In the nineteenth century British asylums were large-scale buildings with luxurious equipment; they showed an extraordinary cleanliness that only the asylums in Switzerland could match; they provided the inmates with good or very good nutrition; and statistical registration of the insane had attained an enviable quality. Family care in Scotland was a model for the whole of Europe.

This was the image that German psychiatrists visiting England and Scotland in the mid-nineteenth century had when they praised the British care of the insane. Such enthusiastic assessments were not only related to the mental health care system but also to surgery and public health. In 1836 the physician Adolf Mühry from Hanover praised English surgeons for their practical skills and pragmatic attitude. In 1873 the hygienist Max von Pettenkofer praised the English public health system and the sanitary conditions of British cities. The nineteenth-century British health care system was obviously seen as a highly attractive model for Germany. This view of British physicians resonated very well with a broader German cultural and political orientation toward the United Kingdom.

A mutual exchange of ideas between British and German psychiatrists in the second half of the eighteenth and the first half of the nineteenth century has already been described by Max Neuburger more than half a century ago. He referred to the translations by German doctors of several British works on madness and related themes and, in a few cases, vice versa. He also addressed the mutual reception of theories on madness, but maintained that the idea of sin, guilt, and bad conscience as real origins of mental derangement, discussed by some German doctors in the early nineteenth century, would appear absurd to most English readers. In 1999, Wolfgang J.
Mommsen pointed out that in the nineteenth century Great Britain and its political culture functioned as a model for the early liberalism in Germany. Several authors questioned the thesis of a German Sonderweg, although there were obvious differences between Britain and Germany not only in the role of the aristocracy but also in the function of parliament and the civil service. For instance, in the nineteenth century most German observers did not fully understand the parliament’s role in English public life. They misunderstood the significance of ministerial responsibility and tended to see it in terms of their own legal categories. Despite such cultural and political differences, it is indisputable that in the nineteenth century, a German-British cultural transfer took place, even if the motives of the persons involved were different in the two national contexts. In Germany, the motive for cultural transfer was to some extent due to political conditions such as “precensorship”; after the abolition of censorship in the early 1870s, the press was no longer relying on enthusiastic descriptions of English conditions as a replacement for criticizing concrete circumstances in Germany, but could roundly address the situation at home.

Nevertheless, the publications of German psychiatrists also pointed to differences between German and British mental health care systems. These publications were part of a specific debate about the structure of the future German mental health care system; as a consequence, the questions and considerations of the German authors concerning conditions in British asylums were related to the issues and arguments used in the debate. Thus, we cannot expect to find an unbiased description of the British situation. The psychiatrists’ orientation toward foreign countries was used to support the arguments for their own position in debates at home, and to discredit the statements of their opponents. The images of the British mental health care system depicted by German psychiatrists therefore reveal more about the authors’ own position than about the reality of the British asylums. In the course of the nineteenth century, the focal points addressed in this debate about the structure of the future German mental health care system altered due to political and social changes in both Britain and Germany.

One of the main issues in this discourse was the position of doctors, not only as medical experts within the asylums, but also as the decisive power in the whole system of mental health care. The British doctor’s status, marked by his real or alleged dependence upon nonmedical supervision, was one of the most crucial points of difference discussed by German psychiatrists. For example, the debate about “nonrestraint” of inmates was associated with the topic of subordination versus autonomy. Several German authors believed that in Britain, society, primarily represented by the lunacy commissioners and visitors, would insist on a high level of “nonrestraint.” The Germans associated such social oversight with a position of inferiority and
dependence. blamed this situation on the “inferior” and dependent position of their colleagues abroad.

In this context the idea of *Wissenschaft* (a broad understanding of science) played an important role. This German term was used in reference to research in the humanities and the social sciences, the natural sciences, and medicine, whereby medicine had not developed a separate and specific notion of *Wissenschaft*. The term was strongly connected with the establishment of academic disciplines at universities, as well as with teaching and broader educational agendas. This broad and unified notion of *Wissenschaft* claimed to involve a rigorous pursuit of “scientific” truth free of metaphysical or ideological presuppositions. It also implied that *Wissenschaftler* (scientists) had to carry out appropriate empirical research that aimed for “objectivity” and that was understood to be the basis for all further activities, e.g., teaching, expert statements, or medical treatment. Thus, in this perspective, scientists differed from those who used scientific research or technology for pragmatic ends by virtue of their genuine interest in a subject “for its own sake” rather than for utilitarian purposes. This programmatic position of epistemological independence was used to claim authority in explaining the world.

