

# History of Psychiatry

<http://hpy.sagepub.com>

---

## **Benevolent theory: moral treatment at the York Retreat**

Louis C. Charland

*History of Psychiatry* 2007; 18; 61

DOI: 10.1177/0957154X07070320

The online version of this article can be found at:  
<http://hpy.sagepub.com/cgi/content/abstract/18/1/61>

---

Published by:

 SAGE Publications

<http://www.sagepublications.com>

**Additional services and information for *History of Psychiatry* can be found at:**

**Email Alerts:** <http://hpy.sagepub.com/cgi/alerts>

**Subscriptions:** <http://hpy.sagepub.com/subscriptions>

**Reprints:** <http://www.sagepub.com/journalsReprints.nav>

**Permissions:** <http://www.sagepub.com/journalsPermissions.nav>



---

## Benevolent theory: moral treatment at the York Retreat

LOUIS C. CHARLAND\*  
*University of Western Ontario*

*The York Retreat is famous in the history of nineteenth-century psychiatry because of its association with moral treatment. Although there exists a substantial historical literature on the evolution of moral treatment at the Retreat, several interpretive problems continue to obscure its unique therapeutic legacy. The nature of moral treatment as practised at the Retreat will be clarified and discussed in a historical perspective. It will be argued that moral treatment at the Retreat was primarily a matter of affective conditioning guided by ‘benevolent theory’.*

**Keywords:** *benevolence; conditioning; emotions; history; moral sense; moral treatment; passions; 19th century*

Established in 1796, the York Retreat in England is considered to be one of the birthplaces of moral treatment. A religious hospice run by Quakers, the Retreat was quite unlike the large medical hospitals in France and Italy, where moral treatment arose independently under the tutelage of medical practitioners such as Chiarugi and Pinel. The therapeutic success of the Retreat and its religious methods were well known to medical writers of the time. It raised in an acute way the question whether the lay ‘moral treatment’ practised at the Retreat was superior to the medical ‘moral treatment’ practised in Pinel’s and Chiarugi’s hospitals.

Although there is a substantial historical literature on the evolution of moral treatment at the Retreat, several major interpretive problems continue to obscure its unique therapeutic legacy. The problems are largely philosophical,

---

\*Address for correspondence: Departments of Philosophy and Psychiatry & Faculty of Health Sciences, University of Western Ontario, London, Ontario, Canada N6A 3K7. Email: charland@uwo.ca

which may explain why they are generally ignored in historical writings on the Retreat. They are: (1) variable meanings of the term 'moral'; (2) the peculiar mix of religious and medical practices that combined to characterize moral treatment at the Retreat; and (3) wide variation in the use of affective terms such as 'passion', 'emotion' and 'sentiment', in both French and English.

None of the above problems have been squarely faced in historical discussions of the Retreat. The argument advanced here is that its moral treatment was unique because of the manner in which it fused affective and ethical considerations under the aegis of an overriding commitment to benevolence. It was a primitive form of affective conditioning guided by 'benevolent theory' and not a medical treatment in any traditional sense.

### Philosophical critique

The Retreat is regularly cited for its humanitarian reforms in the treatment of the mentally ill (Digby, 1985; Foucault, 1972; Glover, 1984; Goldstein, 2001; Goodheart, 2003; Hunter & MacAlpine, 1982; Pigeaud, 2001; Porter, 1987, 2002; Rothman, 1971; Scull, 1993; Shorter, 1993; Stewart, 1992; Weiner, 1999; Whitaker, 2002). Invariably, it is also cited as a focal point in the history of moral treatment. Contemporary historians generally define this as the attempt to treat mental illness by psychological means (Digby, 1985: 85–7; Porter, 2002: 127–34; Shorter, 1993: 19–21).

The early pioneers of moral treatment certainly thought they had discovered a successful new method of treatment of the mentally ill. They also tried to provide evidence of its efficacy (Chiarugi, 1793: 5; Esquirol, 1805: 48; Pinel, 1809: 412–28; Tuke, 1813: 190–212). Most contemporary historians concur that, in terms of discharge rates, moral treatment was superior to other treatments used at the time (Digby, 1985: 29–30; Porter, 2002, 105–15; Scull, 1993: 102–8, 148–55; Whitaker, 2002: 19–38). One notorious voice of dissent in this chorus of praise is Michael Foucault's. He not only provides a very different historical reading of the emergence of moral treatment, but also criticizes those historical developments within the framework of his philosophy.

Foucault offers a scathing denunciation of the Retreat as a duplicitous exercise in religious internment and social coercion, and a pernicious ideological ploy that substitutes moral rectitude and mind control for physical manacles and confinement (Foucault, 1972: 600–1). In this transformation, it is no longer madness that causes fear, but madness itself that becomes fearful: '*Maintenant le folie ne devra plus, ne pourra plus faire peur; elle aura peur, sans recours ni retour.*' ('Now madness shall no longer instil fear; it can no longer cause fear; it has become fearful itself, with no recourse or turning back.'). (Foucault, 1972: 600). According to Foucault, the internalization of fear at the Retreat is part of a wider symbolic transformation in the meaning of madness. He argues that the underlying truth behind these developments is

not the march of enlightened reason towards the liberation of the mad, but rather a desperate attempt by reason to conquer madness from the inside, through the internalization of fear and other modes of psychological control and oppression (Foucault, 1972: 591).

Foucault's philosophical interpretation and evaluation of the therapeutic practices of the Retreat go well beyond standard historical matters. He engages the history of the Retreat philosophically. Any disagreement on such issues must accordingly be conducted – at least partly – on philosophical grounds. In what follows, I set aside Foucault's more speculative pronouncements about the significance of the Retreat in the history of madness. However, I continue his philosophical line of enquiry into the role of fear in the Retreat's therapeutic practices. To do so, I enlarge the purview of his discussion to include the role of the passions in general. The objective is to provide an alternative to Foucault's philosophical interpretation of moral treatment at the Retreat, particularly his negative evaluation of the role of fear.

The alternative interpretation that is offered is based on the contention that the therapy practised there largely by-passed the intellect and worked instead on the passions through the passions. In the philosophical parlance of the day, moral treatment provided an avenue to reach patients through their 'moral sense'. The treatment used at the Retreat is said to have been 'one of invariable mildness and benevolence, founded on the principle of kindness, as the only rational mode of influencing the insane' (Digby, 1985: 33). This characterization needs to be qualified, since 'heroic' aggressive medical treatments and psychological interventions based on fear were employed at the Retreat in its early days. Nevertheless, properly interpreted, these considerations do not negate the fact that benevolence is the central defining concept in the Retreat's therapy. Moral treatment was also fundamentally designed to encourage autonomy, not oppression. Hence, both Foucault's historical interpretation and philosophical evaluation of moral treatment at the Retreat appear to be seriously off the mark.

