

Moral Treatment: Contexts Considered

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Many scholars associate the 19th-century practice of moral treatment with occupational therapy practice. A more thorough understanding of moral treatment is therefore relevant for occupational therapists. This article considers moral treatment within the contexts that shaped both its characteristics and the course of its practice—the medical community and 19th-century society. This consideration may provide therapists with a broader understanding of moral treatment and enable them to address the question of a relationship between the two practices.

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Moral treatment is intriguing in its emergence, its essence, and its decline. The fascination with moral treatment deepens when one encounters the 20th-century term *occupational therapy* used in historical commentaries about this 19th-century practice. Digby (1985), in discussing moral treatment, noted that “occupational therapy took a variety of forms” (p. 63). Bell (1980) and Grob (1973) both identified occupational therapy as a component of moral treatment. Although this identification is incorrect in the strict historical sense, it is perhaps apt in other ways.

Three views provide different representations of the nature of the relationship between moral treatment and occupational therapy. Bing (1981), an occupational therapist, described the relationship as evolutionary: “Occupational therapy’s roots are in the subsoil of the moral treatment developed in Europe during the Age of Enlightenment. . . . Moral treatment came to the U.S. as part of the Quaker’s religious and intellectual luggage. . . . During the last quarter of the 19th century moral treatment disappeared. It re-emerged in the early decades of the 20th century as Occupational Therapy” (p. 499). In contrast, Bockoven (1971), a psychiatrist, insisted that “the history of moral treatment in America is not only synonymous with, but *is* the history of occupational therapy before it acquired its 20th century name of ‘occupational therapy’ ” (p. 225). Engelhardt (1977), a philosopher familiar with Bockoven’s work, suggested a similarity between moral treatment and occupational therapy in the attempt to “effect more successful adaptation to society through organizing certain activities for patients in special environments” (p. 668). These divergent views suggest that a clearer understanding of the nature of moral treatment is relevant for occupational therapy professionals. Such an understanding seems particularly valuable in light of the continued desire within the profession to clarify its identity and its lineage.

A Definition of Moral Treatment

Dr. Thomas Kirkbride (1880/1973), a physician and the superintendent of the Pennsylvania Hospital for the Insane from 1841 to 1883, described moral treatment in terms of daily efforts to provide “system, active movements, and diversity of occupation” to the patients (referred to then as “inmates”) (p. 275). Dr. Amariah Brigham (1847), a contemporary of Kirkbride, interpreted moral treatment as “the removal of the insane from home and former associations, with respect and kind treatment upon all circumstances, and in most cases manual labor, attendance on religious worship on Sunday, the establishment of regular habits of self control, [and] diversion of the mind from morbid trains of thought” (p. 1).

More than 150 years later, Dain and Carlson (1960) characterized the theory and practice of moral treatment as the psychological medicine that constituted milieu therapy in the 19th century. Tomes (1984) believed that moral treatment was based on the assumption that one could appeal to the patient's innate capacity to live an ordered and rational existence. To allay any concern that moral treatment meant the enforcement of moral standards, Bockoven (1963) argued that early psychiatrists used the word *moral* to mean *psychological* or *emotional*. He viewed moral treatment as "the first practical effort made to provide systematic and responsible care for an appreciable number of the mentally ill" (p. 12).

Other interpretations articulate various goals and principles underlying moral treatment. Several of these suggest that moral standards were, in fact, guiding principles. Grob (1973) described the goal of moral treatment as the "inculcation, through habit and understanding, of desirable moral traits and values" (p. 12). Rothman (1971) viewed the process of moral treatment as the arrangement of a disciplined routine that provided stability for a person suffering from environmentally generated ills. Bell (1980) considered moral treatment to be a distinct method of therapy that enabled the patient to understand right from wrong within a total therapeutic community. Through moral treatment, the physician manipulated both the environment and the patient to help the patient overcome past associations and to create an atmosphere in which natural restorative elements could assert themselves (Grob, 1983). The image of moral treatment emerging from these interpretations is one of a treatment of the mentally ill that occurred in virtually all institutions; it included humane treatment, a routine of work and recreation, an appeal to reason, and the development of desirable moral traits.