The most important place of scientific research and education in this specific sense of “objective” and “disinterested” was the German universities. They were institutions of the state, and the German professor had the status of a civil servant. This position was seen as a barrier against special interests of political, social, or industrial groups, and was designed to maximize independent research. Although the idea of the modern university as developed by Wilhelm von Humboldt around 1810 opposed state influence on all research subjects and on internal affairs of the universities, in the course of time German professors embarked on a close alliance with state interests and often served the interests of the nation-state. The use of the term *Wissenschaft* not only included epistemological distinctiveness but also authority and power in relation to academic institutions and social and political issues. For the specific context of nineteenth-century psychiatry, the notion of *Wissenschaft* was an important factor in legitimizing the position of the German asylum director. This term may constitute another point of difference between British and German discourse on mental health care.

The first part of this chapter contains an outline of early German publications on British mental health care from the first half of the nineteenth century. The second part deals with the debates on the proper location and organization of asylums in the 1860s and 1870s. The third part focuses on the emergence of a new type of asylum in the final decades of the nineteenth century, and on the contemporary German movement labeled “anti-psychiatry,” which criticized psychiatrists and attempted to integrate patients’ views of mental health care into the system.
Psychiatrists and Asylums in the First Half of the Nineteenth Century

In 1845 Nikolaus Heinrich Julius from Berlin published an article titled “Progress of the British Mental Health Care System.” He reported on the “bill to amend the laws for the provision and regulation of lunatic asylums for counties and boroughs, and for the maintenance and care of pauper lunatics in England” formulated by Lord Ashley, Sir James Graham, and M. Vernon Smith. Julius reconstructed the statement of Lord Ashley and commented on it. Ashley had distinguished between curable and incurable patients and stressed that it would be extremely useful to render easy access to the asylums for the curably insane. Because the asylums were overcrowded, it was impossible to admit every curably insane person. Therefore, curable insanity would, in time, become chronic and in the end incurable. In order to avoid this detrimental development, the new laws to be enacted obliged the counties and boroughs to establish new asylums and to differentiate between the chronically incurable and the acute and curable cases of insanity.

The topics addressed in this article were related to a comprehensive German debate that took place in the 1830s and 1840s about the nature of future asylums in Germany. In the first decades of the nineteenth century, psychiatric asylums in Germany had been established outside the cities and in the countryside. Initially, castles and former convents had to accommodate the new institutions. After 1830–40, however, specific buildings were erected to serve as psychiatric asylums. The leaders of the debate about future asylums were three directors of asylums who were also the founders of the Allgemeine Zeitschrift für Psychiatrie, the first German-language journal of psychiatry: Heinrich Philipp August Damerow, Carl Friedrich Flemming, and Christian Friedrich Wilhelm Roller, themselves all well-known psychiatrists. These middle-class alienists were promoters of the first asylums as “monuments of humanity.” They favoured the countryside for various reasons. This location reflected the natural philosophical bias in favour of the rural idyll. The curable patients were supposed to be mentally overhauled and brought to reason whilst having recourse to nature in isolation from the hustle and bustle of society. The exclusion of the lunatic from public life was considered fair and humane because they were integrated into a family setting where patients and staff lived together and shared the same communal facilities of the asylum; the patient’s isolation was viewed as a remedy. This approach relied upon an image of the city as a pathological location. Moreover, there were arguments against the city location for financial and administrative reasons, since property of adequate proportions was expensive in large cities. To ensure reasonable access to necessary supplies and services, some psychiatrists thought that the best compromise was the establishment of
asylums about half an hour away from a city. However, the question of how to accommodate the curable and the incurable patients remained. Should the two groups be lodged in two separate asylums far away from one another, or should both groups be accommodated in one single asylum, each group assigned to a special wing of the building? In 1831 Roller devised a model that integrated “sanatorium” and “curatorium,” i.e., which combined the accommodation of the incurably and curably ill. This model became a blueprint for German asylum building for the next forty years.

