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Psychiatric therapy in Georgian Britain

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ABSTRACT

Background. This paper examines the emergence of 'moral treatment' in British psychiatry.

Method. Re-examining a range of largely well-known sources, this article begins by outlining the social and intellectual shifts entailed by the secularization of madness at around 1660. The boundaries of various schools of psychiatric treatment are distinguished according to: (*a*) how much moral autonomy they accord the insane patient; and (*b*) whether they promote 'body' or 'mind' first (are 'somatopsychic' or 'psychosomatic'). I have also incorporated newly-discovered material that proves the existence of 'classical moral treatment', or therapeutic argumentation.

Results. The paper outlines four distinct models of psychiatric treatment: 'classical moral treatment'; the 'pious fraud'; 'charismatic stewardship'; and 'moral treatment'. Neither the 'pious fraud' nor 'charismatic stewardship' allowed that the patient was morally autonomous – rather, lunatics were stereotyped as animals. After the 1780s, some psychiatrists began practising in ways that understood the patient as being capable of some rationality. But none of these practitioners saw 'moral' therapies to be independent of the body's workings – they used: (*a*) psychological methods to ease the administration of physic; and/or (*b*) psychological and medical remedies interchangeably. The Tukes, who developed the famous asylum 'The Retreat' at York, were the first to find successful ways to make psychological means predominate in therapy.

Conclusion. The Tukes of York are reinstalled in their position as founders of moral treatment as a therapy aimed at the autonomous human mind.

INTRODUCTION

When and how did psychological treatment enter British psychiatry? Throughout the eighteenth century, London's infamous Bedlam treated its patients with vomits, bleeding and purges on a seasonal basis, and recent scholarship confirms it to be 'true that Bethlem's medical officers remained committed into nineteenth century to traditional depleting and antiphlogistic remedies' (Andrews *et al*. 1997, p. 260). Others had different ideas: when King George III went mad in 1789, Francis Willis treated him medically, with cupping-glasses and doses of bark, but also by training the King to behave calmly and compliantly, with a personalized regime of threats and rewards. There was a kind of psychology at work here, but it was unsophisticated, and Willis continued to use harsh medicines. A revolution was around the corner:

> There is near York a retreat for lunatics, which appears admirably managed, and almost entirely by *reason* and kindness … Most of the patients move about at liberty, without noise and disorder, [and with] demure and grave deportment … Some of the patients are allowed to go out of the premises, and even to town alone. (Hibbert, 1968, pp. 109–110.)

This was 'The Retreat', an asylum founded by the Tuke family in the 1790s. Here, I shall argue, is to be found the emergence of the first predominantly psychological therapy for insanity. To begin examining the long journey to psychological therapy for insanity, let us contextualize the Enlightenment psychiatry that the Tukes inherited, by outlining the traditional understandings of madness which were rejected in the Age of Reason.

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THE SECULARIZATION OF MADNESS

Historians agree that during the latter half of the seventeenth century, a medical model of insanity permeated the British social and intellectual landscape, supplanting the traditional amalgam of divine, diabolical, magical and transcendental conceptions of madness (MacDonald, 1981, 1982; Porter, 1987*a*; Suzuki, 1995*a*). Previously, Christian theology endorsed and explained any number of therapies for mental disorder: fasting and prayer for those estranged from God, or exorcism for the diabolically possessed. Physical remedies, including purges, bleeding, evacuation and doses of bark or quinine, as well as stripes from the whip, provided another line of attack. While some thought that medicine could prepare the body for the mind's ingress of grace, (e.g. Bright, 1586) and was thus distinct from divinity, other commentators held that physic was rightly fused with theology: 'There bee those that prescribe physicke … 'tis Gods instrument and not unlawful. The divell works by mediation of humours, and mixt diseases must have mixt remedies' (Burton, 1632, vol. 3, p. 443). The relationship between physic and faith was both antagonistic and complementary (MacDonald, 1982).

Madness thus incorporated a rich and inclusive array of moral, mystical, theological and transcendental meanings, as well as less exalted ones indicating abasement and loss. In the Enlightenment, however, the idea of insanity shrivelled under the rationalist glare, and its clusters of meaning reduced from many to one – physical sickness (Suzuki, 1995*a*). With England still shaken after the Cromwell years, rationalist strands of Anglican and Dissenting philosophy, opposed to the Puritan claims to superior insight ('Enthusiasm'), joined with medicine to declare the fanatics mad, rather than simply wrong (Porter, 1987*a*, pp. 62–81). The sectarians erred not because they were misled, hypocritical or ill-informed, but, their detractors charged, because their bodies were sick. And where before, the soul itself had its maladies and could sicken, by contrast, in the Enlightenment, humanist philosophy along with orthodox theology and mainstream medicine declared that the soul was off-limits to physic (Suzuki, 1995*b*). Thus, the soul's immediate links with the flesh were severed: previously, souls and bodies fought together in the war for salvation and grace – spiritual health – but now, the soul was, like the king in chess, the scarcely-participating object of the battle. An important side-effect of the Enlightenment vision of madness as disease was to reconfigure the insane as wholly guiltless: the mad were not accountable for their deeds.

