Looking Back

Moral Treatment: How a Caring Practice Lost Its Rationale

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The 19th-century practices of moral treatment and phrenology serve as historical examples of a narrowing focus in health care and reveal the manner in which theories can shape practice. The story of moral treatment, as it is told in connection with phrenology, emphasizes the push for success and right solutions. The push followed several shifts in the conceptualization of mental illness, the last of which proved moral therapy unreasonable. If practitioners in this century hope to ensure that the heart of moral treatment will withstand the effects of ever-changing theories, they must hold caring attitudes, words, and actions at the center of their practice.

Early caregivers struggled, as do helpers today, to practice in a manner that was both effective and caring. To understand how difficult it was to achieve that balance, one need only consider two discarded 19th-century treatment attempts and their curious connections with one another: moral treatment and phrenology. The historical influences of moral treatment and phrenology reveal the shaping force of rational constructions, or theories, on treatment practices in general. They also serve as less cited examples of the manner in which health care narrowed its focus over the course of the 19th century from illness as a personal experience to disease as a pathological condition.

This narrowing focus followed a growing need in health care to justify any action with a rationale that was logical, that not only made sense but also could withstand a linear analysis of cause and effect. According to Schön, "The question 'How ought I act?' could be reduced to a merely instrumental question about the means best suited to achieve one's ends" (1983, p. 33). Practitioners resolved disputes about how to proceed by invoking a theory that explained the cause of the problem; they then discussed treatments in terms of the treatment's capacity to address the cause. At its outset, moral treatment seemed an eminently rational practice for treating mental illness; it derived support from popular medical theory that included phrenology. Over the course of the 19th century, however, scientific inquiry found the practice to be irrational.

The story of moral treatment and its use as an early form of occupational therapy is a complex one that invites many readings (Bell, 1980; Bockoven, 1963; Bing, 1981; Browne, 1864; Cooter, 1976; Davis, 1964; Deutsch, 1949; Digby, 1985; Foucault, 1965; Galt, 1973; Grob, 1973; Kirkbride, 1973; Leuret, 1840; Peloquin, 1989; Peloquin, 1991; Scull, 1981; Tomes, 1984), but one point seems certain—moral treatment and its connection to phrenology can be understood only after achieving some grasp of what the period's general health care was like. Radical changes transformed earlier 19th-century health care practices to such a degree that Rosenberg called them, collectively, a therapeutic revolution. He wrote, "To understand therapies in the opening decades . . . its would-be historian must see that it relates, on the one hand, to a cognitive system of explanation, and, on the other, to a patterned interaction between physician and patient" (1985, p. 39). Health care practices will always reflect the rationalizations that patients and helpers assign to illnesses and the patterns of relationship to which they are accustomed.

Early 19th-Century Therapeutic Practices

The key to understanding therapeutic practices in the early 19th century, according to Rosenberg, is to see the implications of the following construction:

Central to the logic of this social subsystem was a deeply assumed...
Two corollary assumptions flowed from this central theory: first, every part of the body is related to every other; second, the body seeks balance through a process of intake and output. Equilibrium means health; dis-equilibrium means illness. Staying well was the embodiment of balance.

Rosenberg explained that "the American physician in 1800 had no diagnostic tools beyond his senses, and it is hardly surprising that he would find congenial a framework of explanation which emphasized the importance of intake and output" (1985, p. 41). The body was thus seen as an ever-changing system, and physicians aimed to maintain its natural balance. The physician's most potent action was to "regulate the secretions—to extract blood, to promote perspiration, or the urination or defecation which attested to his having helped the body to regain its customary equilibrium" (Rosenberg, 1985, p. 41). Drugs and purgatives restored balance; the sweat, diarrhea, or skin lesions that followed their administration imitated the bodily functions that accompanied natural recovery.

With a perspective that held that climate or job could change the body's balance, physicians saw environmental, occupational, and interpersonal experiences as important. They acknowledged that the mind and body are separate entities but are always in close connection with each other. Furthermore, because each patient was deemed a "unique physiological identity," physicians investigated constitutional, familial, and environmental factors in treating what they called the specificity of illness (Rosenberg, 1985, p. 44). Treatment was individualized because the manifestation of any illness was thought unique. Because patients also held this belief, home remedies mirrored those of physicians. The system was thought rational because it passed the test of linear analysis: treatments addressed the cause of illness.