In 1842 the Illenau Asylum in Baden between Freiburg and Heidelberg was opened to house approximately three hundred patients and Roller became the first director. Three doctors, including the director, and about eighty employees worked there and the ratio of nurses to patients was about one to four. During the last decades of the nineteenth century this asylum was enlarged and at the turn of the century it accommodated about six hundred patients. Occupational therapy was given priority and about 30 to 40 percent of the patients worked regularly. The architecture structured by corridors separated male from female patients, as well as the curable from the incurable. The educated patients lived closest to the rooms of the doctors and the director, followed by the calm; the agitated persons and the raving mad were housed far away from the centre.

Despite the fact that Roller and other asylum directors ruled as authoritarian patriarchs over the asylum’s “extended family” (Grossfamilie), clinical observation of the patients’ behavior, sometimes complemented by the post-mortem investigation of the brain, became a common method of obtaining information about the supposed somatic basis of mental illness. This kind of research underlined the claim to scientific methods in the sense sketched out above. The directors of the newly founded asylums considered themselves both benevolent rulers of their own little kingdom and contributors to the scientific explanation of insanity. Some directors used or abused the inmates to build up an enclosed retreat and to repulse the influences of modern society, particularly the negative consequences of industrialization and urbanization. Paradoxically, then, this asylum model was an obvious attempt to create a small and stable microcosm of insanity within a changing and challenging social environment that was believed to cause mental illness by its accelerated rhythm of life and the tremendous demands of the modern world.

Even in the medical journal associated with the political revolution of 1848/49, Die medicinische Reform, the Berlin psychiatrist Rudolf Lebuscher put forward an argument for a concept of modern psychiatry that placed the institution’s director in a paternalistic position. He described medicine as a humane and social Wissenschaft and maintained that psychiatry should also become a Wissenschaft that explained the phenomena of psychology. With respect to the situation in Berlin he complained about the crowded
living and the bad sanitary conditions of the mentally ill at the Charité Hospital, and the lack of space for outside work for the inmates. He demanded autonomy for the director of the ward, and maintained that his authority had to be decisive for the whole arrangement of the setting.22

Apart from Leubuscher’s specific ideas for a modern form of psychiatry and the accentuation of the humane and social side of medicine, his statement about the role of the asylum director, published in the most important German revolutionary medical journal, was by no means different from the positions of the nonrevolutionary asylum directors. The attempts to reject the influences of society on asylums and doctors were led by some German doctors who visited Britain in the 1840s and 1850s. In 1848, Theodor Schlemm published a book that gave a positive assessment of the British mental health care system.23 However, the reviewer of this book, Willers Jessen, stressed the heavy restrictions of the medical directors of the asylums in Britain. He held that, as opposed to the development in France and Germany, where sensible and humane doctors initiated the reform of the mental health care system, the British parliament was repeatedly forced to legislative activity because of crimes committed against the mentally ill. The result was the establishment of the Board of Lunacy Commissioners, which had great power over the doctors. As a consequence, psychiatrists were directed by lawyers, and were subordinate to the administration, which made all relevant decisions; there was no regard for “scientific” needs.24

