their needs provided for with minimal disturbance to their existing living arrangements and in ways that preserved and protected their basic social capacities.

To an extraordinary extent, however, expectations like these rested upon *a priori* reasoning rather than empirical demonstration; and, as Kirk and Thierren have pointed out, the notion that they even remotely correspond with actual outcomes is simply a myth, "reflecting more the intentions and hopes of community mental health than the uncomfortable realities."[41]

In the midst of all the excitement about the replacement of the mental hospital and the breathless proclamations about the virtues of the community, few people noticed the degree to which the new programs remained castles in the air, figments of their planners' imaginations. Nor did many appear to realize, for some considerable time, that despite all the rhetoric on both sides of the Atlantic about "better services for the mentally handicapped" (the title of an official statement of British policy),[42] the reality was the much darker one of retrenchment or even elimination of state-supported programs for victims of severe and chronic forms of mental disorder. As Peter Sedgwick put it, with pardonable sarcasm, "The reduction in the register of patients . . . has been

achieved through the creation of rhetoric of 'community care facilities' whose influence over policy in hospital admission and discharge has been particularly remarkable when one considers that they do not, in the actual world, exist."[43]

Sooner or later, however, any audience becomes disenchanted with a shell game in which there is no pea. For almost a quarter century, there was a remarkable dearth of "major research projects of academic respectability that [showed] either the extent of the need or the extent of the failure" of mental health policy.[44] But more recently, the implementation of community care has finally begun to attract more critical attention, much of it journalistic, but some of it (belatedly) from scholarly sources.[45] In consequence, it is now generally conceded that, on both sides of the Atlantic, a policy of deinstitutionalization was implemented with little or no prior consideration of such basic issues as where the patients who were released would end up; who would provide the services they needed; and who would pay for those services.[46] What is perhaps more surprising, the massive reassignment of patients has continued in the face of continuing lack of attention to these matters, with the predictable consequences I shall discuss shortly.

Given the general emphasis on the therapeutic value of reintegration into the community, and leaving to one side the fact that "the belief in the value of reintegration has been devoid of any systematic analysis of what constitutes a relevant community,"[47] one might have "expected that, by now, a substantial body of research would have been built up to demonstrate the advantages that accrue when the educational, occupational, domestic, and protective functions of mental hospitals are taken over by alternative

agencies. In fact, such studies [as exist] . . . have been,

in the main, descriptive rather than experimental, and are rarely epidemiological in nature, so that it is difficult to know how far the results can be generalized."[48] For example, the study of Pasamanick and his associates[49] which is often cited as demonstrating the feasibility of maintaining schizophrenics in the community, deals only with those who are members of intact families, who, as we know, form only a very small percentage of long-term mental patients. Moreover, a subsequent follow-up study with even these patients produced much less favorable findings, possibly the result of the failure of the authorities to maintain adequate funding for the program.[50] On the other side of the equation, we also lack thoughtful and careful analysis, based on a sufficiently representative sample of ex-patients, of the social and economic costs of maintaining such people in the community—defining cost in the broadest sense and moving beyond a narrow concern with fiscal costs to the state to incorporate a consideration of human as well as monetary costs to the patients, their families, and the community at large.

Ex-patients, and those who would formerly have been sent to mental hospitals (for many jurisdictions have sharply cut back the criteria justifying commitment), are to be found, of course, in a wide variety of settings, and attempting to generalize about their situations is necessarily a hazardous business. The problem is intensified by "the paucity of followup studies whose data can be generalized and compared and that trace the movement of discharged patients through the labyrinth of psychiatric facilities and living conditions after their release."[51] And it is, of course, still more acute when one is discussing more than one country. Among state mental health bureaucrats, ignorance about the fate of their former charges is often so great that they may not even know where the discharged patients are to be found.[52] A recent American study, for example, discovered with disconcerting regularity that "information on what happened to former mental hospital patients and residents in institutions for the retarded was generally not available. Follow-up of released patients was generally haphazard, fragmented, or nonexistent."[53]

