

RATIONALES FOR THERAPY IN BRITISH PSYCHIATRY: 1780–1835

by

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ANY GENERAL history of psychiatry between, say, the Renaissance and the end of the nineteenth century would likely stress, among other things, the following two points. First, that during this period there was a growing acceptance, both within the medical community and among the general public, that certain behavioural patterns, and certain kinds of mental states, are the result of *disease*, and hence are the proper objects of medical description and treatment; this instead of the ascription of these queer ways of acting or thinking to such things as the possession by daemons, a state of sin or wilful criminality. Second, a growing acceptance, again among both physicians and laymen, that the mind is the function of the brain, that a phrase like “mental physiology” is not a contradiction in terms, and that while perhaps it is not equivalent to “cerebral physiology” the two processes are so closely linked that the one cannot be properly understood without reference to the other. This commitment received its fullest expression in the school of German somatic psychiatrists of the last half of the nineteenth century, the school of Griesinger, Meynert and Wernicke, a group that Ackerknecht has called the “brain psychiatrists”.¹

My end point for the above broad summary was the end of the nineteenth century. This was deliberate, for despite the fact that in a general way these two trends have continued to the present day, implicit or explicit challenges to both claims still exist. For example, what might be called the “educational process” among laymen continues unabated: they are told that “mental illness is nothing to be ashamed of”, or that “mental illness is just like any other illness”. At the same time, within the psychiatric community itself, the whole concept of mental health and mental illness as it is presently formulated has been severely criticized, from the political left by psychiatrists such as R. D. Laing; while from another vantage point, much more to the right, Thomas Szasz has raised doubts about the “scientific” status of psychiatry, has suggested that our whole notion of “mental illness” is essentially a fiction, and that psychiatrists, instead of being scientific physicians, are actually custodians and public servants, charged with the care of people whom society for various reasons finds intolerable. In some of their roles at least, psychiatrists are thus placed by Szasz in roughly the position of a gaoler or poorhouse attendant in the seventeenth and eighteenth centuries, when “lunatics” or “madmen” were identified by law as a species of vagrant whose liberties had to be curtailed in the interest of the safety or convenience of society at large.²

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The second line of development mentioned above, the gradual theoretical shift in thinking about insanity from categories of mind to categories of brain, has also been rechannelled in the twentieth century, and this largely of course because of Freud. It is ironic that Freud was the product of German brain psychiatry and that he never lost his belief that mental processes, conscious and unconscious, are completely correlated with physiological changes in the human body. He recognized, however, that the neurophysiology of his day was inadequate to provide an account of psychiatric diseases in neurophysiological terms.³ His therapeutic measures, notably psychoanalysis, were developed with little reference to his physicalist commitment. Freud adopted a metaphorical language which allowed him to speak about mental phenomena without being simultaneously required to spell out their physiological correlates which he fully believed would be specified in the course of time. The same position has provided other psychiatrists the licence to talk as if psychiatric development were independent of neurological development. It was Freud's influence more than anything else which formalized the separation of psychiatry from neurology. At a time when evolutionary biology has undermined the ontological position of the human mind, we still live more or less in a Cartesian world. We recognize diseases of the brain and diseases of the mind, and if the border between is not quite so clear as it might be in the world which Descartes constructed, the number of patients which psychiatrists and neurologists fight over is on the whole rather small. Both of these problems, then, the status of mental disease and the relationship of mental function to brain anatomy and physiology, are still unresolved, which perhaps enables us to appreciate more easily some of the peculiarities which have attended the past theory and practice of psychiatry. I shall here be concerned with aspects of these two problems as they relate to the theoretical and practical implications of moral therapy in British psychiatry of the last decades of the eighteenth and the first decades of the nineteenth centuries.

I

The development of "moral therapy", as it was frequently called at the time, is of course one of the high points in the history of psychiatry. Although the myth that Pinel struck off all the chains of his patients in one dramatic gesture has been punctured; and although recent research has shown that others besides Pinel were at the time actively engaged in the same kinds of therapeutic experiments, both the drama and the importance of the movement are still recognized in the historical literature. "Moral therapy" was simultaneously a triumph of humanism and of therapy, a recognition that kindness, reason, and tactful manipulation were more effective in dealing with the inmates of asylums than were fear, brutal coercion and restraint, and medical therapy.⁴ It is this last parameter, medical therapy, with which I shall be particularly concerned.

"Broadly constructed, 'moral treatment' included all nonmedical techniques, but more specifically it referred to therapeutic efforts which affected the patient's psychology."⁵ This definition of Carlson and Dain adequately reflects the kinds of differences which early nineteenth-century advocates of moral therapy saw between their own approaches and the therapeutic programmes of previous generations.

Nevertheless, coercion and restraint can operate psychologically just as can liberty and non-restraint. Benjamin Rush with his restraining chair, and Erasmus Darwin with his rotating chair, were presumably just as well intentioned as Pinel or any other advocate of moral therapy. And if these rather brutal eighteenth-century methods “cured” as their inventors claimed they did, we may assume that these cures were “psychological” in precisely the same way as those attained by moral treatment. The *modus operandi* in both cases was via the patient’s mind. The moral therapy of nineteenth-century psychiatrists was admittedly different from the harsher approaches of their earlier colleagues, but much of the change stemmed from the attitudes of the doctors themselves rather than from some entirely new appeal to the patient’s psychology.

