JOHN CONOLLY
AND THE
HISTORICAL INTERPRETATION OF MORAL MANAGEMENT

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A number of explanations have been offered to account for the development and decline of the movement to reform the care and treatment of the insane, which began in Britain in the late eighteenth century, and was to find its most complete expression in the system known as moral management. The traditional or internalist school argues firstly, that humanitarianism was the motivating force behind the changes in the treatment of insanity, and secondly, that conditions for the mad improved because of a growth of medical and scientific knowledge. These views of the reform of the treatment of insanity were challenged by Michel Foucault, and other revisionist historians who were affected by his insights. Andrew Scull has been a most influential member of this group. He viewed insanity reform as having grown out of a socio-political need to manage deviancy, which led physicians to appropriate a non-medical form of asylum management, known as moral treatment, and recast it as a medical therapeutic requiring medical expertise for its administration. This helped justify their attempt to make themselves indispensable in the care and treatment of insanity.

Recently, Scull used this approach in analyzing the career of John Conolly, a well-known asylum doctor of mid-nineteenth-century Britain, who instituted, in a large public asylum, a form of moral management known as the non-restraint system. Scull described Conolly as an unsuccessful general practitioner who achieved renown and economic security because of his position as an asylum administrator, despite his earlier criticisms of asylum care.

In this thesis, I have examined Conolly's writings on the theories and practices of moral management, as well as writings on those subjects
by other important figures of late eighteenth- and nineteenth-century psychiatry. I have drawn on the work of Robert Castel, Roger Smith and Karl Figlio in order to demonstrate that the practices of moral managers like John Conolly are better understood in terms of a group of concepts--the schema of stimulated motion, predisposition, and hierarchy--which developed out of a combination of medical, social and philosophical influences which were themselves generated in an epistemological framework constituted around the general principle of organization. In addition, these concepts provided a rationale for regarding the theoretical and practical aspects of asylum medicine as integrated. This conceptual analysis helps explain Conolly's adoption of the practice of moral management. Thus, his role as advocate cannot be understood exclusively in Scull's terms, as an example of careerism, but is better understood as a practical corollary of existing psychiatric theory and practice.
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INTRODUCTION

THE HISTORICAL DEBATE ABOUT MORAL MANAGEMENT

To turn from these horrors, and to record improvement and advance, and the triumph of kindness and judgement over severity and brute force, is a relief to the mind.

John Conolly

Various explanations have been offered to account for the development and decline of the movement to reform the care and treatment of the insane which began in Britain in the late eighteenth century and was to find its most complete realization in the system known as moral management. Today, there is a great divide between what might be described as a traditional, internalist school (represented by writers such as Leigh, Jones, Hunter and MacAlpine), and a critical, revisionist school (represented by writers such as Foucault, Castel, and Scull). Such a controversy is not unusual in the history of science and medicine. However, because contemporary social critics of psychiatry such as Laing, Szasz, and Sedgwick are said to be allied with the revisionist historians in an attack against what has been termed the liberal enterprise of the last two hundred years, the revisionists' critique of the interpretative canons of traditional historical explanation is especially worrisome to its defenders.

Jones, Hunter and MacAlpine, and other historians devoted to the traditional stance, tend to advance two lines of argument that are predicated upon the basic epistemological assumption that madness is an objective entity. Taking the immutable status of madness as a given, these historians of
psychiatry argue first that humanitarianism was the motivating force behind the reform in the treatment of the insane in nineteenth-century Britain. Humanitarianism is presented as having grown out of the secularism and rationalism of the Enlightenment, which made possible new and humane attitudes towards the afflicted in English society—the mad, criminals, the poor and weak in general. These new conceptions of kindly use and rational responsibility are evident in such movements as the reaction against cruelty, the reforms of institutions like asylums, hospitals, and prisons, and in the economic realm, the enactment of legal restraints upon capital in its relations with labour. The development of the tenets of moral therapy are thus seen as indicative of the humanitarian sentiment which gradually gained medical and public acceptance throughout the century, and which was responsible for the development of effective techniques of psychotherapy and the amelioration of ignorant, popular conceptions of mental illness.

The second line of argument employed by historians like Hunter and MacAlpine and Leigh invokes a growth of medical and scientific enlightenment. According to their explanation, the improvement of therapeutic and institutional practices and the elaboration of psychological theory is chronicled in terms of the acquisition and utilization of an increasingly scientific outlook. The outline is as follows. In the late eighteenth century, physicians began to see insanity as disease rather than as the product of occult forces and began to search for medical methods of treating it. During the course of the nineteenth century, they discovered the unconscious, the real symptoms of specific psychiatric disorders, and the principles of effective psychotherapy. Moral management was thus the first attempt at explicating a humanistic psychotherapeutic system, but it lacked the
intellectual rigour of Freud's achievement, which was the culmination of the long process of uncovering the real entities that compose the unconscious.

Hunter was a neurologist interested in the development of modern methods of treating the insane, so he and MacAlpine focused their investigations especially upon nineteenth-century advances in the study of neurology, the enlargement and refinement of the pharmacopeia, and the diminution in the use of physical restraint. In the end, both the humanitarians and the internalists would return to the acquisition of a proper medical outlook by certain gifted physicians whose innate humanitarian leanings prompted them to devote themselves to the insane, and who proceeded to educate the public into a better understanding of mental illness, an undertaking which was facilitated by the infiltration of the humanitarian sensibility and general scientific knowledge throughout Victorian society.

In this analysis, the achievement of scientific illumination is believed to be an activity which occurs without much interference from socio-political and economic factors. These historians admit the influence of eighteenth-century secularism and naturalism and nineteenth-century humanitarianism, but they place more weight upon the ability of individual physicians to discern scientific truth through the development of an objective methodology in their research and treatment of what became "mental illness". The underlying philosophical assumption is that mental illness exists as an objective entity that is essentially unchanging over time, and thus is only incidentally conditioned by external factors. By the acquisition of psychiatric skill and understanding through the ages, "the truth" about madness has been uncovered, this truth being that madness is "mental illness".

Some modern psychiatric historians are hard-pressed to fit moral management into this progressive model of scientific advance, partly because
the early proponents of moral management often made an issue of their renunciation of more orthodox somatic theories and practices. But the development of moral management fits handily with the humanitarianism thesis; indeed, at times it seems that rather than being explained by humanitarianism, moral management acts as evidence for it. If moral treatment is regarded as a precursor of, or as an early example of, contemporary therapeutic strategies, then it can be included as evidence of the medical-scientific theory as well.

What is significant about both the internalist and the humanitarianism histories is their undisguised adherence to a teleology of reform. In both cases, improvement in the conditions of practice are inevitable because the best way to go about things lies out there waiting to be discovered. The scientific school has, perhaps, a better case for its persistent Whiggism: it is hard to dispute concrete demonstrations of the facts of brain structure and function and neurological disease. But even in this situation, there is a tendency to overlook or avoid the extra-scientific aspects of the growth of theory and practice; indeed, there is often an active resentment of the implications of socio-cultural influences on the acquisition of knowledge.

It is within this context of the discussion that Foucault’s _Madness and Civilization_ should be seen. In this work, Foucault not only questioned the kindly sensibilities of the late eighteenth-century psychiatric pioneers, (e.g. Tuke and Pinel) but also cast aspersions on their intellectual enterprise by suggesting that even medical concepts about madness were affected by socio-cultural factors which were themselves historically constituted. 5 Foucault wrote of the development of the asylum system as the enacting of the exclusion of both the mad person and the figure of madness from the wider realm of social and cultural understanding. For him, the great
significance of both Tuke's and Pinel's moral treatment is that they tried to combat madness by creating in the lunatic a sense of responsibility in which his failure to maintain acceptable levels of self-control was to be a source of guilt which would spur him to moderate his behaviour. In effect, moral therapy was a direct attempt to inculcate the social norms of self-help and emotional restraint, of discipline and orderliness which were the essential elements of the new habits of the industrialized factory and workshop. It was expressive of the wider social tendency to move from external coercion of the body to internal coercion of the "soul", which Foucault has described as typical of the changes in penal practices of the same period.  

Foucault's approach has been a starting point for a number of historians of psychiatry, the most prominent, in the field of British history, being Andrew Scull. Scull moves in a different direction from Foucault by transforming the older outline of the development of moral management and the asylum reform movement. Both of these, he analyzes in relation to concurrent changes in economic and social structure, and also in relation to a particular element of these changes: the process of medical professionalization. Scull treats this whole process as part of a larger movement toward the institutionalization of the deviant. This, he argues, became necessary as an increasingly industrial society was organized around the market system, especially the labour market. He proposes that, out of a need to manage socially disruptive elements, came the private asylum system of the eighteenth century, a network of facilities which was entrepreneurial in spirit and not especially medical in orientation. Doctors who were infused with this spirit went into the lucrative madhouse business and discovered that it was a fruitful field for the extension of their regular practices. The "moral"
methods of treatment, which became fashionable as a result of Tuke's book, were a direct challenge to the increasing medical hegemony over the insane. This challenge was met by the growing number of specialists in insanity—"mad-doctors"—with the elaboration of theoretical and physical explanations about the nature of insanity which confirmed it as a disease. Eventually, they incorporated "moral treatment" into their therapeutic regimen. By creating a field of expertise for themselves and proclaiming a high rate of cure, the "mad doctors" were able to extend their influence on the lunacy reform movement until it became axiomatic that physicians were necessary to the discovery and management of this entity that had come to be known as "mental illness". By the time the asylum had been revealed in its irretrievably custodial actuality, the mere existence of an institutional approach with expert management was an inducement to its perpetuation.

Scull explains that the perceived increase in the number of pauper insane after 1845 was, in part, a result of the asylum itself. The poor discovered more insanity among themselves when some relief from its burdens was provided.

In Scull's view, medical theory about insanity was formulated to accord with the existing therapies, which in turn, were either borrowed from accepted medical techniques or were formed in response to social pressures or institutional constraints. The inadequacies of the medico-psychological explanations of madness and its treatment were more or less obscured by the early psychiatrists who wished to establish their expertise. Scull voices suspicions of what he calls "the rhetoric of intentions", a phrase he uses to denote the expression of humanitarian motives by the asylum reformers. He intimates that these individuals may well have been aware of the probable effect of their actions, and suggests that traditional historians who
have been all too willing to accept the reformers' explanations of their intent have contributed to a myth by distorting the factual evidence which contradicts it.

The reformers did indeed profess to be actuated by a 'humane' concern with the well-being of the lunatic. (I have yet to meet a reformer who conceded that his designs on the objects of his attentions were malevolent.) But whatever the Victorian haute bourgeoisie's degree of sympathy with the sufferings of the lower orders, and however convinced one may or may not be of the depth of their interest in the latters' welfare, it remains the case that to present the outcome of reform as a triumphant and unproblematic expression of humanitarian concern is to adopt a perspective which is hopelessly biased and inaccurate: one which relies, of necessity, on a systematic neglect and distortion of the available evidence....There would, I think, be a widespread consensus on the dearth of almost any real knowledge base in early nineteenth-century medicine which would have given the medical profession a rationally defensible claim to special expertise vis-a-vis the insane.

This is a fair indictment of the form of historical compliance which has permitted the progressive version of the development of psychiatry to gain such currency. However, I think Scull is not properly concerned with the meanings that informed the actions of the asylum reformers. Admittedly, meanings and intentions are not identical, but they may be related, and what Scull rejects as questionable in the profession of humane motives may be considered as an expression of a complex constellation of theoretical structures, social attitudes and personal beliefs which were themselves the working out of an epistemological framework that we need to understand in order to best interpret nineteenth-century asylum practices.

Scull has one thing in common with the traditional historians whose work he criticizes. Like them, he focuses upon the specifics of the actors because he wishes to expose their rhetoric and intentions. He too is
concerned with the problems of interpreting individual behaviour and its relation to stated understanding and observed effects.

A final important school of historiography takes the same critical position as Foucault and Scull but expresses itself in an analysis that is fundamentally different from that of Scull. It is indebted to Foucault's more recent work which is concerned with the distribution of power throughout social institutions and which attempts to subordinate the issue of "subjectivity".\textsuperscript{10} This school is represented by Roger Castel, in \textit{L'Ordre Psychiatrique}, his extensive work on French psychiatric history, who emphasizes the constitutive elements which both make possible and embody a range of practices which are the limits and definition of possibility for the individual in a given historical situation.\textsuperscript{11} Particular behaviours and their meanings to the individual are not privileged. Instead, he concentrates on the asylum as a meeting-ground for several strategies of control, especially those of the bureaucratic administrator and the "compassion in the form of paternalism" of the philanthropist, which, when combined, created an institution that was not medical or therapeutic, but pedagogical in effect. He attributes the limited explanatory power of those models of madness embraced by nineteenth-century medical psychologists as necessarily inadequate from a scientific standpoint because the asylum was more useful as a vehicle for the development of expertise in social management. He attributes the change in social attitudes towards insanity that is characteristic of the eighteenth century to the advent of a bourgeois "contractual society", in which individual self-responsibility is requisite and paramount. Madness challenged this contract—the mad were dangerous yet innocent—and so had to be dealt with in a different social and legal framework, one that
encompassed a new "relation de tutellarisation". In a liberal society, this meant "translating the political desire to erase remnants of absolutism into a technical problem with moral implications". According to Castel, Pinel's great contribution was to provide a synthesis of three heterogeneous lines of development: the first, theoretical reclassification; the second, reform of the institution; and the third, changes in treatment. The moral treatment that he utilized, when practised within a specifically closed milieu, was the "paradigm of an authoritarian pedagogy".

In the end, Peter Miller describes Castel's argument in this way:

The formation of the 'synthèse asilaire' is, however, not an unique historical 'event' and must be located instead within the formation of the 'social'...the site at which a number of diverse strategies intersect....The formation, that, of a multitude of governable or administratable sites which is also the formation of the population itself. Crucial to this process, and indeed a part of it, is the constitution and recognition of the various activities of what Castel terms as 'expertise'...doctors, psychiatrists...whose evaluations are founded on a technical competence which imposes on certain 'marginal' groups as a status, one which has legal value although it is constituted through technico-scientific criteria....Such activities operate by hierarchically distributing behaviours according to a norm established through the operation of various disciplines.

The "social" is not, however, co-extensive with an "historical epoch".

It should, instead, be viewed as the investigation of the mode in which a number of distinct, yet at times overlapping and interdependent processes combine to produce an ensemble which neither exhausts everything which occurs within its domain nor operates simply as a grouping of contingent occurrences.

Thus Castel would restrict the definition of the "contractual society" to "the identification of the 'juridico-administrative fiction' on which the new bourgeois order established itself." It is, according to Miller, a
nominalist position, which desires only to "locate the new technologies which fashion the web of social relations within the principles of contractual exchange."\textsuperscript{17}

The advantage of Castel's approach is that it requires a balanced, detailed and nuanced discussion of a multiplicity of factors, and yet, as his work on Pinel reveals, it permits analysis of an individual's theories and practices, and adds depth to the analysis by providing a broad framework in which the particular subject can be situated. At the same time, the meaning of the individual's actions assumes less importance, and intentions are subsumed under a general category of social undertakings.

Once again, because I consider it unlikely that meanings and intentions are formulated independently of one another, it may be possible to penetrate the "rhetoric of intentions" by analyzing the factors which operate in an individual's understanding of his behaviour. In order to effect this, I would embrace Roger Smith's statement that "meanings are not subjective but exist objectively in practice."\textsuperscript{18} Smith takes the "discourse" of the medico-psychologists as his controlling interpretative framework, rather than something as inclusive as Castel's "social". He is careful in his use of the term:

As I use the word, a discourse is the abstract source of first the language and belief which constitute a version of reality, and second, the corresponding disciplines, institutions, and political choices. There is a danger of treating the discourse itself as an object, which it is not: rather, it is a group of relations between possible objects....The discourse is therefore the framework within which particular statements or judgements have validity....\textsuperscript{19}

This definition would seem to encompass most of the factors which need to be considered when attempting to place John Conolly's activities in the
development of nineteenth century psychiatry. Again, subjective meanings are included, but they are not necessarily privileged, which, I think, is a major weakness in the approaches of both Scull and the traditional historians when discussing Conolly's contribution to the phenomenon of moral management.

John Conolly, the English physician, achieved fame in the first half of the nineteenth century as a major spokesman for the moral management of the insane. He publicized its theories and practices from 1830 until his death in 1866. By that time, the institutions which had been developed under its auspices were already retreating from a full implementation of its principles. While Conolly was active, the British Government established standards of care for the insane that required medical attention and institutionalization, government licensing and supervision of the facilities and treatments employed in the treatment of the insane. In addition, because madness had been conceptualized as disease, physicians began to exhibit a professional concern for insanity that led to the establishment of a distinct medical speciality.

I think that a more comprehensive study of moral management should be undertaken, one that attempts to link theoretical factors and administrative techniques. I think that John Conolly's writings are characteristic of nineteenth-century British psychiatry and that his ideas about medical agency and mental functioning were integral to his understanding of asylum practice. Moreover, when the elements of moral management are considered in relation to the deep-seated conceptual categories which I believe to constitute the framework of nineteenth-century psychiatry, the picture of the reformed asylum and its physician-managers which emerges has a greater coherence.
Both the question of John Conolly's reputation and the question of interpretation which envelops the study of moral management can be understood best as two related problems in historiography. In order to address these problems, I will begin with a recapitulation of the development of moral management. Next, I will outline the principal features of the theories of mental disease and treatment which were utilized by the asylum doctors, and I will show that Conolly was clearly within the bounds of contemporary medico-psychological discourse. Then I will describe the career and the writings that Conolly produced about moral management. Lastly, I will suggest a different interpretative strategy for the understanding of moral management, one which will account for both theory and practice, as well as the social and intellectual influences on the asylum reform movement.

In approaching these problems, I have identified a group of concepts that were employed by doctors involved in asylum medicine. These can be categorized as the schema of stimulated motion, predisposition, and hierarchy. These ideas had been developed out a combination of medical, philosophical and social influences which were themselves generated in a specific epistemological framework constituted around the general principle of organization. The metaphor of organization was the controlling theme from which grew both societal responses and medical thinking about insanity. These three essential ideas—stimulated motion, predisposition, and hierarchy—provided an explanatory system which gave coherence to the theories of mental functioning and behavioural motivation that were central to the moral managers' understanding of their enterprise. In addition, they provided a rationale for regarding the theoretical and practical aspects of asylum medicine as integrated. This kind of conceptual analysis helps to
explain Conolly's adoption of the practice of moral management. No longer can his role as advocate be understood as a simple example of careerism. It is more fully comprehended as a practical corollary of existing psychiatric theory.

In this paper, I intend to give an account of Conolly's work within the limits of the discourse in which it had validity. I hope to contribute to an understanding of the constitution of the "social" in which the discursive strategies of the moral managers had their place. That understanding can be furthered by considering the metaphor of organization as a fundamental concept within the structure of the "social". The major explanatory systems utilized by asylum doctors were informed by their relation to "organization", which in turn was a substantive principle within political and socio-economic discourses as well. "Organization" served to situate the theories and practices of the moral managers within their epistemological boundaries, and to permit the meanings that their enterprise had for them to be located accordingly.

In analyzing the elements of moral management with special reference to the epistemological configurations from which it was constituted, this thesis is not intended to supplant the "sociological" type of analysis that has enriched our understanding of the asylum reform movement. I will be arguing that an examination of the conceptual foundations of asylum medicine leads to a clearer picture of nineteenth-century British psychiatry as it was understood and practiced by its physician-managers.
CHAPTER I
THE HISTORY OF MORAL MANAGEMENT

...the outside walls of an asylum were regarded with awe; the shrieks issuing from it made night hideous; the frantic creatures, inclosed in their dens, furnished appalling subjects for the artist or novelist; squalor and dirt, and famine and ferocity, were everywhere to be met with. Now, all is changed, or all is changing. Asylums are hospitals for disordered minds....

John Conolly

The diminution of the use of physical coercion in the care of the insane, with the concomitant increase of attention to strategies for inducing self-control, and the interest in methods of affecting the mind so as to restrain behaviour, were all elements of the range of techniques known as moral management, or moral therapy. The development of this system was inextricably linked with the increase in the number of asylums in the eighteenth century and the extension of medical interest into the area of mental illness. The change from a physically coercive to a morally constructive basis for treatment was concurrent with similar alterations in the treatment of criminals; because of this similarity, changes in asylum care have been included within studies of the movement towards and the advocacy of change in the management of deviance.

From the middle of the eighteenth century, there was a steady increase in the construction of hospitals in Britain, many of which included facilities for the insane. At the same time, there was an expansion of the system of private asylums and a heightening of concern among the educated elite about the regulations that determined entry into these institutions. Further, throughout the eighteenth century, the fund of literature about madness—medical, cultural, administrative, legislative, and scientific—
was steadily enlarging. The illness of George III also stimulated interest in the treatment of insanity. By the 1780's, one or two asylum managers were beginning to speak about the efficacy of treatment through "moral" methods as an adjunct to physical means.

There was a growing belief in the curability of mental disease which corresponded with the shift to "psychological" methods of treatment. The idea of cure was indicative of a redefinition of the nature of madness that embraced both lay and medical constituencies. The earlier view of the lunatic as "other", as less than human, because of his lack of reason, was in opposition to the still prevalent concept of the mind as the location of the soul. Reason was essential to the soul, and the soul could not be diseased because it was beyond the reach of corruption. If the condition of the lunatic was absolute, then it was irrevocable, implying corresponding loss of soul, a view that could not be tolerated theologically or morally.

Hence, a view of the mind and brain as a separate—with the brain a possible source of diseased mental functioning—was preferable. This view permitted madness to be defined in organic terms, (and hence, made it treatable) without discarding mental factors, which could be altered by outside influences and thus cured. For moral managers, it was essential that the underlying causes of madness be physiological; otherwise medical treatment could not be applied; at the same time, the therapeutic efficacy of their management precepts had to be incorporated into medical discourse.

Moral management first began to attract public attention in the 1790's. Prompted by several sensational investigations into the conditions in private asylums, there was an explosion of public concern about the treatment of lunatics. This encouraged early nineteenth-century English doctors
interested in asylum care to develop therapeutic rationales that would permit them to employ the techniques of moral treatment while retaining their self-conceived identity as scientific men committed to a "scientific" enterprise, the study of medicine. By the time John Conolly became active in the movement, moral methods were being advocated by doctors who could claim a special expertise in the treatment of lunatics. By 1845, Parliament decreed that physicians must be in charge of the treatment of all lunatics requiring confinement (in effect, this included all the insane since the necessity for confinement was an axiom of moral management), and that these physicians employ moral methods, as well as pharmacologic and other suitable forms of "medical" or "physical" therapy.8

The basic elements of moral management as it was practised in the late eighteenth century began with the limited use of mechanical restraints and an emphasis upon order and tranquillity that was founded upon the expectation of nonviolent behaviour among asylum attendants. Equally important was the cultivation of a "domestic" atmosphere, with attention to clean and well-maintained accommodation, clothing, and food, the provision of employment of occupation, and some forms of entertainment. Two assumptions determined all contact with the mentally ill: the first, that the insane were unfortunate victims of a disease, and second, that the goal of care was to inculcate in the patient a capacity for self-control. The watchwords of treatment were kindness and gentleness because such forbearance set an example of self-restraint for the insane. Physical means of restraint were discouraged because they actively undermined the motivation for the lunatic's acquisition of the capacity for self-control. Several other techniques were intended to approach the madman through his mental functions. These included
threats of physical restraint to induce fear, ostentatious displays of dominating character by physicians to create awe, and the use of punitive physical therapies, such as rotating chairs, to ensure compliance.

The two men whose work is most closely associated with the early period of moral management are Phillipe Pinel in France and William Tuke in England. Both entered the field of asylum management in 1792 with a new approach to treatment, one that was in line with some of the change of the previous fifteen years, and yet, sufficiently unorthodox so as to create much controversy. Because Pinel was a physician, his reforming efforts are usually considered to have been a response to perceived medical problems. Tuke, a Quaker layman, is seen as having constructed a new style of administration as a challenge to the physically punitive methods employed in other institutions.

A myth developed around Pinel's management of the Bicêtre, a Parisian hospital for the insane, to which he was appointed in the early years of the Republic. He is supposed to have become so disturbed by the ravings of a furious maniac that he ordered the ward attendants to remove the man's chains, whereupon the lunatic became quite composed. Actually, a form of moral treatment had already been introduced by the lay managers of some French asylums, and Pinel decided to employ similar methods when his position was established. From his observations, Pinel drew the conclusion that too much physical restraint exacerbated the ferocity of maniacal behaviour. He argued that violent treatment of the insane was indicative of an inadequate understanding of the nature of mental illness and its prognosis. The old belief that insanity was caused by a lesion of the brain had led to the notion that insanity was incurable, and hence that therapeutic measures were
useless. On the basis of observation and experiment, Pinel reported that a substantial improvement in the behaviour of maniacal patients might occur when they were treated more kindly and with only moderate physical coercion. He reasoned, as had John Ferriar, an English physician, that by making the lunatic partially responsible for his behaviour, he might be induced to control it better. Thus the use of punishment schemes and appeals to feelings of shame of fear as techniques for patient management were justified.