In 1856, Hermann Dick, director of the Klingenmünster Asylum, discussed “nonrestraint.” He did not totally reject the idea of abolishing mechanical restraint but believed that partial mild restraint was still necessary. He conceded that during the previous two decades, public care for the insane in Great Britain had been very effective, and that Germany should adopt several British achievements. “Nonrestraint” was in general fruitful for the development of life within the asylum. He thought that certain asylum buildings and a better internal management would make a reduction of restraint in Germany possible. Yet, in his article, Dick revealed the interesting difference between the German and the British systems of asylums—the position of the doctors. He was convinced that in England restraint had previously been practiced excessively, to the point of abuse; the response was a backlash of extreme “nonrestraint.” Dick believed that the lunacy commissioners were the most committed to “nonrestraint,” far more than the doctors themselves. He cited an English psychiatrist who said that the physicians were not free to act as they wished. The establishment and increasing dissemination of a system of “nonrestraint” was due to pressure from outside the asylums. Only a minority of the doctors supported this system of treatment. He also reiterated the view that English psychiatrists, not patients, were under restraint. Furthermore he referred to the widely practiced seclusion of agitated patients, which he viewed as another kind of restriction.25
Dick maintained that in no country other than Germany were asylum members, both inmates and staff, united as a great family whose centre was the physician. The doctor created the atmosphere and made the asylum into a place of care and cure. Other facilities of the asylum, such as padded rooms, were of minor importance. He described the German asylum as a closed, self-controlled system. Its complete segregation enabled it to ward off the harmful influences of the surrounding society. In contrast to this psychiatric seclusion in Germany, the British system was an openly organized system. According to the German visitors, the influence of society, of the controlling boards and laymen, were so powerful that the control of the doctor was reduced to an unacceptable degree. This difference was primarily a difference of culture and politics and not of medical attitudes, knowledge, or skills. According to Dick, the opinions of the majority of English and German doctors about restraint were broadly in agreement. In contrast to German conditions, the English political culture empowered the laymen, and suppressed the power and influence of the medical experts.

Discussions in the 1860s and 1870s

In 1861 Wilhelm Griesinger visited Britain and became an enthusiastic proponent of “nonrestraint,” which was put into practice for the first time in Germany by Ludwig Meyer in 1862. Griesinger not only pursued a policy of “nonrestraint” but also developed a new concept for psychiatric care. His intention was to open the asylums to society and to medical teaching. Although in the 1820s some university professors already taught psychiatry, sometimes in collaboration with the director of an asylum, the majority of the directors had rejected the transformation of “their” asylums into teaching hospitals. Moreover, they feared that contact between students and patients would result in harmful effects on the latter. Now, Griesinger attempted to combine humane treatment with scientific research. He believed that academic teaching and medical research on insanity needed more emphasis than in the past, and he no longer considered it necessary for the director to live within the asylum.

Griesinger subdivided the mentally ill patients according to the duration of their illness, differentiating between patients with chronic and those with acute conditions. He no longer made the distinction between curable and incurable patients. On the basis of this new differentiation, he demanded two kinds of asylum: the urban asylum for the acutely ill, and the rural asylum for the chronically ill. Although the urban asylums were to be placed in a pleasant environment, they would need to be in close proximity to a city. Every major city, he thought, should have an asylum in its immediate vicinity for the proper accommodation and treatment of acute cases. These
asylums were to be affiliated with the universities as clinical institutions so that the patients would be available for teaching medical students. Only the chronically ill were to be accommodated in rural asylums, which would be organized along the lines of agrarian colonies with family care as the standard of treatment. Patients could be transferred from one institution to the other, according to their status; thus the mental health system could adapt the form of accommodation to the individual patient.30

The discussion about the best system of mental health care reached a climax in 1868. At a meeting of the psychiatric section of the “Gesellschaft Deutscher Naturforscher und Ärzte” in Dresden, the majority of the assembled psychiatrists voted to continue the traditional policy of housing all classes of inmates in one asylum.31 Heinrich Laehr, one of the leading asylum directors, stressed that only large asylums could provide sufficient case material and deliver enough corpses for autopsy. He also disapproved of separating the acutely and chronically ill, arguing that the same physician had to observe the course of the illness in both classes of patients from beginning to end.