Nevertheless, if the virtual equation of “moral” with “psychological” blurs some of the distinctions between Pinel’s therapeutic endeavours and what went before, the connotations of the phrase “moral therapy” are sufficiently precise to justify its use in describing the reform in psychiatric treatment associated with Pinel, Tuke, and the other late eighteenth-century activists. In fact, the prehistory of the concept of moral therapy appears quite meagre. One can assume that many earlier physicians were tactful enough, humane enough, and perceptive enough to deal with mentally disturbed patients in the quiet, efficient manner which seems to have been the norm at the famous York Retreat, founded by the Quaker philanthropist William Tuke in 1792. Part of the reason for the absence of more objective evidence on this point in the earlier medical literature might be attributed to the lack of many detailed case histories. Obviously the conditions of the York Retreat never obtained at the large public institutions like Bethlem, but physicians dealing with private, individual, and paying patients perhaps used different tactics. Perhaps they did, but the evidence is hardly overwhelming. And when we consider the therapy which was meted out for the most famous patient of his day, King George III, we can appreciate the real contrast which moral therapy presented. A great deal was at stake with this patient, and there is every reason to believe that Francis Willis, his sons, and other assistants treated the king in a manner which (in Willis’s considered opinion) would most likely result in the royal patient’s recovery. Yet, as the Countess Harcourt described the situation, “The unhappy patient . . . was no longer treated as a human being. His body was immediately encased in a machine which left it no liberty of motion. He was sometimes chained to a stake. He was frequently beaten and starved, and at best he was kept in subjection by menacing and violent language.”⁶ He was in addition blistered, bled, and given digitalis, tartar emetic, and various other drugs.

The intimidations and threats technically come under the rubric of moral therapy, in the sense that it was his mind which was being appealed to. Perhaps “immoral therapy” is a better description of this approach, but in any case I am less concerned with that than with the blisters, bleeding, digitalis, tartar emetic and other therapeutic measures. In point of fact, physicians at the time generally decided that George was labouring under a “delirium” instead of a madness.⁷ But that little matters, since he was treated by “mad doctors” (i.e. broadly speaking, psychiatrists), and the methods they used with him were not out of the ordinary.

One reason that medical treatment for madness might seem odd is the fact that

eighteenth-century theories of mind took far less cognizance of the brain than ours do. Their universe was more nearly Cartesian than ours in their separation of mind from brain, and, more important, their conflation of the philosophical and medical concept of *mind* with the theological concept of *soul*. This conflation can be seen even in David Hartley's physical model of the mind. Hartley's 1749 *Observations on man, his frame, his duty, and his expectations* developed an association psychology based on a psychophysical parallelism whereby all mental events have their physical representations in the vibrations of fibres in the brain. Hartley, a devout Christian, introduced a scholium making it against the rules to deduce the materiality of the soul from his physical model of the mind.⁸ It is worth noting that in the first volume of Hartley's work (in which he developed his psychology) the word *soul* occurs only in the context of the scholium. The rest of the book is about mind, but the wording of the scholium demonstrates that the two concepts were identical for him. They had been of course for Descartes as well; indeed, the French use the single word *l'âme* for both. It was the possession of an immaterial soul which distinguished man from the animals, theologically, of course, but psychologically as well. Descartes' strict dualism created a number of philosophical problems; but these were compounded when the same framework was used to talk about mental *disease*. If it is the soul which gives man his reason, is it this same theological soul which is diseased in those individuals who have either lost their reason, or never developed any? The kinds of compromise a physician working within what was essentially a Cartesian framework had to make may be seen in the writings of Thomas Willis. Willis modified the Cartesian picture somewhat in adopting Gassendi's notion that there exist two kinds of soul: sensitive souls which are material and which man shares with animals; and rational souls, immaterial and the possession of man alone. Willis conceived madness to be a disease of the rational soul; but since he also believed in the pristine inviolability of the rational soul, he postulated that in order to function properly, the rational soul is absolutely dependent on the *phantasie*, an attribute of the sensitive soul, possessed by animals and located by Willis in the corpus callosum. Thus Willis could talk about mental disease only by making the rational soul so dependent on the brain that, to modern eyes at least, his distinction between the two kinds of soul becomes for all practical purposes meaningless.⁹

The problem of insanity in the medical literature before the nineteenth century is further complicated by the almost exclusive emphasis on disturbances of *reason*, or the highest intellectual faculties of man. Insanity was conceived as a derangement of those very faculties which were widely assumed to be unique to man; as a matter of fact, we sometimes find in the literature the presumed absence in animals of any condition analogous to insanity taken as proof that man's highest psychological functions result from some principle totally lacking in other animals, that is, the soul. On the surface then, Willis' position seems odd, for he recommends the almost exclusive use of medical therapy to treat a disease the manifestations of which are a malfunctioning of a faculty, reason, which itself results from the operation of an immaterial principle. How, in a Cartesian universe, can physicians cure mental diseases by physical remedies? The answer of course is that they don't; they protect the soul, locate the disease in the brain, humours, or elsewhere in the body, and

treat that instead. And as long as one conflates the concepts of mind and soul, mental disease is either a misnomer and actually brain disease indirectly affecting mental functions; or a visitation from the devil or the Deity, i.e. possession or retribution. Seen from this perspective, some of J. C. A. Heinroth's rhapsodies make more sense.¹⁰ More common however was the opposite position, namely that the soul or mind is never primarily deranged. Late in the nineteenth century solid American psychiatrists such as John Gray and Pliny Earle were physicalists in order to protect the soul. Gray wrote in 1885 that insanity is "simply a bodily disease in which the mind is disturbed more or less profoundly, because the brain is involved in the sickness either primarily or secondarily. The mind is not, in itself, ever diseased. It is incapable of disease or of its final consequence death."¹¹

