Original article: history of medicine

Nineteenth Century Moral Treatment of Mental Illness Wore Many Hats

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Abstract. While its lessons are some two centuries old, moral treatment remains the greatest advance in the history of inpatient treatment of mental illness. Recent books and reviews have generally shaped our understanding of moral treatment into an early 19th century enclave in humanitarian psychological care for those suffering from insanity that was preceded by violence and banishment and followed by custodialism and therapeutic nihilism. This paper uses literature both from the era in question and previous to our generation to present a new picture of its contributions and limitations. A multi-fold definition is proposed for moral treatment. Its components are asylum sequestration, authoritarianism, compassion, early psychology, occupational treatment, self-control, and therapeutic optimism. A number of previously under-described features stand out when examined through this lens. Rather than uniquely charitable, it was best suited to wealthy patients. Impractical for average or severe patients, moral treatment was most applicable to those who were convalescent and suitably intimidated. Early psychological treatments were only a minor armament in its therapeutic arsenal. The heralded restraint-free conditions were an exaggeration. The anticipation that high rates of patient cures was limited to the moral treatment era (cult of curability) is likewise mistaken. Pessimistic cure rates in the era of custodialism failed to merit the title nihilistic. These limitations are frequently unknown or ignored by scholars and lend some context to the praise of moral treatment, which is no less praiseworthy, just a bit more seasoned and nuanced.

Key words: coercion, Conolly, custodialism, inequality, Pinel and Tuke.

Introduction

Moral treatment rightly receives high praise for lifting modern psychiatry out of medieval maltreatment of patients. Eight of the world's top 20 most influential psychiatrists of all time were moral therapists (1). Many of the best features of today's inpatient psychiatry can be traced to moral treatment. Yet features that undermine its mainstream understanding are the subject of this essay. Little has been done to examine its workings and to compare the gap between rhetoric and practice. The following pages briefly scrutinize what moral treatment actually was and the context of its application, not to criticize, but instead to mitigate today's confusion over what it was and its implications.

A recent biography of a mid-19th century French moral treatment leader known for his Treatise on Madness (1846) reads "By the 1840s French psychiatrists had abandoned Moral Treatment as an individual psychological treatment, as opposed to an institutional practice." (2). This is representative of many moral treatment descriptions that reveal more than one curiosity. For example, how could an 1846 text spearhead a movement that had already ended? How can there be multiple conceptions of moral, preceded by one or more qualifiers? These are the kinds of questions that motivated this manuscript: what and

when were moral treatment and how well did it fit its nominal features?

What was moral treatment?

The rise of psychology and compassion for the "insane" hastened a new era in the concept and treatment of mental illness at the turn of the 19th century. The "lunatic" (3) was newly distinguished from those who misuse alcohol, criminals, diseased, sufferers of epilepsy, persons with developmental disabilities, "heretics" and the commonplace "pauper" (2). Humanitarian reform coincided with the rise of asylums where keepers pitied rather than indiscriminately beat, mocked and victimized patients. No longer did London's Bethlehem Royal Hospital (Bethlem, Bedlam) sell admission to the public to enjoy spectacles of "inmates" treated like animals.

These developments came to be known as moral treatment. This term is used not in opposition to moral therapy or moral management, but rather to reflect a more inclusive verbiage. Long since confusing in 1874: "No term has of late years been more profusely and empirically employed, and none has been less understood, than 'the moral treatment of insanity." (4). Frustrated by indistinct, and, alternatively, overly precise descriptions in the literature, the author proposes a definition of moral treatment as the summation and negotiation of the seven principles shown in Table 1 (Tab. 1). Not merely the dualistic antithesis of Old York, Bethlem and St. Luke's London asylums, specific features stand out. Some are individually recognized by one observer or another, and few are familiar to all. Moral treatment enjoys (4) general association with the humanization of, and kindness toward patients. It also encompasses (2) promoting what might be likened to psychology over medicine, (3) coercion justified by therapeutic paternalism, (2) sequestration in asylums, (4) the rewards of physical labor and various diversions, and (5) self-control through firm but fair enforcement of rules. The cult of curability (6) came to describe moral treatment's unusually optimistic outlook on the potential for patient recovery. What separates the prison turnkey from the "alienist" is a commitment to treat patients; to restore them to sanity.

When was moral treatment?