Benevolence is pivotal in understanding the historical and philosophical climate in which moral treatment evolved at the Retreat. On the one hand, it is important as an *affective* notion, especially the manner in which it implies and presupposes specific passions, emotions and sentiments. On the other hand, it is an important *ethical* notion, tied to a particular view of morality and virtuous conduct. The first modern medical theory of how a therapy guided by affective and ethical notions tied to benevolence can alleviate mental illness was proposed by Philippe Pinel (1801, 1809). In his own simple and devout way, William Tuke, the founder of the Retreat, came across a similar path by following the dictates of his religion.

There is a close affinity between the lay religious therapy practised at the York Retreat and the medical treatment employed at Bicêtre and the Salpêtrière, Pinel's Parisian hospitals. This is reflected in the widespread tendency to refer to both as instances of 'moral treatment'. However, despite

important similarities, referring to the two therapies with this single rubric is a dangerous anachronism. In his *Description of the Retreat*, Samuel Tuke, William's grandson, regularly refers to its therapeutic practices as 'moral treatment' (Tuke, 1813: 131–87). The English expression 'moral treatment' is his translation of the French expression '*traitement moral*', which he borrowed from Pinel's *Traité medico-philosophique sur l'aliénation mentale* (1801). Ambiguities surrounding the meaning of the term 'moral' in French and English make it hard to disentangle the early therapeutic practices of the Retreat from Samuel Tuke's medicalized Pinelian reconstruction of these. They also make it difficult to distinguish both of those perspectives from Pinel's own '*traitement moral*'.

### Early observations and results

At least in principle, from its inception the Retreat was supposed to offer a 'milder and more appropriate system of treatment' (Tuke, 1813: 22). The Quakers were a peaceful people, devoted to non-violence and equality (Stewart, 1992: 52–5). However, the establishment of moral treatment and its mild methods did not unilaterally begin the day the Retreat opened its doors.<sup>1</sup> Prior to opening the Retreat, both William and his personal physician, Timothy Maud, did their best to educate themselves about madness and its treatment (Digby, 1985: 21; Glover, 1984: 8). This resulted in a strangely contrasting set of goals and ideals for the new Retreat when it opened in 1796.

On the Quaker side, there was William Tuke's conviction in the therapeutic importance of benevolence and charity, as well as the provision of physical comfort and a living environment that encouraged spiritual reflection and 'stillness' (Glover, 1984: 38–9; Stewart, 1992: 57–9). This contrasted greatly with the recommended medical practices of the time, which included debilitating purges, painful blistering, long-term immobilization by manacles, and sudden immersion in cold baths – all administered in a 'regime of fear' governed by terror and brutality (Glover, 1984: 53–5; Scull, 1993: 64–77). Since William Tuke was clearly committed to the premise that the Retreat had to have a physician, the early days of the Retreat were marked by unhappy tensions between medical and Quaker ideals, resulting in a therapeutic record that is quite at odds with the harmonious picture of the Retreat that Samuel Tuke and later historians have painted for posterity.<sup>2</sup>

The population of patients at the Retreat in its first two years was very small, starting with three patients and eventually reaching eight. The staff to patient ratio was also very high compared to public asylums, initially with a planned proportion of 'seven staff to a planned total of thirty patients' (Glover, 1984: 36). It is not a misnomer to call the Retreat a 'family establishment', and this indeed is how it was known (Scull, 1993: 147–8; Tuke, 1813: 108). Tuke himself referred to the staff and patients at the Retreat as a 'family' (Glover, 1984: 43;

Stewart, 1992: 62). In keeping with Quaker practice, both staff and patients at the Retreat were referred to as 'friends'; the Quakers were, after all, a 'Society of Friends'. On the whole, an atmosphere of 'affectionate intimacy' prevailed (Digby, 1985: 50).

This intimacy permitted close and extended observation of all aspects of patient life. George Jepson, the first superintendent of the Retreat, was a very careful observer by all accounts. A man of allegedly Herculean size, he was 'fearless and full of resource' and, like William Tuke, commanded authority (Glover, 1984: 61). At the same time, he was patient and indefatigable with patients and capable of devoted love and attention (p. 58). Prior to being hired at the Retreat, Jepson had worked as a weaver and amateur apothecary. He had no formal medical training but was apparently widely consulted for medical advice (p. 46). He was also considered a spiritual healer (Digby, 1985: 35–6). Daniel Hack Tuke later attributed Jepson's open mind and capacity for innovation to his lack of formal training as a physician and his freedom from conditioning (Glover, 1984: 47). Jepson soon exceeded even the most 'sanguine expectations' and proved to be an exceptional nurse in addition to being a superintendent (Tuke, 1813: x). When he arrived at the Retreat, he joined another particularly talented Quaker nurse called Katherine Allen. In 1806 the two were married. With a Quaker couple at its helm, the Retreat came even closer to resembling a family home (Stewart, 1992: 62).

In this familial atmosphere, patients were cared for and treated on an individual basis, a marked departure from the warehousing and indiscriminate physical treatment that was typical of large public asylums. This permitted prolonged observation of patients on an individual basis, something that proved central to the development and adoption of new methods of patient care, and the abandonment of others. The realization that kindness promoted patient comfort and well-being was a discovery based on observation, and not simply the a-priori application of a Quaker ethical precept (Glover, 1984: 55). Another similar and very important discovery had to do with fear: the traditional belief that fear was an effective means of controlling patients was challenged by the finding that allaying fear was generally more effective (Glover, 1984: 42, 57; Tuke, 1813: 141–50).

As Jepson's partnership with Dr Fowler, the Retreat's physician, evolved, both became increasingly convinced that the traditional 'regime of fear' and its associated physical treatments not only failed to benefit patients, but actually made them worse. They worked very closely together and reported jointly on any changes they proposed to the community in charge of the Retreat's activities. As their partnership proceeded, Dr Fowler, who at the start gave standard medical treatments 'ample trial', eventually sought to replace them with milder methods (Glover, 1984: 53–6; Tuke, 1813: 111; Stewart, 1992: 37). This may be one of the first examples of the systematic use of 'clinical' observation to develop evidence-based principles of treatment in psychiatry.