The reports on the British asylums during the 1870s dealt with the well-known questions of “nonrestraint,” family care, and the dependence of doctors upon official visitors and commissioners. In 1871 Carl Wilhelm Pelman, director of the Stephansfeld Asylum, discussed the advantages of the English system. He mentioned the use of corridors to separate patients and the adequate number of cells for seclusion. According to him, the success of “nonrestraint,” which he did not deny, was due to the use of seclusion in the early stages of the patient’s agitation. He maintained that this early seclusion was sufficient to render mechanical restraint unnecessary.32 Despite his positive description, Pelman also criticized the power of the committee of visitors, believing that these laymen had too great an influence on the management of the asylum. Such a high degree of authority by laymen would hardly be accepted by a German director.33 The activities of the British doctors were heavily restricted, and the number of physicians working in an asylum was seen as very small, and as a consequence physicians could neither carry out treatment according to the individual needs of a patient nor pursue medical research on insanity. He pointed out that in Haywards Heath, only four postmortem sections had been performed in 1868, and only in cases of sudden death, but not as a method of systematic pathological research.34 In 1874, Emanuel Mendel, director of a private asylum in Pankow, critically commented on the small number of doctors working in English asylums, and the conditions under which they were forced to work. He argued that because of the excessive powers of the commissioners, the doctors were overburdened. Mendel believed that this detrimental development was responsible for a revival of the use of restraint in the British mental health system and he presented some examples of restraint in the asylum at Colney Hatch from a commissioner’s report.35
In the mid 1860s, university chairs of psychiatry had first been established at the medical schools in Munich, Würzburg, and Berlin. This was the beginning of a process of integrating psychiatric care with medical research and teaching that was to last up to the first decade of the twentieth century. It was accompanied by an optimistic attitude with respect to successful cures and toward a physiological explanation of insanity through pathological alterations of brain tissue. The equation of the lunatic with the somatically ill was used by psychiatrists to ask for the establishment of new asylums, which were proposed as modern hospitals for mentally ill people. In order to underline these demands and to find conducive arguments, the British example was again referred to.

Mendel compared the situations in England and Prussia using statistical surveys. He praised the English statistics, which in his opinion were of much better quality than those of Prussia: In 1873 England had 60,296 mentally ill persons out of a population of 23,356,414, which implied a ratio of 1 lunatic to 387 persons. In 1871, Prussia counted 52,634 mentally ill persons in a population of 23,971,337, which was a ratio of 1 lunatic to 468 persons. Mendel maintained that the difference was a result of problematic statistical methods applied in Prussia, and concluded that the number of mentally ill persons recorded in Prussia was too low because 7,439 psychiatric patients had not been counted. He also looked at the number of mentally ill persons lodged in asylums, and found again a considerable difference. In England there were 52,803 patients living in asylums and 7,493 in family care or in their own families. In Prussia, only 11,460 lunatics lived in asylums and 41,174 were on their own or with families. Moreover, he compared the number of paupers in asylums and found that in England there were 37,879 whereas in Prussia only 8,617 paupers were accommodated in asylums. When considering the reasons for these differences Mendel assumed that the manifestations of insanity in England were the same as in Prussia. He discussed several possible points of explanation for the low numbers in Prussia, such as dense or sparse population figures, access to asylums, modes of payment, overcrowding of asylums, and finally the aversion of the population to the asylums. In order to address the reservations of the population, he believed that it was necessary to guarantee public access to the institutions. He completed his article with an enthusiastic appeal to the public authorities and demanded the establishment of many more asylums, which, he argued, was a duty to humanity and absolutely necessary.

Thus, Mendel used British statistical data to support a program to extend the number of psychiatric asylums, which was in accordance with the views of German psychiatrists. Such a program required a large amount of public financial support. Psychiatrists were aware of this problem of funding. Looking for a solution to avoid the expense of building new asylums, they once again provided images from Britain to support their argument.
In 1875 Friedrich Jolly, Professor of Psychiatry in Strasbourg, visited Kenneway Asylum in Scotland and then published an article on family care. He declared that more expense was inevitable for the cure and care of the insane in Germany, yet he recommended a special kind of care that was cheaper than a stay in an asylum. He pointed out that it would be better to reimburse families for the care of insane persons rather than build new asylums. Another suggestion in his article was that control should be extended to lunatics who up to this time had lived on their own or in families without medical supervision. Considering the high number of insane people in Prussia living outside the asylums, as presented by Mendel one year earlier (about forty-one thousand), it was not surprising that the psychiatric profession was attempting to gain access to this large but disseminated group of the mentally ill. Jolly concluded his article with praise for the Scottish model of family care outside the asylum system and recommended that similar organizations should be adopted by other countries.  