Thus secularized, British psychiatry maintained one surprising characteristic; its model of mind/body interaction was somatopsychic rather than psychosomatic. Odd ideas were understood to be the function of bodily workings (Suzuki, 1995*a*, *b*). Therapists proceeded accordingly: 'If the intellect appears to be disordered', ran an accepted wisdom, 'it is the business of the physician to attend to the habit of the body' (Hunter & Macalpine, 1963, p. 527). 'Psychology', we can even say, did not yet exist in psychiatry. Where previously, theology and folk naturalism intertwined to create a hybridized account of the (mad) self, the Enlightenment, by contrast, distinguished some maladies of the mind as theological or philosophical, i.e. 'moral' (with the subject morally accountable, not innocent) while others were 'real' and medical (vice versa). Within the moral register, an emergent psychology of madness is apparent, but in realist psychiatric discourses, psychology remained *outré* – 'philosophical physicians' were widely derided. Cartesian dualism split only normally working minds from bodies; Georgian doctors and the public understood that in authentic madness the problem was medical, that bodies needed attention if minds were to be fixed.[1]†

MANAGEMENT FOR THE MAD

In treating insanity, a long-standing and common practice was to confine the lunatic in separate quarters. Custodial care answered the immediate need to restrain a fractious individual, and in general, restraint was required only for the dangerously disturbed, those who offered violence to themselves, to others or to property. The innocuously deranged, as well as the frail, tended not to be kept forcibly in close confinement. Yet the 'trade in lunacy' – England's burgeoning system of

† The notes will be found on pages 1295–1296.

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private madhouses – provided a setting in which in-house treatment of lunatics became linked to curative optimism: the '"practical science" of madhouse keeping … was precisely psychiatry's English matrix' (Porter, 1987*a*, p. 228).

Within the madhouse, the manipulation of the subject's environment for salutary purposes – everything from diet to exercise regime to the number and frequency of visitors – became known as 'management'. At least before the 1750s, no physicians argued that management could cure by itself, although the record must be read with caution. In the late 1600s Oxford neuroanatomist Thomas Willis, for example, charged that 'Furious Mad-men are sooner, and more certainly cured by punishments, and hard usage, in a strait room, than by Physick or Medicines … let their diet be slender and not delicate, their clothing course, their beds hard, and their handling severe and rigid.' (Hunter & Macalpine, 1963, pp. 191–192). But punishment and rough treatment aimed to suppress and cool the animal spirits, not to join battle with an autonomous 'psychological' realm. And Willis took care not to deny medicine its rightful place: 'a course of Physic ought to be instituted besides, which may suppress or cast down Elation of the Corporeal Soul. Wherefore in this Disease Bloodletting, Vomits, or very strong Purges, and boldly and rashly given, are most often convenient' (p. 192).

Willis's ideal was significant in that it seemed to accord management an equal place with physic: for later therapists, by contrast, management was relegated to the teaspoon of sugar, and it was the medicine that followed which cured. Madhouse owner and quack Thomas Fallowes, for instance, in a tract from 1705 argued that 'good Management of the Patient is a great Assistance to the Cure', specifically referring to his own 'incomparable Oleum Cephalicum', a blistering agent, which 'never fails to allay the Orgasm of the Animal Spirits, and sweetly compose 'em'. (Hunter & Macalpine, 1963, pp. 294–295). By the 1720s, a London physician, Nicholas Robinson, was arguing that management could be useful as a stand-alone treatment, but only in response to the lesser disorders such as the spleen (mild melancholia); importantly, he insisted on the application of strong physic for the insane (Robinson, 1729, 309 et seq.). Madhouses proprietors were hesitant to claim that management cured the mad.

By the 1750s, management became the focus of renewed optimism in psychiatry. William Battie, physician to the newly established (1751) St Luke's Hospital in London, restarted discussion about management in his *Treatise on Madness* (1785). This tract was a broadside aimed particularly at Bedlam, where a 'staunchly conservative' regime continued to mobilize 'routine and coercive' therapeutics throughout the Georgian age (Andrews *et al*. 1997, pp. 276, 279). Indiscriminate dosing was bad enough, Battie felt, but attention must be paid to management, for crowded cells and jeering visitors vitiated the practice of rational psychiatry. The visits of 'affecting friends as well as enemies, and the impertinent curiosity of those who think it pastime to converse with Madmen and to play upon their passions, ought strictly to be forbidden' (Battie, 1758, pp. 68–69). Rather, a carefully-tailored managerial programme entailing cleanliness, good food, fresh air, and retreat from the distractions of kith and kin, was 'necessary'. This was surely a boost for management, but was not a clean 'thumbs-down for medication', as Porter has argued (Porter, 1987*a*, p. 207; Ingram, 1991, p. 47). Instead, managerial techniques served the same purpose as 'rest is recommended to bodies fatigued, and the not attempting to walk when the ancles [*sic*] are strained': (pp. 68–69) they helped to avoid worsening a bad situation.

A generation later, William Cullen, Glasgow-educated teacher of physic at Edinburgh, proposed in his influential *First Lines in the Practice of Physic* (1784; 1818 edn.) that 'restraint is … to be considered as a remedy', because 'Angry passions are always rendered more violent by the indulgence of the impetuous motions they produce' (p. 312). For Cullen, however, restraint was a somatopsychic intervention: the strait-waistcoat helped to marshal the body's passions by redirecting the blood-flow, it had no unmediated psychological function. This point is buttressed by Cullen's insistence that 'it may not be safe to allow maniacs to be upon their legs … [or] to allow them to walk about'; rather, 'they should be more or less in an erect position' in order to guard against 'preternatural fulness or increased impetus of blood in the vessels of the brain' (p. 313). And Cullen firmly endorsed

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bleeding, purging and (where symptoms indicated) 'the frequent use of pretty drastic purgatives' (pp. 315–317; 317). Thus, even by the 1780s, management was not genuinely thought to be a cure in its own right, and although increasingly, practitioners advertised that management was equal to, if not better than medicine, internal evidence suggests that they did not believe their own rhetoric.