One thing is certain: the overwhelming majority of them are not being serviced by the new community mental health centers. The existence of several hundred of these federally sponsored centers in the United States has fostered the comforting notion, particularly among overseas observers,[54] that those discharged from state hospitals have simply been transferred to a setting that provides a more modern and effective way of delivering treatment. Such assumptions are quite natural. (After all, the patients are allegedly being discharged to receive "community treatment," and the community mental health centers are one of the few places where community treatment is conceivably being dispensed.) Nevertheless, they are also quite mistaken. Even if one disregards the centers' uneven geographical distribution and their current fiscal problems, it remains the case that neither their ideology nor their most common services are "directed at the needs of those who have traditionally resided in state psychiatric institutions."[55] From the outset, those running the new centers have displayed a pronounced preference for treating "'good patients' [rather] than chronic schizophrenics, alcoholics or senile psychotics"[56] —in other words, precisely a desire not to treat the patients being discharged from state institutions. Unsurprisingly, therefore, studies show "no large consistent relationship between the opening of centers and changes in state hospitals resident rates."[57] Indeed, National Institute of Mental Health data demonstrate that "public mental hospitals accounted for fewer referrals to community mental health centers [less than 4 percent] than any other referral source reported, except for the clergy."[58] Partly as a consequence, community health centers "have no direct bearing on the bulk of publicly funded mental health care in the public sector."[59]

Nevertheless, some of those discharged from mental hospitals have unambiguously benefited from the shift in social policy. Victims of an earlier tendency toward what the Wolperts have called "overhospitalization,"[60] they have experienced few problems obtaining employment and housing, maintaining social ties, and so forth, blending all but impercep-

tibly into the general population. Such benign outcomes are, however, far from constituting the norm.

Rather as one might expect, among those with more noticeable continuing impairment, ex-patients placed with their families seem on the whole to have fared best. Even here, there have been costs, sometimes serious costs. John Wing has recently expressed "surprise" that, in view of the greatly increased likelihood of someone with schizophrenia living at home instead of in a hospital, so little research is being done on the problems experienced by their relatives.[61] His own work, and that of his associates, has provided us with much of what little data we do possess on this subject and demonstrates that "the burden on relatives and the community was rarely negligible, and in some cases it was intolerable."[62] A good deal of the distress and misery has remained hidden because of families' reticence about complaining—a natural tendency, but one that has helped sustain a false optimism about the effects of the shifts to community treatment. As George Brown puts it, "relatives are not in a strong position to complain—they are not experts, they may be ashamed to talk about their problems and they have come to the conclusion that no help can be offered which will substantially reduce their difficulties."[63] (Such conclusions may have a strong factual basis, in view of the widespread inadequacies or even absence of after-care facilities and the reluctance, often refusal, of the authorities to countenance rehospitalization.) The new policy has thus unquestionably seen "a considerable burden being placed on the health, leisure, and finances of the families [involved]."[64] The evidence may not be sufficient yet to warrant Arnhoff's claim that "the consequences of indiscriminate community treatment may often have profound iatrogenic effects. . . . We may be producing more psychological and social disturbance than we correct."[65] But at the very least, we must recognize that "if . . . state policy is to shift more responsibility on to 'the family,' then the physical and psychological burdens on individuals will increase disproportionately."[66]

Their public silence and lack of protest notwithstanding, more research into these families' situations is clearly essential. Yet even without that additional research, we know that one consequence of the new policies is all but certain: "community care," in this form at least, means tying down women in traditional servicing roles for their disabled kinfolk. To put it another way, in the absence of "genuine, socially funded resources of community care, [attempts] to loosen the tyranny of the mental institution [proceed at the price of] re-enforcing an archaic sexual division of labour."[67]

Yet whatever the difficulties encountered by these ex-patients and their families, they pale by comparison with the experiences of the greater number of ex-patients who have no families or whose families simply refuse to accept responsibility for them. Particularly in the United States the precipitous decline in mental hospital populations from the mid-1960s onwards has been matched by an equally dramatic upsurge in the numbers of psychiatrically impaired residents of nursing homes. This trend is particularly marked among, but not confined to, the aged mentally ill. Table 3 suggests how rapid and complete the elimination of the elderly from American state hospitals has been. That the majority of them have simply been transferred from one institutional setting to another is suggested by the fact that between 1963 and 1969 the number of nursing home inmates with mental disorders virtually doubled,[68] and evidence from the National Center for Health Statistics shows a further 48 percent increase through mid-1974, from 607,400 to 899,500.[69] Data from the National Institute of Mental Health show that by the mid1970s, nursing homes had become the "largest single place of care for the mentally ill," absorbing 29.3 percent of the direct costs associated with coping with them.[70] More than 50 percent of these nursing home residents were placed in facilities with more than a hundred beds, and more than 15 percent in "homes" with more than 200 beds.[71]

