Wittenberg University

Madenmen and Poor Wretches:
Changing Perceptions of Madness in Early Nineteenth-Century London

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By
Sarah McCance

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The first half of the nineteenth century saw a major reformulation in the way in which insanity was perceived and dealt with in the western world. Rates of institutionalization increased as asylums became a more generally used receptacle for the insane.\(^1\) Despite this growing use of confinement and the anonymous, invisible nature of insanity implied by the removal of the insane from society, madness in fact became a more visible presence. This was partially due to an active reform movement, fostered by the Enlightenment belief in the secular nature of social problems and the Evangelical belief that it was the responsibility of God’s people to rehabilitate their fellow human beings, which aimed at halting the abuse of patients by madhouse keepers. The absolutist picture of confinement as a social necessity was questioned by the reformers, who felt that the use of chains and manacles as means of restraint, the poor conditions endured by inmates of traditional asylums, and the absence of a therapeutic program called into question the social benefits of confinement. These factors, combined with and assisted by the increased coverage of insanity in the newspapers due to incidents of madness in well-known people and a number of important criminal cases in which insanity was cited as a defense, brought insanity to the fore of public consciousness and created the impression that the absolute rate of madness was increasing. This perception that there were more mad people in England than ever before made finding a socially-acceptable method for dealing with the insane imperative. This essay seeks to examine the increasingly complex perceptions of insanity that developed in nineteenth-century

\(^1\) The language used in this discussion will inevitably fail to pass current standards of polite discourse. The terms “lunacy,” “insanity,” and “madness” and their derivatives are used here in order to reflect the terminology of the time period rather than to condemn or objectify the mentally ill. Likewise, descriptions of the staff of asylums as “keepers” is consistent with self-applied labels.
London and the ways in which these views of madness influenced and were influenced by doctors, patients, and the public.

In order to highlight the opposing views of madness and its treatment, the testimony of both patients and doctors ought to be explored. Neither group was homogenous. The insane came from all tiers of society, experienced treatment in a variety of institutions, and displayed varying degrees of awareness and acceptance of their disorders. The doctors, rather than pursuing a uniform course of treatment, dealt with a number of internal controversies in their writings and held differing views of their patients and the proper method of dealing with them. As a result, an exploration of the various interpretations within each group is important in order to create a picture of a society’s attempt to deal with an extremely complex issue.

To limit the number of medical personnel discussed while still demonstrating the high rate of variation among practitioner viewpoints, each source used was written by a doctor who worked at Bethlem Royal Hospital in the first half of the nineteenth century. Bethlem, considered to be Europe’s oldest mental institution, was a highly-recognized edifice whose name and its variant, Bedlam, were understood in English popular culture as a synonym for madness. Its age and status make it a logical choice as a historical source. The variety of interpretations of madness, its causes, and the way in which it was to be treated displayed both among different doctors who practiced at the same time and among doctors of different time periods highlights the conflicting views of insanity as well as a few distinct trends. These differences in approach, when contrasted with the larger societal issues raised by specific cases of insanity and the ways in which the insane
saw their own incarceration, illustrate the crises faced by mad-doctoring in the first half of the nineteenth century.

The model for the discussion of patient experiences is Roy Porter’s *A Social History of Madness: The World Through the Eyes of the Insane*, which explores the autobiographical writings of people discussing their experiences with their own insanity. Each of the cases he explores are well-documented and the majority of them were relatively well-known at the time, either because of the patients’ social positions or the nature of their encounters with madness. The subjects of Porter’s work span several centuries and countries, from a Bavarian demoniac in the seventeenth century to Sylvia Plath in mid-twentieth century America. One can easily argue that his focus on well-known cases would be balanced by an examination of less familiar narratives, but the newness of his approach—to “examine not the unconscious of the mad but their conscious…to explore what mad people meant to say, what was on their minds,” offers a non-traditional interpretation of the source material and provides the mad with a historical voice. In his introduction, Porter acknowledges the weakness of this work in that “this book is highly selective and episodic. I have focused upon a small number of relatively famous cases, for which the documentation is particularly rich or the issues sharply drawn. Clearly the mad people who wrote their autobiographies are a highly unrepresentative sample of all mad people. I am not advocating the ‘great madmen’ approach to history.”

The same caveats apply to this study. Each case was selected because it highlighted a particular issue faced by English society. As a result of the public notice

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3 Ibid., 6.
they received because of the importance of their cases, their lives cannot be considered as
typical case studies, and so their experiences do not provide a straightforward explanation
of the typical experience with madness in this time period. Where they can prove useful,
however, is to highlight changing perceptions of madness and the evolution of its
treatment. Those who were relatively unknown during their lifetimes also provide useful
accounts of their experiences in asylums and their impressions of treatment and life
inside the madhouses.

Porter, the author of A Social History of Madness, has written extensively on the
nature of insanity and its role in English history. A social historian with an interest in a
wide range of topics, including medical history and the history of sexuality, Porter began
his study of insanity with two books, A Social History of Madness and Mind-Forg’d
Manacles: A history of madness in England from the Restoration to the Regency, both of
which were published in 1987. In Mind-Forg’d Manacles, he approaches many of the
essential questions of madness—the nature of insanity, the rise of asylums, the
development of psychiatry as a discipline—from a deeply historical viewpoint, tracing
these factors over an extensive period of time in order to ground them in the narrative of
English history. In addition, he studies the testimony of the insane, exploring the
psychiatric revolution through the eyes of its patients. He expands on this approach in A
Social History of Madness. Porter’s work has served to integrate and contextualize
previous scholarship, heightening the academic rigor of the discipline. As will be seen
below, he also adds an important critical voice to the history of insanity, analyzing the
work of major authors in order to provide an interpretive guide to the historical narrative.
The majority of the fundamental questions about the meaning of insanity and asylums were originally raised in Michel Foucault’s *Madness and Civilization: A History of Insanity in the Age of Reason*, published in French in 1961. The study was a portion of Foucault’s larger work, which sought to establish a history of systems of thought by exploring cultural ideas such as sexuality, confinement, and imprisonment. It took several years for the English-speaking historical community to feel the full impact of Foucault’s scholarship, in part because of a four-year delay in translation but more significantly because of Foucault’s position outside the mainstream of the historical discipline. A philosopher and cultural analyst, he has been quoted as saying, “I am not a professional historian; nobody is perfect,” and his critics would argue that his not being a historian should be obvious to anyone reading his work. He has been accused of oversimplifying, ignoring empirical data, and mixing up dates, all cardinal sins to the conventional historian. Yet, despite his inadequacies, the theoretical groundwork he established cannot be ignored by modern-day scholars of madness. It caused scholars to question the traditional analysis, which held that the insane were put away for their own good. The rise of the asylum was seen as a humanitarian attempt to provide a structured system of care for a disabled portion of society. Foucault’s interpretation, which added economic elements to what had previously been a social and ideological picture, shifted the focus from the shortcomings of the mad to the conditions in society which dictated that asylums organized around a system of confinement were the appropriate response to madness in the community.

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5 Ibid., 132-3.
Foucault’s argument is that in the classical period (roughly 1600-1800) the “great confinement” swept through Europe. The insane were incarcerated at much higher rates than before, and the idea that all people suffering from a mental disorder belonged in asylums, regardless of the severity or nature of their complaint, became prevalent. In establishing the social status of the insane he draws comparisons between the madman and the leper, the quintessential Other of preceding centuries. In this interpretation, confinement was implemented not for the good of the insane but for the benefit of the community at large. Madmen were confined not for their protection or rehabilitation, but to remove them from society, essentially cutting off any dialogue between reason and madness. Rather than allow the mad to wander the streets or live with their relatives, institutions provided a receptacle for economically unprofitable members of society. Madmen had nothing to contribute to the common good, and also reduced the productivity of their caretakers due to the time and resources involved in maintaining an insane person in the home. In addition to their economic impact, madness was also seen as a destabilizing influence in the community, adding its own irrational perceptions to the common discourse and thus distorting reality. Confinement was designed to remove this economic burden and allow “normal,” rational behavior to reign unopposed.

The turn toward institutionalization created a situation in which the sane were pitted against the insane in a struggle in “which men, in an act of sovereign reason, confine their neighbors, and communicate and recognize each other through the merciless language of non-madness.” He goes on to outline various ways in which society responded to the threat of unreason, most notably through institutionalization and the

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bestialization or infantilization of the insane. This allowed them to communicate with the sane society only through the mediation of doctors and asylum keepers who functioned as translators, refining and contextualizing their speech and thereby rendering it impotent.

Recent scholarship has refined this interpretation, acknowledging the overly simplistic nature of the humanitarian representation while questioning Foucault’s cynical portrayal of confinement culture and emphasizing his deviations from historical truth. Many historians of insanity in Britain have protested against the unhesitating application of Foucault’s theories to British history by undiscerning scholars. In his introduction to *Mind-Forg’d Manacles*, Porter notes several differences between the French and English cases. He argues that the rates of institutionalization were much lower in England, and indeed in most of Europe, than Foucault supposes; that the insane were not made to work in accordance with a popular ideology regarding the value of labor; and that lunatics were not treated as cruelly as a reading of *Madness and Civilization* would convey.\(^7\) These factual objections are certainly legitimate; however, the importance of this work is not based in its historical argument but its theoretical input. Foucault’s work served to shift the focus from the maladies of the mad to the motives of the keepers and of society at large, who espoused the commitment of their insane countrymen. As such, it opens up an avenue of interpretation in which the insane are no longer deserving of incarceration. Rather than a logical reaction to insanity, confinement can be seen as an outgrowth of societal factors; the conditions of a particular society dictate its response to the presence of unreason in the community. While the many factual issues that exist in the text must be noted and accounted for, *Madness and Civilization* provides an important paradigm in

which to view the history of institutionalization. As much as some contemporary authors attempt to remove themselves from the Foucauldian paradigm, his rendering of confinement as a social mechanism imposed upon the insane rather than a natural outgrowth of insanity and his attempts to explore the interactions between reason and unreason have made a significant impact on modern scholarship.

