Treatment of the Insane in Modern Great Britain: A Ship of Fools

Steven A. Shimmon
Social Studies Department
Lowell High School
San Francisco, CA

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“What opinion our descendants in the year 2000 are likely to hold of the view that insanity is increasing at the beginning of the twentieth century owing to the hurry and rush of life, the increased severity of competition, the crowding into the towns, the spread of education, and the general rise in the standard of living”—Charles Mercier (1900)

One of the most famous images depicting the treatment of the mentally ill in England is William Hogarth’s *The Rake’s Progress* engraved and published as a print in 1735. Tom Rakewell is depicted in Hogarth’s painting in London’s Bethlehem debtors’ prison after wasting his inherited fortune. Bethlehem Hospital, also known as Bedlam, was the only specialized hospital for the institutionalization of so-called lunatics until the 17th century and was highly criticized for its inhumane treatment of patients. *The Rake’s Progress* reveals some of those abuses: the religious zealot is chained to a straw pallet; the musician with delusions of grandeur who thinks he is pope wears five manacles; and well-dressed bourgeoisie women have come to pay a few pennies to watch a “king” urinating against the wall. According to many contemporary accounts, Hogarth’s depiction of Bedlam does not stray too far from the truth. Evidence presented before a Select Committee in 1815 revealed that patients were generally chained to the wall or tables, sometimes sitting naked for long periods of time (Mercier 1853).

Bedlam may have been the oldest asylum, but it was not unique in its inhumane treatment of the insane. At Lancaster Asylum, muzzles, chains, girdles, handcuffs, manacles, and leg-locks were used as late as 1840 (Mercier 1853). Evidence presented against York Asylum in 1813 revealed physical and sexual abuse by the innkeepers, overcrowding of 199 patients into a space designed for 54 patients, dark and poorly ventilated rooms throughout the asylum, lack of clothing, unsanitary food, and cohabitation of violent and incontinent patients with harmless others. For example, at
York, four hidden cells only eight feet square and inches deep in excrement were discovered to have housed thirteen elderly women. Further, up to seven females and six males occupants were assigned to each bedchamber with multiple occupation of most beds (Digby 225). Parsimonious attitudes on the part of local parishes contributed to the poor conditions. For example, although the Napoleonic Wars had led to runaway inflation, pauper lunatics paid only one more shilling per week in 1813 than in 1777 (Digby 230).

Fig. 1: The Rake’s Progress

Although these asylums most readily come to mind reflecting upon the history of psychiatry in Great Britain, an earlier model of psychiatric care in the 16th and 17th century was more prevalent. Prior to the 18th century, families and communities were expected to deal with all “outsider” groups, including the insane, vagrants, minor criminals, and physically handicapped, rather than shift their burdens onto institutions.
Families either had to provide out of their own resources or receive subsidies from the community in order to support those in their care (Scull 338). The local clergy played an important role in early psychiatric treatment. Those who suffered from mental problems often viewed their condition in religious terms—thus, the clergy saw themselves as “physicians of the soul” (Houston 122). Before the 17th century, hospitals were more concerned with spiritual salvation than providing a cure for those suffering from a disorder. The general belief (including among physicians) was that madness was due to demonic possession and was a threat to the society at large as the possessed person could be the vessel through which demons would attack others. Thus, hospitals, fearing an “outbreak” of madness, expelled those who were not from the community and isolated others.

In the 17th century, the old belief in the supernatural competed with a new confidence in the growing scientific method. This can be seen in Matthaius Greuter’s print around 1620 entitled *The Doctor Curing Fantasy and Purging Folly with Drugs* where the patient’s head is placed into an oven in order to sweat profusely so that his distorted thoughts can evaporate through the vents (Karp 7). Here “scientific” technology is utilized in the treatment of delusional thoughts.

Fig. 2: *The Doctor Curing Fantasy and Purging Folly with Drugs*

The rise of capitalism in the late 18th century also brought forth the rise of the asylum as a specialist institution for the care of the insane. As the traditional community and family unit became less able to take care of the insane, a new attitude developed toward “problem populations.” Economic relationships were now oriented toward the market and
changed the upper class attitudes toward the less fortunate. For example, with the rise of industrial capitalism, poor relief expanded, but with the new attitude that large institutions with harsh methods should be established to deter all but the most deserving from applying. These workhouses were set up to teach the able-bodied poor “proper” work habits through order and discipline. However, order and discipline were threatened by the presence of the madman who despite punishment would not conform (Scull 343). The insane--unproductive economic units--could not contribute much in this environment. Often madmen in workhouses were chained in the cellar or the garret, fastened to the leg of a table, tied to a post in an outhouse, shut up in an empty room or left half-naked and half-starved in the country. One woman transferred to Wakefield Asylum opened in 1819 had been chained up in a cell for 36 years at the Barnsley Workhouse. Jail was not a good substitute for these camps nor were general hospitals, which refused to accept the insane due to safety concerns (Digby 220).