These numbers alone might cause one to suspect that "the return of patients to the community has, in many ways, extended the philosophy of custodialism to the community rather than ending it at the gates of the hospital."[72] But there is a growing volume of more direct evidence that demonstrates the "ghettoization of the returning ex-patients along with other dependent groups in the population; the growing succession of inner city

land use to institutions providing services to the dependent

TABLE 3 In-patients over 65 in State Mental Hospitals in Selected States			
State	*1969*	*1974*	*Reduction (%)*
Alabama	2646	639	76
California	4129	573	86
Illinois	7263	1744	76
Massachusetts	8000	1050	87
Wisconsin	4616	96	98
SOURCE: Senate Special Committee on Aging, *Role of Nursing Homes*, 719.			

and needy . . . the forced immobility of the chronically disabled within deteriorated urban neighborhoods . . . areas where land use deterioration has proceeded to such a point that the land market is substantially unaffected by the introduction of community services and their clients."[73] The 1977 General Accounting Office study of deinstitutionalization reported "a general tendency to place formerly institutionalized persons in those nursing homes where the quality of care was poorer and safety standards not complied with as rigidly as in other nursing homes. . . . Generally speaking, the more mental patients there were in a facility, the worse the conditions."[74] Despite their titles, these places frequently provided neither nursing nor a home. In the words of an Oregon Task Force, "a typical day for a mentally ill person in a nursing home was sleeping, eating, watching television, smoking cigarettes, sitting in groups in the largest room, or looking out the window [*sic*]; there was no evidence of an organized plan to meet their needs."[75] To make matters worse, state agencies typically provide few or no follow-up services, and little in the way of effective supervision or inspection. In the absence of such controls and lacking the bureaucratic encrustations of state enterprises, nursing home operators have found ways to pare down on even the miserable subsistence existence characteristic of state institutions.

Of course, many discharged mental patients of all ages end up in other, perhaps still less salubrious settings—board-and-care homes and so-called welfare hotels. In Philadelphia, for example, a Temple University study revealed that some 15,000 ex-patients were living in approximately 1,500 boarding homes in the city. In New Jersey, a whole new industry has sprung up, utilizing the huge, cheap, run-down Victorian hotels in formerly fashionable beach resorts as accommodation for several thousand more discharged mental patients. In New York, there have been repeated media exposés of the massive concentrations of ex-

inmates in the squalid single-room occupancy welfare hotels of the upper west side of Manhattan and in the Long Island communities surrounding Pilgrim and Central Islip state hospitals. Many of the boarding homes in the latter area, in a pattern which is becoming all too familiar, were opened by those formerly employed by the state hospitals.[76] In Michigan, the pattern is depressingly similar:

> Many of the foster care homes serving the mentally disabled were in innercity areas with high crime rates, abandoned buildings, sub-standard housing, poor economic conditions, and little or no recreational opportunities. Of a total of 378 community placement residences in Detroit serving the mentally disabled, 165 were located in the inner-city, with 101 on one street. State officials attributed this to the availability of large homes at relatively low prices . . . and to restrictive zoning which limits after-care homes to the older, run-down sections of the city. Although the number of mentally disabled in these facilities was not known, it has been estimated to be several thousand. The only service being provided many released mentally ill patients was medication.[77]

Such developments have not occurred without implicit and explicit state sponsorship and encouragement. In New York State, the scandals associated with the connections between the board-and-care industry and the political establishment eventually forced a full-scale inquiry and subsequent prosecutions.[78] Pennsylvania, with remarkable foresight, repealed its provisions for inspecting boarding homes the same year (1967) it began "a massive deinstitutionalization program aimed at moving patients out of mental hospitals into community programs."[79] Hawaii faced a massive shortage of beds in licensed boarding homes when it adopted a policy of accelerated discharge. The problem was resolved, with unusual bureaucratic flexibility, through "the proliferation, with the explicit encouragement of the state mental health division, of unlicensed boarding homes for the placement of ex-hospitalized patients."[80] Nebraska at first shied away from such a laissez-faire approach, deciding apparently that some form of state oversight was called for. Accordingly, in a splendidly original variant on the ancient practice of treating the mad like cattle, the state placed licensing and inspection of the boardand-care homes in the hands of its state Department of Agriculture. Subsequent citizen complaints about the resulting conditions led to the

withdrawal of licenses, but not the *patients*, "from an estimated 320 of these homes, leaving them without state supervision or regulation."[81] Missouri simply noted the existence of some "755 unlicensed facilities in [the] State housing more than 10,000 patients"[82] and continued to dispense the state funds on which their operators depended. And still other states, like Maryland and Oregon, opted for perhaps the safest course of all—no follow-up of those they released, and hence a blissful official ignorance about their subsequent fate.[83]