This theological motive thus furnished one reason why a physician of the seventeenth or eighteenth centuries would not find medical therapy for mental disease odd. Another aspect which I shall not discuss is perhaps more obvious: this was the general inheritance of the humoralism of Greek physiology, pathology, and therapy. On one level at least, humoralism accounted for mental diseases theoretically and dictated the appropriate medical therapy. It provided a traditional rationale for medical therapy, and both of these factors, the theological and the humoral, should be kept in mind when evaluating the reactions of British physicians to moral therapy.¹²

Another factor was more obviously social and economic. Work by historians such as Foucault, Ackerknecht, Rosen, and others has pointed to the profound changes in social attitudes towards insanity between the sixteenth and nineteenth centuries.¹³ Despite the fact that physicians had frequently been concerned with what might be called the disease concept of insanity, the care, or custody at least, of the insane was less frequently in their hands. England's 1744 Vagrancy Act is instructive here. Section 20 of the Act dealt with "those who by lunacy or otherwise are so far disordered in their Senses that they may be dangerous to be permitted to go Abroad." Any person could detain such a vagrant, and the consent of two justices of the peace was adequate to "cause such Persons to be apprehended and kept safely locked up in some secure place". No medical certificate was necessary and the decision about ultimate release was in the hands of either the gaoler or the local magistrates.¹⁴ This was how the 1744 Act left the situation, but during the next half-century or so several significant changes occurred. The medical community began to assume an increased responsibility for the care of the insane, and this phenomenon is reflected in various institutions, in various acts of parliament, and in a growing medical literature on the subject. The institutions include St. Luke's Hospital, London, founded in 1751, the Manchester Lunatic Hospital (1766), and the Newcastle Lunatic Hospital (1767). St. Luke's was conceived by its founders as a rival to Bethlem, and while conditions apparently left something to be desired, they were a decided improvement over those at Bethlem. The physician to the new hospital was of course William Battie, whose 1758 pamphlet *On madness* was construed by John Monro, physician to Bethlem, as an attack on the latter's father. Their debate need not concern us here.¹⁵

This same period also saw the growth in the number of "private madhouses", about which Dr. Parry-Jones has recently written.¹⁶ These private establishments (run by individual *entrepreneurs* for a profit) have been a feature of English life for

several centuries, but in fact their relation to the medical profession itself remained unclear during the eighteenth century. Anyone could open a private madhouse, i.e. receive lunatics in his house on a paying basis. Many, and perhaps even most, of these proprietors were medical men, but there was nothing which required them to be, and tacit in the lack of legal regulation was the implication that either (a) their function was custodial rather than therapeutic; or (b) anyone could select and administer the therapy indicated by insanity. The first act aimed at licensing these establishments was passed in 1774. It said nothing about the medical qualifications of the proprietors, keepers, owner, or consultants; but the act did recognize medical jurisdiction in cases of insanity in two ways. First, it set up a commission to inspect private madhouses within the metropolitan area, and this commission was composed of members appointed by the Royal College of Physicians. Second, it required that a medical certificate be obtained before a person could be committed to such an establishment.¹⁷ Before the licensing acts of the nineteenth century better defining who in fact was a "medical man" this second part of the act was of uncertain practical importance.¹⁸ Nevertheless the social significance of this act lay in its recognition that insanity was a medical issue, rather than, as implied in 1744, a condition which any person could recognize and which any magistrate could formalize.

By the end of the eighteenth century, then, British physicians were playing an increasing role, legal and practical, in the diagnosis and therapy of the insane. A large number of medical works dealing with insanity appeared during the last decades of that century, partly the result of the wide interest aroused by George III's illness; but also the reflection of those more general considerations mentioned above. The best known of these works include Thomas Arnold's *Observations on the nature, kinds, causes, and prevention of insanity* (1782–86); sections of John Ferriar's *Medical histories and reflections* (1792–98); William Pargeter's *Observations on maniacal disorders* (1792); Alexander Crichton's *Inquiry into the nature and origin of mental derangement* (1798); Andrew Harper's *Treatise on insanity* (1789); and John Haslam's *Observations on insanity* (1798).

This growing medical interest in and control over the insane was to some extent challenged by the spread of moral therapy. From the beginning British commentators identified the emphasis on moral therapy as one of the striking characteristics of Pinel's 1801 *Traité sur l'aliénation*. His English translator David Daniel Davis (1777–1841) noted in his introduction to the 1806 translation that "this volume is chiefly valuable for the great attention to the principles of the moral treatment of insanity which it recommends".¹⁹ Pinel was not the first to stress psychological factors in the causation of insanity. Indeed, he himself referred to earlier writers on this point, for example, to Alexander Crichton's consideration of the passions in the generation of what Crichton called mental derangement. Pinel, however, explicitly completed the circle: that which is psychologically caused is most effectively psychologically treated. The relationship between causation and treatment is a two-way affair, for "the successful application of moral regimen exclusively, gives great weight to the supposition, that, in a majority of instances, there is no organic lesion of the brain nor of the cranium."²⁰ For Pinel, insanity was a mental condition, hence logically treated by psychological methods. Such was his success with moral therapy that he completely

abandoned medical therapy on most of his patients, giving them a trial of moral therapy and resorting to medicinal (physical) remedies only with those on whom the psychological measures had failed.