Pinel claimed that his methods were more philosophical since they involved not only an appeal to the mind of the patient, but were also grounded in a common-sense empiricism that permitted the physician to discard elements of older programs for treatment as having no appreciable effects. He was skeptical of the efficacy of many of the standard medical remedies, and advocated an increased reliance on aspects of regimen, such as diet and activity. He also believed that the truly scientific treatment of insanity, which was his goal, could be achieved only with an attention to proper nosological principles, since correct classification was a prerequisite for appropriate treatment. All of these ideas were discussed in his *Traité médico-philosophique d'aliénation mental* of 1803 (translated in 1806 by Donald Davies under the title, *A Treatise on Insanity*). By this time, there was a rising tide of enthusiasm in England for the approach to treatment that Pinel called "moral", thus, his work was received with great interest and soon was used to bolster the movement for asylum reform.

The groundwork for this encouraging English response to Pinel had been laid by William Tuke, who had established an alternate asylum, called the Retreat, in the city of York in 1792. His intention to treat Quaker lunatics under new principles was a reaction to the unexplained death of a Friend
placed in the York asylum by her family who were then denied access to her. When she died, an inquiry found considerable abuse of patients. Tuke decided that different methods of treatment could, and should, be pursued.\textsuperscript{12}

Tuke's Retreat was arranged upon a domestic plan in which the patients, attendants, and physicians were to regard themselves as a family. Only mild forms of physical restraint were to be employed, and the general tone of the establishment, in keeping with Quaker precepts, was to be kindly, gentle and firm, with much emphasis on personal responsibility for behaviour. The patients were to be regarded as wayward children who would respond to pleasant treatment mixed with a wholesome fear of ridicule or punishment. In this setting, it was found that the inmates were noticeably less violent and unmanageable. Care was largely in the hands of non-medical personnel, the superintendency having passed from Tuke to a physician who, despite his professional background, was content to relinquish most of the recommended medical therapies since Tuke was suspicious of the aggressive physical treatments characteristic of the period.

The Retreat was visited by several physicians who were eager to publicize its efforts,\textsuperscript{13} but its greatest impact came after the 1813 publication of the \textit{Description of the Retreat}, written by Samuel Tuke, William's grandson.\textsuperscript{14} As described in Tuke's book, the procedures at the Retreat contrasted vividly with the practices at Bethlehem Hospital which were then being scrutinized by the Parliamentary inquiry of 1815, where William Tuke was called as a witness.\textsuperscript{15} Although some members of the medical profession were suspicious and resentful, an influential segment of the lay elite, with a number of reform-minded doctors, set about popularizing the philosophy of moral management with its concentration on limited restraint and kindly
treatment. Along with this went a commitment to the idea of the asylum as a curative agent, and, thanks to medical lobbying, to the physician as the central figure in the provision of and medical treatment within and without the institution.\textsuperscript{16}

Public concern about the care of the insane can be traced through developments in two related areas. First, the asylum system was expanded and reformed. Second, legislation was enacted establishing standards of care, admission and certification, and public responsibility for the provision of institutions. Both of these movements can be said to have peaked in the year 1845 when Parliament made the construction of public asylums, their maintenance and inspection in all counties, compulsory. Guidelines for proper management were set out in the Act.\textsuperscript{17}

Throughout the eighteenth century, there had in fact been a continual increase in the establishment of private asylums for the insane, paralleled by the growth of subscription hospitals, several of which were soon to designate certain areas for lunatic care. In 1714, a Vagrancy Act instructed local magistrates to see that dangerous madmen were cared for, and this was expanded in a 1744 Vagrancy Act to specify the need for therapeutic attention.\textsuperscript{18} Most lay concern was focused on the certification issue, however. Thus, the legislation of 1744 established the need for a doctor and two magistrates to order confinement, and also regulated the licensing of private houses and made internal inspection compulsory.\textsuperscript{19}

This growing interest in the treatment of lunacy was reflected in the burgeoning of medical literature on the subject.\textsuperscript{20} This, in turn, contributed to the increased awareness of reform-minded individuals such as Lord Ashley, later the 7th Earl of Shaftesbury. By the first decade of the
nineteenth century, their receptivity to innovation was profound, as demonstrated by the publicity generated by Parliament's investigation into Bethlehem Hospital in 1815. The Parliamentary Commission showed itself sympathetic to the principles of moral management. Attempts were then made to establish public asylums for pauper lunatics. In the 1828 Act, concerned with inspection and certification, there was also a recommendation that county asylums be constructed. However, the energy of the reformers was still directed largely towards regulating practices in private asylums, since most lunatics, whatever their financial capabilities, were confined in such places.

By 1838, the influential physician, George Mann Burrows, was moved to include a discussion of methods of moral management in his lengthy work, the Commentaries upon Insanity... However, moral management seems to have been all things to all men at this time. It could be defined simply as non-punitive treatment, or as the complete absence of physical restraint which Robert Gardiner Hill would do in 1836 at the Lincoln Asylum.

It is difficult to establish how much the standards of care had actually changed by 1830. Nineteenth-century historians of psychiatry such as Daniel Hack Tuke declared that in public asylums and hospitals, and in a few good private ones, moral therapy along the lines of the Retreat was being practised, but that the majority of the private houses remained sunk in degradation. It is more likely that, while details of regimen had probably improved in most institutions, and excessive use of physical restraint had largely disappeared, the idyllic domestic atmosphere of the Retreat was rare indeed, especially in public institutions.
Besides the requirements of less restraint, better food, and cleaner accommodation, the only other facet of moral management to meet with evident enthusiasm in public asylums was the introduction of profitable employment. The idea of the self-sustaining asylum was very popular, because by the mid-1820's it was becoming apparent that the number of people declared insane was increasing, and because most treatment was obligatory for the pauper insane. Since the costs of care were to be supported by a system of assessments, there was considerable interest in a reduction of expenses to make the asylums more self-supporting.

Class divisions in treatment had long existed, of course, but the medical literature on the nature of mental illness, as well as the preferred treatment, tended to emphasize uniformity. Thus, all insane, regardless of ability to pay, required confinement and treatment according to the new enlightened principles of the moral managers, who were convinced that occupation had a distinctly curative effect. The wealthier insane "occupied" themselves at riding or walking or needlework, while the poor laboured in the gardens, kitchens and laundries. The need for the erection of public asylums was intensifying, especially after the new Poor Law of 1834, but so were efforts to reduce the financial burden of institutionalization.

By 1835, a number of observers had redefined the philosophy of moral management in response to the new doctrine of non-restraint. This was deemed the logical extension of the principles of moral therapy by its two principal advocates, Robert Gardiner Hill and John Conolly. Non-restraint required the abolition of all forms of physical coercion in the asylum. When some restriction of behaviour was necessary, a seclusion room was utilized. Hill first began to reduce the amount of restraint at Lincoln
Asylum in 1836, and the success of his venture was publicized in a lecture he gave to the Mechanics' Institute in 1838, which was later published. The reform-minded press also complied in publicizing the regime at Lincoln, Mr. Sergeant Adams being especially helpful, as he was later to be to Conolly. Conolly visited Lincoln in 1838, and when he took over Hanwell on June 1, 1939, he immediately put Hill's system into practice.

As its advocates consistently reiterated, the non-restraint system could only be established in asylums where all the other principles of moral management were in place. It was essential that the institution be built along therapeutically-designed specifications; that it be well staffed with adequately paid and properly trained attendants who were carefully selected for their imperturbability and moral strength; that the patients be well fed and clothed, and occupied, both usefully and entertainingly, in congenial pursuits; and that all aspects of asylum management be under the control of a physician familiar with the latest and most progressive ideas and practices in medical psychology. Above all, the commitment to non-coercive management had to be absolute.

It was this last requirement that met with the greatest amount of disagreement in England and abroad. While the British and continental doctors were willing to give their consent to the ideal of total non-restraint, they were not prepared to relinquish their need for gentle physical coercion, to be used only when entirely unavoidable. American physicians were more vociferous in their opposition: not only did they claim that total non-restraint was impracticable (a frequent criticism of their British counterparts as well), it was also non-therapeutic. Restraints helped cure in some cases, and, besides, seclusion or solitary confinement, as they named it, was far
more damaging. They argued that it was better to be confined into a restrain­
ing chair or tied in a strait waistcoat in the company of one's fellows than to be locked in an empty room by oneself for an indeterminate time. The proponents of non-restraint argued that physical coercion demoralized patients and attendants alike, that it decreased the need for self-control in both parties, and that it increased the level of frustration in the patient to the point that it would worsen his condition. They defended the use of seclusion rooms by denying that the practice had any real identity with the prison's solitary confinement: seclusion was for short periods only, it was monitored by staff and was to be explained to the patient as non-punitive in intent.  

The debate about non-restraint found its way rapidly into the public realm, and particularly into the Parliamentary Commissions. The Report of the Commissioners of 1847 expressed approval of moral treatment as a therapy in consonance with medical treatment and also endorsed non-restraint. Although the Commissioners refused to make it compulsory, they did lay down careful regulations to ensure proper reporting of all incidents requiring restraint. The argument about total non-restraint did not end at this point, however. It was to continue well into the 1860's, with Conolly fighting what seems to have been a rearguard action against the reappearance of physically coercive devices in the asylum with a series of articles in the Medical Times and Gazette of 1862. By this time, most other commentators had adopted a modified non-restraint posture. 

Ironically, the Act of 1845, which made obligatory the construction and maintenance of public lunatic asylums at the county's expense, dealt the death blow to the non-restraint ideal. Asylum governors were acutely con­scious of the cost of keeping lunatics. Nineteenth-century reformers
complained constantly that, although they accepted the notion of the curative asylum, in practice the governors had a tendency to handle its expenditures as though it were simply a custodial device. Most asylum boards simply refused to hire the number of staff that the moral managers had declared were necessary to prevent recourse to restraint and lapses in hygienic standards. As the population of the newly built institutions continued to climb throughout the mid-century, the boards of governors made increasingly utilitarian additions onto existing facilities and later even lobbied for a two-tiered system of acute and chronic institutions in order to accommodate the larger proportion of the mentally ill who were identified as incurable.

Since moral management was intended as much to reduce the inactivity of the attendants as to counteract their brutality, the increasingly custodial qualities of the public asylums were directly antithetical to moral therapy, as the non-restraint promoters recognized. Passive attendants used restraints to maintain order, and activity was almost impossible in a setting infected by incurability. The uneconomic demands of non-restraint made it increasingly impractical, and its strident moralism seemed somehow less suitable in an age which regarded itself as having advanced socially and scientifically since the early days of asylum mismanagement.

"The chimera of the curative asylum" was exposed in the second half of the nineteenth century, and the lack of strong scientific information about either the nature of madness or the efficacy of treatment continued to be a major stumbling block to intra-professional advance, as well as to improved patient care. However, this did not adversely affect the medical-psychologists' claims to expertise in the field. The second part of the century saw an increased attention to preventative measures in the form of the mental
hygiene movement. This movement developed out of the recognition of low curability and from adherence to two cardinal beliefs of nineteenth-century psychiatry: the first, that insanity was essentially a physical disorder though it was often the result of immorality; and the second, that it was inheritable and that, indeed, a physical predisposition or tendency towards degeneracy must be present for the disease to manifest itself. At the same time, the asylums grew larger and more crowded, and their function became increasingly custodial. As the possibility of cure in the asylum became less likely, the emphasis in medical psychology shifted from a concern with the treatment of mental disease to a preoccupation with the prevention of insanity.
CHAPTER II
DISEASES OF THE MIND AND STRATEGIES FOR CURE:
THE STATE OF THE QUESTION, 1770-1860

We do not comprehend the nature of the movements or actions on which mental manifestations depend;...but we know the phenomena which result from these movements...and can plainly discern that they are wrought through the agency of corporeal organs.

John Conolly

Richard Hunter and Ida MacAlpine had a tendency to regard late eighteenth-century and early nineteenth-century speculations about the mind and mental illness as a sourcebook for twentieth-century psychiatric beliefs and practices. Scull challenges them with the theory that Victorian beliefs about moral management were developed in order to justify a set of institutional practices for controlling mad behaviour that were already in place. This tends to diminish interest in the content of the theories themselves, insofar as they seem an ideology rather than a set of definitions, a superstructure of beliefs which disguise the techniques of management which are the real subject of discussion. Recently, several other historians--most notably Roger Smith and Michael Clark--have examined aspects of nineteenth-century medico-psychological thinking within the framework of contemporary medicine and social beliefs. In this chapter, I shall attempt to give an overview of the major facets of the "body of knowledge" that informed the practices of the asylum doctors. I will use a developmental scheme that will relate various aspects of the conceptual structures to one of the deep-seated intellectual conflicts in which the moral managers found themselves. I will concentrate on the writings of several physicians whose work was considered by most nineteenth-century asylum doctors to have been of especial interest and of particular influence in the field of medical psychology.
I

The theoretical underpinnings of moral management can be studied under three headings. The first deals with the supposed operations of the mind and their relation to the body. The second is concerned with the definition and causes of insanity. The third purports to establish proper modes of treatment. The roots of moral management theories stretch back into the early eighteenth century, but probably the most comprehensive early discussion of the structure of the mind and the causes and treatment of madness could be found in the work of William Cullen, who taught chemistry, medicine, and the practice of physic at Edinburgh University between 1775 and his death in 1790. His works, First Lines on the Practice of Physic (1784) and Nosology (1772) were two of the principal medical texts to which many British and French physicians of the late eighteenth century and early nineteenth century referred. His summary of the relation between the mind and body set out the boundaries of the problem for the next hundred years.

In Cullen's view, man possessed an immaterial thinking substance, or mind, constantly present and connected with the material and corporeal part of him, and particularly with the nervous system; thus, motions excited in it gave rise to thought, and thought, however occasioned, led to new motions in the nervous system. This much could be ascertained to observation and experience, although the process by which it operated was unknown. Cullen concluded that thought must be caused by an immaterial substance—the authority for this belief being the writings of "divines and metaphysicians". While some philosophers had adopted explanations that were mechanistic and materialistic, physicians chose to remain orthodox and admit the soul. An earlier authority for this decision was Robert Whytt, who had demonstrated the necessity of the soul as a sentient principle, necessary to motion, but
not rational. The mutual influence of the soul and body must take place by physical necessity, but "there is nothing arbitrary in the power of the soul."⁶

The interdependence of body and mind or soul was described again in Cullen's treatment of the functions of the brain. The brain was the seat of the soul, the organ of volition and sensation. The soul acted by means of the brain, but the body could be independent, governed by mechanical actions of the nervous system. These actions of the brain could be excited by such influences as the will, the passions and emotions, and appetites or desires, as well as the impulse to procure gratification or avoid pain: in other words, by sensation. The vital action of the brain was dependent upon a certain force in the flow of blood to that organ, which influenced the level of the nervous fluid—that power by which the nerves were exercised—so that the nervous power could be either "excited" as in mania, or in a state of collapse as in coma.⁷

In turn, the operations of the intellect—judgement, volition, memory, attention—depended upon the motions of the brain, although such motions had never been seen or located in the brain. Those motions occurred because of the movements of a fluid which was a substance in the brain and nerves. It travelled around the nervous system from the sentient extremities to the brain causing sensation. When added to volition, it caused motion to be transmitted from the brain to the muscles. The proper exercise of these intellectual functions was dependent upon the excitement of the brain being complete and equal in every part. Mental disturbance was occasioned by an inequality of that excitement.⁸
Thus, the basic elements of the mind-body relation were established: an immaterial thinking substance connected by some unknown process to the corporeal brain, which directed all physical motions and in which all intellectual activity had a corresponding physiological manifestation. The operations of the mind were given a separate, semi-organic status, and the whole apparatus—mind, brain, body and thought—was mediated by the movements of a fluid.

The importance of a continuum between mental events and physical consequences was reiterated by George Mann Burrows, whose *Commentaries Upon the Causes, Forms, Symptoms, and Treatment, Moral and Medical of Insanity* (1828) was the first comprehensive textbook of insanity. Burrow's object seems to have been to incorporate into medical discourse, in its entirety, the definition and treatment of lunacy, with its underlying unresolved problem of the mind-body relation. Burrows proclaimed emphatically that experience confirmed "that the operations of the mind are wonderfully influenced by our corporeal movements,...and that the influence is reciprocal." He continued with a concise description of the connection between the immaterial mind and physiological processes.

Every impression on the sensorium through the external senses, and every passion in excess,...vices, also, which occasion changes in the physical constitution,...all impressions that affect the feelings are conveyed to the sensorium, and operate according to the degree of constitutional susceptibility, and the nature and force of the impression, and re-acts on the brain and nervous system. Hence, there are two impressions: the one primitive, affecting the sensorium; the other, consecutive, but simultaneously affecting the heart. Thus the nervous and vascular systems are both implicated.

Impressions, which were ideas formed from sensations, and passions, were mediated in a location known as the sensorium, which transferred their effects to the brain and nervous system and thus to the rest of the body.
It was not sufficient, Burrows argued, to attempt to deal with the mad by attending exclusively to mental symptoms, because the mental and physical were interdependent. 12

Even James Cowles Prichard, who attempted to speak only of mental processes, used a language of physical action and physical disease that undermined his initial purpose. Author of an important reference book, A Treatise on Insanity (1835), 13 Prichard was primarily concerned with the relations between various mental attributes in the production of madness. He utilized the intermingled languages of physical illness and mental disorder.

...it is easy to conceive that when any morbid change has ensued in the connecting faculty, by which the ideas, if we may so speak, cohere, when they become disjoined and incoherent, no longer follow each other in their natural order of suggestion, the mind loses the power of reasoning through the shattered condition of its instruments. 14

When he came to discuss therapeutic techniques, his dependence upon the established formulae of the mind-body relation became apparent.

The moral treatment of the insane comprehends all the means which are known to exercise immediately on the mind an influence tending to restore the healthy and natural state of its operations. The medical or therapeutical treatment includes the use of remedies which act upon the body and are designed to remove the disorder of cerebral or other functions, known or believed to be the cause of derangement in the mind, or at least to be intimately connected with its manifestations. 15

Marshall Hall, the famous nineteenth-century neuro-anatomist, 16 also adhered to the orthodox explanation of the relationship between mind and brain. He divided the nervous system into three parts: the first being the cerebral or sentient and voluntary; the second being the true spinal or excito-motory; and third, the ganglionic or nutrient and secretory. 17

The cerebral subdivision incorporated sensation, perception, judgement, volition and voluntary motion. These functions constituted "the animus,
the soul", and were psychical. "The true spinal functions appear to be entirely of a vital kind, distinguished from psychical or sensational..."\(^{18}\) He thought it important to distinguish between these spinal and physical functions because "this is the only view of the subject according to which the individuality of the sentient being can be maintained."\(^{19}\) He was more explicit about the relationship between faculties and anatomical structures in a later work:

...the seat of volition is the cerebrum, and that its action is along the fibres which decussate in the medulla oblongata; and that the seat of emotion is below that of volition and that it acts along fibres which probably do not decussate...In these respects the effects of emotion resemble those of respiration, as seen in yawning. This function is known to act in a direct manner...volition has an object, an aim. Emotion and the \textit{vis nervosa}, however subdued to certain laws impressed the Creator, and destined to special purposes, are aimless on the part of the individual, nay frequently opposed to his volition... These agents act upon different instruments--volition along the intravertebral cord of the cerebral nerves; emotion, and the \textit{vis nervosa}, upon the fibres of the true spinal \textit{marrow}.\(^{20}\)

Some changes can be ascertained in the development of theory between Cullen and Hall. The fluid which had acted in the nerve substance for Cullen has been discarded, although it does not seem that neurophysiologists had yet discovered any physical agent to take its place. The various functions of the mind were now located in specific structures of the brain, not simply relayed by a sensorium. However, the lack of precise knowledge about the nature of either the psychical or the physiological processes described by Hall remained a serious problem for physicians who were engaged in treating and writing about insanity.

Even in 1858, when J.R. Bucknill and D.H. Tuke published their new definitive textbook, \textit{A Manual of Psychological Medicine},\(^{21}\) the chapter on
the pathology of insanity opened with an apology for the paucity of reliable physiological information about the brain.

An agglomeration of delicate cells in intimate connection with minute tubes or filaments, which communicate impressions made upon the cells at one end, to those cells which lie at their other extremities; this is the nervous apparatus. Its *modus operandi* is, and probably always will be utterly unknown to us... the connection between nerve-function and nerve-organization is a mystery which remains veiled from our most anxious scrutiny...\textsuperscript{22}

It was therefore necessary to proceed on principles of logical thought insofar as the mechanisms of insanity were concerned. Thus Bucknill, who wrote this chapter, was able to use the analogy of a stomach ulcer to construct a defence for the prevalent methods of theorizing about brain function.\textsuperscript{23} Thus it was possible to observe that the seat of intellect and instinct lay in the convolutions of the cerebrum, and that disease must exist in that area of the brain. All disease was organic—the result of altered chemical composition. The brain was a congerie of organs, and any cause disturbing the physiological conditions might concentrate on one emotion or property, especially a well-developed one. However, a predisposition or constitutional weakness must have been present in the brain and the development of its faculties for insanity to have arisen.\textsuperscript{24}

John Conolly also wrote on the nature of the mind and its relation to the body, especially in the *Inquiry* and in several shorter papers and addresses he gave to medical groups.\textsuperscript{25} His ideas were in complete accordance with the general theories outlined by Cullen and Burrows. Conolly defined "the mind" as "such mental actions which are the most separate and plain, those which all men may perceive in themselves, and which, in morbid states of mind, are visibly affected in degrees which indicate their distinctness."\textsuperscript{26} The principal "mental actions" which he distinguished were sensation,
attention, memory, and comparison. By means of the five senses, the mind "becomes impressed with the idea of certain properties existing, or deemed to exist, in surrounding objects," and these ideas are then correlated with the common experience of mankind. "Each of the senses excites the state of mind which is called attentive...and we possess the ability through the will of fixing our attention for long periods of time in order to understand something." We also notice the functions of memory, "the wonderful power of recalling both the impression made by the sensation, and by the object which excited it, in the absence of such objects." Finally, when "we receive new impressions from other objects, and sensations either resembling those experiences, before, or differing from them we can pay an alternate attention to the new sensation...this alternate attention constitutes comparison." He included a limited role for the faculty of imagination in recalling impressions with the memory, so that they "not only...revive past impressions...but successive images in a long series;" a process which is sometimes involuntary, but can also be directed by the exercise of the will. In these processes, we see what appears to be a conjoint office of the memory and imagination, which has been sometimes called the association of ideas. Because of the importance of the association of ideas, Conolly eventually decided that attention, memory, imagination, and comparison were "the great attributes of human understanding...Reasoning is nothing more than successive or controlled exercise; and what we call reason is but the product of this exercise."

Conolly went on to account for the production of other aspects of the mind, such as the affections. Sensations are stored and called up as recollections which in turn, evoke pleasure or pain, the pleasure and pain
caused "by certain influences operating on the nervous system in a manner we cannot explain," any more than we can explain the process of external sensation.

But the association which is formed between certain objects and certain ideas of pleasure and pain becomes the source of...the affections, each affection being in reality in the first instance founded upon emotions of pleasure or emotions of pain, and even afterwards guided by a judgement or opinion effected by the use of the intellectual faculties.  

Passion is simply the degree of vehemence with which we experience sensations or emotions, and the will to act springs immediately from the affections, emotions or the sensations, "a property or faculty of our being, distinct from the understanding, but evidently not independent of it; and in a well-regulated constitution it is governed by it."  

Conolly believed that the interaction between the faculties and the emotions constituted and defined the character. In this way, "it is evident that the character of an individual must depend upon the degree in which the natural or acquired strength of his mental faculties is able to control his natural sensibility to emotions and to the impressions of sense." As a result, he argued, there existed a hierarchy of human types:

...those lowest on the human scale are wholly given up to the passions and appetites; many far above these are yet the sport of every emotion and affection; others more fortunately constructed, or who have been guided and disciplined to better ends, acquire various degrees of command over these impulses...  

But whatever may be the gifts of mind with which an individual might be endowed, the attributes of mental life were dependent upon the development of his brain. Thus, the mind, "out of reach of physical injury...works by physical instruments, and the exactness of its operations depends upon the growth, maturity, integrity and vigour of its instruments, which are the brain and nerves." The most important faculty in the definition of sound
mind was the capacity for comparison. It was essential that the property of comparison be intact and powerful, because it provided "all exact knowledge" and without it, no judgement could be exercised and "the wisest are hardly more than instinctive." 

