Introduction

Therapy and empowerment, coercion and punishment. Historical and contemporary perspectives on work, psychiatry and society

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Patient work was a major feature of lunatic asylums or mental hospitals during the modern period. It was considered not only therapeutic but also to contribute to the upkeep of institutions. Although many other aspects of psychiatric treatment have been focused on by historians, patient work has not received any in-depth, systematic assessment.[1] This can largely be accounted for by the enduring emphasis in the history of psychiatry on the medical ideas and administrative interventions that contributed to the transformation of lunatic asylums into mental hospitals and psychiatric care facilities. This book therefore constitutes the first attempt to examine patient work in a wide range of psychiatric institutions and to conceptualise the meaning of work in relation to its specific sociocultural, economic and political contexts. Due to the current dearth of studies on work and psychiatry, the closest thematic link with other historical literature exists in relation to the fields of industrial therapy (IT)[2] and occupational health.[3] The conceptual and methodological concerns connected with the central themes of this book therefore require further elaboration.

Labour, work and action

What kind of human activity counts as work has over time been subject to varied definitions. In its most basic, biological sense, human activity is essential to meet the need for sustenance and comfort. Beyond the satisfaction of basic necessities, its role in what makes man and woman human and enables them to realise their potential as social and political human beings has been a central concern for philosophers, economists and the general public. The amount of attention being paid to human activity, variously referred to as work, labour or action, tends to wax and wane with life's vicissitudes, relative

economic prosperity, dearth and deprivation, and the cultural and ideological preoccupations of particular sections of society at particular times and places.

From his socially privileged position in fourth-century BCE Athens, the Greek philosopher Aristotle mused on the difference between labour and work on the one hand and political action on the other. He defined labour as activity that meets the basics of life, being connected with tasks of living that are necessary for survival (food production, shelter). Work entailed, in contrast, the creation of an artificial world of things that were of lasting value in the public realm and enhanced the quality of collective life. In this scheme neither labour (pursued by *animal laborans*) nor work (performed by *homo faber*) are considered free activities as they are shackled to the necessities of survival (labour) and the pursuit of a comfortable, collective or 'good' life (work). Both are also subject to prevalent social inequalities (such as slavery, social and gender stratification) within the household and the public sphere. Aristotle postulated a third kind of human activity that was situated in the public and political sphere and elevated above labour and work: action.

The fact that only full citizens, a minority of the population in ancient Greece, had access to the political arena does not, arguably, distract from the philosophical principles underlying the classical understanding of human activities. Inequalities and issues of power that frame labour, work and political action are recognised by classic philosophers, but not located at the centre of analysis in the same way that post-Enlightenment thinkers such as Marx, Foucault and Arendt have proposed. This underlines the complexity of dealing with the subject of work in relation to particular historical and cultural contexts and alerts us to the varied ways in which human activities have been classified. Despite various different emphases, modern authors tend to agree that the human condition entails more than the mere satisfaction of basic human needs through labour, insisting that all aspects of the classic tripartite scheme of human activity are required for a fulfilled and dignified life or *vita activa*. In other words, being alive as a complete human being, rather than merely as a fed, watered and exercised body is seen to entail the freedom to act and communicate freely. This premise should be an important ethical consideration in any investigation of people's work activities. In the case of patients such analysis is complicated by the fact that their activities take place within institutions that are expressly designed to inhibit the free expression of the full range of their inmates' physical, mental and emotional inclinations, and to segregate them from the wider public sphere and, and in some circumstances, to impose rather than merely encourage engagement in labour and work activities.

Other aspects of work and labour that require analytical attention are those highlighted by the political economists and their critics. While Adam Smith's distinction between 'productive' and 'unproductive' labour is now considered

by mainstream microeconomics to be an outmoded aspect of his economic theory, its ambition to assess labour in relation to the wider context of capitalist production enables us to ask in what way patients' activities were productive and contributed to the generation of value and profit. According to the classical political economists of the eighteenth and nineteenth centuries, labour that produced value and was potentially profitable (as in the manufacture of a bed or chair) was considered productive, while labour that left no lasting result (such as domestic duties) was unproductive. What counted as 'productive' labour in institutional settings? Were the same criteria employed as in the world of manufacture outside the walls of the asylum? Were the goods resulting from productive work marketed outside the closed institution and hence part of the local economy and the wider cycle of economic production? Did patients' activities merely enable institutions to be 'self-sufficient' and, in Smith's reading, involve 'unproductive' labour in the shape of domestic tasks? Or was the labour performed in the asylum located outside the realm of modern market economies and hence its usefulness defined in terms of its contribution to a type of internal subsistence economy?