ARGUING WITH THE INSANE

The suppression of bad (*recte* mad) behaviour, rather than entry into the subject's mental processes or their justifications, was prominent in managerialism. Nevertheless, in the Georgian age there emerged a therapy wholly and explicitly directed at the subject's delusional apparatus: it tried to cure by arguing with the mad. Here the historical argument necessarily becomes sticky, for to understand the intellectual context of therapeutic argumentation, we need to examine the novel vision of insanity's structure and significance as articulated by John Locke, in his *Essay Concerning Human Understanding* (1689).

Locke hypothesized a model of mind in which cogitation was the process of marshalling incoming sense-data, as opposed to thought being the direct engagement with a stock of in-built ideas. Madness, Locke suggested, simply comprised the incorrect organization of correct ideas (Porter, 1987*a*, pp. 188–193; Suzuki, 1995*b*). Contrasted against idiots who thought too little, the mad thought at the normal rate, but with the wrong combinations, the conjunctions in odd places. For Locke, insanity was not a case of the mind coming under siege from the passions, like a castle being attacked from outside, for the mind was not a fixed and stable entity in the first place. Rather, madness represented the wrong process of reasoning – reasoning itself was the problem – and madness came and went by degrees.

Importantly, however, if madness was error (and error madness), then logically, insanity should be corrigible by direct intellectual confrontation, that is, by argument. But Locke wrote the *Essay* from an explicitly non-medical perspective, ignoring the mind's relationship to the body in order to concentrate on the internal economy of thinking processes. And his theory nullified the paradigmatic guiltlessness of the mad – the attribution of innocence no longer applied when insanity was viewed 'morally' rather than 'really'. The morally mad, those who adhered to wrong ideas for which they were morally accountable, should indeed be argued with, but the really mad, suffering bodily ailments, ought not to be brow-beaten with useless opposition. Therapeutic argumentation within psychiatry, then, represented the unmediated application of moralist principles to real madness, and for this reason I term it 'classical moral treatment'.

Because it contravened accepted notions of real insanity's significance, classical moral treatment was used neither by Locke nor by any British psychiatrists in the period before the 1750s. Dr Battie of St Luke's was the first British psychiatrist to experiment with it. Battie proposed that (*inter alia*) insanity manifested in deluded imagination. He propounded a Lockean model of insanity, arguing that it showed in the patient's intellectual make-up, rather than as an upsurge of passions: madness need not display itself only as furious exclamation, disorderly appearance, or (for the dejected) social withdrawal and causeless apprehension, but was best assessed in terms of the lunatic's ensemble of wrong ideas. But Locke's influence notwithstanding, Battie retained a somatopsychic aetiology, viewing madness primarily as an affliction of the flesh, rather than as a problem internal to the mind's workings. He laboured to identify the physical processes of perception and cognition as they arose materially in the brain, and correspondingly his therapies were somatic ones, arranged along the classes 'depletion', 'revulsion', 'removal', and 'expulsion' (Battie, 1758, p. 73).

Newly uncovered evidence, however, shows that Battie secretly maintained another weapon in his therapeutic arsenal, classical moral treatment. In 1758, the year of the *Treatise's* publication, Sir Charles Hanbury Williams, erstwhile ambassador to Russia, went mad in Hamburg and was freighted back to England to be confined under Battie's tutelage in a house in Kensington.[2] Lord Chesterfield heard tell of what transpired, writing that:

> Sir Charles Williams is still in confinement, and, I fear, will always be so, for he seems *cum ratione insanire*

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[mad with reasoning]; the physicians have collected all he has said and done, that indicated an alienation of mind, and have laid it before him in writing; he has answered it in writing too, and justifies himself by the most plausible arguments that can possibly be urged. (Chesterfield, 1758, vol. 3, p. 1212.)

The physicians', Battie's agents, plainly sought to redirect Hanbury Williams' insanity by a process of immediate encounter with his words and deeds; that is, to debate him out of his madness.

Within traditional Christianity, argumentation (the provision of spiritual advice, or the exhortation to avoid the devil) was a legitimate response to madness. In the Enlightenment, however, moral reprogramming as therapy for insanity was understood to be out-of-bounds; silly, aimless and ultimately counterproductive. At the end of the eighteenth century, psychiatrists queued to rebut therapeutic debate, ironically indicating that this method remained in need of refutation.[3] Clinicians like Staffordshire private madhouse operator Thomas Bakewell declared it 'ridiculous' to argue with a lunatic: 'you might as well attempt to extinguish fire, by throwing upon it oil, or gunpowder' (Bakewell, 1809, p. 40). But who, we wonder, actually was attempting to argue with the mad? Perhaps Dr Ferriar of Manchester was referring to himself when he announced in 1795 that he had seen 'great exertions thrown away, in attempting to influence lunatics by arguments, or to surprise them into rationality by stratagem. I never knew such endeavours answer any good purpose' (Ferriar, 1795, vol. 2, p. 137). Because psychiatrists and lay commentators alike condemned attempts to reason with the mad, historians have been seduced into thinking that *ipso facto* it was abandoned utterly; 'By 1750 … everyone agreed that trying to outwit madness by argument was hopeless' (Porter, 1987*a*, pp. 208–209).[4] The evidence of Battie's treatment of Hanbury Williams shows that in fact, argumentation as therapy, practised within secular psychiatry, began in the 1750s. But classical moral treatment was illegal, hence the hugger-mugger.

It is apposite, nevertheless, to emphasize that Battie's use of classical moral treatment marks a watershed moment in the history of psychiatry, for it assumed (rightly or wrongly) the insane to possess a degree of moral autonomy. To counter a mad idea intellectually, one must suppose patients to be responsible for their actions and utterances. Indeed, notions of the moral responsibility of the mad were immanent in Battie's nosology: formulating 'deluded imagination' as the basic character of madness entailed 'taking the perceptions of the insane seriously' (Doemer, 1981, p. 41). There was, however, a long way to go before the moral presence of the lunatic would be understood in ways that did not result in the descent into therapeutic argumentation.

