Models of Moral Treatment:
British Lunatic Asylums in the Mid-Nineteenth Century

by

Austin James Spain

A thesis submitted to the Graduate Faculty of
Auburn University
in partial fulfillment of the
requirements for the Degree of
Master of Arts in History

Auburn, Alabama
May 7, 2018

Approved by

Christopher J. Ferguson, Chair, Associate Professor of History
Cathleen M. Giustino, Mills Carter Professor of History
Ralph Kingston, Associate Professor of History

Abstract

Samuel Tuke established a model of moral treatment for British insane asylums in the first half of the nineteenth century with his *Description of the Retreat* (1813). The West Riding Pauper Lunatic Asylum at Wakefield—under the direction of William Charles Ellis and, later, Charles Caesar Corsellis—took up Tuke's model and changed it into a passive system of custodianship. The Middlesex County Lunatic Asylum at Hanwell first employed the passive model of moral treatment developed at Wakefield, but then shifted to an active model when John Conolly implemented his non-restraint system. Moral treatment as practiced in British asylums in the first half of the nineteenth century was not psychiatry or psychology—as scholarship on the subject has typically described it—but existed as many different models of treatment all of which were contingent upon decisions made by various members of the public.

Acknowledgments

This research would not have been possible without the assistance of the Wellcome Library, London in navigating its extensive collections. Cathleen Giustino first encouraged me to take up this subject and introduced me to the history of psychiatry. Ralph Kingston encouraged me to pursue graduate study in history and helped me to acquire a better understanding of the history of nineteenth-century science and, in particular, fostered an interest in the implications of architecture for the history of science. Christopher Ferguson, as my adviser, not only instructed me in British history and the history of Victorian science and medicine, but provided patient guidance that has produced innumerable improvements to this work and has been critical to my development as a researcher.

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Introduction

> But the application of medical science is not limited in any disease to the administration of drugs, or the abstraction of blood; and least of all in diseases of the nervous system. Hence it arises, that the general management of an Asylum, the regulation of the diet, the exercise, the hours of rest, the occupations, the amusements, the dress, and conduct, becomes of wide application and extreme importance. These matters, well arranged, become general medicines; influencing the whole frame of the body, and bringing it into a state in which the mysterious troubles of the brain have the best chance of becoming composed.[1]

The moral treatment of the insane as practiced in British insane asylums in the first half of the nineteenth century proved difficult to define. Philippe Pinel (1745-1826) in France and the Tukes—William (1732-1822) and Samuel (1784-1857)—in England popularized their systems of moral treatment from their asylums in the late-eighteenth and early-nineteenth centuries. Broadly, moral treatment consisted of systems aimed at transforming aspects of the conduct of an asylum into tools for the amelioration or cure of the insane—as opposed to viewing the conduct of an asylum as merely the context in which curative medical treatment occurred. Scholarship on moral treatment has generally presented its advent at this point as a pivotal moment in—if not the dawn of—psychological approaches to the treatment of the insane.

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1. John Conolly, *The Report of the Resident Physician of the Hanwell Lunatic Asylum, Presented to the Court of Quarter Sessions for Middlesex, at the Michaelmas Sessions, 1840* (London: J. T. Norris, 1840), 69-70; found in T .216, Wellcome Library, London.

Roy Porter championed moral treatment as only one pivotal moment among many in the *longue durée* of the origins of "psycho-sciences."[2] He argued that far from origin hunting being a useless pursuit, in reality debates over the semantics or anachronistic use of modern professional labels were the fruitless endeavors. "'Psychiatry'," Porter argued, "is as old as the hills if we treat it as a portmanteau term for all attempts to 'minister to the minds diseased'."[3] He admitted, however, that "psychology" and "psychiatry" were rare before the nineteenth century.[4] Consequently, he argued for a moral treatment in mid-eighteenth-century psychiatry, before either term came into use.[5] He also characterized David Hartley (1705-57) as an "extraordinary psychologist (with him the term is barely an anachronism)."[6] Porter likewise dubbed the job of asylum director the occupation of "proto-psychiatrist," at least by the end of the eighteenth century.[7]

Porter was not alone in his examination of psychiatry's longer history. Richard Hunter and Ida Macalpine began their examination of "three hundred years of psychiatry" with a sixteenth-century edition of the thirteenth-century Bartholomæus Anglicus's text on medicine, and concluded with the professionalization of psychological medicine in the 1850s.[8]

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2. W. F. Bynum, Roy Porter, and Michael Shepard, "Introduction," in *The Anatomy of Madness: Essays in the History of Psychiatry*, eds. W. F. Bynum, Roy Porter, and Michael Shepard (New York: Tavistock Publications, 1985), 1: 8.
3. Roy Porter, *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (London: Athlone Press, 1987), 169.
4. Roy Porter, "The Doctor and the Word," *Medical Sociology News* 9 (1983): 21-8.
5. Roy Porter, "Was There a Moral Therapy in Eighteenth Century Psychiatry?," *Lychnos* (1981-82): 12-26.
6. Roy Porter, *Flesh in the Age of Reason* (New York: W. W. Norton and Company, 2003), 348.
7. Porter, *Mind-Forg'd Manacles*, xii.
8. Richard Hunter and Ida Macalpine, *Three Hundred Years of Psychiatry 1535-1860: A History Presented in Selected English Texts* (London: Oxford University Press, 1963).

Scholars have typically argued that psychological or psychiatric treatment can be discussed at least by the end of the eighteenth century with the development of moral treatment. Michael Fears wrote not only on how the Tukes mobilized bourgeois moralizing on discipline and work ethic—a thread that Andrew Scull has repeatedly pursued since—but also how their focus on self-restraint established the Retreat as a psychiatric space.[9] Similarly, Eric Carlson and Norman Dain presented the rather plain formulation that "'moral treatment' included all nonmedical techniques, but more specifically it referred to therapeutic efforts which affected the patient's psychology."[10]

William Bynum accepted the fundamental psychological nature of moral treatment but observed that its "psychology" was neither novel nor necessarily gentle. Erasmus Darwin (1731-1802) with his rotating chair, or any physician for the insane that employed imaginative contraptions or threats—so long as they aimed to have an impact on the patients' minds—engaged, effectively, in moral therapy according to Bynum. Bynum provided the qualification that "if the virtual equation of *moral* with *psychological* blurs some of the distinctions between Pinel's therapeutic endeavors 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."[11] Bynum skirted what Porter

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9. Michael Fears, "Therapeutic Optimism and the Treatment of the Insane," in *Health Care and Health Knowledge*, ed. R. Dingwall (London: Croom Helm, 1977), 66-81; Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900* (New Haven: Yale University Press, 1993), 104-10.
10. Eric T. Carlson and Norman Dain, "The Psychotherapy That Was Moral Treatment," *American Journal of Psychiatry* 117 (1960): 519n4.
11. William F. Bynum, Jr., "Rationales for Therapy in British Psychiatry, 1780-1835," in *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, ed. Andrew Scull (Philadelphia: University of Pennsylvania Press, 1981), 37, italics in original.

dismissed as the semantic complaint here, but wrote of eighteenth century physicians for the insane as "psychiatrists" and David Hartley's work as "psychology."[12]

Scholars who disagreed about the start-point of psychology or psychiatry did not necessarily avoid examinations of earlier conceptions and practices respecting insanity. Michel Foucault, for instance, argued that psychology emerged in the nineteenth century, stating, "There is no sense in hunting for a distinction in the classical age between physical therapeutics and psychological medication, for the simple reason that psychology did not exist."[13] The bulk of his *History of Madness*, however, concerned insanity in the seventeenth and eighteenth centuries, which he named the classical period of madness. Psychology emerged for Foucault when illnesses became the province of medicine proper and madness was confined in moral institutions—like the Retreat at York under the influence of the Tukes. In short, psychology was born with the new asylums modeled on Tuke's and Pinel's systems—systems where reason dominated unreason, physical restraints were traded for psychological ones, and the asylum staff infantilized patients as "psychological subjects."[14]

Other scholars have taken the same stance as Foucault—that Tuke and Pinel were principal figures in the movement that established psychical approaches to treating insanity. Sir Aubrey Lewis argued that Tuke's and Pinel's movement approached the insane "on medical rather than moral lines. They could at last speak for themselves.

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12. Bynum, "Rationales for Therapy in British Psychiatry," 37-8.
13. Michel Foucault, *History of Madness*, ed. Jean Khalfa, trans. Jonathan Murphy and Jean Khalfa (New York: Routledge, 2006), 338-9.
14. Foucault, *History of Madness*, 389, 488-90.

Psychiatry was thus born."[15] Pinel and Tuke advocated for moral over medical treatment and neither the first generations of Tukes nor the Retreat's early superintendents had any medical background. These points aside, Lewis kept plenty of company in arguing for the birth of psychiatry around the dawn of the nineteenth century and in arguing that Tuke's system was psychical.

Also following Foucault's line of argument, Andrew Scull has argued that the rise of moral treatment, which was largely associated with lunacy reform efforts, represented a shift in the "cultural meaning of madness" and constituted a "rupture with the past."[16] Capitalists lauded the efficacy of the mastery of nature. The insane, so moral treatment advocates held, no longer needed to wallow in a subhuman state forever because they lacked the capacity for reason at present. Consequently, Scull held that moral treatment aimed not merely to dominate the animal passions of the insane as earlier eighteenth-century therapeutics had done, but to "*transform* the lunatic, to remodel him into something approximating the bourgeois ideal of the rational individual."[17] This project required patients to internalize the system of education—similar to the capitalist system of education for children, which increasingly favored instilling self-discipline over corporeal punishments—and come to exercise self-control.[18]

In the same vein, Anne Digby, whose *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* remains the most detailed study of how the Retreat in fact

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15. Aubrey Lewis, *State of Psychiatry*: *Essays and Addresses* (London: Routledge and Kegan Paul, 1967), 7; Porter, *Mind-Forg'd Manacles*, 169, 325n2.
16. Andrew Scull, "Moral Treatment Reconsidered: Some Sociological Comments on an Episode in the History of British Psychiatry," in *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, ed. Andrew Scull (Philadelphia: University of Pennsylvania Press, 1981), 108, 110.
17. Scull, "Moral Treatment Reconsidered," 111.
18. Scull, "Moral Treatment Reconsidered," 105-18.

operated, explained that "Moral treatment as it was understood by its practitioners in the eighteenth and early nineteenth centuries meant that psychological methods were employed to help in what was seen as a mental disorder."[19] The Retreat made its patients work and surrounded them with soothing scenes and familial, domestic comfort as tools of this psychological approach.[20]

Whether the advent of moral treatment represented the birth of psychiatry or merely a pivotal moment in the psychological treatment of the insane, subsequent scholars have agreed that it was psychological and significant. The first generation of British medico-psychologists likewise concurred precisely with this view of moral treatment.

John Conolly (1794-1866), one of the most famous Victorian asylum superintendents in his day, laid out his view of the evolution of his profession in the 1850s. The treatment of patients in the eighteenth century, he argued, had been barbaric, until Pinel came along and struck their chains off. The founding of the Retreat held a similar place in the epic of British moral treatment. Private investigations and Parliamentary inquiries finally exposed the hidden abuses in asylums by 1815. The Retreat's system of humane treatment then emerged as the enlightened path. Medical men, such as Conolly, took it up and the rest was history—medical psychology was born.[21]

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19. Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985), 33.
20. Digby, "Moral Treatment," in *Madness, Morality and Medicine*, 33-56.
21. John Conolly, *The Treatment of the Insane without Mechanical Restraints* (London: Smith, Elder and Co., 1856), 2-34.

John Charles Bucknill (1817-97) and Daniel Hack Tuke (1827-95) performed the same origin hunting quest for their profession in their *Manual of Psychological Medicine* (1858). They reached back, however, as far as ancient Egypt for their starting place. They then moved through classical Greek and Roman medicine all the way up to their present day. They effectively reprised, even cited as evidence, Conolly's version of the history from the mid-eighteenth century onward.[22]

Their version of events contained some accurate information. Samuel Tuke's publication of his *Description of the Retreat* in 1813 launched the public profile of the Retreat and its moral treatment. The investigations into asylum conditions conducted by private individuals and culminating in the 1815 inquiries of the Committee Appointed to Consider of Provision Being Made for the Better Regulation of Madhouses in England mobilized public pressure for asylum Reform. Tuke's *Description* emerged as the model for humane and effective treatment in asylums—thereby exporting moral treatment to asylums across Britain.

Moral treatment, however, did not survive as one model. It evolved in many different directions based upon the local circumstances of its practitioners and patients. Some models of moral treatment included precise, medical explanations for their efficacy. Others contained no explanations. Some required active engagement with patients. Others strived for a passive, one-size-fits-all system. Some explicitly addressed the patients' minds. Others justified work-a-day matters of institutional management intended to keep the Poor Law system running smoothly.

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22. John Charles Bucknill and Daniel H. Tuke, *A Manual of Psychological Medicine: Containing the History, Nosology, Description, Statistics, Diagnosis, Pathology, and Treatment of Insanity, with an Appendix of Cases* (Philadelphia: Blanchard and Lea, 1858), 17-85.

Neither Samuel Tuke's initial model nor the subsequent variations upon it were psychiatry or psychology as the fields that later claimed those titles came to understand them. The various models of moral treatment were historically specific phenomena that must be understood on their own terms and not forced into a teleology of psychiatric professionalization—for the sake of understanding asylum practice at the time as well as for the sake of understanding the role moral treatment played in the formation of medical psychology.

Chapter 1 examines the emergence of Tuke's moral treatment as a model for export. Tuke's *Description*, which served as the model—as opposed to the actual operation of the Retreat—was one of a number of texts that advocated management as a curative measure. His work, however, went to print just as counties received the authority to fund asylums from the poor rates and just as a series of scandals respecting asylum conditions forced the question of the treatment of insanity into the public realm. In this context, the *Description* emerged as a blueprint for the establishment of a model asylum. As such, its method of moral treatment is examined carefully in order to establish the point of reference for the asylums examined in the subsequent chapters.

Chapter 2 examines the implementation of Tuke's version of the moral treatment at the West Riding Pauper Lunatic Asylum at Wakefield. Samuel Tuke assisted in its design and the Magistrates that orchestrated its founding had been involved in efforts to advocate for the general adoption of the Retreat's moral treatment in asylums. As one of the earliest county asylums and an institution that attempted a direct imitation of the Retreat's model of moral treatment, the alterations to the moral treatment when it was used at Wakefield are of particular note.

Wakefield's first director, William Charles Ellis (1780-1839) began the shift to a passive, one-size-fits-all model of moral treatment by emphasizing manual occupations for patients. He also greatly increased the use of conventional medicine as a necessary component of moral treatment and provided medical explanations for moral treatment's efficacy. Wakefield's second administrator, Charles Caesar Corsellis, oversaw—not without complaint—the overcrowding and massive expansion of Wakefield. With his time split between so many patients and administrative duties, Wakefield's moral treatment shifted even further to a passive, custodial model.

Ellis, meanwhile, took up a new post at the newly built Middlesex County Lunatic Asylum at Hanwell. Chapter 3 examines the evolution of moral treatment when implemented at Hanwell. While Corsellis complained about crowding and the impossibility of providing each patient their due attention at Wakefield, Ellis encouraged crowding at Hanwell. Ellis concerned himself with gaining economies of scale and fending off accusations from the local vestries that his asylum was squandering the county rates.

After Ellis fell ill, and following an abortive attempt at lay management, John Conolly took over the administration of Hanwell. While Corsellis oversaw the evolution of Ellis's model of moral treatment to a yet more passive and custodial model, Conolly took the model he inherited from Ellis in the opposite direction. Conolly eschewed all physical restraints for patients, thus forcing the asylum staff to constantly supervise and engage with patients personally in order to train them in self-restraint. This approach represented the most ambitious and active model of moral treatment—even more so than Tuke's lauded original. It was short-lived, however. In a demonstration of one way that

local circumstances drove treatment, the governing magistrates bowed to pressure from ratepayers and ended Conolly's tenure and with it the active model of moral treatment at Hanwell.

Moral treatment as practiced in British asylums in the first half of the nineteenth century thus was not psychiatry or psychology, but existed as many different models of treatment all of which were contingent upon decisions made by various members of the public, including medical professionals, politicians, and ordinary parishioners.

Chapter 1

Making a Model of Moral Treatment:

Changes in Asylum Practice in the Early-Nineteenth Century

Godfrey Higgins toured the kitchen. He spotted an old door almost concealed by another door left ajar. He asked the attendant accompanying the head keeper, Charles Atkinson, to open the door. The attendant responded that he did not have the key.[23] Higgins threatened to force the door open with a fire iron if the key was not found. The attendant then took out his key and opened the door. The three of them proceeded through to a passage off of which protruded four cells strewn with straw soaked in human waste.[24] Higgins saw that the only recent renovation was the installation of a new chain, which was bolted to the floor. There was no ventilation. Higgins observed that the cells themselves only had one small air hole apiece, all of which were clogged with excrement.[25]

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23. Godfrey Higgins, *A Letter to the Right Honorable Earl Fitzwilliam Respecting the Investigation which has Lately Taken Place, into the Abuses at the York Lunatic Asylum* (Doncaster: W. Sheardown, 1814), 14.
24. James Birch Sharpe ed., *Report Together with Minutes of Evidence, and an Appendix of Papers, from the Committee Appointed to Consider of Provision Being Made for the Better Regulation of Madhouses in England (Ordered by the House of Commons to be Printed 11th July, 1815): Each Subject of Evidence Arranged Under its Distinct Head* (London: Baldwin, Cradock, and Joy, 1815), 12-13.
25. [W. H. Fitton], "Lunatic Asylums," *Edinburgh Review* 28, no. 56 (August 1817): 436-437.

Amongst all of the human waste stood only the three observers. Higgins asked whether anyone stayed in those cells. The attendant informed him that the women whose cells those were only slept in them. Higgins demanded to be taken to those women. He found the thirteen women who slept in those four cells at night huddled together, trammeled in a seven-by-twelve foot room during the day. Higgins left to retrieve more governors of the York Lunatic Asylum and show them how their donations had been employed at their Asylum.[26] Accounts of Higgins's visit circulated first in York and then throughout Britain as advocates of asylum reform vied for new regulations during a push for national lunacy legislation between 1813 and 1816.

Godfrey Higgins inspected the York Lunatic Asylum in January of 1814. The York Asylum was one of relatively few Asylums in Britain. Three types of lunatic asylums existed at the time: private (also called licensed houses, after 1774), public, and county. Private houses provided for small numbers of patients through a personal contract between the keeper and the patient, their family, or supporting parish—parish officers shifted away from supporting paupers in private houses and toward supporting them in county asylums and workhouses as the century progressed.[27] The Act for Regulating Private Madhouses of 1774, made perpetual in 1786, provided for the inspection and licensing of private houses by a committee appointed by the Royal College of Physicians in London and Westminster and in a seven mile radius around them, and by justices of

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26. Higgins, *A Letter to the Right Honorable Earl Fitzwilliam*, 14-15.
27. David R. Green, *Pauper Capital: London and the Poor Law, 1790-1870* (Burlington: Ashgate Publishing Company, 2010), 155.

the peace elsewhere.[28] By 1819, however, only forty metropolitan licensed houses and forty-nine provincial licensed houses had been established.[29]

Public asylums, like London's Bethlem and St. Luke's, relied upon private charity and fees—provided either privately or by the supporting parish—for revenue. Throughout the late-eighteenth century a small number of public asylums opened outside of London. The York Lunatic Asylum was one such asylum. Counterintuitively, magistrates possessed less authority to inspect public asylums than private ones.[30]

Counties did not gain the authority to fund asylums with county rates until 1808.[31] After Parliament granted that authority, counties acted only slowly to build asylums—only twelve counties built asylums before 1845. The counties that did found asylums in the first half of the nineteenth century were often rural counties, not responding to urban growth. Most insane people remained in the community until the mid-nineteenth century.[32] As such, Britain did not experience a "great confinement" as described by Michel Foucault, at least until the mid-nineteenth century.[33]

The methods of treatment in the small number of asylums in Britain experienced considerable changes over the eighteenth century. Sixteenth- and seventeenth-century physicians worked largely within the Hippocratic and Galenic tradition of medicine. They

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28. Act for Regulating Private Madhouses, 1774, 14 Geo. 3, c. 49; 1786, 26 Geo. 3, c. 91.
29. William Ll. Parry-Jones, *The Trade in Lunacy: A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries* (London: Routledge and Kegan Paul, 1972), 9-10, 30.
30. Roy Porter, *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (London: Athlone Press, 1987), 129-36.
31. County Asylums Act, 1808, 48 Geo. 3, c. 96.
32. Andrew Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (New York: St. Martin's Press, 1979), 13-14, 28-29.
33. Porter, *Mind-Forg'd Manacles*, 155-6; Michel Foucault, "The Great Confinement," in *History of Madness*, ed. Jean Khalfa, trans. Jonathan Murphy and Jean Khalfa (New York: Routledge, 2006) 44-77; see also Andrew Scull, *Hysteria: The Disturbing History* (New York: Oxford University Press, 2009), 62-63.

explained many ailments by means of the humoral theory. They claimed that there were four humors in the human body: phlegm, yellow bile, black bile, and blood. Illness resulted from an imbalance in the humors. Too much blood, for instance, might cause someone to become manic.