At roughly the same time that *Madness and Civilization* was working its way into the scholarly consciousness, Richard Hunter and Ida Macalpine published *Three Hundred Years of Psychiatry, 1535-1860*. Essentially a collection of historical texts, this sourcebook has been consulted by almost every student of English insanity since its publication in 1963. The endurance of the book can be credited to the variety of sources it contains, the length of time surveyed, and the goal of the authors to treat “important themes and movements such as the development of legislation, the mind and brain controversy, mesmerism, phrenology and non-restraint” at length. The efforts of Hunter and Macalpine were a significant step toward alleviating the problem of “how little groundwork had been done and how few studies of original material made” up to that time. Their compilation of texts has been extremely useful to this study in providing excerpts from the work of Bethlem physicians.

This commitment to finding and implementing primary sources brought a wealth of new voices to the history of insanity. Revisionist historians questioned the largely positive reception of the reform movement espoused by the traditional historiography, choosing instead to explore the underlying motivations of the reformers. One of the most notable contributors to the revised history of insanity is Andrew Scull, a sociologist by

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9 Ibid., vii.
training, whose “status as a disciplinary ‘outsider’ has not prevented him from becoming one of the most influential historians of psychiatry working today.”

His first book on the subject, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England*, included a call for historians to “transfer [their] attention away from the rhetoric of intentions and to consider instead the actual facts about the establishment and operation” of asylums. He proceeds to do so through a detailed analysis of the rise and fall of asylums and the accompanying approaches to treatment.

Like most important scholarly arguments, Scull’s ideas have stimulated both discussion and disagreement. He has been criticized for his Marxist tendencies which, following in the footsteps of Foucault, tend to portray the evolution of asylums as a mechanism which removes the undesirable classes from the economic and social arena. Historian Janet Oppenheim condemned his willingness “to invoke the ‘English ruling classes,’ the ‘English elite,’ or the ‘upper classes’ as if they formed an undifferentiated mass functioning in unison to suppress all threats to their hegemony.”

Porter has raised sharp objections to Scull’s characterization of new treatment methods as an abrupt break with previous techniques, rather than the result of a process with causal links to the past. The objection is valid; a “historical” account which focuses on conditions in a specific period without reference to the past creates an argument that only functions within a vacuum. However, the thoroughness of his research and the tightness of his arguments within his paradigm makes his work worthy of study.

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Another “disciplinary outsider” whose contributions have been widely discussed is Elaine Showalter, author of *The Female Malady: Women, Madness, and English Culture, 1830-1980*. A professor of English, Showalter specializes in feminist literary criticism. In *The Female Malady*, she applies this approach to the study of women and insanity, concluding that “while the name of the symbolic female disorder may change from one historical period to the next, the gender asymmetry of the representational tradition remains constant. Thus madness, even when experienced by men, is metaphorically and symbolically represented as feminine: a female malady.”

Her work has drawn considerable criticism of both her historical and symbolic analyses. Nancy Tomes, a historian of medicine and gender issues, points out that “given the numerical predominance of women over men…and the tendency of women to live longer, the slight majority of women in…asylums…hardly seems to constitute a ‘feminization.’”

Joan Busfield, a sociologist who, like Scull, specializes in mental illness, corroborates and expands on this objection and adds a convincing discussion of the male archetypes of insanity, noting that the existence of these types weakens Showalter’s connection between women and symbols of insanity. Although it is certainly commendable to reinsert women’s voices into the historical narrative, the flaws in Showalter’s argument make her perhaps a less important source than the heavy citation of her work would seem to indicate.

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In addition to feminist histories such as Showalter’s, another interesting subset of the history of insanity is the study of insanity and the law. The definitive work on the subject as it relates to England is Nigel Walker’s *Crime and Insanity in England* (1968). His work spans the history of the English legal system from the Norman invasion through 1960, highlighting important cases and changes in the legal status of insanity. However, it is his methodology that makes the work so important. Rather than limiting himself to famous cases, Walker scrutinized thousands of court records in order to trace the rise of the insanity plea and its rate of efficacy throughout English legal history. In the process he uncovered hundreds of cases in which the insanity plea has been used, giving scholars a greatly increased number of sources. Both *Crime and Insanity in England* and Joel Peter Eigen’s *Witnessing Insanity: Madness and Mad-Doctors in the English Courts*, which made heavy use of Walker’s sources in an exploration of the rise of the expert witness in insanity trials, have been invaluable to this paper.

Each of the works discussed above are part of a revisionist narrative which arose in response to the Whiggish interpretation that had dominated the old historiography. This approach portrayed the creation of asylums as the result of altruistic reform movements designed to counteract the eighteenth-century legacy of confinement and punishment. In the second half of the twentieth century, this traditional approach was superceded by the revisionist exploration of underlying motives in society’s attempts to deal with the insane. The work of Foucault and those who came after him provides a more complex picture of the many issues surrounding insanity and the continual interplay of madness and mainstream society.
Although Porter is correct in asserting that Foucault’s description of the great confinement falters when applied to England, it is certainly true that the use and acceptance of institutions became more widespread in the eighteenth and nineteenth centuries. Previously, people who showed symptoms of mental disturbance who were not placed in Bethlem or one of the few other public asylums were likely to find themselves in prisons or workhouses beside the criminal and the indigent. All this changed in the nineteenth century, when institutionalization rates exploded: “Between 5,000 and 10,000 people were confined as lunatics by 1800, and about 100,000 by 1900.”

The number of available institutions grew in response to this increased need within the community. The move toward institutionalization was facilitated by Parliament, which in 1714 began passing laws designed to regulate the care of insane paupers. In this system, “institutional care was provided and paid for from the public purse or was purchased by the parish at public expense from institutions run by private proprietors.”

Official legal mechanisms for the incarceration of lunatics in public asylums began in 1800 with the passing of the “Act for the safe custody of insane persons charged with offenses.” This legislation moved the issues of insanity and the care of the insane into the public domain, recasting them as societal issues rather than the concern of specific individuals facing private afflictions. While the growth of institutions specifically designated for the insane is not sufficient to argue improving attitudes toward

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16 Roy Porter, introduction to John Haslam, Illustrations of Madness: Exhibiting a Singular Case of Insanity, and a No Less Remarkable Difference in Medical Opinion: Developing the Nature of Assailment, and the Manner of Working Events; with a Description of the Tortures Experienced By Bomb-Bursting, Lobster-Cracking, and Lengthening of the Brain (London: Routledge, 1988), xii. This increase in the population of identified madman in no way indicates an epidemic of madness; rather, it can most likely be attributed to a growing tendency among physicians to identify and label the insane as such.


18 See page 27.
the insane—separation does not indicate the presence of treatment, nor does it necessarily
demonstrate an urge to protect the insane from other socially marginalized groups—it
does indicate a differentiation in the minds of policymakers among causes of
incarceration and a recognition of the insane as a unique deviant group.

In the nineteenth century, two different approaches to asylum management
developed. The traditional approach employed mechanical restraint in the form of chains
and manacles and used physical treatment methods such as vomiting and purges in an
attempt to cure madness. However, it seems that neither the restraint nor the medicine
were administered as part of an individualized treatment plan; one doctor reported that he
ordered that all of his patients be bled either toward the beginning or end of May every
year, “according to the weather.”19 In response to the failure of the traditional approach
to develop new treatment methods, a competing school of thought proposed the idea that
insanity was a disease of the mind and thus must be treated through personal interaction
with the patient. This approach to insanity found its outlet in moral management, which
was pioneered at a Quaker institution known as the York Retreat and also in Paris by
Phillipe Pinel.

The work of Pinel, a French physician whose A Treatise on Insanity (first printed
in English in 1806) advocated the reduced use of restraint and a turn to more subjective,
psychologically-oriented methods of treatment, provided an alternative to the old system
of confine and punish. This new philosophy of asylums “was a general, pragmatic
approach which recognized the lunatic’s sensibility and acknowledged (albeit in a highly

19 Committee on Madhouses, “First Report, Minutes of Evidence Taken Before the Select
Committee…,” 1815, in Three Hundred Years of Psychiatry, 702.
limited and circumscribed sense) his status as a moral subject.” Although the groundwork was laid by Pinel, it was focused and anglicized in Samuel Tuke’s *Description of the Retreat*, published in 1813. The book contains an account of how the author’s grandfather, William Tuke, founded the York Retreat in a Quaker community and an explanation of the methods used there, which were designed to encourage a return to a rational state through intense staff-patient interactions promoting respectable behavior. By 1815, *Description of the Retreat* had impressed upon philanthropists that the insane could be handled, and even cured, without using mechanical restraint.

The moral management movement received official public sanction during the 1815 hearings of the House of Commons Select Committee on Madhouses, which were intended to investigate “the conditions endured by those insane confined in institutions.” Both Bethlem Royal Hospital and York Asylum were condemned as being dirty and unfeeling places in which patients were treated as animals, kept in chains in dark, cold, smelly rooms. By contrast, Tuke’s York Retreat was commended as a model asylum. The Select Committee hearings essentially standardized the reformers’ views of what an asylum should be, relegating traditional approaches to the status of archaic barbarism.

Moral management, however, eventually proved to be unsustainable. The extremely low attendant-patient ratio required for the level of interaction envisioned by the pioneers proved impractical in face of the burgeoning population of lunatics. Even at the height of the movement, most asylums applied only limited versions of the moral management technique combined with more traditional restraint and physical

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medications. As popular devotion faded, the appearance of moral management remained in the reduced use of restraint, but the vision of “a strenuous battle of wits between mad-doctor and patient”\(^{22}\) that would eventually convince the patient of his insanity and lead him to reason had faded. However compromised its application may have been, however, the change in thought patterns associated with moral management had a significant impact on the treatment of the insane. Madmen had been elevated from the status of brutes incapable of interaction to ailing human beings. While it still could not be said that doctors actually empathized with their patients—the moral management approach required enough attention to recognize the method of a patient’s delusion in order to logically counteract it, but there was no attempt to analyze or find causes for irrational modes of thought—the possibility that doctors should interact with their patients on a personal level opened the door to the analytical approaches developed in the next century.

The changing perceptions of madness in London, whose effects can be seen in the trial and ultimate rejection of moral management as well as other concrete changes in administration, can perhaps best be explored through the lives of the insane at various points throughout the first half of the nineteenth century. Each of the lives examined below were significantly changed by their experiences with mental instability, and each attained some fame, during their lives or later, through position, the notoriety of their actions while insane, or the impact their situations had on society as a whole. The cases chosen are not representative of the mass of madmen; as noted above, their experiences are atypical because of the public attention they received. However, they provide useful

\(^{22}\) *Mind-Forg’d Manacles*, 222.
insight into the important changes in perception and management that took place in English society at this time.