THE PIOUS FRAUD

The relative sophistication of classical moral treatment is clarified by its being compared to the 'pious fraud', the art of tricking the lunatic into sanity. Consider an example listed in 1792 by William Pargeter, a Aberdeen-educated M.D. and private madhouse owner. The patient thought himself to be dead, and syllogizing that the departed had no need for meals, refused to eat. His friends:

> sent into his bed-chamber, which they had purposely made as dark as possible, some fellows wrapped in shrouds, who carried with them victuals and drink, sat down at the table, and began to eat heartily. The disordered man, seeing this, asked who they were, and what they were about. They replied, they were dead persons. *What then*, says the patient, *do the dead eat? Yes*, *yes*, say they, *and if you will sit down with us, you may eat likewise*. Upon this, he jumps out of bed, and falls to with the rest; and having made a hearty meal … he went to bed again, fell into a fine sleep, and in a short time recovered his health and senses. (Pargeter, 1792, pp. 45–46.)

The passions, rather than delusion *per se*, were being attacked here; the delusional notion, indeed, was left unchallenged. Pargeter did not attempt to counter the wrong idea by installing a correct apprehension of the world, but was content to have encouraged an external display of rectitude, and to have forced the subject to eat. Compliance was an end unto itself, and the relationship between the treatment and recovery remained obscure; the subject simply 'fell into a fine sleep, and … recovered his health'.

Others proceeded along similar lines. In the early 1800s, Bristol madhouse proprietor Joseph

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Mason Cox showed how:

> to try the effect of certain deceptions, contrived to make strong impressions on the senses, by means of unexpected, unusual, striking, or apparently supernatural agents; such as after waking the party from sleep, either suddenly or by a gradual process, by imitating thunder or soft music, according to the peculiarity of the case, combating the erroneous deranged notion, either by some pointed sentence, or signs executed in phosphorous upon the wall of the bedchamber, or by some tale, assertion, or reasoning by one in the character of an angel, prophet, or devil: but the actor in this drama must possess much skill, and be very perfect in his part. (Haslam, 1809, pp. 304–305.)

Mason Cox's pious fraud aimed to control the passions, approaching the mad idea ('combating the erroneous deranged notion') within its own internal economy, and utilizing the terms of the subject's own delusion to counter it. (Porter wrongly argues that for Mason Cox, 'No advantage lay in attempting to enter into the delusions of the insane' (Porter, 1987, p. 212).) But like Pargeter's Mason Cox's entry into the subject's fantasy-world did not acknowledge the moral autonomy of the insane: Mason Cox attacked only the particular signs of insanity, leaving the subject's motivations and rationalisms unquestioned.

Although the pious fraudsters' methods aimed to identify in highly personal, specified ways the precise therapeutic needs of their patients, this treatment lacked sophistication. Understandings of the subject's moral presence *qua* delusion remained crude. 'Men prove with child as pow'rful fancy works':[5] classical moralists would treat pregnant men by arguing against male parturition; pious fraudsters would prod at bellies.

SHOCK TREATMENT

So far, classical moral treatment excepted, we have seen no predominantly psychological therapeutics. Some techniques, however, seem to adumbrate psychological rationales via a kind of aversion therapy; such were the Georgian equivalents of shock treatment. Devices for ducking lunatics in water, or for dousing them from above, were popular. Early in the eighteenth century, Lancashire physician Patrick Blair theorized the virtues of therapy by water-shock through reference to its overtly punitive value, and to its capacity to be tailored to the individual case:

> 1. The Surprize upon being blindfolded … is a great means to the recovery of Reason. 2. Tho'at a second operation there is no more a surprize, yet the Terror of the former creats such a dread & horrour of it [as] much contributes to produce the desir'd effect … 3. The difference in the pressure is very considerable betwixt the high & low fall … 4. The pondus [i.e. weight] of the water that fell is easily calculated. (Hunter & Macalpine, 1963, p. 325.)

Unmistakably, a form of aversion therapy was being trialled here, although the calibration of the shock lent his system a kind of scientific credibility.

Blair's robust behavioural reprogramming, however, would be unfashionable by the end of the century, when theoretical justifications for shock treatment were beginning to stress mind–body interaction, rather than the efficacy of mere punishment. Physicians Erasmus Darwin, Sir Alexander Morison, James Carmichael Smyth and Joseph Mason Cox worked up devices like the 'swinging chair', in which the subject was strapped into a seat, dangled in the air, and by means of a system of ropes and pulleys, transformed into a human centrifuge. Naturally, few wished for a second ride, and 'the physician will often only have to threaten its employment to secure compliance with his wishes' (Hunter & Macalpine, pp. 597–598). But medical theory buttressed the argument for the machine's efficacy, for it could 'excite a new order of symptoms, creating considerable commotion in the animal economy, interrupting the morbid associations, and even occasioning temporary disease' (p. 595). Re-jigging the animal spirits enabled psychological rewiring; hence Mason Cox called this intervention 'both a moral and a medical … treatment' (p. 596).