These economistic questions are important because, even if work in psychiatric institutions was not fully integrated into the structures of market-based economies and merely part of a mixed economy of subsistence and marketable labour, the monetary value attributed to patient activities in institutional financial accounts as well as asylum staff's perception of the social and economic value of particular types of work were ultimately anchored in and constrained by the premises of the wider economy extant at a particular time and place. For example, inside as well as outside institutions domestic labour did not count as a productive activity and hence was not entered into account sheets; nor was food produced for inmates' consumption. Surplus produce and domestic duties sold or performed by patients outside the asylum were, however, accounted for in monetary terms. The economic benefit derived from patients' labour and work, whether considered unproductive or productive, went well beyond what can be discerned from monetary value-focused institutional book keeping and superintendents' statements about the profit realised from the sale outside the institutions of goods and services produced by patients.

If the focus is shifted from work and labour to the person who pursues them, the issue of work satisfaction arises. Most prominently, Marx has dealt with this in depth. His notion of 'alienation' was developed in relation to labour performed in the mills and factories of industrial capitalism. It could be argued that this limits any applicability to patient work. However, some of its tenets help sharpen our focus on the varied ways work may have affected people, especially when their activities were not self-determined but dictated by others who, like Marx's bourgeoisie, held power over them within a highly

hierarchical context characterised by inequality. Patients in the asylum lost the freedom to determine their life and destiny, and to direct their own actions. They may not even have been able to freely define their relationship with other people but have been ascribed particular roles (of patient *versus* staff; violent maniac; idiot). They were also usually not permitted to own the products of their labour and make use of the value of the goods and services they produced. Patients may therefore have been subject to one or several types of alienation that Marx has so deftly identified: the workers' alienation from, first, the product (no control over product, from design to its consumption); second, the act of producing (no choice of psychologically satisfying activity); third, themselves (being subjected to external demands imposed by others); and fourth, others (being forced to compete with others). All of these aspects require probing with regard to the very different institutional settings and conditions within which patients performed – mostly unpaid – work and labour.

However useful concepts such as alienation, unproductive labour and the tripartite systematisation of activity may be, we also need to consider that abstract categories and common meanings of work are not necessarily identical and that a great variety of understandings have prevailed and affected people's lives in different ways over time. The light-hearted 1960s British ditty that 'work is a four-letter word'[4] encapsulates sentiments and echoes the experiences of a generation of people that are worlds apart from, say, those who during the 1930s and 1940s put up gates at Nazi concentration camps that proclaimed '*Arbeit macht frei*' (work makes you free). Moreover, apparently identical definitions of what work is supposed to mean and achieve vary depending on the wider context. In Weimar Germany, for example, during the 1920s, public work-generation schemes intended to fight widespread unemployment used the same slogan of '*Arbeit macht frei*' that later was to become irrevocably linked with Nazi atrocities. From the point of view of some, the intention of the Weimar work schemes may have been to alleviate the misery of those suffering from structural economic factors beyond their control. For those who considered the unemployed as culpable loafers and criminal elements, they constituted a way of turning these people into morally less despicable citizens. Earlier usage of the phrase '*Arbeit macht frei*' during the late nineteenth century by authors such as the nationalist novelist and lexicographer Lorenz Diefenbach also accentuated the moral disciplining effect of work.[5] At the other end of the political spectrum, ant enthusiast, eugenic psychiatrist and one-time socialist Auguste Forel likened the 'free work' done by ants for the greater good of the insect colony to socialist collectivism, claiming, like Diefenbach, that '*le travail rend libre*'.[6]

The meaning of work is clearly subject to different interpretations that lend themselves to a range of ideological positions. The varied and wider social and

political connotations and agendas that framed and influenced the perceptions of patient work in institutions, and the conditions under which it was performed, require as much attention as the medical ideas and regimes that are more commonly at the centre of histories of psychiatry.