The New Asylums

From the 1870s onwards, a large number of new asylums were established throughout Germany. They now followed a new architectural layout that consisted of detached pavilions disseminated in parks. In the Langenhorn Asylum in Hamburg, for example, which opened in 1892, approximately 1700 patients, male and female, were separated along a central axis dividing the area into two equal parts. The director’s quarters were far away from the central building. Relatively close to his house was the mortuary, linked to postmortem facilities, which represented one side of the scientific requirements. In addition to these buildings, which also housed an anatomical collection, the asylum provided well-equipped laboratories that were prepared for microscopic research.

The public and private asylums were very different. The group of public asylums comprised first the university hospitals for psychiatry and neurology, second, the Provincial-Irrenanstalten, comparable to county asylums, and finally asylums established by the communities. The private asylums were made up of the denominational asylums run by Protestant or Catholic congregations, and the asylums owned by private persons or doctors.

Despite the increasing number of newly built public asylums, they could not provide the facilities needed for the cure and care of the insane. In 1877, the German Reich had ninety-three public asylums and by 1904 that number had risen to 180. In Prussia the public asylums provided about 75 percent of all institutionalized care. In general, the private asylums had to fill the gap in all cases, and in particular for the long-term care of the chronically insane. In 1861 the physician Eduard Levinstein opened his own
sanatorium in Schöneberg, near Berlin, which very soon became a private asylum. Because of the increasing number of insane persons and the lack of asylums, the municipal administration of Berlin had to look for further accommodation for the mentally ill. In 1870 the city administration signed contracts with Levinstein, and in 1885 his private asylum “Maison de Santé” in Schöneberg gave shelter to four hundred patients. The costs were now covered by community funds.41 Similar conditions existed in other areas of Germany. It was mainly the chronically insane needing long-term care that were transferred to these private asylums.42

Thus, the mental health system in Germany during the 1880s and 1890s suffered, according to contemporary psychiatrists, from too few asylums and inadequate facilities. Not surprisingly, the publications of that time that dealt with British mental health care referred again to the Scottish family care system. Two authors who reported very positively about the Scottish system were Ernst Siemerling43 of the Berlin Charité in 1886 and Wilhelm Julius König44 of the Berlin Dalldorf Asylum in 1896. König referred to the reports of doctors from twenty Scottish asylums, according to which the nursing staff of Scottish asylums was considered good, and even sometimes of excellent quality. He stressed the strict selection of staff, the elaborate training program, and the optional high-level examination.

The number of insane persons as well as the number of inmates in Germany increased dramatically in the 1870s. Other European countries faced a similar situation. In Prussia the number of inmates grew significantly; in 1880 there were twenty-seven thousand cases treated in Prussian asylums and by 1910 that number had increased to one hundred forty-three thousand. Dirk Blasius argued conclusively that this process reflected the changing relationship between state and society as well as the transition from public care (Armutsspsychiatrie) to governmental control (Ordnungspychiatrie).45 Three Prussian governmental decrees, of 1894, 1896, and 1904, illustrate a growing interest by the administration and the police in the affairs of the mentally ill. In 1894, the state tried to obtain control over patients outside the asylums and the government took steps to bring such individuals into the asylums, thus, it was argued, guaranteeing public safety. On the one hand there were differing views amongst psychiatrists concerning the reasons for this increase in the number of insane persons and of inmates. Broadly speaking it was thought that the growth was caused by the establishment of new asylums, easier access to them due to the expansion of public transport systems, improvement of diagnosis, the higher ratio of incurable patients with long-term stays as compared to cured persons who could be discharged, and finally better hygiene and thus decreasing mortality of insane persons.