The Advent of Change

During the first quarter of the 19th century, however, discontent grew over what people began to see developing: the "routinism and frequent severity" of drugging and purging (Rosenberg, 1985, p. 45). Although many physicians struggled with their doubts about the older ways, Rosenberg has contended that few mid-century American practitioners rejected traditional therapeutics. The principle of specificity especially, argued Warner (1986), is one to which physicians adhered tenaciously: the commitment of American physicians to therapeutic specificity was remarkably durable. Despite the dramatic upheavals that occurred in therapeutic theory, epistemology, and practice during the last two thirds of the 19th century, the principle of specificity endured virtually uncontested as a central dogma in the accepted therapeutic belief system.

An emerging empirical trend began to increasingly challenge the efficacy of therapeutics that did not prove successful in clinical trials. To most American practitioners, this new skepticism seemed at first more suited to European academics who did not treat and interact with patients (Rosenberg, 1985). Physicians knew their role: to create meaningful regimens for patients who held traditional beliefs in the body as a dynamic system. Most physicians thus enacted methods that held some continuity with traditional ones. When heroic dosing with drugs seemed extreme, physicians lessened the dose but continued the practice.

Over the years, a differing perception of illness grew more prevalent: diseases were seen as distinct entities with specific courses and symptoms. Many ailments were seen as self-limiting and needing no intervention. Illnesses did not signify a systemic imbalance after all. This new perception notwithstanding, most patients still sought the kind of medical care that they had received in the past. If a regular physician would not provide a treatment thought effective, patients might easily turn to a homeopathic or botanic physician whose methods were more traditional.

This new and conflicting concept of illness, combined with expectations from patients that physicians persist in the old ways, posed a dilemma. Treatments no longer seemed rational in that they did not seem congruent with the causes of illness. Physicians saw little congruence between the demands of clinical practice and those of laboratory science (Rosenberg, 1985). However, according to Rosenberg, "even when they felt anxiety in particular cases, physicians took assurance from the knowledge that they were following a mode of practice endorsed by rational understanding and centuries of clinical experience" (1985, p. 44). The push to be therapeutic among their patients was at first larger than the push for methods considered scientific or rational.

In time, however, the traditional belief system that had borne centuries of scrutiny was judged blind to the true nature of disease and lesions. The new system, based on previously unseen bodily parts and scientifically established norms, promised more sensible remedies than traditional methods based on metaphor. By the end of the 19th century, skepticism about traditional therapeutics dominated medical practice. Strategies such as bloodletting and purging were viewed as unscientific compared with the numerical standards that flowed from medical circles in Germany and France. Warner explained that...
Instrumental measurement and chemical tests became better guides to understanding illness than the physician’s senses; consultation of numerical norms supplanted inquiry into the patient’s experience. This New Rationalism deemed compartmentalization and quantification of bodily problems congruent with the new vision of illness (Warner, 1986). Within the context of these shifting perspectives, the practice of moral treatment developed and dwindled, reflecting the popular metaphor of illness in its inception and the new recognition of disease in its decline. Moral treatment, likened to the current practice of milieu therapy among mentally ill patients, was truly a practice of its time.

The story of moral treatment, as it is told in its connection with phrenology (a practice known to many as the study of bumps on the human skull) emphasizes the push for success and right solutions. As caring a practice as moral treatment seems, and as much as the term moral treatment implies the kindness sought by patients today, the story can easily sober those who claim that caring was easier then.

Insanity in the Early 19th Century

In the early 19th century, and within the traditional metaphor of the human body as a dynamic system, society’s perception of insanity changed. Persons with mental illness were deemed capable of reason. Before this change, they had been judged lacking in rational capacity and therefore considered less than human. Their condition had been thought a matter of possession. In 1864, physician Browne described the type of treatment that reflected this belief:

As you entered, the creak of bolts and the clank of chains were scarcely distinguishable amid the wild chorus of shrieks and sobs which issued from every apartment. The passages were narrow, dark, damp, exhaled an offensive smell, were never lighted after sunset, and were provided with a door at every two or three yards. Your conductor was stern and surly; he carried fit accompaniments—a whip and a bunch of keys. The first room you examined might measure 12 by 7, with a window, placed near the ceiling, which did not open, and without a fireplace, or means for artificial heating, and without furniture. Cruelty, and chaining, and rigour, and rigid confinement, were resorted to, not so much because the guardians were inhuman or unsympathising, but to quench the spirit, to frighten men into their senses, to subdue and train, to overcome and tame the passions. (1864, pp. 309-310)

