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Discussion

Was Insanity Increasing? A Response to Edward Hare

Andrew Scull

One of the central paradoxes of the Victorian reforms in the treatment of the mentally ill was the curious fact that the "scientific" discovery of mental illness and the adoption of a more rational approach based on this discovery—an approach which aimed at treating and curing the lunatic, rather than neglecting him or incarcerating him in a gaol or workhouse—were associated with an explosive growth in the number of insane people. Edward Hare's recent Maudsley Lecture raises again the interesting question of whether or not this reflects a true increase in the incidence of mental illness in nineteenth century England. As he correctly notes, the aggregate data collected at the time do not allow a "decisive answer", but I am pleased that his reassessment of the probabilities led him to endorse my prior conclusion that its incidence was indeed increasing. (Scull, 1979).

Hare does dispute, however, the explanation I offered of this increase, which attributed much of it to the development of a more expansive view of madness. Instead of an expansion of the boundaries of what constituted mental illness, he argues that the growth in numbers reflects a real rise in the most serious forms of mental disorder, more specifically, "a slow epidemic of schizophrenia" (Hare 1983: 451). The dispute between us is not purely an academic debate (in the bad sense of that term) since Hare argues that the adoption of his explanation provides some "speculative" support for "a medical explanation of the asylum era", and for a viral aetiology of schizophrenia (Hare, 1983). I should therefore like to point to some of the evidence which seems instead to favour my own hypothesis, recognising (as does Hare) that in this matter we can at best obtain an approximation of the truth, given the data with which we have to work.

At least prior to the adoption of *DSM-III* in 1980, the research evidence demonstrates that even twentieth century psychiatric diagnoses lacked reliability and validity. Diagnosis remained dependent upon clinical supposition and consensus, with the consequence that "the reliability of diagnoses of mental disorders, including those considered the most severe, measured by independent rater agreement, often failed to rise over 50 per cent" (Morse, 1982; see also Spitzer and Fleiss, 1974; Beck, 1962; Chapman and Chapman, 1969). Everything we know of the practice of nineteenth century psychiatrists suggests an even stronger reliance upon clinical experience to legitimise and certify the authenticity of the individual practitioners' decisions. Certainly, many of the leading men in the field devoted a good deal of their energies to the elaboration of complex nosologies, encompassing a plethora of sub-types and varieties of insanity, but as Henry Monro (1850) noted, those who tried to rely on these categories in their practice were soon obliged to abandon the attempt in despair:

> All who have charge of asylums must well know how very different the clear and distinct classification of books is from that medley of symptoms which is presented by real cases. . . It is useless to attempt to paint pictures with more vivid colours than nature presents, and worse than useless if practical men (or rather, I would say, men obliged to practice) receive these pictures as true representatives.

Notwithstanding all efforts to alleviate the situation, and with the exception of extreme cases of violent mania or complete dementia, alienists were forced to confess that "the task of declaring this to be reason and that insanity is exceedingly embarassing and, to a great degree, arbitrary . . . no palpable distinction exists, no line of demarcation can be traced between the sane and the insane." (Brown, 1837). Thus, "the practitioner's own mind must be the criterion by which he infers the insanity of any other person." (Haslam, 1809; see also Mayo, 1854).

"Such emphasis," as Freidson (1970) has noted, "is directly contrary to the emphasis of science on shared knowledge, collected and tested on the basis of methods meant to overcome the deficiencies of individual experience. And its efficacy and reliability are suspect." In this instance, beyond the initial hard core of easily recognisable behavioural and/or mental disturbance, the boundary between the pathological

and the normal was left extraordinarily vague and indeterminate. Hence the frequent and embarrassing disputes between alienists over individual cases in the courts (Smith, 1981). In the circumstances, the assumption that identifying who is and who is not mentally ill was an activity governed by some uniform, objective, and unchanging standard will not survive critical scrutiny.

