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Keywords

Measurement, decline, moral, therapy

Disciplines

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CHAPTER 15
Measurement and the decline of moral therapy

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Abstract
The key theme of this historical paper is to highlight the misallocation of resources that can result from mis-measurement in social programs. The social phenomenon explored in this paper is a treatment for mental illness practiced in 19th century Britain called "moral therapy".

One of the factors in the rise of moral therapy was that moral therapy asylums could point to mathematical, "scientific" cure rates based on discharge and readmission rates to moral therapy asylums. These cure rates were far higher than the cure rates of other, merely custodial institutions of the time.

However, failure to properly allow for the difference between acute and chronic mental illness in the way that cure rates were calculated for these institutions led to a decline in funding for moral therapy asylums.

This paper provides a cautionary vignette of how the (mis)use of statistics influenced an important social policy in 19th century Britain. Quantification also profoundly coloured the view that 19th century legislators and mental health professionals held of the curability of mental illness and hence the appropriate treatment and funding models used.

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Introduction
This paper traces the ascendency of a particular treatment for mental illness, "moral therapy", in 19th century Great Britain and the role of the misuse of quantification and statistics in the decline of moral therapy towards the end of the 19th century. This paper is relevant to researchers in accounting history because it is an interesting illustration of the power of numbers and statistics and how they can be misunderstood and misused.

The rise of institutionalisation in mental illness
Institutionalisation is characterised by Scull (1984, p.16) as the shift from the predominantly medieval treatment of people with mental illness to the modern treatment begun in the 18th century. The medieval approach to mental illness had two main points of interest to the current analysis. Firstly, it regarded the care of people with mental illness as chiefly the concern of their families or parishes (local communities). Secondly, it made little

discrimination in treatment between the various types of deviancy or dependency (Scull 1984, p.17).

The 'modern' approach to people with mental illness begun in the early 18th century had the following key attributes (Scull 1984, p.15):

➢ The development of a rationalised, centrally administered approach to mental illness with the substantial involvement of the State.
➢ The rise of institutions providing the segregation of various deviant and dependent classes of people from society at large.
➢ The making of distinctions between various classes of deviant and dependent populations. For example, different treatments, expertise and professions were assigned to people with mental illness than were assigned to 'the deserving poor', criminals, or the physically ill.

This 'modern' approach is not to be confused with the 'community care' approach of the 20th century.

Setting the stage – care of people with mental illness in the 1800s
Private 'madhouses' and some charitable asylums emerged in the 18th century. For example, Scull (1993, p.18) mentions small charitable institutions being founded in Norwich (1713), Newcastle upon Tyne (1764) and Manchester (1766). However, these were small institutions and housed only a small fraction of people with mental illness in England (Scull 1993, p.25). The majority of people with mental illness in 1800 were still cared for either by their families or by their local parishes. Smith (1999, p.12) points out that in 1800 there was a "mixed economy of care" in mental illness involving the private sector madhouses; care at home; and institutional care in the form of the workhouse, 'boarding out' of lunatics and outdoor relief granted by parishes to the insane and their families.

It was not until 1808 (with the passing of the "Wynn's Act" or, to give this Act its full title, "An Act for the Better Care and Maintenance of Lunatics, being Paupers or Criminals in England") that magistrates were given discretion to grant asylum accommodation for pauper lunatics by raising a levy in the local area (Scull 1993, p.28; Smith 1999, pp.23-24). Because of the tremendous diversity in these institutions, there was a great variety in the treatment and care that their inmates received (Scull 1993, p.18). Generally, conditions in asylums in 1800 were overcrowded and inhumane – as will be discussed in greater detail later.

In the United States of America, the development of asylums appears to have lagged behind the developments in England. Before the American Revolution of the late 18th century, care of the mentally ill was substantially a matter for families and (where family care was not available) the local community (Grob 1994, p.6). Colonial America's lack of institutions was ascribed by Grob (1994, p.21) to the particularly low population density making the family and local community care model the dominant one.

This low population density did not last. According to Grob (1994, p.23) immense demographic and economic changes between 1800 and 1850 as well as the "privatisation of family life" and separation of home and the workplace brought by the emerging urban-industrial society, led to the breakdown of traditional arrangements for the care of people with mental illness.