Brutal methods promised to break the irrational "beast" (Deutsch, 1949, p. 80). When judged irrational, persons with mental illness were treated as animals. Physicians aimed to control, not harm, them. Only when patients were thought capable of controlling their bestial natures could treatments move toward relationship and care. Growing confidence in the reasoning powers of patients inspired the enactment of humane treatments: individualized care, a balanced routine of work and recreation, and an effort to help patients shape desirable traits (Peloquin, 1989). The picture of patients working at domestic crafts or cultivating the farmlands of the asylum differs dramatically from an earlier one of dishonored Lunatics, isolated and terrorized, chained to walls. From their vantage point 150 years later, Dain and Carlson called the practice caring; they likened moral treatment to “a psychological medicine that constituted milieu therapy” (1960, p. 151). One 19th-century physician described moral treatment thus:

Our moral management chiefly consists in allowing every patient all the liberty consistent with his own safety and that of others; to conciliate his good will by kindness and gentleness of manner; to excite in him the sentiment of self-respect; to exercise his judgment [sic] in useful and agreeable occupations; to divert him from his hallucinations by pleasant and innocent amusements; and to pursue that system of needful and wholesome discipline and restraint which is least irritating and offensive. Our medical treatment consists in restoring every part of the human system to its healthy function. (Galt, 1973, pp. 496-497)

The following anecdote from another physician, Leuret, serves nicely as case narrative and speaks to the imagination of moral treatment:

Physicians were kind and concerned. They found nurses and attendants of the best character who became constant companions for one to six patients each (Galt, 1973, p. 498). Patients and staff members dined together regularly in one large room to invoke a sense of family. Staff members used restraints rarely and only when patients might harm themselves or others. Energetic activity, they thought, would release hostility. The practice seems personal by today’s standards; practitioners seemed to care, and a caregiver’s character mattered as much as skills.

In these small early asylums, moral treatment brought success; patients who received such care were cured. Not surprisingly, these successes led to a wild optimism—a “cult of curability” (Dain, 1964, p. 78). This humane practice took shape in the hands of the medical profession. Physicians, enacting what seems to be a holistic function, actively sought the roles of asylum superintendent and director of moral treatments. What shaped physicians’ regard for the emotional nature of their patients, when just previously the unbridled passions of...
At this point, the phrenological theory proposed by Franz Gall and Johann Spurzheim (1967) becomes important to consider. The belief in the connection between mind and body was highly developed (Spurzheim, 1970). This direct referencing on the convolutions of the brain marked the beginning of cerebral localization theory and the use of brain localization to understand behavioral patterns. Gall (1807) unfolded the brain section by section, gently peeling and scraping to see the interconnecting parts. Much of Gall's research also consisted of noting connections between skull protuberances and a person's daily behaviors. Gall created casts from the skulls of persons who had strong personality traits, and he later collected their skulls for comparison with his casts. Many considered his work empirical science. One anecdote describes Gall's method (Haskins, 1839). He assembled numerous boys, many of them thieves, and divided the crowd into three groups: those who admitted stealing, those who claimed to be horrified by it, and those who seemed indifferent. During his examination of the boys, Gall found a similar cranial prominence on each of the thieves. Curiously, not one who claimed to deplore stealing had a right side of the skull that was an organ whose enlargement explained the propensity to steal. The practice today: a form of quackery. (1970, p. 9)

As complex and curious a phenomenon as reading of bumps on the skull grew to be, phrenology gave influential alienists further cause to provide moral treatment—a rational link that connected emotional concerns to a medical condition (Cooter, 1976). Dozens of phrenological societies sprang up all over the United States, and the general social and intellectual level of society advocates was high. Among those who endorsed phrenology were Horace Greeley, Ralph Waldo Emerson, Walt Whitman, Horace Greeley, Henry Ward Beecher, and Edgar Allen Poe (McCord, 1959). Carlson (1958) argued that the founders of the American Psychiatric Association were among those physicians who showed the greatest interest in phrenology. Gall's phrenology located insanity in the physical brain, a hypothesis consistent with the perception of insanity as an illness. Insanity was not merely a functional disturbance of the nonbodily mind but a demonstrable physical condition. Cooter explained: "Phrenology's reference to brain physiology for the understanding of psychological therapy reassured physicians that special medical treatment was required to deal with the insane" (1976, p. 135). Cooter argued that a closer look at early phrenological developments would yield "abundant evidence to substantiate the claim that phrenology completely reoriented psychiatric thought" (1976, p. 3).

After securing his medical degree in 1785 and establishing a successful practice in Vienna, Gall began to study the human brain. His inquiries followed two distinct courses: he dissected the brain, and he observed cranial features. He then rendered skilled and accurate drawings of his work. Gall's method of dissection was novel, enabling him to produce drawings unlike any before. Brain dissection had previously consisted of sawing the head in half and then examining cross-sections of brain tissue. Gall (1807) unfolded the brain section by section, gently peeling and scraping to see the interconnecting parts.
and each organ’s size reflects its degree of development (Hughes, 1986). Intellectual faculties such as cunning and talent for languages, and moral faculties such as pride and goodness, reflected the functioning of the brain organs that controlled them. The propositions of phrenological science seemed reasonable, and if they relied on inferences, Gall’s outstanding anatomical work gave them credibility.