As Hare (1983) notes, I have suggested that asylum doctors' professional self-interest provided one set of motives for the adoption of an expansionary view of madness. But other forces also prompted them to behave in this fashion. On humanitarian grounds, for example, since doctors were convinced that asylums were benevolent and therapeutic institutions, and believed that laymen were incompetent to cope with, and liable to maltreat the mentally ill, they were impelled to seek out still more cases rather than reject any who were proffered. Moreover, professional 'imperialism' provides only one—and to my mind by no means that most important—reason to suspect an ever-wider practical application of the term mental illness. The asylum provided a convenient and culturally legitimate alternative to coping with 'intolerable' individuals within the family, offering, if its proponents were to be believed, a level of care and possibilities of cure far beyond what even the most dedicated family could hope to provide in its midst. So far from being blamed, families were encouraged to place their mentally unbalanced relatives where they could receive professional care and treatment at the earliest possible moment. The attraction was obviously greatest for those with fewer resources for coping with the dependent and economically unproductive. Significantly, the statistics demonstrate that by far the largest portion of the increase in insanity occurred among those drawn from the lowest socio-economic classes.

Contemporary observers frequently commented on the dynamics of this process: the superintendent of the Northampton General Lunatic Asylum noted in his 1858 report that "persons in humble life soon become wearied of the presence of their insane relatives and regardless of their age desire relief. Persons above this class more readily tolerate infirmity and command time and attention. The occasion may never occur in the one case, which is urgent in the other. Hence an Asylum to the poor and needy is the only refuge. To the man of many friends it is the last resort." In the words of another asylum superintendent, "Poverty, truly, is the great evil: it has no friends able to help. Persons in middle society do not put away their aged relatives because of their infirmities, and I think it was not always the custom for worn out paupers to sent to the asylum. . . It is one more of the ways in which, at this day, the apparent increase of insanity is sustained. It is not a real increase, since the aged have ever been subject to this sort of unsoundness." (Huxley, quoted in Arlidge, 1859).

One should note, moreover, that the level of disordered behaviour or dependency that a family could not or would not put up with was not fixed and immutable, but likely to vary over time, with individual circumstances and with the gradual growth of the perception that there existed alternatives to the retention of the disturbed and troublesome within a domestic setting. (Such a pattern is, however, much more difficult to reconcile with the hypothesis of a viral-induced epidemic of schizophrenia). Finally, as Maudsley (1877) himself suggested, the central government contributed significantly to the process by enacting legislation "whereby the government said in effect, to parish officials, 'We will pay you a premium of four shillings a head on every pauper whom you can by hook or crook make out to be a lunatic and send into an asylum' [thus putting] a direct premium on the manufacture of lunacy."

Hare makes much of the fact that recovery rates declined over time in Victorian asylums, arguing that "milder" cases should have been more likely to recover. It is, however, not at all clear why we should accept this argument. First, there is no obvious warrant for the claim that Victorian psychiatry was more successful in treating milder cases (unless one tautologically assumes an identity between "milder" and "more treatable"). Indeed, "mild" mental symptoms often co-existed with chronic and incurable underlying disease states. Bucknill, for example, while superintendent at the Devon County Asylum, found that

> Patients have been admitted suffering from heart disease, aneurism, and cancer, with scarcely a greater amount of melancholy than might be expected to take place in many sane persons at the near and certain prospect of death. Some have been received in the last stages of consumption, with that amount of cerebral excitement so common in this disorder; others have been received in the delirium or stupor of typhus; while in several cases the mental condition was totally unknown after admission, and must have been unknown before, since an advanced condition of bodily disease prevented speech, and the expression of intelligence or emotion, either normal or morbid (quoted in Arlidge 1859).

(Such catalogues of decrepit and all but moribund admissions were anything but exceptional: see, for example, Caterham Lunatic Asylum Annual Report 1873; Hanwell Asylum Annual Report 1875 and 1880; Commissioners in Lunacy Annual Report 1881. In the light of evidence of this sort, Hare's contention (1983)

that the admission of milder cases "should have decreased" the asylum death rate does not seem particularly plausible).