By 1800, institutions such as the madhouses at Williamsburg, Virginia, Pennsylvania, and New York had opened, but the clear majority of people with mental illnesses were outside specialist institutions (Grob, 1994, p.19). The use of the term "specialist institutions" must also be used with caution, as Grob (1994, p.18) pointed out that there was little difference between conditions in an almshouse (also known as a "workhouse" or a "poorhouse") and conditions in a "hospital".

This situation was to change rapidly. Major asylum building projects were undertaken in the 1840s and 1850s. From 1850 onwards, institutions had become "the foundation on which mental health policy rested" (Grob 1994, p.53). This was not solely brought about by changes in economic and social structures and population density. An alternative to the family and community care model had also appeared in the form of "moral therapy" (Grob 1994, p.25). By 1800, the "moral therapy" movement began to suggest that an alternative to these inhumane madhouses or parish relief settings both existed and was effective in the treatment of mental illness. These developments were important motivating factors for the 19th century reforms yet to come.

Conditions in asylums
"Treatment" of mental illness in asylums by 1800 was archaic even by the standards of the non-asylum medical and scientific knowledge of the day. Much of this "treatment" meted out in asylums (establishments using "moral therapy" are an exception to this) dated back to the work of Hippocrates and the four humours of the human body (Jones 1972, p.7). Jones also noted that a standard text of the day (with new editions until 1821) was Burton's (1621) *Anatomy of Melancholy*. This text recommended various herbal purgatives and bloodletting to help balance the four humours of blood, choler, phlegm and bile. Somewhat more deadly were this text's recommendations of blistering the skin with hot irons and boring holes in the sufferer's skull to allow the removal of excess humours affecting the brain. Lewis (1988, p.8) and Kosky, Eshkevari & Carr (1991, p.6) also mention these treatments as taking place in England and the United States into the early 19th century. Perhaps fortunately, these "treatments" would have been available to only those patients who the asylum keepers of the time thought it worthwhile to treat.

The most famous, and possibly most ancient, of all asylums was London's infamous "Bedlam". The name derives from its site on a former priory of the Order of St Mary of Bethlehem. This institution was used for those with acute mental disorders from as early as 1377 (Jones 1972, p.12). To refute the absolute validity of Foucault's view (1965) that in the classical age madness disappeared from art and literature, conditions in Bedlam certainly represent an exception. Jones (1972, p.15) relates at least one poem (anonymous) from 1776 and a Hogarth Painting from 1733 relating to the vile conditions there. He also outlines the physical restraints and fiscal and moral scandals which characterised conditions at Bedlam until 1815 (Jones 1972, pp.16-17). An excellent quote from Dr Thomas Monro (the Monro family dominated the office of "physician" and thus the treatment at Bedlam from 1728 until 1852) clearly illustrates the disinterest in any real "treatment" or research which characterised that institution as late as 1815:

> Patients are ordered to be bled about the latter end of May, or the beginning of June, according to the weather and after they have been bled, they take vomits once a week for a certain number of weeks; after that, we purge the patients. That has been the practice invariably for years, long before my time; it was handed down to me from my father, and I do not know any better practice. (Monro, as quoted in Jones 1972, p.16).

Apart from the highly questionable standards of "treatment" received by the patients at Bedlam in 1800, other physical conditions were characterised by overcrowding, and few, if any, clothes or warmth. Dirty, insanitary straw for bedding and constant physical restraint in the form of chains (Jones 1972, p.16) were the order of the day. Both Jones (1972, p.17) and Scull (1993, p.56) point out that it is easy to be over-simplistic in damning the superintendents of Bedlam for their shameful treatment of people with mental illness. Both authors suggest that the standards of the time and the dearth of research or other models of treatment available at the time (apart from moral therapy) should be considered. Nonetheless, Scull (1993, pp.55-56) concludes that the available evidence of abuse (both physical and sexual), cruelty and misappropriation of funds available in the Bedlam archives is such that Bedlam's oppressive reputation was probably well-earned. Jones similarly concludes that:

> An institution for the reception of violent patients can never be wholly a pleasant place, and, however enlightened the policy of the authorities, there will always be patients who suffer extremely through delusions of persecution, depression or squalid habits that defy the most patient and sustained attempts at cleanliness; but the available evidence shows that the policy of the authorities (at Bedlam), even by eighteenth century standards, was very far from enlightened (Jones 1972, p.17).