II

The second major theme of the asylum physicians who wrote on moral management was concerned with the nature of madness and its causes. By the last quarter of the eighteenth century, a broad definition of lunacy had been formulated, and a number of agencies which were believed to be responsible for its advent had been identified and grouped into two categories, the moral and the physical. Moral in this sense referred to the functions of the mind and such events or activities which most directly influenced or were expressed through the exercise of mental faculties. Physical causes encompassed not only bodily ills and accidents and the effects of heredity, but also the basic strength or weakness of the individual's whole being. Despite the distinction between moral and physical causes, each was believed to be able to extend its effects into the realm of the other, so that mental events might have physiological outcomes and vice versa.

William Cullen endorsed moral causation in a large number of cases of mental disturbance. He stated that passions and emotions, in promoting the violent exercise of the brain, could either increase or decrease the energy of that organ. Violent emotions were therefore a cause of mania, and anxiety and fear could provoke melancholia. Moral causation implied a recognition that mental events could provoke somatic events: that physiological changes in brain substance which were the result of violent emotions or
errors of judgement could be reversed or, at least, palliated by a combination of physical and mental therapies. Cullen's idea of "temperament", which appears to have been derived from the humoral typology of medieval medicine, postulated a psycho-physiologic continuum of mind and body that he believed had a great impact upon the sort of derangement any individual might exhibit.

Pinel's decision to devote much attention to moral causation and treatment was in part a result of his appreciation of Cullen's work. In many cases of madness, Pinel perceived that the illness was characterized by a disorder of the passions, the judgement, or the intellect. At the same time, he identified the action of nervous excitement in provoking the unpredictable and unsatisfactory behaviour of those he regarded as lunatics.

A coarse and unenlightened mind considers the violent expressions, vociferation and riotous demeanor of maniacs as malicious and intentional insults...A man of better feeling sees in those effervescences...the necessary effects of a nervous excitement.

He had observed that "any cause of fear or tension may produce a habitual susceptibility to those emotions, and, by undermining the constitution, may induce dangerous debility and death."

Pinel's emphasis upon the somatic aspects of mental disorder was especially apparent in his utilization of the concept of the "vis conservatrix" or nature's own method of terminating insanity. He referred to Stahl's "principle of conservatrix, whose office it is to repel any attack upon the system" and asked if this principle was not also applicable to theories of insanity. He identified the source of mental derangement as an uneasy sensation in the epigastric region, "symptomatic it would appear of some great commotion in the center of the system;" which excited a general
reaction whose strength was dependent upon the sensitivity of the individual. Physical signs of this reaction were listed. In the end, "the gastric and abdominal affections, often having continued some time, cease. A calm succeeds and brings with it a recovery more or less permanent." But if the paroxysm had not risen to the degree of energy necessary, the same circle of action was repeated and continued periodically, diminishing gradually in violence, until a complete recovery was established. If this gradual termination was not achieved, and the violence of the attacks had heightened until death supervened, then it was possible that "the general and salutary laws of the vis conservatrix, were impeded in their action by some organic lesion of the nervous system." Thus, when insanity manifested itself as paroxysmal, the course of the disease and its outcome might well have been dependent upon a natural physiological progression.

George Mann Burrows also endorsed the prevailing belief that a series of somatic or psychic events, such as episodes of passion, or sudden changes in fortune leading to altered living arrangements, could so affect the substance of the body as to cause lesions in the brain. This was the familiar etiological territory of the eighteenth-century physician—passions, emotions, sudden shocks, vicious habits. However, Burrows extended the reach of causation further.

Burrows believed that living in civilized society could precipitate derangement. It had long been believed that over-use of the intellectual faculties, especially those associated with artistic endeavours, could cause illness. Burrows went further to say that all aspects of modern life, even the development of ethics and religion, were possible antecedents of lunacy. Civilized life could induce mental disease largely through its
capacity for providing avenues for the indulgence of "vicious" propensities. Thus, the rich were susceptible because of their greater refinement and their habits of luxury, while the poor "unhappily provoke it by their excesses; and thus voluntarily ingraft on themselves the evils which, from their condition, they might otherwise escape.""42

There was a distinct problem associated with the expanded role of civilized society in the causation of mental illness. If the good effects of organized or artificial life were potentially pathological, then it might seem necessary to account for all the people who were not mad, and did not suffer ill consequences from the strains of this complex life. Burrows emphasized the voluntary and excessive indulgences of both rich and poor as a major factor in their susceptibility. Another response was to look to "organization", to predisposition and physiological processes for the source of the specific determinants of derangement. He decried the "long prevailing error of studying the mental to the neglect of those corporeal phenomena which are almost always cognizable," for men are created to work perfectly, and if impairment occurs, it must be the result of "accident or that artificial condition of society which begets disease.""43 The functions of the brain seemed to be subject to the same general laws as the functions of other organs, in other words, they developed and deteriorated with age, they could be modified by habit, gender, temperament, and, of course, certain processes that were inexplicable. Brain disease could be structural or functional, and, indeed, derangement that began in the functions would, over time, exact its toll in the form of identifiable physical lesions, as post-mortem studies had demonstrated."44
Another element of "organization" was the doctrine of sympathies. "Although we know not the causes, nor the mode by which sympathies act, yet we have abundant proof of their operation in originating disease which reciprocally acts on the mind." Thus, it was possible to account for the derangement that often accompanied hepatic or gastric disturbance, or that which followed blows on the head, intemperance, or uterine activity.

Predisposition could be both temperamental and hereditary. Burrows observed that "most of the sanguine and nervous temperaments are maniacal, and of the bilious and melancholic melancholy." But familial inheritance of a predisposition towards derangement was of greater significance. "Every disease that assumes a constitutional character can, John Hunter said, be given to a child; and it then becomes what is called hereditary. There is, however, no such thing as an hereditary disease; but there is an hereditary predisposition for a disease." The experience of all ages confirmed the liability of various forms of derangement to pass through families, although it was not always the specific type which was propagated, as with suicide or hypochondriasis; it was as likely to be a general tendency towards disturbance. Burrows had observed that six out of seven of his patients had an hereditary predisposition and those cases that were exempt had a sympathetic derangement originating in another organ, as with puerperal insanity.

The final physical propensity towards mental disease lay in basic physiological functioning. Burrows argued that it was necessary to have a balance of the nervous and vascular systems for perfect health: if either predominated, disease ensued. But the two systems were so closely connected both by propinquity and sympathy that any impression causing irritation to one would spread to the other. It appeared that life itself and the
functioning of the mind were more dependent upon the circulatory system than the nerves. However it was equally certain that nervous activity impinged upon the movement of the blood. 48

Concepts like civilization, organization, predisposition and a balance of nervous and vascular functioning were all causes of insanity in which moral and physical causes were intermeshed. Elements of each could be distinguished, but their overall effects were continuous throughout the mental and physical realms. Burrows's use of more complex categories of causation was expressive of a growing need to accommodate the multifarious symptoms of madness, as well as a desire to place the manifestations of mental disturbance firmly within the grasp of the physician by linking together physiological processes and mental events.

The tendency towards increasingly formalized and elaborate medical explanations of insanity is demonstrated in Esquirol's Mental Maladies, a work which was a major starting-point for many English psychiatrists from the 1820's until the later part of the century. 49 Esquirol's system of causation emphasized moral events to a large extent, and it gave first place to the psyche; but it was fully grounded on a physical model of the operation of mental events, so that "moral impressions determined a movement, a kind of shock in the fibres: the forces are modified; and the organs acquire an action, adequate to the solution of the maladies." 50 In the end, all that could be said of the actual character of insanity was that it "depends upon an unknown modification of the brain," 51 which might well be functional in its origin, but would often result in structural change. The causes of mental illness could sometimes fail to act on the brain at all, beginning their work on the remote organs, and a predisposition could act with so much energy as to produce derangement without an exciting cause. 52
Esquirol's emphasis upon the physical aspects of mental disease was not intended to diminish the importance of moral or psychic influences. However, it is indicative of a continuing confusion within the theoretical formulations of the moral managers, because they believed that, although mental factors might be of greater interest, the physiological effects of their presence were more easily monitored and described. The inextricable tangle of moral and physical causes, effects, and remedies could not be untied easily. Even Benjamin Brodie, the nineteenth-century physiologist, discussed hysteria as "one of the severest penalties of high civilization," whose causes can only be physical, as with a local injury, or the imperfect development of the nervous system, and moral, as in the effects of a bad education of lax habits of early life. In addition, he identified a hereditary factor which created a predisposition towards a decline of physical power in the system.

Given the growing concentration upon somatic causation in British psychological medicine, J.C. Prichard's interest in the moral factors of mental disease might appear to be indicative of a major break with the accepted tradition. Prichard began his Treatise with a division of insanity into two types, the first being moral insanity, the second intellectual. Moral insanity, he defined as a disorder of the feelings, passions, or will that manifests itself without a corresponding disruption of the thinking faculties. This category was also found in Pinel and Esquirol. Prichard felt that moral insanity was often an exaggeration of a character trait or a type of disposition, as in the case of a woman who exhibited mental excitement which developed into female immodesty. Broadly defined moral insanity was seen as the working-out of innate moral perversity, which suggested the existence of a strong natural predisposition.
Prichard followed with a discussion of intellectual insanity, but his nomenclature reverted to the time-honoured classifications of monomania or melancholy, mania and dementia. In these cases, he outlined a progress from partial to almost complete derangement of the understanding. He described melancholy only in terms of its mental manifestations, but when he discussed mania he reported that all bodily functions would be deranged. However, his attention was concentrated on the state of the intellectual faculties, and the passions and will as they were involved in the various types of mental disease.  

Prichard's discussion of insanity appears to be truly mentalist. However, he also argued that lunacy must arise from "a congenital imperfection, [rather] than a disease resulting from external impressions." A predisposition must have been inbred into the constitution. If it was not inherited, then it was an individual peculiarity of organization, which would become hereditary. "Thus, both idiots and lunatics are persons born with a defective structure of the brain." He came to this conclusion not through an understanding of neurological research, but from an analysis of the impact of civilization upon mental processes and emotional expressions, as well as the increase of pauper lunacy. The effects of the greater complexity of European society were so ubiquitous that madness should be epidemic, unless the insane could be distinguished by some innate imperfection of organization which rendered them especially vulnerable to external influences. An increase in the numbers of the insane must therefore be related to hereditary transmission of this inherent weakness. The relative absence of insanity among savages was a product of their lack of a congenital predisposition as well as their possession of different brain structures which had developed
along alternate lines, because the savages exercised a different series of mental faculties. Prichard was unsure about the actual morbid condition of the brain, but he seemed to lean towards an inflammation theory based on increased vascularity of the tissues which was productive of irregular mental excitement.

However confident physicians such as Burrows, Brodie and Prichard might have appeared to be in their increasingly complex discussions of the physical causes of madness, they continued to be plagued by a serious lack of hard information about the physiological processes involved. Moreover, an entity like moral insanity acquired greater significance precisely because it could not be explained except as a "lesion" of the will; and yet no such lesion could be identified by brain dissections. Therefore, theorists of psychological medicine attended more closely to moral causes and to an increasingly detailed examination of the various symptoms of more specialized disease categories.

In addition, physicians such as Bucknill and Tuke, attempted to utilize general scientific principles to establish a process by which insanity could be identified and then described. It was a comfort to remember that the mind had laws, which were as "regular as any other natural laws," and which were ascertainable by the trained physician, who must be both a doctor and "a metaphysician...in that better sense which designates a lover of truth, seeking to ascertain, not the essence of mind or any other unattainable abstraction, but the laws of the mind..." For the rules which governed mental functioning, the medico-psychologist could rely upon the categories of intellect laid down in the eighteenth century: the functions of judgement, comparison, attention and memory, the process of association of ideas, and their interaction with the will, and "the passions of the soul."
A working definition of mental illness was provided by Dr. Combe:

It is a prolonged departure, and without an adequate external cause, from the state of feeling and modes of thinking usual to the individual who is in health.\(^60\)

This definition "has the merit, however, of making the mind of the individual himself, and not that of the physician, the standard of comparison by which to determine his insanity."\(^61\) The varieties of madness could be divided into those corresponding to a disturbance of the intellect, the emotions and the will. The language of diagnosis and treatment remained that of mania, melancholy, monomania, dementia and idiocy. Methods of treatment were to be applied according to the type of illness, its severity, and its peculiarities.

A most interesting example of the way in which physiological knowledge was put to the service of the enduring mentalist explanations of the functions of the mind and the disorders of the insane is found in Daniel Tuke's discussion of moral insanity. He accepted Esquirol's division of that disease into two categories: first, the affective monomania, in which reason remains intact but the affections and disposition are perverted; the second, instinctive monomania, in which the madman commits involuntary acts, which "neither reason nor sentiment determines."\(^62\) In this latter form were found original lesions of the will, while other monomanias begin with lesions of the intellect or the affections which subjugate the will. The importance of the distinction lay with the evaluation of responsibility:

Thus, then, it is highly important to remember, that all examples of what are called moral insanity are not necessarily instinctive, impulsive, irresistible. For although, (in a loose use of the word) the man morally mad may be said to be irresistibly so—that is, his condition of mind is not voluntary,—the examples of irresistible impulse belong to quite a different class.\(^63\)
It is significant that this attempt to locate responsibility is referred to the recent descriptions of the reflex:

Modern physiology teaches that there is a reflex action of the cerebrum, as well as of the spinal cord; and thus satisfactorily explains the existence of the automatic or instinctive acts. To such cases Dr. Carpenter alludes when he says, "So far as the directing influence of the will over the current of thought is suspended, the individual becomes a thinking automaton, destitute of the power to withdraw his attention from any idea or feeling by which his mind may be possessed, and is as irresistibly impelled, therefore, to act in accordance with this, as the lower animals are to act in accordance with their instincts."64

Conolly also adhered to a conventional division of the causes of insanity into the categories of moral and physical. He was more likely to assign cause to moral influences, because it was his experience that few cases of mania could be clearly shown to be dependent upon any bodily disorder, and the physical problems which appear to be connected to melancholia were generally restricted to "peculiar states of the liver, stomach, and bowels."65 Women were more often affected by physical causes because of the disruptive effects of menstruation, childbirth and menopause.66 Physical debility was a frequent cause of mental illness.67

However, in most cases, Conolly tended to ascribe the onset of the disorder to a combination of moral effects and a constitutional predisposition.68 In a case of melancholia, one might find "in a brain hereditarily predisposed to disturbance, the depressing effect of fear and anxiety is with difficulty resisted, and has a tendency to become permanent."69 Strength and weakness of the various faculties, susceptibility to the emotions and affections and to external stimuli all appeared to be constitutional, although they were amenable to education and training.70

Constitutional infirmities, when combined with "the violent emotions and
passions of the mind, and propensities rendered masterly by indulgence, and the undue employment of certain intellectual faculties, tend to produce disturbances in the functions of the brain..."71 Other moral causes were situational: domestic problems, the anxiety produced by poverty or illness, the mental shock resulting from sudden gain or loss of wealth, grief and sorrow from death of loved ones. In these cases, it would be assumed that the pernicious effect of the experience lay in their potential for inducing or augmenting violent emotions which increased brain excitement and disturbed the balance of faculties.

Despite the emphasis on the disorder of the faculties as a sign of mental illness, Conolly believed that, at bottom, insanity was brain disease. There was a difficulty in accounting for the connections between mad behaviour and physical illness because of the paucity of real physiological knowledge.

The physiologist requires a deeper insight than is yet accorded to him into the fountain of nervous actions...He must yet inquire if the just measure of sensation, and of propensities, the sentiments, and the power of the intellect, is associated with intelligible conditions of the brain or the nerve in their minute structures, or the power or agency, whatever it is, that lies within that portion of our systems, and appears indispensable to the possession and exercise of the functions of animal life.72

To whatever extent physicians were capable of ascertaining the processes by which insanity was expressed in the brain, the conclusion appeared to be that nervous energy was unbalanced, as a result of disturbances in the circulatory system.

We mainly ask what the state of the brain may be which thus detaches a living and reasoning being from reality, and ceases him to dwell in a land of shadows and of unreal things. Some portions only of the brain may be stimulated, or may be inactive, fuller of blood than natural, or anaemic; too energetic, or impeded, and the judgement vitiated.73
He sounded most convinced about physical manifestations in comments before the Royal Institution:

It may perhaps be strictly said that all the forms of mental disorder are dependent on one of three states of the Nervous System—a state of increased, or a state of diminished, or a state of unequal excitement of that system. There is almost always an accompanying disorder of some of the bodily functions.  

Throughout his work, Conolly had no choice but to avoid precise statements about the physiological manifestations of mental illness, because he felt that verifiable knowledge on this subject was very limited in scope, and because he believed that treatment could be applied to disorders on the basis of their clinical signs, combined with a due attention to the functions of the mind as they have been outlined.

Conolly's conclusion might appear to be a superficial synthesis of an incoherent bundle of doctrine, speculation and rudimentary physiology; but it would seem that most of the important writers on moral management were equally unable to unravel the complexities of the mind-body relation or derive much benefit from the emergent neuro-physiology. The nineteenth-century asylum physicians began with long-standing beliefs about the constitution of the mind and the nature of madness, and combined these with whatever pieces of information could be gleaned from anatomists and other researchers investigating the physical workings of the body and brain. The concepts formed out of those elements were also influenced by the growing body of information about the efficacy of various forms of treatments.
III

Moral management was initially judged by empirical standards, but from its inception, in the hands of the physician Pinel and the layman Tuke, moral treatment was informed by a number of theoretical propositions that had been developed out of the ideas of mental functioning and moral and physical causations outlined above. Just as the moral managers had attempted to give some somatic grounding to their primarily psychic concerns, in order to explain what was evident but scientifically inexplicable—the obvious connection between mental and physical processes—so they also laboured to provide a foundation for the empirically sound but intellectually unprovable claim that changes in physical treatment could alter mental disturbance, and that applications directed towards psychic functions could be reflected in bodily changes. The theory of moral treatment possessed a strong somatic element, based in large measure upon the well-established notion of the necessary equilibrium of brain and nervous activity.

Cullen's provisions for treatment were related to a scheme of unequal brain excitement. In mania, when the excitement was generalized and intense, physical restraint and confinement with few objects within sight and hearing were necessary. It was believed that fear could be effectively used in treatment because it was thought to decrease excitement. This was combined with a low diet with evacuants to diminish, and purges to reduce, fullness of brain vessels. The shaving of the head to promote perspiration, and constant hard labour as a diversion, were part of the treatment. Melancholics might need some restraint but with less force than maniacs. Some bloodletting, purging and efforts to produce in the patient an emotion like
awe completed the therapeutic regimen. Melancholia was dependent upon the pre-existence of a suitable temperament of the body in which there existed a degree of torpor in the motion of the nervous power with respect to sensation and volition. This torpor was probably the result of a drier and firmer texture in the medullary substance of the brain. A certain amount of diversion might also be useful with melancholics who exhibited partial delusions. It was also useful for hypochondriacs.

Cullen's therapeutic regimens blended conventional medical nostrums with examples of the early variants of moral treatment. Cullen's advice was imbued with physiological rationales; the medical remedies and the moral agencies he prescribed were expected to have an effect on brain excitement and overall bodily energy. In Pinel's work, by contrast, there was a greater emphasis upon and refinement of the moral aspects, with special concentration upon the deleterious effects of heavy physical restraint. Pinel argued that madness which was manifested in a disorder of the passions was receptive to the manipulation of other emotions and the use of diversion and employment. Like Cullen, he held that part of the curative effect of labour was its capacity to "prevent the determination of blood to the head by rendering the circulation more uniform, and [inducing] tranquil and refreshing sleep."

Passions, emotion and intellectual disorders had clear connections with physical processes, although it was very difficult to demonstrate organic disease in most cases of derangement. Moreover, manifestations of mind were aspects of the disease that could be directly influenced. A new note was sounded in Pinel's work: "the happy effects of intimidation, without
severity; of oppression, without violence; and of triumph, without outrage." Permit "an irresistible control" to be exercised over the patient. Moral treatment was preferable because it produced a compliance that was internal as well as external, and it was, therefore, more complete.

Pinel's work stressed the importance of the medical control in treatment of the insane. This factor was to play a major role in Burrows's ideas about therapy. Burrows's highly medicalized view of insanity caused him to identify three distinct stages: the incipient, the active or confirmed, and the convalescent or declining. He referred to this as a "scientific" system of classification which was a prerequisite of good treatment, and his therapeutic provisions centered around this division of symptoms.

In light of his experience, Burrows set out a program for accurate diagnosis based upon observation and detailed history-taking, followed by the application of specifically medical remedies in the initial stages. Only in the third stage of the illness was moral treatment to become the primary focus. In the first two stages, despite the fact that the derangement was probably functional rather than structural, the physical symptoms of excitement, with the attendant vascular and nervous irregularities, were to be dealt with, and only after these physical problems had subsided could moral management be considered as an aid. It was also possible that in certain cases no corporeal aspect of the mental derangement could be ascertained. In such situations the hereditary predisposition was especially strong and here, too, moral treatment might be a more appropriate remedy.

Despite these limitations on the exercise of moral methods, Burrows insisted upon the unique role of the physician in its application. "The tact of the physician, however, is, in this particular, the pivot on which
everything moves. It is an art, in fact, that cannot be taught. The qualifications are intuitive, not acquired: they may be elicited by accident, and then can only be perfected by experience." The skill of the physician is especially important in discerning the early symptoms of convalescence, so that immediate trial of moral principles can begin. Such symptoms were obscure, and required all his experience and training to be elicited. Then, the doctor must exercise all the attributes of his character.

He has not only to exercise a sound judgement, to encourage every dawning sign of returning sense, and to reason with his patient, (for reasoning now is highly useful in removing weakened and decaying illusions) but he must add the soothing voice of friendship...

In this way, Burrows advanced the claim of medical expertise in the conduct of all aspects of the treatment of the insane. Medical definitions of the causes and progress of the disease laid a foundation for the argument that the physician's mind, was properly suited to dealings with "a naturally fine and well-cultivated mind [which] requires tact, delicacy, and discrimination..."

The importance of the physician's role in the application of moral remedies was taken further by Esquirol. Following Pinel very closely, Esquirol argued that the principal curative feature of an asylum was the authority which emanated from a sole and undisputed Head, from whose personality and power flowed the confidence which was essential to the cure of derangement. A divided authority would allow for a spirit of independence and a lack of obedience among the patients, which would retard their progress since they were but "grown up children" in need of direction. The attendants must set the example for deference and obedience which would prevent a need for the use of force. Dependency encouraged a recognition of the existence of illness, and that in itself was conducive to cure.
Another factor in Esquirol's therapeutic program, also borrowed from Pinel, was the use of the passions in opposition to one another. This was to help break the train of ideas which had overtaken the lunatic's reason. Subjection and repression of some patients might be necessary, and thus a cold bath (the douche) was advocated. Evacuants caused the patient to experience a sense of unease in the stomach which rendered him docile and, hence, more amenable to instruction. Other physical remedies suggested by Esquirol included narcotics and the rotary chair. In addition, specific disorders, such as lypemania, monomania and mania, as well as puerperal disturbances, would require the administration of ordinary medical agents, such as bleedings, purgatives, emetics, cauteries, and drugs.

In Esquirol's work, the interdependence of moral and physical treatments becomes more transparent than ever. Fear reduced brain irritation and so would decrease the symptoms of mania. Lypemania, or melancholy, was best treated with conventional medical remedies, as well as passion substitution. This combination of therapies is also evident in Prichard's Treatise. Prichard restricted the term "moral treatment" to such techniques as were directed primarily at mental symptoms, but his general plan for the medical management of lunacy made it clear that appeals to moral entities still existing in the minds of lunatics were at the basis of any plan of care.

The first principle of treatment was to remove or reduce this diseased condition of the brain, and for this he prescribed the usual purgatives, bloodletting, baths and certain drugs, as well as the rotary swing. The second principle was to restore or maintain the natural functions, and, to this end, he advocated both physical remedies, especially those that would reactivate the excretory processes, and the mental therapies that were
involved in the application of moral management techniques. His discussion of moral management followed the established lines: the necessity of confinement, the controlled environment, and the achievement of self-respect through the exercise of voluntary controls of disruptive behaviour. He perceived that moral discipline, especially in the form of kindly direction, had an impact on lunatics comparable to its influence on healthy individuals, and thus it should not be neglected. Employment was a powerful therapeutic device, and he illustrated its potential by referring to a German physician who harnessed a number of inmates to a cart laden with wood and had them pull it around a designated track in the asylum grounds for several hours each day. He also approved of harmless methods of intimidation, such as threats of recourse to strait-jackets or the use of cold showers.