Fowler's decision to abandon traditional treatments was apparently 'painful'. He had to face the realization that 'medicine, as yet, possesses very inadequate means to relieve the most grievous of human diseases' (Tuke, 1813: 111). In his *Description*, Samuel praises Fowler's medical humility and his humane attitude not to administer treatments that caused harm to patients (Tuke, 1813: 112). Indeed, it has been said that 'the most creative thing Dr. Fowler did during his short time at the Retreat was his courageous abandonment of traditional treatment' (Glover, 1984: 54). The Retreat then entered its 'Golden Age', a period that lasted roughly from the end of the second year until Jepson retired in 1823. This is the period discussed in the *Description*, and it is also the focus of the present discussion.

### **Golden Age of the Retreat**

In the Golden Age of the Retreat, medical practice and Quaker policy combined to form a relatively clear and consistent philosophical orientation. The main therapeutic objective of the Retreat was 'to assist nature in her own cure' (Tuke, 1813: 216–17). For that reason, William often preferred to speak of promoting recovery rather than effecting a cure. Samuel also preferred to talk of 'recovered' rather than 'cured', though for him treatment sometimes did lead to cure (p. 216). It was recognized that simply following the Hippocratic injunction to 'do no harm' was already an important contribution to recovery. Early observations proved to be supportive of William's assumption that providing a friendly and intimate familial environment helped to assure patient comfort and promote recovery. Location and healthy activities were important ingredients of this healing environment, and a great deal of attention was paid to the geographical location and layout of the Retreat (Digby, 1985: 37–42; Glover, 1984: 31; Tuke, 1813: 93–107). (To this day, the Retreat's buildings and grounds constitute a splendid country estate.)

It was soon noticed that boredom could compromise recovery. Idleness was also incompatible with Quaker conceptions of a healthy meaningful life. Accordingly, ways were devised to occupy patients in meaningful activities. A small farm provided various occupations and distractions for those in need of them. The presence of animals was believed to help awaken 'the social and benevolent feelings' (Tuke, 1813: 96). Participation in various arts and crafts was encouraged, marking the birth of modern occupational therapy (Digby, 1985: 42–9; Glover, 1984: 57). Diet was thought to be extremely important in caring for patients, and food and alcohol were dispensed carefully but plentifully, resulting in major expenses (Glover, 1984: 63; Tuke, 1813: 123–7; Stewart, 1992: 35–6). Staff and patients ate together, like a family.

The importance of early intervention and admission was a significant discovery of the early days of moral treatment. One Report notes that, 'experience this year abundantly convinced us, of the advantage to be derived from an early attention to persons afflicted with disorders of the mind' (Tuke, 1813: 59). Part of what lay behind this observation is the realization that patients had

to be removed from the circumstances that originally triggered their illness (p. 88). For the same reason, it was important not to send patients home too soon, lest they relapse. Premature discharge was thought to be a major cause of relapse (p. 215). All these interventions involved managing 'moral' factors in the environment that could worsen or precipitate mental illness or relapse.

### **Inner light**

It has been said that the moral regime practised at the Retreat was simply a matter of 'Christianity and common sense' (Jones, 1996: iv). It was pragmatic rather than theoretical (Porter, 1987: 224). This was fundamentally a religious hospice run according to religious principles inspired by the Quaker faith (Digby, 1985: 14, 30; Stewart, 1992: 51–3; Tuke, 1813: 161).

Initially, the Retreat was to offer asylum to Quakers only (Tuke, 1813: 22). However, eventually provisions were made to permit the admission of non-Quakers on a discretionary basis (p. 91). Yet the Retreat was a religious institution in every sense of the word. Patients were invited to attend religious meetings when they were capable (p. 52). The Bible was often read to patients and this apparently had a soothing therapeutic effect (Glover, 1984: 58). Quaker religious values and principles were thus integral components of treatment and recovery. As Digby (1985: 25) states, 'it was hoped that the Religious framework that had supported Friends when sane would prove even more efficacious in meeting the greater needs of those who in some degree had lost their sanity'.

In the *Description*, Samuel explicitly remarks that 'the influence of religious principles over the mind of the insane, is considered of great consequence, as a means of cure' (Tuke, 1813: 161). Indeed, analysis of the rules and regulations of the Retreat and its regime of moral management reveal five Quaker values that clearly have an ethical character: benevolence, charity, discipline, self-restraint, temperance. This 'moralistic element' was pervasive in the early days of the Retreat (Digby, 1985: 85). It was considered advisable to 'promote in the patient, an attention to his accustomed modes of paying homage to his creator' (Tuke, 1813: 161). This was done by nurturing and appealing to the 'inner light' which, through the grace of God, was thought to lead to salvation (Digby, 1985: 28, 31; Glover, 1984: 13–14).

The Quaker notion of the inner light is the main reason why they believed that the mad were still human despite their condition (Digby, 1985: 25–32; Glover, 1984: 11–14). Not even madness could extinguish that light. Thus despite their condition, the mad were still deserving of benevolence and, indeed, dignity and respect. They were human, and most assuredly not like wild ferocious raving animals, a common prejudice of the time (Scull, 1993: 41, 56–64, 93, 187). The Quakers believed that nothing, even madness, could extinguish the inner light of God (Stewart, 1992: 52–3).

The humanity of the mad, then, lay not in reason, but rather in the presence of an indestructible moral sense or sensibility. This typically was characterized as the ability to experience and exercise benevolence, a popular philosophical notion of the time, which also permeated popular culture. So, according to the Quakers, the mad may have lost their minds, but not their hearts.<sup>3</sup> They could still be reached through their 'religious feelings' which tapped into their inner light (Digby, 1985: 64).

Referring to the early, more religious, phase of moral treatment at the Retreat, Digby (p. 85) states that, 'the ethos of these early years did include a disciplinary and moralistic element'. The Quaker religion and its values were the origin of that moral code. It was not simply a 'moral' code in the sense of defining socially appropriate conduct, such as when and whom to marry, and so on. Instead, it was this *and* an ethical code in the strict sense. The ultimate aim of 'moral' treatment in these early days of the Retreat was 'moral good' and the 'preservation of moral character' in this ethical sense (p. 97). The 'moral feelings' that moral treatment was supposed to awaken were not only affective in nature, embodied and tied to the exercise of related passions and feelings; they were also ethical (p. 96). Even the regulation of food and drink had an ethical dimension (p. 132). Therefore, 'moral' treatment at the Retreat was not simply mental and psychological; it was also 'moral' in a specific ethical sense which derived from Quaker values and morality that relied primarily on affective conditioning.