Moral Treatment Within Its Various Contexts

An understanding of certain 19th-century conditions is crucial to an appreciation of the significance of moral treatment's emergence. Two environments—the medical community and 19th-century society as a whole—did much to influence the characteristics of moral treatment and its emergence in institutions.

The medical community's perception of insanity greatly influenced the development of moral treatment. A shift in 19th-century thinking revolutionized medical thought: persons with mental disorders, then labeled "the insane," were capable of reason. Before this awareness, insane persons had been considered subhuman because they were believed to be devoid of reason (Deutsch, 1949). Torturous methods were used to treat insane persons. These methods were

used not to inflict pain, but to frighten the irrational beast. Methods congruent with contemporary theory included chaining the patients, placing them in cold showers, and lowering them into water-filled wells. The physician's goal was to dominate patients to cure them (Carlson & Dain, 1960). Only when it was acknowledged in the early 19th century that insane persons retained intellectual and rational capacities could treatment methodologies change.

The new philosophy of insanity generated the first humane systems for treatment in Europe. Philippe Pinel, a physician in France, and William Tuke, a Quaker in England, established the specific regimen of moral treatment. Pinel first used the term *moral treatment* (*traitement morale*) in 1801, but it was not until 1817 that a hospital was founded in the United States expressly for the purpose of providing moral treatment. This hospital, built by Pennsylvania Quakers for members of their Society and patterned after Tuke's York Retreat in England, was named the Friend's Asylum. Within 7 years, three more privately endorsed mental asylums (called *corporate asylums*) were built: McLean Hospital in Massachusetts, Bloomingdale Hospital in New York, and the Hartford Retreat in Connecticut. All of these corporate asylums practiced moral treatment (Bockoven, 1963).

This humane system of moral treatment became identified with institutional care. Its character was shaped by the medical men of these early institutions. Scull (1981) called the first four asylums the "earlier generation of asylums" (p. 151). Many developments among this earlier generation significantly influenced later institutions. The first influence related to lines of authority for providing treatment. The Bloomingdale Hospital and the Friend's Asylum, which were patterned after the York Retreat in England, were initially managed by lay superintendents, a custom prevalent in Europe. These superintendents oversaw the provision of moral treatment, and resident physicians provided mild medical treatments for physical conditions. At the Hartford Retreat, a physician named Eli Todd was superintendent. Todd endorsed and supervised traditional therapeutics as well as an increasing use of opium and morphine to complement moral treatment. He campaigned for medical treatment at the other three asylums. As a result of his efforts, medical treatment came to figure more prominently at all of these institutions. Over time, an uneasy relationship developed between the medical leadership and the moral leadership. In 1850, the tension culminated in a codification: An asylum superintendent would be a well-qualified physician. This new role that combined moral and medical functions became the leadership model adopted by the second generation of asylums (Scull, 1981).

A second early asylum influence was the adoption of public relations measures in the community. Superintendents realized that the negative image of European “madhouses” was powerful. They made a point of using annual reports to communicate the advantages of asylum treatment. The widespread communication of these messages was continued by later superintendents.

A final measure through which early superintendents ensured their influence on second-generation asylums was their personal involvement in the establishment of the first state asylums: Worcester State Hospital and Utica Asylum. These two facilities, though designed more for public than for private use, were patterned after the early asylums. These second-generation asylums, in turn, became models for later state facilities. The consolidated physician–superintendent role, the public relations efforts, and the tutelage of second-generation superintendents solidified the manner in which moral treatment would be practiced. The setting would continue to be institutional, the overseers would be physicians, and the public would remain convinced of the utmost practicality of this arrangement.

Changing social patterns during the 19th century helped to place the practice of moral treatment in institutions. America was industrializing, and many people moved from farms to urban centers. The urban family clustered into smaller units and became less able to deal effectively with its ill members. Not surprisingly, the new view of insanity was linked to these changing social patterns of industrialization and urbanization. Dr. Isaac Ray (1861), superintendent of the Butler Hospital, noted that many of his patients displayed deranged moral faculties of the will and of the emotions, although their intellectual faculties remained apparently intact. Deranged moral faculties could be attributed to societal tensions and chaos in the community, which social observances and institutions of the time were unable to handle. The result, for some, was moral insanity (Rothman, 1971).