Medical ideas

Activity or exercise has been a mainstay of a variety of medical paradigms. In the pre-modern period, they were, in the Graeco-Roman tradition, part of the six 'non-naturals', namely factors external to the body over which a person had some control. Motion or exercise (*motus*) was considered alongside rest and relaxation (*quies*), and together they figured alongside the other five constellations in Galen's pathology of the humours that required balancing out and use in moderation: atmosphere and environment; food (diet) and drink; sleep and wakefulness; retention and evacuation; and passions of the mind (emotions). Non-European traditions such as Ayurveda and Chinese medicine, too, identify activity as an integral part of their medical regimens. According to these medical systems well-designed activity has beneficial effects on both body and mind. Emphasis is on regulation of the body – and hence the mind – and on actions that facilitate its natural processes. Importantly, care has to be taken to avoid overexertion and strain. Therefore, in Ayurveda, exercise (*vyayama*) should avoid employing more than half the capacity of the individual and not consist of vigorous activities such as fast running. According to *Charaka Samhita* (*c.* 300–500 CE) 'death runs after one who runs'. Although Chinese Qigong exercises draw on various kinds of humdrum work activities, such as grinding the millstone, like Graeco-Roman and Ayurvedic medicine, it too emphasises moderation. Hard physical labour does not figure as part of a health-enhancing regime. In fact, in Ayurveda, for example, the facilitation of the capacity for work (*karma-smarthya*) constitutes one of the benefits of motion and exercise rather than a therapeutic aid in itself.

While the idea of activity, exercise and occupation as part of therapy is not confined to the modern period, the extent to which physical labour is supposed to be employed in medical regimens seems to have emerged only more recently. This may be linked to changes in the social and economic fabric of European societies that occurred from the mid-eighteenth century onwards. Some of these imbued work more generally with new connotations and accentuated particular meanings in the employment of activity as part of medical regimes. Foremost among these developments was the changing locus of the treatment of the mentally ill: To begin with, patients were confined in relatively small, mostly privately run madhouses, but, increasingly, from the mid-nineteenth century, they were housed in large-scale public lunatic asylums that provided for hundreds of inmates, in some cases even

a couple of thousand. Institutionalisation on a progressively larger scale was expensive and an emphasis on motion or work rather than rest became a way of setting off the costs of public institutions during a period when the term 'industry' harboured its double meaning of 'processing of raw materials' and of 'industriousness'. Whole families, including women and children from the age of five or six, spent more time working than they had hitherto done in agricultural employment – in England between 1750 and 1800 annual working hours increased by at least one fifth.[7]

The idea of work as punishment also flourished, within the prison sector in particular, where inmates and those transported to penal colonies like Australia were forced to work. The ideal public institution, be it lunatic asylum or orphanage, was supposed to be, and frequently was, both a place of industriousness in the wider sense and, more specifically, an economically profitable place of industry, manufacture, or of otherwise usefully employed labour. We should not forget that in many countries the nineteenth century was not only the century of industrialisation and urbanisation but also the heyday of the workhouse, where inmates were forced to employ their labour power within a punitive context and to earn their keep. Work was an economic necessity and the workhouse was, as Jeremy Bentham put it, 'a mill to grind rogues honest, and idle men industrious'.[8] The workhouse also came to install, as Foucault suggested, a new 'ethical consciousness of labour', and turned it into a moral symbol that affirmed the value of work. Punishment, economic necessity and morals were intrinsically bound up. Attitudes of the elite towards work had evidently crystallised in Britain by the early and in Germany by the late nineteenth century as industrialisation took hold. Work was a moral duty and a source of individual improvement, both morally and materially. Values of thrift, toil and sobriety associated with the growing class of entrepreneurs derived, according to Max Weber, from a mindset he termed the 'Protestant work ethic'.

Within this context the meanings of 'motion', 'activity' and 'exercise' were no longer the same as in the Hippocratic or subsequent pre-modern medical traditions. Nineteenth-century and present-day social and medical understandings of work and of occupation as therapy are, from a historical perspective, very specific ways of conceptualising these terms. Currently, medical thinking chooses to focus on work as empowerment; on work satisfaction; on the aim of rehabilitation and reintegration; and on the dangers of 'bore-out' in the absence of meaningful and productive work (rather than of 'burn-out' in the face of overwork). Within institutional psychiatry, emphasis has shifted since the late eighteenth century. The aspects of punishment on the one hand and of self-improvement and economic and personal empowerment on the other were accentuated to a varying extent at different times, and both medical rationales and moral and economic considerations were appealed to by

asylum superintendents and psychiatrists when they argued in favour of patient work.