Thus, specialized institutions run by the central authority of the state were established to segregate the insane, who were now treated by a new occupation of “mad doctors.” Asylums grew in size and importance. Within twenty-five years of the first state-supported institution, the larger asylums had between 500-1000 inmates. These “mad doctors” claimed a scientifically based expertise in dealing with lunacy. Unfortunately, their theories had little basis in actual science and treatment often entailed crude procedures (Skull 345). For example, Dr. T. Munro, a physician at Bethlehem in 1800, recalled: “Patients are ordered to be bled about the latter end of May, according to the weather; after they have been bled they take vomits once a week for a certain number of weeks; after that we purge the patients. That has been the practice invariably for years, long before my time; it was handed down to me by my father, and I do not know any better practice.” To treat mania, 30-40 ounces were drawn at a time followed by 20-30 leeches to the temple (Mercier 1853). Other remedies included blisters to the head and legs, opium, camphor, musk, medicated snuffs, ice and snow to the head, and music. Dr. Pargeter, an authority on the insane recalled his technique of “catching the eye”: “I suddenly unlocked the door, ran into the room, and caught his eye in an instant. The business was then done; he became peaceable in a moment, trembled with fear, and was as governable as it was possible for a furious madman to be.” (Mercier 1854). In
essence, the psychiatric profession did not have the prestige or training it does today and institutions were more akin to custodial warehouses that stressed routine, monotony and discipline. Moreover, it was often the lowly keeper—untrained, poorly paid, and over-worked—who largely determined the treatment received by inmates (Scull 346).

By the end of the 17th century and continuing through the 18th century, private madhouses for the middle and upper-classes proliferated in addition to the large asylums described above that housed mainly paupers. Although often run by clergymen, businessmen, widows, surgeons, speculators, and physicians also ran madhouses. Many clergymen, unable to support themselves on tithes, looked for extra income, especially in the second half of the 18th century (Houston 132). In the 18th century, an increasing number of men licensed by the Royal College of Physicians began to replace the clergy with 44 of 68 licensed private madhouses in 1831 being run by doctors or surgeons. The number of private licensed madhouses rose throughout the first half of the 19th century with the peak being in 1844—all run for profit and regulated by legislation as early as 1774. Of course, not all who ran them were qualified (Rollin 300). In fact, madhouse doctors in general enjoyed little social or professional status until 1788 when Reverend Dr. Francis Willis ministered to George III and brought respectability to the trade in treating lunacy (Houston 134). With enough money, those in private madhouses enjoyed privileges and treatment unlikely to be administered in the large asylums. Thus, “lords could continue to live like lords even if mad” (Rollin 300).

As the institutions devoted to taking care of the insane evolved, so did the attitudes about the cause of insanity and its treatment. In the early 18th century, England viewed the madman as someone more bestial than human, unable to reason, best served in confinement and disciplined with fear and brutal treatment (Digby 220). For example, St. Luke’s Hospital, built in 1787 in response to overcrowding at Bethlehem, had no chapel unlike other hospitals, the idea being that the insane had lost their “humanity” and could be treated as animals with no need for spiritual salvation (Karp 14). The animal nature of the insane justified chains and harsh restraints that even George III had to endure. Medical treatment, such as purges, vomits, bleedings, and blisters were intended more as a means of discipline than curing the patients with the goal to reduce their violent behavior (Digby 221).
In the mid-18th century, a new belief emerged that although the madman had distorted reasoning, his essential humanity was unimpaired. For example, John Locke believed madmen “do not appear to have lost the faculty of reasoning.” Rather “madmen put wrong ideas together and so make wrong propositions, but argue and reason right from them.” (Digby 221). The view that the insane could reason did not necessarily lead to more sympathy or better treatment. Descartes argued that irrationality was not an illness or the result of fate, but that a person chooses insanity or reason. By their “choice” of irrational or antisocial behavior, madmen abandoned the good of society. Thus, madness was seen as the loss of rational truth, a willful choice of a deranged state, remedied only by harsh punishment and incarceration as a form of social control (Karp 9).