So much can be said for the unwholesome conditions of patients in one institution in England in 1800. How widespread were these conditions to people with mental illness in the 1800s generally? Were all asylums as bad as Bedlam? It is hard to be sure of this. It is the most scandalous conditions that tend to be the most reported. Certainly, however, scandals occurred outside of Bedlam. Scull (1993, p.111) discusses the 1814 scandal at York Asylum. A Yorkshire magistrate, Godfrey Higgins, suspicious of rumoured abuses at the York Asylum, forced an investigation into longstanding abuse and corruption in the York Asylum:

> These investigations provided evidence of wrongdoing on a massive scale: maltreatment of the patients extending to rape and murder; forging of records to hide deaths among the inmates; an extraordinarily widespread use of chains and other forms of mechanical restraint; massive embezzlement of funds; and conditions of utter filth and neglect (Scull 1993, p.111).

The increasing size and centralisation of government and a desire for stability in 18th century society brought increased government intervention into citizens' lives. Not all people with mental illness were in asylums. Some were arrested and kept in jails or workhouses (Jones 1972, pp.17-24). According to Lewis (1988, p.2) however, the days of homogenous treatment for all "dependent" people in workhouses whether they were vagrants, alcoholics or mentally ill was nearly over by 1800. The mid 19th century brought a vogue for specialisations, and most people with (diagnosed) mental illness were thought to have been segregated into asylums by 1850.

Separate lunatic hospitals (other than Bedlam) began to open for the first time in 1751 with St Luke's Hospital in London (Lewis 1988, p.3) and were spread all over England. This was often done to clear some of the insane out of regular jails, lock-ups and standard hospitals where people with mental illnesses proved to be disruptive. Non-criminals could also be sent by their relatives to these new lunatic hospitals, although they or their parish were supposed to make a financial contribution to their upkeep. Conditions in these "madhouses" were often little different from conditions in jails at the time with heavy use of physical restraints such as manacles, chains, and strait waistcoats (similar to the strait-jackets of recent history) and

severe discipline. The staff at the time had often previously been employed as prison wardens, with little or no medical training and received poor wages and conditions. For the better-off patients, there were privately run institutions, or staff privately employed to care for people with mental illness at home.

Certainly, conditions in asylums in 1800 appear to have been such that the 19th century reformers had no shortage of material from which to draw their complaints of the inhumane treatment of people with mental illness.

The birth of moral therapy

The time from the dark ages to 1800 saw some changes in the treatment of people with mental illness even if the "treatments" were unchanged. There was the change from religious authority to medical authority over people with mental illness. There was also a massive change in the face of society. The mentally ill were still feared, but less as possessed tools of Satan than as a bad example to susceptible members of society. The emphasis was now on segregation of the mentally ill from the rest of society. This was viewed as being administratively easier than incarcerating the mentally ill along with the more general class of miscreants. Despite the half-hearted (and to today's reader misguided) treatment of the four "humours" discussed earlier, there was little sustained optimism about lasting treatment for people with mental illness.

Even King George III, who began to have depressive episodes beginning around 1790 (Kosky, Eshkevari & Carr 1991, p.3; Levine 1981, p.14), was subjected to purging and bleeding treatments which cared little for the dignity of his royal person. However, this illness of the King did serve to lend a certain aristocratic gloss to mental illness and to bring alienists into the public spotlight more than had previously been the case. But it was not until the moral therapy or moral treatment movement that there was any sustained and well-organised optimism about the "cure" of mental illnesses short of the mysterious workings of God.

Slightly before the turn of the century, but very much a precursor of things to come, was Tuke's Retreat. The religious society known as the Quakers founded a revolutionary hospital in York in the 1790s. This hospital came to be known as Tuke's Retreat. The revolutionary aspects of Tuke's Retreat were that the use of physical restraints was minimised and improvements in patients' behaviour was sought by appealing to the patients' "moral capacities" (Lewis 1988, p.8; Kosky, Eshkevari & Carr 1991, p.4). This approach of co-operation and trust between patient and therapist had adherents in Britain and America (and, to a lesser extent, Australia) in the early to the middle 19th century. This style of treatment was called "moral therapy" or "moral treatment".

