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What is This?
THE HISTORY AND PRESENT STATUS OF MORAL INSANITY

John Ellard

Psychiatric taxonomies, always a little uncertain, are most confused and illogical when they endeavour to encompass the moral and legal aspects of human behaviour. The concept of moral insanity represented a step backwards when it came into being, but it has persisted for a century and a half, changing only its title. Its creation and its subsequent history exemplify some of the common errors in psychiatric theorising.

This essay is concerned with the development of a particular concept in psychiatry. The concept is as old as psychiatry itself, and its vicissitudes may be used to exemplify many of the errors and circularities which are to be found in psychiatric theorising. It is not a pointless exercise, for it will emerge that traps identified and avoided by authors writing centuries ago still manage to ensnare the unwary.

Anyone who is interested in making careful observations, and then constructing hypotheses derived from them, is likely to encounter a difficulty. The number of objects to be observed and the multiplicity of their qualities soon become overwhelming: something has to be done to simplify the task. A well established response is to group the data: since a large amount of data can be classified in many ways the observer is likely to choose criteria relevant to his or her interests. It is sometimes forgotten that for every accepted system of classification there are also innumerable equally valid alternative systems. They may not be as interesting, but they are as sound.

Perhaps the first classifications were of plants, because of their importance as foods and sources of medicine. Aristotle’s student, Theophrastus, wrote 15 books on their nature and growth [1] and the phytologies of botanists were cited by Sydenham in his insistence on the necessity for accurate observations “of the clear and natural phenomena of the disease”. From such observations will “... all diseases be reduced to definite and certain species” (all italics are those of the original authors). Elaborate a priori hypotheses are to be discarded: “Writers, whose minds have taken a false colour under their influence, have saddled diseases with phenomena which existed in their own brains only ... Add to this, that if by chance some symptom really coincided accurately with their hypothesis ... they magnify it beyond all measure and moderation ... while if it fails to tally with said hypothesis they pass it over either in perfect silence or with only an incidental mention, unless, by means of some philosophical subtlety, they can enlist it in their service, or else, by fair means or foul, accommodate it in some way in their doctrines” [2].

Sydenham wrote these words almost exactly 300 years ago: one may still hope that his advice will be heeded. Fifty years later the most famous botanist of them all, Carolus Linnaeus (styled Carl von Linné after he was ennobled in 1761), published his Systema naturae, which was followed by many works advancing the taxonomy of plants, animals, minerals and diseases. He was well qualified for this latter task, for he had also practised medicine as a physician, and at one time held the chair of medicine at the University of Uppsala [3]. His success was enormous, and from then...
on the urge to classify was irresistible.

Early psychiatric classifications existed but were based on such criteria as disorders of the four Galenical humours, or the activities of the Devil and his attendant demons, imagined and fanciful criteria of the kind damned by Sydenham. Empiricism began to flower, however tentatively, and in the 17th century Richard Napier based his categories upon inspection of his patients' behaviour [4].

One of the first major attempts at a taxonomy of psychiatric illness was that of the scholarly Dr Thomas Arnold, writing at the end of the 18th century, and the very beginning of the 19th [5]. Acknowledging his debt to Sydenham, "the late illustrious Linnaeus" [6], and other as well, Arnold knew what he was about. "Of causes we know too little to make them a foundation of the arrangement of diseases: and particularly of proximate causes; which alone can make us perfectly acquainted with their internal nature. When the science of causes shall be complete, we may then make them the basis of our classification: but till then we ought to content ourselves with an arrangement according to symptoms ... the road is right; and must ultimately lead to no small success in the discovery of truth, and the establishment of science" [7].

The authors of the Third Edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association took several times as many words to say the same things 170 years later [8].

In short, both Sydenham and Arnold recognised that all clinical classifications are methods of ordering data so that pertinent questions may be asked, and then hypotheses raised and tested. To assign an object or a patient to a category says something about the qualities or symptoms they exhibit, and about the interests of the person who designed the classification; it says no more about the person or object classified. Classification \textit{per se} is no more than one possible systematisation of the data; it may lead to something else, but it is not of itself any more than that.