Whether practitioners sought to realign the animal spirits, or used shock therapy as plain punishment, they understood that the body remained central; work on the body provided the open-sesame to the mind. Even when a physician directed therapeutic horseback rides, it was usually the realignment of the animal spirits, rather than the enjoyable distractions of bucolic delights, which cured. The flesh would fix itself

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while the subject was jostled about: 'while we are on Horseback, … we cannot be said so well to exercise, as to be exercis'd' (Robinson, 1729, p. 332). Regarding the less immediately somato-psychic effects of shock therapy, it is easy to envision a primitive psychology at work, with its threats, punishments, counter-threats and rewards. But this is a psychology known to any animal-trainer – no beast, however stupid, fails to respond to the switch. Like the pious fraud, shock treatment scarcely allowed that the lunatic was capable of autonomous moral agency: control was imposed from without.

CHARISMATIC STEWARDSHIP

Around the 1780s, there emerged a system of one-on-one tutelage, a doctor–patient relationship based on the negotiation of acceptable behaviour. Symbolically at least, Dr Francis Willis' celebrated treatment of King George III ushered in the new methods, which I term 'charismatic stewardship'.[6] Willis championed a method of governing the insane through a system of rewards and punishments. Witnesses reported that he 'conducted himself with wonderful management and force. As the King's voice rose attempting mastery, Willis raised his and its tone was strong and decided. As the King softened his, that of Dr Willis dropped too … The King found stronger powers in Dr Willis … gave way and returned to somewhat of composure' (Porter, 1987*b*, p. 48).

Plainly, the therapist's overwhelming personal charisma was the source of much of the success in gaining the subject's compliance. Obedience in the patient was central to the therapeutic relationship. Consequently, charismatic stewards proclaimed that the first step was to secure domination over the lunatic. The clinician 'must employ every moment of his time by mildness or menaces, as the circumstances direct, to gain an ascendancy over them, and to obtain their favour and prepossession. If this opportunity be lost, it will be difficult, if not impossible, to effect it afterwards' (Pargeter, 1792, p. 49).

In gaining instant control, therapists like Pargeter and Willis used 'the eye' – fixing the mad person with a stern and apparently penetrating gaze. This trick anticipated the hypnotist's mysterious powers, suggesting that the therapist wrought a magical control over the lunatic's will. Proponents of 'the eye' were reluctant to outline the precise methods by which furious maniacs were transfigured, and unsurprisingly, the sources of the charismatic stewards' efficacy were contested. Haslam suspected that the presence of burly attendants counted for much:

> I have never been able to persuade [his colleagues like Pargeter] to practice this rare talent tête à tête with a furious lunatic … if any influence were to be gained over maniacal patients by assumed importance, protracted staring, or a mimicry of fierceness, I verily believe that such pantomime would be much better performed in Paris than in London. (Haslam, 1809, pp. 276–267.)

Edinburgh educated physician W. S. Hallaran furthered the critique of charismatic stewardship by wondering if ultimately, it were not counter-productive:

> The first introduction of a Physician to a maniacal patient, carries with it that extent of credence, by which his worth and quality are shortly decided upon. … he who will attempt to impose upon their credulity by aiming at too great a refinement in address or intellect, will often find himself detected, and treated by [the insane] with marked contempt. (Hunter & Macalpine, 1963, pp. 654–655.)

As critics like Haslam and Hallaran recognized, charismatic stewardship was deeply flawed: it fostered a kind of absolutism, and too often, practitioners enjoyed playing the ringmaster. Thus, the stewards helped to perpetuate stereotypes of the mad: by acting the lion-tamer, they endorsed the popular misconception that lunatics were like lions, and in need of taming. 'They may be made to obey their keepers, with the greatest promptitude; to rise, to sit, to stand, to walk, or run at [the steward's] pleasure; through only expressed by a look' wrote Samuel Tuke (1813, p. 148).

Furthermore, charismatic stewardship, like the pious fraud, lacked an account of the potential in lunatics for moral autonomy. For stewards like Pargeter, lunatics were understood to be scarcely human: 'destitute of the guidance of that governing principle, reason', the insane were like the 'inferior animals … all is confused and deranged, every look and expression testifies internal anarchy and disorder' (Pargeter, 1792, pp. 2–3). Pargeter distrusted maniacs, who were, he found, 'exceedingly timorous, and … easily

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terrified', but this attitude sought to supplant the view of 'superficial observers', that the insane were 'extremely daring and courageous' (p. 61). Even while moving away from the grosser stereotypes of furiousness, stewards continued to hold that lunatics lacked the means to control themselves from within.

Moreover, charismatic stewardship was more closely somatopsychic than 'psychological' in one specific sense: its practitioners tailored their regimes around the administration of physic. Willis used behaviouralist techniques to control George III, but the remainder of his therapy entailed the usual round of depletions, purges and doses of bark (Macalpine & Hunter, 1969). Consider also the example of Pargeter's treatment of a woman sent mad during an 'unfavourable parturition' (p. 58).

> I endeavoured to draw her into a more rational conversation; but I could not accomplish this by any artifice whatsoever. However, I could plainly perceive that I possessed, in a considerable degree, her good opinion … and therefore determined to seize every advantage by it. I accordingly prescribed some aperient [i.e. purgative] physic, which her habit of body rendered her much in need of, and gave it her myself … (pp. 59–60).

After which she was cured: the key to her recovery was the recommencement of 'the process of lactation (the suppression of which caused her indisposition)' (p. 60). Indiscriminate dosing was out, but rationalized physic remained very much in, for lunacy was understood to be a somatic complaint. Pargeter's endorsement of 'mildness' and 'conciliation' amounted to a plea to avoid 'compulsion' in the administration of medicine, not a call for psychology to supplant physiology: routinized physick 'is every way prejudicial, and ought not, in any case whatever, to be put in execution' (p. 94). Medicines remained central, provided one chose carefully, and administered without too much violence. Depending on the case, bleeding, cupping ('with or without scarification'), cathartics, emetics, issues and setons, and blisters, were useful (pp. 63–80).