Given the environmental causes of insanity and the family unit’s growing inability to keep a family member with insanity at home, upper- and middle-class members of the community saw the asylum as a new, less chaotic, and more effective environment that could first halt and then reverse the process of insanity. The acceptance of institutions was not a desperate measure. With physician–superintendents and asylum supporters advertising their effectiveness in curing insanity, families admitted the insane with a sense of optimism (Rothman, 1971). The community supported physicians in this new movement toward institutionalization of a class of the population heretofore treated at home. Poor persons, commonly

housed in local jails and poorhouses, were minimally affected during the early years of moral treatment (Dain, 1964; Deutsch, 1949; Galt, 1846/1973).

American superintendents shaped the practice of moral treatment. In Europe, the prevalent belief was that moral treatment alone cured insanity; in the United States, some form of medical treatment accompanied moral treatment (Scull, 1981). Tomes (1984) claimed that American superintendents reworked Pinel’s original concept of moral treatment to justify treatment by medical doctors. This reworking is evident in Brigham’s (1844) writings. He believed that deranged moral and intellectual faculties were generally the result of a diseased brain, although he thought that emotions and great trials of affection could derange brain function and cause insanity. Treatment of insanity stayed within the province of medical practice because physicians continued to link insanity to a disease process. Additionally, moral treatment in the United States was considered most appropriate for recent cases of insanity; more chronic cases (often the long-standing cases among the poor) were considered less likely to be reversed. The chronicity of disease among the poor made them less suitable candidates for moral treatment. For the most part, the asylum community consisted mainly of upper-middle-class doctors treating upper- and middle-class patients.

The Asylum: Structuring a New Environment

American physicians became involved in the design of the new therapeutic environments. As asylum superintendents, they were responsible for individual patient care, management of daily operations, and supervision of asylum personnel. Largely from the upper middle class, they were said to prefer treating patients from their own social stratum (Bell, 1980). They enforced the admission policies specific to their asylums, although they sometimes made concessions to local authorities and accepted a few poor people. Admission policies varied widely. Many corporate institutions totally excluded the poor; others, such as the Quaker asylums, admitted them more freely.

The standards set by the private asylums also set the example for state institutions eager to attract curable patients (Tomes, 1984). The Pennsylvania Hospital for the Insane, a public institution that began receiving patients in 1841, has been called by much of the literature one of the best American mental institutions of that era. Superintendents of corporate asylums welcomed public institutions as an alternative for poor inmates. The previous two-tier treatment system of the asylum versus the poorhouse or jail was evolving into one of the private versus the state institution.

Appropriate construction was a critical factor. Kirkbride thought "a properly constructed building . . . indispensable for such an effect [cure]" (Dain, 1964, p. 76). The building design was also important because it had to appeal to the public. The typical state hospital of the 19th century was constructed according to the Kirkbride Plan, which was officially endorsed by the Association of Medical Superintendents of American Institutions for the Insane. The Kirkbride Plan called for a large central administration building, from which extended several long, straight wings for housing patients. The design of the wings, with windows spaced evenly, embodied the belief that insanity could be cured by an ordered and rational environment (Rothman, 1971).

The internal structure of the asylum was considered as important to the ability to effect a cure as was the external structure. Classification of patients was an essential component of moral treatment and was incorporated into the building's internal structure. In the 19th century, physicians classified insane patients as manic, melancholic, or demented. These categories continued to form one basis for their classification in the asylum. Inmates were also separated according to sex, behaviors, and degree of illness (Tomes, 1984). At the private Friend's Asylum, for example, quiet convalescent inmates were separated from more acutely ill, violent, and noisy patients. Asylums that admitted more heterogeneous populations housed and grouped their inmates according to classes as well. Tomes described the rationale: "Since, in a non-institutional setting, patients would have expected to see class distinctions in housing and employment, the asylum replicated these features of everyday life" (p. 126).

Classification dictated various levels of care. Private asylums usually gave paying patients better treatment than they gave poor patients; this meant better accommodations and more attention. Moral treatment methods for individual patients, then, varied according to their socioeconomic status, sex, degree of illness, and ability to gain admission to an asylum.