Arnold followed his own advice, for his categories are based upon observation and description. Human behaviour being what it is, there is no end to the number of ways in which it may be divided, and his Pathetic Insanity, in which "one passion is in full and complete possession of the mind" had 16 varieties, ranging through such emotions as amorousness, jealousy, despondency, suspiciousness and irascibility [9].

He could see further than most of us. "How much disposed the several species of insanity are to run into, and mix with each other, I have expressly and fully noted in my books; and if that circumstance be considered as incompatible with the discrimination of species, all distinction of species in this disorder must be annihilated; and as I have allowed but of one genus, so I fear that there is but one species of insanity; since whatever distribution of species we adopt, I suspect we shall find it difficult to keep clear of this propensity to intermix, and combine. I know of no arrangement which is not objectionable on this account" [10]. Nor do I, and yet the pursuit of absolute distinctions, based on symptoms, still continues.

To move closer to the central point of our discussion, Dr Arnold also saw the need to set limits of another kind: "... my definitions \textit{exclude all but really insane persons}". He made it clear that his system was not such that it "too much enlarges the boundaries of the disorder, and comprehends within the limits of the derangement the vices and follies of the whole human race". One had to be insane first, on definite criteria, and only then could a consideration of the vice-ridden behaviour cause one to be assigned to a particular sort of insanity. "I do not esteem persons insane, merely because they are under the influence of strong, or even habitual passions ... I reckon such person \textit{vicious}, but not \textit{insane}" [11].

Interestingly, and forebodingly, there was in Dr Arnold's pellucid discussion one small confusion, a cloud as small as a man's hand, soon to descend and swell into a fog which still obscures our path. In making his very firm distinction between the insane and the vicious he wrote that he had gone to much trouble not to confound "medical and moral insanity" [12]. The problem is that "moral insanity" nowhere appears in Arnold's formal classification, and one is left with the medically insane, carefully defined, some of whom are vicious, and the morally insane, not further described, all of whom are vicious. Why the morally insane are insane at all is not stated; the result is a fundamental confusion about the meaning of "insanity". The conceptual confusion is still with us, even though the words have changed.

Things were to get much worse. The urge to classify became boundless, and no aspect of human activity was allowed to escape. Thus at about this time, John Adams wrote of Benjamin Rush [13]: "Rush is so near to my heart, that I must return to his very interesting Volume. It seems to me, that every excess of Passion,
Prejudice, Appetite; of Love, Fear, Jealousy, Envy, Revenge, Avarice, Ambition; every Revery and Vagary of Imagination, the Fairy Tales, the Arabian Nights, in short, almost all Poetry and all Oratory; every écart, every deviation from pure, logical mathematical Reason; may in Some Sense be called a disease of the mind”.

There was and is a major source of obfuscation. There is a criminal justice system; wickedness attracts punishment. Some offenders are mad by any imaginable criteria, and as a consequence escape the usual penalty. There is room for debate about the details of their disposition, but most accept the general principle. There is another group of offenders whose behaviour is so extraordinarily wicked that some observers feel that they are qualitatively different from the rest of us, and that they must be mad. For some curious reason if the observer believes that he understands their motivation he is less likely to make this judgement; it is the more likely when he is bewildered by what he sees. The same pressure to import psychiatric concepts into the criminal law existed then as exists now. Arnold’s distinction between viciousness and insanity was soon lost, and Sydenham’s careful differentiation between categorisation and causation was swept aside. The offender was insane because he has done these monstrous things; he did them because he was insane. The logic is circular, and therefore endless: one still hears the same argument today.