During the eighteenth century patient work did not feature prominently within psychiatric institutions in Europe. It was employed by only some mad-doctors, such as Francis Willis who treated King George III in 1788. He set the monarch to work, alongside other men of distinction, on the farm and stables attached to Greatford Hall, near Bourne, Lincolnshire. Contemporary reports tell us that:

> As the unprepared traveller approached the town, he was astonished to find almost all the surrounding ploughmen, gardeners, threshers, thatchers and other labourers attired in black coats, white waistcoats, black silk breaches and stockings, and the head of each '*bien poudre, frise et arrange*'.
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> These were the doctor's patients with dress, neatness of person, and exercise being a principle feature of his admirable treatment system where health and cheerfulness conjoined to aid recovery of every person attached to that most valuable asylum. (1796, French visitor)[9]

Willis's regime was based on the usual range of physical treatments such as blistering as well as on the carrot and the stick. Patients were told off for misdemeanours and symptomatic behaviour, fixed with the eye and put under physical restraint; when placid and symptom free they were allowed to engage in gentlemanly pursuits and polite conversation. More generally though, patient work was rarely used as part of asylum regimes.

With the emergence of 'moral treatment' around the turn to the nineteenth century, patient work became, as Andrew Scull put it, a 'major cornerstone' of treatment, with emphasis on the development of the patient's self-control, as distinct from control established by a therapist.[10] The York Retreat in Britain became the epitome of this kind of reformed regimen, along with Pinel's Salpêtrière. Historians have been divided on the role of work within moral treatment during the early nineteenth century. Foucault considered the Retreat's use of patient work as an attempt to impose 'a moral rule, a limitation of liberty, a submission to order, an engagement of responsibility' in order to 'disalienate' the mind.[11] Others believe that Foucault has overemphasised the repressive nature of occupation and moral therapy. While patient work might require subordination to routine and the acceptance of discipline, such habits were seen as important in preparing the convalescent patient for re-entry into the world outside the asylum.[12] On balance, it might be fair to suggest that work within the context of 'moral therapy' as practised at the Retreat aimed at social conformity through humane means.[13]

Moral therapy was a reform movement and for a while an inspirational ideal realised in but a few institutions in Britain, France and other Western and colonial countries around the world. Patients' experiences at the York

Retreat and establishments modelled on it were more salubrious than those persisting in old-style, unreformed institutions that made use of physical restraint and punishment. By the late nineteenth century, the principles of moral therapy were still widely celebrated, but the feasibility of implementing them in the large-scale public institutions that emerged all over Europe was restricted. Patient work, however, was more easily retained as a cornerstone of institutional management of the insane and an income spinner. Reference to patients' self-improvement through work was common in institutional reports and doctors' writings. The divide between rhetoric and practice and between favourable and even exquisite conditions for rich patients in private establishments and overcrowded and deteriorating circumstances for the poor in public asylums widened during the course of the nineteenth century and beginning of the twentieth century.

If we look at the available evidence on the wider context within which patient work was organised in the large public asylums of the late nineteenth and early twentieth centuries, we find that the emphasis came to be increasingly on institutional profit, intolerance to 'idleness' and work as the default setting rather than as a matter of patient choice. Reports of profiteering on the part of asylum staff, coercion of patients, and withdrawal of food and rewards such as cigarettes or outings as punishment for non-compliance were not uncommon for this period. The huge mental institutions of the late nineteenth and early twentieth centuries, were not only, as the anti-psychiatrist Thomas Szasz has suggested, places where madness was 'manufactured', but also became self-supporting if not lucrative manufactories or agricultural enterprises.[14]

The profit motive became in some countries entangled with eugenics during the first decades of the twentieth century. The *Gütersloh* model of Hermann Simon, for example, was for a while an inspiration not only for social psychiatrists in Europe and across the globe (for example Argentina and India) but also for those keen on ridding society of those who would or could not be productive.[15] His '*aktivere Krankenbehandlung*' or more active therapy entailed work being deployed in a planned and systematic way as a sheet anchor of psychiatric treatment. Those unable to work were labelled '*minderwertig*' (inferior) and considered as '*Ballastexistenzen*' (burdensome encumbrances) or '*soziale Parasiten*' (social parasites) who should undergo forced sterilisation or even be exterminated and hence '*erlöst*' (redeemed). Even if Simon's fully blown extermination regime was not adopted in other countries, his efficient, work-focused institutional design and the paradigm of work as social duty were well received.