Thomas Willis, Sedleian Professor of Natural Philosophy at Oxford University, triggered a reconceptualization of medical thought in Britain in the mid-seventeenth century. In 1664 he completed *Cerebri anatome: cui accessit nervorum descriptio et usus*, which included a more detailed mapping of the brain and nervous system than had yet been attempted. In *An Essay on the Pathology of the Brain and Nervous Stock,* Willis explained how defects or damage in the brain or nervous system caused illnesses. This theory of illness as the result of nervous disorder remained the primary mode of medical thought throughout the eighteenth century.[34] Medical men still employed remedies and procedures previously explained through humoralism—bleedings and purges, for instance—but classical humoralism declined as an explanatory model.[35]

William Battie, physician of St. Luke's Hospital for Lunatics from 1751 to 1764, distinguished between "original" and "consequential" madness. The categories presaged the later categories employed by asylums of curable and incurable. Battie theorized that "consequential" madness resulted from some new physiological state or circumstance and, therefore, could be cured if the patient were restored to their previous health or if the

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34. Porter, *Mind-Forg'd Manacles*, 176-86; see for example, Thomas Trotter, *A View of the Nervous Temperament; being a Practical Enquiry into the Increasing Prevalence, Prevention, and Treatment of those Diseases, Commonly Called Nervous, Bilious, Stomach and Liver Complaints, Indigestion, Low Spirits, Gout etc.* (Newcastle: Edw. Walker, 1807), xv-xviii. Trotter, a Royal Navy physician and influential medical man, thought most known diseases to be somehow nervous in origin.
35. See for example William Battie, *A Treatise on Madness* (London: J. Whiston and B. White, 1758), 82. Battie was superintendent of St. Luke's Hospital for Lunatics. He recommended vomits and purges despite offering regimen as a more efficacious tool than the standard system of bleedings and purges carried out at Bethlem.

circumstantial cause were removed. "Original" madness, in contrast, consisted of seemingly incurable cases.[36]

Battie established his system of treatment as a reaction against what he saw as the neglectful, one-size-fits-all system of bleedings and purges at Bethlem. He devised a system that valued the efficacy of careful management and confinement over conventional medical approaches. He commented, for instance, that,

> The Regimen in this is perhaps of more importance than in any distemper. It was the saying of a very eminent practitioner in such cases *that management did much more than medicine*; and repeated experience has convinced me that confinement alone is often sufficient, but always necessary, that without it every method hitherto devised for the cure of Madness would be ineffectual.[37]

His *Treatise on Madness* sparked a movement toward employing tools of management and routine in the cure of insanity.[38] This movement of "moral managers," such as William Pargeter and John Ferriar, constituted what Roy Porter has termed the "individualistic, heroic phase of early psychiatry."[39]

Across the Channel in Paris, Philippe Pinel garnered perhaps more attention by implementing his style of moral treatment—a system he developed after consultation with the non-medical superintendents of the Parisian asylums that he directed. He too valued matters of management, thinking, for instance, that patients would behave more calmly were they not chained like beasts.[40]

These advocates of management, however, comprised a small class among those charged with the care of the insane. As noted, few asylums or houses of any size had

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36. Battie, *A Treatise on Madness*, 5-6, 59-62, 93.
37. Battie, *A Treatise on Madness*, 68, italics in original.
38. E. T. Carlson and N. Dain, "The Psychotherapy That Was Moral Treatment," *American Journal of Psychiatry* 117 (1960): 519-24.
39. Porter, *Mind-Forg'd Manacles*, 222.
40. Jan Goldstein, *Console and Classify: The French Psychiatric Profession in the Nineteenth Century* (Cambridge: Cambridge University Press, 1987), 72-3, 95.

been built in order to accomplish the confinement and management of the insane in Britain. In the early-nineteenth century, however, the question of asylums became more pressing. In 1807, Parliament began investigating public and private madhouses in preparation for the writing of what became the County Asylums Act of 1808, which allowed for rate-funded asylums. In 1815, a series of scandals respecting asylum conditions and stoked by Benthamite reformers, captured national attention and became the subjects of a Parliamentary Select Committee. Proposed acts for national asylum regulation failed in 1816, 1817, and 1819. The efforts to pass such legislation attested to the increased public attention that insanity and its confinement or treatment received. Parliament, however, passed acts respecting county asylums, pauper lunatics, and criminal lunatics during that period.[41]

In 1813, Samuel Tuke published his *Description of the Retreat.*[42] This work advocated for a system of moral treatment not wholly unlike those proposed by the earlier moral managers. Tuke's work, however, came at this moment of increased public attention respecting asylums. Tuke helped to stoke some of the 1815 scandals, which included the foul conditions at the York Lunatic Asylum exposed by Higgins. In this context, the Retreat, a Quaker asylum and subject of Tuke's *Description*, emerged as the moral foil to the immoral treatment of lunatics in other asylums—most notably the York Lunatic Asylum and Bethlem. The *Description* secured the enduring popularity of the moral treatment of the insane in Britain—and it did so just as counties gained the

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41. County Asylums Amendment Act, 1811, 51 Geo. 3, c. 79; County Asylums Amendment Act, 1815, 55 Geo. 3, c. 46; Criminal Lunatics Amendment Act, 1815, 55 Geo. 3, c. 117; Pauper Lunatics Act, 1819, 59 Geo. 3, c. 127.
42. Samuel Tuke, *Description of the Retreat an Institution Near York, for Insane Persons of the Society of Friends, Containing an Account of its Origin and Progress, the Modes of Treatment, and a Statement of Cases* (Philadelphia: Isaac Price, 1813).

authority to fund new asylums from the poor rates. Tuke's *Description*—as opposed to the Retreat as it actually operated—served as the most prominent model for the moral treatment, which asylums, new and old, began to imitate and build upon.

Scandals

A group of Yorkshire philanthropists met at York Castle with His Grace the Archbishop of York, Robert Hay Drummond, on the 25th of August 1772. They went in response to the advertisement placed in all of the local papers that proposed to gather governors and funds needed to found an asylum for lunatics. After raising sufficient funds, they purchased five acres of land in Bootham-Bar, contracted the architect John Carr to submit plans for a suitable building, and determined that the new York Lunatic Asylum would initially accommodate sixty-four patients from Yorkshire or indeed anywhere in Great Britain.[43] After the completion of the building in 1777, the Asylum began receiving patients.

The York Lunatic Asylum was a public, subscription and charity based, house for the insane. Patients with the means, or whose family had the means, to pay the fees did so. Middle class families, while less likely to patronize a general hospital, more frequently sent insane relatives to reputable public asylums. Patients who could not afford the fees were supported by funds gathered from the contributions of the governors, the patients' parishes—if they had settlement as a pauper—or surplus funds from the paying patients. The patients who were admitted either sought out the services of the

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43. York Lunatic Asylum, *The Annual Report of the Lunatic Asylum Erected at York; With a Short History of Its Rise and Progress* (York, 1785), 1.

Asylum, or were compelled to enter it as the result of an order by a magistrate or other official.[44]

Dr. Alexander Hunter initially led the Asylum staff, which also included an apothecary, matron, head keeper, and six servants.[45] The community received little information about the conditions in the Asylum that was not provided by members of the Asylum staff or Board of Governors.[46] Despite its public, charitable status, the York Lunatic Asylum existed as an opaque institution.

When Parliament's Select Committee Appointed to Enquire into the State of Lunatics wrote on the York Lunatic Asylum in 1807, it appeared to be a perfectly respectable institution. The expense to maintain a patient at the York Asylum per week was nine shillings, a moderate cost. The Committee desired reasonable costs. However, its members also wanted the treatment of patients to be of good quality. They primarily, however, concerned themselves with financial best practices since the purpose of the Committee was to collect useful information for the benefit of legislation to grant authority to counties to establish rate-funded asylums.

Most importantly, the Committee lauded the York Lunatic Asylum for its high (fifty percent) success rate at curing and releasing patients.[47] The Committee saw asylums not as permanent places for the sequestration of the insane, but as institutions designed to return people to a state of social normalcy and productivity. The best way to avoid allowing asylums to burden ratepayers with the support of the insane was to cure

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44. Porter, *Mind-Forg'd Manacles,* 133-4.
45. Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985), 11.
46. Anne Digby, "Changes in the Asylum: The Case of York, 1777-1815," *The Economic History Review* New Series 36, no. 2 (May 1983): 220-223.
47. House of Commons Select Committee on the State of Lunatics, *Report from the Select Committee Appointed to Enquire into the State of Lunatics* (London: G. Ramsay, 1807), 6-7.

and discharge them. As such, the York Lunatic Asylum carried out its proper function well.

Sir George Onesiphorus Paul, the Gloucestershire magistrate and prison reformer of some renown, wrote to the Secretary of State for the Home Department to make suggestions for the construction of new asylums and commented on the excellent management of the York Lunatic Asylum.[48] The Committee attached his letter as expert commentary.

The Committee held the York Lunatic Asylum up as a model for the proposed new asylums. The Committee may have simply failed to give its investigation its due diligence. The House of Commons convened the Select Committee in response to an attack on the person of King George III by a man later acquitted by reason of insanity.[49] Its job was to help to provide a solution for the problem of loose lunatics by preparing the way for the County Asylums Act of 1808, not to seek out problems within the existing asylums. Regardless of whether the abuses later discovered were truly absent from the York Lunatic Asylum in 1807, at this time the Committee claimed to have found it to be an exemplary institution. The Committee also demonstrated an acceptance of prevailing treatment methods and a relative lack of curiosity about the conditions in asylums.

Godfrey Higgins, in the course of his duties as a magistrate, granted a warrant for the arrest of William Vicars, who apparently assaulted a woman, in 1813. Higgins, upon inspecting Vicars, decided that the proper course of action was to commit Vicars to the

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48. George Onesiphorus Paul to Earl Spencer, October 11, 1806, in House of Commons Select Committee on the State of Lunatics, *Report from the Select Committee Appointed to Enquire into the State of Lunatics* (London: G. Ramsay, 1807), 19.
49. *Hansard Parliamentary Debates*, HC Deb. vol. 8 cols. 514-515, 23 January 1807.

York Lunatic Asylum.[50] After Vicars's release, his wife Sarah complained to Higgins about the treatment of her husband. Higgins inspected William Vicars and saw faded bruises. He noted marks as if from flogging.[51] Higgins procured a letter from the surgeon who examined Vicars upon his release from the Asylum. Charles Maples, the surgeon, noted that upon his release Vicars was lice infested, bruised, and could not stand under his own power due to a partially mortified (gangrenous) leg.

Higgins published his observations on the case of Vicars in the *York Herald.*[52] He notified the Asylum doctor, Dr. Charles Best, that those materials would be published. Dr. Best published his own defense, accused Higgins of abusing his power, and called for a meeting of the Asylum Governors in order to hear any additional complaints from the community.[53] The Board of Governors of the Asylum, chaired by the Archbishop of York, met on the 2nd of December 1813 to hear complaints and review the case of Vicars. The board determined that Vicars had been treated "with all possible care, attention, and humanity."[54] They were disturbed mostly by the way that the case, thanks to Higgins, had been publicized. At one point, the Archbishop threatened to leave the room if testimony continued to be elicited from the Asylum servants, whom he assumed were lying about conditions being bad in the Asylum.[55] The board resolved to review other cases at a later

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50. Higgins, *A Letter to the Right Honorable Earl Fitzwilliam,* 3.
51. Higgins, *A Letter to the Right Honorable Earl Fitzwilliam*, appendix, 7-8.
52. Higgins, *A Letter to the Right Honorable Earl Fitzwilliam*, appendix, 8-10.
53. Charles Best to the Editor of the *York Herald*, November 26, 1813, in Godfrey Higgins, *A Letter to the Right Honorable Earl Fitzwilliam*, appendix, 3-6, 11-12. Higgins attached this letter to his published, open letter. Best never contested its accuracy and it was republished as evidence in a number subsequent documents.
54. Higgins, *A Letter to the Right Honorable Earl Fitzwilliam*, appendix, 17.
55. [Fitton], "Lunatic Asylums," 436-437.

date before the Archbishop politely but firmly disinvited Higgins from the subsequent meeting.[56]

The Asylum Governors stood firmly by their administrators and shut Higgins out, making further investigation impossible. The Governors and administrators of the York Lunatic Asylum reacted with self-defense. Higgins, a gentry level county magistrate, implicated them in the abuse of a community member and brought increased scrutiny from the community by his publication of the affair in the *York Herald*. Whether his version of events was distorted, as the Governors maintained, his story attracted publicity and received distribution on a national scale. The response of the Governors demonstrated their continued belief that the business of asylum management ought to remain private—it was not a public question.

Higgins resolved to continue with his investigation. The York Lunatic Asylum had established that anyone who contributed twenty pounds in one year to the institution earned a spot on the governors' board.[57] Higgins had the means to make such a donation, but one vote in twenty-seven would be insufficient to force an investigation. He sought help from a friend, Samuel Tuke.

Tuke was a wealthy Yorkshire Quaker. His family had been involved in trade and asylum management for generations. Tuke had published his *Description* in 1813, the same year as the Vicars controversy. In his *Description*, Tuke elucidated the Retreat's formula for the moral treatment of patients (discussed in detail below). Samuel Tuke was the grandson of the Retreat's founder, William Tuke. William Tuke organized the

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56. Higgins, *A Letter to the Right Honorable Earl Fitzwilliam*, appendix, 17-19.
57. York Lunatic Asylum, *The Annual Report of the Lunatic Asylum Erected at York; With a Short History of Its Rise and Progress*, 1-2.

establishment as a public asylum, primarily for Quakers, in response to the death of a Quaker woman, Hanna Mills, at the York Lunatic Asylum in 1790.[58] He remained involved with the affairs of the Retreat and eventually testified before the 1815 Select Committee on matters of asylum management, but the younger Samuel Tuke engaged most directly with the controversies at this time.[59]

Godfrey Higgins and Samuel Tuke orchestrated a hostile takeover of the York Lunatic Asylum. They organized a group of like-minded reformers, which dubbed itself the "Retreat Party," each paid the twenty pounds necessary to earn seats on the Board of Governors for the York Lunatic Asylum.[60] The numbers of the Board swelled from twenty-seven to sixty-six.[61] The existing Governors were furious with the Retreat Party and did little to conceal their ire.[62]

Backed by the new Governors, Higgins gained access not only to the facility, but also to its records. He discovered horrific abuses at the asylum. It was at this point that he conducted his tour—his account of which was detailed above—and saw its residents huddled together in cells strewn with excrement. He found the staff to be either recklessly incompetent or willfully malicious. He demonstrated the longstanding embezzlement of funds by administrators—at least £20,000, but likely nearer to £40,000.[63] He also found that Dr. Best had been keeping his own private patients at the asylum. As such, Best profited by taking asylum resources for his own practice—as the original physician at the

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58. Porter, *Mind-Forg'd Manacles*, 134, 223.
59. *Report Together with Minutes of Evidence 1815*, 160-2.
60. Higgins, *A Letter to the Right Honorable Earl Fitzwilliam*, appendix, 23.
61. Higgins, *A Letter to the Right Honorable Earl Fitzwilliam*, appendix, 16, 19-20.
62. Jonathan Gray, *A History of the York Lunatic Asylum with an Appendix Containing Minutes of the Evidence of the Cases of Abuse Lately Inquired into by a Committee* (York: Hargrove, 1815), 34.
63. *Report Together with Minutes of Evidence 1815*, 25; Higgins, *A Letter to the Right Honorable Earl Fitzwilliam*, 22-23.

York Lunatic Asylum, Dr. Hunter, had also done.[64] He demonstrated the embezzlement of substantial funds because this malfeasance was not only an abuse of the patients for whom the funds were intended, but also an abuse of the charitable contributors and parish ratepayers.[65] As such, he mobilized public opprobrium over the swindling of the charitable and rate-paying public alike.

Higgins proved that attendants had raped a number of female patients. He also demonstrated that over the years a number of patients disappeared from the records in mysterious fashion. Higgins insinuated that such patients, one hundred and forty-four by his count, had been neglected and abused to the point of death if not outright murdered.[66] A fire burned down part of the asylum and killed several patients soon after Higgins's investigation. Higgins assumed that the fire had been set intentionally to conceal evidence respecting the missing patients.[67]

Higgins had a local publisher print the results of his investigation as an open letter to Earl Fitzwilliam, who also sat on the board of governors for the York Lunatic Asylum. Higgins's letter contained a reasonably extensive report on the York Lunatic Asylum as well as an appendix, which included a number of additional documents intended as evidence. He imagined his audience to be not merely the Earl, but also educated men in the area and in a position to help force the changes that he wanted. He frankly stated that his aim was to leverage public opinion to force the asylum to reform and implement the model of treatment practiced at the Retreat.[68]

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64. Porter, *Mind-Forg'd Manacles*, 134-5.
65. Higgins, *A Letter to the Right Honorable Earl Fitzwilliam*, 12, 20-22.
66. Higgins, *A Letter to the Right Honorable Earl Fitzwilliam*, 24-25.
67. Porter, *Mind-Forg'd Manacles*, 134-5.
68. Higgins, *A Letter to the Right Honorable Earl Fitzwilliam,* 5.

Higgins juxtaposed the kind treatment at the "Quakers' Retreat" to the abuses at the Asylum.[69] He compared the mortality rates at the two institutions, which showed that the York Lunatic Asylum had a significantly higher annual mortality rate. He also claimed that patients discharged from the York Lunatic Asylum regularly described the abuses they suffered, but that the Retreat's discharged patients reported on their good treatment. To prevent the York Lunatic Asylum from blaming its problems on the quality of its patients, Higgins noted that the Retreat had succeeded in curing a number of patients who had previously been deemed old and hopeless cases.[70] Higgins held up the Retreat as the "monument of goodness," which served as the standard of good care for comparison and the model of treatment that ought to be adopted.[71]

Higgins also endeavored to oust the administrators who had overseen the abuses. Higgins, for instance, accused one administrator, Charles Atkinson, of lying in order to keep a patient away from family in order to conceal abuses.[72] Higgins launched numerous accusations at the resident physician Dr. Best, who was eventually removed from his position and discredited.[73] In his letter to the Earl, Higgins made attempts to demonstrate his deference to the established authorities. Ultimately, however, Higgins's letter forced into the public eye an issue that the Governors had repeatedly worked to keep private. The Governors—local elites—were personally implicated in condoning the abuses. Moreover, Higgins—as a Benthamite reformer—vied not simply to address the exposed abuses, but to establish the Retreat, as Tuke described it, as a model to be imitated.

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69. Higgins, *A Letter to the Right Honorable Earl Fitzwilliam*, 7,8.
70. Higgins, *A Letter to the Right Honorable Earl Fitzwilliam*, 7, 25.
71. Higgins, *A Letter to the Right Honorable Earl Fitzwilliam*, 8.
72. Higgins, *A Letter to the Right Honorable Earl Fitzwilliam*, 9.
73. Scull, *The Most Solitary of Afflictions*, 116.

Higgins crafted the scandal at the York Lunatic Asylum in order to gain attention and support for his mission to establish the Retreat as a model for asylum reform.

National Attention

The Parliamentary Committee Appointed to Consider of Provision Being Made for the Better Regulation of Madhouses in England convened in 1815. The Committee heard testimony from medical professionals, asylum administrators, alleged abusers, and reform advocates such as Godfrey Higgins. The materials that Higgins published caused such interest, uproar, and conversation that the Committee published his testimony at the head of their report. The Committee heard testimony and received evidence from forty other witnesses or experts associated with nearly as many asylums.[74]

Certain asylums stood out from the Committee's report. Bethlem and the York Lunatic Asylum stood out as examples of the cruelty of older asylums, not suited to the more enlightened views of the day. At Bethlem recent investigations into the alleged long-term, physical restraint of James Norris sparked inquiries into other abuses. The Board of Governors, much like the York Lunatic Asylum's Board, initially stood by its employees and dismissed the charges. Thomas Monro, the superintendent, and John Haslam, the apothecary—who carried out most of the actual treatment at Bethlem—both testified in front of the 1815 Committee in the aftermath of this scandal. Their testimony comprised an impressively large portion of the whole report produced by the Committee.[75] The Committee allowed all of those accused of abuses opportunities to explain themselves fully, wishing not to seem to be on a mission to punish the accused.

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74. *Report Together with Minutes of Evidence 1815*, ix-xii, 160-2.
75. *Report Together with Minutes of Evidence 1815*, 78-132.

Monro and Haslam, however, blamed one another for what came to be exposed as Bethlem's institutionalized neglect of its perpetually restrained patients. The Committee sent a copy of its report to the Board of Governors for Bethlem. The Board fired Haslam and permitted Monro to resign.[76]

St. Luke's Hospital for Lunatics, which had been founded over half a century earlier in response to poor conditions at Bethlem, appeared to be nearer in kind to the Retreat than the York Lunatic Asylum despite perceived deficiencies in the method of categorizing and separating types of lunatics.[77] St. Luke's served as the foil to Bethlem just as the Retreat would serve as the comparison for the York Lunatic Asylum. In both cases, the moral managers came out for the better.

The Governors of the York Lunatic Asylum had already dismissed Dr. Best and most of the old staff before the Committee began hearing testimony. Higgins was the Committee's first witness and his testimony appeared at the head of their report. He offered the Committee the story, findings, and substantiating evidence of his investigation in great detail, employing the same flair and playing to the same macabre fascination and sense of righteous indignation as he had in his published works on the subject.[78]

Best offered his testimony and flatly denied the accusations that Higgins's publications and testimony had placed upon him. Best's testimony provided him no

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76. Scull, *The Most Solitary of Afflictions*, 115-22.
77. *Report Together with Minutes of Evidence 1815*, 163-77.
78. *Report Together with Minutes of Evidence 1815*, 11-27.

redemption—he remained discredited and out of the job. [79] It primarily served only to further air the details of the abysmal condition of the York Lunatic Asylum at the time.[80]

Higgins, however, had embarked on a media and public pressure campaign first to disabuse the York Lunatic Asylum of its administrators and then to leverage the case at York for nationwide reform. His intentions and desired outcome might have been cause to doubt the accuracy of his reports. His case may have been more compelling with exaggerated tales of abuse. Best's testimony, however, only confirmed the abhorrent state of his asylum's management.[81] As such, Higgins's accounts were trustworthy as well as useful for his purposes.

Higgins won at least the public adulation of his previous rivals on the York Lunatic Asylum's Board. In August of 1815, the Board of Governors for the York Lunatic Asylum, under the chairmanship of the Earl Fitzwilliam by this point, offered Higgins their thanks for bringing about the improvement of conditions in their asylum in a formal resolution that was reproduced in every York newspaper and in Higgins's annotated edition of his Committee testimony.[82]

Higgins's version of events at York was the most pervasive. His narrative and conclusions were printed not only in the York papers and Higgins's open letter, but also in multiple editions of the Select Committee's report and in critical reviews. Jonathan Gray later compiled an account of the investigation at the York Lunatic Asylum including its consideration by the Select Committee on behalf of William Wilberforce,

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79. Scull, *The Most Solitary of Afflictions*, 115-22.
80. *Report Together with Minutes of Evidence 1815*, 28-43.
81. Scull, *The Most Solitary of Afflictions*, 111, 116-117.
82. York Lunatic Asylum, *Proceedings of the General Court, August 1815*, in Godfrey Higgins, *The Evidence Taken before a Committee of the House of Commons Respecting the Asylum at York; with Observations and Notes, and a Letter to the Committee* (Doncaster: W. Sheardown, 1816), appendix 14.

who was on both the 1807 and 1815 Committees. Gray referenced and attached most of the evidence collected by Higgins and the Committee to his account. In his dedication, he remarked how well publicized and central to the Committee's considerations Higgins's account had been.[83] Higgins's testimony, however, represented only the first step in his mission to establish the Retreat as a model institution. Higgins highlighted the problems; the Tukes suggested the solutions.