The confusion is worse than it seems. It is exemplified in the writings of Dr. J. C. Prichard of Bristol, published some 30 years after Dr. Arnold [14]. Prichard observed that in some of the insane the disease was essentially of the intellect and that in others the mind was totally overthrown. But there is another “form of mental derangement in which the intellectual faculties appear to have sustained little or no injury, while the disorder is manifested principally alone, in the state of the feelings, tempers or habits” [15]. There are problems in this statement as it stands, but its further development had unhappy consequences which are still with us. Prichard cannot be condemned, for his was but the clearest voice of his age. Less innocent are those who have continued his confusions for the next century and a half.

The first problem is that he has confounded the data and its source of generation. He does not say that he has categorised behaviour thus, but instead he attributes what he observes to a faculty, and asserts that the faculty is deranged. He offers no proof that there is such a thing as an intellectual faculty, and no description of its attributes. Needless to say, once one has begun to invent mental faculties the only limit to their production is the size and flexibility of the English language. Furthermore, they can act in combinations and these combinations can be named as well. There can also be varieties of faculties, such as abilities, propensities, sentiments, drives, motives, dynamic forces, ids, super-egos and a dozen others as well. An attempt to identify and describe them is like enumerating the inhabitants of the Hindu empyrean, in which there are innumerable gods, many of them different forms of other gods. The most active theoreticians of the day were the phrenologists. Combe, writing in 1837, described 35 such mental entities [16]; O.S. Fowler, writing in 1849, found 37 [17].

To look ahead, the development of statistical method has been of great assistance to those who search for more faculties. Factorial analysis is perhaps the best example, for it is fatally easy to slip from a factor to a faculty; one needs scarcely to think at all. This is not the place to go into the details of factor analysis: in essence it is an extension of the method of correlation which allows one to move from a bivariate situation to one in which the variation in one variable may be accounted for by a reference to the cumulative variation in other variables. There is often an underlying assumption that the factors which so emerge refer to some quality or qualities to be found in the minds of the population from which the original test scores were obtained. Indeed they may, but this fact is not established by that procedure. Factor analysis, indeed the whole of statistical method, is a way of asking questions, not of achieving explanations. The doctrine of the mental faculties is to be found in Aristotle [18], and for all I know existed before that. It is a seductive doctrine, for it permits one to pluck explanations from the air, while at the same time pointing to a set of data as if the explanation rose from it. Those interested in pursuing the topic should read Professor O’Neil’s thoughtful article in the Australian Journal of Philosophy and Psychology [19].

Prichard exemplifies the confusions which can arise. He has four categories of madness, some based on observations of behaviour, others on presumed disorders of the intellectual faculty. Worse, since intellectual disorders can lead to the assumption of a disordered intellectual faculty, similarly immoral behaviour can lead one to assume the existence of a
moral faculty which also has become disordered. Therefore one can have an intellectual insanity and a moral insanity of equal status, the latter depending upon the description of wicked behaviour alone, for that is sufficient evidence of a derangement of the moral faculty. It can be made quite concrete, for as I write I have before me L.N. Fowler’s Phrenological Bust: the moral faculties are located near the vertex.

It will be noted that by his assumption of faculties as the cause of the phenomena which he was observing Prichard has totally rejected Arnold’s view that one should not use an aetiologically based classification, the more particularly when one does not know what the aetiologies are. Indeed he wrote that Arnold’s views were “preposterous”[20].

Moral insanity is one of Prichard’s categories. At this point the distinction between insanity and wickedness was lost, and we have yet to regain it.

There is another major problem in Prichard’s concept. The word “moral” has been in the English language since the 14th century; the Latin word moralis was formed by Cicero, and passed into the Romance and Teutonic languages with the meaning that it had in the original Greek: pertaining to character, as virtuous or vicious, good or bad. Somewhere along the way it came to refer to the aspects of character, or those forces operating on the character, which were neither physical nor intellectual. The examples given in the Oxford English Dictionary do not make it clear, but it seems that in both England and America at the end of the 18th century “moral” had two meanings: one referring to morality, as ordinarily understood, and the other approximately equivalent to “emotional”. Thus the moral treatment of the insane meant that they were to be assisted not by blood-letting, purging and restraint, but with kindness and tolerance: what we might call improving the milieu. Moral treatment did not mean that they were to be the recipients of uplifting exhortations, but in fact they would be lucky to escape them.