### **Benevolent theory**

Samuel Tuke had a clear conception of what he wished to accomplish in his *Description of the Retreat*. Referring to the treatment of insanity by traditional medical means, he observes that 'benevolent persons in various places had long been dissatisfied with the system of management so generally pursued'; the problem was that in treating the mad 'benevolent theory was powerless when opposed by practical experience' (Hunter & MacAlpine, 1964/1996: 5). What was needed was proof – medical proof – of the efficacy of benevolent theory. The *Description* was written to provide evidence that 'benevolent theory' was, in fact, effective and to explain the methods and assumptions behind its success.

Moral treatment at the Retreat was premised on the observation that core benevolent affections in humans remain mostly untouched by madness. Even in madness, 'the existence of the benevolent affections, is often strongly evidenced' (Tuke, 1813: 134). The fact that the mad often show affection to animals is cited as further evidence of the continued existence of 'social affections' in madness (p. 136). Samuel also notes that, even in apparently hopeless cases of madness, 'warmth of affection is frequently evinced; and that patients of this class may, in general, be easily amused and pleased' (p. 138). Apparently, despite their madness the mad are still capable of experiencing

and expressing basic social affections. Moral treatment capitalized on this premise which was increasingly confirmed by observation. Thus the key to the success of moral treatment is that it focused on the ‘moral affections’ and ‘moral feelings’ of the mad (Scull, 1993: 100). It was a therapy of the passions that worked through the passions. Reason had little to do with it. This was not primarily a ‘talking’ therapy like our modern cognitive psychotherapies. It was a primitive form of affective conditioning with benevolence at its core.

We are entering treacherous exegetical waters. By this point it should be clear that there were clearly two ‘moral’ aspects to the treatment and management practices of the Retreat. They were ‘moral’ in a wide, mental, psychological sense, as opposed, say, to physical methods and interventions. But they were also ‘moral’ in a narrower ethical sense that derived from Quaker values and morality and the doctrine of inner light. The overall historical context of the Retreat is important here. This was the age of ‘moral sense’ and ‘moral sensibility’, and it was not only the Quakers who believed in an inner sense. Its supporting philosophical principles were articulated by many different philosophers and literary thinkers in France, England and Scotland. Scholars of the evolution of moral treatment in France have taken careful note of the impact of these philosophical developments (Goldstein, 2001). However in the case of moral treatment in England they are often ignored (Scull, 1993).

The doctrine of moral sense and its special moral sensibility need to be distinguished from the doctrine of ‘nervous sensibility’ which was also very popular at the time. The details of the latter doctrine – sometimes called ‘the doctrine of nerves’ – have primarily to do with the degree of sensitivity of the human nervous system, and not ethics or morality. It is most often associated with the work of Albert Von Haller and Robert Whytt and their debate over the scope of ‘sensation’ and ‘irritability’ in physiology (Porter, 1987: 176–84; 1997: 250–4). Although it is sometimes hard to disentangle nervous from moral sensibility in some discussions, especially when the concept of ‘feeling’ is at issue, the doctrines are quite different in origin.

A helpful way to summarize the relevant aspects of the doctrine of moral sense and sensibility is to say that ‘each one of us is possessed, at birth, of a moral sense that signals its perceptions to us through certain sentiments – love, pity, generosity, gratitude’ (Reddy, 2001: 178). It is important that moral sense and moral sensibility in this context are understood affectively. Thus moral sense and sensibility are not simply ethical notions. They also involve *affectivity*: passions, emotions and sentiments. This affective dimension of moral sense and sensibility is evidenced by the fact that it is through affective states like the above that we exercise our moral sense and sensibility. Essentially, this is the Hutcheson’s doctrine of benevolence:

Benevolence drives us to seek the natural good or happiness of others. It is an ‘instinct’ that is ‘antecedent to all reason and interest’, and is weaker than self-love. However, it is important to note that benevolence

is also conceived as the common quality inherent in many affections or passions that motivate human actions. Fundamental to Hutcheson's moral philosophy is the doctrine that benevolence underpins every virtue. (Turgo, 2003: 137)

Of course, during this period, benevolence is understood differently by many of the scholars who discuss it (Dwyer, 1998; Turgo, 2003). For our purposes, what is significant about Hutcheson's view of benevolence is that it was widely known in both scholarly and popular culture. It also has many affinities with some of the guiding premises of Quakerism. One especially important example is the manner in which Hutcheson's account of benevolence fuses affective and ethical components: morality and the passions. Also important is the fact that Hutcheson believed that 'as every man has a capacity to make moral distinctions, so the weighing of moral virtue is within the competence of every man' (Turgo, 2003: 138). This sounds very much like the Quaker doctrine of an inner light which is universal among humans. Hutcheson also believed that 'moral excellence can be attained by any person, independently of his learning, power, or riches' (Turgo, 2003: 138). Could this perhaps include the mad? The Quakers certainly thought so.

None of this should be taken as proof that the Quakers were followers of Hutcheson, or even that William Tuke had read his works. The point is rather that the Quaker doctrine of inner light and its accompanying focus on benevolence was one among a number of variations on the theme of moral sense and sensibility which permeated popular culture and scholarly debate in the days of the Retreat. The idea that in benevolence the affective and ethical capacities might be fused was therefore not without popular and scholarly precedent. This is very important in understanding why moral treatment at the Retreat worked the way it did, and why it was apparently so effective.

### **Judicious kindness**

In the *Description*, Tuke (1813: 136) notes that the mad are capable of responding to positive expressions of feeling such as kindness and benevolence with positive affective dispositions of their own – for example, gratitude. They are also capable of responding with anger and resentment when that is warranted (p. 135). Most importantly, the survival of basic affective capacities in the mad means that they are amenable to simple forms of behavioural modification. But note that this is behaviour modification on an affective level. Because their intellectual functions are mostly absent or compromised, it is generally pointless to try to reason with the mad (p. 151–2). In the case of melancholy, it actually makes their condition worse (p. 151). Fortunately, it is possible to reach the mad through means other than the intellect. They can be reached through their moral affections – their 'moral feelings'.

Positive 'affections' are especially important in moral treatment. They are its primary healing agents. Above all, kindness is the main therapeutic agent. As Tuke states, 'the power of judicious kindness over this unhappy class of society is much greater than is generally imagined' (p. 168). But note that this is not simply a formula that recommends 'kindness for kindness' sake' (Scull, 1993: 99). It was kindness administered for a specific ethical goal: instilling discipline and self-control in accordance with Quaker social and religious values.