Occupations Within the Asylum Context

Pinel (1806/1962) said that silence and tranquility prevailed in the Asylum de Bicetre when the Parisian tradesmen supplied the patients with employment that held their attention. He noted that even "the natural indolence and stupidity of idiots [*sic*] might in some degree be obviated, by engaging them in manual occupations, suitable to their respective capacities" (p. 203).

American superintendents made daily routine and occupation a central component of moral treatment. They claimed that the ultimate results of these two components outweighed the considerable initial

cost of the arrangements necessary for their implementation. Labor, or occupation, judiciously used, contributed not only to patient comfort but also to health and recovery (Kirkbride, 1880/1973). Asylum staff went to exceptional lengths to engage patients in manual tasks. Kirkbride encouraged his patients to do any task; the critical thing was to keep busy. The therapeutic rationale was that occupation inculcated the regular habits necessary for recovery (Rothman, 1971). Throughout each carefully structured day, men engaged in agricultural pursuits, carpentry, painting, and general maintenance. Women performed domestic chores and manual crafts. The superintendents agreed that productive labor was the most important element in moral treatment (Grob, 1973). A precise schedule and regular work characterized the best private and public institutions.

The superintendents assigned occupations according to a patient's classification. Not all occupations were considered suitable at all stages of illness; superintendents were cautious about overtaxing patients or exposing them to potentially hazardous situations. Brigham felt that the members of the curable class benefited most from the rational engagement of the mind through reading, writing, drawing, music, and various studies and recreational pursuits. Patients viewed as incurable benefited more from manual labor to preserve whatever mind they still possessed (Brigham, 1847). In some cases, hardworking patients could reduce their board payments or earn placement on the free list (Tomes, 1984). Cooperative and industrious behaviors could also result in the acquisition of special privileges or "advancement to a better gallery" (Galt, 1846/1973, p. 497). In most asylums, occupation was supplemented by religious exercises, regular physical exercise, and group amusements organized by the staff. The use of occupations reflected an awareness of individual differences, of comfort level, and of degree of illness, but it also revealed a class and sex bias.

Dr. Lee, the superintendent at McLean Hospital, described the results of occupation: "Give a man constant employment, treat him with uniform kindness and respect, and, however insane he may be, very little may be feared from him, either of mischief or indolence" (Galt, 1846/1973, p. 50). He said that bodily labor proved immeasurably superior to all other aspects of treatment with a large class of male patients. The asylum staff encouraged patients to engage in energetic labor as a way to work off irritability. Perseverance and ceaseless efforts resulted in a patient's return to industrious habits, even with chronic cases. In these cases, attendants often helped patients initially with the motion required for a task until it was mastered. Asylum reports touted the successes at length and in great detail. Labor helped to inculcate

moral habits in the patients; as a secondary benefit, labor often helped maintain the asylum.

Besides occupation, other treatment operatives were used in the early asylum. The superintendents in all institutions invoked the use of kindness. The patient population was kept low to facilitate individual care, and doctors met with individual patients daily. The Hartford Retreat, for example, housed only 40 patients (Deutsch, 1949). The staff used restraints minimally, appealing instead to patients' rationality. A system of rewards and privileges replaced a system of punishments. Cooperative patients could be promoted in classification, which encouraged self-control (Galt, 1846/1973). Radical medical treatments such as bleeding and the use of purgatives and emetics were replaced by the use of tonics and narcotics such as opium (Galt, 1846/1973). Family members were discouraged, but not forbidden, from visiting, because new associations were essential. The attendants became the patients' constant companions, and each attendant cared for one to six patients. The superintendents were diligent in obtaining attendants and nurses of the best character (Galt, 1846/1973). Families were encouraged to commit patients for a minimum of 3 to 6 months, time enough to demonstrate some progress. Confinement in a new environment and isolation from previous associations marked the beginning of a cure for environmentally caused insanity (Rothman, 1971).

Early Successes

In the small early asylum, success meant a cure. Statistics from the Worcester State Hospital between 1833 and 1842 show recoveries in 70% to 75% of the patients admitted, and improvements in 3% to 8% of the patients. Dr. Eli Todd of the Hartford Retreat reported recovery in 90% of the patients admitted with mental illness of less than 1 year's duration (Bockoven, 1963). Kirkbride (1880/1973) described his clinical observations of patients' behaviors both before and after the introduction of evening amusements. He said that a comparison of results "leaves no room to question the importance and great superiority of the last" (p. 273). Countless case histories validated moral treatment's success. Many of these case histories appeared in Galt's *The Treatment of Insanity* (1846/1973) and in the asylum's annual reports. One man, for example, reportedly suffered violent fits at least once a month. After he took up gardening and became involved, he was subsequently free of attacks (Rothman, 1971).