Prichard’s “Moral Insanity” was therefore taken to mean two quite separate things. The first was insanity not of the reason, but of the passions, such as depression and mania. The second was that it was a disease of the moral faculty which led to wicked behaviour. The possibilities for confusion, both voluntary and involuntary, were enormous, and none of them has been missed.

There are many examples, some quite striking. Thus Dr. Isaac Ray, the doyen of American medical jurisprudence, set out his ideas in 1871 in a chapter entitled “Moral Mania”[21]. He quotes Pinel’s description of manie sans deliber[22], and in that discussion quite specifically equates the moral and the affective faculties. He then moves to support Prichard’s identification of a group of individuals whom we might consider variously as paranoid, hypomanic, or schizophrenic. This leads into some examples of classical bipolar disorder, and then into a case of Pinel’s in which a grossly indulged young man behaved with total selfishness, but no discernible irrationality. The concept widened still further and in Ray’s “Partial moral mania” we find shoplifting, “an inordinate propensity to lying”, lasciviousness and fire-setting.

Ray [23] finds the nettle and grasps it braavely: “...the absence of positive symptoms of mental disorder, as well as the presence of those which appear to show that the reason is sound, is not incompatible with the loss of moral liberty”. Later he quoted some cases from Dr. Thomson, surgeon of the General Prison for Scotland at Perth and then reproduces some of Dr. Thomson’s report: “...in several (cases) the intellect was very slightly affected, and almost the only proof of mania was the act itself, which was involuntary, impulsive, irresistible, and scarcely preceded or followed by any disorder of the intellectual functions”[24].

There was one more step to take, but Woodward had already taken it in 1844[25]. He was quite certain that moral insanity could be distinguished from mere depravity because it was always preceded or accompanied by “some diseased function of organs, more or less intimately connected with the brain and nerves”. This disease was so subtle that it could be detected only by a psychiatrist, but not a court or a jury. One should not be surprised at this, for it existed only in the psychiatrist’s imagination.

By the middle of the 19th century or thereabouts the whole disaster had been assembled. Faculties could be invented as causes of any behaviour you chose, without assuming the burden of describing where the faculties were, how they came to be there and what their qualities were; moral and mental aberrations were inextricably mixed; the whole of human behaviour could be encompassed in psychiatric classifications, the criteria of which were both imprecise and derived from more than one universe of discourse; and above all, the evidence for the existence of moral insanity was so subtle that ordinary mortals were unable to see it. Only psychiatrists could perceive and unravel its mysteries. Each of us must decide how far
we have moved from that position.

Prichard probably had more influence on psychiatric theory than any other psychiatrist writing in the English language. One hundred and thirteen years later my undergraduate psychiatric text quoted Prichard in some detail, giving his views, but changing his nomenclature [26]. As you will see there has been much activity in this respect: the Emperor has had many sets of new clothes.

In all this time some commentators have had misgivings, others none. Thus in 1871 Dr Fielding Blandford published the lectures on insanity and its treatment that he had given at St George's Hospital. Although he accepted the notion of moral insanity he felt that the existence of viciousness was not enough. “Now, I deny that absence of the moral sense proves or constitutes insanity, any more than its presence proves insanity ... it must be remembered that insanity, if it exists, is to be demonstrated by other mental symptoms and concomitant facts and circumstances, and not by the act of wickedness alone” [27].

Twenty six years later the celebrated Henry Maudsley had no doubts at all about the contrary view. The moral sense could be absent “as an occasional result of descent from an insane family”, or it could be disrupted by head injury. Since it was an entity within the cranium perhaps it could be put right by physical means. “Dr Wigan puts the matter in a way that may seem a little more extravagant than it really is when he says - ‘I firmly believe that I have more than once changed the moral character of a boy by leeches to the inside of the nose’ “ [28]. Presumably neither Dr Wigan nor Dr Maudsley possessed Fowler’s Phrenological Bust, for if they had they would have known that the leeches should have been placed on the top of the boy’s head.