Thus, in this scheme kindness is intimately linked to the goal of teaching the mad how to discipline and control and restrain themselves. Thus,

whatever tends to promote the happiness of the patient, is found to increase his desire to restrain himself, by exciting the wish not to forfeit his enjoyments; and lessening the irritation of mind, which too frequently accompanies mental derangement. (Tuke, 1813: 177)

Of course, the mad often display wildly disordered affections. But when they do, it is primarily because of how they have been treated in the past (p. 135). Since they usually have operative affective capacities, they can also respond negatively to maltreatment. Treating them badly therefore logically leads to resentment and anger. This is a remarkable 'clinical' observation. Rather than attributing the negative affections of the mad to their madness, these are attributed to their maltreatment and conditioning. In the end, those negative behaviours are largely iatrogenic.

The ethical and religious goals of moral treatment at the Retreat explain why attendants were expected to exemplify the Quaker way of life and its values (Digby, 1985: 140–1, 155). Today they would be referred to as ethical role models. On the whole, this is a view of life and health where ethical passions and healthy passions are inextricably linked. It is a model of the self where a healthy 'moral' life in a general *psychological* sense requires a balanced 'moral' life in the *social* sense, which in turn requires an upright 'moral' life in the *ethical* sense. The result is a healthy mental life, defined by healthy passions, which in turn depend on a healthy morality and ethical direction.

### **Self-control and self-esteem**

The desire for self-esteem is central to moral treatment (Tuke, 1813: 158). Indeed, the primary aim of moral treatment is to instil self-restraint by building on the capacity for self-esteem (p. 160). It is probably fair to say that self-esteem and its associated social affections form the core of moral treatment. Self-esteem itself is thought to be a powerful force, even more powerful than fear (p. 157). Self esteem and respect for self and others are intimately linked in this formula. There is a sort of reciprocity involved in learning how to experience and manifest these properly. Respect for oneself

depends on the ability to respect others, and vice versa. Proper esteem of self is thought to depend on proper esteem of others, and vice versa. Thus,

the patient feeling himself of some consequence, is induced to support it by the exertion of his reason, and by restraining those dispositions, which, if indulged, would lessen the respectful treatment he receives; or lower his character in the eyes of his companions and attendants. (p. 159)

Strategically, moral treatment seems to have functioned by a process of conditioning and 'internalization' (Digby, 1985: 77; Scull, 1993: 100). The basic strategy is to selectively reinforce specific positive social affections using emotional cues and other stimuli, while extinguishing negative ones in a like manner. Modelling, or leading by example, is of central importance to this strategy. Thus, those in charge of healing the mad must treat them with dignity and respect if they expect to instil those dispositions and to be treated like that in return. Trust between the mad and their keepers was believed to be essential for this approach to work (Digby, 1985: 72–3). Accountability is also fundamental. For example, when discipline is exercised, every effort needs to be made to make the reasons for the disciplinary action as clear as possible, otherwise its therapeutic value is lost.

The overriding goal of disciplinary action in moral treatment is to promote self-restraint. The underlying hypothesis is that 'insane persons generally possess a degree of control over their wayward propensities' (Tuke, 1813: 133). In other words, 'most insane persons, have a considerable degree of command; and that the employment and cultivation of this remaining power, is found to be attended with the most salutary effects' (p. 140). The proposal is ingenious: control the mad by teaching them how to control themselves. What self-esteem and its associated reinforcing social affections do, then, is 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.

Tuke (p.142) states that 'there can be no doubt that the principle of fear, in the human mind, when judiciously excited, as it is by just and equal laws, has a salutary effect'. He goes on to say that 'it is a principle of great use in the education of children, whose imperfect knowledge and judgment, occasion them to be less influenced by other motives' (p. 142). He emphasizes that 'there is much analogy between the judicious treatment of children, and that of insane persons' (p. 150). He also mentions Locke, whose views on education were still highly influential at the time:

Locke has observed, that 'the great secret of education lies in finding a way to keep the child's spirit easy, active, and free; and yet at the same time, to restrain him from many things he has a mind to, and to draw him to things uneasy to him.' (p. 150)

This analogy between moral treatment and education is pivotal to the former. It is the rationale for the important role allotted to authority and intimacy in the relationship between healers and sufferers. For the very same reasons that a figure of authority is thought to be important in the education of children, so it is also held to be important in moral treatment. In both cases, the authority figure in question must secure the confidence and esteem of those they oversee. The bond must be intimate and kindness is essential.

### **Role of fear**

Fear was used at the Retreat, but this fact requires careful historical interpretation. A key principle governing its use there was that it was 'not allowed to be excited, beyond that degree which naturally arises from the necessary regulations of the family' (p. 141). We should also not forget that at the Retreat 'neither chains nor corporeal punishment are tolerated, on any pretext' (p. 141). Clearly, in this context, the use of fear is always intended to be therapeutic and is never simply punitive. Its purpose is to help to instil discipline and help the mad to regain control of themselves. Furthermore, it is imperative to realize that fear 'ought only to be induced, when a *necessary* object cannot otherwise be obtained' (p. 143). Above all, fear and discipline must not be allowed to compromise the mutual respect and esteem patients and their keepers have for each other. This is because moral treatment relies on these bonds for its therapeutic success. Too much fear, or too much discipline, and moral treatment is bound to fail. Most of these precepts regarding the role of fear can be found in Locke's writings on education, where he notes that 'beating is the worst, and therefore the last, means to be used in the education of children' (Scull, 1993: 108).

Foucault has tried to cast the role of fear and discipline in moral treatment in a cynical light. It is now possible to respond to this charge. While it is true that fear and discipline can be employed for illegitimate and unhealthy purposes, the ability to experience fear is an essential ingredient of social life. So is the ability to discipline and restrain oneself in the face of negative and unruly impulses and passions. When used judiciously, fear can be an important instrument in the education of the passions generally, and the instruction of discipline and respect. There is therefore a plausible philosophical case to be made in defence of the use of fear and discipline in moral treatment. William Tuke saw this. He saw that fear and discipline could heal as much as they could injure. Thus, in both design and practice, his discipline was a healing discipline; its primary goal was never simply punitive and always therapeutically designed to benefit the patient. But the exercise of fear, like kindness, had to be 'judicious' in order to be effective and promote recovery.