Although his most famous illness occurred before the focus of this study, an exploration of George III’s illness is essential to an understanding of cultural perceptions during and after his reign. The lunacy of a ruling monarch raised drastic questions for the government administration, threatened political stability, and forced the public to grapple with their ideas of madmen. His bouts of insanity, which occurred in 1788-89, 1801, 1804, and from 1810 until his death in 1820 (some historians argue that there was an earlier episode in 1765 which went unrecognized or was “hushed up” by his physicians at the time), were much talked about and highly politicized, sparking a public debate about the desirability and propriety of a regency. However, in part because of the political stakes intertwined with his illness, few reliable facts about his experience are available to us.

The actual cause of King George’s illness is unknown. In “Retreat from Environmentalism: A Review of the Psychohistory of George III,” Robert Detweiler notes that “we seem to be faced with a classic cycle of interpretation” in the retroactive diagnoses of the 1765 attack. While the earliest historians agreed that it was merely a physical illness, by 1840 scholarly opinion considered it the first battle in the King’s lifelong war with insanity. Historians such as J. H. Plumb and Richard Pares paint a portrait of an overly conscientious man whose insanity was brought on in part by “resolute fidelity to a hideous queen.” However, Hunter and Macalpine redirected the

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23 Three Hundred Years of Psychiatry, 509
25 Richard Pares, King George III and the Politicians, 65, quoted in Detweiler, 41.
historical picture in their widely-acclaimed *George III and the Mad-Business* (1969), in which they advance the theory that, rather than being classically insane, the King suffered from a rare hereditary affliction called porphyria.\(^{26}\) This disease, with a modern incidence rate of 1-5 per 100,000, manifests in acute attacks of gastrointestinal disorders with accompanying psychiatric disturbances such as delirium and depression.\(^{27}\) Acute attacks can be brought on by fasting, which may have contributed to the King’s symptoms; he was known to follow a strict diet. Their argument is supported by their observation that his episodes of insanity did not coincide with the most stressful periods of his reign, a circumstance which undermines the argument that he went mad because of the psychological pressure of his royal position. While Hunter and Macalpine’s conclusions are still heavily debated, their suggestion of a physical cause redirected the psychohistorical inquiry and provided an alternative to the picture of a neurotic, mentally weak king incapable of handling the stress of his office.

The 1788-89 attack has drawn the most scholarly attention because it was the first publicized episode and began the regency debate that culminated in George IV becoming Prince Regent in February 1811. It also illustrated for the public the way in which madmen were treated, setting the stage for the popular acceptance of moral therapy in the early portion of the next century. He began manifesting symptoms of psychological disturbance in the fall of 1788, displaying increasingly erratic moods and delirium. His personal physicians, Sir George Baker, Sir Lucas Pepys, and Richard Warren, treated him


in the traditional manner, recommending purges and applying blisters. Despite their ministrations, he grew worse.\textsuperscript{28}

Detweiler argues that “in the eighteenth century the King’s physicians diagnosed their patient’s condition as a physical illness; when his mind appeared deranged in 1788 and periodically thereafter they diagnosed that as a bizarre symptom of his physical ailment.”\textsuperscript{29} During the initial stages of the illness that was certainly the case. The King’s first complaint was of severe stomach pains, and the physicians clung to the belief that he suffered from gout.\textsuperscript{30} However, as early as November 8, 1788, Richard Warren wrote in his diary that the King was insane, and a letter written on November 26 by Mr. W. Grenville to the Marquis of Buckingham recounted that “Warren told Pitt yesterday that the physicians could now have no hesitation in pronouncing that the actual disorder was that of lunacy.”\textsuperscript{31} Sir George Baker, who “was formerly a Pupil of Dr. Batty’s [sic], who attended an Hospital, where [Baker] had an Opportunity of seeing many Instances of this Disorder,” also recognized the King as insane (Dr. William Battie helped to found St. Luke’s Hospital for Lunatics and served as its first physician from 1750 to 1764).\textsuperscript{32} Later discussions of King George’s “indisposition” referred to his mental disarray rather than any gout-like symptoms. The term “fever,” which was usually employed as a euphemism

\textsuperscript{28} This account of the onset of George III’s madness taken from \textit{A Social History of Madness}, 43.\textsuperscript{29} Detweiler, 40.\textsuperscript{30} Christopher Hibbert, \textit{George III: A Personal History} (New York: Basic Books, 1998), 254, 257.\textsuperscript{31} Oscar A. Browning, ed., \textit{The Political Memoranda of Francis Fifth Duke of Leeds, Now First Printed From the Originals in the British Museum} (Westminster: Printed for the Camden Society, 1884), 120 n. 1.\textsuperscript{32} House of Commons, “Report From the Committee Appointed to Examine the Physicians Who Have Attended His Majesty, During His Illness, Touching the State of His Majesty’s Health, 1788,” in \textit{Three Hundred Years of Psychiatry}, 510-1.
in the bulletins on the King’s health, could be used at the time to specify “a state of intense nervous excitement, agitation, heat”\textsuperscript{33} in addition to its current meaning.

The madness of the King created a crisis in protocol. How could one treat an insane monarch when it was expected that a king’s doctors should defer to his wishes? Should his wishes be honored without reason behind them? Baker, a man with a deep respect for hierarchy and protocol, “suffered a case of total funk when faced with the traumatic prospect of having to take charge of the King.”\textsuperscript{34} The situation deteriorated rapidly while becoming further complicated by the regency question. Once the King’s illness became apparent, the Whig opposition immediately began lobbying that the Prince of Wales be established as regent. Richard Warren, a Whig and a friend of the prince, was “in the bizarre position for a doctor of being adamant that, despite the best treatment he could offer, the King was not mending and indeed could not recover.”\textsuperscript{35} An anonymous article in the \textit{Times} argued:

\begin{quote}
the indisposition, under which his Majesty labours, seems to be obstinate and persevering, and to have hither to baffled all the skill of the faculty. It seems therefore necessary, to consult the means to supply the loss thereby occasioned to the public, and to enable the wheels of Government, now impeded, to roll on again smoothly and safely: some fit and able great personage must shortly be requested to occupy the place of Chief Magistrate of the nation, during the indisposition of the sovereign.\textsuperscript{36}
\end{quote}

The “great personage,” the author makes clear, could only be the Prince of Wales. In the interest of impartiality, a similar article entitled “Reasons Why the Prince of Wales Should Not Be Appointed Sole Regent” was published the next day; the author argues

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\textsuperscript{33} Oxford English Dictionary, 2\textsuperscript{nd} ed., s. v. “fever.”
\textsuperscript{34} A Social History of Madness, 45.
\textsuperscript{35} Ibid.
\textsuperscript{36} “Reasons Why The Prince of Wales Should Be Proclaimed Sole Regent,” \textit{Times} (London), 1 Dec 1788.
\end{flushright}
only that the prince should not be given the title of sole regent because of the likely harm he would do to his own chances of a prosperous reign later in life, as he would place himself in an insecure position open to reproach. It seemed unanimous that, regardless of who took charge, someone had to take over for the ailing ruler.

While the political establishment was searching for someone to handle the King’s responsibilities, his friends were searching for someone to take him in hand. Between Warren’s vested interests in keeping the King insane and Sir Baker’s inability to confront his royal patient, the sickroom was in a state of anarchy. Despite the instability of the situation, there is no record of anyone suggesting that the King be confined, either because hospitals, whether for the mad or for the ill, were the domain of those who could not afford to pay for private care or because the government thought it best that the King be kept available to resume his duties the instant he recovered. Finally, in December of 1788, Lady Harcourt suggested calling in the Rev. Dr. Francis Willis.

The queen’s hesitation to call in Dr. Willis was due to a number of factors. She had heard of “his reputation for using force and fear to cow his patients”37 and was evidently afraid that this sort of autocratic approach, when applied to a king, would be a prolonged ordeal. There was also the concern that “to summon a specialist mad-doctor…would be both an unmistakable admission that the King was indeed insane and also a vote of ‘no confidence’ in the King’s regular physicians.”38 Yet the lack of progress and the political pressures evidently left her little choice.

This debate demonstrates the status held by mad-doctors in late-eighteenth century London. Despite Dr. Willis’s experience—he owned a private asylum in

37 Andrew Scull, Social Order/Mental Disorder: Anglo-American Psychiatry in Historical Perspective (Berkeley: University of California Press, 1989), 66 n. 58.
38 A Social History of Madness, 46.
Lincolnshire and had been treating the insane for at least twenty-eight years—calling him in was both a last resort and an affront to the regular physicians. The implication was that a practicing physician should be able to handle all diseases, physical and mental, regardless of rarity or complexity. A specialist was neither required nor desirable. The regular physicians evidently considered him an interloper and questioned his abilities, as he was not a member of the Royal College of Physicians. Richard Warren, concerned about his loss of political power as well as social status (he no longer had the last word as to whether the King was capable of running the government), tried to maintain the appearance that he was the King’s primary physician by saying that he “spoke to Francis Willis ‘with authority’, and…hardly even deigned to speak at all to Willis’s son, John.  

Despite these suspicions and objections, however, Dr. Willis managed to take charge of the errant King, creating an atmosphere in which healing, if not actively encouraged, became at least possible.

Dr. Willis, unlike his predecessors, had no qualms about treating his monarch as he would any other madman. The King was rarely allowed to see Queen Charlotte or their children, and was placed in a straightjacket whenever he showed signs of violence or the inability to control his thoughts. Willis also relied upon his famous “eye” to quell his patient. It was, in the irreverent words of Porter, “all a bit like lion-taming.” This method of treatment was the cause of some debate. While Willis argued that he was

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39 Ibid., 47.
41 A much cited incident occurred in a House of Commons committee meeting in which Edmund Burke questioned Willis for allowing the king to shave with a straight razor while insane. Willis claimed the ability to control his patient through the use of his hypnotic eye and, placing a candle between them, demanded that Burke look into his eyes, saying “There Sir! by the EYE! I should have looked at him thus, Sir—thus!” Burke instantaneously averted his head…evidently [acknowledging] this basiliskan authority.” *Social Order/Mental Disorder*, 66 n. 58.
42 *A Social History of Madness*, 48.
using the only technique he knew of “by which the lowest and the highest person could
be treated with effect”—and, as Bynum has argued, it is highly unlikely that he would
have used any but his most effective methods in such a high-profile case—the Lady
Harcourt saw his approach as brutal. The Queen’s Lady of the Bedchamber, and thus
well acquainted with the events of the household, she observed that:

the unhappy patient...was no longer treated as a human
being. His body was immediately encased in a machine
which left it no liberty of motion. He was sometimes
chained to a staple. He was frequently beaten and starved,
and at best he was kept in subjection by menacing and
violent language. The history of the King’s illness showed
that the most exalted station did not wholly exempt the
sufferer from this stupid and inhumane usage.