On the other hand, however, the general population perceived the increasing number of committals to asylums with widespread disapproval. In the 1880s and 1890s there were several well-publicized attempts to get
relatives out of asylums. Ann Goldberg described the story of the “liberation” of a Scottish priest in 1893 from the “clutches” of a Catholic insane asylum in the Rhineland. Beginning in the 1890s, a movement emerged that criticized psychiatrists and accused them of arbitrary deprivation of liberty and other crimes committed against lunatics. This movement consisted primarily of patients, lawyers, priests, and journalists. Between 1909 and 1921, the movement published a journal, which had a circulation of about ten thousand. The psychiatrists who were defending their position called this movement “anti-psychiatry.” Despite the aggressive tone of the articles, the movement’s aim was a general mental health law that would not only address grievances but also regulate the care and cure of lunatics and enhance the “scientific” character of psychiatry.

The final aspect of asylum culture that is worthy of discussion is the work of patients in the production of goods and services in the newly established large asylums at the end of the nineteenth century. For example, the already mentioned Langenhorn Asylum not only produced all the milk needed for the inmates but also flowers and other plants for the hospitals of Hamburg. It ran a pig farm that sold eight hundred pigs a year on the general market. The economic aspects of asylum life became more and more relevant. The new type of asylum was a self-sufficient organism, centred on the steamer, machine house, and farm, and not around the dining hall or recreation facilities; it was partially integrated into the market economy. In 1912, the asylum industry was on the agenda of the meeting of the psychiatric society of the Rheinprovinz. Psychiatrists not only considered the kind of work that was appropriate for treatment but also the work that would best meet the economic needs of the asylum. It was discussed how the asylums could avoid unnecessary rivalry and the overproduction of goods. Several psychiatrists emphasized the main function of the asylum as a place for psychiatric purposes but it was also suggested that it would be useful to exchange patients that were suited for special requirements of particular production facilities at different asylums. Moreover, psychiatrists considered the question of whether it was necessary to specialize production in a single asylum or whether to establish a rich variety of producing sectors according to the manifold abilities of the inmates. Work and self-sufficiency influenced the psychiatric discussion on how to organize and structure the modern asylum at the beginning of the twentieth century. A considerable part of the inmates served as a cheap and disposable human resource for this production.

Conclusion

During the second half of the nineteenth century, the structure and organization of asylums in Germany changed. There was a transition from a
relatively small type isolated in a rural environment to a modern large type in close proximity to the cities. The first type was organized along a family structure with the director as an authoritarian patriarch ruling over his “extended family” (Grossfamilie). In contrast to this traditional structure and organization, the “modern type,” which was partially integrated into the market economy, was headed by a director who acted like the manager of a production company. The individual inmate of the modern asylum was subjected to a regime that differed according to the asylum’s production needs. From the 1890s, increasing governmental control brought more insane people, who had previously lived outside the asylum, into these institutions.

All through the second half of the nineteenth century, German psychiatrists referred to the British example. On the one hand, by doing so, they instigated several internationally valid standards of mental health care, such as adequate accommodation, good nutrition, high quality statistics, family care supervised by a physician, and well qualified nurses. The British system was seen as being ahead of the German system in many respects, and the positive references to the British, and most particularly the Scottish model, were used as arguments in debates on the state of German psychiatry and asylums.

On the other hand, German psychiatrists stressed the differences between the German and the British systems in order to reduce the influence of forces coming from outside the asylum. The debate on “nonrestraint” of inmates reveals those intentions because German psychiatrists did not reject the reduction of mechanical restraint in general, yet they insisted that the specifically British form of “nonrestraint” was a product of the ideology of laymen that ignored the experience of medical experts. Therefore they mostly criticized the exaggeration of this idea of “nonrestraint,” emphasized their solidarity with their medical colleagues abroad, and tried to prove that against all official statements the practical treatment in some British asylums required milder forms of restraint or seclusion, which was seen as another kind of restraint.

Another point of critique concerned the subordination of the asylum’s doctors to lawyers and other laymen and the consequent low estimation of Wissenschaft by those who exercised control over the asylum. This subordination, combined with the small number of doctors working in the asylums, was seen to result in a neglect of medical research on insanity. According to the German doctors who visited British asylums, the scientific side of the mental health care system in Britain did not receive the support it needed. Several articles mentioned that in British asylums doctors did not perform pathological research. The high importance of Wissenschaft for the self-image of German psychiatrists was thus linked to this second difference between the two systems. This highly estimated ideal of Wissenschaft could produce impressive effects even outside the community of doctors: the “anti-psychiatric” movement of the late nineteenth century demanded, among other things, more
Wissenschaftlichkeit (scientificity) for psychiatry and assumed that in this way the abuses of this medical discipline might be overcome.