This approach towards moral therapy was not sourced from Tuke's Retreat alone. According to Levine (1981, p.14) and Kosky, Eshkevari & Carr (1991, p.3) Philippe Pinel's writings of his experiments with humane treatments in Paris were translated into English in 1806 and were widely read. Thus Pinel's and Tuke's ideas were influential in the willingness to try moral therapy in America, Australia and England. The moral therapy movement can be dated either from Pinel's reforms in the Bicetre prison in Paris in 1794 or from William Tuke establishing the York Retreat in England in 1792 (Ingleby 1983, p.149).

From the previous sections, it is clear that conditions in the jails, workhouses and hospitals were often quite appalling in 1800. It will also be seen that (because of the advent of moral therapy) an alternative to these conditions was seen as both possible and desirable.

Adding impetus to the 19th century willingness to change was the fact that conditions were not only dreadful, they were seen to be dreadful. After Pinel's early protest in Paris, other reformers followed. Public attention was called to the overcrowded, cruel and dirty conditions that were the lot of almost all people in mental institutions at the time.

The rise and fall of moral therapy
The spread of moral therapy was hastened by three main factors. First, the reformers of the 19th century revealed the squalor of the asylums. This will be discussed in more detail later on in this paper. Second, the dominant mindset of the day was (somewhat) open to change and was very alive to the wonders of science and medicine, with everyone agog to see what these forces could do when allowed to work on mental illness. Finally, moral therapy was in the offing as a new, much more "scientific" and high-minded approach to the problem. It advocated self-discipline and reason – two virtues very much prized in the 19th century. Also, it worked. However, in some ways it was this very success and the fact that its support base was largely drawn from those with a great respect for science and quantification that were partly responsible for its downfall.

One of the most surprising things to the modern eye (accustomed to treatment of mental illness with medication) is just how successful moral therapy was:

> By all accounts, moral treatment was startlingly successful, even in terms entirely familiar to today's administrators – discharge and readmission rates. The Bloomingdale Asylum, for example... admitted 1,841 patients between 1821 and 1844. Of these, 1,762 were discharged, including 672 cured, 104 much improved, and 318 improved; cure was defined as minimal function within both the patient's family and society at large. Most of those discharged were not readmitted (Johnson 1990, p.7).

This is borne out by Kiesler and Sibulkin (1987, p.34) with the caveat that those judging what comprised a "cure" were philosophically committed to the system of treatment.

The success of moral therapy depended upon the relationship built up between the superintendent and the patient. In order for this to flourish, it was necessary to have the correct sort of personal magnetism in the superintendent and a sufficiently small number of patients to allow the relationship to exist. This limited number of patients was also necessary to foster a sense of community – almost of family – with the superintendent as the paterfamilias (Johnson 1990, p.7; Jones 1972, pp.49-54).

Some rather extravagant claims were made early on for the ability of moral therapy to cure patients:

> As tends to happen to true believers, their zeal for their own cause easily overcame their respect for truth, and they oversold their case by inflating their rates of cure (Johnson 1990, pp.7-8).

As time went on, of course, the cured left the hospitals whereas chronic cases remained. The cure rate was calculated by dividing the number of patients released by the total number of

patients. Once the total number of chronic (incurable) patients began to build up, taking up more and more available beds, cure rates naturally decreased.

As well as the build-up of chronic cases damaging cure statistics, two further factors brought down moral therapy. Firstly, there was a rush of immigrants to both America and Australia in the mid to late 19th century. Many of these immigrants found their new life away from family, friends and culture quite unbearable and thus the rates of mental illness in this population were high. Also, many of these new immigrants spoke little or no English and thus could hardly be expected to form any curative relationship with asylum superintendents as they could not understand them (Johnson 1990, p.9).