Such systematic academic research as has been done on conditions in board-and-care facilities (and again the research is noticeable mainly by its absence) confirms the picture. Lamb and Goertzel concluded that "it is only an illusion that patients who were placed in board and care homes are 'in the community.' . . . These facilities are for the most part like small long-term state hospital wards isolated from the community. One is overcome by the depressing atmosphere, not because of the physical appearance of the boarding home, but because of the passivity, isolation, and inactivity of the residents."[84] Kirk and Thierren use remarkably similar language to describe their findings in Hawaii: "Many ex-patients are placed in 'ward-like' environments where they are supervised by exstate hospital staff, and they participate in a state hospital routine, albeit now 'in the community.' But many of these former patients do not even have the limited involvement provided by a day hospital. They spend the majority of their time in a boarding home which promotes dependency, passivity, isolation and inactivity."[85]

In the United States over the past quarter century, with the wholesale assistance of federal funds—Supplemental Security Income (SSI), Medicaid, Medicare, and so forth—mental patients have been transformed into a commodity from which various professionals and entrepreneurs extract a profit. The consequence has been the emergence of a new "trade in lunacy"[86] that in many ways bears a remarkable resemblance to the private madhouses that were employed to deal with the mentally disordered and distracted in eighteenth-century England. In that earlier period, anyone could enter this business, and there was no regulation of conduct, with the result that gross exploitation and maltreatment of patients were commonplace. As critics at the time pointed out, in such "trading speculations [operated] with a view to pecuniary profit . . . the extent of the profit must depend on the amount that can be saved out of

the sum paid for the board of each individual."[87] Proprietors must therefore "have a strong tendency to consider the interests of the patients and their own at direct variance."[88] Given free entry into the business and the difficulties associated with the inspection and supervision of a multitude of operations, the least scrupulous were likely to be the most successful, and appalling results were all but structurally guaranteed. So it proved: It was precisely the abuses to which this system was prone that led to a campaign for reform and to the establishment of England's state mental hospitals.[89]

Again the cycle is repeating itself. We now live in a period, also hailed as an era of

reform, when anyone can open a boarding home for mentally ill patients discharged from the state system. Once more the mentally disturbed are at the mercy of speculators who have every incentive to warehouse their charges as cheaply as possible, since the volume of profit is inversely proportional to the amount expended on the inmates.[90]

At the beginning of this chapter, I alluded to the case of Mary Jones, one of a number of "exemplary tales"[91] the nineteenth-century reformers used to point out the horrors of the nonasylum treatment of the insane. Contrary to their expectations, horrors of a virtually identical sort continued to be generated by the mental hospitals they succeeded in establishing.[92] Recent investigations suggest that they continue unabated in the new community settings. I must confess that beyond a certain point I have difficulty calibrating human misery, but certainly the condition of a

Mrs. Bond, an ex-patient found in an Illinois nursing home seems to differ little if at all from that of her Welsh counterpart of the midnineteenth century. As the Senate Committee on Aging reported:

> Mrs. Bond was covered with decubiti (bed sores) from the waist down, that decubiti on the hips were the size of grapefruit and bones could be seen; that the meatus and the labia were so stuck together with mucous and filth that tincture of green soap had to be used before a Foley Catheter could be inserted; that her toes were a solid mass of dirt which stuck together and not until they had been soaked in TID for three (3) days did the toes come apart; that body odor was most offensive; edema of feet, legs, and left hand.[93]

On a less lurid level, we possess a handful of studies that systematically compare the social functioning and clinical condition of hospitalized chronic patients with those of their counterparts in quasi-institutional community settings. "From both American and Canadian studies we have reports that fewer of the [hospitalized] patients were incontinent, fewer took no part in bathing, more were able to bathe without help, fewer took no responsibility for their own grooming, more dressed without assistance, fewer failed to dress and remain in hospital gowns, and more had money available and were capable of making occasional purchases."[94] More dramatically, a number of studies appear to demonstrate a close correlation between the relocation of chronic patients and sharp increases in their mortality rates.[95]

Intended as a cheap alternative to the state hospital, the ramshackle network of board-and-care homes and welfare hotels stand as an indictment of contemporary American mental "health" policy. They constitute perhaps the most extreme example of what has become the new orthodoxy, an "almost unanimous abdication from the task of proposing and securing any provision for a humane and continuous form of care

for those mental patients who need something rather more than shortterm therapy for an acute phase of their illness."[96] Here, ecologically separated and isolated from the rest of us, the most useless and unwanted segments of our society can be left to decompose quietly and, save for the occasional media exposé, all but invisibly.