Fashions change. As the years passed the word “insanity” became unpopular, and the word “moral” moved back irresistibly towards the meaning which Cicero assigned to it, and we accept today.

At first alternatives were sought for “insanity”: there is no shortage of them. Spitzka, for example, preferred “moral imbecility” [29]. We have seen that Isaac Ray had general moral mania and partial moral mania; he also used the terms moral imbecility and moral depravity, without defining them [30].

Eugen Bleuler grouped together enemies of society, antisocial beings, moral oligophrenics, moral idiots, moral imbeciles and the morally insane as suffering from a moral defect which may be either congenital or acquired. He was aware of the problems, and offered the classical psychiatric solution. After mentioning Prichard and his concepts he went on to say: “German psychiatry adopted the name (moral insanity) in the sense of a defect of the moral feelings. Both the name and the concept have become discredited because they have been abused practically and theoretically. The concept should not however be dispensed within psychiatry, because it designates a definite disease; but everyone agrees that a substitute should be found for the name” [31].

Everyone did, and the search went on. Even so, the term lasted well: Baroness Wootton reports that John Bowlby referred to “moral defectives” at a conference in 1949 [32]. “Moral defectives were also given statutory recognition in the English Mental Deficiency Act of 1927: the deficiency was not of intelligence, but of morality” [33].

In fact the next name for “moral insanity” had been provided by Koch in 1891 [34]. He had applied the term “psychopathic personality” to those who were abnormal, and yet not insane. In other words it was a quantitative description which might be applied to any sort of mental abnormality at all. It included the neuroses and those peculiar and eccentric people who still trouble the tidy mind. It had nothing to do with wickedness. Thirty four years later Kraepelin took it up and expanded it: most of his categories contained the truculent and the wicked.

Twenty six years later Cleckley wrote The Mask of Sanity [35]. Psychopathy was for him no longer a quantitative description, but a firm category. Its heredity was beyond doubt: evidence was given to the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957 that the psychopath and the moral defective were indeed the same person [36]. It soon became a household word, for it retained its status as both an explanation and a cause. Why has this man done these terrible things? Because he is a psychopath. And how do you know that he is a psychopath? Because he has done these terrible things.

It has always surprised me that so popular a word did not endure better. Probably the constructors of taxonomies were aware that American psychopaths were wicked, while European psychopaths were merely statistically and amoral deviant. Indeed they could even benefit the society in which they were living, for there were “creative psychopaths” such as Joan of Arc, Napoleon and Lawrence of Arabia [37].
It was time for another change: in 1952 the First Edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association settled upon “Sociopathic Personality Disturbance”. This too failed to please, and in subsequent revisions we encounter “Antisocial Personality Disorder”. ICD-9 has arrived at rather a similar nomenclature; I shall confine my discussion to DSM-III. Perhaps I should mention that the last official American Psychiatric Association mention of “psychopathic personality” I could find on my shelves was made in 1975, in the Glossary. It was defined as “An informal term for antisocial personality. Such individuals are sometimes referred to as ‘psychopaths’” [38]. I wonder what Cleckley would have thought of that.

It is now time to compare the current “antisocial personality disorder” with Prichard’s “moral insanity”. I wish to make it quite clear that the latter diagnosis included a much wider array of entities than does the former: the question is, is the core group in Prichard’s category the same as in the DSM-III category?

To achieve a DSM-III diagnosis one must have five characteristics. The first is that one must be at least 18 years old: Prichard describes adult psychopathy.

The second is that there must be evidence of the disorder before the age of 15. Prichard was constructing a general theory, and not giving full details of individual cases, so this test must be put aside.