Bucknill and Tuke agreed with Prichard's system of treatment. The first object in caring for acute cases was to remove all causes of excitement through the application of established principles of hygiene and the occasional medicinal agent. Only in later stages were specifically moral techniques useful, especially in connection with a tonic regimen and "the diligent application of counter-irritants to the scalp..." Once again, the combination of medical remedies and moral treatment was taken for granted. Indeed, in Bucknill and Tuke, the distinction between moral and physical treatment becomes difficult to distinguish because they were so determined to claim physiological effects from manipulation of psychic factors, and mental improvement from the application of physical remedies.

This blurring of the definition of what constituted moral treatment led Bucknill and Tuke to advocate a form of management that was more active and interventionist. They argued that "to remove the causes of cerebral
excitement is not moral treatment; and even to be kind and gentle in word and
deed to the insane, cannot rightly be called moral, but physiological treat-
ment." Thus, truly moral means had to be defined as the individualized
treatment "recommended by the wise and experienced physician of Hanwell."94

What is this individualized treatment...but the influence of
a sane mind peculiarly apt to express itself beneficially
upon the insane mind, that is, moral treatment, or more
strictly speaking, intellectual and moral treatment...any
officer, who is successful in the management of the insane,
who daily impresses upon them the influence of his own
character to their improvement, undoubtedly practises moral
treatment.95

The curative effect was derived from the quality of the sane mind which
made the impression. Thus the person wishing to embark on such a program of
care had to possess a highly developed character and powers of insight and
personal discipline in order to make correct estimations of the type and
extent of insanity he was approaching, as well as sufficient intuition to
know which emotions to encourage or develop, and which should be discouraged
by distraction or repression.

A faculty of seeing that which is passing in the minds of men
is the first requirement of moral power and discipline,
whether in asylums, schools, parishes or elsewhere. Add to
this a firm will, the faculty of self control, a sympathising
distress at moral pain, a strong desire to remove it; and
that fascinating biologizing power is elicited, which
enables men to domineer for good purposes over the minds of
others. Without these qualities, no man can be personally
successful in the moral treatment of the insane...That so
much of it can be so well done vicariously by orderly
attendants is a most happy circumstance for mental sufferers,
and proves that the possession, at least in a moderate degree,
of the qualities in discussion, are consistent with a defec-
tive education and a lowly social rank.96

Moral treatment "is education applied to a field of mental phenomena extend-
ing beyond the normal size by the breaking down of all the usual limits."97

It required the special facility of an inspired medical psychologist to be
efficiently and effectively employed.
Bucknill and Tuke closed their discussion of treatment procedures with some remarks on restraint. They suggested that it should only be used in exceptional and desperate cases; it was a barbarous remedy, like cautery, which could not be discarded. This reluctance to eliminate recourse to restraint was an expression of contemporary opinion that total non-restraint was a practical alternative, but no methods of patient control, especially if it might still be justified as therapeutic, should be discarded. The rationale of moral treatment was based on a belief that emotions received reinforcement from their expression, so that if they were repressed, the emotions would weaken and dissipate. It was theoretically possible that physical restraint was an efficacious methods of inducing emotional control.

Still, Bucknill and Tuke appear to have been more enthusiastic about the therapeutic effect of non-restraint. Physical restraint involved an appeal to fear which was to be considered the lowest motive of the insane. Its abolition required an appeal to higher impulses. "It was the brutalising influence of fear, and the degrading sense of shame, which constituted the true virus of mechanical restraint." 99

Bucknill and Tuke's opinions on the use of restraint are representative of the main body of asylum physicians practising in mid-Victorian England. Non-restraint was an ideal, perhaps achievable in a large number of situations, but impracticable when dealing with the refractory patient. A notion of hierarchy did obtain in their thinking: Bucknill and Tuke recognized Conolly's basic principle that the highest and best behaviour could only be produced by the most refined forms of treatment. Affection was a better motivator than fear, and gratitude more effective than resentment. However, even by 1858, it was clear that the levels of staffing which were
necessary to the fulfillment of the non-restraint system were not forthcoming, and Bucknill and Tuke reflected a professional consensus that order and acquiescence could only be maintained at some cost to the emotional well-being of the patients.

It may have been a desire to compensate for their descent towards pragmatics which induced Bucknill and Tuke to wax so eloquently on the personal requirements of the physician-administrator. The central position of the asylum doctor had been an axiom of medical psychology since Pinel, and, no doubt, the persistence of the theme in the literature of moral management owed something to the desire of lunacy-specialists to lay claim to the fruits of the expertise. By 1858, doctors were in firm control of most institutions devoted to the care of the insane, and, because of the growth of the inspectorate, physicians were overseeing the treatment of lunatics in virtually all locations in which they were to be found.¹⁰⁰

Bucknill and Tuke's paean to the inestimable character of the moral manager cannot be accounted for solely on the grounds of professional advantage. In addition, it would seem to have been an expression of a fundamental element of moral management theory, which was that all men learn by example, and that the asylum was at its best like an organism, directed from the top by a mind and heart well-trained and specifically equipped for the enterprise. Just as the mind and body of the madman were to be renewed in a harmonious conjunction by the effects of the whole range of asylum therapeutics, so the institution itself was to demonstrate the influence of character, breeding, and education over its essential but less-endowed members. Conolly transformed the empirical results of Gardiner Hill's well-intentioned experiment into the apotheosis of moral management by making
clear the connection between total non-restraint and the inspirational, all-embracing figure of the physician-administrator, whose personal qualities of forbearance, wisdom, and self-control were to substitute for manacles and strait-jackets.

The asylum physicians of the first half of the nineteenth century have been criticized for having manufactured a theoretical system in order to justify their utilization of a series of management techniques which lacked prior intellectual content. However, this survey of writers on lunacy and its treatment suggests that moral management theory and practice developed in connection with one another, that the refinement of the administrative aspects was penetrated by the increasingly complex formulations about the inexplicable mental and physical phenomena which comprised the objects of control and revision. It is possible to recognize in these writings at least a rudimentary interdependence between theories of disease and treatment and the recorded asylum practices, based as they were upon an unresolvable conundrum concerning the real character of the mind and the body.

The meshing of mental and physical in the theoretical discussion mirrored the interpenetration of the psychological and the practical within moral management. However, the dichotomies between the moral and the physical, and mind and body, at the basis of the theoretical framework, were in the end insoluble. Victorian physicians were entranced by a disease like the general paralysis of the insane, which provided them with an apparent connection between progressive motor and mental degeneration and specific organic lesions which were manifest upon autopsy. Most of the time, they were forced to deal with a nebulous entity like moral insanity, which had to be attributed to a "lesion of the will", a formulation in which moral
and physical categories were mixed but not clarified. It is possible, sometimes, to describe the language of the moral managers used in the construction of their theories as metaphorical; it was, at the very least, analogous and less often as empirical as they desired it should be. This was in keeping with the social nature of their program, which required that the theory and practice remain ambiguous to a degree because such indeterminacy provided a space by which speculation and improvisation could occur.

This outline of the theoretical background of the asylum physicians explored three elements which helped to make up the discourse of moral management. The discourse of the moral managers was constituted in part by the interrelationships between the definition of the mind-body connection, the delineation of moral and physical causation, and the provisions for treatment which were devised by asylum doctors such as Burrows and Esquirol. John Conolly's most exhaustive contributions to that discourse are found in his writings on asylum management, which will be explored in more detail in the next chapter.
...restraint vitiates everything, neutralizes all moral treatment....It is not so where the patients are treated with uniform kindness—I would say like children; but I ought rather to say like human beings.

John Conolly

John Conolly's achievements in asylum management were highly regarded during his lifetime, and they have continued to occupy an eminent position in traditional chronicles of the care of the insane. Less notice has been taken of his writings on asylum organization or his theories of mental functioning. Recently, Andrew Scull produced a lengthy critique of Conolly as an advocate of moral management, focusing upon some of his early writings and contrasting these with his later activities. Scull's approach has limitations which will be explored in a section of this chapter, but because his argument is based largely upon an examination of Conolly's career, it is important to begin with a short biography and then proceed with an outline of Conolly's principal works seen in relation to the major events of his career. In addition, his approach to moral management must be considered in relation to the discursive strategies outlined previously, from which his understanding of moral treatment was constituted.

I

John Conolly was born in Market Rasen, Lincolnshire, in 1794, the second son of an impoverished Irish gentleman who died shortly after John's birth. Conolly's mother, a member of the Tennyson family before her marriage, was left destitute, and as a result she allowed her eldest son to be adopted
by his grandmother. John remained with her until he was sent to school in Hull at the age of six, and he described his early education as miserable and inadequate. However, at age thirteen, he was able to return to his mother who had married again, this time to an emigre Scot from France who personally supervised Conolly's schooling. During the next five years, Conolly read widely in the classics and in French and English philosophy and literature. In 1812, he took a commission in the Cambridgeshire militia and spent the next four years with his unit travelling throughout the British Isles. After his marriage to Eliza Collins, the daughter of a Royal Navy captain, in 1816, the couple spent a year or two in France with Conolly's brother, William, a physician with a practice in the Loire region.

In 1818, having decided to make medicine his profession, Conolly enrolled in the university medical school in Glasgow. During his year in the city, he visited Glasgow Royal Asylum and read Samuel Tuke's famous account of the founding of a Friends' Asylum at York, The Description of the Retreat. In 1822, he completed his education at Edinburgh University, with a graduating essay entitled De Statu Mentis in Insania et Melancholia. While in Edinburgh, he was drawn to the philosophical works of Dugald Stewart, one of Adam Smith's fervent admirers. Stewart was to remain a major reference for Conolly. In addition, Conolly was introduced to the phrenologists, George and Andrew Combe, whose theories about cerebral and mental functioning played an important role in the formation of his attitudes towards lunacy and its treatment.

Conolly first attempted to set up a practice at Lewes, but he was unsuccessful and moved to Chichester in 1823. There he became a friend of John Forbes, with whom he shared the editorship of publications like the British
and Foreign Medical Review and the Cyclopaedia of Practical Medicine. Since there was a lack of sufficient employment for two physicians in Chichester, he moved again to Stratford. There he appears to have been well-respected. He was twice mayor, he established a dispensary, lectured to the Mechanics' Institute, and was engaged as a visiting inspector to the private asylums of Warwickshire. Conolly was not pleased by the conditions he found in the local facilities, but he recognized that they were typical of the standard of care that could be expected in such institutions at that time.

During his residence in Stratford, he made the acquaintance of Dr. George Birkbeck, who introduced Conolly to the Mechanics' Institute movement and to Lord Brougham, the great Whig politician who was deeply involved in social improvement activities. One of Brougham's most important projects in the 1820's concerned the establishment of a non-sectarian university in London, which came to fruition in the late 1820's. A medical school was included in this venture, and because of his acquaintance with Brougham, Conolly was given the position as Lecturer in Clinical Medicine. In preparation for his lectureship, Conolly made a tour of French medical schools and also visited the asylum at Charenton, where Esquirol was the chief physician. He returned to London in 1827 and devoted himself to his teaching, leaving no time to maintain an active practice. He was able to continue writing for the Society for the Diffusion of Useful Knowledge, and through them contributed some articles to the Penny Magazine and another of their publications, the Working Mens' Companion of which Charles Knight, the editor of the Penny Magazine, thought highly. Conolly also formed a close friendship with Thomas Coates, then the secretary of the SDUK.
Conolly's association with London University ended with his resignation in 1831. The early years of the institution were overshadowed by endemic internecine squabbling, and Conolly became embroiled in a number of disputes with the governing council. He was also very frustrated by the unwillingness of the university to make available adequate facilities for clinical teaching, as well as by its failure to respond to his offer to lecture on the subject of insanity. Conolly's other problems were financial: because he did not establish an independent practice, his income was confined to the per capita payments of the students, and these were insufficient to support his growing family.

In 1831, Conolly moved to Warwick, where he was to remain until 1839. While the financial gains of his practice were adequate but not outstanding, the loss of much intellectual and social stimulation consequent upon his move from London made him rather despondent. Thus, in 1838, when a vacancy occurred in the post of attending physician at Hanwell, the public asylum in Middlesex which had been founded in 1831, he applied for the position. It was awarded instead to John Millingen, an ex-army surgeon, but his superintendency was so disruptive that he lasted only one year, and Conolly's second application was accepted. To prepare for his new job, Conolly visited Robert Gardiner Hill, the attending surgeon at the small private asylum at Lincoln Hill, who had stopped using physical restraint in his asylum some two years previously, and who was enjoying considerable success in his new system of management.

A few months after taking up his post at Hanwell on June 1, 1839, in his first report to the County Quarter Session in September, he declared that no form of physical restraint had been used on any patient for over two
months. This remained the standard of care for all patients throughout Conolly's association with Hanwell. Because of his connections in London, especially with Thomas Wakley, editor of the *Lancet*, and the advocacy of Mr. Sergeant Adams, the governor of Hanwell, the public was soon made aware of Conolly's achievement. For the next five years, while he remained the superintendent of the asylum, he worked to expand the educational, vocational, and recreational facilities of the institution. He began a series of lectures to medical students considered to be one of the earliest courses in mental science ever given. His plan of care for the insane did not meet with complete professional acceptance, but its principles were endorsed by the Parliamentary Committees of 1844 and were made part of the bill regarding provision of care and the erection of asylums which was passed in 1848. This bill was the legal foundation of the public asylum system.

After 1844, an administrative reorganization by the governors resulted in the removal of Conolly from direct control over asylum maintenance although he continued on as visiting physician. In that capacity, he visited the wards and gave advice on treatment and management, and he continued to figure in the reports to the magistrates as an advocate of expanded services. He also began to lecture and write again prolifically, and the second of his books, *The Construction and Government of Lunatic Asylums*, a very specific and detailed administrative treatise, complete with architectural drawings of model asylums, was published in 1847. A series of clinical lectures on insanity was featured by the *Lancet* in 1845 and 1846, and, in 1848, he gave the Croonian Lectures to the RCP. Toward the end of this period, his health began to fail, and he retired to the position of consulting physician to Hanwell, which effectively ended his direct involvement with that institution.
For the last fifteen years of his life, Conolly continued to be in the public eye, publishing in 1856, another book, Treatise on the Treatment of the Insane Without Mechanical Restraints, which argued powerfully for the rejection of methods of physical restraint. This was in reaction to his perception of an increase in the use of these methods. He testified in several famous criminal insanity trials and was featured in a number of dubious certification disputes. He also published frequently in medical journals and wrote extensively for the public. He was made the subject of satire in Charles Reade's Hard Cash. At the same time, Conolly was the recipient of public and professional testimonials to his achievement, most notably from Lord Ashley. He maintained an extensive consulting practice, and it is in this later period of his life that he became associated with the private asylum system, both in partnership with his brother in one house at Hayes Park and also taking private patients into his care at Lawn House.

II

Conolly's actual experience as a moral manager began when he was already well-advanced in years. In the years after 1839, Conolly was always to be involved, to at least some degree, in asylum management; his most active period as a moral manager was confined to his first five years at Hanwell. This late arrival in the field of asylum medicine is a key factor in Andrew Scull's analysis of Conolly's career. Scull argues that Conolly's acceptance of the superintendancy at Hanwell was provoked by personal concerns (especially financial), rather than professional inclination. Much of the basis for Scull's contention lies in his examination of Conolly's 1830 publication, the Inquiry Concerning the Indications of Insanity, written during his tenure at
London University. However, it should be remembered that, in Conolly's works, there is ample evidence of a lifelong preoccupation with the treatment of insanity.

The most revealing indication of his early concern with lunacy is Conolly's graduating essay from Edinburgh, written in 1822 and entitled De Statu Mentis in Insania et Melancholia. This document deserves some attention as a precursor of the Inquiry as it touches on several themes which prove to be characteristic of Conolly's mature approach to questions about mental functioning and therapeutic technique.

The title page of Conolly's essay highlighted a quote from Pinel:

Dans cette maladie comme dans beaucoup d'autres, l'habilité du médecin consiste moins dans l'usage répété des remèdes, que dans l'art profondément combine d'en user à propos ou de s'en abstenir.

By appending such a remark from Pinel, Conolly showed his sympathy with one of the major tenets of moral management—that treatment of insanity should not consist primarily of the administration of time-honoured nostrums selected in accordance with an out-dated understanding of mental disease. Instead, the physician must be sensitive to the particular facets of the illness as it was manifested in individual patients. The quotation seems to endorse a conservative approach to therapeutic technique for all illnesses. Conolly favoured this view throughout his professional career.

Conolly began with a brief statement describing the method he considered to be the most productive for the understanding of insanity. Just as any physician would base his understanding of a physical illness upon his knowledge of the workings of the healthy body, so should a doctor concerned with "the malfunctioning of the mind" begin with a consideration of its healthy state. Accordingly, Conolly proceeded to outline what he
conceived to be the essential functions of sanity. These included memory, the ability to perceive external sensations, the ability to conceive new ideas, to compare and differentiate between sensations, and to "judge well, and [in so doing] to act with wisdom." He then acknowledged that the human mind develops throughout life and outlined the successive changes which could be expected to take place as an individual matured. He concluded that a sort of mental restraint was necessary for sanity, so that when such control was lost, lunacy was manifested.

Conolly was concerned that mental disease not be regarded as a single entity, absolute in its difference from mental health. Symptoms of sanity and insanity could coexist in the same person, and many lunatics were not continuously insane. Geographical factors could influence the mind. As examples, he suggested the frequency of insanity in countries where disasters had occurred or where people are encouraged to be emotionally excitable. He declared that insanity was rare in countries where stress was placed upon the cultivation of the mind. Conolly then provided a nosological table which he described as being of his own devising, but which can be seen to have drawn upon the incidence of impairment of the major mental faculties, comprising Imagination, Memory, Judgement, and Attention. These were standard terms utilized throughout the eighteenth century when speaking of the faculties. In addition, he employed the conventional division of types of insanity into mania and melancholia, using William Cullen as a source for his discussion of melancholia but omitting mania almost entirely for want of space.

The final section of his essay discussed methods of treating the insane. He began by referring to the obvious but poorly-understood relation between mental illness and the state of the body, and went on to endorse explicitly
the techniques employed at the Retreat. He emphasized the importance of the physician's role in the provision of moral treatment: he must be a man of humanity, mental health, distinguished character, and good judgement. Conolly emphasized "how much [could] be accomplished through attention to the abilities of the mind," citing cases from the Retreat, and concluding that "insane people can often restrain themselves, and therefore we should assiduously urge and encourage them to do so."^13 Conolly had little to say about the conditions of asylum life as he had observed them, but quoted one of Esquirol's remarks which described the asylum as a place where "les liens sociaux sont brisés, les amitiés cessent, la confiance est détruite, les habitudes sont changées; on agit sans bienséance, on obéit par crainte, on nuit sans haine; chacun a ses idées, ses pensees, ses affections, son langage, chacun vit pour soi, l'egoisme isole tout."^14 On the basis of these remarks, Conolly suggested that convalescents should be removed from the asylum in order to complete their recovery. His last remarks referred to the importance of proper education for children susceptible to hereditary insanity, as it was possible to identify in their early forms the signs of incipient madness, and the earlier the illness could be treated, the better the chance for recovery.

*Insania et Melancholia* can be seen as an early expression of several theoretical and therapeutic principles to which Conolly adhered throughout his lifetime. His understanding of mental functioning remained structured around a model of faculties in all of his later work, whether diagnostic or expository. He always argued that madness was, in some fundamental way, a physical disease, although its causes and manifestations might be only identifiable as psychological, and that effective treatment must combine
attention to mental and physiological disorders. He retained a commitment to the efficacy and the "humanity" of the practices at the Retreat and the tenets upon which it was based. Above all, Conolly continued to emphasize the centrality of the physician as guide and model in the curative process.

Conolly's next major work on insanity was the *Inquiry Concerning the Indications of Insanity*, published in 1830. It begins with the fullest treatment of human psychology that Conolly produced, delineated in the context of a problem of diagnostic practice relating to confinement. It also contains some notable animadversions on the subject of the asylum. In brief, Conolly made it clear that he considered an insane asylum to be no place for a curable lunatic. Thus consigned, the madman was deprived of any influence from healthy minds, and his illness would only intensify with prolonged contact with other diseased minds. Not only would he adopt new forms of aberrant behaviour that he had acquired by observation, but, in Conolly's view, the disorderly atmosphere of the asylum itself augmented his interior disorganization and further weakened his will to resist those influences. If, by some chance, he should begin to recover, the likelihood was very great of his witnessing some horrible outburst that would upset what tenuous hold his reason had resumed, and he would deteriorate even further. Worst of all, he might recover but have his recovery ignored because the physician visited the asylum so infrequently. Thus his confinement would be prolonged, his permanent health impaired, and certainly his moral and legal right to freedom would continue to be abrogated.

According to Conolly, the "lamentable" state of asylum management was at the root of these problems. Contemporary care of the insane was itself derived from "erroneous" views of mental disorder. For Conolly, the most
important defect in current asylum practice was that treatment was generalized when it should have been specific. Each individual lunatic must be seen to differ, just as healthy individuals differ— in their characters, habits, and beliefs, and those elements were ignored in ordinary asylum practices. All patients were subjected to the same regimen, a regimen which was especially abhorrent to Conolly. The patients were bled, strait-jacketed, and had their heads shaved. They were purged, subjected to cold shower-bathing, fed a minimal diet, and kept in darkness. "Starvation, imprisonment, loneliness, and threats are then resorted to; or if the proprietor happens to be very alert...some unjustifiable experiment is tried; whirling round upon a horizontal wheel, intoxication, or some strange method of astonishing the patient..."\textsuperscript{17} The lunatic, Conolly argued, might well respond to this abuse by learning to disguise his illness so as to avoid treatment.

Furthermore, since patients in all degrees and types of disorder were grouped together, the less deranged and convalescent were subject to the influence of the incurably maniacal. There was, he emphasized, little in the way of actual mental therapy, which would necessitate careful attention to remaining functions. In his view, the attendants were ill-educated, rough, and unsympathetic. Often medical attendance was perfunctory: the proprietors had an interest in maintaining the illness so as to keep a paying patient in the asylum. Moreover, he argued, the accommodations were often inadequate and unsuited to the care of the insane. Not only did all treatment of lunacy involve restraint in the form of confinement in an asylum, but it also depended upon the application of physical methods of control which were often unnecessary or prolonged beyond the point of utility. Conolly argued that all these faults would persist until physicians began to study
the mind and its corporeal seat, the brain, in order to discover the actual constituents of mental illness from which a rational therapeutic could be constructed. 18

The Inquiry was remarkable chiefly for its condemnation of the asylum as a therapeutic institution. That it was unusual, indeed unfashionable, for early nineteenth-century physicians interested in lunacy treatment to denigrate asylum care is just one of the surprising features of Conolly's reaction. Implicit in his argument was a distrust of the contemporary practice of medicine in relation to the insane, and a radical skepticism regarding the social attitudes which contributed to the definitions of insanity and which shaped the accepted modes of treatment.

However, it should be recalled that Conolly had established the context for his critical attitude. He expressed disgust with the asylum as it was then being managed; he believed that conditions within the institution made it unfit as a therapeutic site. Nowhere did Conolly deny the importance of medical attendance for the insane; he asserted the curability of many disorders and considered medical and moral treatment to be efficacious. Where conditions permitted, the asylum could be a therapeutic tool: thus, he included the outlines of correct asylum management at the end of the Inquiry. 19 He would still have preferred that any person suffering from a mental disorder be cared for singly, under the direction of a physician, and according to a particularized regimen; but for those who could not pay, confinement in the asylum need not be the confirmation of their incurability.

The critique that Conolly offered is a reverse outline of the measures which he adopted after he became superintendent at Hanwell. In reaction to current practices, he adopted and then refined the "non-restraint system". It
became a complete blueprint for the care and cure of the insane which Conolly spent the remainder of his life publicizing and defending. The asylum was central to this scheme, but for a specific reason, and it was an asylum very different from the chaotic institution he described so vehemently in the Inquiry.

Conolly's inspiration for the reforms which he enacted at Hanwell came from the experiments of Robert Gardiner Hill at Lincoln Asylum. In 1835, Hill had assumed the position of house physician to the Lincoln Asylum under the superintendency of Dr. Charlesworth. During the next three years, he dispensed slowly with the use of all the conventional forms of physical restraint, that is, strait-jackets, chairs, manacles, etc. Hill lectured on the success of his experiment to a Mechanics' Institute in 1837, and the paper was published in 1838. Conolly was sufficiently impressed by Hill's achievement to visit Lincoln. There he observed a plan of asylum organization that entirely abjured physical restraint and the fear of punishment which he believed was its necessary accompaniment. It was a system devoid of overt coercion. Restraint was achieved through internal means; the patients were induced to exert their powers of self-control to moderate their behaviour in accordance with the examples of "healthy" behaviour with which they were surrounded. No other asylum had yet been managed without the threat of or actual recourse to physical restraint. Lincoln provided Conolly with a model of asylum management that he was able to implement when he assumed the post of superintendent at Hanwell in June of 1839.