Second, there are other, at least equally plausible ways of accounting for the decline. Many Victorian critics of the asylum system, including Maudsley himself, thought that there was a clear connection between increasing size and decreasing therapeutic efficacy. As John Arlidge put it,

> In a colossal refuge for the insane, a person may be said to lose his individuality and to become a member of a machine so put together, as to move with precise regularity and invariable routine; a triumph of skill adapted to show how such unpromising materials as crazy men and women may be drilled into order and guided by rule, but not an apparatus calculated to restore their pristine condition and their independent self-governing existence. In all cases admitting of recovery, or of material amelioration, a gigantic asylum is a gigantic evil, and figuratively speaking, a manufactory of chronic insanity. (Arlidge, 1859; see also Bucknill, 1880).

Modern research on 'institutionalism' (Wing, 1962; Wing and Brown, 1970; Barton, 1965; Belknap, 1956; Stanton and Schwartz, 1954) surely lends considerable credence to this hypothesis. And we know that the average size of English county asylums rose remorselessly through the course of the nineteenth century, from just over a hundred patients in 1827 to almost a thousand by the end of the century, paralleling the development of a steadily more hopeless and 'institutional' environment. Increasingly, within such mammoth institutions, "the classification generally made is for the purpose of shelving cases; that is to say, practically it has that effect . . . in consequence of the treatment not being personal, but simply a treatment in classes, there is a tendency to make whole classes sink down into a sort of chronic state. . . I think they come under a sort of routine discipline which ends in their passing into a state of dementia." (Granville, in House of Commons, 1877).

Almost certainly, then, increasing size and the associated changes in the treatment of the inmate population had negative effects on cure rates. In turn, this provoked a steadily more pessimistic assessment of the prognosis for insanity among alienists themselves, forced to account for the falling rate of cures despite the advances of medical science. As explanations of mental illness were ever more frequently couched in terms of structural brain disease, defective heredity, and Morelian degeneration, so there emerged an entrenched expectation that most cases of mental illness would prove to be incurable. Expectations of this sort, through their effects on staff morale and the quality of care provided (to say nothing of the negative placebo effect), became a relentlessly self-fulfilling prophecy, further diminishing the underlying recovery rate while providing tautological 'proof' of their essential accuracy. I suggest it is this combination of factors, rather than "the admission of less favourable cases" (Commissioners in Lunacy 1899, quoted in Hare, 1983), which accounts for the dismal therapeutic results of late nineteenth century asylum care—though for obvious reasons this was a conclusion that both the psychiatric profession and the Commissioners in Lunacy were reluctant even to consider.

Beyond this, a good deal of contemporary testimony supports my suggestion that the boundaries of what constituted committable madness expanded over the course of the nineteenth century. A wide range of nineteenth century observers commented on how much laxer the standards were for judging a poor person to be insane, and how much readier both local poor law authorities and lower class families were to commit decrepit and troublesome people to the asylum, individuals who, had they come from the middle and upper classes, would never have been diagnosed as insane. In the words of William Ley, superintendent of the Littlemore Asylum, "Orders for the admission of Paupers into the County Asylum are given more freely than would be thought right as regards the imputation of Lunacy, towards persons equally debilitated in body and mind who have the means of providing for their own care." (Littlemore Asylum Annual Report 1855). Over time, this tendency grew more marked. Just over twenty years later, John Joseph Henley, the General Inspector of the Local Government Board, informed a Select Committee of the House of Commons that in his inspectors' experience, "there is a disposition among all classes now not to bear with the troubles thay may arise in their own houses. If a person is troublesome from senile dementia, dirty in his habits, they will not bear it now. Persons are more easily removed to an asylum than they were a few years ago." (House of Commons 1877). Workhouse authorities, too, according to the medical inspector of the London workhouses, routinely used asylums to "relieve their wards of many old people who are suffering from nothing else than the natural failing of old age" as well as to rid themselves of troublesome people in general. (House of Commons 1877; see also Commissioners in Lunacy Annual Report 1861).