This statement highlights the effect King George’s illness had on popular perceptions of
insanity. It is questionable how much the general public knew about how their King was
treated—although they almost certainly realized that his “indisposition” was in fact
lunacy, they would not have been informed in explicit terms about the methods of
treatment. The gentry, however, would have heard of Willis’ methodology from
firsthand witnesses like Lady Harcourt. The situation was “openly discussed in clubs and
coffee-houses,” allowing the educated classes to formulate their ideas about madness.
The fact that it was their monarch who had been afflicted rather than a member of the
lower classes forced the acceptance of insanity as a disease which could strike anyone,
regardless of their position. Madness could no longer be dismissed as the unfortunate but
deserved result of moral degeneracy. This shift of attitudes can be shown in that “nobody

43 Social Order/Mental Disorder, 66 n. 58; William F. Bynum, Jr., “Rationales for Therapy in
British Psychiatry, 1780-1835,” in Andrew Scull, ed., Madhouses, Mad-Doctors, and Madmen: The Social
44 Jones, 41-2.
45 Ibid., 42.
suggested that the King was being punished by heaven for his sins; nobody regarded him as being possessed by the Devil”—those being the more traditional explanations for madness. Instead, “insanity had become a respectable malady—one which might happen to anyone; and, which was even more important, one which was susceptible to treatment and capable of cure.”

Lady Harcourt’s statement illustrates that, beyond this awareness of mental illness as an affliction which reached even “the most exalted station,” there was also a re-examination of the methods used to treat insanity. As noted above, George III would have been treated with the most effective means available. However, Lady Harcourt evidently found those methods barbaric, and it is probable that her feeling was shared by other members of the ruling classes. These new perceptions of madness certainly paved the way for the reform movements on the nineteenth century.

Although the King recovered from this attack just in time to prevent the passing of the Regency Act, he was to suffer from periodic bouts of insanity throughout his life. The Willises continued to treat him for his illness, at one point taking the extraordinary measure of “hijack[ing] him physically…as he was driving to Kew, and…literally [keeping him] prisoner for nearly a month.” In 1810 he descended into madness and never recovered; Prince George IV was appointed Regent in February of the next year. George III died on 29 January 1820. The last mention of him in The Times comes on March first of that year, in an advertisement for “the only likeness taken during his lamented illness,” a sad memorial for a ruling monarch.

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46 Ibid., 44-5.
47 A Social History of Madness, 51.
The King’s life was touched by more than his own insanity. He faced at least two assassination attempts brought about by others’ madness. In 1786, Margaret Nicholson attempted to stab him with a dessert knife because she believed that she was the rightful heir to the throne and that “England would be deluged in blood for a thousand years if her claims were not acknowledged publicly.”\footnote{Jones, 204.} He took pity on her, saying “the poor creature is mad; do not hurt her; she has not hurt me.”\footnote{Ibid.} She was sent to Bethlem, where she remained until her death at the age of 94. A more well-known case, in 1800, resulted in one of the first major pieces of legislation designed to regulate the care of the criminally insane. In this incident James Hadfield, a silversmith and war veteran, fired twice at George III while he was attending a performance at Drury Lane Theatre. His trial both illustrated and updated the prevailing legal attitudes toward insanity at the time.

Hadfield, a private in a dragoon regiment, served as one of the Duke of York’s bodyguards in the Battle of Lincelles in 1793, where “he was left three hours among the dead in a ditch, and was there taken prisoner by the French. His arm was broken by a shot, and he had eight sabre wounds in his head.”\footnote{“Attempt on the King’s Life,” Times (London), 17 May 1800.} His behavior seems to have changed after these injuries, and he was discharged on the grounds of insanity. Upon his return to England he became apprenticed to a silversmith named Hougham. It is during this period that he encountered Bannister Truelock, who was later committed to Bethlem because of his belief “that he was a great prophet named Saturn, or even the Messiah.”\footnote{Jonathan Andrews, et. al., The History of Bethlehem (New York: Routledge, 1997), 390.} Truelock convinced Hadfield that he, like Christ, had to die in order to bring about the apocalypse. In Hadfield’s mind, this created a religious dilemma. He had to die in order to save the
world, but Christian theology prohibited suicide. Therefore, he decided that he had to create the appearance of having committed a horrible crime so that others would bring about his death. He began to make plans for an unsuccessful assassination of the King. After purchasing a pistol from a broker named Wakelin, he went to Drury Lane Theatre on 15 May 1800 because he had heard the King would be attending that afternoon’s performance. He fired the pistol when

His Majesty had scarcely entered the box [and was] in the act of bowing with his usual condescension to the audience….The ball struck the roof of the royal box, just at the moment when the Queen and Princess were entering. His Majesty…waved his hands as a signal to dissuade the royal party from making their immediate appearance, and instantly standing erect, raised his right hand to his breast and continued bowing for some minutes.⁵²

Reportedly, the King then “peered calmly round the house through his opera glasses” and stayed to watch the rest of the performance.⁵³

The other attendants, naturally, were not quite so calm. Jeremiah Parkinson, a musician at the Theatre, told the court at Hadfield’s trial that “as soon as [Hadfield] had fired [the pistol], some Gentlemen near him pulled him from the bench, and with the assistance of other Gentlemen, he was thrown over the orchestra, and taken into the Music-room under the stage.”⁵⁴ Meanwhile, the audience’s cheers that their king was unhurt “at length gave way to angry demands for the punishment of the would-be assassin, until an actress came on to the stage to announce, ‘I have the pleasure to tell you

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⁵² Cited in The History of Bethlehem, 392.  
⁵³ Hibbert, 229.  
the man is in custody.” Hadfield was immediately arrested and stood trial a mere six weeks later.

A large part of the significance of this trial was due to the participation of Thomas Erskine, one of the greatest legal minds of the day. His defense of Hadfield added a new and more sophisticated definition of insanity to the legal lexicon: that of partial insanity, in which a person may be capable of rationally planning and executing an action whose motives stem from an irrational assessment of reality. Traditionally, this idea of insanity had not been recognized; rather, sanity was either total or else could not be used as a legal defense. The opening remarks of the Attorney General, Sir John Mitford, at Hadfield’s trial sum up the accepted viewpoint:

If a man be completely deranged, so that he knows not what he does—if he be so lost to all sense that he cannot distinguish good from evil, and cannot judge of the consequences of his actions…then the mercy of the law said, that he cannot be guilty of any crime, because the will which, to a certain extent, is the essence of every crime…But it would be a grievous thing indeed, if those who had ever laboured under a temporary insanity, should therefore be excused any crime that they might thereafter commit. Gentlemen, the case of idiocy and the absolute privation of reason stands excused, because it is not blessed with that faculty which enables to discover right from wrong….Lord Chief Justice Coke states, in his Pleas of the Crown, that a non compus mentis cannot commit High Treason, but it must be an absolute madness.

Rather than attempting to prove Hadfield’s insanity under this definition—an approach made difficult by his professed knowledge that he was committing a crime, albeit in the

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55 Hibbert, 229.
56 Unless otherwise noted, all information about Hadfield’s history and assassination attempt taken from The History of Bethlem, 391-2.
57 “Trial of James Hadfield, for Treason”
hopes that “the people would fall upon him, and kill him”\(^58\)—Erskine began by critiquing the validity of that line of argument. He observed to the jury that a person in the depths of insanity as described by the prosecution would be incapable of forming any plans at all, much less carrying them out, thus calling into question the use of such a definition in a court of law. Rather, he proposed that Hadfield, although capable of recognizing that he was committing a *legal* crime, did not consider his actions to be a *moral* crime, and was therefore eligible for legal protection as an insane person—in essence, he “introduced the concept of delusion.”\(^59\) Erskine argued that since the crime Hadfield had committed was a direct offspring of his insanity, he could not be punished for it, even though he had the will and the appearance of sanity necessary to carry out his designs. The judge and jury agreed with him (although this may have been due in part to the blatantly obvious physical evidence of Hadfield’s insanity—the saber wounds left his head distinctly misshapen), and Hadfield was judged not guilty by reason of insanity.

This put the English legal system in a rather embarrassing situation: although it had the precedent to deliver such a verdict, there was no legal protocol in place that would allow the government to sentence Hadfield, as he had been acquitted. In order to prevent his being turned loose, Parliament passed the “Act for the safe custody of insane persons charged with offenses” in 1800 and applied it to Hadfield retroactively. He was committed to Bethlem, where he allegedly killed another patient (a report denied by the *Times*).\(^60\) He escaped two years after his commitment, was apprehended, and served

\(^{58}\) “Attempt on the King’s Life”
\(^{60}\) “To the Public…,” *Times* (London), 7 Apr 1802.
fourteen years in Newgate prison before returning to Bethlem where he remained until his death in 1841.

Both Hadfield’s trial and the subsequent legislation illustrate changing attitudes toward insanity. The true impact of Erskine’s delusion defense has been heavily debated, as the precedent was not often used in subsequent cases and the severity of Hadfield’s head wounds may have had a greater impact on the jury (Eigen suggests that Hadfield’s acquittal may have owed something to patriotic sentiment, as “it was, after all, a Frenchman’s sword,” although it is doubtful that patriotic sentiment alone would have been able to protect a man who had attempted to assassinate the ruling monarch).

However, it is worth noting that Erskine had, for the first time, introduced the idea that insanity need not be total in order to constitute a legal debilitation. The fact that Hadfield was, at least in part, acquitted based on this argument indicates that the public had grown willing to accept this more complex picture of madness. The insane were no longer simply raving animals incapable of forming ideas or acting independently; rather, they had become people who could act on their own notions, however unreasonable their logic may have been. This new picture opened the door to a more compassionate view of madmen as victims of their own disturbed psyches.