William Tuke testified before the Committee on behalf of the Retreat. His testimony made the Retreat stand out as the one apparently problem-free institution considered by the Committee. Tuke's testimony was quite short—a good sign given that long testimony tended to detail the abuses that the Committee was meant to ferret out and find solutions to. Tuke detailed the light system of restraints employed at the Retreat—their leather belts connected to straps attached at the wrist and, thereby, restricting the full use of the arms without completely impeding the use of the hands compared quite favorably to the systems of chains intended to restrict the full body employed at Bethlem. The Retreat's preference for management over purges, bleedings, and punitive baths also showed it in a favorable light.[84]

Most of his testimony concerned the inspection of the Retreat. The Committee members were most interested to hear about the visitors selected by the Retreat's governing Committee. The Retreat's Committee had long since elected female visitors to inspect the female side of their establishment regularly and report back to the Committee with any problems or recommendations for improvement, and had just implemented the same system for the male side. William Tuke—whose idea it was to found the Retreat

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83. Gray, *A History of the York Lunatic Asylum*, i-v.
84. *Report Together with Minutes of Evidence 1815*, 160-2.

and who served as a committee member and treasurer of the Retreat—also visited the asylum regularly to inspect all of the various spaces. This system of constant inspection coupled with the Retreat's general benevolence prevented the sorts of hidden abuses that had taken hold in the York Lunatic Asylum and Bethlem. Surrounded by a catalogue of abuses and problems, the Retreat became the one source of redemption for madhouses. [85]

Another cause for the brevity of William Tuke's testimony was Samuel Tuke's *Description*. The Committee asked William Tuke if his grandson's account of the treatment at the Retreat was accurate. The Committee referenced both the *Description* and its review in the *Edinburgh Review*, which attested in part to its relatively wide distribution for a text on such a specialized subject. William Tuke answered that he had reviewed the whole work before it went to print and could confirm that it was an entirely accurate reflection of the practices at the Retreat. With that confirmation, no more testimony was needed. The Committee had access to a full volume detailing every aspect of the Retreat.[86]

The shift in opinion regarding the York Lunatic Asylum between the Select Committees in 1807 and 1815 represented a larger transformation in the public view on whether the treatment of the insane, wherever they were housed, was a public question. The Retreat and, more importantly, the *Description of the Retreat*, emerged from the 1815 inquiries as the enlightened solution to the prevailing abuses in asylums precisely at the moment that asylums became a more pressing public question.

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85. *Report Together with Minutes of Evidence 1815*, 160-2.
86. *Report Together with Minutes of Evidence 1815*, 160-2.

The Model

The Retreat exercised its influence over nineteenth-century asylums primarily by serving as a model. The Retreat rose to fame in 1813 with the publication of Samuel Tuke's *Description,* just five years after counties were first empowered to found and finance asylums on county rates. Tuke's *Description* enjoyed a favorable reception. Sydney Smith, for instance, wrote in the *Edinburgh Review* that the *Description* was "full of good sense and humanity, right feelings, and rational views."[87] The *Edinburgh Review* published the issue with Smith's commentary in April of 1814, after the Vicars controversy, but before Higgins published his open letter to the Earl Fitzwilliam. Tuke's book arguably exercised greater influence than the Retreat itself.

Some aspiring asylum physicians and directors did visit or work for some time at the Retreat, but the Retreat was a small institution not a training center. Its records were not available for even expert consumption. The Retreat, as it existed on paper in the *Description*, served as the model that old and new asylums imitated more than the actual institution. It is more essential, therefore, to understand the Retreat's method of moral treatment as an idealized model rather than as it was in fact practiced.

The *Description* established the moral treatment as the sole hope for aiding the recovery of the insane. Tuke skipped all issues of theoretical explanation, but insisted on the efficacy of his system. He stated, "If we adopt the opinion, that the disease originates in the mind, applications made immediately to it are obviously the most natural."[88] Alternatively, if critics objected that the "mind is incapable of injury or destruction, and

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87. [Sydney Smith], "Description of the Retreat an Institution Near York, for Insane Persons of the Society of Friends, Containing an Account of its Origin and Progress, the Modes of Treatment, and a Statement of Cases," *Edinburgh Review* 23, no. 45 (April 1814): 190.
88. Tuke, *Description of the Retreat*, 84.

that in all cases of apparent mental derangement, some bodily disease exists," then one most still admit that the object is "whatever is calculated to affect the mind."[89] So, he asserted, however one conceived of insanity, treatment ought to be aimed at the mind. It is understandable, given claims like these, that Tuke's system has been described as psychological or psychiatric—though such characterizations are substantively inaccurate. Deviation from even this degree of "psychology" will be examined below.

The *Description* dismissed existing medical practices as a set of ineffective attempts at treatment. Tuke derided physicians who, in his view, could do little more than to see to the "alleviation and suppression of symptoms."[90] The superintendent of the Retreat, George Jepson, also placed his trust in moral treatment over medicine, which was primarily used for the treatment of non-insanity related illnesses that occurred in the Retreat. Tuke claimed that the Retreat's superintendent agreed with Philippe Pinel's preference for moral approaches over medical approaches. It is worth noting that Tuke, like his medical successors discussed below, differentiated between moral and intellectual faculties describing insanity as a perversion of "intellectual, active, and moral powers."[91]

Tuke divided the Retreat's system into three categories of consideration: assisting the patient in self-control; the comfort of the patients, which Tuke admitted could be included under the first category; and the means of coercion when necessary.[92] In effect, therefore, he created two categories of consideration: restraint and self-restraint. Tuke did

89. Tuke, *Description of the Retreat*, 84.
90. Tuke, *Description of the Retreat*, 84.
91. Tuke, *Description of the Retreat*, 85.
92. Tuke, *Description of the Retreat*, 88.

not invent this system, but it was his description of it that served as a widespread contemporary model.

It is advisable to begin with Tuke's description of what their moral treatment was not. The work was polemical, taking a number of jabs at the specific practices and general attitudes of the "bad," old asylums. For Tuke, the general principle for restraint was to use it only when absolutely necessary. Tuke remarked that he doubted that even "the most enlightened and ingenious humanity, will ever be able entirely to supersede the necessity of personal restraint."[93] The staff informed patients upon arrival that their treatment depended on their conduct. Of course, Tuke also maintained that their conduct depended on their treatment. It was the management of that reciprocal process in the correct direction—better treatment leading to better conduct ad infinitum—that defined the Retreat's approach. In practical terms, Tuke illustrated this concept with tales of Retreat patients.

He recounted, for example, the progress of one particular patient: "A man … of almost Herculean size and figure was brought to the house. … he [had] been kept chained, that his clothes were contrived to be taken off and put on by means of strings, without removing his manacles."[94] So, he had, therefore, been considered too dangerous to permit the free movement of his limbs and his treatment had proved to be of no avail. But now he was given over to the care of those who practiced moral treatment. As such, his restraints "were, however, taken off when he entered the Retreat, and he was ushered

93. Tuke, *Description of the Retreat*, 103.
94. Tuke, *Description of the Retreat*, 93.

into the apartment, where the superintendents were supping. He was calm; his attention appeared to be arrested by his new situation."[95]

Even before treatment, the patient was improved. So standard was the removal of restraints that this was done before even the superintendent had observed the patient. The therapeutics of a change of situation became commonplace among the Retreat and its imitators. "After [dinner] was concluded," Tuke continued, "the superintendent conducted him to his apartment, and told him the circumstances on which his treatment would depend; that it was his anxious wish to make every inhabitant in the house, as comfortable as possible; and that he sincerely hoped the patient's conduct would render it unnecessary for him to have recourse to coercion."[96] Immediately, the Retreat placed responsibility on its patients—it was up to the patients to restrain themselves, or else they would be forced to comply.

Responsibility was a key component of Tuke's moral treatment. Tuke, for instance, recorded that attendants, who were always suspected as potential abusers of the patients, were reminded that restraint was only used when necessary to keep the patients themselves safe and that the patients were "really under the influence of a disease, which deprives [them] of responsibility."[97] So, Tuke seemed to absolve patients of responsibility for their actions. Yet, their moral treatment was predicated on assisting patients in accomplishing their own cure. Most broadly, a key component was to assist

95. Tuke, *Description of the Retreat*, 93.
96. Tuke, *Description of the Retreat*, 93.
97. Tuke, *Description of the Retreat*, 110.

"the power of the patient to control the disorder."[98] Though they required assistance, the implication was that patients must come to control their disorder themselves.

Tuke illustrated this point by recounting the recovery of a man (not a patient at the Retreat) who chose to strengthen his mind by studying mathematics. This recitation demonstrated the critical role of the patient's responsibility for recovery. This man "perceived by the faint glimmerings of remaining reason, the still worse state to which he must be reduced … he resolved to exert the power which he still possessed to control his unhappy dispositions. For this purpose, he determined, immediately to apply himself to mathematics."[99] The man's own determination to control his actions and direct his attention started him along the path to recovery. Tuke continued that the man's "first attempt to go through the easiest problem, cost him indescribable labour and pain. But he persisted in the endeavor … and very shortly recovered the use of his faculties and his former temper of mind."[100] Full recovery required persistent self-control. Tuke admitted that "few persons … would have had the courage to form such resolutions; and still fewer, the fortitude to perform them."[101] The Retreat aimed simply to foster such pursuits of self-mastery.

Notice also, that this man was aware of his condition and acted purposefully to diminish it by directing his attention to an intellectual pursuit. Tuke held that while patients may not always be aware that their conduct is irrational "they are generally aware of those particulars, for which the world considers them proper objects of

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98. Tuke, *Description of the Retreat*, 88.
99. Tuke, *Description of the Retreat*, 116.
100. Tuke, *Description of the Retreat*, 116.
101. Tuke, *Description of the Retreat*, 116.

confinement."[102] So, patients were aware of their disorder in some sense—or at least the abnormality of their conduct—and were expected to gain control over it.

Returning to the Herculean man, the patient understood his assignment and his circumstances. "The maniac," Tuke reported, "was sensible of the kindness of his treatment. He promised to restrain himself, and he so completely succeeded that during his stay, no coercive means were ever employed toward him."[103] That did not mean, however, that the patient immediately gained full self-mastery. "The patient was frequently very vociferous, and threatened his attendants, who in their defence were very desirous of restraining him by the jacket."[104]

The remedy to these episodes lay entirely in personal attention and was predicated on the close relationship established between those offering the moral treatment and those receiving it. During such episodes, Tuke claimed, "The superintendent … went to his apartment; and though the first sight of him seemed rather to increase the patient's irritation, yet after sitting sometime quietly beside him, the violent excitement subsided, and he would listen with attention to the persuasions and arguments of his friendly visiter."[105] By appealing with argument to the patient, the superintendent succeeded in persuading the patient to control himself. The superintendent made the appeal directly. He administered no medications. He employed no restraints. Four months passed in this way until the patient fully recovered.[106]

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102. Tuke, *Description of the Retreat*, 89.
103. Tuke, *Description of the Retreat*, 93.
104. Tuke, *Description of the Retreat*, 93.
105. Tuke, *Description of the Retreat*, 93-4.
106. Tuke, *Description of the Retreat*, 93-4.

The apparent simplicity of this method underscored the barbarity of the prevailing methods of public and private asylums. The Retreat used restraints when necessary, but no chains. Straight-waistcoats were the most restrictive tools of individual confinement. More often, attendants used bands fastened around the waist, tied to cords attached at the wrist to restrain patients. This device restricted the movement of the arms just enough to protect against violence. For patients that required restraint at night, the superintendent employed two strong straps of linen that fastened to the bedstead. Each strap had cuffs for the arms and legs. The patient lay on top of the straps and was bound by the cuffs. This system allowed the patient to adjust positions in the night, but not to get out of bed or have free use of their limbs. But at anytime, so Tuke reports—and again, his report was what others took as a model—the Retreat never had more than a few patients restrained.[107]

Restraint, Tuke argued, was only to be used in lieu of self-restraint when the latter utterly failed. Tuke held that restraint generally "retard[ed] the cure, by opposing the influence of the moral remedies employed" and consequently was only used as a "necessary evil."[108] Even still, the staff used them with consideration to their "effect on the mind of the insane."[109] As such, the Retreat avoided restraints both because of their direct negative impact on the mind and because they precluded the liberty necessary to engage in training in self-restraint.

Tuke postulated four primary considerations in the matter of self-restraint: the principle of fear, the desire of esteem, religion, and comfort. With the principle of fear,

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107. Tuke, *Description of the Retreat*, 105.
108. Tuke, *Description of the Retreat*, 105.
109. Tuke, *Description of the Retreat*, 103.

Tuke made a clear distinction. He harangued the old asylums for their brutality. He noted that they relied on fear so heavily that they could, in fact, compel patients to obey. But this obedience was like "the readiness with which the savage tiger obeys his master," and was "the result of treatment at which humanity would shudder."[110]

Tuke thought that fear was essential in the moral treatment of the insane because patients needed to fear the disapproval and punishment from the staff. But neither chains nor violence were ever used as punishments—lighter restraints, seclusion in the bedroom, and simple reprimands were the most often employed punishments at the Retreat. As such, Tuke did not accept the apology made on behalf of asylums that used beatings, chains, violent baths, or any more extreme contrivances as tools of the principle of fear.[111]

He recounted, for instance, an occasion on which a new attendant at the Retreat, seeing a patient in an airing court up on the sill of a first-story window of the house, physically forced the patient to the ground. The patient attacked the attendant. After this altercation, the patient always behaved more violently. Tuke intended this episode to demonstrate that harsh treatment—practiced at conventional asylums with the belief that harsh treatment excited the fear of the patients and, thereby, taught them to control their fits—made maniacal patients worse, not better.[112]

The counter-example of the moral treatment's approach to such occasions of violent outbursts came in an anecdote about a patient walking in one of the fields next to the Retreat in the company of the superintendent. The patient picked up a nearby stone

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110. Tuke, *Description of the Retreat*, 94.
111. Tuke, *Description of the Retreat*, 94-5.
112. Tuke, *Description of the Retreat*, 92.

and made as if to throw it in attack. The superintendent calmly but firmly ordered the patient to lay down the stone, which the patient did.[113] The patient's momentary violent inclination served as an opportunity. Instead of endeavoring to force the patient to submit through violence—or constantly preempting such violence by regularly keeping this patient restrained—the superintendent instructed the patient to exercise self-restraint.

Fear was only useful when employed at the level necessary in legal or—much more aptly according to Tuke—family regulations. Tuke likened the management of an asylum to Locke's views on education. Patients needed to be restrained from mischief, compelled to conduct themselves appropriately, but also allowed liberty in their actions. Fear might be necessary for the former concerns, but the latter was critical. The purpose of moral treatment was to teach patients to control themselves, not simply to exercise control over them.[114]

Despite writing of the asylum family, using the fatherly regulation of the family as a reference point, recounting the filial attachments of patients to the superintendent, and commenting on the apt comparison of Locke's views on the education of children, Tuke claimed that patients were sensible of when they were mistreated like children. He warned that patients ought never to be treated as children because they found such treatment offensive. He implied that Retreat patients were never infantilized in this way. Tuke's model of treatment also, of course, aimed to assist patients in keeping to high behavioral standards. Moreover, disrespectful infantilizing undermined the most

113. Tuke, *Description of the Retreat*, 108-9.
114. Tuke, *Description of the Retreat*, 90, 95.

important tool of moral treatment in assisting patients to exercise self-restraint, the principle of esteem.[115]

The principle of esteem enjoyed much wider application at the Retreat. A melancholic patient once traveled with a friend over two hundred miles by foot to seek the treatment of the Retreat. The superintendent noted the apparent positive effects of the fresh air, physical activity, and change of scenery. He inquired as to the previous occupation of the patient. Learning that the new patient had been a gardener, the superintendent took him to the garden and spoke to him about the particulars of his trade. The superintendent often found it advisable to speak with patients on matters in which they possessed good knowledge as well as to set the patient to filling their time with activities in which they held skill. The staff brought well-educated patients to show their knowledge on various subjects of learning. Other patients might have skill in manual labor.[116]

The gardener, for instance, felt intelligent when consulted on the state of the Retreat's gardens. The superintendent put the patient under the direction of the Retreat's gardener as an assistant. The patient could then feel useful by plying his trade for the benefit of others. This sense of intelligence and usefulness gave the patient cause for self-esteem. The critical point here was that the principle of esteem only could be brought to bear where the superintendent or attendants took the time to learn about the particular knowledge and skills of their patients.[117]

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115. Tuke, *Description of the Retreat*, 101, 111.
116. Tuke, *Description of the Retreat*, 96-8, 100-1.
117. Tuke, *Description of the Retreat*, 96-8.

The Retreat brought the principle of esteem into action by having patients perform regular duties of domestic labor. Female patients, for instance, sewed, knitted, and performed household chores. Labor accustomed patients to conducting themselves in an orderly way. The Retreat staff treated patients in as ordinary and respectful a way as the patients' behavior permitted. Having achieved esteem and respect, Tuke found, patients worked even harder not to lose those sources of pride.[118]

The principle of esteem, therefore, assisted the patient in "strengthening his mind, and conducing to a salutary habit of self-restraint; an object which experience points out as of the greatest importance, in the cure of insanity by moral means."[119] The principle of esteem also acted reciprocally. Tuke thought it essential that the asylum staff gain the esteem and confidence of the patients in order for moral treatment to succeed.[120]

The influence of religion also assisted patients in practicing self-restraint. Tuke thought that where religious principles had been "strongly imbued in early life, they become little less than principles of our nature; and their restraining power is frequently felt, even under the delirious excitement of insanity."[121] Most of the Retreat's patients and employees in the first half of the nineteenth century were Quakers. Many patients, therefore, traveled with asylum staff to meetings of their coreligionists in York. On Sunday afternoons, the superintendent regularly read Bible verses. Tuke observed that patients generally succeeded in restraining themselves during such religious observances.

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118. Tuke, *Description of the Retreat*, 100-1.
119. Tuke, *Description of the Retreat*, 100.
120. Tuke, *Description of the Retreat*, 102-3.
121. Tuke, *Description of the Retreat*, 101-2.

As with the principles of fear and esteem, Tuke saw the employment of religious sentiment as a curative tool within the larger moral treatment.[122]

Tuke argued that all matters that increased the comfort of the patients assisted them in exercising self-restraint by reducing the irritation of their minds and providing a set of privileges that they would not want to lose as a punishment for misbehavior. Tuke named comfort, in consequence, a curative tool of moral treatment just like fear, esteem, and religion.[123]

Comforts included the occasional tea parties, hosted by the female superintendent. The staff expected patients to dress neatly and converse politely. These parties also afforded opportunities for the patients to conduct themselves in more organized social settings. Similarly, the superintendent sometimes approved of patients traveling to York to visit fellow Quakers. The Committee governing the Retreat appointed female visitors to travel to the Retreat to speak with female patients and propose improvements to the benefit of the patients. The superintendent permitted convalescent patients more liberty and allowed them to stay up with the staff past the general patient bedtime of eight o'clock.[124] In order to reduce the negative effects of ennui, the Retreat permitted patients to read and write as well as draw and play games. The Retreat provided books, though not stories to incite overactive imaginations. Mathematics and natural history seemed the most salutary.[125]

Tuke noted that amusements must be tailored to the particular needs of the patients. Writing, for instance, provided the means to record incorrect notions and was,

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122. Tuke, *Description of the Retreat*, 102.
123. Tuke, *Description of the Retreat*, 111.
124. Tuke, *Description of the Retreat*, 111-12.
125. Tuke, *Description of the Retreat*, 114-15.

therefore, counterproductive for patients obsessed with hallucinations. More active pursuits assisted the melancholy, while less stimulating pastimes benefitted the maniacal.[126] Again, Tuke's model of moral treatment insisted on tailoring the regimen of each patient to their own particular needs.

Tuke recommended a program tailored to each individual patient that employed restraint only in the greatest need so that the staff could engage personally with the patients at liberty and bring fear, esteem, religion, and comfort to bear in order to induce the patients to restrain themselves. Tuke allowed for his system to be improved upon stating that the Retreat's progress in moral treatment "has only served to convince them how much more may probably be effected" by it.[127] Contemporary and future asylum superintendents took it upon themselves to extend this model of moral treatment. Evolutions of this model of moral treatment as practiced at two county asylums—the West Riding Pauper Lunatic Asylum at Wakefield and the Middlesex County Lunatic Asylum at Hanwell—constitute the subjects of the two following chapters.

126. Tuke, *Description of the Retreat*, 113.
127. Tuke, *Description of the Retreat*, 116.

Chapter 2

Treatment and Scale:

The West Riding Pauper Lunatic Asylum at Wakefield, 1816-1845

In 1844, Charles Caesar Corsellis, who had served as the director for the West Riding Pauper Lunatic Asylum at Wakefield (hereafter called, "Wakefield") since 1831, lauded the importance of asylums, which in his view were "receptacles into which society pours off its refuse ingredients."[128] He continued by observing that "too much importance [cannot] be given to the discreet regulation of an establishment, in which so great a mass of perversion is brought together."[129] Corsellis's pessimistic 1844 description marked a significant shift in the attitude of Wakefield's management, which had once viewed its facility as the cutting-edge in asylum architecture and curative treatment for insanity.

Wakefield's system of operation changed drastically during the period from its opening in 1818 to the passage of national insane asylum regulations in 1845. Wakefield opened in 1818 on the orders of the West Riding of Yorkshire Magistrates who believed that moral treatment promised a future of asylums with higher cure-rates. By 1845,

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128. C. C. Corsellis, *The Twenty-Fifth Report of the Director of the West-Riding of York Pauper Lunatic Asylum* (Wakefield: Rowland Hurst, 1844), 6; found in WLM28.BE5W53 1831-1850, Wellcome Library, London.
129. Corsellis, *The Twenty-Fifth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 6.

however, its administrators had begun to see the asylum as a place the insane were kept in long-term custody, not a place where the insane were regularly cured. When this shift in attitude occurred, the nature and significance of treatment plans at Wakefield also shifted.