Pinel's programme achieved impressive results which he thoroughly substantiated in his treatise. Nevertheless, it raised several questions. What, for instance, was the role of the physician to be? The successful application of moral therapy required most of all a willing and sensitive staff, and Pinel's case histories were filled with patient-keeper interactions; much less frequently did he record direct interaction with himself. He further mentioned the "common sense and unprejudiced observation" on which his work was based; again, Pinel paid warm tribute to the principal keeper of the asylum, from whom he had obviously derived a great deal.

The same kinds of questions were implicit in the history and structure of the York Retreat. The Retreat, as it was affectionately known, was founded in 1792, but it was not until 1813 and the years following that its methods were widely discussed. Samuel Tuke's *Description of the Retreat* was published in 1813, and Sydney Smith eulogized Tuke's book and the institution it described in the *Edinburgh Review*, one of the leading periodicals of the day.²¹ The Retreat had a ready foil, for Tuke's work emerged from the controversy surrounding the alleged mismanagement of the other York institution for the insane, the York Asylum. Whereas the Retreat was founded and largely run by laymen, the York Asylum was easily recognized as a typical medical concern presided over by a physician, Dr. Charles Best. Public attention continued to be focused on the condition of the insane during these years through the hearings of a parliamentary select committee concerned with the "better regulation of madhouses" in 1815 and 1816. The committee accumulated and published some 600 pages of evidence which according to the *Edinburgh Review*, contained "beyond all question, the most important body of information, that has ever appeared, upon the subject of Insanity."²² Such was the public esteem accorded to the ideals of the founders of the Retreat that Edward Wakefield in 1815 could think of no higher praise for the private madhouse of Mr. Finch at Laverstock than by remarking, "In this establishment I saw all that Tuke has written realized".²³ After a visit to the Retreat in 1812, Dr. Andrew Duncan had asserted "that the Retreat at York, is at this moment the best-regulated establishment in Europe, either for the recovery of the insane, or for their comfort, when they are in an incurable state."²⁴

Tuke's *Description* was hardly polemical in tone; yet the work contained a rather damning attack on the medical profession's capacity to deal with mental illness. Samuel Tuke was not a physician. In fact, he had wanted to become one, and quite naturally to specialize in the treatment of mental disorders. Family pressure kept him in the family business. Nevertheless, we can presume that Samuel did not possess his grandfather William Tuke's general aversion to the medical profession.²⁵ It is clear from the *Description* that the experience of the Retreat had convinced Samuel Tuke of the decided superiority of moral over medical therapy.

From the beginning the Retreat was provided with the usual visiting physician. Kindness and the various trappings of moral therapy were always the aims of the Retreat, but Tuke insisted that the minimization of medical therapy was not built into the institutional structure; it had merely evolved from careful observation. Only

gradually had the Retreat's first physician, Thomas Fowler, abandoned the "bleeding, blister, setons, evacuants, and many other prescriptions, which have been highly recommended by writers on insanity".²⁶ Fowler was no general therapeutic nihilist; his three major publications all concern therapy and he compounded and gave his name to the arsenical solution which was so popular in the nineteenth century and which in Britain still has its devotees.²⁷ Like Pinel's, Fowler's was the therapeutic scepticism of a physician who had simply explained his therapy carefully. As Tuke summarized it, Fowler "plainly perceived how much was to be done by moral, and how little by any known medical means".

At the Retreat, like the Bicêtre, the physician was a shadowy figure, the burden of therapeutic responsibility having fallen on the keepers and other staff whose personal contacts with the patient were much greater than that of the physician. Tuke never proposed to abolish the office of physician to the Retreat. Indeed, he suggested that the physician could be a very important figure: "The physician, from his office, sometimes possesses more influence over the patients' minds than the other attendants". The phrase "the other attendants" is telling; it suggests that very little of the physician's role was dictated by his specific medical training, a great deal by simple benevolence and common sense.

The success of moral therapy thus threatened to change the rather newly established place of the medical man in the treatment of insanity; and, as we have seen, theories of insanity were also at stake. Pinel was explicit in drawing out the theoretical implications of moral therapy, in seeing mental disease as frequently a functional condition unaccompanied by structural changes. However, Pinel's work was somewhat confused by his emphasis on the epigastrium in the origin of many attacks of insanity.²⁸ Samuel Tuke on the other hand refused to commit himself on the ultimate nature of insanity, but he recognized the problem in the terms outlined above: "If", he wrote, "we adopt the opinion, that the disease originates in the mind, applications made immediately to it, are obviously the most natural, and the most likely to be attended with success. If, on the contrary, we conceive that mind is incapable of injury or destruction, and that, in all cases of apparent mental derangement, some bodily disease, though unknown, really exists, we shall still readily admit, from the reciprocal action of the two parts of our system upon each other, that the greatest attention is necessary, to whatever is calculated to effect the mind." Tuke's attitude was essentially pragmatic; it was enough for him that moral therapy was effective, whatever the reason.

