HISTORICAL REVIEW

The role of work in psychiatry: Historical reflections

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ABSTRACT

Until recently, the role of patient work in the history of psychiatry has been a neglected dimension. Yet, in the psychiatric institutions that emerged across the world from the late eighteenth century onwards, work and work therapy were prominent features, culminating in the rise of a specialist profession affiliated to medicine – occupational therapy. This article explores the changing meanings of work within varied medical, social, and political contexts.

Key words: Work therapy, punishment, occupational therapy, moral therapy, history of psychiatry, empowerment

In 1751, St. Luke's Hospital for Lunatics was established by philanthropists for the reception of pauper lunatics in London. A few years later, in 1758, its first resident physician, William Beattie (Battie), published his Treatise of Madness, which was to become an authoritative and influential reference work for 18th-century doctors. It has been described as "the first by a psychiatrist who could draw on his experiences with a large number of patients."[1] Based on his experience, Beattie insisted that "management did much more than medicine."[2] In due course, practitioners began to recommend patient work as an aspect of "moral treatment."[3]

Historians' views of work and occupational therapy in psychiatric institutions do not always overlap with practitioners' own perspectives. For a historian, the historical role of patient work in psychiatry is subject to vacillation between therapy and empowerment on the one hand and coercion and punishment on the other hand. In contrast, the present-day occupational therapists and other practitioners allied with psychiatry might not consider the latter features as characteristic of their profession. What does historical research tell us about the development of work therapy in Europe, North America, and South Asia during the course of the last three centuries?

Rest and activity were two of the mainstays of a variety of medical paradigms. In the Greco-Roman tradition, they were part of the six "nonnaturals," namely, factors external to the body over which a person had some control. Motion or exercise and rest figured alongside the other five constellations that required balancing out and use in moderation: air and environment, food (diet) and drink, sleep and wakefulness, retention and evacuation, and passions of the mind (emotions). Traditions such as Ayurveda and Chinese Medicine too consider exercise or work as an integral part of medical regimens. The idea of work as therapy is, therefore, not confined to the modern period.

However, from the mid-18th century onward, changes occurred in the social and economic fabric of Western societies. Some of these imbued work more generally with new connotations and accentuated particular meanings

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in its employment within medical settings. 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 from the mid-19th century onward, they were increasingly housed in large-scale public lunatic asylums that provided for hundreds or sometimes a couple of thousand inmates. This development was mirrored in British India.[4] Institutionalization on a progressively larger scale was expensive, and an emphasis on motion or work rather than rest became a way of lowering the costs of public institutions. It was during this period that the term "industry" began to harbor its double meanings of "processing of raw materials" and of "industriousness." Whole families, including women and children from the age of 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.[5]

The idea of work as punishment too flourished, particularly within the prison sector where inmates and those transported to penal colonies like Australia were forced to work. The ideal public institution, whether a lunatic asylum or an orphanage, was a place of industriousness and of economically profitable manufacture or otherwise usefully employed labor; frequently they were. The 19th century was not only the century of Western industrialization and urbanization but also the heyday of the workhouse, where inmates were forced to employ their labor power within a punitive context as well as 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."[6] The workhouse came to install, as Foucault suggested, a new "ethical consciousness of labuor" and turned into a moral symbol that affirmed the value of work. Punishment, economic necessity, and morals were intrinsically bound up. Attitudes of the elite toward work had evidently crystallized in Britain by the early, and in Germany by the late, 19th century as industrialization 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 mind-set he termed the "Protestant work ethic."

Within this context, the meanings of "motion," "exercise," and "work" were no longer the same as in the Hippocratic or in non-Western medical traditions. 19th-century and our present-day social and medical understandings of work and of occupation as therapy are, from a historical perspective, very specific ways of conceptualizing these terms. Currently, we choose to focus on work as empowerment; on work satisfaction; on the aim of rehabilitation and re-integration; and on the dangers of "bore-out" in the absence of meaningful and productive work (rather than of "burn-out" in the face of overworking).

Within institutional psychiatry, emphasis has shifted over time since the late 18th century. The aspects of punishment on the one hand and of self-improvement and economic and personal empowerment on the other hand were accentuated to varied extents at different times and in different contexts. Both medical rationales and moral and economic considerations were referred to by asylum superintendents and psychiatrists when they argued in favor of patient work.

During the 18th century, patient work did not feature highly within psychiatric institutions in Europe. It was employed only by some mad-doctors like Dr. 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 principal feature of his admirable treatment system where health and cheerfulness conjoined to aid recovery of every person attached to that most valuable asylum.[7]

Willis' regimen 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 misdemeanors and symptomatic behavior, fixed with the eye and put under physical restraint. When they were 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 regimens.[8]

With the emergence of "moral therapy" around the turn to the 19th century, patient work became, as 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.[9] The York Retreat in Britain became the epitome of this kind of reformed regimen, along with Pinel's Treatise on Insanity of 1806. Historians have been divided on the role of work within moral therapy during the early 19th century. Foucault found the work regimen at the York Retreat repressive, referring to its "constraining power," through which the patient was returned to "the order of God's commandments," submitting "his liberty to the laws that are those of both morality and reality."[10] He 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 over-emphasized the repressive nature of employment at the Retreat. While patient work might require, subordination to routine the acceptance of discipline and of maintaining concentration, such habits were seen as important in preparing the convalescent patient for re-entry into the world outside the asylum.[12] It would be fair to suggest that work within the context of "moral therapy" aimed at social conformity through humane means.[13]