Conolly went to Hanwell armed with the vision of Lincoln, and, according to Scull, greatly relieved at finally having achieved what appeared to be secure and adequately remunerative employment. He immediately set about
implementing Hill's system with the result that by October of 1839, the magistrates were singing the praises of non-restraint, and had also voted enough extra money to allow for the services of nine more attendants and an enlarged diet for the patients.26

The comfortable relationship between Conolly and the governors was short-lived. Excerpts from his annual reports reveal a steadily increasing volume of complaint on Conolly's part concerning the growing size of the institution, the inadequate funding, and the resistance to improving certain aspects of treatment, such as including education.27 In addition, Conolly was ill in 1841, a recurrence of a "rheumatic fever" he had suffered from in 1830, and a foretaste of his later illnesses and decline.28 Despite the failure of their first attempt at placing the supervision of the asylum in the hands of a lay administrator, the Middlesex magistrates decided to implement just such a system again. They believed that nonmedical administration would reduce costs. This type of divided authority was completely opposed to all Conolly's principles, so he resigned, but the magistrates were eager to retain their advantageous connection with Conolly, so they persuaded him to accept the position of a visiting and consulting physician at a slightly reduced salary. A retired army officer, John Godwin, was appointed to be Governor of Hanwell in the spring of 1844, with two medical officers under his direction. However, Godwin resigned in August of that year (probably because of incompetence), and by early 1845, the magistrates declared themselves satisfied with the medical management of Hanwell.29 Conolly continued in this reduced capacity until 1852, when he retired to private practice.30 He continued to agitate for various kinds of improvement in the asylum's management, and he wrote extensively, publishing a series of lectures in the

We will turn to them now. The Construction and Government of Lunatic Asylums is a distillation of all his most important conclusions regarding the successful organization and maintenance of a system of moral management centered around total non-restraint. Its exhaustive discussion of the details of asylum organization is proof of Conolly's commitment to lunacy reform. He began by giving credit to the county magistracy for its desire to comply with the 1845 Act which compelled the provision of care for pauper lunatics, and made the erection of rate-supported county asylums preferential. However, he had noticed that a number of the magistrates, for reasons of economy, preferred to house the pauper insane in infirmaries attached to workhouses or to continue to provide for them in private asylums. Conolly felt that an asylum was a much better alternative to both these systems; although less economical, it was in design and effect therapeutic, something neither private houses nor workhouses could claim. Conolly drew on mortality statistics and cure rates to argue that private asylums were more dangerous to the patient and that workhouses offered little hope of amendment.

Conolly's switch to asylum advocacy might have been, in part, a reaction to the over-economizing of the magistracy, of whose stringency he was to complain through the remainder of his life. According to Conolly, few private asylums were yet practising the non-restraint system, even in a modified form, which he felt was essential to the therapeutic environment. The workhouse was not intended as a hospital and thus it was also negligent, but negligence
could be expected there. Only in properly constituted asylums could the insane poor receive truly remedial attention.

The key factor was the "properly constituted" asylum. Certain factors in design and administration were necessary. The subjects outlined in the first seven chapters of *Construction and Government* comprise these essential elements of Conolly's system. These include architectural design, patient classification, diet and dress, ventilation, employment and amusement, the activities of the attendants, and the role of the physician. The constitutive principle was "non-restraint"—the refusal of all forms of physical coercion. All the other factors were an outgrowth of that determinate practice. Together they constituted a system of management that acted also as a therapeutic regimen for the "comfort and cure" of the insane. This was to be the only standard by which hospital arrangements were to be evaluated; every detail which contributed to that goal was worthy of attention from the superintending physician.

Ease of supervision was an essential element for the maintenance of all these other aspects, because constant watchfulness was the only substitute for restraint. This was not just the surveillance of the insane, but also unending monitoring of the activities of the attendants and of all the details of asylum routine. As Robin Evans has suggested in his fascinating book, Victorian prison architecture was not only intended to promote virtuous behaviour, but it was designed to compensate for the unavoidable shortcomings of the men who directed and staffed "progressive" institutions. Conolly clearly had in mind a scheme of design that found its support in a notion that even deficient empathy could be at least partially counteracted by a structure that kept all manifestations of patient care out in
the open, or if private, secured the patient from all attention, even that of the staff.37

Patient classification was another essential element of moral management. Conolly advocated a separation of patients based, not on the obscure gradations of a nosological table, but rather upon gender and behaviour. The underlying principle seems to have been orderliness and calm: behaviour that was disruptive was to be isolated from behaviour that conformed to the standard of sociability that was considered appropriate to each group and which would contribute to (or at least not detract from) the general "tranquil" and "cheerful" tone of the whole establishment. The therapeutic distribution of patients must avoid all penal aspects of military appearances. The building had to be so planned as to allow for a carefully controlled "flow"—one that was regulated but not repressed.38

Much has been made of the moral managers' fascination with the asylum which could pay for itself.39 Conolly's view of the role of patient employment as an area of moral management practice differed from that of other asylum physicians. He was angered by those who made public asylums into little more than workhouses for the mad; it was axiomatic to him that the utility of any patient employment was to be subordinated to the therapeutic principle.40 Employment was to serve as a distraction from the mental disorder or as an activity to stimulate favourable mental functions. In addition, it was a method of reducing physical and mental irritation. Whatever benefits that accrued to the institution were entirely gratuitous. For Conolly, work was essential to the foundation of character, and occupation was natural and necessary to normal human functioning. Lethargy and idleness were no better than overwork. A patient willing to work was viewed
by Conolly as exhibiting signs of recovery, and a neglect of assigned tasks or a refusal of labour was a sign of pathology.

Conolly was opposed to the practice of allowing convalescents to serve as attendants on the more severe wards, believing that this put too great a strain on the not yet healthy mental faculties of the recovering patients. Hence the physical tasks which contributed to the management of the asylum were fit occupations for the lunatics, but not the broader psychological and emotional burdens.

Occupation was part of the therapeutic program, and thus was integrated into a carefully designed daily schedule. The schedule was organized so as to include both work and exercise, rest periods, regular meals, and possible evening entertainments. The schedule was expected to regulate the behaviour of the attendants as much as that of the patients. 41 Work periods and exercise periods were placed so as to necessitate prompt fulfillment of housekeeping and supervisory duties. Moral management in the non-restraint system required constant watchfulness, and the day was divided so that the warders had to spend virtually every minute with their charges. The physicians made rounds in the early part of the day, and were expected to return later as well in order to keep control of the management problems.

Very large demands were made upon the attendants, and policies for their easy management formed a large part of Conolly's recommendations. They should be selected with an eye to their characters because kindness, sympathy and patience were necessary qualities for the effective discharge of their duties. Conolly preferred younger people, especially women, because they were less likely to have been influenced by the restraint system. The attendants were required to accompany, assist, and supervise the patients
at all their activities throughout the day. There were provisions for a night-shift to watch in the suicidal or other refractory areas. At no time was an attendant permitted to discipline, punish, or even raise his voice to a patient. All forms of physical coercion were taboo, and any breach of this rule was to be handled with the utmost severity.

With regard to the patients' disturbed mental functions, the responsibilities of the attendants are rather less clear. They might be summarized as the promoting of tranquillity and trust at all times. Therefore, they were enjoined to avoid disputes with the patients, to arbitrate all disagreements, to quench disruptive behaviour by "firm yet gentle" persuasion. In addition, the attendants were to collect information for the physician about the patient's state of functioning. The major impact of the attendants was to be indirect or environmental; they were to maintain the atmosphere of ordered calm that Conolly felt was essential to moral treatment.42

The final indispensable element of the non-restraint system was the physician-superintendent. As described in the Construction, he defined the object of the care, set goals, coordinated the myriad of details of administration and patient management, and actively sought to familiarize himself with the patient's symptoms in order to better adapt the treatment to the specifics of the case. He must visit all areas of the asylum each day so as to make himself accessible to the patients and to exercise due supervision over the routine to ensure that the proper tone was maintained. He must be available to the lunatics for questions and appeals, and to the attendants for direction with regard to the use of seclusion and dealings with the recalcitrant. As a medical doctor, he must attend to the physical ailments which accompanied his patients' mental disorders. He should have the
capacity to do all the hiring and firing of staff who had direct association with the patients. His decisions were to be the guiding principles of the asylum management, and, in return for this, he was to assume total responsibility. To be equipped for such an immense task, the physician-superintendent must be a man of culture and liberal education, with a modern medical background and a familiarity, preferably gained in an institution utilizing a non-restraint system, with the details of moral management. He must also be a man of principle, of kindness, empathy and utter dedication to his work, content to live among his charges, immersed in the totality of detail that perfect control of the asylum would entail.43

Conolly had been critical of traditional medical treatment since he first considered the subject in Insania et Melancholia. Such an attitude conformed with the anti-medical ethic then prevalent among physicians who espoused moral management. However, it would be an exaggeration to assume that Conolly had rejected most current medical therapeutics. According to his texts, he made considerable use of most of the standard therapies available for the treatment of mental illness in which an accompanying physical disorder could be ascertained. Moreover, he argued succinctly against those practitioners who would dispense with all medical forms of treatment.44 His rationale was not atypical of lunatic physicians of the period: mental illness was predicated upon brain disease, although it appeared that sometimes the functional disorder had preceded or indeed had never occasioned, a corresponding physical lesion. Despite the formidable metaphysical problems which were implied by questions about the relation of brain and mind, Conolly was as certain as most of his colleagues that insanity was brain disease and that it could be affected by physical therapies. As we shall
see, Conolly's moral management theories were resolutely physicalist; he liked to account for the effects of measures, such as quiet conversation, kind handling, and warm clothing, by suggesting that they contributed to a decrease in cerebral excitement that was essentially physiological in origin and action.45

Conolly argued that medical therapy directed to identifiable physical disease was essential to complete care of the insane. He was conservative when it came to the apparent absence of such manifestations, believing in these cases that it was best to restrict treatment to the indirect effects of the non-restraint system. His repertoire of physical treatments was conventional, composed of variations of older, well-established therapies.46 Again, the restoration of equilibrium and order seems to have been the underlying principle of Conolly's medical practices. Some disturbance in the production or consumption of nervous energy was the probable basis of much mental disorder, and this could be rectified by careful measures designed to diminish excitement or increase physical strength, to relieve congestion, or to encourage activity. Thus, violent or overly-invasive procedures were to be avoided since they would simply increase any imbalances present.

All but one of the topics considered in the Construction and Government of Lunatic Asylums were conventional elements of moral management as it had developed in the late eighteenth and early nineteenth centuries.47 The exception was total non-restraint, and it is important to recognize that the heart and soul of Conolly's program was the abolition of all forms of physical coercion and the disuse of any attempts to exert mental coercion through fear. This meant the absence of possible recourse to even such "mild" methods of control as the straitwaistcoat or muffs for hands, as well
as the complete prohibition of threats, expressions of anger, or even irritation or the utilization of petty punishments for bad behaviour. The completeness of the renunciation was the key to its efficacy. Only when mechanical restraint and moral force were entirely outside the scope of the asylum's therapeutic atmosphere would it be possible to train attendants to work efficiently within a "cure and comfort" framework and to instruct medical students in the actual manifestations of mental disease, uncomplicated by the interferences occasioned by the application of restraints.

Conolly's insistence on the fundamental importance of total non-restraint was fully developed in his last major work, The Treatment of the Insane Without Mechanical Restraints, written in 1856, but also defended in several articles published during the later part of his life. He maintained that the non-restraint system worked to control behaviour through two methods. The principal form that it took was embodied in the emphasis on order and calm that was to be the constitutive quality of asylum life. The prohibition of excited speech and loud or rapid activity of any sort, the careful attention to routine, the concern with minimizing noise, especially at night, and the frequent references to the tranquilizing effect of various measures were all evidence of Conolly's therapeutic intent. Any violence, whether physical or emotional, must be avoided because it would create excitement in the minds of the tranquil.

A second line of defence was medical. He contended that the order and comfort and calm of a non-restraint asylum was especially powerful in reducing the brain excitement and calming the functional disturbance which had occasioned the violent outbursts. Equilibrium could be restored in such an atmosphere; a balance between various mental faculties might be achieved,
or, at least, the fluctuations in nervous energy which caused the symptoms might be controlled by the tranquilizing aspects of non-restraint care. It should be emphasized that this tranquillity was believed to be physical; excitement and irritability were thought to be expressions of actual disturbances in the neurophysiology which were, in turn, the result either of lesions in the brain or other bodily tissues, or of disruptions in the functioning of the faculties of the mind. These disturbances could be inferred to have had a concurrent influence on the brain, producing observable symptoms of mental disorder.

Non-restraint was medically useful in another sense. Conolly is famous for having introduced, for medical students, a series of clinical lectures in mental disease at Hanwell in 1842, the first such instruction to be given since William Battie's efforts in the 1760's. In these lectures, and in his Croonian Lectures, he argued that the imposition of restraints actually obscured the real symptoms of mental illness, and that in order to give correct treatment, a patient who had been so handled must be allowed to go without such restrictions and be observed closely for a few days following admission. The implication seems to be that intractable violence was not a necessary quality of most forms of insanity; occasional outbreaks might have been provoked by some outside irritant; and a tendency to become agitated by certain forms of stimulation might be quite typical, but few lunatics were constitutionally violent. Uncontrolled behaviour was more likely to be a reaction to some exterior influence than a response to an interior event. The emphasis on confinement in an institution or on maintaining an environment of order and tranquillity minimized or eradicated the usual irritants that had been observed to occasion violence. However, its
curative effect was sufficiently extended so that for a few early days of hospitalization, the patient exhibited unadorned lunatic symptoms which if he were curable, would soon fade in the remedial situation, aided by whatever medical means might be thought appropriate.

Nevertheless, some provision had to be made for the difficult-to-manage patient, and he was to be restrained as a last resort by seclusion. Conolly designed seclusion rooms that were to be as comfortable as possible, with attractive furniture so that any punitive associations the patient might make could be minimized. He devised careful guidelines to regulate the use of seclusion, suggested non-physical methods of placing the patient in the room, and outlined the extent of the surveillance that would be necessary while the patient was confined. All of these guidelines were meant to reinforce the idea that seclusion was a therapeutic tool, to be employed when necessary, but with especial care and only in relation to some overt pathological manifestation.52

Conolly also advocated seclusion because of its physiological benefits. A plain but comfortable room, an absence of any irritating sights or sounds, were intended to permit the brain excitement to dissipate quickly. As his agitation lessened, the lunatic would be rendered capable of reasserting his powers of self-control, and usually signalled a return to calm by requesting release. Control of the patient's behaviour was thus obtained through enhancing methods or techniques which reinforced his own most admirable qualities without having recourse to any demeaning features of his or anyone else's conduct.53

The analogy to the family that had begun with Tuke was perpetuated by Conolly. His vision of the administrative order and comfort of the asylum
resembled the attributes of a closely-knit and well-run family establishment—a healthful regimen, cleanliness, occupation, regulated hours, pleasant entertainment, all conducted in a kindly, cheerful but controlled atmosphere, permeated by the attitudes of the physicians who directed treatment as a parent might direct all family activities. In this way, the asylum became an institution, not run on extraordinary principles like a prison, but a "normalized" establishment.

The Treatment of the Insane Without Mechanical Restraints included a discussion of two further refinements of the non-restraint system. The first was the "individualized" approach. Conolly remarked that:

None but those daily familiar to the events of asylums can duly appreciate the great effects of such treatment in special cases. After the first improvement in patients received into the best asylum some will remain stationary for a length of time without the special attention of a watchful attendant whose duties are almost exclusively confined to such cases.

This intervention appears to have been conceived empirically; it had been observed that certain patients recovered when given close contact with a sympathetic attendant. The individualized approach was essentially an intensification of a warden-inmate friendship, not a new psychotherapeutic relation created by the doctor, and acquiesced in by the patient, as was established by Freud. In that sense, it was still meant to be part of the general environment, directed by the physician, from who its qualities derived, but who had to function as a general symbol throughout the asylum, and who therefore could not be intimately involved with certain specific patients.

The other new aspect of Conolly's endeavours which appeared in The Treatment of the Insane was a description of the non-restraint system as it was being practised in the private asylums of Lawn House (also his residence),
Wood End, and Hayes Park, all of which he was helping to manage after 1850. Conolly had been openly critical of the conduct of most private establishments throughout his career, but he had not entirely denounced all private care, especially when it was directed by a physician versed in the tenets of non-restraint. But the application of his original program had to be altered in a setting that would cater primarily to financially secure, educated, and more cultivated patients. There was no question in Conolly's mind that, in the area of treatment for mental illness, paupers had heretofore enjoyed a real advantage, because even moral management, let alone the non-restraint system, had been very slow in finding the way into the private asylum.

As with the pauper insane, the most important therapy was "the separation of the patient from all the circumstances which surrounded him when he became insane, and placing him in the centre of new and salutary influences." The objective was the same: "To tranquillize and to cure, and not merely to subdue,...nothing in the treatment is at variance with the great system of non-restraint...." A major problem was encountered in the superior education and cultivation of the mind common to patients of higher economic status, but the removal to an asylum was often sufficient to induce a more cooperative attitude in the patient. An ill-regulated moral education productive of self-indulgent habits was another source of difficulties peculiar to the situation of the well-to-do insane. The routine of the asylum was often a help in counteracting the effects of a lax upbringing. Upper-class women were more likely to have adopted extreme or enthusiastic religious opinions as a result of their insufficiently-controlled education, and, again, the carefully balanced regimen of the asylum could aid in reducing their brain excitement and encouraging more temperate habits of thought and belief.
For treatment, a good asylum was preferable to an isolated residence or the patient's home, which were the alternatives for patients of the higher classes, because it "promotes the health of the body, and to maintain a peaceful mental state; so that as the bodily constitution becomes composed and healthy, nothing counteracts its favourable action or the feelings and the understanding." A private asylum, like a public one, had to be managed on the principle of the primacy of the patient. Most of all, the selection of attendants became of paramount importance. They had to be individuals fitted to accompany the patient, and yet able to maintain a routine of regular activities. The power of the physician in enforcing a regimen was especially important in a situation in which the patients were less likely to accept the direction of an individual from an inferior social position. For this reason, it was to the patient's advantage that the physician reside in the private asylum he managed.

It will be clear by now that the constituents of the non-restraint system differed in only one aspect from those of moral management. Conolly maintained that his difference was in kind rather than degree: that the imposition of non-restraint policies resulted in a radical change in the atmosphere of even well-run "moral" asylums. The non-restraint asylum fulfilled the promise of the moral managers that a total environment could be created within the institution, and took this vision one step further by arguing that the curative regime could be sustained by recourse only to the characters of the attendants and the physician.

Nothing must be now omitted that can have the effect of gaining the patient's entire confidence....Among the obstacles to the acquisition of this confidence, none is found practically to be so great as any previous manifestation of anger....Lunatics, however audacious, in aspect, are
generally the prey of fears and suspicions;...They are only assured and rendered attached by a continual course of kind and encouraging conduct....The reliance of the patient must be entire in order to be salutary.62

The patient-staff relationship was clearly intended to be contractual in nature. The staff agreed to dispense with overt means of coercion, and the lunatic surrendered his confidence, adopting the comparatively docile behaviour which was necessary to the smooth functioning of the institution. This was the great advantage of the non-restraint system: it compelled both parties to engage in an agreement respecting both their spheres, whereas the use of restraints made such an arrangement superfluous. As Castel demonstrates, a notion of contractual agreement predicated upon individual responsibility was a major feature of nineteenth-century bourgeois concepts of social relations.63

The problem with the insane was that social feeling breaks down, and it was to facilitate the reinstatement of social cohesion that the non-restraint system was developed. The basic ingredients for appropriate social behaviour were not necessarily eradicated by mental disease, and moral treatment sought to revitalize them. "Generally speaking, human nature is seen at a disadvantage in mental disorders; the social feeling is lost, and sympathy with others seems extinct."64 But the insane were not depraved; their kind feelings and virtues were buried but not lost. "To those feelings we apply it," and since the lunatic was very grateful for kindness, it created in them a sense of obligation which they were quick to acknowledge when able to do so.65
In general, observers of Conolly's career have had a tendency to focus upon the reform he enacted at Hanwell while giving little attention to his writings on moral management or his theories of mental functioning. As was indicated earlier, from the beginning of his tenure at Hanwell, his innovations were regarded with suspicion by a widely-assorted group of physicians and governing bodies; the range of critics included those who believed methods of physical restraint were essential to a therapeutic regime, as well as those whose major complaint lay with the expenses incurred in maintaining the overly-luxurious facilities which Conolly believed were essential to a truly curative establishment.

However, commentators, such as Sir James Clark and Daniel Hack Tuke, were laudatory in their evaluations of Conolly's achievements. Clark and Tuke saw Conolly in terms of a grand tradition of asylum reform and social meliorism which was admirable in its own terms without reference to progress in understanding the activities of the mind. Another important nineteenth-century evaluation of Conolly was provided by Henry Maudsley, Conolly's son-in-law, a young ambitious asylum practitioner. Maudsley's memoir was striking in its ambivalence; he praised Conolly for his success in extending the "humane science" of moral management, but he undermined his appreciation of the achievement by calling attention to Conolly's limitations as a theorist, his undirected early career, and even the qualities of his character which marked him, in Maudsley's view, as feminine and therefore weak.

Twentieth-century commentators have approached Conolly's career along lines similar to their nineteenth-century counterparts. In 1964, Denis Leigh published a small volume, entitled *The Historical Development of*
British Psychiatry, which was composed of biographical sketches of the principal advocates of asylum reform. His piece on Conolly derives from Maudsley: Conolly was an ineffectual physician and an overly emotional reformer with a broad humanitarian outlook who luckily resurrected his career when he received the appointment at Hanwell.

Richard Hunter and Ida MacAlpine were interested in identifying the antecedents of twentieth-century practices and theories in nineteenth-century reforms, and they found Conolly a sympathetic subject. The reformed asylum of the Victorian period was, to Hunter and MacAlpine, the foundation of modern psychiatric treatment; hence Conolly's administrative accomplishments could be praised unreservedly. Hunter, a neurologist by profession, was not as concerned with connections between the theories of mental functioning which prevailed among nineteenth-century moral managers and the techniques of moral treatment. His belief that good psychiatric treatment was based on sound neurological understanding led him to emphasize investigations into physiology and neuroanatomy which began in the Victorian period. Thus, for Hunter, Conolly's achievement was not marred by an inadequate theoretical base. Hunter and MacAlpine researched Conolly's life extensively; they were at pains to disprove Maudsley's opinion of Conolly's pre-Hanwell insufficiencies. They tried to establish that Conolly was a competent professional before 1839, and the quality of his accomplishments as a moral manager, rather than public reaction to the reforms, was responsible for his well-deserved position in the history of nineteenth-century psychiatry.

Scull followed Maudsley and Leigh in describing Conolly's early career as ineffectual and his behaviour as reckless. However, Scull was impressed by the Inquiry, which he depicted as a comprehensive attack on
the asylum system as a method of treating lunatics. He was therefore perturbed by Conolly's appointment at Hanwell because it appeared to Scull to be an act of betrayal, occasioned by a middle-aged desperation provoked by financial insecurity and the prospect of professional oblivion. Scull alleged that Conolly began his career in the grip of a radical distrust of the asylum as a centre of treatment, and that he altered his opinion of its therapeutic potential when self-interest dictated a need to conform to the prevailing psychiatric ideology of the period, which posited the necessity of asylum care. Scull went on to interpret the second part of Conolly's life as a perpetual effort to sustain a high level of public recognition and economic stability, which required that he gradually relinquish any therapeutic principles he might have held to in his early career.

Conolly's decision to accept the post at Hanwell was based, as I have argued, on his appreciation of Gardiner Hill's achievement at Lincoln Asylum. Doubtless, self-advancement was a powerful inducement for Conolly. However, a desire for personal advancement could have coexisted with a well-constructed plan of administrative reform which was informed by the accepted nineteenth-century understanding of mental functioning. Moreover, Conolly's commitment to the non-restraint system as the most perfect realization of the principles of moral management was not professionally popular, but he promoted and defended non-restraint until the end of his life. His consistency on this point made him vulnerable to the criticisms that he was unrealistic and that his character was feminized.