Grob (1973) thought that the success of the early asylum rested on a series of circumstances: (a) the small number and homogeneous nature of patients, (b) the internal therapeutic atmosphere arising from

the enthusiasm of the superintendent's personality, and (c) close interpersonal relationships. All this success resulted in a wild optimism that Deutsch called "the cult of curability" (Dain, 1964, p. 78).

The Demise of Moral Treatment

Moral treatment can perhaps be called a system. The systematization of moral treatment contributed in part to its own demise. Certain aspects of the practice and principles characterizing moral treatment made its survival incompatible with later 19th-century conditions.

Changes that led to the demise of moral treatment occurred first in 19th-century society, and second, in the medical community. While the providers of asylum care were touting its curative effects, a social reform movement was pushing to extend humane care to all insane persons. The push was successful; thousands of persons were crowded into existing asylums. A Civil War-taxed economy could not provide the rapid institutional growth that was needed to house this influx of patients. Asylum conditions deteriorated both from overcrowding and from a radical change in the types of patients treated. Because it was almost impossible to provide moral treatment, custodial care prevailed. Curative moral treatment was eliminated. Meanwhile, medicine was committing itself to more scientific inquiry and somatic treatments of all illnesses. A shift in thinking had occurred: insanity was caused by lesions in the brain. Therefore, consideration of environmental causes or treatments for what was essentially a physiological problem was unnecessary.

This course of events contributed to the demise of moral treatment partly because of certain characteristics inherent in the moral treatment system. For all its successes, moral treatment had its problems from the outset. One significant problem was the early superintendents' reluctance to deal with the poor, whether because of class bias or because of a genuine belief that the advanced condition of their disease precluded a cure. The early asylum experience tended to validate the assumption that poor persons presented hopeless cases. This validation occurred in the following manner. Superintendents sometimes labored under financial limitations. Public officials capable of providing funds were less concerned with effectiveness of treatment than with convenience of placement. These officials pressured superintendents to accept less curable cases to the asylum in greater proportions than had been recommended (Rothman, 1971). Additionally, it had been assumed that a therapeutic asylum would have a transient population because of a constant turnover of cured patients. In practice, a percentage of more

chronic cases stayed at the asylum. This situation created a different type of institution from that originally envisioned (Grob, 1973). The poor and the chronically ill, because they stayed, validated physicians' assumptions about their hopelessness. This would create a major obstacle when larger numbers of poor persons were later admitted.

Given their original expectations, physicians embraced middle-class behaviors and values as the norm; their emphasis was on the order, moderation, and self-control inherent in a middle-class life-style (Rothman, 1971). The initial theoretical and practical groundwork of moral treatment (that insanity was curable and that moral treatment was the cure) could have inspired a vigorous progressive movement across all classes. Instead, asylums were small-scale experiments that reached only a select group. Moral treatment was isolated amid a scene of widespread stagnation begging for reform (Rothman, 1971). At the time, public provision for poor persons consisted of sending the "dangerous and violent" to prison; the harmless and mild "paupers" went to auction or the almshouse (Deutsch, 1949, p. 115). The asylum superintendents showed little desire to treat the very patients who were to dominate asylum populations after the reform movement.

Michel Foucault (1965), a harsh critic of institutions in any form, for any reason, described moral treatment of mentally ill patients as a gigantic moral imprisonment: a "structure that formed a kind of microcosm in which were symbolized the massive structure of bourgeois society and its values . . . centered on the theme of social and moral order" (p. 274). Digby (1985) countered that any experience of moral imprisonment in the subjective estimation of patients would "turn on the extent to which they shared the moral values of the establishment" (p. 54). Real treatment successes would come from inducing self-control in patients sharing the values, assumptions, and objectives of their therapists. Those not sharing institutional values would only conform superficially; problems would surface with discrepancies in values (Digby, 1985). In fact, as Bell (1980) wrote, "When poor people having different values formed the majority of the patient population, moral treatment ran into difficulties" (p. 14).