Of greater significance is the legislation passed by Parliament as a result of Hadfield’s trial. Although it only applied to those guilty of treason, murder, or felony, it created a precedent of legal authority over the treatment of insane persons and a mechanism by which they could be committed to state-sanctioned asylums. The effect of this legislation can be seen in the 1807 House of Commons Select Committee Report on the State of Criminal and Pauper Lunatics, “which noted that by the time of the report 37

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61 Eigen, 50.
criminal lunatics had been detained under the Hadfield-inspired 1800 legislation, and that
the building of regional centres of detention were required.\textsuperscript{62} Hadfield’s trial had
resulted in a legal tangle that caused the state to refine its approach to the legal issues
involving insanity, a process which would be further extended by the trial of Daniel
McNaughton.\textsuperscript{63}

Hadfield’s madness was later explained by another famous Bethlem inmate, John
Tilley Matthews, as being the result of a French mind control plot.\textsuperscript{64} Matthews, a London
tea merchant, had become convinced that the French were using Mesmerism, an early
precursor of hypnotism pioneered by the Viennese doctor Franz Anton Mesmer, as a tool
to control the British parliament. His case was the first to be explored as a single-subject
psychological study published by John Haslam, Bethlem’s apothecary, in 1810.
Haslam’s \textit{Illustrations of Madness} stemmed from medical disagreement regarding
Matthews’ sanity and aimed at revealing rather than explaining his madness. The book,
combined with Matthews’ interactions with the government while ill, made his case well-
known enough for him to be mentioned and inquired after at the 1815 Select Committee
Hearings. \textit{Illustrations of Madness} and the accompanying historical background provide
insight into the status of psychological diagnosis and measurements of sanity at the time
of Matthews’ illness.

Matthews first encountered Mesmerism during a trip to France in 1793 during a
conversation with “a Mr. Chavanay, whose father had been cook to Lord Lonsdale. One
day, while they were sitting together, Mr. Chavanay said, ‘Mr. Matthews, are you

\textsuperscript{62} K. J. M. Smith, ed., \textit{Lawyers, Legislators, and Theorists: Developments in English Criminal
\textsuperscript{63} See pages 40-4.
\textsuperscript{64} \textit{Illustrations of Madness}, 21-2.
acquainted with the art of talking with your brains?’ Mr. [Matthews] replied in the negative. Mr. [Chavanay] said, ‘It is effected by means of a magnet.’ Upon his return to England in March 1796, he began to contact government officials to warn them of this new weapon in the French arsenal. The new government’s “magnetic spies” had been deployed throughout England, where they positioned themselves near seats of power in order to influence policymakers through the manipulation of magnetic vapors which made them susceptible to the spies’ mind control. He believed that the French had realized that he was aware of Mesmerism and the threat it posed to British national security and had organized a gang of seven to incapacitate him through the use of an “air loom.” A sketch of this influencing machine appears in *Illustrations of Madness*. It was used to subject him to a variety of tortures, including the “Bomb-Bursting, Lobster-Cracking, and Lengthening of the Brain” of the title. Matthews’ letters of warning to the British government went largely unanswered. Finally, after accusing Lord Liverpool of being a traitor in league with the French spies, he was taken into custody and placed in Bethlem. His family, unconvinced of his madness, campaigned for his release but were over-ruled.

The family’s next intervention, in 1809, summoned two “learned and conscientious Physicians,” Drs. Birkbeck and Clutterbuck, to examine Matthews. After interviewing him several times, they both issued letters to the King’s Bench testifying that he was entirely sane. The hospital, whose staff considered Matthews quite mad, retaliated by assembling a team of consultants, including Sir Lucas Pepys and Robert

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65 Ibid., 39.
66 Ibid., 19-20.
67 Ibid., 3.
Darling Willis, to form their own conclusions. The consultants determined “that the patient is in a most deranged state of intellect, and wholly unfit to be at large.”68

This divergence in medical opinions raises questions about the status of diagnosis, as it did for John Haslam at the time. In his opening remarks on the case, he notes that:

Madness being the opposite to reason and good sense, as light is to darkness, straight to crooked…it appears wonderful that two opposite opinions could be entertained on the subject: allowing each party to possess the ordinary faculties common to human beings in a sound and healthy state, yet such is really the fact: and if one party be right, the other must be wrong: because a person cannot correctly be said to be in his senses and out of his senses at the same time. [original emphasis]69

Haslam’s statement reveals a dualist conception of insanity which avoids any sort of fellow-feeling with madmen. An insane person was seen as being distinctly different from a rational person, having crossed a definite dividing line, and thus should be judged and treated by entirely different standards than those employed in interacting with a normal man. Birkbeck’s and Clutterbuck’s failures to recognize the difference between a sane person and an insane person was inexcusable in this light; Haslam goes on to observe that gaining a medical education does not necessarily protect a person from lacking or losing his “ordinary faculties,” essentially portraying the two doctors as educated fools, and further objects to their “silent approach and secret inquisition”70 in interviewing Matthews without first soliciting the opinion of Bethlem’s staff. 71

68 Ibid., 14.
69 Ibid., 15.
70 Ibid., 18.
71 Bethlem seems to have been peculiarly susceptible to unsolicited visitors; Edward Wakefield, whose testimony formed a large portion of the evidence against the hospital in the 1815 Select Committee Hearings, was also objected to because he toured the hospital without being invited.
Despite the testimony of Birkbeck and Clutterbuck, Matthews remained in Bethlem, where he spent a good deal of his time drawing plans for the new building (some of his suggestions were incorporated in the St. George’s Field structure).\textsuperscript{72} In 1814 he was transferred to Fox’s London House Asylum in Hackney, where he died a year later. That he continued to be held in asylums “despite numerous medically endorsed attempts to free him and no direct evidence of any violent propensities”\textsuperscript{73} demonstrates the acceptance institutionalization had gained as the logical treatment for madmen. Rather than judging whether insanity rendered an individual dangerous, the very presence of unbalanced thinking made a person fit for confinement.

Matthews died shortly before the 1815 Select Committee Hearings, where his case became one of the standard topics of discussion. However, the Bethlem inmate who received the most public attention was James Norris, an American Marine admitted on 1 February, 1800.\textsuperscript{74} He remained in the hospital until his death from tuberculosis on 26 February 1815 at the age of fifty-five. Six months after his death, he became a symbol of all that was wrong with Bethlem hospital and, by extension, the traditional methods of treating the insane.\textsuperscript{75}

Nothing is known of Norris prior to his consignment to Bethlem by the Office for Sick and Wounded Seamen, and the information about his early years in the institution is tainted by the controversy surrounding his case. In their testimony to the Select Committee, both Haslam and Dr. Thomas Monro portrayed him as a ferocious,

\textsuperscript{72} A Social History of Madness, 58.
\textsuperscript{73} The History of Bethlem, 358.
\textsuperscript{74} There is an inconsistency in the literature regarding Norris’ first name—in some texts he is referred to as John, while in others he is William. Here I defer to the authors of The History of Bethlem, who note that he was “mistakenly called William in the press.” The History of Bethlem, 425.
\textsuperscript{75} The History of Bethlem, 424.
mischievous lunatic capable of attacking a man with a shovel or a knife at the slightest provocation. Because of his violent tendencies, they argued, he had to be restrained. However, the bone structure of his hands made regular manacles useless, as the widest point of his hand was narrower than his wrist and so he could slip any manacles off easily. In order to restrain him, then, they contrived a new arrangement consisting of:

a stout iron ring [riveted] round his neck, from which a short chain passed to a ring made to slide upwards or downwards on an upright massive iron bar, more than six feet high, inserted into the wall. Round his body a strong iron bar, about two inches wide was riveted; on each side the bar was a circular projection which being fashioned to and inclosing each of his arms, pinioned them close to his sides. This waist bar was secured by two similar bars, which, passing over the shoulders, were riveted to the waist bar both before and behind. The iron ring round his neck was connected to the bars on his shoulders by a double link. From each of these bars another short chain passed to the ring on the upright iron bar….his right leg was chained to the trough [bed].

The chain connecting the neck ring to the bar was estimated to be twelve inches long.

This contraption was put on Norris in June 1804 and removed only a few weeks before his death. John Haslam testified that to his knowledge, the restraints were never removed at any time during this almost nine year period.

In April 1814, a Quaker reformer named Edward Wakefield visited Bethlem with a group of reformers in order to assess conditions in the hospital. While touring the wards, they discovered Norris in his harness. Wakefield’s testimony to the Select Committee depicts a quiet man who “read a great deal of books of all kinds…the newspaper every day, and conversed perfectly coherent on the passing topics.”

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76 “Bethlem Hospital: Mr. Edward Wakefield, of Pall Mall, called in and examined,” *Times* (London), 25 Aug 1815.
77 Ibid.
subsequent visit in June, Wakefield brought with him George Cruickshank, who produced an engraving of Norris which was widely publicized. The contrast between the forlorn man in Cruickshank’s illustration and the raging maniac of Haslam’s and Monro’s descriptions is pronounced.

Transcripts of the Select Committee hearings, the more interesting of which were published verbatim in the Times, demonstrate that the Committee put to trial both Bethlem and its major staff members, using Norris as its smoking gun. Although the questioning is certainly thorough, the course of inquiry demonstrates an agenda on the part of the Committee members to create definite change in the regulation of madhouses. Haslam and Monro, in efforts to protect their jobs, inadvertently promoted the Committee’s cause by creating an impression of an established medical staff that was barbaric, petty, and evasive. Haslam, whose testimony spans four days of Times coverage, appeared in an especially poor light. The following exchange, in which the interviewer attempted to ascertain whether Norris’ restraints were removed before or after Wakefield began to protest his situation, is typical of both parties:

You were only asked, whether you know, or believe, it was before those visits?
I cannot tell.
Do you know, or believe, that the report of the keeper, in consequence of which Norris was released from that species of confinement in which he had been so long kept, was made to you before the visits which took place in Bethlem Hospital?
I cannot connect dates in my recollection in that way.
Have you really no belief on the subject?
I cannot say that I have a belief on the subject; I cannot fix the epoch of the public conversation any further than from reading something of it in the newspapers.
Have you any belief on the subject, or not?
I have not.
The Committee are to understand you have no belief or opinion on the subject? I have not sufficient recollection to found a belief on.  