TOWARDS MORAL TREATMENT

The methods we have now observed scarcely amounted to a sophisticated psychological approach to insanity. Historians have over-stepped the mark: to suggest that clinicians like Pargeter evolved 'a kind of empathy with their patients', risks serious anachronism (Porter, 1987*a*, p. 213). Rather, as the King's experiences with Dr Willis amply attest, for the stewards the relationship between patient and therapist remained a one-way street. British psychiatry had not yet developed a 'philosophy of moral discipline', implying a self-contained theory of psychological treatment, and neither was one being planned: nobody yet argued that 'mental treatment *had* to supplant physical' (Porter, 1987*a*, p. 12: emphasis added.). Nevertheless, a handful of physicians in the 1790s began to theorize that the mad were authentically capable of rationally-driven thought and action. One such clinician was Benjamin Faulkner, who, writing in 1790, proposed that the lunatic ought to be 'treated as a rational creature, with attention and humanity' (Hunter & Macalpine, 1963, p. 527). Faulkner, a layman, employed a doctor to administer physic. Faulkner's understanding of the role of medicine in therapy is noteworthy, for he asserted that 'medicine only, allowing it to be judiciously and honestly administered, can produce but a partial relief'. Physic was necessary, but only to 'put the body into the best frame for the returning mind', (p. 527) suggesting that mental operations – psychological processes – were the ultimate causes of cure. But for Faulkner, the mind would be unable to 'return' before the flesh was suitably primed: psychological means – 'presenting objects of amusement, directing the attention, and humouring the imagination' – were restrained by the need to remain 'consistent with physical and medical operation' (p. 527). Recovery was impossible for the patient whose bodily integrity was compromised.

John Ferriar, physician to the Manchester Lunatic Hospital, is lauded by latter-day historians as having propounded a philosophy of mentalist therapy closely aligned with Tukean moral treatment (Porter, 1987*a*, p. 212; Scull, 1989, pp. 82–87; Digby, 1985, pp. 10–11; Shorter, 1997, pp. 18–22). Ferriar indeed rejected system-building; somatic aetiologies seemed too assured, and so he counselled a kind of agnosticism:

> We are ignorant by what laws the body possesse[s] a power of representing the most hazardous disorders, without incurring danger; or counterfeiting

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the greatest derangement in the circulating system, without materially altering its movements; of producing madness, conscious of its extravagancies … by oppressing the common sensorium. … Nature, as if in ridicule of attempts to unmask her, has in this class of diseases, reconciled contradictions, and realised improbabilities, with a mysterious versatility, which inspires the true philosopher with diffidence, and reduces the systematic to despair. (Ferriar, 1795, vol. 2, p. 12.)

All this was a step in the right direction *qua* later developments: circumspect, undogmatic and inquisitive. Furthermore, Ferriar's ideas concerning the management of the mad, read selectively, indeed show a relatively sophisticated understanding of the potential for behavioural modification via a system of rewards and punishments, and seem to acknowledge moral autonomy in the insane:

It has long been my wish, that a room might be appropriated in our hospital, to convalescents, and that the privilege of admission to it might be made the reward of regular behaviour among the patients. Such a distinction would act powerfully in creating a habit of self-restraint, the first salutary operation in the mind of a lunatic. (Ferriar, 1795, vol. 2, pp. 139–140.)

The lunatic in this instance was, apparently, held to be capable of self-directed moral behaviour: 'the patient must "minister to himself"' (p. 140). There is some sophistication here, but crucially, the subject was not to be cured *either* by moral exertion *or* via medical intervention. Rather, a mixture of both was required: 'medicine may restore him … to the command of his intellectual operations; discipline must direct him in their exertion' (p. 140). At all odds, management before the Tukes was not intended as a cure *per se*: Ferriar's endorsement of the internalization of restraint needs to be contextualized in these terms.

But more to the point, historians have overlooked the fact that Ferriar kept faith with the independent efficacy of somatic cures. Certainly, he proposed that many medicines were useless: camphor and digitalis, for example, did nothing (vol. 1, pp. 217–218). But the inquiring physician could advisedly use 'other diuretics' instead of digitalis, such as 'a cold infusion of salt of tartar, and wormwood ashes' (p. 219), and Ferriar's experience also showed that some remedies worked well in conjunction with others:

In cases of deep melancholy, where there was evidently a relaxed state of the solids, and in maniacal paroxysms, where the appearances resembled those of the low delirium in fevers, I have employed the bark, combined with opium and aromatics, with the best effects (vol. 1, p. 220).

Other therapies included applying a seton (a length of cotton passed under the skin), and 'inoculat[ing] the patient for the itch' (vol. 1, pp. 224, 226). Emetics, repeated bloodletting (but 'only in case of an evident congestion, with an apoplectic tendency'), and purgatives ('when moderately used') were all proper, in their places (vol. 2, pp. 122–125). Thus, Ferriar remained a somatopsychic practitioner, albeit one with a conscientious regard for the value of observation, a faith that lunacy was not a total state, and who tailored therapy to suit the individual. Ferriar's approach was progressive, rational, attentive and rigorous; but clearly it was not in the modern sense a psychological one.