The high degree of personal and physical intimacy at the Retreat probably deepened the sense of responsibility and commitment patients felt for those who cared for them. In return, this must have increased patients' motivation to control and discipline themselves to behave appropriately, since positive and negative rewards for behaviour were immediately forthcoming and quickly felt, as well as personally relevant. In general, moral treatment at the Retreat was a highly personalized affair. As one visitor notes: 'a great deal of delicacy appears in the attentions paid to the smaller feelings of patients' (Tuke, 1813: 225).

### **Medical description of the Retreat**

One of the main sources of evidence on the York Retreat is Samuel Tuke's *Description of the Retreat* (Tuke, 1813) already much cited above. Published almost two decades after the opening of the Retreat, his account is one of the best historical sources on the evolution of moral treatment at the Retreat. But it is not always the most accurate, and it is important to place its interpretation in the context of other available historical information. There are a number of crucial points of philosophical exegesis raised by Samuel's account that have not been sufficiently discussed.

Initially, Samuel had misgivings about the adequacy of his medical knowledge and his ability to do justice to the topic of his book (Tuke, 1813: vi). Nevertheless, after extensive self-education, he embarked upon the project with vigour and commitment. The book was specially tailored for medical men and reformers (Digby, 1985: 237). It was immensely successful and turned the already popular Retreat into a 'Mecca for the Enlightened' (Digby, 1985: 237; Hunter and MacAlpine, 1982: 686). As Jones (1996: xi) aptly states: 'Samuel recorded what the Retreat had done, and with what results, in dry, detailed prose suitable for men of science'. One reason for this medically oriented account was that word of the Retreat's success was widespread. A growing number of medical specialists were coming to York to observe and learn the secret of its famed moral treatment. But success can cause resentment and jealousy, and the Retreat had its critics. Clear evidence of the efficacy of moral treatment was becoming increasingly necessary as many medical specialists reacted defensively to the encroachment of 'mild' moral management on their professional domain (Hunter & MacAlpine, 1982: 6–17).

Aside from these more pragmatic considerations, Samuel Tuke also had powerful personal reasons to write the *Description*. Obviously, he felt admiration for his grandfather and wanted to pay tribute to his achievements. He ultimately dedicated the book to William: 'The first active promoter of the establishment described in the following pages, and to whose persevering exertions for its welfare, unrelaxed at the advanced age of eighty years, much of its present reputation may be justly attributed' (Tuke, 1813: iii). Finally, Samuel had deep personal religious reasons for writing the book. A devout

Quaker, he wanted to spread the word of the Retreat and its message of divine grace and salvation to the world. The success of the Retreat was for him a clear indication of the presence and indestructibility of God's inner light in all of us.

The influence of Pinel is evident throughout Samuel's book, and the French doctor is cited numerous times (e.g., pp. 120, 128, 132, 205). Samuel's debt to Pinel is clearly evident in the medical categories he uses to classify the various sorts of insanity that were treated at the Retreat. The most basic ones are mania, melancholia and dementia. Idiocy is added to these categories at a later stage of the discussion (p. 215), but it is not listed in the 'Tables and Statistics' for the Retreat, because idiots were not supposed to be admitted for treatment. Their condition was thought to be incurable.

Samuel's debt to Pinel is also evident in his attention to the more passionate or affective dimensions of mental disorder. He observes that there can be cases of intellectual insanity where affective capacities survive: 'in the wreck of the intellect, the affections not infrequently survive' (p. 162). He also notes that there can even be cases of insanity where most affective capacities are compromised and only a few primitive ones survive. In his words, there can be 'partial perversions' that can be 'found to obtain in this disease with regard to the affections' (p. 134). As we have seen, in Quaker terms what remains in such cases is the inner light. In the language of the British moralists, it is a primitive form of moral sense and moral sensibility. The crucial observation here – and it should be treated as a clinical observation – is that even in some dramatic cases of insanity 'the existence of the benevolent affections is often strongly evidenced' (p. 134). A good example of this is the affection that insane persons display towards animals (p. 96).

These observations point to a central clinical pillar of moral treatment: that 'insane persons possess a degree of control over their wayward propensities' (p. 133). There are primitive affective capacities that usually survive the onset of madness. The capacity to experience and exercise benevolence is particularly important. It requires further affective capacities related to respect, fear, trust and hope. Those affective capacities, in turn, provide the means through which moral treatment works to effect change. So, although the mad may have 'lost their minds', and although their passions may be grossly distorted and compromised, there is still a primitive affective core through which they can be reached. They can be reached through their passions. Moral treatment at the Retreat, then, was ultimately a therapy of the passions. It worked on the passions, through the passions, and reached the mad despite the fact that their intellectual functions were severely compromised.

### **Problems with 'moral'**

In a commentary on Tuke's *Description*, Jones (1996) argues that there is a major difference between '*traitement moral*' as it was advocated by Pinel and

'moral treatment' as it was practised at the York Retreat. She claims that the English expression 'moral treatment' is misleading as a translation of *traitement moral*. Her point is that for Pinel moral treatment was a therapy of the 'emotions', while for William Tuke it had to do with the 'moral sense'. In her words, for Pinel moral treatment 'was directed to the emotions and not to the moral sense' (Jones, 1996: xii). A similar claim is made by Grange, who argues that 'Pinel used the word "moral" to describe emotional factors in mental experience' (Grange, 1961: 443). Both of these claims expose the confusing state of the vocabulary of morality and affectivity in vogue at the time.

In a landmark discussion devoted to the 'psychopathology of affectivity' from the late eighteenth century to the end of the nineteenth century, Berrios (1985) adopts the term 'affectivity' as a loose umbrella term for states variously called 'passions', 'emotions', 'feelings' and 'sentiments'. During the period under discussion, it was also common to refer to such states more generally as 'affections' (*affections*) or 'mental affections' (*affections mentales*). The terminology of 'moral affections' (*affections morales*) in these discussions is often used to qualify the fact that the 'affections' in question are closely linked with morality and ethics, and are not simply intellectual and 'psychological' in nature. But not always. In writings of this period, the manner in which we are to understand the term 'moral' usually hinges on context. Sometimes, 'moral affections' are to be understood as intellectual posits – as psychological but *not* ethical. At other times, 'moral affections' are supposed to be understood as primarily ethical and linked with morality, and thus as posits that are not only mental in a psychological sense but *also* ethical. In many cases, little is done to qualify which sense of 'moral' or 'affection' is meant, since the intended contrast is simply to oppose what is 'moral' in a mental psychological sense to what is physical.