Moral therapy, then, was hardly a straightforward affair; and its implications for both medical theory and medical practice were not lost on the physicians of the early nineteenth century who attempted to assess its true significance. However much they might profess to admire the methods of Pinel or the Tukes, very few were prepared to abandon entirely the medical treatment of insanity. When William Tuke had been asked by the parliamentary committee of the effect of medicine in cases of mental derangement, the venerable old man had replied: "In cases of mental derangement, from what I have learnt, it is thought very little can be done; but when the mental disorder is accompanied by bodily disease of one kind or other, the removal of the complaint has frequently recovered the patient; this comes within my personal observation, having frequently enquired into the effect of medical treatment."²⁹

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If physicians *qua* physician could do nothing for the lunatic except treat his bodily afflictions, then the medical man had no special claim to a unique place in the treatment of mental illness. Their income, prestige, and medical theories were all threatened. So, in some instances at least, was their integrity, for many of the abuses which the parliamentary committee had called to notice involved medical men.

It is not surprising, then, that we find a certain defensiveness in the British psychiatric literature of the 1810s and 1820s. For the doctor at least, the rise of moral therapy was not an unmixed blessing.

II

The Parliamentary Select Committee which in 1815 and 1816 examined the management of various institutions responsible for the care of the insane was not actively hostile to the medical profession. The committee was particularly concerned with improving the quality of care available for the lunatic in both public and private institutions, and the hearings focused on several specific instances of brutality and neglect which had come to light in the immediate past. William Norris for instance had spent the last ten or fifteen years of his life chained in a damp cold cell in Bethlem, no-one remembering precisely how long it had been. The committee repeatedly queried the practice of keeping violent or incontinent patients naked and chained, and the odd pregnancy of a female patient or the sudden death of an inmate under mysterious circumstances kept the discourse at a dramatic level. Bethlem and the York Asylum fared badly at the hearings and the scandals which came out of these institutions put the medical men who controlled them on the defensive. Even the printed transcripts convey the tight-lipped resentment with which Thomas Monro, John Haslam, and Charles Best answered many of the questions put to them during the proceedings.

The committee for instance was anxious to determine how frequently Monro visited Bethlem in his capacity as sole physician to the hospital. On 8 May 1815 Bethlem's steward George Wallet expressed his opinion that Monro attended "but seldom; . . . I hear he has not been round the house but once these three months; he may have been there without my knowledge, he has been at the Hospital more frequently, but not round the gallery [where the patients generally stayed]." ³⁰ Four days later Haslam informed the committee that Monro visited the hospital "twice a week, Saturday and Wednesday, or Tuesday; he suits his convenience". A week later Monro himself put the figure at "About three times a week". ³¹

Patient neglect was of course not a medical monopoly, and one group of mad-houses also at fault were those at Hoxton owned by Sir Jonathan Miles. Miles himself was not a physician, and while each of his madhouses had a regular apothecary, the official limit of the apothecary's responsibility ended with the patients' bodily complaints. Should the patient or his family be concerned about the mental disorder, an outside physician had to be specifically engaged to visit the patient on a consultant basis. ³² That no medical treatment was routinely provided for the psychiatric complaints was obviously viewed by the committee as an abuse. Nevertheless, one of the questions frequently put to the various witnesses concerned just that issue. John Latham, President of the Royal College of Physicians, was asked point-blank,

“Are you of opinion that if medicines were occasionally administered to patients for insanity only, it would be productive of any chance of recovery?” Latham answered, “I think it is probable it would.”³³ This is the response that a physician might be expected to make and Latham’s opinion was substantiated by Dr. James Veitch, Dr. John Weir, Sir Henry Halford, and Dr. Thomas Monro.

But was medical therapy to be aimed at the mental disorder itself, or only at bodily conditions accompanying it? Thomas Bakewell, a non-medical proprietor of a much-respected private madhouse in Staffordshire, told the committee. “I do not look upon medicine as of great importance for the mental disease; but there are bodily complaints connected with it, requiring the application of medicine.”³⁴ Edward Wakefield, a Quaker land agent who was active in exposing the abuses at the York Asylum, Bethlem, and other asylums, was even more definite about the place of medicine in the care of the insane. Asked whether medical men ought to be “Inspectors and Comptrollers of Madhouses”, he replied, “I think they are the most unfit of any class of persons. In the first place, from every enquiry I have made, I am satisfied that medicine has little or no effect upon the disease, and the only reason for their selection, is the confidence which is placed in their being able to apply a remedy to the malady.”³⁵ Wakefield’s attitudes had been coloured by the unfavourable contrast between the medically-orientated York Asylum and the Retreat, where “there are Quakers who are neither medical men or of any Professional class, who are conspicuous for the extraordinary treatment of Insane persons, by the attention and kindness which they pay to them”.