Thus, the reference to Wissenschaft in the German context implied the construction of an inner normative standard, and this is why German psychiatrists placed such great emphasis on it. With the reference to Wissenschaft they could attain the desired reputation without the unpleasant smell of arbitrariness. Wissenschaft stood for the self-controlling system of the scientific community; it could be used in order to legitimize the eminent position of the asylum director who did not want to subject himself to control by laymen. German psychiatrists could reject this kind of external control by referring to self-control by internal standards in the profession. A functioning “scientific” psychiatry could diminish the influence of laymen. The intensive consideration of the British system may therefore be seen as a consequence resulting from the confrontation of two different cultural concepts of control: the British lay leadership on the one hand and the German expert “scientific” leadership on the other.

Notes

1. Adolf Mühry, Darstellungen und Ansichten zur Vergleichung der Medizin in Frankreich, England und Deutschland (Hannover: Hahnsche Hofbuchhandlung, 1836), 194–221.

9. Fritz Hartmann, “In der Heilkunde wirksame Begriffe von Wissenschaft und die Frage nach einem möglichen Wissenschaftsbegriff der Medizin,” in Der Wissenschaftsbegriff in den Natur und Geisteswissenschaften (Wiesbaden: Franz Steiner, 1975), 57–88; Hartmann pointed out that medicine needs its own notion of “Wissenschaft” in order to integrate ideas of other disciplines and to focus them on the central problem of medicine—the practical side of medical care.


12. Timothy Lenoir has scrutinized the way in which academic power in the second half of the nineteenth century was exercised by a group of modern physiologists and how their strategies for the implementation of their scientific beliefs fitted very well into the political and economic development of Germany. Timothy Lenoir, Politik im Tempel der Wissenschaft: Forschung und Machtausübung im deutschen Kaiserreich (Frankfurt: Campus, 1992), 18–52.


20. German psychiatrists did not use the term “soziale Psychiatrie” before 1903: Stefan Priebe, Heinz-Peter Schmiedebach, “Soziale Psychiatrie und Sozialpsychiatrie—Zum historischen Gebrauch der Begriffe,” Psychiatrische Praxis 24 (1997): 5–9. However, from the middle of the nineteenth century the term “sozial” was linked to medicine in numerous ways. The term described a communal or public perspective of medicine, according to which a large number of diseases were caused by damaging social circumstances. “Sozial” was also used to indicate political options relating to the social problems of society, and stood for the establishment of democracy, equality, welfare, education, and health; See Rudolf Virchow, “Mittheilungen über die in Oberschlesien herrschende Typhus-Epidemie,” Virchows Archiv 2 (1849): 143–322. “Sozial” was also used in the sense of humane and philanthropic interaction, and this aspect was particularly relevant to doctor’s attitudes toward the mentally ill: Wilhelm Griesinger, “Vortrag zur Eröffnung der psychiatrischen Klinik zu Berlin am 2. Mai 1867,” Archiv für Psychiatrie und Nervenkrankheiten 1 (1868/69): 143–58.


23. Theodor Schlemm, Bericht über das britische Irrenwesen in Hinsicht auf Einrichtungen und Bauart der Irrenhäuser, auf Verwaltung und Heilkunde nach eigenen Aeusserungen gegeben (Berlin: Albert Förstner, 1848).


26. Ibid., 415.


33. Ibid., 169.

34. Ibid., 173.


36. Ibid., 626.

37. Ibid., 642.


45. See Blasius, Einfache Seelenstörung, 61–115.

46. Ibid., 100–103.

Kaiserreich.” *WerkstattGeschichte* 3 (2002): 22–44; for this analysis the author utilized many of the contemporary lunatics’ rights pamphlets.