To complicate the matter, some writers in the period under discussion attempted to stipulate and define affective terms in particular ways. In some cases, there was a tendency to replace the affective vocabulary of the passions and its ethical connotations with a more secular vocabulary based on emotions (Rorty, 1982). This is characteristic of the work of nineteenth-century writers such as David Hume, Thomas Brown, Herbert Spencer, Charles Darwin and William James (Dixon, 2003). But the tendency is by no means uniform, and there are many dissenting cases. For example, French medical writers such as Pinel and Esquirol remain stubbornly committed to the vocabulary of the passions and its ethical connotations. While both sometimes employ the term 'emotion' (*émotion*) little seems to turn on this alternative use of terminology. Perhaps this is the fault of Descartes. After all, it is he who boldly stated that 'passions' (*passions*) could also be called 'emotions' (*émotions*) (Descartes, 1650).

It is unfortunate that Jones, Grange and so many other historians of this period seem to overlook these philosophical exegetical problems. To their

credit, Jones and Grange do recognize that ‘moral’ in these contexts does not always simply refer to mental states in their general psychological and intellectual capacity. Both point out that for Pinel ‘moral’ states are also ‘emotions’. Despite this insight, however, Grange and Jones both fail to appreciate that, in the present context, is also true that the English term ‘emotion’ is not a satisfactory definition for the French term ‘*passion*’, which is Pinel’s favoured term for affective matters. The difference is that the English ‘emotion’ does not have the ethical (‘moral’) connotations of the French ‘*passion*’. The distinction between French ‘*passions*’ and English ‘passions’ on the one hand, and French ‘*émotions*’ and English ‘emotions’ on the other, is fundamental to the development of affective terminology and concepts during this period. Indeed, it has been skilfully argued that there is an important transition from passions to emotions that takes place in the period we are discussing – a paradigm shift in which the predominantly religious and ethical passions of Augustine and other medieval writers give place to the more neutral biological and physiological emotions of Thomas Brown and Charles Darwin (Dixon, 2003; Rorty, 1982).<sup>4</sup>

What emerges out this conceptual and semantic quagmire is that the use of the expressions ‘moral sense’ and ‘emotion’ during this period is simply not uniform or consistent enough to sustain the kind of claim Jones (1996) asserts, at least not without extensive explanation and documentation, which is not provided. Consider the fact that the word ‘emotion’ is used only twice in Tuke’s *Description*. Throughout the book, affective states like ‘emotions’, ‘passions’ and ‘sentiments’ are referred to as ‘affections’. Significantly, in his ‘Tables of Cases’ (Tuke, 1813: 191–201), he lists ‘disappointment in the affections’ as one of the most common causes of madness. Apparently, the term ‘*passion*’, so frequently used by Pinel, is nowhere mentioned in the *Description*. Therefore, in the area of terminology, at least, the influence of Pinel on Samuel Tuke is not complete – he does not adopt Pinel’s terminology of the passions.

Now consider the notion of ‘moral sense’. In the present case, the doctrine of moral sense referred to by Jones (1996) is probably the one associated with Hutcheson and Hume.<sup>5</sup> While these two authors differed on the exact nature of benevolence and its relation to morality, they showed a marked tendency to identify it with a kind of feeling or ‘sentiment’. This would seem to place the concept of benevolence squarely in the domain of affectivity, along with passions and emotions. However, at the same time, benevolence also seems to be an ethically primitive notion, which places it in the domain of morality.<sup>6</sup> This means that, logically at least, benevolence may be ‘moral’ in at least four ways: (1) it is a mental as opposed to physical theoretical posit; (2) it is a mental posit which is primarily affective but not ethical; (3) it is a mental posit which is primarily ethical but not affective; and (4) it is a mental posit which is both affective and ethical.

Let us now recast Jones' argument using benevolence, since the concept is so central to the doctrine of moral sense and to moral treatment at Tuke's religious Retreat and Pinel's medical hospitals. Jones' point would appear to be that, at the Retreat, benevolence would have been understood ethically but not affectively, while at Pinel's hospitals it would have been understood affectively but not ethically.

In the light of the historical and philosophical interpretation of moral treatment at the Retreat just adumbrated, this last suggestion seems implausible. The situation actually appears to be precisely the opposite. For it is virtually impossible to disentangle exegetically the ethical and affective aspects of moral treatment at the Retreat. Likewise with benevolence: this is confirmed by the philosophical interpretation of the Retreat's therapy provided above. The case of Pinel is more complicated, but even here it is clear that the passions and other affective notions are often supposed to be understood ethically. For example, he states that in treating the mad, it is often helpful to resort to the philosophical, ethical, therapeutic insights found in Plato, Plutarch, Seneca and especially Cicero (Pinel, 1801: I, 36).

## Conclusion

As the many equivocal twists of the term 'moral' suggest, affective and ethical therapeutic principles and practices were inextricably intertwined in moral treatment at the Retreat. The 'moral sense' of the mad which the Retreat's keepers tried to reach and nurture was both ethical and affective – two sides of the same coin – and so were the means to reach and treat it. Samuel Tuke saw that the medical white coat he wished to use to dress his account of moral treatment at the Retreat fitted perfectly with the ethical religious body it was intended for. In the end, it was the same passions that were encouraged and discouraged, by the same means, even though different complementary accounts – ethical or medical – of those practices and their rationale could be given. This was not a 'talking' therapy in any traditional sense, but rather a form of primitive affective conditioning that emphasized rewards and used punishments judiciously (Lindsey, 1956; Skinner, 1954).

Tuke had to downplay the connection between the ethical and medical aspects of moral treatment to make it more medically palatable to his intended audience: supportive or sceptical medical doctors. That makes it very easy to miss the real philosophical nature of moral treatment at the Retreat. Epistemologically, it was based on a seamless fusion of ethical and affective principles and practices. It is not implausible to suggest that 'the Retreat's moral therapy did indeed contain a hidden kernel that was spiritual healing' (Digby, 1985: 36). Samuel Tuke could not emphasize this for fear of alienating his medical readers, but he probably believed it.