Two events just prior to 1800 tend to mark the beginning of moral treatment and three events nearly a generation later indicate its acceptance. It began in 1796, when the Retreat near York, England was opened by Quaker William Tuke (1732-1822) and family. This was followed by the said literal and dramatic removal of the chains and shackles from hapless Bicêtre and Salpêtrière asylum patients in Paris by colleagues of physician Philippe Pinel (1745-1826) in 1797. The genius of Italian Chiarugi went substantially unnoticed in England and America.

Table 1. Seven features that encompass moral treatment.

	Definition/Description
a	"a short-lived period of *humanitarian* hospital care of mental patients in [the] 19th-century" (5). "The delivery of therapy through compassion, understanding, sympathy and respect for the individual. Often described as 'restraint through *kindness* rather than restraint by chains'. Designed to induce patients to collaborate in their own recovery." (6).
b	"all nonmedical techniques, but more specifically it referred to therapeutic efforts which affected the patient's *psychology.*" (7)
c	"persuasion and suggestion—as well as the *authority* of the figure of the" superintendent (8). "subservience and submission to authority (un ascendant moral), as well as trust (confiance) are important preconditions for the success of moral treatment" (9).
d	"The acceptance of mental patients as sick people and their release from chains into a benign, *hospital* environment" (10)
e	"*Occupational* therapy", such as manual labor, sewing, recreation, etc (11)
f	"to strengthen the capacity for *self-restraint*. The hope is that patients will eventually be able to restrain and battle their own symptoms: hallucinations, delusions, impulses and unruly passions" (12).
g	"A cardinal claim, upon which all others hinge, was the belief that madness was *curable*." (13).

Moral treatment was known and praised in the "alienist" community shortly after a description of the York Retreat was published in 1813 (14) Scandals at Bethlem and Old York were publicized in the first report from England's Committee on "Madhouses", Great Britain (1815) (15). Pinel's clinical chef d'oeuvre, the 2nd 1809 expanded version of his 1801 Treatise (16) generally missed English-speaking readers (17). The first U.S. humane moral treatment hospital was in Philadelphia. The Friend's Asylum, supported by (im) probable (18) moral treatment leader Benjamin Rush (1745-1813), opened its doors in 1817. Moral treatment was adapted and adopted by other institutions.

A total of eight U.S. moral asylums in 1840 grew to 30 by 1847 (19). Moral treatment folded in the following decade. Public asylums were flooded with patients until personalized medicine became impossible. The onset of the American Civil War, (1861-1865) marks the end of moral treatment (20). None of the approximately 60 U.S. mental asylums in 1875 relied upon the moral model (21). In this time of custodialism, therapeutic nihilism is said to have reigned, and the rate of cure for "insanity" approached zero (see below). Little improvement in the treatment of mental illnesses occurred until the shock therapies of the 1930s, followed by anti-"psychotic" and anti-depression pharmaceuticals in the 1950s.

All of this suggests that the era of moral treatment peaked between 1810 and 1850 in New England and Great Britain. These dates can be infinitely disputed, yet, to the best of our knowledge, they are the first defensible numbers to be proposed.

Moral treatment was frequently for the wealthy

Quakerism is suited to a patient, paternalistic and kinder approach to treating "insanity." Known as the Society of Friends, it is a protestant faith caricaturized by benevolence, charity, discipline, equality, non-violence, peace, self-restraint, temperance, and capitalism. The last quality should not be ignored. Rather than needy, a 19th century observer remarked that from 1796 to 1840, patients at the Retreat near York were "well-to-do people" (22). In 1800, the Retreat was intended to be philanthropic. By 1900, the dream of a charitable Quaker-only hospital found itself disappointed by a patient population of 50% wealthy non-Quakers. Likewise intended to be charity facilities, less than 10% of Bloomingdale asylum's patients were unemployed in 1848. Their census was skewed toward New York City's commercial and wealthy patrons (23).

The two socio-economic tiers recognized as the highest, including property owners, merchants, retailers and craftsmen, consistently composed approximately 80% of the patients at the York Retreat over its history from 1796 to 1910, while there were only 4% in the fourth tier: unskilled laborers and indigents (24). Many early 19th century patients on both sides of the Atlantic declined to participate in moral occupational treatment because they considered manual labor degrading. It was simply beneath their station. The superintendents must have been sympathetic because their patients' will held (23, 25).