Another problem of the moral treatment system was its administration by physicians. The patients might have fared better had asylums been under the direction of lay superintendents (Bockoven, 1963). Physician-superintendents focused on the cure. When scientific theory was to later challenge moral treatment's curative potential, physicians rejected their recovery statistics and early successes. Eager to join the mainstream of scientific medicine, they increasingly distanced themselves from the moral care of the insti-

tutionalized mentally ill patients (Grob, 1983). Bockoven described the situation as one in which psychiatry did not have the courage to pursue its original course.

Moral Treatment in Crisis

Moral treatment in the asylum meant cure. Social reformers thought that all insane persons should have access to asylum cure. A widespread reform movement in the 1830s and 1840s worked to improve the lot of persons who were blind, deaf, slaves, alcoholics, convicts, or insane. Dorothea Dix, using superintendents' annual reports as testimony, led state after state to construct asylums. Her dream, however, soon turned into a nightmare (Bell, 1980). New state laws mandated that dangerously insane persons be sent to asylums. Those insane persons previously housed in jails and almshouses also went to asylums. This rapid admission of large numbers of patients taxed superintendents and facilities prepared for small homogeneous patient groups. Psychiatrist-superintendents were largely unsuccessful in their protest against the influx and their suggestion that violent or chronic patients be segregated (Bockoven, 1963).

Overcrowding restricted the practice of moral treatment. Rooms used for leisure activities and workshops became sleeping quarters. Individualized patient care was no longer possible in the congested asylum maze. Overcrowding stressed the sewage, ventilation, and water systems; the health of the patients was compromised. Epidemics struck at numerous institutions (Bell, 1980). The superintendents became increasingly concerned with order, regularity, and control among growing numbers of patients. They reinstated the use of restraints among patients who were noisy or violent. The attendants assumed responsibility for larger groups of 8 to 15 patients each. Inmates were often appointed as temporary nurses and attendants because of the staff shortage. The most critical personal quality sought in an attendant shifted from kindness to obedience (Grob, 1973). Overtaxed institutional facilities provided fewer patients with meaningful work; idleness further complicated behavioral problems. The superintendents recognized a growing gap between their original theory and their practices; their powers to close the gap were diminishing.

The wide range of persons admitted to the asylum jeopardized adequate care. Older patients with dementia accounted for 10% of the number of admissions from 1830 to 1875, thereby complicating hospital management considerably (Grob, 1973). Insane criminals often required maximum security. Alcoholic patients, mentally retarded patients, and patients suffering from general paresis (resulting from the advanced stage of a syphilitic infection) or other

organic diseases often required individual care at a time when none was possible. Under these conditions, chronic patients failed to respond to treatment. They became troublesome, engaging in disruptive behaviors, escapes, and physical violence that perpetuated the need for restraint (Tomes, 1984).

Poverty-stricken immigrants joined this influx in the post-Civil War years. American physicians had difficulty empathizing with "foreign insane paupers" (Bockoven, 1963, p. 25). Admitted to already deteriorating institutions, foreign patients quickly became apathetic, leading physicians to believe them less capable, less motivated, and less curable. A vicious cycle developed, with predictable consequences. Because they were thought to be incurable, poor patients received less care. Without care, these patients showed little improvement—This confirmed their incurability.

New theories about mental illness dealt moral treatment yet another incapacitating blow. One school of thought linked mental illness with heredity; another linked mental illness with a somatic, mechanical defect. Both views led to a decline in optimism about a cure and to a total disillusionment about moral treatment in the 1850s. By the 1870s, pessimism was the trend; by 1900, moral treatment was reduced to a minor form of therapy even in the most affluent of corporate asylums (Dain, 1964).

Emphasis on hereditary predisposition began to fill the psychiatric literature. Heredity was thought to predispose the poor person to poverty and insanity (Bockoven, 1963). Inferior biological stock was thought to produce conditions leading to insanity. Some physicians debated the logic of heredity as an explanation for insanity; they argued against the heredity explanation in defense of a somatic view (Bell, 1980). Although earlier in the century it had been understood that a weakening of the body's vital forces could damage the brain, microscopic lesions now found in the central nervous system of mentally ill patients upset previous environmental theories and confirmed the somatic cause of insanity (Bockoven, 1963).