The moral treatment of the insane—popularized in Britain by its reported success as a more effective method of curing insanity at the Quaker asylum in Yorkshire, the Retreat at York—initially constituted a system of treatment that relied on training in self-restraint in order to restore patients to a state of social normalcy. Moral treatment began as Wakefield's main proactive therapy and the primary reason that its administrators saw cause to hope for high cure-rates. By 1845, however, moral treatment had become a passive tool of custodianship. It still justified and organized the systems of management for the administrators, employees, patients, buildings, and grounds of the asylum. Physicians at Wakefield, however, now applied the moral treatment only as a proactive therapy for convalescent patients. Examining this shift in the meaning of moral treatment at Wakefield alters larger scholarly conceptions of moral treatment as a practice overall that have portrayed it as an early form of psychological therapy.

Wakefield serves as an ideal case study for the evolving meaning of moral treatment in nineteenth-century Britain because its designers went to great efforts to replicate the Retreat's style of moral treatment, which they intended to be the asylum's central form of curative therapy. The Magistracy employed Samuel Tuke (1784-1857)—the chief popularizer of the moral treatment in Britain and grandson of the founder of the Retreat—as a consultant and hired the same architectural firm that designed the Retreat to build the asylum at Wakefield. The Retreat, however, always existed as a small, primarily

Quaker institution. The moral treatment soon shifted to a model of custodianship when it was moved to a larger, county institution. It is in the history of institutions like Wakefield, therefore, that the broader history of the moral treatment's influence on the Victorian medical profession and the emerging discipline of psychology must be analyzed.[130] The model of moral treatment at Wakefield shifted from one of optimistic, curative treatment to one of passive, pessimistic custodianship.

Planning

The planning of Wakefield emerged out of a public debate between 1813 and 1816 over how lunatic asylums ought to operate. In 1813, controversies surrounding the conditions at the York Lunatic Asylum—a public asylum funded by charity and fees—stoked efforts to implement the national regulation of asylums. Local notables, particularly magistrates from the West Riding of Yorkshire, worked with Samuel Tuke to present the moral treatment as an alternative to the system of custodianship that pervaded most asylums.[131] This support of Tuke represented an endorsement of the model of treatment pursued at the Retreat and a condemnation of asylums that viewed the insane as incurable, insensitive, less-than-human inmates who needed only to be kept in custody. The Retreat's model of treatment—as the reformist Magistrates saw it—represented the

130. See Barry Edginton, "A Space for Moral Management: The York Retreat's Influence on Asylum Design," in *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context*, eds. Leslie Topp, James E. Moran, and Jonathan Andrews (New York: Routledge, 2007), 94-6, 100; and Leonard Smith, "The Architecture of Confinement: Urban Public Asylums in England: 1750-1820," in Topp, Moran, and Andrews, *Madness, Architecture and the Built Environment*, 50. Both Edginton and Smith examined the influences the Retreat had on asylum design with particular mention of Wakefield. Neither devoted much attention to the impact those spaces had on the moral treatment itself.
131. Scull, *The Most Solitary of Afflictions*, 100-14.

one cause for hope that meaningful reform could improve the lives of patients and their chances of recovery.

The West Riding Magistrates set as their immediate goal the reform of existing institutions to a mode of operation closer to that of the Retreat. National reform efforts repeatedly failed (until 1845), but the West Riding Magistrates had already decided to improve the care for the pauper lunatics in their own jurisdiction. They drew up an advertisement that called for architects to submit plans for a new asylum in 1815.

Samuel Tuke wrote *Practical Hints on the Construction and Economy of Pauper Lunatic Asylums* (1815) at the request of the Magistrates in order to provide additional instructions to the architects. The advertisement, and Tuke's *Practical Hints*, called for something very much like the Retreat, but significantly larger. They wanted space for equal numbers of men and women up to a total of about one hundred and fifty patients, but built with the expectation of future expansion. The asylum would include twelve dayrooms, which would double as dining rooms, and eight courts for outdoor exercise, which were meant to overlook the better view to the south with limited obstruction. They allotted nearly a bedroom per patient, twelve of which were to be soundproofed but not separated from the main accommodations. The bedrooms, dayrooms, and courts were to be arranged in contiguous, gender segregated clusters to allow for the easy classification and movement of different kinds of patients. The Magistrates also asked the competing architects to provide for a workroom where thirty or so looms could be placed for weaving to occupy the patients. Wakefield also required rooms for the staff, two sickrooms, a chapel, an apothecary's shop, a laundry, a brew house, a bake house,

kitchens, and privies.[132] The Magistrates sought an asylum that could function with a certain degree of self-sufficiency. They were also very clear that the spaces must always facilitate easy supervision of the patients and "as great a degree of cheerfulness as is compatible with the requisite degree of security."[133] The Magistrates, in short, wanted a new Retreat on a grander scale.

Samuel Tuke did not design the Retreat and thought that its design could be improved.[134] Wakefield, therefore, offered Tuke a chance to influence the design of an asylum by offering his *Practical Hints* as instructions. The Magistrates received forty design submissions. After deliberation, the Magistrates settled on the design proposed by the same firm that had designed the Retreat, the York-based firm Watson and Pritchett. The new asylum built at Wakefield represented the Magistracy's decision to do for their community what they had hoped reform would do across the nation, offer Retreat-style moral treatment to more patients.

Having selected their chosen design, the Magistracy pressed forward to construction. Watson and Pritchett made only a few changes to their plan as submitted for consideration. They originally submitted plans for a two-story building with one central hall running east and west that terminated on both ends in towers. Wings extended from the towers running north and south as well as further east and further west—forming a

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132. James Birch Sharpe, ed., *Report Together with Minutes of Evidence, and an Appendix of Papers, from the Committee Appointed to Consider of Provisions Being Made for the Better Regulation of Madhouses in England (Ordered by the House of Commons to be Printed 11th July, 1815): Each Subject of Evidence Arranged Under its Distinct Head* (London: Baldwin, Cradock, and Joy, 1815), 361-2.
133. *Report Together with Minutes of Evidence 1815*, 362.
134. Tuke, *Description of the Retreat*, x.

double-cross design.[135] The Magistrates preferred to begin with an H-block design and add on further wings as need required. Tuke, in his *Practical Hints*, had recommended both the double-cross and H-block designs as practical ways to accomplish gender segregation, the first listed among his first principles of asylum design.[136] Wakefield enforced strict gender segregation, including among the staff.

Additionally, a declivity in the selected land required the architects to amend their original design to a three-story building. This change meant that some classes of patients slept in bedrooms off of galleries that were not contiguous with their designated dayrooms. The Magistrates decided that convalescent patients could handle walking through the gallery of another class to their dayrooms and that the system of classification would not suffer excessively. While these changes were significant, the final design still fit best with Tuke's recommendations. With the design agreed upon, workmen from Wakefield began construction in February of 1816.[137]

Classification and Supervision

The broadest level of spatial organization for Wakefield regarded its physical placement in the countryside, near to a town of moderate size. The asylum sat roughly in the center of twenty-five acres of land, about a mile northeast of the town of Wakefield. It was close enough to markets to provision itself easily, but far enough away from

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135. Watson and Pritchett, *Plans, Elevations, Sections, and Description of the Pauper Lunatic Asylum, Lately Erected at Wakefield, for the West-Riding of Yorkshire; to which is added, a New and Enlarged Edition of Mr. Samuel Tuke's Practical Hints on the Construction and Economy of Pauper Lunatic Asylums* (York: W. Alexander, 1819), IX.
136. Samuel Tuke, *Practical Hints on the Construction and Economy of Pauper Lunatic Asylums* (York: William Alexander, 1815), 11, 47.
137. Watson and Pritchett, *Plans, Elevations, Sections, and Description of the Pauper Lunatic Asylum, Lately Erected at Wakefield*, 2.

residents to offer patients privacy and seclusion. Its walls encompassed nearly seven acres of land, which were divided into fields, gardens, airing courts, and a courtyard. Hedges lay out beyond the walls, providing Wakefield a further degree of privacy from passersby.[138]

The final design of Wakefield afforded classification, gender segregation, and supervision in a three-story, H-block plan. The central hall ran east and west, terminating in two towers on either end. Wings extended from those towers north and south. The male patients, staff, and director all stayed in the east-wing, with all of the female patients, staff, and matron in the west. The towers, which were built around spiral staircases intended for use by staff only, also housed the dayrooms, workrooms, kitchens, and laundries. Each class of patients, of which there were twelve—six female, and six male, both ranked from convalescent to hopelessly incurable—in all, had its own gallery that contained its bedrooms, its own dayroom, and its own airing court. With the exception of the workrooms and special events, patients had no cause to interact with patients from any other class.

Classification was a tool of supervision. The magistrates modeled Wakefield on the Retreat's version of moral treatment, which required similar architectural considerations. The importance of environmental design to the moral treatment makes the Retreat's own architecture worth investigating. Having determined to found the Retreat, William Tuke employed John Bevans of the firm Watson and Pritchett to design a

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138. Watson and Pritchett, *Plans, Elevations, Sections, and Description of the Pauper Lunatic Asylum, Lately Erected at Wakefield*, II.

building that could accommodate the Tukes' desired treatment plan.[139] The classification of patients allowed for effective supervision.

The Tukes had the Retreat built to allow for strict gender segregation, the first layer of classification. Two wings extended from the central hall of the Retreat. The west wing housed the women, and the east the men.[140] The Tukes classified their charges in a rough sense by the amount of trouble they posed—a method that Wakefield effectively copied. Two groups per sex at the Retreat each had their own designated bedrooms, galleries, dayrooms, and courts. All of those spaces, for each separate group, were contiguous so that a charge never had to pass through some area designated to another class. That architectural arrangement also made matters simpler for attendants, who were also designated a particular class to supervise.[141] This arrangement made the matter of constant supervision rather simple. The attendants patrolled their designated areas constantly while the superintendent roamed from space to space to offer charges individual attention. The design and management of the Retreat facilitated systems of classification and movement that allowed for the constant supervision of charges by attendants, which was necessary for their version of the moral treatment.

Watson and Pritchett built Wakefield in such a way as to allow attendants to easily watch the patients almost constantly so that behavior could be rewarded or punished. The architects argued that they improved upon the model of classification that Tuke provided in his *Practical Hints*, which recommended only three groups of patients

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139. A. Digby, "Moral Treatment at the Retreat, 1796-1846," in *The Anatomy of Madness: Essays in the History of Psychiatry*, eds. W. F. Bynum, Roy Porter, and Michael Shepard (New York: Tavistock Publications, 1985), 2: 54-5.
140. Peter Atkinson, *Plans and Drawings of the Proposed Retreat* [ca. 1794]; found in RET/2/1/1/1, The Retreat Archive, Borthwick Institute for Archives, University of York.
141. Tuke, *Practical Hints on the Construction and Economy of Pauper Lunatic Asylums*, 18-19, 30.

per sex as opposed to Wakefield's six.[142] Classification and strict management of movement allowed the staff to easily observe the activities of the asylum and, thereby, direct the treatment of patients.

A space in which asylum staff could easily observe all activity was necessary in order for the administrator to direct moral treatment. William Charles Ellis, who took his M.D. at the University of St. Andrews, had openly criticized the roles that his fellow physicians played in asylums during the push for national reform.[143] Ellis worked as a physician at the Sculcoates Refuge, a private asylum at Hull that styled itself and its treatments explicitly on the Tukes' method. Ellis's decision to side with reform advocates against his professional brethren earned him the attention of the Tukes and the West Riding of Yorkshire Magistracy.[144]

The West Riding Magistracy selected Ellis to serve as the director of Wakefield. He was the first physician to be appointed as director of a county asylum in Britain.[145] At Wakefield, Ellis did not simply copy the treatment of the Tukes. Rather, he rationalized and assimilated it into a medical model of moral treatment. The choice of Ellis as director, however, marked a digression from the Retreat's non-medical model.

Ellis contended that insanity was a disease of the brain or nervous system. In order to treat it, a physician must identify its causes and eliminate or counteract them. He recognized two types of causes for insanity—physical and moral. He used contemporary

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142. Watson and Pritchett, *Plans, Elevations, Sections, and Description of the Pauper Lunatic Asylum, Lately Erected at Wakefield*, 1-2.
143. William Charles Ellis, *A Letter to Thomas Thomson, Esq. M.P: Containing Considerations on the Necessity of Proper Places Being Provided by the Legislature for the Reception of All Insane Persons and on Some of the Abuses Which Have Been Found to Exist in Madhouses with a Plan to Remedy Them* (Hull: Topping and Dawson, 1815), 7.
144. Scull, *The Most Solitary of Afflictions*, 197-200.
145. Leonard D. Smith, "Ellis, Sir William Charles (1780-1839)," *ODNB*.

medical knowledge to explain insanity from physical causes. Physical agents, like tumors or fevers, impacted the proper function of the brain. In such cases, the physician should simply employ the conventional medical treatments, such as pharmaceuticals. Moral treatment proved useless in impacting a mind disturbed by physical causes.[146]

Ellis thought that the treatment of insanity by moral causes was more complicated. He argued that exciting events, bad habits, and emotional conditions caused over-excitement in the brain. Over-excitement caused excessive blood-flow to the brain, which altered the correct function of the brain and, consequently, the mind.[147] As such, Ellis's explanation of insanity by moral causes also rooted the problem in physiology.

Moral treatment, for Ellis, consisted of removing the moral causes of insanity—the exciting circumstances—and encouraging healthier mental habits that increased future resistance to excitement. Ellis thought moral treatment only practicable after some medical treatments had reduced the initial pressure of excessive blood-flow to the brain.

Ellis, for instance, treated a patient at Wakefield—a woman who had gone insane from the moral cause of witnessing her child go lame—by shaving her head and by applying leeches to her temples, cold wraps to her head, and hot wraps to her feet. All of those measures were aimed at reducing heat and excessive blood-flow to the head. Similarly, Ellis treated H. S., a patient at Wakefield, by creating a blister on the neck and placing leeches on the temples.[148] Ellis's medical stopgaps, again, were meant to reduce blood-flow to the brain. Ellis thought these stopgaps to be necessary but not sufficient

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146. W. C. Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity, with Practical Observations on Lunatic Asylums, and a Description of the Pauper Lunatic Asylum for the County of Middlesex, at Hanwell, with a Detailed Account of its Management* (London: Samuel Holdsworth, 1838), 25, 151.
147. Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*, 6, 101, 166.
148. Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*, 93, 107-8, 187.

treatments for patients insane by moral causes. They were not sufficient because the root moral cause would continue to create over-stimulation in the brain until that cause was removed. After the medical stopgap, the physician needed to identify the root moral cause of the insanity. Then, he could tailor a program to remove that moral cause.

Ellis's system also allowed him to explain the efficacy of the Retreat's methods in medical terms. Insanity caused by unhealthy mental action could be solved by healthy mental action. Patients simply needed to avoid over-stimulation of their brains, which caused physical damage. Ellis recognized, however, a wide variety of moral causes of insanity. In order to conduct effective moral treatment, the physician had to identify the specific moral cause in a case. Ellis, therefore, advocated for a model of moral treatment based on individual attention.

In many cases, Ellis found that simply removing patients from the stresses of their daily lives served to remove moral causes of insanity. Ellis thought that patient J. C., who was treated at Wakefield, benefitted from the application of cold wraps to the head and hot wraps to the extremities, but recovered primarily due to his removal from the harsh conditions of poverty. The conditions of poverty affected this patient directly, by causing over-exertion, and indirectly because he also, according to Ellis, witnessed his family's suffering. While immoral or immoderate habits, which Ellis associated with the working class, constituted many of the moral causes of insanity that he described, the simple lack of food and resources could also cause insanity. Ellis described a weaver admitted to Wakefield, for example, who suffered from insanity because of the stresses of poverty despite sober habits and good character.[149] Wakefield relieved these common moral

149. Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*, 64-6.

causes of insanity, such as hunger and exhaustion, simply by providing a sufficient diet and moderating the amount of strenuous labor patients engaged in.

In practice, Ellis's moral treatments at Wakefield fit patterns—standard physical occupations, for instance. Patients suffering from insanity caused by moral means, Ellis thought, needed to be distracted from their over-exciting thoughts by constant occupation. Patients at Wakefield, during Ellis's time as director, all engaged in some type of manual occupation such as gardening, carpentry, or weaving. These tasks, Ellis said, not only distracted the mind from whatever thoughts previously excited it, but also drew blood away from the brain and to the muscles.[150] Nevertheless, the use of a set of standard occupations for all patients shifted Wakefield's model of moral treatment closer to a one-size-fits-all model that required less personal attention.

Ellis still thought it important, despite the use of standard treatments, for the physician to acquaint himself with each patient. "Tastes and habits," Ellis stated, constituted the "lever . . . by which the moral man can be moved."[151] For a physician to truly understand how to improve the mind of a patient, he must know how circumstances affected that patient and to what state of mental normalcy the patient ought to return. Despite this view, moral treatment increasingly lost the ingredient of personal attention because by the time Ellis left in 1831 to take up a post at the Middlesex Lunatic Asylum at Hanwell the number of patients at Wakefield had risen from 150 to 270.

Despite the magistracy's selection of Ellis, who agreed with the Tukes that moral treatment required extensive personal interaction between those offering the treatment and those receiving it, they also realized that managing a large number of patients on a

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150. Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*, 193, 198, 201.
151. Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*, 194.

limited budget required permanent, passive tools of management. At the Retreat, the system of classification served as the main aid to supervision. The Retreat's attendants simply had to monitor all of their designated areas diligently. Wakefield facilitated not only actual supervision, but also the constant expectation of supervision. Wakefield built supervision into the walls. Watson and Pritchett designed the spiral staircases in the towers to serve also as a series of observation platforms. The towers contained the dayrooms and workrooms as well as doors to the galleries. Watson and Pritchett placed windows high on the interior sides of the common rooms as well as above the doors to the galleries. While walking up or down the staircases, at a point about half way between one floor and the next, staff could look down both wings into the galleries as well as into all of the dayrooms and workrooms. Through the day room exterior windows, they could also see into the airing courts.[152]

This system was not a perfect panopticon. There were six observation platforms throughout the building, they offered no view into the bedrooms, and patients could place themselves so as not to be observed. Nevertheless, staff could view large portions of the daytime common areas from these points. Patients, who could see staff through the windows just as easily as they could be seen, never knew when some attendant might walk up or down the stairs and observe the common rooms. As such, the expectation of supervision was built into the walls at Wakefield. This built-in expectation shifted the supervision and engagement necessary for the Retreat's moral treatment to a more passive model.

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152. Watson and Pritchett, *Plans, Elevations, Sections, and Description of the Pauper Lunatic Asylum, Lately Erected at Wakefield*, VII.

The West Riding Magistracy—in their review of submitted plans for Wakefield—rejected panopticons. James Bevans, a London-based architect (not to be confused with John Bevans of the York-based Watson and Pritchett), offered a response to the Wakefield advertisement. He took the request for easy inspection to an extreme. He offered a plan for a panopticon-like structure. He planned for the bedrooms, dayrooms, and galleries to be all on one floor overlooked by the elevated rooms of the governor and matron, each for their respective side. The elevated rooms were not observable from any other part of the asylum. Bevans asserted that this provided for perfect supervision.[153] Bevans, though respected in London and consulted by the House of Commons Select Committee on Madhouses on matters of asylum design, did not receive the contract for Wakefield.

In his *Practical Hints*, Samuel Tuke derided panopticon designs.[154] The moral treatment required supervision, but not at the expense of common decency. The Tukes' theory stated that charges needed to be retrained to operate in a normal environment, not a special prison.

Wakefield's inclusion of the observation platforms thus marked a digression from the Retreat's system. Samuel Tuke thought that the model of moral treatment practiced at the Retreat gave patients the best chance for recovery.[155] The space of the Retreat facilitated that treatment model. Nevertheless, the Tuke's moral treatment relied heavily on the presence of the attendants and the administrator. The space and management systems supported a treatment that required copious amounts of personal attention, which

153. *Report Together with Minutes of Evidence 1815*, 363-5.
154. Tuke, *Practical Hints on the Construction and Economy of Pauper Lunatic Asylums*, 33.
155. Tuke, *Description of the Retreat*, 216-17.

the Retreat staff supplied to its always-small number of patients.[156] Wakefield, with its larger number of patients and higher patient to attendant ratio, attempted to achieve supervision by building the expectation of supervision into the walls. That system of expected supervision served to maintain order, but it was not a substitute for personal attention. Tuke, ultimately, criticized that approach because it ran contrary to the principle of personal attention necessary for moral treatment.

Comfort

Watson and Pritchett also accounted for comfort. Each class of patients had its own airing court. They arranged the airing courts for the most convalescent patients—who were defined as convalescent because of good behavior—as large, level gardens. They were fenced in with iron railing so as to allow a view of the wider countryside. The architects considered security more important for other classes of patients. The more troublesome classes of patients had access to airing courts that were walled in with ten-foot-high walls. The land, however, was elevated in the center of the yard and sloped down to meet the walls.[157] Consequently, patients could see the countryside by standing nearer the center of the yard, but remained more secure within solid walls.

The Tukes also considered comfort during construction. The south face of the building opened up on five distinct airing-courts meant to allow the charges fresh air and exercise.[158] While the courts were partitioned, they built the wall at the perimeter of the

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156. Digby, *Madness, Morality and Medicine*, 50-4.
157. Watson and Pritchett, *Plans, Elevations, Sections, and Description of the Pauper Lunatic Asylum, Lately Erected at Wakefield*, II.
158. Watson, Pritchett, and Watson, *General Plan of the Retreat and Its Estate 1828*; found in RET/2/1/5/3, Retreat Archive, Borthwick Institute for Archives, University of York.

grounds at the bottom of a steep slope.[159] That approach ensured that the charges could not wander off of the grounds unsupervised, while also permitting a view of the countryside.