MORAL TREATMENT

Beginning in 1796 at York, the Tuke family developed and oversaw an institution, The Retreat, in which moral treatment was cultivated as a non-medical therapy.[7] The madhouse setting itself was vitally important – like others before them, the Tukes rejected Bedlamite clutter and high walls for a clean and welcoming house. Restraint was not done away with but was minimized: the Tukes took care to encase door locks in leather to muffle the intimidating clack of the bolt, and disguised the bars on the windows as mere frames. The Retreat's extensive gardens included a 'ha-ha' – a sunken wall scarcely visible yet impassable. The Tukes indeed possessed strait-waistcoats (with straps of 'green morocco leather' for the women (Tuke, 1813, p. 173)), but preferred to use gentle talk as the first resort, reasoning that soothing words and the anticipation of restraint was often sufficient to quell the fractious. All was individually tailored: entering the asylum, the patients were 'arranged into classes … according to the degree to which they approached to rational or orderly conduct', suggesting a sort of character summary, mixed with a state-of-mind assessment (p. 141). There followed a kind of induction: the patients 'quickly perceive, or if

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not are informed on the first occasion, that their treatment depends, in great measure, upon their conduct' (p. 141).

Providing more detail is not easy: we do well to remember that moral treatment was 'emphatically not a specific technique' (Scull, 1993, p. 98). And there is the textual problem that the *Description*, as well as being a psychiatric treatise, reads like part advertisement for the facility, part morality tale (understanding and kindness wins over ignorance and cruelty), especially in the few patient narratives that were recorded. Take the case of 'a man, about thirty-four years of age, of almost Herculean size and strength' whose previous keepers had found him so ungovernable as to keep him 'chained, that his clothes were … taken off and put on by means of strings, without removing his manacles'. This, of course, was treatment for a beast, whereas at the Retreat, the focus was on humanity: the maniac was unchained, and:

> ushered into the apartment, where the superintendents were supping. He was calm; his attention appeared to be arrested by his new situation. He was desired to join in the repast, during which he behaved with tolerable propriety. After it was concluded, the superintendent conducted him to his apartment, and told him the circumstances on which his treatment would depend; that it was his anxious wish to make every inhabitant in the house, as comfortable as possible; and that he sincerely hoped the patient's conduct would render it unnecessary for him to have recourse to coercion. The maniac was sensible of the kindness of his treatment. He promised to restrain himself, and he so completely succeeded, that, during his stay, no coercive means were ever used against him (pp. 146–147).

It was not all smooth sailing: this 'frequently very vociferous' patient 'threatened his attendants' at times, and they wanted to quieten their man 'by the jacket'. But there were more subtle means at hand, and when on one occasion 'the superintendent … went into his apartment' the patient was at first agitated: 'yet after sitting some time quietly beside him, the violent excitement subsided, and he would listen with attention to the persuasions and arguments of his friendly visitor' (p. 147). Even the vigilance of other patients for signs of recidivism in the individual formulated part of Tukean treatment – every aspect of daily life was, or ought to be, therapeutic. Therapy was synonymous with working, taking meals, walking in the grounds, and famously, attending the matron's occasional tea parties, where 'All who attend, dress in their best clothes, and vie with each other in politeness and propriety' (p. 178).

Andrew Scull correctly argues that the emphasis on internal restraint as compared with whips and harsh words signifies a monumental change: external restraint is supplanted by a system aiming to '*transform* the lunatic, to remodel him into something approaching the bourgeois ideal of the rational individual' (1989, p. 89, italics in original). As such, the same impetus informs both the Tukes and their immediate forebears within medicine. But Tukean therapy differed from the other practices current in the 1780s and 1790s through rejecting somatic therapies; only the Tukes approached the mad through a predominantly moral perspective.

There was no animus against physic *per se* in their dismissal of medical psychiatry. Rather, the Tukes, like good Baconians, were methodologically agnostic and commissioned their own observation-based enquiries into insanity. They tested an inclusive array of therapies, beginning with trials of medical interventions conducted by the first physician, Dr Thomas Fowler. 'Bleedings, blisters, seatons, evacuants, and many other prescriptions' were all essayed, and all found wanting: medicine was discovered to be 'very inadequate' to cure insanity (Tuke, 1813, p. 111). Physic was reserved for non-psychiatric ailments, and out of the array of physical means assessed, the 'one remedy' retained was the warm bath (p. 112). The Tukes also dabbled in, and rejected, classical moral treatment, finding that the attempt 'to refute their notions, generally irritates them, and rivets the false perception more strongly on their minds' (p. 151).

Neither medical nor classical moral therapies were intrinsically bad, debased or misguided; they simply failed to work. The Tukes' pragmatic eclecticism also worked to lead them to reject aetiological commitment: so doing neatly and comprehensively obviated an array of metaphysical problems associated with insanity. Theological debates about the nature of the soul, about materialist *versus* immaterialist views of the mind, or about mentalist *versus* somaticist frameworks for mental disorder, all were jettisoned: 'Whatever theory we maintain in

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regard to the remote causes of insanity, we must consider moral treatment, or management, of very high importance' (p. 131).

The Tukes, then, rendered insanity amenable to a therapy in which the means of deliverance were to be found within the moral realm of the patients themselves – they taught their patients to internalize the desire to recover, and fostered in them the means to do so. They differed from their putative forebears by approaching psychiatric treatment within the framework of an autonomous mind. Henceforth, at least when viewed through the prism of therapy, insanity was a fully human problem: responsive to *internal* management, thus mental and moral – 'psychological', in our parlance.