In view of the depths of the misery and maltreatment associated with recent American mental health policy, Kathleen Jones' claim that "so far the United States has made a much better job of the business of deinstitutionalization"[97] would, if accurate, constitute an even more damning indictment of British practice than she perhaps intended. Apparently what led her to make this unfortunate assertion was the combination of a relatively intimate knowledge of the failures of British policies with a rather naive acceptance at face value of the claims made by American advocates of deinstitutionalization. And certainly at the level of rhetoric, Americans have by and large been the more active and shameless. Practically, however, the British experience has not (yet?) been quite as awful.

In part the British record is better because deinstitutionalization has simply not been as rapid or far-reaching as in America. In general, the shift away from the mental hospital in both societies has been powerfully influenced by fiscal considerations, the savings realizable by substituting neglect for even minimal custodial care.[98] In the United States, however, these pressures have been magnified by the fragmentation of the political

structure. Care of the mentally ill has traditionally been a responsibility of the states, but deinstitutionalization has been promoted by the states' ability to transfer most of the costs of community support to the federal level. (The causal linkage is particularly plain in the case of the mass discharges of the elderly beginning in the late 1960s.)[99] In the absence of this additional incentive, the rush to empty mental hospitals has been somewhat less headlong in Britain.

Ex-patients there have also for the most part been spared the excesses associated with the new trade in lunacy.[100] The chains of private boardand-care homes and the dilapidated welfare hotels, now so large a part of American mental health "services," have few precise British equiva-

lents.[101] In part, this situation probably reflects the somewhat lower numbers of chronic patients discharged. Undoubtedly too, it also mirrors the more entrepreneurial character of American capitalism and the greater legitimacy accorded to the process of the privatization of state and welfare services[102] in a society still wedded to the myth of "free enterprise."

All these qualifications notwithstanding, the British experience with community care remains dismal and depressing in its own right. As Peter Sedgwick points out,

> In Britain no less than in the United States, "community care" and "the replacement of the mental hospital" were slogans which masked the growing depletion of real services for mental patients; the accumulating numbers of impaired, retarded and demented males in the prisons and common lodging houses; the scarcity not only of local authority residential provisions for the mentally disabled but of day care centers and skilled social work resources; the jettisoning of mental patients in their thousands into the isolated helpless environment of their families of origin, who appealed in vain for hospital admission (even for a temporary period of respite), for counselling or support, and even for basic information and advice.[103]

Kathleen Jones is not unaware of these catastrophic failures masquerading under the official guise of a "revolution" in psychiatric care. It is her awareness of the failures that prompts her bitter comparison of British policy with an idealized, indeed mythological portrait of American practices. For her, much of the blame can be apportioned to administrative lapses. In particular, the reorganization of the British National Health Service in 1973, which eliminated any distinctive organization for the mental health services, left "no administrative focus, no forum for policy debate, and no impetus to personal development. The result is that the British services are now fragmented and to a large extent the personnel are demoralized."[104]

But while poor morale and administrative chaos have certainly contributed to worsening the situation, they are scarcely the major sources of the current difficulties. More centrally important is the absence of the

necessary infrastructure of services and financial supports without which talk about community care is simply a sham. During 1973–74, for example, while 300 million pounds was spent on the mentally ill still receiving institutional treatment, a mere 6.5 million pounds was spent on residential and day care services for those "in the community." Local authority spending on residential facilities for the mentally ill was a derisory 0.04 percent of their total expenditure.[105] Three years later, 116 out of 170 local authorities did not provide a single residential place for the elderly mentally infirm.[106] And more recently still, the intensifying fiscal crisis of the Thatcher-Reaganite years has simply reinforced the existing conservative hostility to social welfare services and made the prospect of providing even minimal levels of supportive services still more remote.[107]

It should be starkly apparent, though, that our collective reluctance to make a serious and sustained effort to provide a humane and caring environment for those manifesting grave and persistent mental disturbance has far deeper roots than the callousness of our contemporary political leadership. The personal disorganization and defective social skills of the sufferers themselves preclude their forming an effective pressure group in their own behalf. In any event, "the stigma attaching still to their various disabilities and illnesses usually prevents most of them from asserting a group identity in public, for purposes of

demonstration or financial appeal,"[108] while their social marginality and dependency are likely to detract from whatever efforts they *do* make. Worse still, chronic psychotics exhibit persistent dependency, and it is unlikely that even the best programs of treatment will produce "recoveries" on any very large scale.