It is important to emphasize that the principles of moral management which Conolly enacted at Hanwell had been developed and implemented in a wide variety of asylums for a half-century at least. Even non-restraint was
not an innovation. In addition, a set of ideas about the relation between the mind and the body was involved in the practices of moral management, which had an equally established pedigree. Conolly's personal motives and the socio-economic forces by which they were shaped have been described thoroughly by Scull in his article and his previous works.72

Thus, the major question which presents itself in relation to Conolly's career is "Why non-restraint?" Why did he stake his reputation and a conventional program of asylum management on an idea that was regarded as visionary when first advanced, and which, within twenty years of its appearance, was being quietly ignored by a large number of asylum doctors? The answer is partly self-interest. He was the recipient of much public recognition for his reforms, and he must have felt that it was imperative to continue to defend the actions which had given him such prominence. Furthermore, Conolly's program expressed an understanding that the emphasis upon the role of the physician in the non-restraint system, his primacy, and the way in which the institution must centralize all its operations in his person, was the best defence for the medical position in the treatment of insanity. Scull has argued most persuasively that the need for professional stature and recognition was a major impetus to the asylum doctors' theorizing about the curative asylum, the necessity for confinement and medical attendance, which, in turn, reinforced the notion that madness was indeed mental illness.73 Conolly's reforms at Hanwell can be seen as an example of the extension of medical expertise.

More importantly, non-restraint possessed a social meaning which reflected two strains in nineteenth-century social definition. First, it exemplified the contractual aspect of the moral manager's therapeutic. The
lunatic and the physician-administrator entered into an agreement respecting mutual complementary standards of appropriate behaviour. This was not, of course, a contract between equals, but in exchange for a decrease in violent behaviour and the promise of conformity to the rules of the institution, the lunatic received assurances that his physical well-being would be protected and his disorder would be considered as a disease and not as an act of social rebellion requiring punishment. Non-restraint operated at the highest level of agreement because it implied that both parties could be trusted to control their behaviour and responses so as to dispense with the need for physical coercion.

The sense of personal responsibility which lay behind the non-restraint pact was evidence of its second level of social meaning. Moral management relied upon the moral accessibility of the lunatic for its effectiveness. Physical restraints suggested the potentially uncontrollable, the unreachable. Non-restraint worked on the principle that the insane could be contacted by language, by gesture, by the implications which were conveyed by a structure of behaviours. Moral treatment was a strategy of integration; it presupposed that the mentally disordered could be included in the web of social interactions. Lunacy was thus organized; it was located and defined. By eliminating the use of physical restraints, this organized disorder expressed a partial social integration of the lunatic.
CHAPTER IV
MORAL MANAGEMENT IN HISTORICAL PERSPECTIVE

By a combination of all the means now enumerated,...private and public asylums for the insane have become...places of real refuge;...Society is thus at first and at once protected from the consequences that might result from the dangerous irregularities of human beings whose guiding reason is impaired; and then the frame of mind and body is carefully inspected, with a view to restoring in each case,...the active and regular exercise of the intellect, and the healthful flow of the affections, and the consequent restraint of the propensities within safe and reasonable bounds consistent with the restoration of liberty.

John Conolly

To this point, I have discussed the principles which constituted moral management and the theories of disease and mental functioning which were espoused by asylum physicians. John Conolly was representative of the major currents of nineteenth-century psychiatric medicine. Whatever reasons drew him to non-restraint are part of what made possible the change from eighteenth century modes of response to insane behaviour to nineteenth-century modes as they were expressed in the development of the practice of moral management.

Conolly's medical psychology was supported by three underlying concepts which provided intellectual and social rationales for the theory and practice of moral management. They did not possess an explanatory power great enough to resolve enduring metaphysical problems or remove intellectual uncertainties. Nevertheless, they were advantageous to asylum doctors because, in their incompleteness and ambiguity, lay a realm of freedom for productive speculation that permitted toleration of inconsistency and incoherence.

These concepts were the schema of stimulated motion, the doctrine of predisposition, and the idea of hierarchy. The schema of stimulated motion
provided a medium for mind and body to connect, using physiological principles that had been developed in the seventeenth century but which could still be made to fit the existing state of neurological knowledge in the nineteenth century. Predisposition allowed the expression of the ambiguities inherent in the relation of moral and physical causes which permitted the asylum physician to treat the mad without necessarily having either to condone moral lapses or to stigmatize innocent but unacceptable behaviour as vicious. The notion of hierarchy in society explained and justified the hierarchical structure of the asylum—the social environment was ranked and ordered, and the asylum that was so organized was therapeutic because it promoted conformity to social realities. In short, these concepts allowed the asylum physicians to organize madness and mad behaviour into a form that was both medically and socially appropriate.

The first of these three concepts, or doctrines, the schema of stimulated motion, postulated a theory about the functions of the brain which supposed a physiological process whereby mental and physical events could affect each other. One of the first proponents of this theory was Robert Whytt, who identified three principles which regulated thought and animation in the human frame.

The old dualism had recognized only two kinds of action in the world: voluntary action governed by reason, and physical action, governed by mechanism. Whytt now argued for the existence of a third, fundamentally distinct, type of action represented by 'motion from a stimulus'. In the rational and the mechanical determinants of action there was now added a third set of determinants derived from the self-regulation of the living body.

The important idea which was developed from this notion of "stimulated motion" was that the initiating events did not have to be identifiable as particular physical or mental occurrences.
Both physical and mental events could operate in the same way to produce identical effects because their action was mediated by the same 'sentient' principle inherent in the nature of the living organism. A mental event could therefore be regarded as a stimulus, not in a metaphorical, but in a real sense. The stimulus concept now begins to take on a purely functional meaning. What defines a stimulus as such is neither a particular conscious experience nor a physical influence but a certain pattern of effects.  

William Cullen was Whytt's successor at Edinburgh, where he continued to utilize the notion of stimulus by "referring to anything which has the power of exciting animate motion as a stimulus." He also took up Whytt's "sentient soul" as an underlying principle, but altered its substance to that of "energy". The brain was seen as possessing a certain quantity of power which it applied to different parts of the body. As has been quoted above, well into the nineteenth century, mental and physical activity were attributed to levels of excitation which concentrated in the brain, the fluctuations of which were believed to be responsible for insanity. The most interesting aspect of the survival of Whytt's ideas is that of the functional disturbance, the cause of which might be indeterminate, though expressed through the absence of the stimulus, but whose "pattern of effects" can be named and treated.

Nineteenth-century asylum physicians absorbed the ideas of stimulus, the regulatory principle, and the functional disturbance, all of which were of use in establishing the intellectual foundations of asylum medicine. That a stimulus could be non-physiological in origin, i.e. mental, and yet be mediated through a sentient principle, which had some sort of organic status, linked the mind and body in an indeterminate relationship which was very useful to doctors wishing to account for the moral causation of mental disturbance. The regulatory principle had a similarly physiological aura
that corresponded well to the long-established therapeutics of a "tonic" or "lowering" regimen. The idea of the functional disturbance was a boon because it meant that symptoms could be addressed without especial concern for the source of the illness. All of these notions allowed moral management theorists to sidestep the implications of the mind-body dualism which was still a philosophical dogma in the early nineteenth century.

However, Cullen's legacy was not without its ambiguities to physicians concerned with mental and nervous disease:

What defined a stimulus as such were its effects, not its ontological status as belonging to the mental or the physical realm. But this position could easily become subversive of traditional dualism...it actively undermined dualism by its always present tendency to blur the sharp distinction between voluntary and involuntary action.6

So long as the prevailing environmentalist outlook of late eighteenth-century medicine privileged the nervous system in the realm of internal regulation, the threat to dualism was muted.7 However, by the 1830's, "the metaphysical status of mind" was generally considered essential to the proper functioning of the moral and social realms. The controversy between Marshall Hall and William Alison about the concept of reflex function was but one of several disagreements which flourished throughout the nineteenth century and whose fundamental components had to do with questions of necessity and voluntarism.8

Although the concept of stimulus as functional was occasionally perceived as potentially disruptive of the metaphysical doctrines which were inherent in much nineteenth-century social and political thought, it appears that it continued to be widely employed by early psychiatric theorists. Moreover, asylum physicians were not able to avoid other questions regarding free will and responsibility; indeed, their own doctrines, derived in part from what they felt was a strict empiricism, led into the very murky waters
which surrounded such formulations as partial or moral insanity. Many of the principles upon which medical psychology was based possessed an equal or even greater proportion of ambiguity.

The doctrine of predisposition was one of these. It encompassed both hereditary factors and congenital weaknesses, although it could not be confined to any strict correspondence of behavioural disturbance and physical lesion. It could be caused by an inadequate development of the mental faculties. Faulty education might provoke predisposition; functional disease could be the result. The idea of predisposition was, of course, to be found in standard medical explanation, and it derived some of its credibility from a long tradition, based on observation, which asserted that insanity was clearly inherited. In such cases, the acquired defect could be situated either in the tissues or the faculties. This arose from the observation of specific physical characteristics which were passed on in families, such as head shape or the tendency toward cretinism, which were often accompanied by disturbances in intellectual function. The predisposition toward intellectual or moral insanity could also be passed on, and if whole families displayed "vicious" behaviour, it was often assumed that some inherent weakness of the mental attributes must be responsible, although poor education, in the form of inconsistent or deliberately immoral parental actions, might be included as an adjunct explanation.

But predisposition did not need to be inherited. It could simply be acquired, perhaps prenatally or later during childhood in response to the same inadequate moral education that could trigger lunatic behaviour in inherited insanity. A predisposition could also be induced by indulgence in debilitating activities, such as sexual excess, drunkenness, or lack of
useful employment. It might also follow a period of general physical ill-health or excessive mental stress caused by grief, worry, or even over-studiousness.

The existence of predisposition in mental illness was inferred "empirically" from observations of familial patterns of instability. It was also useful in accounting for variations in sensitivity to noxious physical and mental experiences. This was especially important when observers were attempting to explain the apparent rise in the incidence of pauper lunacy by postulating the influence of the increasing complexity of "civilized" society. Such accounts were satisfying, partly because they gave scope to the nineteenth-century concern with the influence of the environment, while emphasizing the sense of social responsibility which could be derived from negative conclusions about the effects of industrialism and poverty on the minds of the lower orders.

Many eighteenth-century observers of types of insanity would have argued that varieties of disturbance were related to social class. By the later part of the eighteenth century, however, more observers were stating that mental illness cut across social boundaries. The associations between class and forms of illness never entirely disappeared, and, by the mid-Victorian period, Conolly was telling medical students that lunacy could occur in any social group, and that its greater prevalence among the poor was not so much the result of "vicious" behaviour as it was the effect of deprivation. He was concerned that a philanthropic attitude toward the pauper insane should not be diminished by a perception that insanity was the outcome of loose living, and was therefore largely within the bounds of personal responsibility.

The problem of responsibility is of great importance when the meaning of the doctrine of predisposition is considered. To say that a certain
lunatic had been predisposed to develop an illness neither excused his illness as socially caused, nor condemned it as individually induced. Both possibilities existed, and from an administrative point of view, neither was important. The principles of moral management were expected to reinforce the power of self-restraint in all cases of madness, and thus a defective or damaged faculty of mind could be improved by exposure to the asylum atmosphere.\textsuperscript{11}

Predisposition possessed impeccable medical connotations which allowed nineteenth-century physicians to regard it as a primarily scientific doctrine, with only secondary moral implications. However, there was no denying the impact that self-indulgence of a moral or physical kind was believed to be involved in many cases of insanity. In speaking of a medical predisposition, physicians could include personal responsibility in the genesis of disease, while continuing to support the philanthropic and paternalistic explanations that were more easily forthcoming when the advent of disease was considered to be accidental. The issue of personal responsibility did not logically relieve society of the need to provide for the insane, but it is evidence of a continuing tension within the theoretical and moral constructs of the therapeutic imperative.

The shift towards an increasingly deterministic theory of the causes of insanity, which focused upon degeneration and inheritance, and which was most powerfully argued by Henry Maudsley,\textsuperscript{12} was, in part, prepared for by the acceptance in the earlier part of the nineteenth century of the importance of predisposition. A predisposed lunatic could be victim of an unavoidable accident of birth, or his own indiscretions. The determined and the voluntary co-existed, and as long as that uneasy combination could
be tolerated, moral management could persist in its claims that causation was not of paramount importance, and that active treatment should be uniform. By the time of Maudsley's ascendancy, the balance had altered in favour of determinism, and treatment was perceived as palliative at best and, to some extent, irrelevant.

Another central preoccupation for doctors like Conolly was revealed in their efforts to locate the insane within the social environment. It was a question of order, of finding a place for the diseased mind within the various hierarchies of which the social world was composed. These included an order of precedence within the mind, between the mind and the body, and within various groups of individuals. These categories may be said to have the power of basic premises in nineteenth-century thinking. Thus, when the eighteenth-century formulation of the lunatic as beast-man, the man without reason, gave way to the concept of the lunatic as a man with a vitiated intellect, or weak control over emotions, or an incomplete will, it was necessary to identify the position of the mentally ill within the general structures of society.

The theories of mental functioning and the development of the principles of moral management were constructed around a general mind housed in an unspecified body. But it was understood that gender and social position would significantly alter certain aspects of mental and physical behaviour, especially as they affected the extent of "sensibility". An ill-defined but often mentioned quality, sensibility seemed to denote both receptivity to all forms of external stimulation and also a certain level of delicacy in the constitution which rose and fell in relation to gender and the degree to which the individual had been exposed to influences of social improvement.
Such variations in mental entities possessed an empirical reality for nineteenth-century physicians. Thus the references to disease types and asylum management had to take account of this data.

Doctors like Conolly did not analyze the relation between what they identified as different categories of mind and social structures consciously or directly. Rather, their associations or unacknowledged beliefs about the fundamental nature of social hierarchy provided a basis upon which they could begin to construct hierarchies of mental types. The mind had its own hierarchy; the intellectual faculties, such as attention, memory, and comparison, were believed to be of greater importance than the emotions or even the will. The strength of the reasoning abilities permitted proper exercise of the will and restraint on the emotions, which were otherwise likely to become unmanageable. The intellectual faculties were concerned in an individual's social participation. It had long been assumed that educated persons could be expected to exercise more self-control, and to behave in a more socially responsible manner than the illiterate. However, the less intellectual man could be taught to reason along lines appropriate to his social station by exposure to principles such as deference, loyalty, and perseverance. The intellectual faculties could be influenced, not only by direct application of texts, but also by example and precept; indeed, the mind unaccustomed to intellectual exercise and insufficiently acquainted with proper moral guidance or lacking a practical outlet for acquired information could be damaged by a rigorous or unbalanced educative endeavour.

It is in such a view that Conolly endorsed the type of learning to be found in Mechanics' Institutes. He decried the view that any educational improvement for the lower orders would be socially disruptive. He argued
that giving them information about the realities of economic life and facts about the natural world would in fact permit them to see and accept their place as subordinate economic agents and decrease social strife. Straightforward empirical knowledge applied to actual situations could do no harm, and, indeed, would strengthen their commitment to present realities, undermining both nostalgic sentiments and social discontents. In this way, control over the personality would proceed from the "highest" mental centres whether they had been developed by exposure to formal educational materials or by a blend of moral example and irreducible empirical data.

The hierarchy of mental functions was continuous with a dominance of the mental over the physical. It could be said that the "lower" elements of the mind, such as the passions, owed their subordination, in part, to their obvious links with physical processes. The intellectual faculties, especially any associated with the reason, on the other hand, had long ago acquired great value because of their presumed proximity to the soul. The mental operations thus took precedence over physical manifestations insofar as the soul ranked above the body. Establishing a necessary association between brain and mind did not diminish the higher status that was enjoyed by the intellectual faculties, and the persistence of this ranking was of particular importance to the development of moral management. Although several of the features of moral management were applied to the body, especially the provisions for housing, food and employment, the therapeutic rationale was intended to modify the mind, both through the creation of an emotionally balanced environment, and indirectly through the physical ministrations. In the degree to which moral therapy was directed towards mind, it benefitted from the status which all aspects of "mind" enjoyed in relation to the lesser value of the body.
This hierarchy of mind and body helps to explain the attraction of total non-restraint for some of the moral managers. The highest good was restraint through exercise of the intellectual faculties. Reason was to direct the will and emotions in the maintenance of self-control. If the object of moral treatment was to bolster or renew the powers of self-control, then surely those methods of management were preferable which appealed most completely to intellectual operations and which relied least upon physical constraints. The body must be made comfortable and secure, but the force of the therapy should apply to the mental status, and, insofar as self-restraint was the kernel of moral management, so the specific aspects of control should be most nearly non-physical.

The other aspects of hierarchy which were of importance to the constitution of nineteenth-century psychiatric theory and practice manifested themselves in social relationships. The ranking of social classes upon which Victorian society was structured informed the major elements of moral management. The theoretical premises of moral treatment were developed in a variety of situations in which the class affiliations of the physician-managers and their patients were very different; but the most renown was obtained by the efforts of the Tukes, who established a system of care which accepted as a primary value the relative equality of all souls before God. This egalitarianism was tempered by a practical paternalism that was clearly enunciated in the Tuke’s equating of lunatics with children. This analogy was not new in the public understanding of madness, and was, indeed, the expression of a deep belief in the ranking of the managers and the mad which was both sociological and psychological.

The socio-political orders which comprised the nineteenth-century British public found their counterparts in a hierarchy of psychologies. The
interdependence of the disease ranking and the social hierarchy is visible in their shared assumptions about the importance of breeding and education in the formation of distinct physiological and intellectual groups. The gently-born and academically-educated male was at the top of the pyramid, followed by his equally well-born and appropriately-educated wife. Lowest in the scale were all those reared in a combination of moral and physical squalor, who had inherited deficient intellectual faculties and who were engaged in immoral activities.\textsuperscript{15}

The importance of these parallel hierarchies did not rest entirely in the realm of diagnosis. They also affected the question of therapy. The management of attendants was a great worry in the annals of moral treatment, for it was widely acknowledged that the psychological demands entailed in caring for the insane were so great, especially in a morally therapeutic institution, that it was unrealistic to expect a high standard of performance from the class of person who could be induced to perform the task.

This explains why the asylum physician expanded his role in the administration. The force of his personality was intended to dominate the whole establishment to the extent that the attendants, who lacked his attributes of education, breeding, and almost divine character, could be inspired to behave toward the patients along the lines laid down for successful moral treatment. A spirit of self-sacrifice equal to that required of the physician-director seemed to be a positive necessity for the ordinary ward attendant, without any of the advantages which accompanied the doctor's commitment.\textsuperscript{16}

The problem grew even more complicated in the situation of the upper and middle class lunatics. It was difficult enough to find attendants with the necessary personal qualities to deal with the pauper insane. A larger
question, one involving the constitution of the emotional environment, existed in relation to the higher orders. Should not their moral treatment involve attention from individuals who possessed an intimate knowledge of the physical and psychological needs of the upper and middle classes? The higher ranks were thought to possess more highly developed sensibilities which required a more richly endowed atmosphere for their most effective expression. It was not merely the need for amenities—private living quarters, better food, more sophisticated entertainment, as well as socially appropriate avenues for occupation. It was also the fundamental requirement of deferential and well-trained service. "Good" servants could be had for the mentally well and well-to-do, but were they to be easily come by in an asylum setting? In some of the most exclusive institutions, such as Ticehurst, it seems that such were available. But in the less lavish private establishment, it was very unlikely that the hardworking, soft-spoken, intelligent ideal of a menial was procurable.

Even if the services of such a gifted domestic could be obtained, was he the most appropriate companion for the upper class lunatic? There were two problems. In order to regain his former sanity, the mentally disturbed individual needed to have some contact with a mind capable of influencing him. In the public asylum, daily exposure to healthy minds came from contact with the attendants whose mental equipment was considered equivalent in breadth and capacity to that of the patients. This individual experience of sanity was not the task of the physician to provide, except insofar as his personality, influencing all aspects of institutional life, had beneficial effects on the characters of those directly involved in the care of the mad.

In the case of the higher-status madman confined in a private asylum, his daily exposure would not be to an equal mind, but to an inferior one,
in the event that his attendant was a servant. His social and mental peer was the physician. Thus, there existed a therapeutic rationale for the intimate quality of the socializing which obtained among the elite insane in tiny asylums such as the one Conolly ran in his later years.\textsuperscript{18} Not only did teas and dinner parties reproduce the social occasions which made up a substantial amount of the public lives of the well-to-do, but such situations allowed the patients to benefit from the remedial influence of the medico-psychologist's character. However, the problem of the impact of the servants' less-refined sensibilities upon the weakened faculties of the upper class lunatic remained, since in all but the smallest private establishments, most of the care was in the hands of badly-educated domestics employed by the management or hired by the patient's family.

The other problem incurred in the treatment of upper class lunatics was related to the issue of subordination. It was axiomatic that effective moral therapy reinforced or renewed powers of self-control, operating through the carefully planned daily routine which was a major feature of public asylum life. Essential to the efficacy of this routine was the capacity to accept direction, to subordinate personal desire and individual will to the wills of the attendants, as they were directed by the physician. Such a chain of command reflected accurately the hierarchy of control which obtained between the social classes, and thus was natural to the environment of the public asylum. It was not so natural in the private institution in which attendants were servants and the physician, in effect, a hired professional. The company of the doctor could be tolerated as he was a relative social equal, but an attendant was there to obey orders, not to give them, and could never be considered as a therapeutic companion because of the sufficiencies resulting from his lack of breeding and education.
But an upper-class insane person must be led, like a pauper lunatic, to see that his powers of self-restraint were his chief aid to recovery. An aspect of such restraint was found in submission to the management by the mentally healthy, including persons who ranked as social inferiors. This predicament was rendered even more acute in the proportion of cases in which the mentally disturbed were behaving grandiosely, either imagining themselves to be exalted personages, or giving orders in an autocratic and self-indulgent manner, or a combination of the two. In such situations, it could be deemed therapeutic to deliberately deflate the pretensions of the patient, not through physical violence, but through lack of compliance with his directives. It might even be necessary to remove from his control all but the most essential servant and to give him the right to enforce discipline on the details of the patient's life. However, to place a well-bred lunatic under the management of poorly educated, albeit warm-hearted servants offended against social propriety for all ranks and undermined the successful recovery of the patient, who was expected to return to a structure of life which required an unquestioning habit of authority among the higher class.

It may be seen that the principles of hierarchy while providing important structural support to certain elements of moral management, also increased its ambiguities. The difficulties encountered in placing the upper class lunatic within the therapeutic framework stemmed from the problem of social identification. Conolly was among the prominent medico-psychologists who were drawn to the nascent study of ethnology. Questions about the human status and the intellectual, physical, and emotional attributes of the "savages" who were being brought to England for display from Africa and the Americas were similar in intent to the unsolved disputes of the eighteenth century concerning the ontological status of the man with vitiated reason.
All writers on psychiatric topics who were concerned about the influence of civilization of the genesis of lunacy began with certain received notions about the incidence of disturbance among the primitive, which led to questions about the constitution of the savage mind and its relation to minds of a more socially-advanced type as well as minds of different races. The existence of different types of minds, and the conditions which had contributed to their differentiation, were ideas which were present in the background of many discussions of the causes and treatments of insanity throughout the early and middle decades of the nineteenth century.

Just as Conolly felt obliged to establish the essential humanity of the retarded children from Central America, about whom he wrote a paper in 1853 for the Ethnological Society, so it was necessary to determine the boundaries of the human within the ranks of the mentally ill, especially in a period in which it might be contended that a more strictly rationalist theory of human nature vied with the older theological understanding, although both relied increasingly upon the faculty of reason as a basic defining characteristic for the possession of a personality. The explanation could be, and was, invoked to excuse and render comprehensible the conduct of the lunatic; but that categorization was not sufficient to account for the madman's position among the other sorts of men who demonstrated what the Eurocentric nineteenth-century physician designated as intellectual deficiencies.

In the end, despite the conflicts it engendered with the existing system of social hierarchy, the lunatic was classed with the pauper, the child, and the criminal (and if the colonial ethic is considered, the savage) as those who had to be managed for their own good and in order to ensure social harmony. This was a category defined in terms of what might be described as
social competence, since it included such factors as a capacity for sustained human interactions and a sense of social belonging identified by adherence to social and legal conventions, as well as a capacity for economic self-sufficiency. These requirements are elements which describe what Castel has characterized as "contractual society"—one in which "the subject participates in free and rational exchanges, or, because of [an inability to do so] is placed under a relation de tutelle." Such an ordering must be described as managerial and "pedagogic", rather than specifically medical or even generally scientific.

Moreover, this classification was not a solution to the enduring ontological problem of locating the lunatic type of man among other men. The above-mentioned hierarchies, the psychological, the socio-economic, and the ethnological were part of the great project of nineteenth-century physical and social inquiry which was to make a place for man in the natural world. In the end, the medico-psychologists were not able to account for insanity as a natural phenomenon, even when the concept of the natural included both the most primitive passions of the savage and the exquisite artifacts of the haute monde.