Despite his reticence, Haslam’s testimony provides the most anecdotal evidence of Norris’ insanity. He describes Norris attacking a keeper with a knife, biting off the finger of a fellow patient, and accusing Haslam of trying to sell him to foreigners. His devious nature is demonstrated by one episode in which “[Haslam] was coming in…to give him medicine, and he had contrived to preserve all the fat from his broth for several days, with which he smeared the bottom of the floor.” Haslam slipped and fell flat on his back to a “shower of howls.”

However, it was Wakefield’s description of a gentle man forced into insanity and violence by his situation and the harshness of his keepers (one keeper’s violent encounter with Norris was seen by Wakefield as Norris’ self defense against the drunken keeper’s brutality) that captured the minds of the Committee and the public. The larger movement toward reform made it easy to convince the public that the madhouse establishment was comprised of unmitigated villains. However, the actual situation is more complex. Although Norris’ harness was certainly an excessive example of the confinement mentality, the use of chains was still typical at this time. It is also worth noting that all of the evidence portraying Norris as a quiet man comes from people who encountered him at the very end of his life while he was weakened and fatigued by tuberculosis, while the depictions of violence are from officials who had worked at Bethlem since before his arrival. Norris’ immortalization as the symbol of the old coercive management

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78 “Bethlem Hospital,” Times (London), 2 Sept 1815.
79 “Bethlem Hospital,” Times (London), 4 Sept 1815.
techniques is due more to existence in a transitional period of lunacy management than to the unusual nature of his confinement.

After the hearings were completed, it was clear that both Bethlem and the York Asylum, which was also demonized, needed to institute reform measures. For Bethlem, this included making public scapegoats of both Haslam and Monro, a move supported by the newspapers. On 15 May 1816, the day of the internal meeting at which new officers were to be appointed, the *Times* ran an article consisting primarily of selected excerpts from Haslam’s and Monro’s testimonies regarding James Norris. The introduction “request[s] the attention of our readers” to the fact that neither Haslam nor Monro ever “during the space of ten long years took a single step towards effecting the [release of Norris from his harness].”

The report of the meeting, published the next day, recounts that “the Court was very numerously attended, and a long and animated discussion took place…that Doctor Monro and Mr. Haslam should be re-elected as the physician and apothecary of the hospital, both which questions passed in the negative [original emphasis].” Dr. Monro was replaced by his son, Edward Thomas Monro, who would be the last of four generations of Monros to fill the post. Haslam’s successor was George Wallet, who had served Bethlem as Steward since 1814 and had provided the Select Committee with the most sympathetic portrait of Norris.

An examination of the cases of Matthews and Norris reveals a growing recognition of the individuality of lunatics. Encouraged by the illness of King George, whose unique political position effectively prevented him from being lumped in with the majority of madmen, and furthered by the reform movement’s conception of the insane as

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81 “A court of the Governors of Bethlem-hospital was held yesterday…,” *Times* (London), 16 May 1816.
suffering human beings eligible for treatment and rehabilitation, it became reasonable to talk about specific cases rather than an undifferentiated mass of faceless insanity. This tendency was facilitated by the publication of patient memoirs, which provided readers with firsthand accounts of madness and of the institutional experience.

Patient memoirs are usually classified as spiritual autobiographies, in which patients recount their journey through madness and draw conclusions or morals from their experiences, or protest writings, which recount the abuses and injustices of the institutional regime. Although the earliest recorded English psychiatric autobiography was published in 1436, the genre became more visible in the eighteenth century with the publications of Alexander Cruden’s *The London Citizen Exceedingly Injured* (1739) and *The Adventures of Alexander the Corrector* (1753), Samuel Bruckshaw’s *The Case, Petition and Address of Samuel Bruckshaw* and *One More Proof of the Iniquitous Abuse of Private Madhouses* (both 1774), and William Belcher’s *Address to Humanity* (1796). All of these fall into the category of protest writings. In the nineteenth century, the most well-known psychiatric autobiographies are those of Urbane Metcalf and John Perceval. Each offers a snapshot of the institutions in which their authors were confined and question the predominant modes of treatment used at the time.

Metcalf provides us with little information about himself. He was a patient at Bethlem between 1804 and 1806 and again in 1817. The primary symptom of his insanity was his belief that he was “the son of Matilda, sister to the king of Denmark, and therefore an heir to the throne of Denmark.”\(^8\) There is no doubt that the staff of Bethlem considered Metcalf to be an irritant. His hospital case notes report that “he is irritable

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\(^8\) Dale Peterson, ed., *A Mad People’s History of Madness* (Pittsburgh: University of Pittsburgh Press, 1982), 75.
and full of complaints respecting the economy of the Hospital as well as against the Keepers.”

Shortly after his release from his second confinement he published *The Interior of Bethlehem Hospital*, a threepenny pamphlet which delineated these complaints. It is interesting that his accusations stem from a confinement which occurred after the reforms put into place as a result of the 1815 Select Committee hearings. While testifying that he “found many alterations in the provisions, and in other things that greatly added to the comfort of the patients,” the tendency of the keepers to depart from regulations and “do just as they please” undermined any material changes for the better. His rather disjointed narrative tells of keepers forcing patients to eat in straightjackets to save themselves the effort of removing and reapplying them, sending unruly patients to sleep on straw in the basement as a form of punishment, neglecting to break up fights, and making themselves unavailable to the patients in case of emergencies. He confirms the reformers’ contention that rather than being in the best interest of staff and patients alike, coercive therapy was an abusive system tailored to the convenience of lazy and unsuitable keepers.

John Perceval’s *A Narrative of the Treatment Experienced by a Gentleman, During a State of Mental Derangement* (two volumes, 1838 and 1840), although richer in personal reflection, is equally condemning of the therapeutic regime. The fifth son of Spencer Perceval, the only British Prime Minister to be assassinated (he was killed by a madman by the name of Bellingham as he stepped inside the House of Commons), Perceval served as a military officer in Portugal before returning home to begin a course of study at Oxford. There he developed a religious mania with accompanying visions

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83 Ibid., 76.
84 Urbane Metcalf, *The Interior of Bethlehem Hospital*, in Peterson, 78.
85 Ibid., 79.
and spiritual voices. He became highly preoccupied with his own sinful nature, a situation exacerbated by his acquisition of syphilis from a prostitute he had visited in order to warn her away from her dubious profession. Finally his mind snapped under the strain of guilt, and he spent two weeks in December 1830 strapped down and raving. He was eventually placed in Dr. Fox’s Brislington Asylum in January 1832, where he remained for seventeen months, and was then transferred to Ticehurst House, one of the most luxurious private madhouses in the country, for an additional ten months.

By the time of Perceval’s confinement, moral management had become the accepted practice in virtually all insane asylums. Rather than keeping patients permanently chained up or locked in cold damp rooms, they were generally allowed somewhat more leeway. Doctors and keepers were expected to interact with their patients in order to train them into more acceptable behaviors. In material conditions and the appearance of humanity, psychiatric treatment had greatly improved. However, Perceval argued that despite these changes the therapeutic system was fundamentally flawed. The alien situation in which he found himself was more likely to cause than to cure insanity. His objections are worth quoting at length:

Tie an active limbed, active minded, actively imagining young man in bed, hand and foot for a fortnight, drench him with medicine, slops, clysters [a medicine injected into the rectum to empty the bowels]; when reduced to the extreme of nervous debility, and his derangement is successfully confirmed, manacle him down for twenty-four hours in the cabin of a ship; then for a whole year shut him up from six A.M. to eight P.M. regardless of his former habits, in a room full of strangers, ranting, noisy, quarrelsome, revolting, madmen; give him no tonic medicines, no peculiar treatment or attention, leave him to a nondescript domestic, now brushing his clothes, sweeping the floors, serving at table; now his companion out of

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86 Biographical details taken from A Social History of Madness, 167-88.
doors, now his bed-room companion; now throwing him on the floor, kneeling on him, striking him under all these distressing and perplexing circumstances; debar him from all conversation with his superiors, all communication with his friends, all insight into their motives, every impression of sane and well-behaved society! Surprise him on all occasions, never leave harassing him night or day, or at meals; whether you bleed him to death, or cut his hair, show the same utter contempt for his will or inclination; do all in your power to crush every germ of self-respect that may yet remain or rise up in his bosom; manacle him as you would a felon; expose him to ridicule, and give him no opportunity of retirement or self-reflection; and what are you to expect?

In short, the experience of confinement removed the insane from their lives, from everything that was familiar and comfortable, at the very moment when they required something normal to which they could anchor. To be faced with disorienting thought patterns and images stemming from one’s own psychology was bad enough without being forced to adapt to an alien environment. Although certainly a step forward in the humane treatment of patients, moral therapy, in Perceval’s eyes, clearly failed to help patients recover from their mental infirmities and return to society. He explained his own recovery as being a result of the mental efforts of surviving the indignities to which he was subjected. His therapy’s only virtue was as a counterirritant.

Metcalf’s and Perceval’s protest writings illustrate that some of the insane had become comfortable assessing their own situations and protesting against what they saw as institutional failures to treat madness kindly and effectively. They also provide relatively concrete evidence regarding the conditions in madhouses at this time. Their stories, which are only samples of the many psychiatric autobiographies which have been published, offer a unique and authentic viewpoint of the history of confinement.
A final case worthy of mention is that of Daniel McNaughton, who in January 1843 shot and killed Edward Drummond, private secretary to Prime Minister Sir Robert Peel. McNaughton believed that he was shooting Peel (there was a physical resemblance between the Prime Minister and his secretary) in self-defense, as he was convinced that members of the Tory political party were subjecting him to large-scale persecution. His subsequent trial resulted in the formulation in July 1843 of the McNaughton Rules, which delineate the legal standards of insanity and the way in which an insanity plea is to be handled in court. The fundamental aspects of these rules are still in effect today.

McNaughton, who was twenty-seven at the time of his trial, was the illegitimate son of a Glasgow wood turner. He became apprenticed to his father in his youth, but eventually started his own shop as a result of a disagreement regarding promotion (his father, who eventually fathered a family of legitimate children, evidently decided that it would be unwise to allow McNaughton too large a share in the family business). He began to suspect that he was being followed five or six years before his trial. The identity of his persecutors varied; sometimes they were policemen, sometimes Catholics. He fled to France and then to Scotland in order to hide from his pursuers, but they inevitably followed him. Eventually he identified the Tories as his foes; they were taking revenge on him because he had voted against them in an election. The logical focus of his paranoia was Sir Robert Peel, the Tory Prime Minister. Drummond began to survey the area around Peel’s office in order to determine his adversary’s whereabouts, at which time he falsely identified Drummond as Peel.