Sufficient attendants to care for patients are necessary for patient care and support activities in every mental health facility. This was said to have been a critical feature of moral institutions (26). In 1847, the ratio of attendants to "inmates" in England varied from 1 in 25 at Lancaster (a "pauper" asylum) to 1 in 4 at the York Retreat (24). The preponderance of attendants reported for moral asylums may actually be too conservative. Wealthy patients brought their own additional servants who were absent from the institutional payroll. The impact of the attendant to patient ratio may be gleaned from the 1815 testimony of Bethlem Hospital's apothecary, John Haslam (1764-1844) and principle physician, Thomas Monro (1759-1833):

> [Mr. John Haslam]
> *You are the apothecary of the hospital at Bethlem?*
> --I am
> *How long have you been in this situation?*
> --I was elected in the year 1795, I have been in that situation nearly twenty years.
> *What number of inhabitants have you in the hospital now?* --I believe there are about 122, within one or two.
> *What number of keepers are there to these patients?*
> --There are two female keepers, and there are five male keepers, two of whom, in rotation, perform the offices of cook and cutter.

> *Are you of the opinion that the five who perform the duty of keepers, are sufficient for the attendance upon 121 insane persons?* --That will depend very much on the state of violence in which such patients may be. . .
> *How many were under restraint when you went round this morning?* --I should think among the females six, and among the males, I think not more than four.
>
> [Dr. Thomas Monro]
> *Would you treat a private individual patient at your own house, in the same way as has described in respect of Bethlem?* --certainly not...
> *What is the difference in management?* --In Bethlem the restraint is by chain ; there is no such thing as chains in my house.
> *Why is not the restraint by chains and fetters, in your private house?* --There is such a number of servants, there is no sort of occasion; I have forty odd patients and as many servants...
> *Are you of the opinion, that if a greater number of keepers was allowed in Bethlem, there would be less necessity for restraint?* --The more keepers there are, the less necessity I should think for restraint; for the more keepers there are, the more there are to watch them, and prevent them from being riotous and mischievous (15).

Strictly speaking, neither Haslam nor Monro were moral therapists, but their treatment of private and public patients is instructive. This exchange suggests that asylums for the wealthy had more in common with moral treatment than did public facilities, many of which were intended to be progressive. Were it not for the rough treatment of King George III, the moral hospital might be mistaken for just another therapeutic abode for the rich. This caveat is reinforced by Pinel, who treated indigent patients in Paris.

To avoid confusion, it is admitted that private hospitals were frequently criticized in the early 19th century. This ire was not directed to the wealthy, but instead toward the common "mercenary" hospitals, run for small financial gain at the lowest sum available from public and private funds. These were said to have provided skilled restraint but little or no care and even less amenities than public hospitals.

Moral treatment required authoritarianism and coercion

Hiding nowhere is *the authority of the figure of the superintendent*. It was intended to be absolute. Some took pride in their ability to stare down patients (27). Leading psychological treatments were admittedly based upon fear: fear of the superintendent, fear of sudden and unexpected immersion in a vat of cold water, fear of physical and sensory deprivation, fear of stomach- and gut-wrenching medicinals, and fear of vigorous gyration. Credible threats were the norm. A major goal of moral treatment was to break the patient's will, reducing them to docile subordinate children; establishing order by awe and dread (28). This is difficult to reconcile with the labels kind and compassionate.

Moral treatment earned much praise for turning its back on indiscriminate violence, neglect and spectacle, but the transition was incomplete. Patients went from iron and chains to straightjackets and cloth restraints. Some observers said cloth restraints were less comfortable than metal due to sweating and chafing. The straightjacket was ostensibly invented by the Quakers (29). A subject matter expert said the strictest restraint he ever witnessed was at the York Retreat, shown to him personally by William Tuke. In the 1830s, this institution was cited for failure to report the use of restraints (24).

Pinel and Tuke eased the burden of restraints borne by inmates by putting them into straightjackets, hand sequestration, and leg irons—dubitable improvements. At the York Retreat, at any one time, 10% of patients were in mechanical restraint. Coercion was also present in chains, handcuffs, and manacles (24). In 1841, Conolly reported his 1000 inmates were managed with seclusion; no restraints, despite some violent inmates. In practice, "restraint-free" meant taking control of "wild" patients by hand and locking them in small dark rooms where walls were padded with coconut fiber-stuffed canvas pillows and the floors were a heap of straw that served as both blanket and toilet (26). If the author is not mistaken, this punishment is today feared

as "the hole" in correctional facilities. Here we have yet another innovative method of coercion from a moral treatment reformer; the inhumane padded seclusion room (30). Patients were also calmed or punished by sedation, revoking privileges and denying meals.