Watson and Pritchett took care that the environment at Wakefield was healthy and comfortable. Heating a building of that size by fireplaces was impractical, though not unheard of. The architects found a way to heat the building throughout at a reasonable cost while also saving the staff time in chores. They contracted the engineer Charles Sylvester to install his new system of stoves and steam engines—driven by coal—which had only been installed in a few buildings, most notably the Derbyshire Infirmary.[160] A system of flues carried hot air to every common room and gallery while steam pipes provided additional heat, drove the washing machines and drying closets, heated the ovens, provided boiling water to the kitchens, and brought hot water to the baths. The flues also provided cool air in the summer. To ensure that the air flowed in the correct direction when not aided by the action of the stoves, they installed turn caps at the entrances of the flue-system in the gardens and their exits in the cupola. The turn caps of the entrance were positioned to catch the wind, while those in the cupola were turned to block the wind. This system was elaborate and, despite long-term savings, represented a considerable initial investment. As such, it demonstrated the importance assigned to the comfort of the patients.

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159. Scull, *The Most Solitary of Afflictions*, 103.
160. Charles Sylvester, *The Philosophy of Domestic Economy; as Exemplified in the Mode of Warming, Ventilating, Washing, Drying, and Cooking, and in Various Arrangements Contributing to the Comfort and Convenience of Domestic Life, Adopted in the Derbyshire General Infirmary and More Recently, on a Greatly Extended Scale at Several Other Public Building, Newly Erected in this Country; Together with an Explanation of the Principles on which They Are Performed* (Nottingham: H. Barnett, 1819), iii-v.

The architects also included glass windows in all of the bedrooms and dayrooms. The windows afforded views and could open to admit air. Iron frames held the panes, but the iron was partially disguised by corresponding wooden sashes attached to the interior.[161] This measure mitigated a prison-like feel and contributed (somewhat) to an illusion of ordinary domesticity.

This desire to lessen the prison-like feel of the asylum and build a comfortable environment derived from Tuke's advice. The Tukes insisted upon glass windows for their bedrooms and dayrooms in the Retreat. Samuel Tuke criticized the construction of other asylums like Bethlem, the famous London asylum, that provided their patients only shuttered windows with iron bars. The bars gave the room the look of a prison. If the shutters were shut to keep out cold weather, then no sunlight could enter the room. Other asylums installed glass windows to permit light, but placed them high as to avoid the patients breaking them. High windows permitted light, but not a view. The Tukes argued that the natural scenes of their surrounding lands and gardens had a positive effect on their charges. Glass windows at the correct height allowed the Retreat's tenants to constantly avail themselves of the views. The architect of the Retreat fit the bedrooms with windows of three by three and a half feet, with the tops of the frames placed at about six feet from the floor.[162] They fit the dayrooms with windows six feet high by three and a half feet wide.[163] Economy was always a consideration and the panes for the windows were eight inches by six and a half and cost only sixpence apiece. Attendants stopped

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161. Watson and Pritchett, *Plans, Elevations, Sections, and Description of the Pauper Lunatic Asylum, Lately Erected at Wakefield*, VII.
162. Tuke, *Practical Hints on the Construction and Economy of Pauper Lunatic Asylums*, 36, 39.
163. Tuke, *Description of the Retreat*, 98-9.

charges who attempted to break the glass before they could cause too much damage.[164] Additionally, the Tukes balanced security with wholesome aesthetics by concealing the iron window frames in wooden sashes. Samuel Tuke thought that these natural scenes and, even better, walks through the grounds had a particularly spiritually uplifting effect.[165] As such, the Tukes justified their aesthetic considerations with their theory of insanity, which sought to reduce mental irritations.

Physicians in the 1820s and 1830s increasingly rationalized such elements of design and co-opted them into medical models of moral treatment. William A. F. Browne, for instance, worked to rationalize the Tukes' popular idea that harsh conditions worsened insanity and wholesome conditions assisted in recovery. Browne studied medicine at the University of Edinburgh and published widely circulated works on asylum management and treatment.[166] In the "were" chapter of his *What Asylums Were, Are and Ought to Be*, he wielded accounts of the old asylums with their excrement-daubed walls, cruel attendants, forced feedings, and pervasive neglect of patients to great effect. He considered all of these abuses, even those that also constituted physical abuses, to belong to a class of "moral abuses" or, in the worst cases "moral torture."[167] The new system of asylum construction and management that he and his colleagues planned out consisted in great degree to minimize the presence of any and all things that constituted moral abuses, which could cause the physical disease of insanity to worsen. He argued that employment, classification, and amusement may all be part of the ideal system, but

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164. Tuke, *Practical Hints on the Construction and Economy of Pauper Lunatic Asylums*, 36.
165. Tuke, *Description of the Retreat*, 94-5, 98-9.
166. Andrew Scull, "Browne, William Alexander Francis (1805-1885)," *ODNB*.
167. William A. F. Browne, *What Asylums Were, Are, and Ought to Be: Being the Substance of Five Lecture Delivered Before the Managers of the Montrose Royal Lunatic Asylum* (1837; repr., New York: Arno Press, 1976), 158-9.

that "every arrangement … from the situation, the architecture and furniture for the buildings intended for the insane to the direct appeals made to the affections … ought to be embraced by an effective system of moral treatment."[168] Patients could never recover in a space that exacerbated their ailments by exposing them to additional stimuli that encouraged damage to the brain. Browne and his colleagues sought to purpose-build asylums to remove as many moral abuses as possible. This medical rationalization occurred after Wakefield was built. Nevertheless, it affected how Wakefield's medical administrators read the space and its purpose.

Wakefield's second administrator, Charles Caesar Corsellis, was also a physician. He viewed Wakefield's management and purpose in ways that increasingly limited the role of active moral treatment and that ultimately led to a model of custodianship. Corsellis's view on matters of the restraint of patients demonstrated this point.

The restraint of patients had been a contentious issue since the controversies between 1813 and 1816 demonstrated how restraint could lead to neglect. John Conolly—who earned the degree of M.D. at the University of Edinburgh and had taught at the University of London's medical school—came to great renown for his complete abandonment of restraints during his tenure as superintendent of the Middlesex County Lunatic Asylum at Hanwell.[169] Conolly argued that restraints were tools of neglect.[170] Even the Tukes employed some restraints when necessary to control violent fits.[171] Conolly's system of complete non-restraint—discussed in greater detail in chapter

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168. Browne, *What Asylums Were, Are, and Ought to Be*, 156.
169. Andrew Scull, "Conolly, John (1794-1866)," *ODNB*.
170. John Conolly, *The Treatment of the Insane without Mechanical Restraints* (London: Smith, Elder and Co., 1856), 323.
171. Tuke, *Description of the Retreat*, 98-9.

three—only survived in full during his short tenure as superintendent at Hanwell (1839-1844). Nevertheless, Conolly's rejection of restraints marked his model of moral treatment as active and earned him and Hanwell good press.[172]

Corsellis did not share Conolly's view on restraints. In 1831, as Ellis was leaving his post, new wings were completed at Wakefield to accommodate the swelling number of patients. Corsellis largely copied, as he stated in his reports to the magistracy, Ellis's system of management.[173] He expressed, however, his pessimism with regard to administering the personal attention that the Tukes and Ellis held as essential elements of moral treatment. By 1844, Corsellis stated that minute observation was not possible in Wakefield—with now up to 433 patients—anymore.[174] He, nevertheless, still acknowledged the role of moral treatment. Now, however, moral treatment meant only occupations, wholesome atmosphere, and discipline accomplished through broad supervision. Wakefield's model of moral treatment had shifted to one of custodianship.

Corsellis's continued use of manacles and chains as restraints reflected this custodial outlook. Though Conolly received nearly unanimous praise both in and out of the medical profession for his abolition of restraints at Hanwell, Corsellis publicly derided non-restraint schemes and insisted that restraint was a necessary, even kind, tool of asylums. Corsellis traded jabs in the medical press over the issue of restraint with Robert Gardiner Hill—who consistently, and justifiably, argued for having pioneered the

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172. Andrew Scull, "A Victorian Alienist: John Conolly, FRCP, DCL (1794-1866)," *The Anatomy of Madness: Essays in the History of Psychiatry*, eds. W. F. Bynum, Roy Porter, and Michael Shepard (New York: Tavistock Publications, 1985), 1: 127-8.
173. C. C. Corsellis, *The Thirteenth Report of the Director of the West-Riding of York Pauper Lunatic Asylum* (Wakefield: Rowland Hurst, 1832), 3-4; found in WLM28.BE5W53 1831-1850, Wellcome Library, London.
174. Corsellis, *The Twenty-Fifth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 5.

system of complete non-restraint adopted by Conolly. Hill won the argument with Corsellis, though he still received little acknowledgement for his personal contributions to the non-restraint system. Physicians, asylum administrators, and Parliamentary reformers lauded Conolly's work with non-restraint at Hanwell.[175]

Non-restraint systems required that attendants keep a constant eye on all patients, and that the administrator keep an eye on all of his attendants (to prevent abuses) and patients. That degree of personal attention and correction of bad behavior through persuasion, as opposed to restraint or violence, forced asylums like Hanwell to administer an active model of moral treatment predicated on retraining and direct appeals to the minds of the patients. Corsellis explicitly argued, in terms of moral treatment, that the use of restraints was preferable to more personal contact. He contended that for non-restraint systems "a very large staff of attendants must be employed, and admitting that an augmented expenditure would be justifiable … it must then be shown that the contention of a lunatic with the attendant is less irritating and prejudicial than the inanimate resistance of a strap or glove."[176] He argued that having attendants personally control violent patients changed the attendant from "[the patient's] friend and guardian into a supposed watchful and suspicious enemy."[177] Corsellis's view on the comfort of patients led him to dismiss the principle of constant personal supervision and persuasion that was foundational to the systems of moral treatment carried out by the Tukes and Conolly. Consequently, Corsellis's insistence on continuing to use and defend harsh restraint at

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175. Leonard D. Smith, *'Cure Comfort and Safe Custody': Public Lunatic Asylums in Early Nineteenth-Century England* (New York: Leicester University Press, 1999), 266-8.
176. C. C. Corsellis, *Twenty-Eighth Report of the Director of the West-Riding of York Pauper Lunatic Asylum* (Wakefield: Rowland Hurst, 1847), 8; found in WLM28.BE5W53 1831-1850, Wellcome Library, London.
177. Corsellis, *Twenty-Eighth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 9.

Wakefield to the detriment of his own professional standing represented Wakefield's regression from a cutting-edge facility modeled on the gentlest and most effective form of active moral treatment to a facility increasingly content with passive models of custodianship.

Wakefield's evolved theory of moral treatment also served to explain why the curative project of asylums appeared to be a hopeless cause by the mid-nineteenth century. Namely, it offered a way to explain insanity through the ability of environmental circumstances to cause physical and mental degeneration. Ellis and Corsellis held that the primary moral cause of insanity was poverty. Harsh and upsetting conditions, or even persistent annoyances like a lack of good sleep, that were common in the lives of working-class people, Ellis and Corsellis contended, caused people to go insane. Comfort, therefore, constituted a central element to Wakefield's therapeutic system.

Ellis sometimes assumed that personal character was to blame when working-class people went insane. He, for instance, described a case in which a woman was driven insane by the grief of having sold her young son to a chimney-sweeper for a guinea. The woman reportedly regretted the decision, but was unable to locate her son ever again. The impact of the intense remorse and grief caused the woman to go insane, a condition from which she never recovered.[178]

Ellis's views on moral causes of insanity did not, however, universally target the working class. He also thought, for instance, that too much education, especially where girls were concerned, over-stimulated the brain and increased susceptibility to insanity.

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178. Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*, 74-5.

Nevertheless, Ellis claimed that poverty was the root cause of insanity for the majority of patients admitted to Wakefield during his tenure.[179]

Corsellis acknowledged a wide variety of moral causes of insanity from religious or political obsessions to the study of astrology.[180] Nevertheless, the most common causes, as Corsellis had them, were forms of distress and irritation stemming from alcohol use and overexertion, which he associated with the pauper patients at Wakefield.[181] Wakefield accepted only legally defined pauper patients (it was legally permitted to accept non-paupers when there were vacancies, but Wakefield never had the space to do so in its first decades of operation). Consequently, Corsellis and Ellis saw only pauper patients—and an ever-increasing number of them—entering Wakefield. The number of paupers for whom applications for entry were submitted, almost from the start, constantly strained the asylum's space and resources. The theory of moral treatment evolved at Wakefield to explain why there seemed to be such a great influx of poor patients. Wakefield's new model of moral treatment explained that poverty and its lack of comfort caused insanity.

New Model of Moral Treatment

Wakefield's theory of moral treatment—despite no longer serving as the sole, proactive, curative treatment as it did at the Retreat even up to 1845—influenced the

179. Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*, 60, 329-30.
180. C. C. Corsellis, *The Twentieth Report of the Director of the West-Riding of York Pauper Lunatic Asylum* (Wakefield: Rowland Hurst, 1838); found in C85/107, West Yorkshire History Centre, Wakefield.
181. C. C. Corsellis, *Twenty-Sixth Report of the Director of the West-Riding of York Pauper Lunatic Asylum* (Wakefield: Rowland Hurst, 1845), 6; found in WLM28.BE5W53 1831-1850, Wellcome Library, London.

daily experiences of the asylum's many employees and patients.[182] Corsellis thought—much like Conolly, Browne, and Ellis—that medical treatments failed to cure insanity from moral causes so long as the sources of moral abuse remained.[183] By 1845, however, Corsellis reported that nearly three-quarters of the patients at Wakefield were confirmed incurables. Only about ten percent of the patients stood a reasonable chance of being cured.[184] He exercised his power as director, therefore, to design the experience of the asylum to make it orderly and somewhat comfortable for its many long-term residents.

Corsellis concerned himself, for instance, with making the patients' diet nourishing so as to provide the requisite energy necessary to survive the exhaustion brought on by mania, but not too stimulating. The resultant diet that patients at Wakefield received during Corsellis's tenure consisted of a breakfast and supper each day of gruel, which some of the female patients helped make. They mixed it in batches of one gallon of milk, two of water, two and three-quarters of a pound of oatmeal, and a quarter of a pound of wheat flour. Each patient received a pint and a half of gruel per meal. Dinner varied between: dumplings with boiled mutton and vegetables on Sundays; "rice currie [sic]" on Saturdays; six ounces of meat apiece on Tuesdays and Thursdays; and soup made from the boiling of meat the day before on Mondays, Wednesdays, and Fridays. All patients could enjoy three-quarters of a pint of beer with dinner. Some of the produce and meat came from the asylum's own farms, which the male patients worked. Female

182. Digby, "Moral Treatment at the Retreat," 2: 56-8.
183. Corsellis, *Twenty-Eighth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 4.
184. Corsellis, *The Twenty-Fifth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 6.

patients assisted in kitchen work under the supervision of staff members.[185] The officers offered luncheons as incentives for labor. Working patients received up to two luncheons a day that consisted of four ounces of bread and three-quarters of a pint of beer. As such, Wakefield's moral treatment, which considered work beneficial to the moral faculties, influenced the diet offered at Wakefield.

Work thus constituted a central facet of Wakefield's moral treatment under Corsellis. He still insisted that work was primarily a curative measure—despite arguing that most of his patients were incurable. Work, he explained, drew excess nervous energy to the muscles and away from the brain.[186] Corsellis, however, used the moral treatment's recommendation to work primarily to justify using patient labor to improve domestic economy.

Corsellis argued that Wakefield employed labor more than recreation as a form of moral treatment because its pauper patients were accustomed to industrious habits (unlike many of the upper- and middle-class patients at asylums like the Retreat) and would feel useless if left to pleasant recreation too often. He also argued that making pauper patients accustomed to too much leisure would only make them more sensitive to the privations of their lives outside of the asylum upon their hoped-for discharge.[187] The primary motivation of domestic economy appeared in Corsellis's complaining that incurable

185. Corsellis, *Twenty-Fifth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 12-13.
186. Corsellis, *Twenty-Fifth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 14-15.
187. C. C. Corsellis, *Thirtieth Report of the Director of the West-Riding of York Pauper Lunatic Asylum* (Wakefield: Rowland Hurst, 1848), 7; found in WLM28.BE5W53 1831-1850, Wellcome Library, London.

patients rendered themselves "pensioners [living] on the bounty of the public."[188] As such, he insisted on the rule that "no labour shall be paid for, which the patients can properly supply themselves."[189]

Male patients gardened, farmed, tended to livestock, hauled coal for the stoves and steam engine, wove linen, and assisted in repair work for the buildings. Female patients engaged in various aspects of domestic work in the kitchens and laundry. They sewed, knitted, and worked as weavers, joiners, and tailors. Female patients made, maintained, and washed the clothes for other patients, which were changed once per week. They also made items for sale. These included not only simple items like thick woolen stockings, but also delicate Shetland shawls, embroidered garments, and dolls dressed in various fashions.[190]

Patients received no pay for their work, but some could derive other benefits. The proceeds from the sale of produce, livestock, and goods went to the Harrison's Fund Charity, which provided temporary relief to discharged patients. The explicit justification for this charity was that, after considerable public investment in their cure, it would be unacceptable to allow discharged patients to relapse because of the stresses of poverty. Local justices typically held the funds for the pauper and dispensed them for essential purchases.[191] The asylum continued to purchase and rent more acres of land in order to provide male patients more outdoor work and extend the benefits of the charity.[192] As

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188. C. C. Corsellis, *Twenty-Ninth Report of the Director of the West-Riding of York Pauper Lunatic Asylum* (Wakefield: Rowland Hurst, 1847), 4; found in WLM28.BE5W53 1831-1850, Wellcome Library, London.
189. Corsellis, *Twenty-Fifth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 15.
190. Corsellis, *Twenty-Sixth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 10.
191. Corsellis, *Twenty-Sixth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 10.
192. Corsellis, *Twenty-Fifth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 17-18.

such, the Harrison's Fund demonstrated how Wakefield's new theory of moral treatment, which postulated that the stresses of poverty were moral abuses and that work was a moral benefit, structured the ways that Wakefield's administrators managed its spaces and the activities and movement of its patients. This impact of moral treatment constituted a significant divergence from the leisurely strolls in the garden that the Retreat's staff recommended.

Most of Wakefield's patients, deemed incurable by Corsellis, never received any funds from the charity, which only assisted patients discharged as cured. Additionally, only some of the patient labor benefitted the charity. A substantial amount of the labor they did only improved the asylum's domestic economy and kept the routine of the asylum orderly.

Corsellis did not replace all recreation with labor. Patients were permitted to spend time in their airing courts for up to three hours in the morning and three in the afternoon, if weather permitted. While in the courts, patients played various outdoor games like quoits, troco, and skittles. Inside, patients played games like German tactics and solitaire or played musical instruments. In the summer, the asylum hosted gender segregated parties on the grounds. At Christmas, the parties were held inside. Attendance to these parties served as an incentive for good behavior throughout the year; consequently, the parties formed tools of moral treatment intended to keep patients in line at all times.[193]

The asylum reform legislation passed in 1845 provided new guidance and regulations for public asylums. Even before 1845, justices elected annually at the

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193. Corsellis, *Twenty-Fifth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 16.

Epiphany Quarter Sessions to oversee Wakefield's operations established the administrative structure and audited the asylum's conduct and accounts. Wakefield's administration during Corsellis's time consisted of five resident officers. The matron and assistant matron directed the staff and managed the female side. The steward ordered, received, and recorded the payments and receipts of all supplies. The medical officer, who had to be a member of a Royal College of Surgeons and licensed by the Apothecaries' Company, mixed all of the pharmaceutical compounds and attended to the daily needs of ill patients along with the visiting physicians and surgeons—who attended every patient once a week.[194]

The director held the formal custody of Wakefield's pauper patients. The Justices gave him full power to direct all aspects of the medical and moral treatment of all patients, on whose care he was obliged to consult once a week with the visiting physicians. The director had to review all applications for admission, correspond with the relevant parish officers in order to take custody of the paupers, and correspond with the asylum's solicitor on the legal standing of the patients. He continued to inform relevant parish officers on the state of patients. On admission, the director examined and classified all patients. He kept records of patients in a medical journal subject to review at annual meetings of the Justices. The director also acted as treasurer, keeping books on all accounts and conducting all banking. He managed all alterations, repairs, and additions to facilities. He composed quarterly reports on the states of the wards, annual reports on the whole institution, and attended Epiphany and Easter Quarter Sessions. He, as principal

194. West Riding Pauper Lunatic Asylum, *Rules, Regulations and Orders, for the Management of the Pauper Lunatic Asylum, for the West-Riding of the County of York* (Wakefield: John Stanfield, 1847), 15-19, 22.

medical officer, had to approve all treatments and order all the necessary drugs and medical instruments. He also had the authority to hire, fire, and instruct all other officers and staff. In addition to these responsibilities, which the Justices forbid Corsellis to delegate, he had to personally visit every patient every day.[195]

Corsellis warned the Justices that the highest feasible limit for such an institution, which he agreed should be under the direction of one man, was three hundred patients. He argued that beyond that limit the personal attention and time of the director was split in too many ways to allow for close observation in each case, which he thought an essential element to medical and moral treatment. When he made this claim in 1844, 433 patients were under his care at Wakefield.[196] Corsellis reduced Wakefield's moral treatment to standard systems aimed primarily at establishing a well-managed institution. With the director's time taken by administrative matters and obligatory visits to incurable patients, Corsellis had little time to spend with curable patients.

The Justices encouraged Corsellis to make room for curable patients—even by discharging non-violent, chronic patients.[197] Corsellis thought the incurable patients to be deserving of care and alleviation even though they would not return as productive members of the public.[198] Wakefield, however, faced problems with overcrowding. As a stopgap for overcrowding in 1843, Corsellis commissioned new apartments for the director and the matron to be added to the south face of the building and converted their old ones into dormitories to hold thirty additional beds. Corsellis thought that dormitories

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195. West Riding Pauper Lunatic Asylum, *Rules, Regulations and Orders, for the Management of the Pauper Lunatic Asylum, for the West-Riding of the County of York*, 9-14.
196. Corsellis, *Twenty-Fifth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 4-5.
197. West Riding Pauper Lunatic Asylum, *Rules, Regulations and Orders, for the Management of the Pauper Lunatic Asylum, for the West-Riding of the County of York*, 12.
198. Corsellis, *Twenty-Sixth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 3-4.

were counterproductive because patients often disturbed one another's sleep—and sleep was essential for moral recovery.[199] John Charles Bucknill—famed coauthor of *A Manual of Psychological Medicine* with Daniel Hack Tuke and first editor of the *Asylum Journal of Mental Science*—later echoed this point. Bucknill argued that asylums should avoid dormitory schemes because, no matter the savings of funds, they worked against the curative mission of the asylum, which was the purpose of its existence.[200] Corsellis placed only patients he had deemed incurable and not troublesome in the dormitories.[201]

At the same time the dormitories opened, Corsellis commissioned a new building to further relieve the crowding. He selected the location for the new building on the asylum's existing grounds because of its elevated position, which afforded the south and west-facing windows of the finished structure partial views of the town of Wakefield and its church spire. He later considered the view to be the most beneficial aspect of the building to the patients.[202] As such, moral treatment, which had long lauded the efficacy of pleasant views, still influenced the construction at Wakefield.