Secondly, the previously mentioned build-up of chronic cases was coupled with a growing population that increased over-crowding in asylums. As doubts had already arisen about the ability of asylums to cure mental illness, there was a reluctance to build new asylums to hold the increasing numbers. Gone was the suggested maximum size of two hundred and fifty patients originally mandated for moral therapy. Gone was the sense of community (Johnson 1990, p.9). Thus by the middle of the 19th century, the belief that moral therapy could actually cure people of mental illness was abandoned and beliefs in mental illness as incurable (short of miraculous intervention) returned. Custodialism ruled and treatment waned.

Moral therapy declined with large wards of (mostly) chronic patients unresponsive to treatment, and a new regime set in. Costs were rising, numbers of patients were rising, and cure statistics had dwindled. The States that funded mental hospitals thus returned to providing purely custodial "treatment" at the lowest possible cost.

Social Darwinist ideas are also cited by several authors as a factor in the decline of moral therapy (for example, Lewis 1988, p.11; Shortt 1986, p.160; Kosky, Eshkevari & Carr 1991, p.7). These ideas were influential in the late 19th century return to the belief that madness was fundamentally incurable. In trying to understand Social Darwinism's impact it is important to understand something of the status that the scientist had in the 19th century.

This was the age of reason and enlightenment. Just as people with a reverence for science had welcomed the change to moral therapy as a more enlightened approach to madness than that of humouralism (being the study and regulation of the body's various humours such as blood, bile and phlegm) so the new social science of Social Darwinism seemed an advance on old-fashioned notions of moral therapy. It is also to be remembered that by the mid 19th century, most of the huge, state-run mental hospitals had become too large, too overcrowded and too clogged with chronic patients to allow for the practice of moral therapy as it was first instigated. In his book on Victorian lunacy, Shortt (1986, p.160) gave two insights which illustrate the nadir into which mental hospitals had sunk by the end of the 19th century. The first of these relates to the power of science in the Victorian mind:

> Scientism, often in the specific guise of positivism, provided an optimistic, secular epistemology by which representatives of Victorian science and medicine justified their claim to authority in fields encompassing both the natural and the social sciences. Empirical investigations, not metaphysical speculation or revealed religion, gave certitude to the knowledge necessary to guide science and society in a progressive fashion and, significantly, (gave) stature to those who provided that guidance (Shortt 1986, p.160).

And by Victorian times, mental illness was (at least in the mind of "alienists" – the Victorian version of psychologists/psychiatrists) a matter properly belonging to physicians and scientists, rather than to philosophers (Shortt 1986, p.161.)

The second quote relates to the influence of "degeneration theory" (an adaptation of Social Darwinism) in the realm of mental illness:

> Borrowing from evolutionary biology, a number of psychotheorists gave detailed form to the concept of mental degeneracy. Expressed with clinical detachment and based on accepted natural science, the theory appeared to provide an objective and accurate explanation for the discouraging prospects of asylum inmates. Yet the popularity of the theory cannot be accounted for simply on the basis of the authority of the science upon which it was apparently based. Rather, degeneration theory owed its appeal less to medical credibility than to its ability to explain and naturalise certain disconcerting realities of late nineteenth century society. The inhabitants of public lunatic asylums were known to come from the working-poor and pauper class. Yet these patients were also defined as neurological degenerates. Poverty and degeneracy, in effect, were two sides of a very warped and inferior coin, a coin that was quite without value in the marketplace of industrial capitalism. In its congruence with – indeed, support for – Victorian class relationships, psychological medicine found the key to its social authority. (Shortt 1986, p.161).

Because of this pessimism about the possibilities of cure, asylums once again became holding vats for the misfits of society. Cure rates were no longer of interest. What was of interest was the cheapest per capita way of keeping the mentally ill out of society (Levine 1981, p.27; Lewis 1988, pp.26-27). These ideas of the incurability of mental illness sat well with the Social Darwinist philosophy sweeping through society at the end of the 19th century. Heredity was thought to be the primary determinant of mental illness. To encourage (or allow to breed) these weak and inferior members of the human race was to weaken the species. It was thought that to segregate and control them (and keep them from breeding) was the only thing for an enlightened society to do.

Conclusion

The rise and fall of moral therapy provides an interesting illustration of how the (mis)use of statistics influenced an important social policy in 19th century Great Britain. Quantification also profoundly coloured the view that 19th century legislators and mental health professionals held of the curability of mental illness and hence the appropriate treatment and funding models.

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