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87 McNaughton’s last name appears with a variety of spellings in both modern and contemporary sources. Here I again defer to the authors of The History of Bethlem.

On 20 January 1843, witnesses observed McNaughton as he trailed Drummond, then pulled a pistol from his breast pocket and fired, hitting Drummond in the side. Drummond fell, extending his arm in a pointing gesture at McNaughton. He may have cried out, proving himself to be still alive, as two of the witnesses state that McNaughton “turned round and drew another pistol from his breast, which he deliberately cocked, and then pointed it at the gentleman.” At this point an officer who had been on the other side of the block reached the scene, fought with McNaughton, and overpowered him before he was able to fire at Drummond again. Upon arresting him, the policeman overheard McNaughton say, “‘He’ or ‘she’ (the policeman is uncertain which) ‘shall not disturb my mind any longer.’” Mr. Drummond was left in considerable pain and died five days later.

After witness statements were taken at the police station, McNaughton was asked if he had anything he wished to say. He declined and was taken back to his cell, but then sent a message stating that he had thought of something he wished to say and was taken back to the Bar. His statement was the first evidence given of his insanity and also reveals the strain his delusions must have placed him under:

> The Tories in my native city have compelled me to do this; they follow and persecute me wherever I go, and have entirely destroyed my peace of mind. They followed me to France, into Scotland, and all over England; in fact they follow me wherever I go; I can get no rest for them night or day. I cannot sleep at nights, in consequence of the course they pursue towards me. I believe they have driven me into a consumption. I am sure I shall never be the man I formerly was. I used to have good health and strength but I have not now. They have accused me of crimes of which I am not guilty; they have every thing in their power to

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90 “Attempt to Assassinate Mr. Edward Drummond, Sir R. Peel’s Private Secretary,” *Times* (London), 21 Jan 1843.
harass and persecute me, in fact they wish to murder me. It can be proved by evidence....I can only say they have completely disordered my mind, and I am not capable of doing anything, compared to what I was. I am a very different man to what I was before they commenced this system of persecution.\(^91\)

He was taken to trial within two weeks, but his attorney applied for a postponement in order to gather evidence of his client’s insanity. The postponement was granted, and the trial reconvened on March third.

The trial focused on McNaughton’s derangement from the beginning. Witnesses for the defense included Edward Thomas Monro and Sir Alexander Morrison, who was then serving as Bethlem’s resident physician, both of whom testified to the prisoner’s evident instability. The trial also included a judicial irregularity that resulted in a special portion of the McNaughton rules. Two additional medical witnesses were called by the defense who had never interviewed McNaughton or had any sort of interaction with him. Their opinions were based on the information they gleaned from attending the trial and listening to the evidence given there. The counsel for the defense, Alexander Cockburn, used the medical testimony in combination with legal precedents, including the arguments made by Erskine in Hadfield’s case, to portray McNaughton as forced by his delusions to take action against a perceived plot. He was acting in self defense and should therefore not be punished, despite the errors in his reasoning. Cockburn had to be very careful in the way he framed the insanity plea, as McNaughton’s general behavior gave the appearance of sanity. He made his argument successfully, and McNaughton was ruled not guilty by reason of insanity and sent to Bethlem, from which he was later transferred to Broadmoor as one of the first criminal lunatics housed there.

\(^{91}\) Ibid.
The importance of the trial, however, lies in the debate begun in the House of Lords on 13 March 1843 and the rules that were established as a result. Their Lordships chose to take the unusual course of summoning judges to give their opinions on the way in which insanity trials ought to be conducted. The questions posed to the judges did not mention the McNaughton trial by name, as the House of Lords did not want to appear to question the outcome of the trial or the authority of its judges, although certain of the questions, most notably number five regarding the propriety of allowing a medical man to testify who had never interviewed the patient, were clearly drawn from the specifics of that case. The results of that deliberation, which have become known as the McNaughton Rules, may be summarized as follows:

1. A criminal is punishable if he knows that what he did was contrary to the law, notwithstanding the insane delusion.
2. If the accused person is deluded, his culpability must be judged as if the delusion was in fact true: thus, if he supposes that a man intends to kill him, and kills that man, believing his action to be one of self-defense, he is exempt from punishment: but if he believes only that the man has damaged his reputation, and kills him, the accused is punishable by law as if he were sane.
3. The onus of proving insanity rests with the defense—that is to say, the accused person is presumed sane until it is proved that he is not.
4. The prisoner must be proved to have been sane ‘at the time when the crime was committed.’

Taken as a group, these rules demonstrate an understanding of three important ideas about insanity. First, they codified the partial insanity first introduced in Hadfield’s defense, providing legal sanctioning of the idea that a person could be legally innocent of a crime without being a readily identifiable maniac. Second, they introduce the idea of

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92 Adapted from Jones, 212.
what would become known as temporary insanity, as demonstrated by the requirements of point four. To require that it be proved that the offender was insane “at the time when the crime was committed” implies that insanity is a flexible state, through which a person can move without becoming a permanent madmen. Third and perhaps most important, the rules acknowledge that madness contains an internal logic. By measuring the guilt of an offender by the thought patterns that led to the crime rather than by objective reality, the rules give credence to the idea that madmen are capable of making reasonable decisions within their distorted frames of reference.

Although at first glance this may seem merely a reiteration of partial insanity, this concession has a deeper meaning. It offers the insane human status in that they are capable of making decisions and following through on their actions. It also effectively divides moral and mental failures. Rather than being simply ravening maniacs or criminal psychopaths, offenders tried by these standards of criminal responsibility are judged by their ability to make the best moral decision under the conditions that they perceive as reality. This level of responsibility brings the insane up to a common human level, allowing them reason within their madness. Both in providing, for the first time, clear standards of criminal insanity and in redefining the limits of the insane mind, the McNaughton rules have had a significant impact on the British legal system. The importance of McNaughton’s case far outlived McNaughton himself, who died of tuberculosis in Broadmoor in May 1865.

Each of these men made a significant impact on the ways insanity was perceived in English society. George III’s bouts of madness brought mental illness to the forefront of domestic politics, allowing his subjects to explore their conceptions of the causes and
symptoms of lunacy. His position forced them to concede that the mad were ill, not
condemned by God, and thus could be redeemed by secular means. The cases of
Hadfield and McNaughton refined and legislated the legal picture of madness, providing
recognized procedures for dealing with cases of criminal insanity. John Tilley Matthews,
through the work of John Haslam, brought the public into contact with an authentic voice
of insanity, furthering the concept of lunatics as individuals with their own perceptions
rather than brutes spouting unintelligible nonsense. Urbane Metcalf and John Perceval
went a step beyond Matthews by publishing their own histories of involvement with
asylums, highlighting the fundamental flaws still prevalent in the system. The sad case of
James Norris became a symbol of all that was wrong with an entire paradigm of
psychiatric management and was instrumental in encouraging new conceptions of
institutional care.

Taken together, their experiences highlight the evolution of an increasingly
complex relationship between madness and society. Each case added new dimensions to
the relationship between sane and insane. Although the insane still had little control over
what happened to them—they could not, for example, check themselves out of hospitals
or lodge complaints against their keepers—they were no longer a silent presence in the
community. The changes that took place in the first half of the nineteenth century may
have created the frightening impression that insanity was everywhere—this small survey
has included a mad king, four very public attempted or successful assassinations, and the
condemnation of two major institutions—but the humanitarian reform movement and the
availability of pamphlets telling the story of insanity from the perspective of the insane
helped to foster a more sympathetic picture of lunacy.
The narrative of patient interaction with the psychiatric profession and with society, then, is a story of the struggle to achieve recognition of the abilities and hardships of the insane. Throughout the first half of the nineteenth century, the picture of insanity becomes increasingly complex as subtler gradations of incapacity were acknowledged. At the same time, firsthand accounts of patient experiences and increased newspaper coverage of the experiences of the insane forced the public to recognize the extent of madness in the community and allowed them to view institutions through the eyes of the patients rather than from the viewpoint of medical professionals. At this juncture it is useful to explore how the doctors saw their role in treating madness. What preoccupations and prejudices informed their decisions about how to treat those under their care?

In order to focus this inquiry, the texts analyzed will all come from medical personnel who worked at Bethlem Royal Hospital in the first half of the nineteenth century. This approach has both benefits and limitations. As a more traditional institution, Bethlem was a mainstay of traditional approaches to treatment and thus largely resisted experimentation with moral management. As a result, the views expressed by its doctors tend to advocate physical treatment of disorders. However, studying the variations in thought of these medical personnel over time demonstrates the conflicting views of insanity within the profession and how changes in approach penetrated even this highly traditional institution. Furthermore, focusing on a particular institution helps to eliminate unusual points of view, ensuring a more typical sample of medical discourse.
As England’s oldest mental institution, Bethlem has come to symbolize madness in the minds of the British. Founded in 1247 by Simon fitzMary as the priory of St. Mary of Bethlehem, the building first housed lunatics in 1403. Due to its status as a Catholic institution, Bethlem was threatened by the religious turbulence that dominated English politics in the Medieval period. The hospital was dissolved by Henry VIII in the middle of the sixteenth century, but recreated as a secular institution after the City of London petitioned for its survival. In 1619, Bethlem attracted unwanted attention due to reports that the Master, Dr. Hilkiah Crooke, had embezzled large sums of money from hospital funds. Dr. Crooke was fired and the governors attempted to improve record-keeping. The hospital moved to a new French-inspired building at Moorfields in 1675 and then to St. George’s Fields, Southwark, in 1815.  

Bethlem gained prominence in English popular mythology because of its age and its status as an exemplification of madness. The name Bethlem is the source of the variant Bedlam, originally used in 1528 to specify the hospital but evolving into a term for general lunacy and then to its present meaning of “a scene of mad confusion or uproar.” “Bedlam scenes” were particularly popular among dramatists of the early seventeenth century. 