Thirdly, one must manifest at least four kinds of reprehensible behaviour from a list of nine. Prichard’s morally insane person has “a propensity to theft”, “perversity of affections”, “angry and malicious feelings ... without provocation”, and always had a “plausible explanation” to offer for his conduct. He indulged in wild projects and speculations”, was “continually engaged in new pursuits ... soon relinquishing them without any other inducement than mere caprice and fecklessness”. He would qualify with these.

The fourth is that the behaviour be long continued. The morally insane continued “for years to be the sources of apprehension and solicitude to their friends and relatives”.

Finally there must be no evidence of severe mental deficiency, schizophrenia or a manic episode. “If the matter is brought before a jury ... the individual gives pertinent replies to the questions put to him, and displays no mental illness” [39].

The wheel has turned full circle; we are back with Prichard, but not exactly. Whereas Prichard’s disorder was a derangement of the moral faculty, an entity in one’s head, the DSM-III disorder is of the traits. Traits are not entirely in one’s head; they are “enduring patterns of perceiving, relating to and thinking about the environment and oneself” [40]. They are processes and not entities, factors rather than faculties. But only just.

Otherwise not much has changed. Apart from the attributes of viciousness there are no other criteria from which one can infer the presence of a mental disorder. Dr Arnold’s fundamental distinction between mental disorder and viciousness has been forgotten, and it is difficult to be thoroughly wicked without achieving a psychiatric diagnosis. It should not be too troublesome to argue in a particular case that if a person has a psychiatric diagnosis then this leads to the question of diminished responsibility. This in turn takes us to the proposition that if one is going to do something wicked then the penalty is likely to be lighter if one has been unprincipled all one’s life, and the crime committed is repetitive and monstrous.

There is another problem. Joseph Stalin and Adolph Hitler were two notoriously destructive men. A standard biography of Stalin [41] describes him as a diligent student of above average ability. At the age of 15 he was in a religious seminary; he remained there without in any way misbehaving for another 5 years.

Adolph Hitler was described by his teachers as lacking “self discipline, being notoriously cantankerous, wilful, arrogant and bad-tempered”[42]. He was lazy, hostile and domineering, and his performance was below what was expected of him. Nevertheless he achieved only one of the three perfidies required before the age of 15: there are 12 to select from. If neither of these gentlemen had an antisocial personality disorder, then who has? One can find candidates enough (the Marquis de Sade was an aggressive monster at the age of 4 [43]) but the issue is more complicated than that.

The description given of an antisocial personality disorder is essentially that of a hoodlum from a poor and disadvantaged family. Build yourself a factory and let it pour mercury into the sea, market steroids for the malnourished children in third world countries or manufacture napalm so it can be dropped on the citizens of Vietnam: no one will call a psychiatrist to measure you up against DSM-III. Not only has psychiatry been distorted by all the processes enumerated above but also it is in this respect a reflection of the customs and prejudices of a particular social group. Most psychiatrists are from that group and
therefore fail to see the incongruity.

I do not believe that the whole of psychiatry will ever be a scientific activity [44], but parts of it should at least aspire to be. It does not carry us in that direction if we mix medicine and morals, and if we adopt the mores of a particular social class. We need to be careful about the meanings of words, and to rid ourselves of the notion that applying new names to old confusions constitutes an advance. We should be most careful to distinguish between the classification of behavioural data, and the hypotheses we make about the psychological processes involved in producing them.

Above all we must stop inventing entities which we place in people’s heads, and then use as explanations for the behaviour observed. In this case why have we done it for so long, and so obdurately? Perhaps because ignorance is uncomfortable: if we can offer no satisfying reasons for some people being much more wicked than others, placing them in a category and giving it a name may get us by until we can do something better.

One could have drawn these conclusions from a consideration of a number of psychiatric topics; moral insanity is an important one because the issues which surround it are concerned with the whole of human behaviour and not merely the part usually thought to be the proper concern of psychiatrists.

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