The new building introduced additional administrative complications. Supplies had to be taken to it from the old building and it relied on the kitchens and laundries of the old building as well. In order to ensure proper supervision, Corsellis placed new apartments for the assistant matron and medical officer in the new building. Consequently, only two senior officers with authority to instruct the staff supervised each building. The senior officers' responsibilities still applied to all the patients of their

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199. Corsellis, *Twenty-Fifth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 4-5.
200. John Charles Bucknill, "Asylum Architecture and Arrangements," *The Asylum Journal of Mental Science* III, no. 21 (April 1857): 285-7.
201. Corsellis, *Twenty-Sixth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 6.
202. Corsellis, *Twenty-Eighth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 5.

gender. As such, they had to walk back and forth between the buildings to inspect their patients.[203]

When construction finished on the new building, Corsellis restructured the classificatory system at Wakefield in order to remove chronic patients, epileptics, and idiots, to the new building.[204] The new building constituted an entirely custodial, not curative, space despite the influence of moral treatment theory on its construction and function.

Wakefield's new custodial attitude reflected a broader pessimism respecting the mission of the asylum. The Retreat had been celebrated not simply because it treated its patients more kindly, but because it reasonably claimed a higher cure-rate than its competitors. The Magistrates invested in Wakefield to replicate the curative advantage of the Retreat. Nevertheless, Wakefield increasingly employed aspects of moral treatment in order to keep patients orderly and comfortable, not in attempts to cure them.

Corsellis still thought moral treatment of the utmost importance. He argued that insanity most often had moral causes and that insanity by moral causes could be cured. The important factor was time. The longer a person remained insane due to moral causes, the less likely they were to recover. If caught in time, before progressing too far, insanity by moral causes often had simple treatments. Anodynes, diet, and routine could ensure good sleep, the lack of which was a common cause of insanity according to Corsellis. If moral treatment was practicable, it was simple and recovery was swift. Usually, however, Wakefield received patients who had suffered under insanity too long and, consequently,

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203. Corsellis, *Twenty-Ninth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 7.
204. Corsellis, *Twenty-Sixth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 3.

were incurable.[205] As such, Wakefield's moral treatment served primarily as a tool of custodianship for a body of incurable patients.

Conclusion

Wakefield opened for patients in November of 1818. Samuel Tuke and the reform-minded Magistrates who had worked with him to popularize the moral treatment were instrumental in directing the design of Wakefield. The asylum represented a significant public investment. The bulk of the investment, however, did not go to staff this new building with enough attendants to allow for anywhere near the degree of personal attention that patients at the Retreat received. Rather, the building itself absorbed the bulk of the investment and took on a more significant role as an agent of moral treatment.

Wakefield opened with the expectation that the Retreat's high cure-rates could be extended to paupers. By the 1840s, Wakefield's management viewed its mission as one of custodianship. The shift in the model of moral treatment began from the outset. The magistrates needed an institution that could hold a larger number of patients. They elected, however, to include the necessary element of supervision by building the expectation of supervision into the walls—instead of hiring a sufficient number of attendants. The selection of Ellis, a physician who always began with conventional medical treatments, marked the second primary digression from the Retreat's non-medical model. Their next selection for administrator, Corsellis, did not simply follow the trajectory of treatment and management in large, public asylums. Instead, Corsellis

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205. Corsellis, *The Twenty-Fifth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 6.

chose to break from the model of moral treatment as it evolved at public asylums by continuing to use restraints. Corsellis did not recommend that rates be raised in order to hire more attendants. He oversaw the spending of funds for new construction and reclassification in order to keep patients manageable. He encouraged patients to work in order to keep the asylum in a manageable routine and to save public funds. Corsellis used moral treatment more as a system to explain why paupers went insane than as a proactive therapy to cure them. He accepted his role as a custodian. Moral treatment was not less important at Wakefield as a consequence—it still shaped the lives of patients, employees, and the director. It also served to explain why there appeared to be high numbers of insane paupers. Nevertheless, it was seldom a form of proactive therapy. By the 1840s Wakefield's moral treatment was a tool of passive custodianship.

Chapter 3

Restrained Optimism:

The Middlesex County Lunatic Asylum at Hanwell, 1830-1845

> your Committee beg to call your attention to the purposes for which Lunatic Asylums are built. They are not like prisons—for the punishment of crime—nor are they like workhouses,—places for the residence of the indigent of all ages laboring under no disease, except such as are casual, and who have no right to expect more than a supply of the necessary wants of nature, and who, if willfully destroying either clothes, bedding, or any other article, would be instantly dismissed from the house. Asylums are hospitals for the insane, for the most suffering part of our fellow-creatures, but many of whom are dispose to continual acts of mischief and destruction, yet are themselves subject to no law and amenable to *no* tribunal. The leading principle in the management of them is not to keep their inmates at the minimum for which human nature can be sustained; but, whatever may have been the cause of the malady, to provide for the health and *comfort* of the Patients.[206]

The Committee of Visiting Justices for the Middlesex County Lunatic Asylum at Hanwell used this passage in part of their rebuke of the charge of squandering public funds leveled at them in 1835 by the Vestry of the Parish of St. George Hanover Square. It reflected the sentiment that, although the patients of a pauper asylum shared a legal

206. Visiting Justices of the County Lunatic Asylum at Hanwell, *Reports of the Visiting Justices of the County Lunatic Asylum at Hanwell to the Epiphany Sessions, 1839* (London: M'Gowan and Co., 1842), 108.

distinction with the paupers of workhouses, they deserved comfort and cure. The Visiting Justice's view of the proper role of an asylum contrasted starkly with the sentiment expressed by Charles Caesar Corsellis, administrator at that time of the West Riding Pauper Lunatic Asylum at Wakefield, who had described asylums as "receptacles into which society pours off its refuse ingredients."[207]

Two of the most acclaimed alienists of their day, William Charles Ellis and John Conolly, served as the Resident Physicians and Superintendents of Hanwell at different times. They both attained the degree of M.D., still an uncommon qualification for an asylum superintendent, and both counted themselves as practitioners of the moral treatment of the insane as espoused by Samuel Tuke in his *Description of the Retreat*.[208]

Hanwell has received little scholarly attention relative to its importance. Its location so near to London made it somewhat atypical for a county asylum; and, therefore, it has received limited coverage in scholarship on county asylums and the poor law like those by David Wright, Peter Bartlett, and Leonard Smith.[209] It has received few references in standard works on asylum architecture despite being the subject of one of the most noteworthy contemporary publications on asylum architecture, *The Construction and Government of Lunatic Asylums and Hospitals for the Insane* by Conolly, as well as serving as the example for large portions of the most widely read treatises on insanity by

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207. C. C. Corsellis, *The Twenty-Fifth Report of the Director of the West-Riding of York Pauper Lunatic Asylum* (Wakefield: Rowland Hurst, 1844), 6; found in WLM28.BE5W53 1831-1850, Wellcome Library, London.
208. Leonard D. Smith, "Ellis, Sir William Charles (1780-1839)," *ODNB*; Andrew Scull, "Conolly, John (1794-1866)," *ODNB*.
209. See for instance Peter Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth-Century England* (New York: Leicester University Press, 1999); Joseph Melling and Bill Forsythe, eds., *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (New York: Routledge, 1999); Leonard D. Smith, *'Cure, Comfort and Safe Custody': Public Lunatic Asylums in Early Nineteenth-Century England* (New York: Leicester University Press, 1999).

Conolly and Ellis.[210] For Andrew Scull, Hanwell was merely one of a number of "museums of madness" (sprawling county institutions for permanently housing the insane) that cropped up in the mid-nineteenth century. Hanwell, for Scull, followed the course of the bloating county asylum system in this period, but had little independent interest beyond this.[211]

Conolly and Ellis themselves, and their theories and practices in the abstract, garnered far more attention than Hanwell. For Andrew Scull, they were both part of a wave of medical men who successfully overcame the threats from asylum scandals and the non-medical, moral treatment model of the Retreat at York in order to secure a permanent place for physicians at the head of the asylum system.[212] Roy Porter deployed Conolly most often when demonstrating the mid-nineteenth-century psychiatric synthesis of the eighteenth-century ideas on insanity with which Porter was principally concerned in *Mind-Forg'd Manacles*.[213] Scull, to the contrary, argued that Conolly's fame in his day and in subsequent scholarship was disproportionately large when compared to his relatively small contributions, which were mostly derivative and made due to a need for self-promotion.[214]

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210. See for instance Leslie Topp, James E. Moran, and Jonathan Andrews, eds., *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context* (New York: Routledge, 2007).
211. See for instance Andrew Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (New York: St. Martin's Press, 1979); Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900* (New Haven: Yale University Press, 1993).
212. Andrew Scull, "From Madness to Mental Illness: Medical Men as Moral Entrepreneurs," in Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900* (New Haven: Yale University Press, 1993), 175-231.
213. Roy Porter, *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (London: Athlone Press, 1987), 5, 101-3, 167.
214. Andrew Scull, "A Victorian Alienist: John Conolly, FRCP, DCL (1794-1866)," *The Anatomy of Madness Essays in the History of Psychiatry*, eds. W. F. Bynum, Roy Porter, and Michael Shepard (New York: Tavistock Publications, 1985), 1: 103-50.

Hanwell must be reevaluated based on the daily experiences and decision-making processes that informed Ellis's and Conolly's views on insanity and moral treatment. Asylum directors and physicians regularly promoted their own theories and criticized others' as a standard facet of self-promotion, necessary for professional success. Most allowed, however, for the principal guide in the progress of treatment and management in asylums to be the personal experience of practitioners. Samuel Tuke lamented that personal, hands-on experience, which was so essential for the treatment of the insane, died with its possessor—thus returning every institution, however well-established, that chose a young practitioner back to a novice state.[215] Conolly not only reprised this point on the essential quality of personal experience, which he affirmed served as the foundation for all of his own approaches, but—far from holding hard and fast, universal rules on treatment—allowed for necessary variations based on geography. He held that national sensibilities and preferences as well as climate affected the manifestations of insanity and the proper mode of its treatment. As such, he allowed for the strong possibility that his own system would prove ineffective in other locations.[216]

Both by merit of their own admissions and by the apparent inconsistencies in treatment from one place to another, physicians did not simply pass the baton and advance, for better or worse, the treatment of the insane in a neat march of ideas. Rather, physicians and asylum directors produced new ideas about the treatment of the insane in response to their experiences and observations, perceived successes and failures, in

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215. Samuel Tuke, *Description of the Retreat an Institution Near York, for Insane Persons of the Society of Friends, Containing an Account of its Origin and Progress, the Modes of Treatment, and a Statement of Cases* (Philadelphia: Isaac Price, 1813), 85.
216. John Conolly, *The Report of the Resident Physician of the Hanwell Lunatic Asylum, Presented to the Court of Quarter Sessions for Middlesex, at the Michaelmas Sessions, 1840* (London: J. T. Norris, 1840), 90-1; found in T .216, Wellcome Library, London.

asylums. The experiences in asylums were the product not merely of the will of their directors, but of the actions and decisions made by patients, employees, and the county justices who made and authorized all administrative decisions. These daily experiences must be studied in order to understand the role of asylums in the production of individual treatment theories and the professionalization of medico-psychology—a field that formed around associations of asylum physicians.

Hanwell achieved the most active form of moral treatment under John Conolly's non-restraint system. This model of treatment, however, began and ended because of community pressure and local government decisions. It represented one, brief strand of moral treatment, not a synthesis of mid-century psychology.

Planning

Robert Sibley, County Surveyor for Middlesex, busied himself, beginning in January of 1828, in inspecting the soil, water supply, and drainage of plots of land referred to him by the Committee of Visiting Justices for the yet-to-be-built Middlesex County Lunatic Asylum. The Committee, which met first in January of 1828, advertised for tenders of land suitable for the construction of their asylum. The Committee convened and set itself to finding a suitable site at the orders of the Court of Quarter Sessions for Middlesex.[217]

Under authority of the County Asylums Acts of 1808 and 1828 the Justices of Quarter Sessions for Middlesex determined to found a pauper lunatic asylum for the reception of persons supported by parish relief, but found to be insane by the parish

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217. *Reports of the Visiting Justices of the County Lunatic Asylum at Hanwell to the Epiphany Sessions, 1839*, 5-9.

officers. Instead of filling workhouses with the insane, or supporting a pauper lunatic in a public or private asylum at greater expense to the parish, parish officers would recommend their pauper lunatics to the country asylum. This measure was particularly necessary for Middlesex, which—once such statistics were compiled—consistently showed that family and friends cared for a much smaller proportion of its lunatic poor than elsewhere in the capital or nation.[218]

County asylums of this structure, possible only after 1808, constituted the first asylums in Britain to be funded by public revenue (private charity and parish or personal subscriptions funded the "public asylums" that predated county asylums).[219] The Court elected a Committee of Visiting Justices to oversee the construction and operations of the new Middlesex County Lunatic Asylum. The Visiting Justices, reelected annually, maintained responsibility for providing quarterly reports to the Court, making all requests for county funds, appointing the asylum's officers, and, upon its opening, conducting regular inspections of the institution and audits of its accounts.[220]

The Committee, after reviewing Sibley's reports, determined to make an offer for the tender of land submitted by the Earl of Jersey. The Earl proposed to sell the land, presently leased to tenants, on the northern end of his property surrounding Osterley Park—where the Earl lived. This piece of land, about forty-four acres very near to Hanwell Bridge, sat in between the road to Uxbridge on the north and the Grand Junction Canal to the south. The River Brent bounded it to the east, and a farm of the Earl's

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218. David R. Green, *Pauper Capital: London and the Poor Law, 1790-1870* (Burlington: Ashgate Publishing Company, 2010), 155.
219. County Asylums Act, 1808, 48 Geo. 3, Chap. 96; County Asylums Act, 1828, 9 Geo. 4, Chap. 40.
220. *Reports of the Visiting Justices of the County Lunatic Asylum at Hanwell to the Epiphany Sessions, 1839*, 2-4.

bordered it on the west. It was near to London—just over eight miles west of the west-end of Oxford Street. The Earl held the land as a freehold, exempt from property taxes and tithes (although the Committee later became aware that a perpetual, annual rent was due to the churchwardens of Northwood). The Committee arranged to mortgage the county rates and purchase the land for £10,925.[221]

The Committee also called for submissions of plans for a building to house three hundred patients, promising to grant awards to the three best. William Alderson's design earned him the top prize and the job of architect for the project, for which he received £1,300. The Committee initially put in a request for £100,000 for the building, but the Court of Quarter Sessions denied that request. The Court approved for £50,000 to be raised by mortgaging the county rates. Nevertheless, the lowest estimate received for the construction of the proposed asylum was from William Cubitt for £63, 200. The Court reluctantly approved for that sum to be paid in installments, and the construction began.[222]

The initial construction consisted of a long hall, split in the middle by a tower. The hall terminated at both ends with kitchens and offices, which joined with long galleries going northward on both sides. Both additional galleries terminated in towers of the same sort in the main hall. The towers contained common areas like dayrooms and workrooms, they also housed the staff and the staircases allowing passage between the

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221. *Reports of the Visiting Justices of the County Lunatic Asylum at Hanwell to the Epiphany Sessions, 1839*, 5-6, 17-18.
222. *Reports of the Visiting Justices of the County Lunatic Asylum at Hanwell to the Epiphany Sessions, 1839*, 6-8.

two floors. The central tower also contained the room for committee meetings and the apartments for the director and matron.[223]

The central tower, home to the head officers, served as the gender dividing point. Gender segregation was the first consideration for preventing the scandalous behavior exposed by the 1815 Select Committee inquiries. It was also the first principle that Samuel Tuke—whose *Description of the Retreat* laid out the model for Ellis's and Conolly's own systems of moral treatment—listed in his *Practical Hints on the Construction and Economy of Pauper Lunatic Asylums*.[224] That work served as the guide for the construction of Wakefield, the asylum with which Ellis (soon to take charge of Hanwell) was most closely acquainted. This system of gender segregation, splitting the institution down the middle and placing the Director and Matron at the point of division, was precisely the same as employed at the Retreat and Wakefield.[225] At Hanwell, the men stayed in the east-wing, and the women in the west. Save for a few domestic spaces that were shared, like the kitchen and laundry (still only worked by the women), the wings operated nearly like separate institutions. Neither patients nor staff members were

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223. W. C. Ellis, "General Plan of the Pauper Lunatic Asylum for Middlesex," in W. C. Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity, with Practical Observations on Lunatic Asylums, and a Description of the Pauper Lunatic Asylum for the County of Middlesex, at Hanwell, with a Detailed Account of its Management* (London: Samuel Holdsworth, 1838).
224. Samuel Tuke, *Practical Hints on the Construction and Economy of Pauper Lunatic Asylums* (York: William Alexander, 1815), 11.
225. Peter Atkinson, *Plans and Drawings of the Proposed Retreat* [ca. 1794]; found in RET/2/1/1/1, The Retreat Archive, Borthwick Institute for Archives, University of York; Watson and Pritchett, *Plans, Elevations, Sections, and Description of the Pauper Lunatic Asylum, Lately Erected at Wakefield, for the West-Riding of Yorkshire; to which is added, a New and Enlarged Edition of Mr. Samuel Tuke's Practical Hints on the Construction and Economy of Pauper Lunatic Asylums* (York: printed for W. Alexander, 1819), II.

allowed on the wing of the opposite sex unescorted. Only the superintendent possessed unchecked authority to visit all spaces of the asylum.[226]

The construction the Visiting Justices ordered also included a dock for taking in supplies from the canal, and the walls that surrounded the asylum, closing in its divided airing courts in which the patients would take out-door exercise.[227] The patients would be classified first by gender, and then on a scale ranging from refractory to convalescent. Each class of patient, fifteen to begin with, would have their own ward containing their bedrooms, gallery, and dayroom—the dinning rooms and airing courts were shared between wards of the same sex. Each ward possessed its own attendant, charged with supervising the patients. Patients saw members of other wards only in shared spaces, in the course of their occupations, at Sunday services, and on special occasions—the staff supervised all such occasions for mingling.[228]

In November of 1830 Cubitt's work was complete. It was not until this point that the Committee took up serious consideration of the appointment of officers.[229] Up to this point, the Committee had not even consulted with any physician or asylum director. Many asylum physicians advocated forcefully that physicians must direct the design of asylums. The Committee, however, with the assistance of a non-medical architect and builder conceived of and constructed Hanwell without calling on any medical expertise.

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226. W. C. Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity, with Practical Observations on Lunatic Asylums, and a Description of the Pauper Lunatic Asylum for the County of Middlesex, at Hanwell, with a Detailed Account of its Management* (London: Samuel Holdsworth, 1838), 265-6.
227. Ellis, "General Plan of the Pauper Lunatic Asylum for Middlesex."
228. Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*, 284-5.
229. *Reports of the Visiting Justices of the County Lunatic Asylum at Hanwell to the Epiphany Sessions, 1839*, 29-31.

Opening

The most critical appointment was that of the superintendent, not only because he would have authority over the other officers, but also because they intended him to act as treasurer and resident physician in charge of all medical treatment as well.[230] They considered twenty-two candidates, but decided that the best-qualified applicant was William Charles Ellis, who had served for the last twelve years in a similar post—as director, treasurer, and chief medical officer—at the West Riding Pauper Lunatic Asylum at Wakefield. Mildred Ellis, his wife who had served as matron at Wakefield alongside her husband, gained the post of matron at Hanwell.[231] Ellis thought that the management of asylums benefitted from its chief officers being married—less for the sake of creating the asylum family written about by Tuke than for the practical reason of the chief officers having a good understanding. The same reasoning justified the resident surgeon and his wife—Mr. and Mrs. Button—both working as officers at Hanwell.[232]

The first thing that Ellis noted upon arriving at his new apartments in the Asylum was that the building Alderson designed and Cubitt built could very well accommodate five hundred patients as it was, or nearer to six hundred with a few alterations. The idea, which the Committee responded to positively, was to gain economies of scale. By taking in more parish subscriptions and striving for efficiency, the asylum would produce more

230. Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*, 291.
231. *Reports of the Visiting Justices of the County Lunatic Asylum at Hanwell to the Epiphany Sessions, 1839*, 31.
232. Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*, 290-3.

revenue and, thereby, be able to reduce the amount of the parish subscriptions as well as render itself less of a burden on county funds.[233]

Hanwell received its first patients on the 16th of May 1831. The Committee not only agreed with Ellis that gaining economies of scale was desirable, but were anxious for filling the asylum with as many patients as possible. They repeatedly complained that parish officers were too reluctant or slow to recommend local pauper lunatics to the asylum's care. Far from exhibiting concern over the asylum's swelling, the Committee was optimistic that increasing its patient population size was a sure way to extend more cures to more patients while reducing the cost of doing so. By 1833 the Justices were happy to report the "very prosperous statement" that Hanwell had already received five hundred and two patients, over two hundred more than originally intended.[234]

This thinking fit with contemporary decisions regarding the support of paupers. David Green has argued that London parishes and unions elected to address workhouse crowding by erecting new specialist institutions, such as county asylums and district schools, that could take advantage of economies of scale. This approach explained London's relative lack of workhouse construction at midcentury. These specialist institutions contained all special architectural, supply, and staffing considerations for their residents, thus allowing workhouses to operate with a reduced burden.[235]

The decision to divorce the curative project of asylums and the educational project of schools from the workhouse also allowed the workhouses to maintain a more

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233. *Reports of the Visiting Justices of the County Lunatic Asylum at Hanwell to the Epiphany Sessions, 1839*, 34.
234. *Reports of the Visiting Justices of the County Lunatic Asylum at Hanwell to the Epiphany Sessions, 1839*, 35-6,
235. Green, *Pauper Capital*, 146-56.

purely deterrent role. In order for Hanwell to play its part, it needed to relieve the workhouses of as many pauper lunatics as possible. The parishes in and around London faced larger problems with overcrowding in workhouses. Lunatics, even after the growth of that category into the midcentury, never reached far above four percent of the paupers supported by parish relief. These considerations explained the Justices' positive reception of the news that Hanwell could take on more patients than initially expected.[236]

Recall, however, that Charles Caesar Corsellis, who took over the post of director at Wakefield after Ellis's departure, dreaded crowding. His complaint was that moral treatment required the physician to become minutely acquainted with each patient.[237] Ellis concurred with Corsellis on this point arguing that "Tastes and habits were the lever … by which the moral man can be moved."[238] Tuke likewise explained that moral treatment was predicated on the fatherly superintendent and benevolent attendants constantly engaging with patients to praise their correct behaviors and reprimand their bad.[239] The Retreat, however, never housed many more than forty patients.[240] Corsellis held that beyond the point of three hundred patients minute observation became impossible.[241] Ellis's, not just acceptance, but recommendation, of crowding Hanwell thus conflicted with many popular models of institutional moral treatment.