The early successes of moral treatment were challenged. In 1877, Dr. Pliny Earle published a critique of pre-Civil War curability statistics and accused early superintendents of having exaggerated their figures (Bockoven, 1963). Earle questioned the validity of the high cure rates cited because in the 1870s corporate asylums could no longer replicate these cure rates. Some physicians argued in response that insanity was becoming less curable because society was becoming more chaotic. Others claimed that insanity had become more complex in the late 19th century; it was less curable because the categories of insanity, such as general paralysis, senile dementia, and hered-

itary insanity, had multiplied. Many thought that the physiological causes of insanity were intensifying: Organic alterations in the nervous system were more involved in producing insanity than before (Bockoven 1963).

Conversion toward a more somatic view seemed inevitable. From 1840 to 1860, three men had been responsible for most of the psychiatric research in the United States: Luther Bell, Amariah Brigham, and Isaac Ray. Their work had largely involved data gathering, certainly not serious research by 20th-century standards. Even the curability statistics gathered between 1833 and 1842 by superintendent Samuel Woodward at Worcester State Hospital had failed to delineate criteria used to determine the recovery or improvement of patients. Those succeeding the early superintendents were deeply discouraged by the apparent failure of moral treatment and by their inability to validate its effectiveness scientifically. Articles in the *American Journal of Insanity* supporting the mechanical defect theory exhorted a move toward somaticism. Scientific medicine was gaining respect and credibility; any psychological approach to the treatment of insanity seemed outdated, illogical, and irrelevant. In 1894, Dr. Weir Mitchell, a neurologist, castigated physicians for having ever believed in some mysterious therapeutic influence (Bockoven, 1963).

Therapeutic regimens differed among asylums, depending on the superintendent's viewpoint. Moral treatment suffered in this respect as well. Bockoven (1963) attributed the demise of moral treatment to the lack of inspired and committed leadership after the death of its innovators. Only 4 of the original 13 founders of moral treatment survived the 1870s, and 2 of these founders had returned to private practice. Leaders seemed to have lacked foresight. They had failed to train moral therapists who might have been able to articulate or redefine moral treatment's efficacy in the face of social changes and scientific inquiry. This seemed a major failure.

The asylum, diverted from its original mission of treatment, and pressured into merely containing insane persons, sank into a mire of apathy and indifference (Bell, 1980). Moral treatment, once considered vital to the cure of persons with mental disorders, disappeared from psychiatric practice.

Conclusion

The complexity of moral treatment precludes the opposing views that it was a short-lived triumph of humanitarian zeal or that it was a rationalization of middle-class morality (Tomes, 1984). Moral treatment was neither of these stereotypes. One thing is clear: Moral treatment cannot be understood outside of the framework within which it developed and disappeared.

One can hope that occupational therapy practice today is free of the limitations that precluded the survival of moral treatment. One would hope to find, in this century, a freedom from class and economic bias, a freedom from a push for professional credibility that is blind to patient need, and a leadership committed to defend those humane aspects of practice only empirically validated.

One can also hope that occupational therapy practitioners understand the powerful forces that often define the character of occupational therapy practice. During the 19th century, the medical community and the society as a whole shaped several guiding principles and treatment concepts into the practice of moral treatment. These two communities cannot be underestimated in the 20th century; their demands shape the duration, direction, location, and quality of occupational therapy. Preventive care, accountability, and documentation of measurable progress are but a few of the trends grounded in challenges from these two sectors.

Moral treatment's decline relates closely to a lack of inspired and committed leadership willing to articulate and redefine the efficacy of occupation in the face of medical and societal challenges. The desire to embrace the most current trend of scientific thought led to the abandonment of moral treatment in spite of its established efficacy. The failure to identify and address the social and institutional changes that had gradually made the practice and success of moral treatment virtually impossible led to the erroneous conclusion that occupation was not an effective intervention. The responsiveness to trends supplanted any reaffirmation of basic assumptions.

Occupational therapists need to recommit, in this century and in the next, to the assumptions about man and occupation that inform the practice of occupational therapy. In the face of changing trends, therapists must continually redefine and rearticulate the value of a humane practice that transcends scientific validation and bureaucratic understanding.

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