Moral therapy was a reform movement and for a while an ideal aspired to, but the idea realized in but a few institutions in Britain and France. Patients' experiences at the York Retreat and establishments modeled on it would have been more salubrious than those persisting in old-style, unreformed institutions that made use of physical restraint and punishments. By the late 19th 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 as an income generator. Reference to patients' self-improvement through work was still common in institutional reports and doctors' writings. The divide between rhetoric and practice and between favorable and even exquisite conditions for rich patients in private establishments on the one hand and overcrowded and deteriorating circumstances for the poor in public asylums on the other hand widened during the 19th and early 20th centuries. This process is also reflected in South Asia, where mental institutions and their management were modeled on those prevalent in Britain and increasingly Northern America.[14]

If we look at the available evidence on the wider context within which patient work was organized in the large public asylums of the late 19th and early 20th 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 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 noncompliance were not uncommon for this period. The large-scale mental institutions of the late 19th and early 20th centuries where, according to the anti-psychiatrist Szasz, madness was "manufactured," became self-supporting if not lucrative manufactories or agricultural enterprises.[15]

The profit motive became entangled with eugenics in some countries during the first decades of the 20th century. The Gutersloh 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 in Argentina) but also for those keen on ridding society of patients who could or would not be productive.[16] His "more active treatment" entailed work to be deployed in a planned and systematic way as sheet anchor of psychiatric treatment.[17] Those unable to work were labeled "inferior" and considered as "social parasites" who should undergo forced sterilization or even be exterminated. Even if Simon's fully blown extermination regimen was not adopted in other countries outside Germany, his work-focused institutional design and the paradigm of work as social duty were well received across the world.

Simon's and other late 19th- and early 20th-century ideas on the role of work in the treatment of the insane were far removed from the classic, Greco-Roman, or Ayurvedic rationale that aimed at adjusting a patient's regimen of rest and motion in relation to his or her individual humor. One major discontinuity with earlier ideas pertains to the emphasis on a person's social class or race rather than their individual physical and mental condition. Willis may have got George III to engage in agricultural work, but the King labored alongside gentlemen and other people of distinction. The emergence of large public institutions for the poor alongside private establishments for the rich during the 19th century occasioned a focus on what kind of work was suitable for what kind of social class. The kind of work to be done by poor lunatics was very different from the active pursuits engaged in by gentlemen and ladies. In colonized countries like India, for example, racial considerations came into play, outweighing divisions of social class.[18] Europeans of any social class were exempted from hard, physical work in mental hospitals, instead being offered leisure activities for distraction and entertainment. Indians, in contrast, were expected to work and, in some institutions, their diet was cut down if they did not comply. For Eurasians or people of mixed race, social class was again relevant; those belonging to the higher classes were treated like Europeans and those of the lower classes like Indians. This was reflected in the admission policies of the European Mental Hospital at Ranchi (now Central Institute of Psychiatry) and the Indian Mental Hospital next door (now Ranchi Institute of Neuro-Psychiatry and Allied Sciences); the former allowed for Eurasians of the "better classes" to be accommodated while the latter catered for all other classes.[19]

It is particularly intriguing to see how race and class-specific work therapy was justified. Medical and moral rationales were given, alongside economic considerations. The poor in Europe and Northern America, and non-Western 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 westerners in the colonies would find physical work unseemly and therefore unsettling.

Besides, their constitutions and moral sense were perceived as different from those of "natives."

Class and racial differences were medicalized, 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 19th and early 20th century, considerations of "culture" were linked up with medical and eugenic ideas, leading to the "culturalization" of race and the justification of varied work regimens in psychiatric institutions on those terms. The wider social, scientific, and economic contexts clearly impacted on how patient work was configured and rationalized and how patients' experiences were framed.

It is from the mid-20th century onward that patient work became increasingly viewed as an entitlement rather than a duty and that psychological paradigms were advanced by mental health reformers that considered work as enabling, empowering, and part of good physical and mental health. Periods of rest or leisure and of work or activity had to be in balance, and a new, professionally trained group of experts became responsible for this task: occupational therapists.

There are still debates on the cultural and social acceptability of particular types of work 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 in each other, and patients' experiences of work in mental institutions have consequently varied over time, being dependent not only on individual patients' predispositions and inclinations but also on the wider social, institutional, and medical context within which work is pursued.

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COMMENTARY

The varied notion of work in the context of persons with mental illness lends itself to a fascinating historical analysis. The meaning of "industry" and "industriousness" in the 18th century, England had its impact not only on penal institutions but also on asylums. Work became seen as an economic necessity, and the impact of industrialization gave work a value not in terms of just "moral duty, but also for individual improvement, both morally and materially." The role of work thus had an economic and symbolic value for this period. Asylums emerged from the tradition of poorhouses, but in countries where the indigent had been provided for by the family or clan, this social need for work (as therapy) perhaps did not emerge till the colonial period. Class and culture came into conflict quite early and continue to be debated (Foucault and Doerner) as discussed in the essay. In the Indian context, an official report of the mid-19th century from Bombay, on the use of occupational therapy, regretted that "the Europeans are not inclined to work, and it would be difficult and not without danger to employ them in the same shed as natives as insane people are almost always full of prejudices and conceits and are possessed of irritable and hasty tempers". It is interesting to note that it is the conceit of the European patient that is being regretted! The concept of work has become integral to rehabilitation services now, but, as Ernst hints, the complex relationship between the individual patient and their illness, employment/employability, and society needs to be put into perspective. "Work will set you free" is an encouraging, enabling slogan but has had darker consequences.