In 1854, English reformers claimed 22 of 27 chief county asylums had abandoned the use of restraints and by 1858 all had. Little progress was made in Ireland or Scotland, and none in France or Germany (31). American moral treatment asylums had straightjackets, leather muffs for the hands, and immobilization devices cleverly designed to allow freedom of movement about the hips. The first resolution of the Medical Superintendents of American Institutions for the Insane in 1844, was to support the use of restraints upon psychiatric patients, including camisole, strapped to benches, handcuffs, ball and chain, and cribbed (32). Some moral treatment superintendents even convinced themselves that tight confinement was an effective treatment for "insanity" (33). If restraint-free was integral to moral treatment, then how could it have occurred in the U.S., where restraints were firmly in place during its tenure?

Moral treatment suited convalescent patients

In the short term, fear maintains order by the unthinking urge to avoid violence. Long term maintenance requires a connection between choices and consequences found lacking in, by definition, the presumably confused minds of those who suffer from psychoses. Delayed punishment and rewards only work on *convalescent* patients. Three great reformers: John Conolly (1794-1866), Pinel, and Tuke admitted that candidates suited to moral treatment had to be close to recovery and in possession of some intellectual faculties:

> respecting the emotional origin of insanity, is by no means adverse to the opinion that moral agencies, properly so called, possess but a limited efficacy in its treatment. . . In first stages of acute Insanity, all attempts at moral treatment are futile (14).
>
> regular intermittent insanity, religious melancholy, and delirium with a total obliteration of the faculties of judgement and reasoning. These are species of the complaint, which, according to my experience, never yield to moral remedies (16).
>
> during the unconfirmed stage of convalescence, when reason is struggling through the cloud which has obscured it, some mental as well as medical treatment is required, is, I presume, what no man will deny, who has really ever thought upon the subject. But can it be applied—is it possible that it should be applied—in the generality of cases in our lunatic asylums? (34).

To maximize their percentages of convalescent patients (the "curable class"), asylums as different as the Retreat and Bethlem picked and chose who they admitted. They turned away "demented", violent and those who had been sick too long or had failed to thrive at other institutions. From 1853-1862, Bethlem refused to admit patients who had been "insane" for more than 6-12 months (35) and those who had failed to recover at other institutions. In 1883, a Rhode Island asylum that followed the moral treatment model admitted patients who were "insane" less than 3 months, less than one year, more than one year but less than two years, and greater than two years at percentages of 56%, 28%, 4% and 12%, respectively (36). For a century following 1837 it was commonplace for asylums to discharge patients after one year, whether improved or not (37). This endured as the "one-year rule".

Non-psychological treatments dominated moral treatment

Feature *ii* of moral treatment suggests many early psychological applications to treatment. Yet moral "asylum" management continued with physical methods. The leadership of asylums was a superintendent, a medical doctor (38) or physician, an apothecary, and sometimes a matron. Often the same person served two or more roles. The words medical and physician have much in common with medicine and physical (physik meant inducing violent vomiting and defecation) but are a poor fit with psychological methods.

An apothecary was an early pharmacist. Institutions limited to psychological treatment would need neither a medical doctor nor an apothecary. Samuel Tuke reassured us in 1811: "The use of medicine is however far from abandoned at the Retreat" (39). In 1828, London "alienist" George Burrows, catalogued 23 therapies to treat "lunacy". Moral treatment made the list, but the remaining 22 were arguably physical with some social therapies, including bathing, counter-irritation, diet, exercise, gyration and swinging, hydropathy, hygiene, ingestion of metals, nutrition, reading, seclusion, sedatives, theater, trauma, etc (40).

Rush deserves his reputation as a bleed and purge physician, yet many consider him the first and foremost American moral treatment leader. His textbook, Medical Inquiries and observations upon Diseases of the Mind (1812) (27) is widely considered the first American psychiatric textbook on mental diseases. He made use of the chair swing and surprise bath. He invented the sensory-depriving fully-immobilizing coercion chair. His practice reflected the four humours lore of inflammation and plethora: illnesses were due to vascular spasms for which the cure was a trinity of bloodletting, purging and emetics. Patients' digestive tracts were forcibly emptied by antimony, castor oil, mercury and herbal poisons like hellebore, hemlock and nightshade. Rush popularized a powerful concoction of 10 grains each, calomel and jalap, that survived him as Rush's good old ten and ten (41). Salivation, urination, blistering, and sweating were also met with enthusiasm. Rush urged aggressive, "heroic" bleeding of "madmen", more than that bled for any other disease. Once again, physical therapies blossomed from the genius of moral treatment leadership.