As a result, as Mortimer Granville (1877) noted, "it is impossible not to recognise the presence of a considerable number of "patients" in these asylums who are not lunatic. They may be weak, dirty, troublesome, but they are certainly no[t]. . . affected with mental disease." Those who had been acquainted

with the county asylum system from its very earliest years could not help but notice the change in the implicit definition of mental illness, the enormous and striking difference "between the inmates of the old madhouses and the modern asylum—the former containing only obvious and dangerous cases of lunacy, the latter containing great numbers of quiet and harmless patients whose insanity is often difficult to determine." (Bucknill, 1880). At least for these well placed observers, there could be no question but that

> the law providing that madmen, dangerous to themselves and others, shall be secluded in madhouses for absolutely needful care and protection, has been extended in its application to large classes of persons who would never have been considered lunatics when this legislation was entered upon. Since 1845, medical science has discovered whole new realms of lunacy, and the nicer touch of a finikin civilization has shrunk from the contact of imperfect fellow-creatures, and thus the manifold receptacles of lunacy are filled to overflow with a population more nearly resembling that which is still at large. (Bucknill 1880: 4)

Hare argues that mild cases could not have provided the reservoir from which the increased asylum population was drawn, because such cases would not have seemed sufficiently urgent to warrant the construction of so many beds. But the definition of 'urgent' in this case is obviously a matter of complex social definition, not something engraved in stone. I see no reason to doubt that those committing patients in 1880 were convinced that their reasons for doing so were urgent and compelling—though one may reasonably question whether the same justifications would have seemed equally compelling some thirty or forty years earlier. Nor should it surprise us that what constituted adequate grounds for commitment should shift over time in this fashion. After all, the past quarter of a century has witnessed a move in just the reverse direction, towards a much more restricted view of the appropriate criteria for involuntary commitment. (Scull, 1984).

Conclusion

Ultimately, of course, the most satisfactory way of deciding between the rival hypothesis offered by Hare and myself would be to look at a random sampling of admissions over time, to see whether the increase occurs among mild or severe cases. Unfortunately, there must be serious doubt about whether the quality of the records that have survived is adequate for this purpose. Case records for upper class asylums were extensive, as in the Ticehurst Asylum casebooks now at the Wellcome Institute. But, as Hare notes, almost none of the increase in the incidence of mental illness occurred among private patients, so that for our present purposes, these materials are unlikely to be very helpful. On the other hand, precisely because the county asylums were so overcrowded, and were filled with paupers, their individual case records are generally too skimpy to be useful for answering this question.

I would suggest, however, that the class-specific pattern of the increase in insanity does pose certain difficulties (though I grant these are not necessarily of an insuperable sort) for Hare's argument. Somehow, the slow epidemic of schizophrenia was a *class-specific* epidemic, so that on top of the highly speculative claim that it had a viral origin, one must add the further hypothesis that the upper classes—whether for constitutional or environmental reasons—were mysteriously immune to its ravages.

It may well be that we shall have to be satisfied with an assessment of the general plausibility of each argument, and the extent to which it makes sense of the wide variety of data and observations that *have* survived. However, since Hare felt free to draw on comparative data to buttress his case, perhaps I may be allowed to do the same. The one careful study we possess of the composition of asylum populations in this period is Fox's examination of legal commitments in California between 1906 and 1929. Using a random sample of commitments from San Francisco in this period, Fox demonstrates that

> Two third of those commited were odd, peculiar, or simply immoral individuals who displayed no symptoms indicating serious disability, or violent or destructive tendencies. The reported behavior of this 66 per cent included primarily nervous and depressive symptoms and a wide variety of fears, beliefs, perceptions, and delusions. In these cases the examiners noted that behaviors which they and various witnesses deemed inappropriate, but failed to indicate any reason why the individual, for his own protection or that of the community, had to be detained. (Fox, 1978; 148).

It goes almost without saying that this finding accords very well with my hypothesis and provides little or no support for Hare's.

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Andrew Scull, B.A., M.A., Ph.D., *Professor of Sociology, University of California, San Diego, La Jolla, California 92093, USA*

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