It is of interest that in 1816 Wakefield retracted his statements concerning the impotence of medical therapy in the treatment of the insane. Between 1815 and 1816 he had discovered a madhouse which conformed to his warmest expectations on how the insane should be most effectively and humanely treated. This was Laverstock House, near Salisbury, run by a surgeon named William Finch. Finch shared the confidence of the majority of his medical colleagues in the efficacy of medical therapy in cases of insanity, and his success convinced Wakefield that insanity is a disease “which in its incipient state is capable of relief from medicine. . . . I examined the register of the many cases which had come under [Finch’s] care, and he has completely proved to my satisfaction, that medical treatment is of the greatest consequence.”³⁶

Wakefield was an important convert for the medical men, since the reforming activities of laymen like him, William Tuke, and Godfrey Higgins represented a viable alternative to the medical model of insanity reflected in the medical literature of the period. If laymen like the Tukes could operate a more effective asylum than the doctors could, traditional therapeutic regimens and theories of insanity were both jeopardized. The medical witnesses which the Committee examined unanimously expressed confidence in the unique role of doctors in the psychiatric situation.

They also spoke for the rest of their profession. Thus, George Man Burrows, writing in 1828, praised the moral treatment of the York Retreat, but he “viewed with regret the little confidence professed by the benevolent conductors . . . in . . . the great efficacy of medicine in the majority of cases of insanity”.³⁷ Earlier, Andrew Harper, even in developing a theory of insanity which was essentially mental, rather than corporeal, expressed his regret that the treatment of insanity had fallen “too

much into the hands of men who never possessed any great share of physical skill”.³⁸ Thomas Mayo, who later became President of the Royal College of Physicians, lamented in the name of medicine what he conceived as a growing emphasis of psychological aspects of insanity to the exclusion of the physical changes which always accompanied it. Insanity, he wrote in 1817, is a “subject so interesting in its nature, as almost to have been wrestled by the philosopher out of the hands of the physician. To vindicate the rights of my profession over Insanity, and to elucidate its medical treatment, are the objects at which I have aimed.” He went on to point out that hypochondriasis, for example, though at that time frequently referred to as a mental disease, was treated in nosological works where it really belonged, as a “disorder of the body”.³⁹

John Haslam was even more explicit in his 1817 *Considerations on the moral management of insane persons*. Haslam in fact was one of the group specifically criticized by Monro for emphasizing psychological features of insanity to the neglect of physical ones. To the extent that he did, we tend to praise rather than censure. Haslam’s writings do contain astute psychological observations, but like Monro, Haslam was in theory a physicalist. Haslam fully admitted that “management”, as he referred to what we are calling moral therapy, could be effective in contributing to the cure of insanity, or at least (and this is an important qualification) to the “comfort and happiness of the lunatic”. But, he went on,

Of late it has been seriously proposed, in a great deal to remove both the medical treatment and moral management of insane persons from the care of physicians, and to transfer this important and responsible department of medicine into the hands of magistrates and senators. For the welfare of those afflicted persons, and for the security of the public, it is to be hoped that such transfer may never be established; but that the medical and moral treatment of the insane may continue to be directed by the medical practitioner, under the sanction and superintendency of the College of Physicians. The concurring opinions of all thinking persons allow insanity to be a disease, and those best acquainted with this disorder are most persuaded of the relief to be obtained by a judicious administration of medicine.⁴⁰

Even in admitting the importance of “management”, as opposed to active medical therapy, Haslam insisted on the absolute right of a medical man to take complete charge of the care of the insane. His comments were obviously directed in part at the York Retreat; but of course any non-medical keeper of a private madhouse might consider himself implicated. Additionally, the investigations of the Parliamentary Select Committee of 1815 and 1816 were still much on Haslam’s mind in 1817. One of the features which had emerged from these proceedings was that there was simply no agreement among medical men about the actual details of medical therapy. Haslam and his chief, Thomas Monro, had disagreed on the value of emetics in the treatment of insanity. The third medical officer to Bethlem, the recently-deceased surgeon Bryan Crowther,⁴¹ had also mentioned in his 1811 book on insanity various routine medical procedures (such as a spring blood-letting) performed on virtually all the Bethlem patients, regardless of their complaints or general condition.⁴² Such indiscriminate therapy was hard to justify, especially in the light of moral treatment, for one of its most important features, stressed by both Pinel and Tuke, was that moral therapy was individually tailored to the needs and capacities of the patient.

Psychological causation is by definition a highly individual matter, and moral therapy required the therapist to know his patient far more intimately than most medically-oriented physicians apparently ever bothered to do.

Medical men could thus neither agree on the specifics of medical therapy; nor could they defend the rigid and indiscriminate therapeutic patterns which sometimes obtained in places like Bethlem. Indeed, when pressed, they could sometimes show a remarkable lack of confidence in all forms of medical therapy for the insane. Thomas Monro once admitted to the Select Committee that management was probably far more efficacious than medicine, that as a matter of fact, the medical measures probably did not do any good. Later, however, he explicitly insisted that his statement should not be construed to mean that he thought medical therapy dispensable.