Broadly speaking, for many nineteenth-century physicians, the insane man was caught between nature and society, his mind-soul preventing him from residing within the former, while his lack of self-control made him unfit for the latter. At the same time, the ideas of nature and society did meet in the notion of the social environment which included all the influences of the physical world and social organization that could be said to have medical significance.

But the desire to complete the picture, to make coherent the growing confusion of the social, the medical, the economic, and the intellectual,
which confronted physicians like Conolly, is expressed by what Karl Figlio has identified as the metaphor of organization. Figlio develops his theory about the importance of an underlying concept for the understanding of the nineteenth-century biomedical sciences by looking at various disputes that took place during the eighteenth through to the middle of the nineteenth century, and which can be shown on analysis to possess a fundamental coherence, despite their surface polarities. Figlio takes pains to distinguish his idea of the utility of such a metaphor from Foucault's much broader scheme of the episteme: organization as a unifying concept operated at a level intermediate to what he terms "history" ("the spoken, but highly regulated strata of discourse") and the "unspoken", totally inclusive episteme. The importance of the metaphorical nature of the concept of organization lies in its capacity to allow for the expression of both scientific discourse and its context. It conveys the notion which was central to early nineteenth-century physiology—that of the depth, the "inwardness" of the living subject. In order to describe this interior reality, the tools of the anatomist were especially prized, and this, in turn, was connected with the older interest in comparative anatomy, which enabled the physiologists to establish the location of their subject in relation to other forms of life. This inwardness might leave signs on the surface, and was thus susceptible to the physiognomist, but it was ultimately "beyond the reach of visibility or total comprehension."

The interior was not exclusively physical, however; it was also moral, and thus organization came into use in areas concerned with human behaviour. This might take the form of medical psychology, or politics, or economics. The essential idea was that the presence of organization in the body, in the
mind, and in society, pointed to the existence of God and his controlling
design. Figlio's allusions to John Barclay, the Scottish philosopher, are
apposite. For Barclay, "...organization is similar to behaviour, to man's
moral faculties and to society; all are living, cohesive, purposeful pro-
cesses." His argument was identical to those used by members of the Scot-
tish School, such as Dugald Stewart or Thomas Reid. It was a "position which
emphasized man's moral faculties, including his capacity to perceive immedi-
ately the design in every aspect of creation and the appropriateness of his
actions, but which stresses equally his bodily frame." What is important
is that there was a clear connection between the emphasis upon human physical
and moral organization and nineteenth-century theories of the state as an
organism.

In the Scottish tradition, organization referred to the
active interrelating of constituent parts according to a wise
plan....At each level (medicine, ethics and political economy)
human knowledge depends upon grasping the organization
expressed by nature.

We may now declare more confidently that practitioners of moral manage-
ment and non-restraint employed three principal strategies of explanation in
order to give a certain coherence to their theory and therapeutics. The
first strategy, the stimulus concept, was neuro-physiological in derivation
and was intended to provide a basis for understanding questions of that
nature with regard to mental functioning. Secondly, the notion of predis-
position was drawn from contemporary medical practice in relation to its
sources and according to its applicability. Finally, hierarchy was used as a
medical fact as well as to account for the complications arising from within
the socio-political structures of society. In each case, there was no
defined boundary between what might be designated as the "scientific" and the
"social". Figlio speaks of the "metaphorical flow" which is permitted by the concept of organization; the ambiguity contained in its several meanings, such as "mere complexity, but also organic body, organized being, or the process of organizing." It was precisely the elasticity of meaning which was conveyed in the three techniques outlined above which gave them the explanatory power they had.

The essentially "linguistic" nature of nineteenth-century medico-psychological discussion has also been noted by Roger Smith:

Medical discourses integrated a scientific ideal and a moralistic practice. While the discourse contained many esoteric elements, it also formulated everyday concerns. Its strength lay in its capacity to rationalize so much within its frame of reference. It was at its weakest when forced to confront specific problems...

...neurophysiology was the language not the occupation of alienists.

It would seem that neurophysiology was one among several languages discernible in the discourse of the nineteenth-century medico-psychologists. The management provisions in the treatises on moral therapy comprise another aspect, along with the more specifically medical justification for certain organizational decisions. It could be said that moral management was a "metaphorical practice". Although, in actuality, the buildings and their behavioural codes were designed to modify or, at least, contain insanity, this was in another sense the enactment of sanity. If the exercise of self-control was the hallmark of the sane, and the multifarious details of the morally-managed asylum were intended to cure the mentally ill (or, in other words, produce self-restraint), then it could be said that the artifacts of containment were themselves a metaphor because, they were things which stand for something else, which is an old definition of metaphor. The language of self-control was represented by the enactment of organization.
If moral management was, then, the language of the nineteenth-century psychiatrists, their occupation was surely administrative. The structure of treatment within the asylum reflects an attempt on the part of the physician managers to incorporate recognized medical expertise with novel forms of organization. Or, as one critic says in his review of Castel:

What can be seen is not the adoption of policies based on the apprehension of scientific truth, but a mutual adjustment occurring among conflicting sources of power dealing with social and economic problems. The experts in insanity had all the advantages of linking medical and administrative practices in their work. What is important, Castel reminds us, is not so much what mental medicine was supposed to be doing at the level of practice as what it was actually doing when masking or covering up the contradictions between its therapeutic and its social and custodial objectives.33

Part of the resolution of those "contradictions" could be obtained from the notion of locating, in the person of the physician-administrator, a confluence of the therapeutic and social. Miller describes Castel as saying of moral treatment that it "represented the paradigm of an authoritarian pedagogy, the possibility for a generalized strategy of moral regulation based on a technical medical reference."34 Insofar as the character of the moral manager was to incorporate both the personal qualities desirable in both patients and attendants, and his person was to stand for the social hierarchy--the "order" of society to which the "disordered" man must be reconciled--he existed as the very figure of "an authoritarian pedagogy," albeit one tempered by its roots in a broader paternalistic philanthropy. The metaphorical nature of moral treatment is again underlined in the figure of the physician who is also an administrator, and who is a representation of the social meaning of sanity. His position became a locus for the strains--medical, technical, social, and managerial--which were brought together in the reformed asylum.
The effectivity of moral treatment is likewise evaluated not in terms of its success in providing a 'cure' but through its 'symbolic effectivity'. Moral treatment, developed as it was on the basis of a pedagogic analogy, was to make the asylum a 'special' form of educational system. John Conolly's works on the theory and practice of asylum administration exemplify the principles and underlying concepts of moral management. In the details of his plans for the non-restraint system can be found all the aspects of the metaphorical practice so far discussed. From his designs for window frames to his delineation of the character of the physician-superintendent, there can be seen an enveloping concern with the meaning of every feature of asylum life. Cure and comfort were his goals, kindness and cheerfulness were to be the primary experiences to be conveyed by the minutiae of asylum design and the careful regulation of the behaviour of the patient, attendant, and medico-psychologist. Non-restraint was the organizing principle around which the "symbolic effectivity" of moral treatment was to be constructed.
CONCLUSION

MORAL MANAGEMENT AS A SOCIAL MEDICINE

The physician, however harassed and impeded, now enjoys, in this department of physic, a pleasure long almost exclusively associated with the treatment of bodily ailments; he sees the progress of improvement in numerous cases from plain and intelligible methods of relief and cure, and he finds a field of contemplation open to him,...the rich products of which will be diffused not only over the disordered and suffering in mind, but mingle with all the intellectual movements now directed to the comprehensive views of that social science to which all useful knowledge is subsidiary, and which embraces not only the relief of social troubles and vices, but their prevention.

John Conolly

The morally-managed asylum was a device for organizing both illness behaviour and therapeutic endeavour. It institutionalized a belief in the necessary connection between mind and body, since it was designed to make possible the direction of interior patterns of thought by means of the manipulation of physical actions in order to produce self-disciplined behaviours. Moral management was an instrument of asylum administration which depended upon a deep-seated idea of hierarchy, extending from outward social forms to inward mental structures. This hierarchy in turn, served as a support to mechanisms of self-control which were essential to sanity as well as to the maintenance of the social order. The success of moral management was derived from the tenets of a physiology which argued that external physical ministrations could determine internal mental events, and that these mental events were subject to an organizing principle which was ascertainable by means of physical observation and introspection. The event of lunacy was itself in part the product of an internal defect of
organization. It was, in turn, influenced by the complexity of the external environment. The internal disorder could be rectified by the imposition of a system of constraint and reward which would reinforce the internal regulatory mechanisms and result in inward conformity to externally sanctioned standards of behaviour.

The non-restraint system that John Conolly envisaged would have completed the process of organizing the manifestations of madness which had been the objective of the moral managers. In the non-restraint asylum, the mental and the physical were mingled so that all provisions of regimen affected each in equal proportion, thus validating the physiological rationales which had been developed to support the ideas of moral treatment. The principle of hierarchy was honoured in the subordination of methods involving physical coercion in favour of a therapeutic based on moral suasion. In addition, non-restraint established an institutional imperative for the centrality of the physician-administrator that rendered him indispensable. Thus, the medical domination of the asylum was assured. It gave ammunition to the medico-psychologists in their battle for intra-professional recognition.

Two difficulties were always present. These were unresolvable within the epistemological framework in which the moral managers had to work. The first had to do with the ontological problem of defining mental illness in an age when mind and soul were still considered to be interchangeable concepts. Did a disruption of mental functioning imply a disorder of the soul which imperilled the victim's salvation? The issue was one of responsibility. Since illness was said to arise from the over-indulgence of passions and appetites, or from surrender to instincts and desires resisted by more
morally developed individuals, did a loss of reason imply a state of sin which the sufferer had brought on himself? Such a condition might indicate the need for less "comfortable" methods of treatment; it certainly militated against an indulgent humanitarianism which proposed lavish treatment for people who were, in effect, morally "vicious". However, the doctrine of predisposition, with its conflation of exogenous and internal factors, softened the problem of sin and responsibility. The non-restraint system, in its repudiation of physical coercion, sought to eliminate the punitive connotations of asylum treatment which had derived, in part, from those unresolved disputes about the soul of the lunatic.

In addition, the theoretical aspects of moral management were plagued by a complex philosophical problem: that of the relation between the mind and the body. As we have seen, the fundamental dogma posited an immaterial mind which interacted with a corporeal body. The difficulties inherent in this metaphysic were reflected in the occasional incoherence of the ideas with which the moral managers approached their practices. The physicians reasoned that a connection existed between mental and physical, and their therapeutics echoed that notion; but their language revealed a deep-seated belief in the separation of mind and body which was reinforced by their use of terms like "moral" and "physical" in relation to causes and treatments. The complexity of the connection between the mind and body in the speculations of the asylum doctors mirrored the interdependence and inter-penetration of practice and theory in the asylum itself.

The moral managers took their concepts of the structure and function of the mind from eighteenth-century formulations, and continued to elaborate definitions and categories of mental disturbance which had been in existence
from the earliest periods of psychological analysis. Scull has held them negligent for having failed to make much use of the increased knowledge about neurological function which was slowly amassing from 1820 to 1850. Robert Castel has, however, suggested another explanation. The antiquated theoretical structure was, he argues, necessary to moral management, because the process of asylum reform was not primarily a medical and scientific project but a pedagogical and social enterprise:

It is in fact, [Castel] suggests, the weakness of the 'theoretical' system of the alienists which constituted its practical strength since it was precisely through its failure to autonomise a properly 'scientific' dimension that psychiatry was able to establish itself through its practical objectives. The nosographies of the first alienists merely reiterated the supremacy of order and ensured that through the form of treatment employed the political strategies of the dominant power were imposed. Psychiatry developed as a "social medicine", according to Castel, and thus its concentration upon behaviour and control was a response to its socio-political mandate. The theoretical and practical aspects of moral management did not exist in a vacuum, but were the products of specific socio-economic and political exigencies of the late eighteenth and early nineteenth centuries and reflected as well a number of broad conceptual categories which informed nineteenth-century British society.

The socio-political context of moral management practices has been thoroughly explored by Andrew Scull. The importance of the influence of social, political, and economic forces upon the theories and practices of asylum physicians cannot be ignored. However, the intellectual content of those theories, and their interaction with the techniques of moral treatment is equally an element in the study of moral management. The limitations of Scull's approach are apparent in his work on Conolly. It is not
enough to interpret the various aspects of Conolly's career and his attitude towards asylum administration in terms of his personal and professional inadequacies, and his need to achieve some long-awaited recognition and financial security. Rather, as this paper has attempted to show, his activities as a moral manager should be examined in relation to the epistemological framework—the "discourse" in connection with the "social"—within which it had meaning and through which it was constituted.
INTRODUCTION


2 In the history of British psychiatry, the traditional school is dominated by the work of Richard Hunter and Ida MacAlpine, whose Three Hundred Years of Psychiatry: 1550-1860 (London: Oxford University Press, 1963), is the first reference for serious study of the principal contributors on psychiatric topics in the eighteenth and early nineteenth century. The book is a collection of excerpts on topics selected by the authors, who attempted to represent everything from theories of mental functioning to restraint devices. However, they clearly state their desire to illustrate the progressive accumulation of true scientific knowledge about the mind, the brain, and the treatment of mental illness which they believed had taken place throughout the period covered by the book. Hunter and MacAlpine also embraced the humanitarian thesis, as is evident in their attitude toward John Conolly. They wrote a series of biographical introductions to the reprints of his major texts, and did some new research into his career because they were impressed by the improvement in the care of the insane which they believed Conolly had achieved in his non-restraint system. Kathleen Jones's A History of the Mental Health Services (London: Routledge and Kegan Paul, 1972) is a straightforward account of the growth of humanitarian attitudes and the concomitant development of legislative strategies for dealing with insanity. Denis Leigh's The Historical Development of British Psychiatry vol. I (Oxford: Pergamon Press, 1961) is a series of biographical studies of the major figures of nineteenth-century psychiatry, with some analysis of their work.


Other anti-psychiatry figures include David Rothman in The Discovery of the Asylum: Social Order and Disorder in the New Republic (Boston: Little, Brown, 1971); and Erving Goffman, Asylums: Essays on the Social Situation of Mental Patients and Other Inmates (Garden City, N.Y.: Anchor Books, 1961) who saw the mental hospital as a total institution that, in effect, produced aberrant behaviour in its inmates.


The phrase about the liberal enterprise of the last two hundred years is drawn from a review article by Lawrence Stone, "Madness," The New York Review of Books, 29 (December 16, 1982): 28-36.

Michel Foucault, Madness and Civilization. William Tuke was a Quaker who established an asylum for Quaker lunatics called the Retreat in 1793. He was convinced that the mad could be treated by less severe measures than those that flourished in most asylums at the time. Philippe Pinel was a French physician who reorganized the care of the insane in two large Parisian public hospitals. He also advocated less punitive approaches. More details about these men can be found in Chapters I and II of this thesis.


Scull, Museums of Madness, p. 15.

Ibid.

For Foucault's recent work on power, see idem, Power/Knowledge: Selected Interviews and Other Writings 1972-1977, ed. by Colin Gordon, trans. by Colin Gordon, Leo Marshall, John Mepham, Kate Soper (New York: Pantheon Books, 1980).


Miller, "Territory", p. 72.

Ibid., p. 78.

Ibid., p. 98.

Ibid.

Ibid., p. 69.

Ibid., p. 99.


Ibid., p. 10.
CHAPTER I

1 John Conolly, On Some of the Forms of Insanity (The Croonian Lectures, 1848) (Southall: St. Bernard's Hospital, 1960), p. 16.


6 Hunter and MacAlpine, Three Hundred Years, pp. 543-546.


10 Hunter and MacAlpine, Three Hundred Years, pp. 543-546.


17 Scull, Museums of Madness, p. 113; Hunter and MacAlpine, Three Hundred Years, p. 955; K. Jones, A History of the Mental Health Services, pp. 145-149.

18 Hunter and MacAlpine, Three Hundred Years, pp. 299-301, 452-456.

19 Ibid., pp. 452-456.

20 Ibid., pp. 696-704.


22 Scull, Museums of Madness, p. 88.


27 Scull, Museums of Madness, pp. 105-106.


29 Hunter and MacAlpine, Three Hundred Years, p. 886.


"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."

(The Times, January 25, 1841, p. 6, quoted in Andrew Scull, unpublished earlier draft of Scull, "A Brilliant Career," p. 31.) Scull points out that the therapeutic efficacy of both mechanical restraint and moral coercion was well established in the literature on insanity treatment; two influential exponents were William Cullen and John Haslam. For references, see Hunter and MacAlpine, Three Hundred Years, pp. 475, 635.


33. Hunter and MacAlpine, Three Hundred Years, pp. 957-958.


37 Ibid., p. 205.
38 Ibid., p. 77.
40 These ideas are constantly present in the literature on madness throughout the nineteenth century. They will be developed at length in a later section of this paper.

CHAPTER II


"This book then is not a systematic treatise but an endeavour to present original sources and through them trace clinical and pathological observations, nosologies, theories and therapies, and the care of the insane as well as social and legal attitudes to mental illness....It is intended to serve the dual purpose of a sourcebook of psychiatric history...and a contribution to clinical psychiatry by providing a record of its problems and growth." (pp. ix-x)


4 There is a steadily growing literature concerned with the development of theories of mind and mental operations in late eighteenth and nineteenth-century Britain. The works listed were of particular help to me in my research.


Hunter and MacAlpine, Three Hundred Years, pp. 473-475. Cullen (1710-1790) was successively professor of medicine at Glasgow University (1751-1755) and then professor of chemistry, of the institutes of medicine, and the practise of physic at Edinburgh University (1755-1790) (Ibid., p. 473).


Ibid., pp. 102-132.

Ibid., pp. 513-517.

George Mann Burrows, Commentaries upon the Causes, Forms, Symptoms, and Treatment, Moral and Medical of Insanity (London: Underwood, 1828; reprint ed., New York: Arno Press, 1976). Burrows (1771-1846) began his medical career as a surgeon and general practitioner. He was chairman of the Association of Apothecaries and Surgeon-Apothecaries. After 1815, he devoted himself to the treatment of insanity: and was the owner of two private asylums. (Hunter and MacAlpine, Three Hundred Years, pp. 777-780.)

Burrows, Commentaries, p. 8.

Ibid., p. 9.

Ibid., p. 7.

James Cowles Prichard, A Treatise on Insanity (London: Sherwood et al, 1835; reprint ed., New York: Arno Press, 1973). Prichard (1786-1848) was appointed to be physician to St. Peter's Hospital in 1810 and to the Bristol Infirmary in 1816. He was the first practising insanity specialist to be made a Commissioner in Lunacy, which position he held from 1844-1848. He was also a respected ethnologist. (Hunter and MacAlpine, Three Hundred Years, p. 836.)

Prichard, Treatise on Insanity, pp. 76-77.

Ibid., p. 185.
Marshall Hall, Lectures on the Nervous System and its Diseases (London: Sherwood, Gilbert and Piper, 1836). Marshall Hall (1790-1857) was the neurophysiologist credited with the discovery of spinal reflex action. (Hunter and MacAlpine, Three Hundred Years, p. 903.)

Hall, Lectures, p. 11.

Ibid., pp. 19, 86-87.

Ibid., p. 87.


John Bucknill and Daniel Hack Tuke, A Manual of Psychological Medicine (Philadelphia: Blanchard and Lea, 1858; reprint ed., New York: Haffner Publishing Company, 1968). This work was designed by its authors to replace the outdated Prichard. Sir John Charles Bucknill (1817-1897) was the first editor of the Asylum Journal of Mental Science and medical superintendent of the Devon County Lunatic Asylum. He was a Lord Chancellor's Visitor in Lunacy from 1862 to 1876 and a co-founder and co-editor of Brain: A Journal of Neurology. The Manual of Psychological Medicine he published with D.H. Tuke was "the standard work for almost a quarter of a century". (Hunter and MacAlpine, Three Hundred Years, p. 1063.) Daniel Hack Tuke (1827-1895) was the son of Samuel Tuke and a son-in-law of John Conolly's. He published extensively on psychiatric subjects and was the visiting physician to the York Retreat. (Ibid., p. 1069.)


Ibid., p. 354.

"A small ulcer in the mucous membrane of the stomach, sometimes deranges all the functions of the viscus; a blow to the head causes vomiting; in either instance we know not how; but we refer the fact to others of a similar nature, tabulated under the terms of sympathy or irritation; that is, we provisionally formulate our knowledge. In doing so, we act in accordance with unexceptionable methods of philosophizing..."

Ibid., pp. 345-348, 364-367.


27 Ibid., pp. 40-41.

28 Ibid., pp. 42-45.

29 Ibid., pp. 52-53.

30 Ibid., pp. 54-55.

31 Ibid., p. 55.

32 Ibid., p. 71.

33 Ibid., p. 62.

34 Ibid., p. 84.


37 Ibid., pp. 530-535.

38 Philippe Pinel, *A Treatise on Insanity*, trans. D. Davies (London: Sheffield, 1806; reprint ed., New York: Haffner Publishing Company, 1962), p. 185. Philippe Pinel (1745-1826) was physician to the Bicêtre (the Parisian hospital for male lunatics) from 1793 to 1795, then becoming physician to the Salpêtrière (the Parisian hospital for female lunatics), at which post he remained until his death. He was also professor of hygiene and later of pathology at the Ecole de Médecine in Paris and a consulting physician to Napoleon. (Hunter and MacAlpine, *Three Hundred Years*, p. 602.)


40 Ibid., pp. 39-40.

41 Ibid., p. 41.


"But many of the causes inducing intellectual derangement, and which are called moral, have their origin not in individual passions or feelings, but in the state of society at large; and the more artificial, i.e., civilized, society is, the more do these causes multiply and extensively operate. The vices of civilization, of course, must conduce to their increase; but even the moral virtues, religion, politics, nay philosophy itself, and all the best feelings of our nature, if too enthusiastically incited, class among the causes producing mental intellectual disorders." (p. 19)
"Still, a disorder of the nerves may be, and frequently is, the immediate cause of insanity; for a violent moral impression being made on any of the senses, is first carried to the brain, which immediately acts synchronously with the heart, and re-acts on the brain...all the passions and emotions are said to be modifications of the will; and whenever the will stimulates the brain to violent exertion, the actions of the heart are always responsible..." (p. 112)


50 Esquirol, Mental Maladies, p. 60.

51 Ibid., p. 71.


54 Prichard, Treatise on Insanity, pp. 20-30.

55 Ibid., pp. 30-79. Prichard's longer definition of moral insanity is as follows:

"Eccentricity of conduct, singular and absurd habits, a propensity to perform the common actions of life in a different way from that usually practised, is a feature in many cases of moral insanity, but can hardly be said to constitute sufficient evidence of its existence. When, however, such phenomena are observed in connection with a wayward and intractable temper, with a decay of social affections...in short, with a change in the moral character of the individual, the case becomes tolerably well marked." (Ibid., p. 28.)
Prichard recognized the legal problems implicit in the identification of a form of madness in which no delusion need operate, but in which the will or emotions were so diseased that the lunatic could not control his behaviour. Moral insanity became involved in situations in which "irresistible impulse" or "psychopathy" would be applied today.

The idea of moral insanity originated with Pinel, who called it "manie sans délire" (mania without delusion). He concluded that it was "marked by abstract and sanguinary fury, with a blind propensity to acts of violence." (Pinel, A Treatise, p. 156.) Esquirol also remarked upon a connection he had observed between insane violence and rational and moral awareness (see Smith, Trial by Medicine, p. 37). Violent behaviour was not essential to Prichard's definition, however.

57 Ibid., p. 252.
59 Ibid., p. 226.
60 Ibid., p. 87.
61 Ibid.
62 Ibid., p. 191.
63 Ibid., p. 193.
64 Ibid.
65 Conolly, "Clinical Lectures," pp. 203, 293.
66 Ibid., p. 204.
67 Ibid., p. 294; idem, "On the Characters of Insanity," p. 376.
69 Ibid., p. 272.
70 Idem, Inquiry, pp. 62-87, 93-284; idem, On Some of the Forms, pp. 68-72.
72 Idem, On Some of the Forms, p. 27.
73 Ibid., p. 59.