Ellis's suggestion to increase the size of the patient population at Hanwell reflected the direction that his model of moral treatment had taken. Ellis theorized that excessive blood flow to the brain caused insanity. This excess might be the result of some

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236. Green, *Pauper Capital*, 163-4.
237. Corsellis, *Twenty-Fifth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 5.
238. Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*, 194.
239. Tuke, *Description of the Retreat*, 99-100.
240. Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985), 50-4.
241. Corsellis, *Twenty-Fifth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 4-5.

discernable physiological source, in which case that source must be removed or mitigated by medical means if possible (the application of leeches, blisters, or hot an cold wraps, or the use of phlebotomy, for instance).

Alternatively, some moral cause might have brought on insanity. A moral cause typically derived from some distressing event or prolonged stress. Ellis reported, for instance, that one of his patients became insane because of the moral cause of the guilt of having sold her son to a chimney sweep and subsequently being unable to find and reclaim him.[242] John Conolly later reported that a young man, a domestic servant, went insane from the moral cause of thinking himself suspected of having stolen an item belonging to his master.[243] More common types of moral causes included domestic unhappiness, excessive alcohol use, and the daily hardships of poverty as often accompanied by the worry of not being able to support one's family.[244]

Ellis maintained that the efficacy of an asylum derived from its ability to remove moral causes of insanity. The asylum provided basic amounts of food, clothing, and shelter—removing moral causes derived from simple want. The asylum rationed beer to its patients, preventing excessive consumption. Where the moral cause consisted of some personal trauma, the asylum strove to distract the patient from their obsessive idea with amusements and more intensive manual occupations.[245]

Ellis believed that providing patients with manual occupations constituted perhaps the most efficacious tool of an asylum. John Conolly later placed Ellis on a list with Pinel, Esquirol, and Tuke by merit of Ellis's demonstration of the efficacy of manual

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242. Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*, 25, 74-5, 151.
243. Conolly, *The Report of the Resident Physician of the Hanwell Lunatic Asylum*, 12.
244. Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*, 64-6, 101, 166.
245. Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*, 193, 198, 201.

occupations.[246] Andrew Scull has argued that this obsession with putting patients to work betrayed that asylums constituted tools of bourgeois morality, in which unproductive people must be controlled and rendered productive.[247] Ellis explained his use of occupations by stating that they forced patients to hold their attention on some innocuous task like weaving, sewing, knitting, cooking, cleaning, or gardening for women; or farming, gardening, or construction work for men. Occupations made patients feel useful, which was a moral salve. Moreover, these manual occupations, Ellis theorized, drew blood away from the head and to the muscles thereby providing a physiological aid to the cure of insanity as well. Where possible, attendants and the resident physician would then apply more minute observation and attempt to tailor a patient's routine in order to address the particular source of their malady. Very often, however, Ellis found the standard regimen to be already the most desirable.[248]

As such, Ellis's moral treatment formed into systems. He developed plans for the diet, exercise, occupation, amusement, religious observation, and general schedule of all of the patients. The officers, attendants, and servants under his direction then oversaw those systems. He transplanted most of the systems he developed for Wakefield into Hanwell.

This model was passive, not active. In practice, attention needed only to be given to maintaining the system, which meant preserving the orderly, prescribed conduct of the asylum. In theory, however, Ellis maintained that his asylum systems provided the best possible moral treatment for patients yet devised. This belief explained why he did not

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246. Conolly, *The Report of the Resident Physician of the Hanwell Lunatic Asylum*, 50-1.
247. Scull, *The Most Solitary of Afflictions*, 104-10, 132-8.
248. Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*, 193, 198, 201.

see the increasing size of Hanwell to be problematic. A larger patient population required only for the same systems to be maintained at a larger scale, not for the resident physician to carry out any active moral treatment for the additional patients.

Moreover, Ellis acknowledged that his system of management and model of moral treatment, with its use of useful occupations for patients, improved domestic economy. Economy constituted an essential element of treatment in Ellis's view:

> The first object that should be kept in view, after providing for the comfort and health of the patients, is economy: for, after all that can be said of the feelings of humanity towards this unfortunate class of our fellow-creatures, their sufferings are too much out of sight to create that sympathy for them which is felt for others, whose wants are more known. It becomes necessary then to show, that to render them efficient assistance need cost very little more than to neglect them: indeed, if the probability of cure be taken into consideration, it is really to the pecuniary advantage of each county to provide asylums sufficiently large to hold *all* their lunatics.[249]

If Hanwell failed to keep to a reasonable budget, Ellis predicted, then ratepayers would decline to fund the curative project at all. As Ellis observed, however, curing patients would remove a pauper from parish relief. Ellis strove to make economy and cure compatible.

The diet at Hanwell was similar to that at Wakefield. Breakfast consisted of gruel similar to that served at Wakefield. It was made of two and three-quarters of a pound of oatmeal or rice and a quarter of a pound of wheat flour. It contained, however, two gallons of water and two of milk. The patients still received a pint and a half at breakfast and supper. The gruel's liquid, therefore, traded a sixth of water for a sixth of milk. The same amounts of oatmeal or rice and flour, however, were diluted in four gallons of liquid instead of three—thus thinning the gruel.

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249. Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*, 267.

Dinner consisted of six ounces of vegetables and four ounces of yeast dumpling or potatoes boiled with six ounces of beef on Sundays, mutton on Tuesdays, and pork on Thursdays. Dinner for Mondays, Wednesdays, and Fridays was made from the water used in the boiling of the previous day's dinner thickened with bones, barley, rice, peas, and onions and flavored with cayenne pepper and seasonal herbs. Saturday's dinner consisted of beef and potato pies that were hardier than Wakefield's Saturday "rice currie." Only the working and sick patients received beer, a half of a pint at dinner—as opposed to three quarters of a pint for all patients at Wakefield. Luncheons for the working patients consisted only of one third of a pint of beer—as opposed to Wakefield's three quarters of a pint of beer and four ounces of bread.[250]

John Conolly later implied that Ellis had been too stingy with the diet. Conolly increased working luncheons to half a pint of beer with bread and cheese. Female patients gained tea with bread and butter in the afternoons while male patients gained a somewhat hardier supper of bread, cheese, and beer.[251]

In the meantime, Ellis began to implement his systems at Hanwell. He aimed for a ratio of twenty-five patients to one attendant. As the population worked its way up to 300, the number of attendants, tasked with managing the patients, rose to twelve. Domestic servants—in charge of the cooking, cleaning, washing, boilers, and grounds—

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250. Corsellis, *Twenty-Fifth Report of the Director of the West-Riding of York Pauper Lunatic Asylum*, 12-13; Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*, 340-1.
251. John Conolly, *The Construction and Government of Lunatic Asylums and Hospitals for the Insane* (London: John Churchill, 1847), 67, 70-2.

effectively worked as attendants as well because the primary work force that they managed in the asylum was comprised of patients.[252]

The male patients brought the surrounding lands into cultivation and kept the livestock—primarily cows for milk. Other male patients worked on the construction and maintenance crew that began to re-outfit the existing structures and expand the number of surrounding buildings in order to allow for an increased patient population. Men also assisted in the keeping of the stores and the cleaning of surrounding buildings (the brew house and stables, for instance). The women, most often, were employed in knitting and needlework. They also, however, assisted in gardening, cleaning, laundry, cooking, and the dairy.[253]

Ellis, and his contemporaries who followed his lead in implementing occupations for patients, liked most often to mention the curative benefits of jobs like needlework and gardening. Scholars have most often recounted these sorts of occupations as aspects of moral treatment as well. Some occupations at Hanwell were more intensive. Ellis employed patients in this more rigorous fashion because the "utilitarian feeling of the present day, which has no other measure for that which is good and valuable, than a pecuniary standard, renders it essential that the manufactures should be so carried on as to be a source not of loss but of profit."[254] Ellis had to accommodate the principle of occupation as curative means to the domestic economy of the establishment. As such,

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252. *Reports of the Visiting Justices of the County Lunatic Asylum at Hanwell to the Epiphany Sessions, 1839*, 32, 84; Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*, 304-5.
253. *Reports of the Visiting Justices of the County Lunatic Asylum at Hanwell to the Epiphany Sessions, 1839*, 84.
254. Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*, 312.

domestic economy and the desires of the parishes and ratepayers explicitly drove the moral treatment plan of Hanwell.

Ellis and the Committee, for instance, continued to brag of their expansion efforts that most projects required only the purchase of materials because they used the labor of the patients. Ellis wanted to bring more land near to the main building under cultivation as a garden and orchard, but the soil in his preferred location was not sufficiently fertile or level, much of it was simply gravel. So, he set the male patients to carting and spreading "Several thousand tons of gravel and earth." Once this work was done, Ellis placed female patients in charge of cultivating the orchard and garden—the produce of which was to be used in the kitchens, in which the female patients also worked.[255]

Nevertheless, Ellis and the Committee placed a high value on providing the patients certain comforts. The heating system for Hanwell—which was initially intended to hold 300 patients, but within a few years held 560 patients—used twelve boilers to heat thousands of gallons of water to near boiling point in order to force it to circulate through all of the pipes running through the whole of the building. In the winter, they ran this system through the night, not only to prevent patients who refused to lie in bed under their blankets from suffering, but also to ensure that the building was sufficiently warm in the morning, when the well ventilated galleries and common areas were too cold if the system had not had time to heat up. The asylum ran this system, at great expense given the coal it required, for three years before a local builder recommended an alternative.[256]

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255. *Reports of the Visiting Justices of the County Lunatic Asylum at Hanwell to the Epiphany Sessions, 1839*, 73.
256. *Reports of the Visiting Justices of the County Lunatic Asylum at Hanwell to the Epiphany Sessions, 1839*, 54.

Mr. Jeakes suggested changing the hot water system for a steam system, which would require two boilers, not twelve. Jeakes suggested a side-by-side comparison since the establishment was effectively split in two to segregate the sexes. He made the necessary changes to one side and, with Visiting Justices there to witness the test, fired up both systems. The hot water system heated its pipes to one hundred and thirty degrees Fahrenheit in eight hours. The steam system heated its pipes to two hundred degrees Fahrenheit in an hour and a half. The Committee found the steam system undoubtedly preferable. It consumed less coal, heated up more quickly (allowing it to be turned off and on when needed with limited delay in its effect), and produced more heat.[257]

The Committee ordered the new system to be implemented on both sides. They soon came to find that the increased temperatures had caused the pipes to begin to separate and leak at their leaden joints. The pipes, therefore, had to be repaired at additional expense. The Committee approved a substantial initial investment in the heating system and subsequent alterations and repairs.[258] The annual expense far exceeded that of heating a workhouse, for instance.[259] They invested more than was needed to sustain life because their aim was to cure patients. The cure of the insane required the absence of moral abuses and irritations—it required comfort. These investments demonstrated that the moral treatment—not just the medical—and its perceived curative function held a high value in the estimation of Hanwell's administrators.

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257. *Reports of the Visiting Justices of the County Lunatic Asylum at Hanwell to the Epiphany Sessions, 1839*, 54-5.
258. *Reports of the Visiting Justices of the County Lunatic Asylum at Hanwell to the Epiphany Sessions, 1839*, 56.
259. *Reports of the Visiting Justices of the County Lunatic Asylum at Hanwell to the Epiphany Sessions, 1839*, 112.

Patients were not necessarily comfortable as a result. Unlike the workhouses, asylums did not permit their residents to leave at will. Nevertheless, the expenditure and value granted to the comfort of Hanwell's patients far exceeded any such considerations for adult workhouse residents. Administrative support fueled by an optimistic view of the moral treatment's efficacy was essential for the practice of moral treatment at Hanwell.

The investments, however, also earned the Committee the ire of a number of parishes. Most notably, the vestry of the Parish of St. George Hanover Square authored a series of scathing reports, which indicted the Committee of squandering public funds and overburdening the parishes. Among their charges laid on the asylum was that, even after Jeakes's coal-saving alterations, the asylum still consumed coal at three times the rate of a workhouse for the maintenance of a comparable population.[260]

The vestry of St. George's first began to complain about Hanwell in 1835. This timing was not merely coincidental, nor was it solely concerned with Hanwell. The Poor Law Amendment Act of 1834 aimed to reduce the soaring costs of poor relief. The Act's move toward centralization and regulation incited the fury of many who wanted to preserve decisions on poor relief for the parish level of government. Nevertheless, the parishes and unions carried out the general aims of the Poor Law Amendment Act—a shift to indoor relief, instead of outdoor relief, and a general reduction in costs—without being forced.[261]

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260. Committee of Vestry of the Parish of Saint George, Hanover Square, "Third Report of the Committee of Vestry, of the Parish of Saint George, Hanover Square, on the Expenditure of the County of Middlesex, Referred to in the above Report," in Visiting Justices of the County Lunatic Asylum at Hanwell, *Reports of the Visiting Justices of the County Lunatic Asylum at Hanwell to the Epiphany Sessions, 1839* (London: M'Gowan and Co., 1842), 137-44.
261. Green, *Pauper Capital*, 110-13.

Part of the mechanism for reducing costs under the Poor Law Amendment Act was the curtailment of the powers of magistrates to order relief. Under the Old Poor Law, magistrates had the authority to order parishes to provide relief to paupers whom the parish had refused. Parish officials often complained that magistrates too liberally ordered relief and summoned parish officers to explain their refusals.[262] The Vestry of St. George's descried Hanwell as an institution that was burdening parishes because it was managed by profligate magistrates—Visiting Justices who were subject to review by the Court of Quarter Sessions for Middlesex.

Hanwell's costs dwarfed the costs of workhouses. The Greenwich workhouse, authorized in 1840 and intended to house one thousand paupers, cost £22,700 to build. The Kensington workhouse, built in 1848, cost £17,000. The most expensive workhouse built in London the first half of the nineteenth century was the City of London union workhouse, which, with its impressive Italianate design, cost £55,000. Hanwell's initial construction alone had cost £63, 200—not including the £10,925 for the land, the payments for its design, administrative fees, or the cost of furnishing it.[263] Taking all of these factors into consideration the general cost for Hanwell's construction—which the asylum used to determine the number of patients it would accept from a particular parish by calculating its relative contribution to the asylum's founding—was counted as £124,456.[264]

The Vestry of St. George's made effectively the same argument about county asylums as the historian David Green has—despite their being controlled by different acts

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262. Green, *Pauper Capital*, 170-3.
263. Green, *Pauper Capital*, 128-9.
264. *Reports of the Visiting Justices of the County Lunatic Asylum at Hanwell to the Epiphany Sessions, 1839*, 2-4; Ellis, *A Treatise on the Nature, Symptoms, Causes, and Treatment of Insanity*, 306.

and regulatory bodies, county asylums were effectively part of the workhouse system.[265] Hanwell, as the Vestry saw it, was intended to be an institution for a special class of pauper.

This was the point at which the Committee chose to remind the vestry of St. George's that "Asylums are hospitals for the insane" and not workhouses.[266] Nevertheless, the argument of St. George's resonated with the other parishes. Despite arguing vociferously against the charges (observing, for instance, that Hanwell had a lower cost per patient than most county asylums and that the burden on the parish per patient dropped considerably below that prior to the asylum's opening, when the parish was obliged to support the pauper lunatic at a more expensive public or private house), Hanwell's visiting justices made attempts to reduce the parish subscription rates and appear as economical as possible.[267]

This scandal had barely died down when Ellis fell ill and was forced to resign his post. The Committee availed themselves of this opportunity to try out a new administrative structure. A lay steward would manage the finances instead of the resident physician, who naturally desired to increase the health of his patients to the highest possible level and whose expertise was in medicine, not economy. They intended this split to reduce costs. The arrangement was an unmitigated failure. The officers failed to coordinate and both treatment and fiscal responsibility broke down. In under a year, the

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265. Green, *Pauper Capital*, 155-6.
266. *Reports of the Visiting Justices of the County Lunatic Asylum at Hanwell to the Epiphany Sessions, 1839*, 108-12.
267. *Reports of the Visiting Justices of the County Lunatic Asylum at Hanwell to the Epiphany Sessions, 1839*, 113-14.

Committee dismissed the new officers and brought in a medical lecturer from University College London, John Conolly, to take the posts of resident physician and superintendent.

An Active Model of Moral Treatment

Conolly, who earned the degree of M.D. at the University of Edinburgh, initially acted as a medical critic of the asylum system.[268] In his work *An Inquiry Concerning the Indications of Insanity* published in 1830, Conolly argued that asylums served as a barrier to recovery for as many as two-thirds of the patients, who in truth needed not confinement but only competent medical attention.[269] In one sense, this argument placed Conolly in the mainstream of medical thought. He thought that physical illnesses in the brain and nervous system caused insanity. Recovery, if it could occur, came through the medical treatment of the physical causes. In another sense, however, this argument placed Conolly outside of the prevailing medical view on the workings of the mind. Conolly's colleagues crafted a theory of the mind and brain that held that habits and everyday stimuli impacted upon the brain and nervous system, which served as the organs for the manifestations of the mind. Conolly's critical view, then, would have held true if asylums all operated as most did before the 1815 inquiries. A properly designed and managed asylum, however, served as an essential element to the treatment of the insane according to Conolly's peers because it allowed physicians to curate every habit and stimulus that might impact upon their patients.

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268. Andrew Scull, "Conolly, John (1794-1866)," *ODNB*.
269. John Conolly, *An Inquiry Concerning the Indications of Insanity: with Suggestions for the Better Protection and Care of the Insane* (London: John Taylor, 1830), 17-18.

In a short space of time, however, Conolly changed his view. He accepted the post at Hanwell in 1839 largely for financial reasons. Once there, he decided to make the best of his circumstances and see if he could perfect the asylum as an institution. His efforts, which earned him national praise and renown, changed his mind on the efficacy of asylums.[270] He came to argue that, "The pride of medical science is disconcerted by the reflection that mere medicine has had but a small part in the cure of many patients who leave an asylum well."[271]

Conolly's colleagues held that he achieved his greatest feat in the complete abolition of restraint, which he deemed to be a mere tool of neglect.[272] Even the Tukes employed light restraints for violent patients.[273] Conolly's complete abolition of restraints would not remain popular for more than a few years. Nevertheless, Conolly rooted his views on restraint in his belief in the efficacy of moral treatment.

He thought that restraints constituted one of the worst classes of moral abuses. Restraints caused patients discomfort, encouraged them to struggle, removed from them any remaining civility, and the physical damage they caused inflicted yet more moral pain. Restraints, in other words, made matters worse. They took patients further down the path to insanity, and away from sanity. Moreover, the worsened behavior of restrained patients, according to Conolly, encouraged attendants to treat them more harshly, which caused even more damage. The abolition of restraints, on the other hand, removed moral pain, benefitted the physical and mental states of patients, improved their behavior, and

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270. Scull, "A Victorian Alienist: John Conolly," 1: 121-3.
271. Conolly, *The Report of the Resident Physician of the Hanwell Lunatic Asylum*, 69.
272. John Conolly, *The Treatment of the Insane without Mechanical Restraints* (London: Smith, Elder, and Co., 1856), 323.
273. Tuke, *Description of the Retreat*, 103-10.

allowed true recovery to proceed.[274] Conolly not only believed that moral treatment, as defined by physicians, provided the likeliest route to recovery for patients, but also the best possible quality of life for those patients whose insanity refused to yield to treatment.

Advocates of the moral treatment had long called for the reduction of restraints. Conolly presented his complete non-restraint system as the next step in the evolution of moral treatment. Pinel famously, so the story went at least, struck the chains off of the inmates of the Parisian asylums. Esquirol proved that Pinel's approach was sustainable and ready for general application in any asylum. The Tukes used restraints only when necessary to protect others and the patient in question from violent paroxysms. Ellis had found occupation effective at busying the hands and expending the energy of patients so that violent outbursts were fewer in number. Conolly argued that the advances of all of these men had shown restraints to retard cures and the elimination of restraints to increase cures. Finally, Charlesworth and Hill of the Lincoln Asylum demonstrated, however briefly, that an asylum could avoid falling into chaos if complete non-restraint was adopted. Thus, Conolly presented his commitment to complete non-restraint as the highest point yet of moral treatment: the disuse of restraints required more attendants to be more vigilant and to constantly engage with the patients personally, it also eliminated the moral abuses of the restraints themselves.[275]

But, order had to be maintained. Conolly's proposed alternative to restraint was seclusion and a comprehensive system for personally engaging with violent patients. By "seclusion" he meant the "temporary protection of the maniac from the ordinary stimuli

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274. Conolly, *The Construction and Government of Lunatic Asylums and Hospitals for the Insane*, 86-8.
275. Conolly, *The Report of the Resident Physician of the Hanwell Lunatic Asylum*, 50-3.

acting upon the senses."[276] This protection constituted Conolly's justification for seclusion as an alternative. Simply restraining violent patients left them exposed to the "noise … the spectacle of a crowd of Lunatics … those who are almost as violent as himself; and … every object likely to add to his irritation."[277] Conolly aimed to reduce the irritating stimuli, not to leave them in place or add to them.