Simon's and other late nineteenth- and early twentieth-century ideas on the role of work in the treatment of the insane were far removed from the classic, Graeco-Roman and other healing rationales that aimed at adjusting

a patient's regimen of rest and motion in relation to his or her individual humour (or constitutional characteristics). Another major discontinuity with earlier and non-Western ideas during the modern period pertains to the emphasis on a person's social class or race rather than just their individual physical and mental condition. Willis may have got George III to engage in agricultural work, but the King laboured alongside gentlemen and other people of distinction. The emergence of large public institutions for the poor alongside private establishments for the rich during the nineteenth century occasioned a focus on what kind of work was suitable for what kind of social class. The work to be done by poor lunatics was very different from the active pursuits engaged in by gentlemen and ladies. In colonised countries, such as India, for example, racial considerations came into play, outweighing divisions of social class. Europeans of any social class were therefore exempted from physical work in mental hospital, instead being offered leisure activities for distraction and entertainment. Indians, in contrast, were expected to work and in some institutions their diet was cut if they did not comply. For Eurasians (people of mixed race), social class became again relevant, as those belonging to the higher classes were treated like Europeans and those of lower standing like Indians. It is particularly intriguing how race- and class-specific work therapy was justified. Medical and moral rationales were given, alongside economic considerations.

The poor in Europe and other races were seen to be used to physical work and hence there was a danger of alienating them from familiar pursuits if they were offered activities enjoyed by the higher classes and races. The rich in Europe and Europeans in the colonies would find physical work unseemly and therefore unsettling. Besides, their constitutions and moral sense were different from natives'. Class and racial differences were medicalised and environmental and hereditary factors that were seen to have a bearing on different social classes and races became criteria for the type of work, if any, that should be pursued in Europe and in the colonies. With the development of the discipline of anthropology during the late nineteenth and early twentieth century, considerations of 'culture' were linked up with medical and eugenic ideas, leading to the 'culturalisation' of race and the justification of varied work regimes in psychiatric institutions on those terms. The wider social, scientific and economic contexts impacted on how patient work was configured and rationalised, and how patients' experiences were framed.

It is from the early to mid-twentieth century onwards that patient work became increasingly viewed as an entitlement rather than a duty. Psychological paradigms were advanced by asylum reformers, which considered work as enabling, empowering and part of good physical and mental health. Periods of rest or leisure and work or activity had to be in balance and a new, professionally trained group of experts – occupational therapists – became responsible

for this task. There remain debates on the cultural and social acceptability of particular types of work and activities for patients from different social and cultural backgrounds, but the link between work and coercion has been broken to such an extent that occupational therapists nowadays find it hard to consider that it had ever been part of their profession's history. Yet work, psychiatry and society are intrinsically bound up, and patients' experiences of work and activity in mental institutions have consequently been varied over time, being dependent not only on individual patients' predispositions and inclinations, but also on the wider social, institutional and medical contexts within which work is pursued.

Themes

The origins of work therapy have commonly been linked with the advent of moral therapy or moral management during the early nineteenth century. The first chapter, by Jane Freebody, investigates this link, identifying when patient work began to figure in English, French and Italian psychiatrists' publications on moral treatment. Freebody shows that while patient work was *de facto* employed in institutional regimes as part of the toolbox of asylum management from the later decades of the eighteenth century, it was not theorised as a central aspect of moral treatment in specialist publications until the early nineteenth century. This highlights the importance of considering both theories and practices in any historical account of a phenomenon such as work. Psychiatric textbooks and other publications may not always allow us to fathom what was actually happening on the ground. On the other hand, Freebody shows that in early psychiatrists' writings bodily exercise and mental distraction through activity *were* central aspects of moral treatment – albeit not necessarily in the shape of menial work. Moreover, they were almost exclusively conceptualised in relation to the humoral framework of the six non-naturals. In the late eighteenth-century treatises exercise remained invariably linked to the language and understandings of classic medicine, and no privileged role was attributed to menial labour in contrast to walks and active games. Later, in contrast, early nineteenth-century accounts increasingly tended to meld the previous, humoral conceptions with contemporary ideas about the moral and economic benefits of work.

The meaning of patient work within late eighteenth-century institutional contexts and its conceptual and tangible links with the prevalent medical, social and political ideas of its period varied from the way it was framed during the early nineteenth century. As medical theories gradually shook off the shell of humoral medicine, exercise, occupation and work became reconceptualised within new frames of medical theory and social conditions. Freebody maps this trend in relation to an emergent industrialising society