Like the books of Pinel and Tuke, then, the Select Committee's investigations made moral therapy seem more efficacious and more humane at the expense of medical therapy. Haslam's comments must be read in the light of the committee's investigations, for he more than any other individual felt the full brunt of the public outcry at the appalling conditions in certain public and private institutions devoted to the insane. Crowther had died just before the committee opened its hearings. Monro was allowed to "retire", but his son was immediately appointed physician to Bethlem, thus assuring the Monro association with the venerable institution for many years to come. Haslam, on the other hand, was dismissed without a pension after more than twenty years' service. He was then fifty-six years old and probably knew more about mental disorders than any other person in Britain.⁴³

With Crowther dead, Monro in retirement, and Haslam and most of the keepers dismissed, the staff at Bethlem almost completely changed in the space of only three years. The institutional policies changed but little, however, and actual reform had to wait until mid-century. The comments of a relatively new staff member at Bethlem give a gloss on the situation there after the Select Committee had adjourned. These were by William Lawrence, Crowther's successor as surgeon to Bethlem. Appointed just before the Select Committee opened its investigations, Lawrence survived the public outcry of that earlier occasion only to have a public indignation of a slightly different sort two years later threaten his position at Bethlem, as well as at Bridewell's, and St. Bartholomew's.⁴⁴ Lawrence's views on moral therapy, and his stated reasons for holding them, lay at the heart of the matter. Believing that the mind is the function of the brain, he found it difficult to conceive that insanity is other than a primary disease of the brain, secondarily disturbing its functions (i.e. mental processes). "The effect of medical treatment [he went on] completely corroborates these views. Indeed they who talk of and believe in diseases of the mind, are too wise to put their trust in mental remedies. Arguments, syllogisms, discourses, sermons, have never yet restored any patient; the moral pharmacopoeia is quite inefficient, and no real benefit can be conferred without vigorous medical treatment, which is as efficacious in these affections, as in the disease of any other organ."⁴⁵ These remarks may tell us more about the state of Lawrence's mind, when they were delivered in 1818 than about the real debate on moral therapy, but they show that one member of Bethlem's "new" staff still had more sympathy for the traditional modes of treating insanity.

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Lawrence's words remind us that there are two diametrically opposed reasons why a person during this period might believe that psychiatric disorders are primary diseases of the brain. If one held to the theological identity of mind and soul, then, as we have seen, such a belief protected the mind as an ontological entity from the ravages of disease, decay, and mutability. On the other hand, if one held that the mind is the function of the brain, totally dependent on that organ, and that all mental functions result from, or at least are accompanied by, physiological processes, then mental derangements might naturally be thought to have a corresponding structural malformation or derangement. Thus we find Lawrence, widely accused of materialism, holding similar views on the subject of insanity with William Newnham, writing in the *Christian Observer* for 1829. Newnham explicitly pointed to the theological implications entailed in ascribing disease to the mind: "A great error has arisen, and has been perpetuated even to the present day, in considering cerebral disorder as *mental*; requiring, and indeed admitting, *only* of moral remedies, instead of these forming only *one* class of curative agents; whereas the brain is the mere *organ* of mind, not the mind itself; and its disorder of function arises from its ceasing to be a proper medium for the manifestation of the varied action and passion of the presiding spirit."⁴⁶ Like Lawrence, but for opposing reasons, Newnham believed that insanity is always brain disease.

The view that mental derangement is always accompanied by physical derangements of some sort was of course not the only position to take on the subject. Among British physicians of the early nineteenth century, however, it was a most widely held opinion, and this despite persuasive counter-evidence. For almost all of them admitted that no convincing anatomico-pathological analysis could always be performed in cases of insanity. There were two aspects to this breakdown between the clinical and pathological correlations. In the first place, no consistent lesion could be found in the brains or skulls of lunatics examined by post-mortem. Certain kinds of lesions seemed to crop up with regularity, evidences of vascular congestion and general cerebral inflammation, thickening of the skull, and so forth, but there was basic agreement that lunatics frequently died at the height of an attack without having any evidence of pathological changes inside their skulls. In the second place, the whole range of changes most often found at post-mortem examinations of lunatics could easily be demonstrated in the brains of persons dying with full possession of their faculties. There was thus no concrete reason to believe that psychiatric disorders are actually brain diseases, and this very lack of post-mortem correlation was taken by some as good evidence that the mind is an immaterial essence not ever primarily affected with disease. But as we have noted, that belief itself furnished strong motivation for throwing the lesions of insanity on to the brain. Other factors besides convincing empirical evidence led British physicians to their belief that insanity is fundamentally a physical condition. Several of these factors have already been alluded to: the conflation of the concepts of mind and soul, the inheritance of physical explanations from antiquity, the lay threat to medical control of the insane implicit in the milieu of moral therapy and early nineteenth-century institutional reform. In addition to Mayo, Lawrence, Newnham, Haslam, and Monro, other medical men who explicitly subscribed to the physical model of mental illness during the period

included Andrew Marshal, George Nesse Hill, David Uwins, Joseph Mason Cox, George Man Burrows, W. A. F. Browne, James Cowles Prichard, Andrew Combe, Sir William Ellis, Francis Willis, and John Conolly. This is a heterogeneous group, united, however, by the proposition that insanity is a condition caused by physical changes and consequently within the reach of medical therapy. Francis Willis, for example, told his audience at the College of Physicians' Gulstonian Lectures of 1822 that: "We must lament, it should ever be gravely pronounced from the lips of any medical experience, that 'medicine is of no use in the disorders of the mind;' an opinion highly detrimental to the practice of Physic, and its ulterior happy results! Yet I remember to have heard formerly at a lecture, that furor uterinus was a disease exclusively of the mind, and on that account incurable."⁴⁷ Willis's therapeutic optimism about the "happy results" of medical therapy was part of his justification for keeping insanity within the scope of medical theory and practice.