CONCLUSION

This paper examines some key strands in one nation's development of psychiatric treatment in the Enlightenment. Its aim has been to balance analysis with exposition and review: there is much that could be added to the story, much one would like to clarify or expand. The contribution of Continental writers (particularly French), for example, would be useful to study further. The essay seeks to bring coherence to a field whose historians have settled on some ill-founded assumptions. Until recently, historians concurred that the emergence of moral treatment marked a revolution in psychiatric thought and practice – even that its development allowed the birth of psychiatry itself (Foucault, 1967; Bynum, 1981; Scull, 1989, pp. 80, 82). In the 1980s, however, Roy Porter's re-examination of moral treatment proposed that its emergence was not as sudden as it appeared, its contents not as dramatically novel (Porter, 1981–1982). Indeed, for Porter, the 'key ideas' of the Tukes' practice were contained in Battie's *Treatise* of 1758 (see Porter, 1987*a*, p. 276). Historians have, by and large, agreed with Porter that significant adumbrations of Tukean therapy are plainly evident in the works of a range of psychiatrists working in the 1780 and 90s (Digby, 1985, pp. 10–11; Scull, 1989, pp. 82–87; Shorter, 1997, pp. 18–22). The Tukean phase of moral treatment, although singular on account of its intimate size and its Quaker character, is held to represent little more than a refinement of existing trends within medicine.

This paper refutes Porter's followers on a number of fronts. First, before the Tukes, managerialism did not provide a stand-alone cure for madness; rather, management played a role at best mixed with, and often explicitly subsidiary to, the administration of medicine. The Tukes were the first to render managerialism central to therapeutics, the first clearly to propose that management was treatment. Secondly, only in The Retreat did psychological ministrations, conceived (for better or worse) as being largely disconnected from somatic influences, predominate in therapy for the first time. It has been useful to examine the category 'psychology'. Porter argued that if Georgian age did not possess a 'psychology', then it would be 'hard to see what other historical label would be better' (Porter, 1987*a*, p. 276). A clear nomenclature may long elude our searches, but it has been fruitful to begin by distinguishing somatopsychic therapies from psychosomatic ones. No longer can it simply be argued that 'psychological intervention is a technique with which physicians have always been familiar' (Shorter, 1997, p. 20). Lastly, I have shown that where a free-standing psychological therapy of madness did appear prior to the Tukes, it intruded into psychiatry illegally, as mere argumentation. The discovery of classical moral treatment shows that the insertion of morality – in its secular form, psychology – into psychiatry required that morals be mobilized as a function of sanity rather than of madness; the Tukes were the first British clinicians to develop this insight within a psychology of the autonomous mind.[8]

NOTES

[1] Laffey, P. 'Two registers of madness in enlightenment Britain' in *History of Psychiatry* **13** December 2002/**14** March 2003.

[2] Horace Walpole wrote that Hanbury Williams 'returned to England Feb. 26, 1758, but appearing to be disordered in his senses, was sent to Kensington and put under the care of Dr Battie, a mad-doctor'. Lewis (1935–1975) vol. 30, p. 322. Walpole's latter-day editor, W. S. Lewis, notes that Hanbury Williams stayed at Kensington 'under Dr Batty's [*sic*] care … for five weeks' (vol. 33, p. 78).

[3] John Haslam, apothecary at Bethlem, sarcastically commented that 'The good effects which have resulted from exhibiting logic as a remedy for

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madness, must be sufficiently known to everyone who has conversed with insane persons, and must be considered to be time very judiciously employed' (1809, p. 241). Some hinted at having experimented with salutary argument. John Aikin, physician and essayist, writing in the 1790s, outlined a rationale for immediate confrontation with the insane. Madness was too grave a disease to counter with 'trifling or casual remedies', rather, one needed to form 'some vigorous plan': not 'persuasion' but 'coercive force' was requisite (Aikin, 1796, vol. 1, p. 175). Completely upending the patient's world was the means: 'Nothing but a total change of habit, effected by means equally powerful and long-continued with those which bred the malady can work a cure' (p. 182). Hoping to cure insanity with mild moral instruction was useless: one might as well trust the 'quiet operation of reason' as 'hope to cure an inveterate cancer without the knife or caustic' (p. 184). Other clinicians, conversely, proceeded indirectly. An anonymous correspondent to the *Quarterly Review* conceded that it was 'almost always useless, and often prejudicial' to argue with the mad, but thought it acceptable to attempt such in ways that were 'indirect, though powerful, rather leading them imperceptively into palpable absurdity, than directly contradicting them' (Anon, 1809, p. 174). Frontal assaults were ill-advised; but the principle of trying to philosophize lunatics out of madness remained the same.

[4] See also, Doerner (1981, p. 44) 'madness ceased to be seen as an error curable by correction'.

[5] Alexander Pope (1714) *The Rape of the Lock*, p. 33.

[6] What I call 'charismatic stewardship' Porter has called 'moral management': he calls the later development, Tukean treatment, 'moral therapy', suggesting that 'treatment' of the Tukes devolved from Willis-style managerialism (Porter, 1987*a*, pp. 206–228). Conversely, Digby has distinguished 'treatment' from 'management' (as practised in the much larger asylums of the 1840s and beyond) under the heading of 'the implication … that the patients were no longer subjects to be treated but objects to be managed' (Digby, 1985, p. 56); 'treatment' thus degenerated into 'management' as asylums – even the Retreat – grew to a size beyond which the therapeutic intimacy of the setting was necessarily lost. Thus, Digby's reading of the difference between the two techniques neatly inverts Porter's formulation. To complicate matters, Scull argues that a subtle but significant semantic shift changed the meaning of 'manage' from one denoting the overt control of the subject's movements (in a sense derived from that implied when we talk about managing animals), to one suggesting the use of 'tact, care or skill to manipulate the behaviour of others' (Scull, 1993, p. 107, p. 207). Thus, Scull's usage of 'management' is closer to Porter's than to Digby's, but emerges from different prior commitments.

[7] Digby (1985) provides an in-depth account of the daily running of The Retreat.

[8] But see Samuel Johnson (1759), *Rasselas* (ed. J. P. Hardy, 1968).

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