76 Thomson, Works of William Cullen, pp. 523-528.

77 Ibid., pp. 530-535.

78 Pinel, Treatise on Insanity, pp. 180, 216-217, 224, 228-234.

79 Ibid., p. 193.

80 Ibid., pp. 60-63.

81 Ibid., pp. 2-5.

82 Burrows, Commentaries, p. 342.

83 Ibid., pp. 572-581.

84 Ibid., p. 667.

85 Ibid.

86 Ibid., pp. 669-670.

87 Esquirol, Mental Maladies, p. 76.

88 Ibid., pp. 77-85.


90 Prichard, Treatise on Insanity, pp. 180-203.

91 Ibid., p. 214.


93 Ibid., p. 404.

"...the removal of a patient from home is hygiene, inasmuch as it removes him from the causes of disease--and moral, insasmuch as it produces novel mental impressions, which are often of much service in the treatment. A blister to the nape may be thought purely medicinal; but there can be no doubt that sometimes its moral effect is not insig­nificant by attracting the attention of the patient from a morbid idea to a new sensation."


Ibid., p. 489.

Ibid., p. 501.

Ibid., p. 502.

Ibid., p. 503.

Andrew Scull, Museums of Madness, pp. 164-204.

General paralysis of the insane was first defined and described by A. Bayle, an intern at Charenton, in 1822. He identified a connection between progressive mental decline leading to dementia and certain physical signs that led to physical paralysis, and attributed these symptoms to a chronic inflammation of the meninges and the outer grey layer of the brain. Burrows saw the importance of the concept since general paralysis of the insane was the first example of a form of insanity in which a disturbance of mental functions could be linked to physical disorders during life and to changes in morbid anatomy. He publicized the work of Bayle in his Commentaries, pp. 77-82, 177-179. Conolly also described patients with general paralysis in On Some of the Forms of Insanity, pp. 29-58. The first monograph on general paralysis was written by Thomas James Austin, A Practical Account of General Paralysis, Its Mental and Physical Symptoms, Statistics, Causes, Seat, and Treatment (London: Churchill, 1859). The disorder was not identified as tertiary syphilis until 1913 when the spirochete was seen in the brain. (See also Hunter and MacAlpine, Three Hundred Years, pp. 777-780, 1052-1053; and Smith, Trial by Medicine, p. 35.)

CHAPTER III


Dr. George Birkbeck began the Mechanics' Institute movement by establishing in Glasgow in 1800, a cheap course of lectures on science for working men. He graduated in medicine at Edinburgh in 1799, and practised as a physician in London where he founded another Mechanics' Institute. He was a founder and councillor of University College, London. (The Concise Dictionary of National Biography, Part I: From the Beginnings to 1900 (London: Oxford University Press, 1953), pp. 105-106.


Conolly was among the group of professors who expressed considerable discontent because of the arrogant, interfering behaviour of the University's Warden, Leonard Horner, who was employed to oversee the daily affairs of the University at a far greater salary than the teaching staff received. The question of salary became especially acute when the Council made known its desire to reduce the guaranteed wages and make the professors more dependent upon fees from lectures. Conolly also supported two colleagues, Granville Sharp Pattison and John Gordon Smith, in their attempts to retain their positions after numerous complaints of their insufficient professional expertise and their inept behaviour in the classroom. This information is drawn from Scull, "A Brilliant Career?", pp. 226-227; the unpublished earlier version, pp. 15-22. Hunter and MacAlpine also deal with the problems at the University in the Introduction to Inquiry, pp. 22-31.


Charles Reade, Hard Cash: A Matter-of-Fact Romance (London: Ward, Lock, 1864). Conolly was identifiable as Dr. Wycherley, the owner and manager of the asylum in which the hero was unjustly confined. Conolly had published A Study of Hamlet in 1863 in which he argued the Hamlet was
not feigning madness. "The hero had only to say 'Hamlet was mad' to gain release from Wycherley's asylum." (Hunter and MacAlpine, Introduction to Construction and Government, p. 11.)

8 Scull, "A Brilliant Career?", p. 221. Conolly's health was poor throughout this period, complicated by problems in establishing his only son in some form of occupation. His wife disappeared from view at an early date, but evidence from his will indicates that she was still alive when he died in 1866. One of his daughters married a missionary and settled in China; the other two married Daniel Hack Tuke and Henry Maudsley respectively, and thus the Conollys remained associated with late nineteenth-century psychiatry.


10 For example, Conolly's visit to Glasgow Royal Asylum in 1818, his visit to Charenton in France in 1827.

11 John Conolly, De Statu Mentis in Insania et Melancholia (Edinburgh: J. Ballantyne and Co., 1822): title page. My discussion of Insania et Melancholia draws upon a rough translation from the Latin which was most kindly produced by a friend of mine, Mrs. Pat Anderson. She has ascertained the general direction of the argument throughout, and was able to provide me with a literal reworking of certain key segments of the document. No formal translation exists, although Hunter and MacAlpine quote from Insania et Melancholia in their biography of Conolly.

12 Ibid., p. 2.


14 Ibid., p. 28.


16 Ibid., pp. 13-34.

17 Ibid., p. 16.

18 Ibid., pp. 15, 313-333.

19 Ibid., pp. 478-482. This plan for care is interesting because in it Conolly advocated a government-financed and administered system of treatment that was surprisingly comprehensive. Three of his most important recommendations were:

"That all persons of unsound mind should become the care of the state; and should continue so until recovery."
Every Lunatic Asylum should be the property of the State, and be controlled by public officers...
All the officers and keepers of each asylum should be appointed by the Secretary of State." (Conolly, Inquiry, p. 481.)


23. Later in his life, Conolly was often credited with having been the first to introduce non-restraint. He repeatedly acknowledged his debt to Gardiner Hill in print; for example, see Hunter and MacAlpine, Introduction to Treatment of the Insane, p. 10, and Conolly, Treatment of the Insane, pp. 176-178; and Conolly, "President's Address to the Association of Medical Officers of Asylums and Hospitals for the Insane, 1858", Journal of Mental Science 5 (1859): 74.

24. The Pauper Asylum for Middlesex at Hanwell was opened in 1831. Its first superintendent was Dr. William Ellis, who had established a reputation for moderate but efficient management in a previous position at Wakefield Asylum. Working with him was an apothecary, while the matron's duties were undertaken by Ellis's wife. The asylum had two hundred and ninety-five patients at the end of its first year, and its numbers were then increased until they totalled some eight hundred by the time Conolly arrived in 1839. During Ellis's tenure, the regime at Hanwell was probably fairly representative of the kind and level of care to be found in most public asylums. Physical restraint of the order of straitwaistcoats, restraining chairs, padded leg and arm devices for attachment to furniture, would have been quite acceptable. There is also evidence that some of the more extreme devices of moral management, such as the swinging chair, baths of surprise, or elaborate illusory performances, were in use at Hanwell.

During Ellis's tenure, the number of patients at Hanwell had trebled. This led the magistrates to attempt an administrative reorganization following Ellis's resignation. The combined position of medical superintendent and steward (the financial officer) was divided, the medical post going to an ex-army surgeon, J.S. Millingen, who had won the competition in which Conolly had also participated. The steward was a layman, Mr. Hunt; and a second medical assistant, Dr. John Begley, joined the establishment. However, Millingen lasted only one year, largely because he made the mistake of attempting "to introduce a system of military discipline among the officers of the asylum...the consequence therefore had been that a spirit of insubordination had arisen....He had also introduced a harsher system of treatment as regarded the patients." In addition, the arrangement dividing administrative responsibility seemed to have increased costs. Millingen was dismissed, and thanks to some energetic lobbying by Mr. Sergeant Adams, then a member of the Committee of Visiting Justices, and the resignation of the former chairman, Conolly was given the post of Resident Physician, which was a
return to the original system of authority under which Ellis had worked. (See Hunter and MacAlpine, Introduction to Construction and Government, pp. 10-21.)


26 Hunter and MacAlpine, Introduction to Construction and Government, p. 28. Apparently, the Middlesex magistrates were sufficiently excited by the public reaction to the reforms at Hanwell to publish in a single volume Conolly's first four Annual Reports. Conolly later attached excerpts from these reports to Treatment of the Insane, pp. 192-274.


28 Hunter and MacAlpine, Introduction to Construction and Government, p. 28.


30 Scull, "A Brilliant Career?", p. 227. Scull claims that Conolly resigned "to the relief of the magistrates, to whom his departure now meant little more than saving the ratepayers some money." He offers no evidence for this assertion.

31 John Conolly, "Clinical Lectures on Some of the Principal Forms of Insanity," Lancet (Vol. 2 1845; Vol. 1 1846), 18 Lectures; idem, On Some of the Forms of Insanity (The Croonian Lectures) (Southall: St. Bernard's Hospital, 1960); idem, Construction and Government.

32 John Conolly, Construction and Government, pp. 1-8. Conolly argued that the cure rates reported by some private asylums, high in comparison with the reports of the public institutions, actually revealed their failure to offer truly remedial care to most patients. The lower rates of the public asylums were a result of their population being formed, in large part, by pauper incurables who were forced to spend the early, and therefore most curable, period of their illnesses in private asylums or workhouses.

33 Ibid., p. 68.

34 Ibid., pp. 1-144.

35 Ibid., pp. 102, 131, 138.

Seclusion rooms, the location of any private care in a public asylum, were to have solid doors with an inspection window covered by a plate which could be manipulated noiselessly so as to minimize distraction to the patient.

See Hunter and MacAlpine, Introduction to Construction and Government, pp. 10-16. See also Andrew Scull, Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England (London: Allen Lane, 1979; reprint ed., Harmondsworth: Penguin Books, 1981), pp. 105-106. The issue of productive employment for all patients had been of particular concern to Dr. Ellis, Conolly's predecessor, who reported in 1836 that he had succeeded in occupying:

"...the imbecile, and even the mischevious patient. It is that of picking in pieces the fibres of the outer husk of the cocoa-nut....Six pounds ten shillings a ton is received for the work; and the employment saves more than the sum paid for the labour in keeping the patients from destroying their clothes, and it also renders personal confinement less necessary. (See Hunter and MacAlpine, Introduction to Construction and Government, p. 18.)

Conolly, Construction and Government, pp. 79-82.

Ibid., pp. 84-87, 112-115.

Ibid., pp. 83-121.

Ibid., pp. 38-44.

Conolly, On Some of the Forms of Insanity, pp. 17-19.

Ibid., pp. 3-5, 24.

Conolly, Treatment of the Insane, pp. 66-80. Where "cerebral congestion" was distinct, local bleeding was advocated by Conolly, as well as the use of counter-irritants. Purging was approved of, in small and well-controlled amounts, for much mental disturbance could be laid at the door of constipation. He did use opium and some other drugs, but he frowned on an overly empirical approach to pharmacological means. He considered the warm bath and cold douche to be useful therapies, to be utilized with discretion but nonetheless efficacious in the right hands. He believed that much illness was occasioned by general debility, and thus argued against the "antiphlogistic" measures favoured by some alienists, although he agreed that with some patients, especially those accustomed to over-indulgent or luxurious living, a simplified and restricted diet was necessary. However, overall, he preferred the use of tonics to emetics and strong purges, and he utterly abhorred the use of devices like the rotary swing or the bath of surprise.
It is perhaps worth nothing that, in 1835, J.C. Prichard was saying of the swinging chair that it seemed to have a therapeutic effect and should not be discarded as a medical tool. Some English physicians were still using it; Prichard mentions Dr. Bompas, the successor to Dr. Cox, and Dr. Wake, physician to the asylum at York. (J.C. Prichard, A Treatise on Insanity (London: Sherwood et al, 1835; reprint ed., New York: Arno Press, 1973), p. 135.

47 Three other aspects of Conolly's plan of treatment included education, entertainment and religious services. Each of these areas was contentious in Victorian psychiatric literature, and Conolly was grieved by the failure of his attempts to expand these features of asylum life, failures resulting, in most cases, from the parsimony of the Middlesex magistrates.

Conolly couched his argument to include education in the Hanwell program in medical terms. Schooling would be therapeutic in three ways. One was that it encouraged the exercise of mental faculties that were often underdeveloped, so that it enhanced the balance of functions in the mind, and might help the higher qualities to regain control. If this was unlikely, the occupation was at least a distraction, and the need to divert a lunatic's thoughts from their pathological channels was an axiom of moral management. A third effect of education was to increase self-esteem, which was necessary to the resumption, or at least the augmentation, of self-control. And if it could achieve none of those three objects, it provided at least an alternative source of comfort and amusement to the chronically ill or the congenitally idiotic.

But despite this argument, other staff and the board at Hanwell eliminated a schoolroom and dismissed a teacher selected by Conolly. He recognized the role of social prejudice in the decision to abolish the school. There was not only the problem of the dangers of educating the lower orders, but an added concern which stemmed from a "less-eligibility" point of view. The governors seemed often to feel threatened by the prospect of a too-inviting system; they seem to have suspected malingering.

A concern with less eligibility may well have been at the bottom of Conolly's long battles over entertainment for the patients. Conolly wanted to institute musical evenings, a lending library, and an in-house press, but received little support from the board. Such entertainments were intended to act on the mind in ways similar to schooling—stimulating dormant functions, increasing self-esteem, diverting the attention to less objectionable subjects, and generally elevating the tone of daily life. Conolly did not approve of excesses of amusement, such as theatricals, which had been tried at other asylums, and which he felt would increase excitability and undermine confidence in external reality.

The question of the suitability of religious practices in the lunatic asylum was a vexing one in early Victorian medical psychology. On the one hand, many lunatics' illnesses were complicated by, or indeed resulted from, some sort of exaggerated religious belief or practice. On this basis, it had usually been argued that any contact with the clergy, or a service or a piece of literature on the subject, would be detrimental. On the other hand, there was a strong social pressure to expose everyone to religious influence, both for its moral effect and to stem the time of encroaching indifference or outright apostasy. This movement was especially concerned
with the lower orders, whose lack of regard for the Church was widely recognized. A related problem was one of toleration; many pauper insane were affiliated with non-conformist and other sectarian groups, and the very fact of their dissenting doctrines was held to have a pathological effect on their minds. A cooperative and sensitive minister could be a great adjunct to therapy, Conolly argued, because he was privy to much of the inner functioning of the patient's mind, and could, if properly instructed and possessed of sufficient delicacy, counsel the lunatic out of some cherished, but erroneous, belief. But he must be prepared to see his ministry was secondary to the medical program. If this proviso were accepted, then patients of virtually any religious persuasion might receive attention, although Conolly drew the line at what he considered obviously fraudulent or psychologically disruptive groups.


Conolly, Construction and Government, p. 28.

Conolly, Treatment of the Insane, pp. 43, 47-49, 54.

Conolly, "On Some of the Forms of Insanity," p. 11.

Conolly, Construction and Government, p. 28.

Ibid., p. 29.

Conolly, Treatment of the Insane, p. 72.

Hunter and MacAlpine, Introduction to Treatment of the Insane, pp. 35-36.

Conolly, Treatment of the Insane, p. 137.

Ibid., p. 148.

Ibid., p. 151.

Ibid., pp. 149-152; see also Conolly, Construction and Government, pp. 120-121.
61. Ibid., p. 164.
62. Ibid., pp. 203-204.


65. Ibid.


69. Hunter and MacAlpine, Introduction to *Inquiry*, pp. 1-2; idem, Introduction to *Construction and Government*, pp. 7, 22, 32.

70. Hunter and MacAlpine, Introduction to *Inquiry*, p. 32; idem, Introduction to *Construction and Government*, pp. 32-35.


CHAPTER IV


As was noted in footnote 54, Chapter II of this thesis, moral insanity was first described by Pinel, under the title of *manie sans delire*. Smith comments that, "It was a very peculiar human whom Pinel described,... General scepticism was reinforced by the law's view of what it was to be human, which excluded such possibilities." (R. Smith, *Trial by Medicine: Insanity and Responsibility in Victorian Trials* (Edinburgh: Edinburgh University Press, 1981): 36.) When J.C. Prichard enlarged upon the concept of moral insanity in his *Treatise*, he recognized that it was difficult to distinguish between violent and illegal acts committed under the influence of an irresistible impulse, and similar acts perpetrated as a result of an unresisted impulse. The difference was crucial in the legal defence of insanity, but it also had an effect in the medico-psychological realm. Moral insanity presented the notion that madness could exist in a person without causing a cognitive disorder, and it complicated the differentiation of madness from eccentricity, since moral insanity might be present in individuals whose reasoning powers were unaffected, but whose behaviour was socially unacceptable. Moral insanity also had implications for moral treatment; because the disorder was often defined as a defect in volition, it called into question the contractual basis of moral management. Could a morally insane individual make a commitment to increase his powers of self-control by exercising self-restraint and submission to asylum authority when his ability to control his will was attenuated or entirely absent? As a result of these complications, moral insanity was believed to present a poor prognosis. See J.C. Prichard, *A Treatise on Insanity* (London: Sherwood et al, 1835; reprint ed., New York: Arno Press, 1973): p. 29; and Smith, *Trial by Medicine*, pp. 36-39.

The emphasis upon eugenics and preventative education which became a prominent feature of much medico-psychological writing in the late nineteenth century can also be construed as evidence for a widely inclusive outlook on the causes of insanity.


"Disease not being, as it was so long thought to be, a specific morbid entity which, like some evil spirit, takes hostile possession of the body or of a particular part of it, and must be expelled by a specific drug, but a state of greater or lesser degeneration from healthy life in an organism whose different parts constitute a complex and harmonious whole; it is plain that a disease of one part of the body will not only affect the whole sympathetically at the time, but may well lead to a more general infirmity of the constitution in the next generation....In a certain sense then one may take comfort and be glad intellectually that failures should fail; for if the weak were not defeated in the struggle for existence it would be because the strong, holding back to the slower pace of their infirmities used not their strength, and so robbed the world of the right which it has to, and the advantages it would get from, the full use of their superior powers."


Ticehurst was a large private asylum with a good reputation for its care of wealthy patients. Set in extensive and beautifully landscaped grounds, it offered secluded houses on the estate, an aviary, a bowling green and a summer house. Many patients had their own rooms and personal

18 When Conolly reduced his involvement at Hanwell in 1845, he turned to private asylum management and consulting. His home, Lawn House, was licensed to receive female lunatics, and after 1848 he ran a similar asylum in the nearby village of Hayes. In 1850, he joined with his brother, William in a joint venture in a larger house for both sexes in Hayes. His consulting involved him in some controversial medico-legal work during the late 1840's and 1850's. His courtroom appearances were not successful, according to Hunter and MacAlpine. See R. Hunter and I. MacAlpine, Introduction to Treatment of the Insane, by John Conolly, pp. 35-41.

19 In Conolly's accounts of the treatment of the higher ranks, there are frequent complaints that habits of luxury common to the upper classes must be broken in order to strengthen their dormant powers of self-restraint. Thus, a simpler diet, less elaborate furnishings and less subservient domestics were considered to be necessary agents of treatment. See Conolly, Treatment of the Insane, pp. 143-175.


22 Ethnological Exhibits, pp. 12-14. Conolly disputed that the two children lacked a brain because they lacked language, and he was firmly convinced that they did not belong to an undiscovered race but were simply mentally handicapped children.


24 Such a widely-inclusive concept of the "natural" was useful to doctors who would have argued that while nature and society were separate entities, they converged in the experience of men to form what might be called the "social environment", a place in which both personal habits of consumption and the social organization of whole civilizations had their importance. This notion of the natural was derived in part from the development of the concept of "hygiene" in late eighteenth-century France. The third great principle of hygiene was called regime and it "contained a range of meanings from the medical one implying the regulation of diet exercise, in fact of mode of living in general, to the more general ones of governing...." (Jordanova, "Earth Science and Environmental Medicine," p. 122).
This connection between the natural and the social also owed something to the effects of anthropological investigation. In their study of physical anthropology, nineteenth-century figures like J.C. Prichard utilized an "analogical method" which extended basic scientific principles usually employed in the examination of other creatures to man himself. Since culture was a product of human endeavour, it too could be studied scientifically. Moreover, nineteenth-century anthropologists demonstrated a particular interest in deviancy, being concerned, like the physicians who were often participants in their research, with pathological phenomena, such as degeneration, deformation, and deviation. All of these were categories of deviancy which, because of their medical overtones, possessed a scientific aura, and they were also flexible enough to range from the behaviour of the individual to the social practices of entire racial groups.

Thus, the insane man was an anomaly in this social environment, a deviant who was caught between nature and society. He could not be incorporated entirely into the realm of nature because, according to the dualism which still prevailed, his mind was an immaterial essence separate from though connected to his body. Thoroughgoing naturalists, such as Thomas Laycock, were materialists; they were attempting to argue from the developments in neurophysiology that mind and brain were identical, and further, that the soul did not exist. By and large, asylum physicians retained a fundamental belief in the soul because atheism and materialism were linked to a political radicalism which sought to undermine social hierarchies. Metaphysical dualism depended upon the concept of a created universe, directed by an omnipotent God who had ordained social hierarchies for the good of man. (See L.S. Jacyna, "The Physiology of Mind, the Unity of Nature, and the Moral Order in Victorian Thought," British Journal for the History of Science 14 (1981): 110-132; L. Jordanova, "Earth Science and Environmental Medicine," pp. 120-146; G. Weber, "Science and Society in Nineteenth-Century Anthropology," History of Science 12 (1974): 260-283.


26 Ibid., p. 38.

27 Ibid., p. 41.

28 Ibid.

29 Ibid., p. 43.

30 Phrenology also gave credibility to the theoretical principles of moral management. Recent work on this subject has uncovered the extent to which nineteenth-century medico-psychologists were involved in support of the phrenological movement, and a careful study has demonstrated the utility of Gall's doctrines in the development of nineteenth-century neurology. Much of the contemporary research has concentrated upon the social and intellectual ramifications of the debate between advocates and opponents, and has its source in a broader concern with the definition of "scientific"
as it is applied to early nineteenth-century medicine. There has been a tendency to locate nineteenth-century psychiatrists in their response to phrenology by researching their contributions to specific phrenological journals and societies, as well as their involvement in certain highly publicized journalistic debates. In these contexts, John Conolly is often cited as an influential adherent.

However, a careful reading of Conolly's works on mental disease does not reveal a preoccupation with the specifics of phrenological doctrine. There are no recapitulations of the indexes of organs, no diagnoses on the basis of external signs of over- or under-development. There is a volume of photographs accompanied by physiognomical analysis in which Conolly figures prominently; but there is nothing of comparable quality about any aspect of phrenology. What do exist are a number of general comments on the localization of functions in the brain, and statements about the physical basis of mental disease. These remarks are not incompatible with his orthodox discussion of faculty psychology and the relations between reason, will and the passions. Indeed, there are more unequivocal references to phrenology present in Bucknill and Tuke's 1856 Manual of Psychological Medicine. They endorse Andrew Combe's definition of mental illness, and they discuss at length the pros and cons of the phrenology debate. In the end, they conclude that, whilst the details of the doctrines are questionable, certain general characteristics are of value in their understanding of mental disease. In particular, they cite the idea of functional organs and the importance of the brain as the locus of disturbance. James Prichard argues at length against the proponents of phrenology, but he too acknowledges the utility of some points.

It is clear that phrenology, by connecting mental to physical entities, was a great boon to nineteenth-century physicians. It not only underscored their theories, especially with regard to the necessary connection between brain and mind, but it posited a doctrine which accounted for a number of observations about brain injury and consequent psychological problems. Like predisposition, a general tenet of phrenology appeared to have an empirical justification, and nineteenth-century medico-psychologists harboured a deep affection for empirical evidence. Moreover, phrenology provided support for the principles of moral management, since it could be asserted that specific activities could strengthen or weaken certain organs of the mind, which lent medical credibility to attempts to strengthen self-control. Thus phrenology provided a way into the structure of the mind from external signs and behaviours, and reinforced what was considered to be the most effective method of reaching into the diseased mind and restoring its health.


32 Roger Smith, Trial by Medicine, pp. 56-57.


34 P. Miller, "The Territory of the Psychiatricist," p. 78.


CONCLUSION


SELECTED BIBLIOGRAPHY

PRIMARY SOURCES


"Clinical Lectures on Some of the Principal Forms of Insanity." Lancet (v. 2 1845)(v. 1 1846): 18 lectures.

On Some of the Forms of Insanity. (The Croonian Lectures of 1848).
Southall: St. Bernard's Hospital, 1960.

A Remonstrance with the Lord Chief Baron Touching the Case Nottidge versus Ripley. London: John Churchill, 1849.

"On the Prognosis of Mental Disease." Transactions of the Provincial Medical and Surgical Association 18 (1851): 195-218.


"On the Characteristics of Insanity." Notices of the Proceedings at the Meetings of the Members of the Royal Institution 1 (1851-1854): 378-381.

"Neglect of Insanity as a Branch of Medical Education." Lancet (v. 2 1853): 512-513.


"President's Address to the Association of Medical Officers of Asylums and Hospitals for the Insane, 1858." Journal of Mental Science 5 (1859): 1-2.


"Licences and Certificates." Journal of Mental Science n.s. 7 (1861): 127-136.

"On the Prospects of Physicians Engaged in Practice in Cases of Insanity". Journal of Mental Science n.s. 7 (1861): 180-194.


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