Spurzheim, Gall’s assistant, elaborated on the meaning of phrenological principles in the treatment of insanity. Overreligiosity in a patient, he argued, might signify an overdeveloped organ of veneration, whereas marked isolation might indicate an underdeveloped organ of amativeness. Phrenological treatment involved stimulating the action of whatever organ might counterbalance the effects of the problematic one (Spurzheim, Knight, & Morisson, 1827). A physician might coax a violent patient, for example, into engaging in nurturing activities, hoping to thereby activate the instinct of generation and offset the violent activity indicative of an oversized organ of murder. Phrenology thus proposed sensible applications that alienists could use within the context of moral treatment. Even those physicians who thought these principles of organology speculative could support any method that promoted restoring the balance thought so important in treating any illness in the early 19th century.

Phrenological theory and moral treatment were well-matched. Phrenologists hypothesized that less developed brain organs could be enlarged by involving the patient in environments, activities, and interactions that exercised those faculties controlled by the organs. The organ of love of offspring, for example, might be enlarged by engaging a patient in positive experiences with young children. The optimism of this theory was consistent with the belief that moral insanity was caused by societal forces such as industrialization and city living. The environmental, occupational, and interactional practices that could develop brain organs were also the essence of moral treatment. Phrenology added a new dimension to moral treatment: as insanity was cured in the asylum, changes occurred in brain organs. Because of the physical effects of moral treatment, it seemed logical that physicians provide moral treatment. The focal point of phrenological intervention was the physical brain, but appropriate therapeutics consisted of the more traditional and holistic strategies that had a physical effect. These treatments were deemed rational because they withheld linear analysis; the method addressed the problem.

Cooter described the appeal of phrenology:

When Gall and Spurzheim paraded through the asylums and prisons of Germany and described with uncanny accuracy the reasons why each inmate was confined, their endorsement of physicians, warders, and civic officials could hardly do otherwise than believe that this was a correct system, however marvelous. (1976, pp. 16-17)

Earlier metaphysical theories had held that madness signaled a possession of the ethereal mind by forces beyond medical intervention. The recognition of insanity as a legitimate illness begged medical interventions. When The North American Review published a critical piece on phrenology in 1833, the anonymous author claimed that the only benefits from phrenology were “confined to one department—that of Insanity” (Phrenology, 1833, no page number available). Because phrenology saw in brain organs clear evidence of mind–body connections, phrenologist-alienists used moral management to treat the body’s brain. Among those who supported phrenology were Amariah Brigham, Luther Bell, Henry Bartolphp, Pliny Earle, Isaac Ray, William Rockwell, Charles Stedman, Samuel White, and Samuel Woodward (Carlson, 1958).

The Advent of Change

Moral treatment was soon affected by the same shifts in theory that visited general medicine. Articles in the American Journal of Insanity increasingly supported the theory that insanity was caused by a lesion in the brain (Brigham, 1844). Anatomical evidence of lesions in brain tissue unsettled the central metaphor of illness and the principles of phrenology. When, in 1861, Paul Broca of Paris located the human speech center in the third convolution of the cerebellum—a site far removed from Gall’s localization of the organ of speech—phrenology faltered as a science (McCord, 1969). Simultaneously, because of many events that changed the character of asylum care such as overcrowding and staff shortages, physicians could no longer tout the cures of moral treatment (Bockoven, 1963; Peloquin, 1989). Neurophysiology advanced to scientific status, with ample proof of brain lesions but little in terms of therapeutics.

 Alienists soon accepted a new theory of mental illness: heredity, and not any systemic imbalance from emotions or the environment, produced the lesions that led to insanity. Heredity theory doused optimism about any form of cure. Although physicians could verify the existence of brain lesions with their newly developed technologies, no known treatments could either heal these lesions or change the inheritance that had caused them. This sure knowledge of causality supplanted traditional therapeutics that had been successful but addressed only speculative causes. By the 1870s, most physicians were pessimistic about medical treatment, and moral treatment became a minor form of therapy even in the most affluent asylums (Dain, 1964). Neither caring practices nor environmental interventions seemed justified in the new scheme. Alienists embraced the anatomically sensible and scientifically verifiable theory, and in the process, says Cooter (1976), they lost the rationale (phrenology) that was essential for the continued advancement of moral therapy.