The 'cult of curability' was at least half wrong

Custodialism is said to have much to do with overcrowding and the pessimistic end of moral treatment's cult of curability. "Asylums" were flooded with patients despite the repeated construction of new facilities. For example, brand new in 1831 and intended to house the sum of the "insane" of London's Middlesex County for all time, the enormous Hanwell Aslyum boasted 500 beds. In 1833 all beds were full; in 1835 it held 100 patients more than it had been built for. In 1837 it was enlarged to fit a total of 800 yet there were already 1000 patients on board. This prompted the construction of a second county asylum. Colney Hatch opened its doors in 1851 with beds for 1200 indigent madmen and women. By 1856, neither hospital could take on more patients, leaving over 1100 pauper lunatics to seek shelter elsewhere. The county commissioners did some shuffling and extensions were built to increase Hanwell's occupancy to 1600 and Colney Hatch's to nearly 2100 (42). And so on. The English Poor Laws that released "lunatics" from almshouses and workhouses receive much credit for asylum crowding but cannot explain the same phenomenon in U.S. and Europe where no such exodus occurred.

Past cure and improvement rates for mental illnesses are dubious from all sources. Descriptions, diagnoses and patient progressions go unstandardized and misrepresented. The same patient data could be interpreted by one "keeper" as a 50% recovery rate and another superintendent as 10% cured (approximately the rate of spontaneous remission). Some rates of cured patients were limited to the bias of the practitioner and that healing rates were a merely a reflection of therapeutic optimism (43). If moral practitioners were unusually optimistic, then high cure rates would be reported during moral treatment and low cure rates described before 1810 and after 1850.

The actual recovery rates are revealing when multiple institutions are considered (Fig. 1). The years from 1750 to 1850 appear to show substantially the same range of percent cures. It also appears that cure rates were reduced from 1850 to 1900. However, trendline fitting of the data never produced a linear regression with an R greater than 0.2. (For reference, an R less than 0.95 is generally considered suspect.) Thus, from the available data, no statistically rigorous argument can be made that percent recovery rates were different, before, during, and after moral treatment.

While no statistically significant conclusions can be made, the data suggest that cures described *before* the years of moral treatment were substantially the same as those during moral treatment: approximately 40-45%. Even Bethlem reported, on average, ⅔ patients of their patients fully recovering in the years 1684-1703 (44). From approximately 1775 to 1800, Exeter, Manchester

and Old York Asylums reported ½ their patients cured and 50% of those remaining improved (45).

There appears to have been a decline in therapeutic optimism *after* the years of moral treatment. However, this debatable decrease after 1860 was gradual. From its opening in 1848 there were no obvious changes in the average percentages of patients discharged from Butler hospital as cured, improved, unimproved, and expired. These stood at approximately 35%, 30%, 15% and 20% without substantial change for 35 years (36). In the late 1800s, most hospitals claimed ¼ to ½ schizophrenics could be cured (Figure. 1). One could hypothesize that recovery rates of no more than 1/3 became the norm by 1900. Taken at face value, this is three times the spontaneous recovery rate, surely something greater than therapeutic nihilism.

Conclusions

Few have taken to trouble to define moral treatment and these have generally missed multiple critical aspects. Moral treatment was a broad entity with seven features. These are compassion, psychology, asylums, authoritarianism, occupational treatment, self-control, and therapeutic optimism. The author suggests an actual time window for moral treatment. Its definition and lifespan are debatable, but there are few, if any, alternatives available to accommodate the data

Like everything else in life, moral treatment fell short of its ideals. It was not the solution to, but rather an improvement upon contemporaneous methods, and frequently limited to the wealthy and convalescent. Psychology never exceeded a minor component and