A more compassionate attitude emerged in the late 18th century called “moral treatment” which aimed at minimizing external, physical coercion. Samuel Tuke in England, for example, wanted to improve conditions in the institutions. In his view, increased urbanization and the industrial revolution were responsible for insanity because they separated man from nature. Tuke advocated “moral treatment” and felt that one must treat the patient civilly if one expects the patient to behave civilly. Kindness was the route to recovery. The advocates of moral treatment recognized that external coercion could force outward conformity, but never the internalization of moral standards (Karp 14). For example, Dr. Hale and his colleague Richard Mead, physicians at Bethlehem, preferred sedatives rather than rough treatment. Moreover, they distinguished treatment between “maniacs” whose “outrageous” behavior called for authority, chiding, and threatening and “melancholics” who needed music and other activities they formerly enjoyed. They further employed evacuants, cold bathing, and therapy after the patient had recovered to prevent relapse. Thus, the living environment was reconstructed in a pleasant manner so as to encourage lunatics to be as well behaved as possible (Andrews 185).

Despite the laudable goals of moral treatment, critics like Foucault argued that mental manipulations of moral therapy had replaced the physical chains of traditional custodialism. In encouraging self-restraint and self-discipline of their patients, moral
managers were replacing external with internal coercion, trying to inculcate bourgeois values. The recipient of moral therapy internalized the asylum and, in having his guilt and anxiety intensified by the therapist, endured moral imprisonment (Digby 222). Moreover, despite the rhetoric of moral treatment, advertised at places like York Asylum to attract patients, lack of supervision amounted to a harsh and repressive regime. For instance, the humane movement against mechanical restraint and substitution of “moral management” often led to the introduction of solitary cells and padded rooms as an alternative to any real therapeutic process (Digby 225). Thus, both in theory and practice, moral treatment is now seen as a failure.

In the 19th century, as the insane were increasingly delivered into a specialized group of professionals called “mad doctors” and an urbanized industrial society demanded that the state assume total responsibility for the insane through institutionalization, a new acceptance emerged that abnormal mental states and behavioral patterns were the result of disease (rather than possession, sin, or irrationality) and should be treated with the medical model in mind (Karp 15). With the popularization of Franz Gall’s phrenology, which suggested that man’s mental faculties could be determined by means of examination of the lumps, ridges, and shape of the cranium, the mind was now seen as a function of the brain. Gall’s doctrine, although specious by our evaluation today, was “the first science of the brain” and between 1820 and 1840 guided thought and action in the care and treatment of mental illness (Karp 16).

Philippe Pinel, chief physician to asylums in France, was one of the great reform advocates for the humane treatment of the insane, no matter how difficult, and increased the number of physicians who often came irregularly to institutions. He greatly influenced treatment of the insane in Great Britain, Europe, and America, shifting emphasis away from punishment of the mad for having chosen the deviant path and toward an understanding of madness as a combination of the consequence of historical development, changing social environment, and most importantly, pathological changes in the brain (Karp 16). The insane were no longer seen as possessed by demons, akin to beasts, or choosing their own irrationality, but individuals with illnesses brought on by external or internal conditions outside their control. This is important to keep in mind as many of the insane were those who did not conform to social norms, such as women who
did not act according to the stereotype of femininity, men suffering from what was called masturbatory insanity, and an open-ended category called “moral insanity.” (Karp 10).

The rise of industrial capitalism in England, state-run institutionalization, and rational secular scientific thought did not necessarily contribute to an improvement in the care for many mentally ill patients. One could look at the story of Richard Napier, a 17th c. Buckinghamshire physician, astrologer, and Anglican minister who practiced from 1597 to 1634 before the growth of market capitalism. His holistic outlook viewed mental, physical and spiritual afflictions as interrelated. Napier’s employment of science, magic, and religion was far more humane than 18th century’s more secular and rational approach, which condemned mental patients to asylums. Purgings, bleedings and drugs prescribed by Napier often helped his patients. His clientele were often female and young people from small towns and villages who came to him with common complaints of anxiety arising from family life, love, problems with neighbors, disease and poverty (Smith 148).

The rise of the capitalist economic order and growth of central authority of the state provided a basis for the development of techniques for the efficient management of large numbers of people who were confined for years while being subjected to neglect and abuse rather than meaningful treatment. In an earlier era, the Flemish artist Hieronymus Bosch revealed in his painting, *The Ship of Fools* ca. 1500, that the free-roaming lunatics on a ship of fools were harmless—they posed no threat to anyone around them and seemed content to drift along, lost in the fog of their dementia (Karp 7). This exile of lunatics from ordinary society developed in the next two centuries into a system of institutions for the segregation of the mentally ill from the rest of the population. The purpose of treatment was to alienate the madmen rather than alleviate their symptoms, to maintain social control rather than provide reentry into society at large. In the 19th century, a more compassionate attitude toward the insane slowly emerged, but geographic and institutional isolation would continue in the treatment of madness.
Fig. 3 *A Ship of Fools*

Works Cited