## Notes

1. Stewart (1992: 10, 37, 51) repeatedly asserts that Glover ignores the imposition of aggressive 'heroic' medical treatments at the Retreat, as well as the use a 'regime of fear'. But this flatly contradicts Glover's own very clear acknowledgement that such practices did occur in the first years of the Retreat (Glover, 1984: 41–3, 54–8).
2. Some historians deny there was a resident physician at the Retreat (Porter, 1987, 223; Shorter, 1993). However, this may be a moot point, since both William Tuke and George Jepson worked very closely with Dr Fowler in the early formative years of the Retreat (Glover, 1984: 56). William also consulted extensively with Timothy Maud, who briefly worked as a physician for the Retreat before Fowler's arrival (Glover, 1984: 35).
3. Following Locke, many believed that madness was a disorder in reason that left some aspects of reasoning intact. However, the recognition that lesions of the intellect could leave affective functions intact was considered more fundamental in Samuel's account of the success of moral treatment at the Retreat.
4. Like Jones and Grange, Digby refers to Pinel's moral treatment as a theory of the 'emotions'. She also suggests that moral treatment at the Retreat was 'moral' in a wider sense than simply this emotional one (Digby, 1985: 31–2). However, as argued below, Pinel prefers the term 'passions' ('*passions*') to 'emotions' ('*émotions*'). A quick glance at the table of contents of his *Traité* should confirm this. Moreover, his understanding of both terms, while variable and eclectic, is meant to be wide enough to include the ethical discussions on the passions of Cicero and others. That surely is enough to include the affective dimensions of the 'moral sense' of Hutcheson and Shaftsbury, and related Quaker ethical notions.
5. See Reddy's *The Navigation of Feeling* (2003) for a detailed account of the doctrine of moral sense and sensibility in France around this time. See Dwyer's *The Age of the Passions* (1998) for an account of related developments across the Channel in England and Scotland.
6. See Taylor's (1989: 248–65) discussion of 'moral sentiments' for a good example of how affectivity and morality are woven together in the doctrine of moral sense. See Turgo (2003) for an especially clear statement of this view in the work of Hutcheson. Jones' (1996) critique assumes that we can distinguish the 'moral sense' in its ethical dimension from affectivity (emotion, passions and sentiments). But this directly contradicts the joint ethical-affective epistemological nature of the 'moral sense' for writers like Hutcheson, whose views provide the best philosophical interpretation of the special epistemological character of moral treatment at the Retreat.

## References

- Berrios, German E. (1985) The psychopathology of affectivity: conceptual and historical aspects. *Psychological Medicine*, 15, 745–58.
- Chiarugi, Vincenzo (1793) *Della Pazzia* (Canton, MA: Watson Publishing International).
- Descartes, René (1650) *Les Passions de l'âme* (Paris: Librairie General Française).
- Digby, Anne (1985) *Madness, Morality, and Medicine* (Cambridge: Cambridge University Press).
- Dixon, Thomas (2003) *From Passions to Emotions: The Development of a Psychological Secular Category* (Cambridge: Cambridge University Press).
- Dwyer, John (1998) *Age of the Passions: An Interpretation of Adam Smith and Scottish Enlightenment Culture* (East Linton, Scotland: Tuckwell Press).
- Esquirol, Jean-Etienne (1805) *Des Passions* (Paris: Librairie des Deux Mondes).
- Foucault, Michael (1972) *Histoire de la folie à l'âge classique* (Paris: Gallimard).

- Glover, Mary R. (1984) *The Retreat at York* (York: William Sessions).
- Goldstein, Jan (2001) *Console and Classify: The French Psychiatric Profession in the Nineteenth Century* (Chicago: University of Chicago Press).
- Goodheart, L. B. (2003) *Mad Yankees: The Hartford Retreat for the Insane in Nineteenth-Century Psychiatry* (Boston and Amherst: University of Massachusetts Press).
- Grange, Kathleen M. (1961) Pinel and eighteenth century psychiatry. *Bulletin for the History of Medicine*, (Sept.-Oct., No. 35), 442–53.
- Hunter, Richard and MacAlpine, Ida (1964/1966) Introduction. In *Description of The Retreat by Tuke, S. (1813)* [reprinted] (London: Process Press), 1–26.
- Hunter, Richard and MacAlpine, Ida (1982) *Three Hundred Years of Psychiatry 1535–1860* (Hartsdale and New York: Carlisle Publishing Inc.).
- Jones, Kathleen (1996) Foreward. In *Description of The Retreat by Tuke, S. (1813)* [reprinted] (London: Process Press), vii–xv.
- Lindsey, O. R. (1956) Operant conditioning methods applied to research in chronic schizophrenia. *Psychiatric Research Reports*, 5, 118–39.
- Pigeaud, Jackie (2001) *Aux Portes de la psychiatrie: Pinel, l'ancien et le moderne* (Paris: Aubier).
- Pinel, Philippe (1801) *Traité médico-philosophique sur l'aliénation mentale, ou la manie* (Paris: Richard, Caille et Ravière).
- Pinel, Philippe (1809) *Traité médico-philosophique sur l'aliénation mentale*, 2nd edn (Paris: Brosson).
- Porter, Roy (1987) *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (London: Athlone).
- Porter, Roy (1997) *The Greatest Benefit to Mankind: A Medical History of Humanity* (New York and London: Norton).
- Porter, Roy (2002) *Madness: A Brief History* (Oxford: Oxford University Press).
- Reddy, William (2001) *The Navigation of Feeling: A Framework for the History of Emotions* (Cambridge: Cambridge University Press).
- Rorty, Amelie (1982) From passions to emotions and sentiments. *Philosophy*, 57, 175–88.
- Rothman, David J. (1971) *The Discovery of the Asylum* (Boston: Little Brown).
- Scull, Andrew (1993) *The Most Solitary of Afflictions: Madness and Society in Britain 1700–1900* (New Haven and London: Yale University Press).
- Shorter, Edward (1993) *A Short History of Psychiatry* (New York: John Wiley & Sons).
- Skinner, B. F (1954) A new method for the experimental analysis of the behavior of chronic patients. *Journal of Nervous and Mental Diseases*, 120, 403–6.
- Stewart, Kathleen Anne (1992) *The York Retreat in Light of the Quaker Way* (York: Erbor Press, William Sessions Ltd.).
- Taylor, Charles (1989) *Sources of the Self: The Making of Modern Identity* (Cambridge, MA: Harvard University Press).
- Tuke, Samuel (1813) *Description of the Retreat* (reprinted, London: Process Press, 1996).
- Turgo, Luigi (2003) Moral sense and the foundations of morals. In *The Cambridge Companion to the Scottish Enlightenment*, edited by Alexander Broadie (Cambridge: Cambridge University Press), 136–57.
- Weiner, Dora (1999) *Comprendre et soigner: Philippe Pinel (1745–1826), la médecine de l'esprit* (Paris: Librairie Arthème Fayard).
- Whitaker, Robert (2002) *Mad in America* (Cambridge, MA: Perseus Books).