He proposed a new system for engagement with disorderly patients. "Habitual intercourse with the insane," he argued, "cannot but impress those most zealous for giving extended exercise for what is termed moral treatment, with the conviction, that the only prudent course with a lunatic during a state of violence, is to interfere as little as possible."[278] Instead, the attendant or officer should approach the violent lunatic with "perfect calmness of demeanor and countenance; forbearance from sharp rebuke; the occasional interposition of a soothing word, or of an idea that may divert the patient's thoughts."[279]

Conolly set down new rules for how all asylum staff were to engage with patients experiencing excitement or in the midst of a paroxysm. First, they were to remove all other patients, for their protection. Second, they were to guard against serious harm by calmly and phlegmatically removing any would-be weapons from the reach of the patient. Then they were simply to stand by, watchful and ready. When the patient became amenable to the idea, the attendants led them first to exercise in an unoccupied airing court, then to their bedroom for a period of seclusion.[280] These periods were brief.

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276. Conolly, *The Report of the Resident Physician of the Hanwell Lunatic Asylum*, 54.
277. Conolly, *The Report of the Resident Physician of the Hanwell Lunatic Asylum*, 54.
278. Conolly, *The Report of the Resident Physician of the Hanwell Lunatic Asylum*, 46.
279. Conolly, *The Report of the Resident Physician of the Hanwell Lunatic Asylum*, 46.
280. Conolly, *The Report of the Resident Physician of the Hanwell Lunatic Asylum*, 55.

Typically between one and three hours, seldom more than five passed before an attempt was made to reintroduce the patient in the general population. An officer, the resident physician whenever possible, visited the patient before their release from seclusion and engaged in gentle conversation designed to earn the confidence of the patient.[281] Conolly aimed through this approach both to assess the state of the patient and to earn their confidence, which he named the "keystone" of moral treatment. If the patient could come to control their outbursts, Conolly held it likelier to come through the asylum staff having earned the confidence of the patient than their fear.[282]

Even when a patient became suicidal, Conolly found that forceful intervention was not always the best approach. In an annual report he recounted an episode of a female patient who attempted to self-strangulate. Instead of violently intervening, the Matron took control of the situation, sent the attendants who had surrounded the patient away, dimmed the gaslights, and calmly attempted to sooth the patient—who eventually agreed to wash her face and hands in cold water. This approach proved perfectly effective and, in Conolly's estimation, avoided doing the patient serious, long-term moral damage.[283] Moreover, Conolly held this approach to dealing with paroxysms and fits, which he named "seclusion," to be "one of the most important curative means" at his disposal.[284] As such, the most difficult patients, prone to harming themselves and others, were in the greatest need of this approach to moral treatment.

Conolly held that the insane, far from being insensitive brutes as they were once thought, were hypersensitive. He instructed his attendants that,

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281. Conolly, *The Report of the Resident Physician of the Hanwell Lunatic Asylum*, 57.
282. Conolly, *The Report of the Resident Physician of the Hanwell Lunatic Asylum*, 55.
283. Conolly, *The Report of the Resident Physician of the Hanwell Lunatic Asylum*, 40.
284. Conolly, *The Report of the Resident Physician of the Hanwell Lunatic Asylum*, 59.

> Every act of violence, that every of word of irritation, that every injudicious expression, of which the attendants were guilty, or into which [the superintendent] himself was betrayed during the most excited period of the patient's malady, remains recorded in the patient's mind: and that no act or word of kindness, no remission of severity, no little indulgence, no encouragement held out to the poor sufferer, past unregarded.[285]

Consequently, both the good and bad moral impressions remained with the patients long after the incidents that caused them and continued to do moral good or ill for the patients. It was critical, therefore, that every stimulus be carefully curated.

In 1846 Conolly wrote a series of articles for the *Lancet*, which he published as a single volume for wider distribution the following year.[286] *The Construction and Government of Lunatic Asylums and Hospitals for the Insane* elucidated Conolly's decisions and observations on matters of design and management based upon his experience at Hanwell. As with the Tukes, his system consisted of methods to facilitate proper supervision, or in Conolly's case proper medical vision, and methods to create as positive an environment as possible. The former category consisted of systems for classification, movement, and direct observation. The latter group consisted of surrounding patients with comforting images and company. The methods overlapped and were related.

With regard to supervision, Conolly took matters a great deal further than the Tukes or Ellis, though not to the level of a panopticon. Conolly thought that patients, ideally, ought to be grouped by their particular diseases. He found, however, that this method was not practicable. He took into account what kinds of hobbies and work patients enjoyed, how boisterous they were, and what kind of company suited their needs

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285. Conolly, *The Report of the Resident Physician of the Hanwell Lunatic Asylum*, 61.
286. Scull, "A Victorian Alienist: John Conolly," 1: 126.

the most.[287] This method reflected a thoughtful system, but one also based on detailed knowledge of each individual patient.

Hanwell regulated movement in much the same fashion as the Retreat. Groups of patients lived together in the same wards. The staff did permit more mingling at meal times, optional religious services, and special events. Parties were regularly held at Christmas, and other special occasions served as excuses to break the monotony of the asylum—Queen Victoria's wedding day, for instance. The staff always enforced proper decorum at such times.[288]

The staff conducted the observation of individual patients in their bedrooms by means of "inspection-plates" in the doors. Conolly found this method preferable to others he had seen implemented or considered such as that of placing windows over the doors and using stepladders to peer into the room. He considered that method inefficient. He also derided the approach of endeavoring to conceal some number of secret observation-plates in the door and walls so as to facilitate inspection without the knowledge of the patient. Conolly thought that approach constituted at best a way that patients could make a game of triumphing over their spectators by noting when observation took place, and at worst a form of moral abuse that kept patients in terror of the eyes seemingly forever on them.[289] Hanwell facilitated the observation of its tenants in such a way that, Conolly thought, struck a balance between the moral abuse of restrictive and intrusive observation and chaos, which defeated the physician's ability to personalize treatment plans for all of the patients.

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287. Conolly, *The Construction and Government of Lunatic Asylums and Hospitals for the Insane*, 18-19.
288. Conolly, *The Report of the Resident Physician of the Hanwell Lunatic Asylum*, 78; Conolly, *The Construction and Government of Lunatic Asylums and Hospitals for the Insane*, 16-20.
289. Conolly, *The Construction and Government of Lunatic Asylums and Hospitals for the Insane*, 26-8.

Conolly thought it important to create a wholesome environment, which contributed to the healing of patients' bodies and, thereby, facilitated the proper manifestations of their minds. On the matter of windows, for instance Conolly thought that dayrooms should possess windows of about six and a half by three and a half feet with good views of the landscape, plants, and birdcages, and for those that caught the most sun, green blinds.[290] Conolly bemoaned that so many of Hanwell's bedroom windows were too small. He thought that the windows of bedrooms ought to sit at a normal height and be about three feet wide.[291] The windows in bedrooms should also admit light and air. With regard to security, Conolly observed the practice of installing thick panes of window-glass in deep frames deprived the patients of the natural views that had such positive effects upon them. He also decried the system of iron bars. He thought instead, that bedroom windows should be made of normal window-glass and be made to open, at least in some small way, so as to allow in fresh air. He mitigated the security risks by installing wire-guards on the interior of the windows.[292]

Conolly sought to balance the elimination of moral abuses with security in other ways. He preferred, were security ensured, quiet, manual locks to spring-locks that shut with a harsh sound. Forever suspicious of the work ethic of the attendants, however, Conolly insisted on spring-locks for sensitive doors like those on fire grates as well as for doors often used but for which security remained a concern like those between dayrooms

290. Conolly, *The Construction and Government of Lunatic Asylums and Hospitals for the Insane*, 15.
291. Conolly, *The Construction and Government of Lunatic Asylums and Hospitals for the Insane*, 21.
292. Conolly, *The Construction and Government of Lunatic Asylums and Hospitals for the Insane*, 34-6.

and galleries. Bedroom doors were fitted with manual locks because attendants had to give each door its due attention in the routine of the day.[293]

Conolly poured his energy into examining and—funds allowing—changing such details because he believed that the asylum itself was one of the most effective tools of moral treatment. Isolating unique moral causes of insanity often proved elusive:

> Happily, however, it is found, in a great majority of cases, that the mere abstraction from ordinary stimuli, afforded by an asylum, its orderly arrangements, its wholesome regimen, and the contrast it affords to the senses and the circumstances in which the mind became deranged, prove remedial to an extent beyond expectation. … the general management of an asylum, the regulation of the diet, the exercise, the hours of rest, the occupations, the amusements, the dress, and conduct, becomes of wide application and extreme importance. These matters, well arranged, become general medicines; influencing the whole frame of the body, and bringing it into a state in which the mysterious troubles of the brain have the best chance of becoming composed.[294]

As with all facets of moral treatment, including non-restraint, Conolly expanded on the practices of previous practitioners—he concentrated on more minute details of design. That expansion, however, was significant. Conolly practiced moral treatment zealously. If restraints retarded the cure, then they were never used. If design impacted patients' minds, every detail must be attended to.

Conclusion

Hanwell achieved the most active model of moral treatment practiced in Britain under Conolly's direction. He expanded on Ellis's principles, forced personal engagement with patients by taking up non-restraint, and attempted to curate the asylum environment with as much precision as was practicable. The Visiting Justices put an end

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293. Conolly, *The Construction and Government of Lunatic Asylums and Hospitals for the Insane*, 29, 43.
294. Conolly, *The Report of the Resident Physician of the Hanwell Lunatic Asylum*, 69.

to that active model when the expense of having the number of attendants for the non-restraint system to work and Conolly's habit of redesigning parts of the asylum caused the accusations of squandering public funds to rise again. In 1844, they replaced Conolly with a retired army officer, John Godwin, and demoted Conolly to visiting physician, reduced his annual salary from £500 to £350, and deprived him of his apartments in the asylum.[295] Conolly's system of moral treatment soon crumbled.[296] Despite Conolly's fame and the relatively good press his approach had garnered for Hanwell, and despite the efficacy that the justices perceived in his approach, the regime of treatment changed at Hanwell due to public pressure in the face of rising expenses.

Hanwell demonstrated the ways that public pressure and practical matters of administration drove the methods of treatment. The Court of Quarter Sessions for Middlesex made the decision to found and fund Hanwell. The Visiting Justices selected the land and design for the asylum. They also chose Ellis as the first superintendent from twenty-two candidates. Ellis had to tailor his approach to his signature contribution to moral treatment—manual occupations—in order to address concerns over domestic economy. Criticism from the vestry of St. George's Hanover Square threatened Hanwell's curative project. Stalwart support from the Visiting Justices preserved Ellis's system against that criticism. The Visiting Justices selected and empowered Conolly's model of moral treatment—including his expensive system of non-restraint and his alterations to Hanwell. However, they ultimately also bowed to public pressure and ended his model of treatment.

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295. Visiting Justices of the County Lunatic Asylum at Hanwell, *Seventieth Report of the Visiting Justices of the County Lunatic Asylum, at Hanwell* (Hackney: C. Turner, 1844); found in WLM28. BE5M62 1842-46, Wellcome Library, London.
296. Scull, "A Victorian Alienist: John Conolly," 1: 127-8.

Conclusion

Insanity and its treatment had been private matters in the eighteenth century. Britain contained few houses for the reception of the insane, and none funded by public revenue. The early nineteenth century saw a moment of greatly increased attention to asylums. An attempt on the life of the King sparked concern over the problem of wandering lunatics. The County Asylums Act of 1808 granted counties the authority to found and fund asylums on county rates, and the establishment of these asylums brought ratepayer interests and parish politics into contact with the questions of asylum practice.

The changed public perception of the York Lunatic Asylum demonstrated this additional scrutiny respecting asylums. In 1807 the Select Committee Appointed to Enquire into the State of Lunatics, in preparation for the 1808 Act, found the York Lunatic Asylum to be in perfectly good order. The Committee cared about finances, not the style of treatment employed.

Godfrey Higgins's investigations into the Vicars case and then the York Lunatic Asylum's general management between 1813 and 1816, however, mobilized a public outcry over the barbaric treatment of the insane, who were meant to be receiving care at the charity-funded institution chaired by the Archbishop of York. After working with Samuel Tuke to force the general investigation, Higgins worked to publicize the Retreat's model of management and treatment as the solution to the exposed problems.

The 1815 Committee Appointed to Consider of Provision Being Made for the Better Regulation of Madhouses in England made extensive inquiries into the actual conditions of lunatic asylums. William Tuke's testimony on the Retreat, which referenced his grandson's *Description*, stood out from the catalogue of abuses as a point of hope. The 1815 Committee demonstrated increased public concern over the question of insanity and its treatment. Acts to amend the County Asylums Act and control criminal and pauper lunatics passed while acts for national asylum regulation were repeatedly offered in the second decade of the nineteenth century.

It was in this context that Samuel Tuke's *Description of the Retreat* captured public attention. The Tukes did not simply revolutionize the treatment of insanity, or give birth to psychiatry, and have their system taken up as the obvious next step to enlightened practices. Public interest in asylums had been rising for years for a variety of reasons. Even still, Higgins, the Tukes, and a coterie of Benthamite reformers and humanitarian paternalists worked tirelessly against considerable resistance to uncover the scandals and undertake the investigations that allowed Tuke's system to stand out as a model to be adopted.

Tuke advocated for a model of moral treatment that consisted of individualized programs of training in self-restraint. The Retreat employed restraints only when patients completely failed to exercise self-restraint. Patients possessed the degree of liberty necessary to make decisions about their actions. The Retreat then laid the responsibility of proper conduct on their patients. It was up to the patients not only to avoid outbursts, but to direct their minds to salutary intellectual pursuits, useful occupations, and religious observances. The staff aided the patients in their mission of self-restraint by mobilizing

fear, esteem, religion, and comfort. The staff used fear in due proportion only. Religion established a pervasive expectation of proper conduct. The desire for esteem led patients to control themselves in order to gain it. Successful self-restraint earned patients comforts, which they then worked even harder to keep.

The Retreat's moral treatment was personal, active, and reciprocal. The staff needed to constantly engage with patients personally, learn about their interests and skills, and offer patients cause for both fear and esteem. The staff needed to be as respectful of patients as the patients' behavior permitted and to gain the respect of the patients. The staff members were responsible for assisting in the patients' cure and also instructed the patients to accomplish their own cure by learning to master their disorders. Asylums took up this model of moral treatment in order to replicate the Retreat's humanity and high cure-rate.

When transplanted to new asylums under new directors with new administrative structures, however, the moral treatment soon evolved into new and different models. The West Riding Pauper Lunatic Asylum at Wakefield demonstrated one such evolution. After the national reform efforts spurred by Tuke and Higgins failed, the Retreat Party—many of whose members, like Higgins, were West Riding magistrates—determined to extend Retreat-style moral treatment to more patients by founding a county asylum. Samuel Tuke assisted the magistrates in directing the design of the new asylum by writing his *Practical Hints*.

Wakefield's deviation from the Retreat's model, however, began with the design of their initial building. Despite Tuke's advise against panopticons, Wakefield's spiral staircases, which served as a series of observation platforms on a panoptic principle, built

the expectation of constant supervision into the walls. Wakefield made personal engagement with patients a less necessary element of their training regimen. Instead of a reciprocal system of better treatment leading to better conduct, of mutual respect and shared responsibility, Wakefield let the building help to keep patients orderly.

The West Riding magistrates also deviated from Tuke's non-medical model by placing a medical man in charge of Wakefield. William Ellis thought that strictly physical illnesses caused some cases of insanity. In such cases, moral treatment was useless. From the first, therefore, Ellis confined moral treatment's role. Even in cases of insanity by moral causes, Ellis thought that medical measures were essential for success. As such, his model of moral treatment incorporated medical treatment.

Even with elements of the moral treatment advocated explicitly by Tuke, such as occupations, Ellis made substantive alterations and provided a new explanatory model. Instead of arguing that occupations provided patients with cause for self-esteem by showcasing their skill and making them feel useful, Ellis argued that physical labor drew blood away from the brain. Wakefield's occupations under Ellis became more intensive and were no longer carefully tailored to the individual strengths of the patients.

After Ellis left to take up his post at the Middlesex County Lunatic Asylum, the West Riding Magistrates chose Charles Caesar Corsellis to replace him as director. Corsellis oversaw Wakefield's transition to an even more passive model of moral treatment. Overcrowding caused many of these changes. As the number of pauper lunatics increased and the parishes came to favor their support in county asylums over licensed houses, demand on Wakefield's space increased. Wakefield's evolved moral

treatment helped to explain why there seemed to be an increasing number of pauper lunatics—the stresses of poverty caused insanity.

As Corsellis warned, placing so many patients under the care of so few employees made personal engagement—a critical element of Tuke's model—impossible. Instead of tailoring occupations, comforts, and conversations aimed at the benefit of each individual patient or engaging personally with the patients to encourage their progress in self-restraint, Corsellis spent his time on obligatory matters of administration. Wakefield built certain elements of Tuke's model— such as incentivizing good behavior and work with comforts like extra food— into a one-size-fits-all system of institutional management.

Crowding alone did not push Wakefield's model of treatment toward passive custodianship. Corsellis's decisions with respect to crowding contributed to the shift in Wakefield's moral treatment. Corsellis oversaw extensive new construction at Wakefield, which relied heavily on the labor of the patients themselves. Corsellis cordoned off certain spaces in the asylum for incurable patients only. As such, the moral treatment, in these spaces at least, lost any curative value. Moral treatment became, at best, a contribution to the comfort of patients in the incurable wards. Whether Corsellis's estimation of the likelihood of cures was reasonable or pessimistic, his view that only about ten percent of Wakefield's patients could be cured led Wakefield's moral treatment to shift to a custodial, not curative, model.

Corsellis also adopted a dormitory system for sleeping arrangements despite his view that the additional mental irritations that came from sleeping in the company of other lunatics likely acted against the cure of the patients. The selection of occupations

for patients increasingly prioritized their contribution to the crowded asylum's domestic economy over their contribution to the patients' cures. While John Conolly rose to fame for his non-restraint system—an extension of the principle of limited restraint from Tuke's system—Corsellis defended the use of restraints at Wakefield. It was not only crowding, but the decisions made by Corsellis and subsequent administrators at Wakefield on how to handle the crowding that pushed its moral treatment to a more custodial model.

The decisions made by the management at the Middlesex County Lunatic Asylum at Hanwell offered a contrast to those made at Wakefield. The decisions that affected Hanwell's model of moral treatment were not only made by its eventual superintendents, but by the Visiting Justices in negotiation with the Court of Quarter Sessions and the parishes. The Justices selected the location and design for their asylum—factors that Tuke, Ellis, Corsellis, and Conolly all held to be important tools for moral treatment. They also selected each of the asylum's superintendents in turn—thereby determining the treatment models that would be employed at Hanwell.

Ellis transplanted his system from Wakefield to Hanwell. His encouragement of crowding and emphasis on domestic economy—at least to appease ratepayers and parishes concerned with expenses and overcrowded workhouses—attested to the passivity of his system. Ellis maintained confidence that the general routine and system of standard occupations that he had developed at Wakefield sufficiently provided for the moral treatment of patients. The simple removal of patients from exciting stimuli and the stresses of poverty served as an important tool of this passive model of moral treatment.

The Justices demonstrated their commitment to supplying the requisite degree of comfort for moral treatment by their repeated expenditures for its sake—expenditures for the expensive heating system, for instance. They also defended Hanwell's costs and staff when the vestry of the Parish of St. George Hanover Square raised accusations that Hanwell squandered public funds. The Justices' support permitted Ellis to continue with his system until he was forced to resign due to ill health.

The Justices, after an abortive attempt at lay administration, also chose John Conolly to superintend Hanwell. Conolly, once in place at Hanwell, developed the most active model of moral treatment employed to date despite Hanwell's size. Conolly's successful establishment of an active model of moral treatment demonstrated how different decisions about how to handle crowding led to different models of moral treatment—and not inescapably to passive ones. Whereas Corsellis oversaw the reclassification and restraint of patients in order to maintain order, Conolly hired on more attendants and—more critically—provided them precise instructions about how to personally engage with patients in order to encourage self-restraint. These rules on personal engagement constituted Conolly's non-restraint system.

Conolly instructed the attendants that patients were never to be restrained. This decision aimed to avoid causing moral damage to the patients and to gain their confidence, which Conolly deemed to be essential for effective moral treatment. Patients experiencing paroxysms were never overwhelmed and restrained—something that even happened at the Retreat—but were approached gently and offered soothing and diverting thoughts. The attendants were to persuade the patient to accompany them for a period of exercise and then seclusion, which was employed explicitly as a curative measure and not

to punish. A medical officer or the superintendent would then engage with the patient in conversation designed to secure the patient's confidence before the patient was reintroduced to the common areas. This approach for managing patients failing to control their behavior correctly was predicated upon personal engagement and persuasions tailored to the individuals in question.

Conolly employed this model of moral treatment as a curative measure for all of his patients. He presented his non-restraint system as the highest point yet in the history of moral treatment, which had repeatedly attested to the benefit of reducing the use of restraints. The Justices ended Conolly's model of moral treatment, however, when they bowed to pressure to cut costs and demoted Conolly to a consulting role at Hanwell. Even Conolly—a medical man in the mid-nineteenth century who pursued an active model of moral treatment that contained elements of direct persuasion—cannot be said to have given rise to psychiatry or psychology through his work at Hanwell. His system ended and his colleagues did not take it up, but shifted to more conventional medical models of treatment for insanity.[297]

Samuel Tuke established a model of moral treatment with his *Description of the Retreat*. That vision became the model for moral treatment only after public pressure and attention singled it out as a cause for hope in the betterment of asylum conditions. The West Riding Pauper Lunatic Asylum at Wakefield took up Tuke's model and changed it into a passive system of custodianship. The Middlesex County Lunatic Asylum at Hanwell took up Ellis's passive model of moral treatment developed at Wakefield, but

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297. See the relative importance of medical and moral means of treatment in John Charles Bucknill and Daniel H. Tuke, *A Manual of Psychological Medicine: Containing the History, Nosology, Description, Statistics, Diagnosis, Pathology, and Treatment of Insanity, with an Appendix of Cases* (Philadelphia: Blanchard and Lea, 1858).

then shifted—so long as the Justices supported Conolly— to an active model when Conolly implemented his non-restraint system. The ways in which these models of moral treatment evolved attested to the diversity of asylum practice as well as to the lack of professional autonomy and methodological stability for physicians employed to treat the insane. Moral treatment as practiced in British asylums in the first half of the nineteenth century was not psychiatry or psychology, but existed as many different models of treatment all of which were contingent upon decisions made by various members of the public, including medical professionals, politicians, and ordinary parishioners.

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