Discussion

The complexity of phrenology, alternately called a scien-
ence, a philosophy, and a religion, counters any view that it was the singular force that propelled moral treatment. Both moral treatment and phrenology emerged within a context in which patients and practitioners, sure of their old beliefs, used methods that addressed the relationships between persons and environments, between the mind and the body. Both moral treatment and phrenology floundered when this rational construction was debunked.

This particular reading of the story of moral treatment may suggest that practitioners should restore the 19th-century belief that caring is linked to cure. If helpers saw time spent in conversation, if they saw caring expressions as actions that cured, surely they would endorse such practices. What if helpers applied rational formulae such as “discussing the meaning of illness lowers patients’ blood pressure” or “listening to patients discuss their values yields great gains in treating depression?” Might practitioners then act with care?

Gregg believes that such caring would be short-lived, arguing that real understanding will elude helpers who seek it through the lens of what is rational: “It [rationality] does not furnish us with tastes, significance, values, and meaning. . . . For in illness, fear, anxiety, shame, and uncertainty call for understanding, sympathy and imagination, courage and companionship” (1941, p. 98).

Patients today, as in earlier days, ask their helpers to encourage them through their illnesses. They ask that helpers care, not because concern may cure, but because caring serves humanity. To embed caring in a formulaic connection with cure is to risk losing sight of its centrality in practices that do not always cure.

Moral treatment and the caring that it embodied flourished when persons saw themselves and their worlds as connected and interdependent. When practitioners saw that illness had personal meaning, they worked to personalize treatment. Several 19th-century ideas bear remembering. A practitioner using his or her senses can find clues about the meaning that each person ascribes to illness. Patients are persons whose recovery goes hand in hand with their being thought unique. A practitioner using his or her senses can find clues about the meaning that each person ascribes to illness. Patients are persons whose recovery goes hand in hand with their being thought unique. A practitioner using his or her senses can find clues about the meaning that each person ascribes to illness. Patients are persons whose recovery goes hand in hand with their being thought unique. A practitioner using his or her senses can find clues about the meaning that each person ascribes to illness. Patients are persons whose recovery goes hand in hand with their being thought unique. A practitioner using his or her senses can find clues about the meaning that each person ascribes to illness. Patients are persons whose recovery goes hand in hand with their being thought unique. A practitioner using his or her senses can find clues about the meaning that each person ascribes to illness. Patients are persons whose recovery goes hand in hand with their being thought unique. A practitioner using his or her senses can find clues about the meaning that each person ascribes to illness. Patients are persons whose recovery goes hand in hand with their being thought unique. A practitioner using his or her senses can find clues about the meaning that each person ascribes to illness. Patients are persons whose recovery goes hand in hand with their being thought unique. A practitioner using his or her senses can find clues about the meaning that each person ascribes to illness. Patients are persons whose recovery goes hand in hand with their being thought unique. A practitioner using his or her senses can find clues about the meaning that each person ascribes to illness. Patients are persons whose recovery goes hand in hand with their being thought unique. A practitioner using his or her senses can find clues about the meaning that each person ascribes to illness. Patients are persons whose recovery goes hand in hand with their being thought unique. A practitioner using his or her senses can find clues about the meaning that each person ascribes to illness. Patients are persons whose recovery goes hand in hand with their being thought unique. A practitioner using his or her senses can find clues about the meaning that each person ascribes to illness. Patients are persons whose recovery goes hand in hand with their being thought unique. A practitioner using his or her senses can find clues about the meaning that each person ascribes to illness. Patients are persons whose recovery goes hand in hand with their being thought unique. A practitioner using his or her senses can find clues about the meaning that each person ascribes to illness.

Each of these 19th-century ideas makes good sense for a 20th-century health care practice. To once again see illness as a life experience, to regard the senses as ways of understanding, to regard the patient as singular, a practitioner must expand any rational theory that values cure or success over kindness. If occupational therapists want the heart of moral treatment to survive the shifts of ever-changing theories, they must hold caring attitudes, words, and actions at the center of their practice.

This position can be an affirming one for occupational therapists who often struggle against difficult odds to create a climate of caring. If giving a crossword puzzle to a patient who might complete the task during leisure hours is not reimbursable, it is a gesture that embodies the kindness of moral treatment. If giving a patient how a weekend pass was spent is not part of the treatment plan, it is a communication that embodies the concern of moral treatment. If giving a patient several choices during each treatment session is not part of a protocol, it is an action that embodies the faith in human capacity that is the hallmark of moral treatment. If occupational therapy treatments are moral, they may be more readily perceived as caring. ▲

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