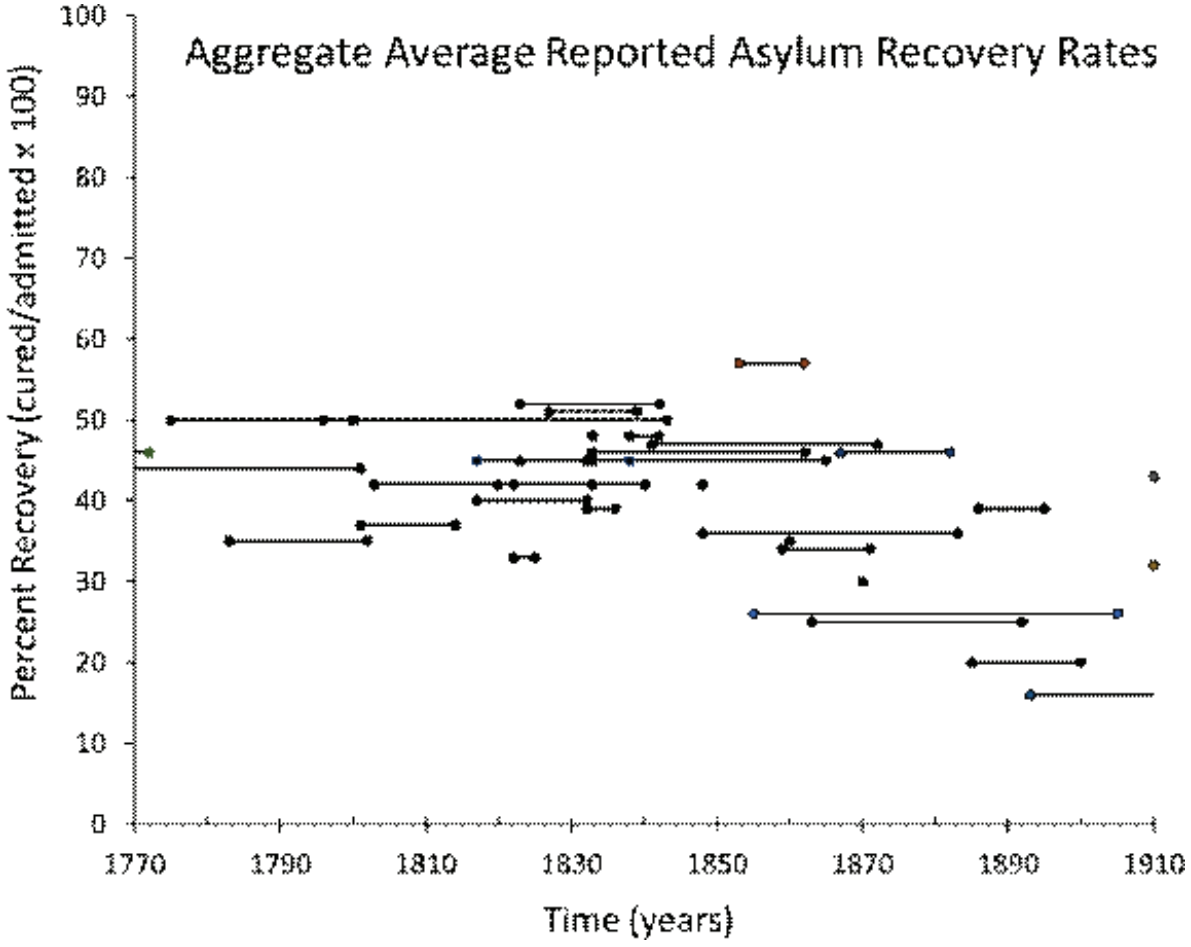

Figure 1. Pooled "insanity" recovery reports. Barbells indicate closed intervals. For example, the highest segment is 57% recovery reported from 1853-1863. Isolated dots are annual reports

restraint-free was a misnomer. Further, only limited evidence exists for unprecedented therapeutic optimism during the era of moral treatment. This is not an indictment of moral treatment, rather a wider context for understanding its milieu and impact.

Moral treatment brought about scores of public asylums. These survived the end of moral treatment and have *always* been overcrowded and miserable. The end of the asylum waited until some 160 years after the end of moral treatment. In painful irony, this was partially due to the fulfillment of a great promise of moral treatment: the right to individual treatment (46). Hospitals could hobble along with overcrowding, but they folded under the pressure for actual patient treatment and the end of uncompensated convalescent "inmate" labor, understood by some to be masquerading as occupational treatment (5).

Psychological methods and pharmaceuticals, have greatly improved since the days of moral treatment but problems remain. Moral treatment's self-deception of "restraint-free" suggests that contemporary solutions to coercion should be carefully considered and carefully monitored. For example, restraints continue to be manufactured and are routinely sold to health care facilities. Padded seclusion rooms remain in place. The gap between the treatment of the rich and poor has decreased, but obstacles to equality remain formidable. Let this work help the modern planner remain vigilant and avoid slipping into complacency, especially when praising the example of the past without considering its limitations. They may be equally encouraged by no longer having to compare themselves to ideal circumstances.

Acknowledgements: The views expressed in this article are those of the author and do not necessarily reflect the official policy of the Department of Defense or the U.S. Government. Clinton Coates provided expert library services.

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