The idea that we bear a collective moral responsibility to provide for the unfortunate—indeed, that one of the marks of a civilized society is its determination to provide *as of right* certain minimum standards of living for all its citizens—has never secured widespread acceptance in the United States. Ideologically, this is a society dominated by the myth of the benevolent "invisible hand" of the marketplace and by a correspondingly amoral individualism. Moreover, in the last decade and a half, this ideology, always congenial to the privileged, has enjoyed a striking resurgence on the other side of the Atlantic. There is little place

(and less sympathy) within such a worldview for those who are excluded from the race for material well-being by chronic disabilities and handicaps—whether physical or mental disease, or the more diffuse but cumulatively devastating penalties accruing to those belonging to racial minorities or living in dire poverty.

The punitive sentiments directed against those who must feed from the public trough extend only too easily to embrace those who suffer from the most severe forms of psychiatric misery. Those who seek to protect the long-term mental patient from the opprobrium visited on the welfare recipient may do so by arguing that the patient is both dependent and *sick* . But I fear this approach has only a limited chance of success. After all, despite two centuries of propaganda, the public still resists the straightforward equation of mental and physical illness. Moreover, the long-term mental patient in most instances will not get better and often fails to collaborate with his or her therapist to seek recovery. Such blatant violations of the norms governing access to the sick role in our societies[109] make it unlikely that chronic schizophrenics will be extended the courtesies and exemptions accorded to the conventionally sick. Instead, even those incapacitated by psychiatric disability all too often find themselves the targets of those who would abolish social programs because they consider any social dependency immoral.

Symptomatic of the status of the chronically mentally ill as the ultimate outsiders is the retreat even of organized psychiatry from any attempt to deal with their problems. Ironically, it was by capturing control in the nineteenth century of the new state-run establishments for the seriously mad that psychiatry both established itself as a profession and ensured medical hegemony in the treatment of mental disorder. But in the long run, this core patient population became a liability rather than an asset. It was, after all, overwhelmingly drawn from the lower classes; it bore the additional stigma of being composed of wards of the state; and psychiatrists discovered that, notwithstanding the extravagant claims of the founders of their enterprise, it was largely beyond the reach of their therapeutic armamentarium. The development, from the late nineteenth century onwards, of a bifurcated profession, saw the creation of a group of higher-status practitioners who increasingly concentrated on an office practice offering a more treatable, more affluent clientele.[110]

But even this expansion of the psychiatric territory only mitigated the

socially contaminating effects of overly close association with an impoverished, clinically hopeless clientele. Hence, perhaps, the alacrity with which the majority of the profession has handed over the task of coping with the chronically psychotic to the operators of nursing homes, boarding houses, and welfare hotels. Psychiatric involvement with such unrewarding cases can now be reduced to the occasional prescription of psychoactive drugs to be dispensed by others, thus providing a bare semblance of "medical" attention. And with these miracles of modern psychopharmacology to hand, our contemporary madhouse keepers possess a restraint with which to subdue their charges, less blatant than the chains and straitjackets employed by their counterparts two centuries ago, and, in consequence, all the more desirable.

Some fifteen years ago, George Brown and his colleagues claimed that "the acid test of

a community service lies in whether it can meet the needs of the seriously handicapped persons who used, in the old days, to become long-stay mental hospital inmates."[111] By even the most generous interpretation of subsequent events, British and American policies have failed to meet that test. Nor should this occasion much surprise. Many of "the most basic needs of the mentally disabled—above all, the needs for housing, for occupation, and for community—are not satisfied by the market system of resource allocation which operates under capitalism."[112] Nor is it realistic to suppose they will be. In this most profound sense, then, Peter Sedgwick is surely correct when he concludes that "the crisis of mental health provision . . . is simply the crisis of the normal social order in relation to any of its members who lack the wage based ticket of entry into its palace of commodities."[113]

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