Nevertheless, some dissension existed even within the medical community as a few doctors toyed with the proposition that insanity is always a disease of the mind. In 1789 Andrew Harper in his *Treatise on the real cause and cure of insanity* had announced that insanity is a primary disease of mind, "independent and exclusive of every corporeal, sympathetic, direct, or indirect excitement, or irritation whatever". Harper thus separated "true insanity" from melancholia and dementia, assumed by him to be purely corporeal diseases. His reasons for coming to this position were hazy, his language confused, and his therapy did not consistently follow from his theoretical pronouncements. He has been seen as a true psychiatric pioneer for his emphasis on the mental nature of insanity, but his influence during our period was very slim.

A more challenging position was put forward by William Saunders Hallaran, in a book published in 1810. Hallaran suggested that the sensorial changes taking place in insanity may be due to strictly mental causes, or to physical causes. He thus distinguished "mental insanity" from bodily disease mimicking mental insanity in its symptoms. The importance of identifying the conditions properly lay in the differing therapeutic regimens required for each. Mental insanity could be cured by moral therapy; whereas medical therapy was required in the cases of bodily disease. Hallaran thus took moral therapy at its face value and used it to support his theoretical structures.⁴⁸

I have outlined above three major positions which can be found in the British psychiatric literature of the late eighteenth and early nineteenth centuries: (1) that insanity is always attended by structural changes and hence is ultimately a physical condition; (2) that insanity is always a mental condition, properly differentiated from any physical disease which secondarily produces mental symptoms; (3) that insanity may be caused by either physical disease or by mental aberrations. The vast majority of British physicians who expressed themselves on the subject of insanity during our period subscribed themselves to the first position, that insanity is a disease of the body. Many of them also supported the increased application of moral therapy. How did they reconcile psychological treatment for physical disease? One way of course was by neglecting to examine the issues very closely and merely accepting moral therapy on a pragmatic basis. Another was by distinguishing (as did Haslam)

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between the value of moral therapy in making patients more malleable and easier to deal with, and its ultimate use in a direct therapeutic sense.

Both of these approaches were essentially negative, but there was a third, more positive rationale for moral therapy which applies to several of the list of sixteen physicalists mentioned above. This concerns Gall's phrenology. It is significant that four of these physicians most keenly interested in moral therapy were phrenologists: Sir William Ellis, Andrew Combe, John Conolly, and W. A. F. Browne. Ellis is remembered for his work with occupational therapy; Browne for his judicious use of moral therapy first at the Montrose Lunatic Asylum, and later as superintendent of the Royal Crichton Asylum. Conolly, of course, is famous for his introduction of the no-restraint system at Hanwell, in Middlesex.⁴⁹ The phrenological concept of mental functions circumvented the traditional Cartesian framework and permitted phrenologists to refer simultaneously to the experienced mental state and its underlying physiological counterpart. The effectiveness of moral therapy could be understood both in terms of psychological benefit and the concomitant hypertrophy of the stimulated areas of the cerebral cortex.⁵⁰

The peculiar features of phrenological doctrine give an underlying coherence to the activities of various phrenologically inclined psychiatrists. Moral therapy was no phrenological monopoly, however.⁵¹ Many medical superintendents and consultant physicians of the growing numbers of county lunatic asylums and private madhouses adopted therapeutic programmes which relied heavily on management. Increasingly, too, psycho-social aspects of insanity were emphasized in discussions of aetiology. In the first few decades of the nineteenth century, however, there was no widespread abandonment of the more strictly medical aspects of psychiatric therapy. Psychiatrists remained what William James once called "medical materialists".⁵² Insanity continued to be conceived as a physical disease potentially within the reach of medicinal agents. There was no great movement towards the lay treatment of the insane along the lines of the York Retreat. In fact, the lay reformers who played major roles in the events leading up to the parliamentary investigation of 1815 and 1816 seemed content to allow medical men to retain their central position in the care of the insane. Doctors in turn responded with an exuberant confidence in their capacities to cure a high proportion of the insane who came under their ministrations in the early stages of the disease. Some even claimed a cure rate as high as ninety per cent under appropriate circumstances.⁵³

In any case, the decades immediately following the parliamentary investigation represent for British psychiatry a period of therapeutic optimism, an optimism founded in part on a concerted medical attempt to retain control of psychiatric institutions and their patients. Both lay reformers and medical men were anxious that insanity be recognized as a disease and that the insane be placed in hospitals and asylums rather than gaols and workhouses. The motives of laymen like Edward Wakefield and William Tuke were essentially humanitarian. The motives of the medical men were much more complicated. Professional, social, and economic considerations coloured their own judgments and tempered the enthusiasm they showed towards moral therapy. They were prepared to adopt many of the features of the York Retreat into their own therapeutic programmes. They were not prepared to

jettison their medical models of insanity, nor were they willing to compromise their central roles in the diagnosis and treatment of the mentally ill. They were successful in establishing the medical speciality of psychiatry. Nevertheless, their psychiatric descendants still face many of the same problems, as evidenced by contemporary debates on the nature of mental disease, the status of lay psycho-analysis, or the amount of general medical education necessary for one who intends to specialize in the management of diseases of the mind.

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41. Haslam told the committee that "Mr. Crowther was generally insane, and mostly drunk. He was so insane as to have a strait-waistcoat." Such information was not likely to increase the committee's confidence in the medical regimen practised at Bethlem.
42. *Report* (n. 23), pp. 129 ff.
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52. James's phrase is cited by Owsei Temkin, *Galenism*, Ithaca, Cornell University Press, 1973, p. 88.
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