Andrews and his associates note that this emergence of Bedlam in the national consciousness may be rooted in the Governors’ decision, in the 1590s, to open the institution to the public. Although exact data on the number of entrants cannot be determined, the asylum certainly developed into a major tourist attraction, comparable in

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95 *The History of Bethlem*, 130-1.  
96 Ibid., 11.
repute to Westminster Abbey. The experience of touring the wards was portrayed as religiously and morally instructive, showing the sane the dangers of vice, but it is unlikely that moral reflection was the primary motive for visitors. There was also the experience of seeing the insane and hearing their ravings. In the late eighteenth century, however, the upper classes grew hesitant about the advisability of such visits. As a result of elite pressure, general admission to the wards was stopped in 1770. Visiting died out, but the image of Bedlam had entered popular culture. Twenty-four years after asylum tours ended, newspapers still ran cartoons of Bedlam, which one would presume could be easily interpreted by contemporary audiences. \(^97\)

At the turn of the nineteenth century, Bethlem was a highly recognized but fundamentally standard institution. Manacles and chains were in heavy usage, in part due to the low staff-patient ratio. In 1815 it was noted that there were only four attendants to 120 patients, a ratio used to rationalize the reliance on mechanical restraint. Popular cures for insanity included leeching, blistering, purging, and vomiting—all physical treatments widely used for other types of illnesses. These conditions were not abnormal; in fact, they could readily be observed at most other hospitals of the period.

The 1815 House of Commons Select Committee on Madhouses changed the perception of Bethlem as a typical asylum. The evidence heard and reports published as a result of these hearings became a condemnation of the York Asylum and of Bethlem. \(^98\) Patients were found chained in small, unpleasant rooms. Some were naked or semi-clothed. The attentions of the medical staff were found wanting, and the treatment of

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\(^97\) Ibid., 185.

\(^98\) *Mind Forg’d Manacles*, 124. Porter notes that Bethlem may have been “singled out for blame in the anticipation that the public disgracing of the kingdom’s premier madhouse would carry the more general reform cause.”
James Norris was publicly reviled. As a result of the testimony given by Bethlem employees and outside surveyors, John Haslam was dismissed in disgrace and Dr. Thomas Monro was allowed to resign. Bethlem, one of London’s most recognizable institutions, found its reputation severely damaged in the midst of the asylum reform movement.

Set against this background of popular reform movements and changing perceptions of insanity, the writings of Bethlem’s medical officers reveal much about the issues of the era and the underlying ideas these men held about their patients. They viewed their work through lenses of class, gender, and religion, judging the sanity of their patients against the standards of the times. Many of their published works also deal directly or indirectly with the struggle for jurisdiction over the insane that preoccupied medical men throughout the nineteenth century.

For most of its history Bethlem has been a very tradition-bound institution, and as such, the treatments used there during the early nineteenth century bore a greater resemblance to the confinement techniques of the past than to the moral management approach popular at the time. During the Lunacy Commission Hearings, Thomas Monro stated that he was still using the treatments handed down to him by his father since he “knew none better” (four successive generations of Monros—James, John, Thomas, and Edward Thomas—served as Bethlem physicians from 1728 to 1855). Another symptom of the conservative nature of Bethlem’s medical staff was its tendency to publish relatively little; John Monro’s Remarks on Dr. Battie’s Treatise on Madness, printed in 1758, was the first written work by a Bethlem physician, although there had

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99 “Bethlem/Bedlam,” 42.
been doctors in practice there for two hundred years.\textsuperscript{100} Even after the publishing silence was broken, texts remained scarce.

The papers that do exist can be credited in part to a growing interest in the treatment of the insane and the debate about who should care for them. As rates of institutionalization increased, the mad-keeping trade became highly lucrative as the state and private clients began spending money to confine charity cases or ailing relatives. At the same time, proponents of the moral management approach demonstrated that laypersons could effectively oversee the insane in small, highly-regulated environments, providing what seemed to be a higher quality of care than was available at the asylums. Even Bethlem, despite its history, was forced to publicize itself through means such as the writings of its staff in order to maintain a client base in the face of newer and more innovative private asylums. Publication established Bethlem doctors as authorities, able to compete with moral managers due to their years of experience and affiliation with a venerable institution.

The jurisdictional debate between moral managers and the traditional approach employed by the Bethlem staff was heavily entangled with one of the fundamental questions of psychiatry: is insanity a disease of the mind or of the brain? Is it possible to have a functional disorder without an organic basis? Not surprisingly, most doctors maintained that insanity was organic in nature so as to make their skill at treating the body seem a reasonable alternative to the moral managers’ attempts to treat the mind. Convincing the public of this contention was a vital step in gaining control over the population of mental patients. William Lawrence, surgeon to Bethlem from 1816 to

\textsuperscript{100} \textit{Three Hundred Years of Psychiatry}, 411.
1867, gives a fair description of the moral managers’ position in *Lectures on physiology, zoology, and the natural history of man*:

They who consider the mental operations as acts of an immaterial being, and thus disconnect the sound state of the mind from organisation, act very consistently in disjoining insanity also from the corporeal structure, and in representing it as a disease, not of the brain, but of the mind. Thus we come to disease of an immaterial being, for which, suitably enough, moral treatment has been recommended.¹⁰¹

As will be discussed later, Lawrence was firmly against this assessment of the situation, however fair-minded his description of the opposition may have been.

As the century progressed, mad-doctors grew in their objection to the mind-oriented analysis of insanity. Bryan Crowther, Lawrence’s predecessor in the post of surgeon, found no evidence that insanity was rooted in physical alterations within the brain. In *Practical Remarks on Insanity*, published in 1811, he recognizes that “very desirable information has been obtained [from postmortem brain dissections], *in as much as* the appearances on dissection are not to be considered either cause or effect of insanity [emphasis added].”¹⁰² However, he goes on to state that:

the insane are subject to diseases, incidental to such as are of sound mind…and it is under this circumstance that the physicians to insane asylums have the twofold opportunity of directing the necessary medicinal treatment of their patient, conjointly with proper management; and it is in these instances that they deservedly merit a distinction from others, who have neither been conversant nor acquainted with mad persons.¹⁰³

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¹⁰¹ William Lawrence, *Lectures on physiology, zoology, and the natural history of man*, delivered at the Royal College of Surgeons, 1819, in *Three Hundred Years of Psychiatry*, 750-1.

¹⁰² Bryan Crowther, *Practical remarks on insanity; to which is added, a commentary on the dissection of the brains of maniacs; with some account of diseases incident to the insane*, 1811, in *Three Hundred Years of Psychiatry*, 660.

¹⁰³ Ibid., 660-1.
The involvement of medical doctors in the treatment of the insane could be justified not by their unique knowledge of mental pathology but by their competence in dealing with explicitly organic disease and the familiarity that their customary treatment of madmen provided. Elsewhere in the book, he attempts to defend medical involvement in the treatment of the insane through a different sort of reasoning. His argument is that “it is true, that in many instances [management of the insane as a curative means] has induced success, when the known medical means had certainly failed; yet judiciously combined, surely their mutual co-operation would encourage us to hope for a more favourable termination of the disorder, than when either is separately employed.”

Whether Crowther is being generous to his opposition or is simply a man who must be honest about his beliefs despite the consequences is unclear. However, it is important to note that he bases his argument in doctors’ familiarity with the habits of the insane and in their ability to treat non-mental illnesses, rather than any inherent qualification to treat insanity itself. It is possible that in this early period, eighteen years after Pinel’s mythical liberation of the inmates of Bicêtre and still two years before the publication of Tuke’s *Description of the Retreat*, the concept of moral management was not yet sufficiently grounded in the English public mind to threaten the established order. Four years later, however, representatives of Bethlem could not afford to take such an even-handed approach to the issue.

Haslam’s strongly-worded *Considerations of the Moral Management of Insane Persons* (1817), published after his dismissal from his job as Bethlem apothecary and “symptomatic of the arrogance and self-belief that presumably enabled him to bear up

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under all these trials,” placed him firmly on the side of the medical profession. He decried the “zealots of reform,” who sought to alter what they did not have the experience to understand.\textsuperscript{105} In an interesting turn of phrase, he uses the language of philanthropy and reform to defend the established institutions:

Before the pure spirit of benevolence and christian piety devised the foundation of charitable institutions for lunatics, these miserable objects were allowed to wander, and considered as interdicted persons—when they became troublesome or offensive they were whipt from tything to tything, and stockt, punished and imprisoned [sic]. The enlightened commiseration of modern philanthropists has afforded them every protection, as the existing public and private asylums sufficiently evince.\textsuperscript{106}

He seeks to create a sense of the tradition and progress in order to defend the asylums against lay reformers, but fails to address any of the accusations made against Bethlem and himself.

In 1819, two years after Haslam’s positive assessment of the modern asylum, William Lawrence\textsuperscript{107} presented more support for the involvement of medical doctors in the treatment of madness. His argument was largely based in the organic interpretation of insanity. Here an intriguing discrepancy comes to light. Lawrence states, “I have examined after death the heads of many insane persons, and have hardly seen a single brain, which did not exhibit obvious marks of disease.”\textsuperscript{108} This is in marked contrast to Crowther’s assertion that insanity could not be detected in postmortem dissections. As Lawrence took over Crowther’s post, it is probable that they were drawing from a fairly...

\textsuperscript{106} John Haslam, Considerations on the Moral Management of Insane Persons, 1817, in Madness and Morals, 105.
\textsuperscript{107} See pages 51-2.
\textsuperscript{108} Lectures on Physiology, in Three Hundred Years of Psychiatry, 751.
similar demographic of specimens, so such a discrepancy seems unlikely. Furthermore, Crowther’s account mentions two other men, an “anatomical teacher of acknowledged eminence” and “another gentleman, whose anatomical skill is also acknowledged,” both of whom found little or no correlation between insanity and physical evidence in the brain.\footnote{109}  

Alexander Morison, who was appointed as Bethlem’s first Resident Physician in 1835, gained that position in part due to his very different approach to the issue of medicine and insanity. In 1823, Morison began teaching courses designed to train medical students in the techniques of treating mental disorders. He published his lectures in 1825, and continued to revise and add to them for the next two decades.\footnote{110} In the introduction to the first edition, he argues for teaching this important branch of knowledge in terms that leave no doubt that insanity should remain in the physician’s domain. He points out that “a knowledge of [mental disorders] is indispensable, not only to the practitioner more immediately engaged in the treatment of diseases of the mind, but also to every one who is called upon to give a certificate of the mental condition of his patient.”\footnote{111}  

These certification procedures provided a governmental legitimization of the doctors’ campaign for authority over the insane. The requirement of a physician’s certificate of insanity was legislated in the eighteenth century as part of the 1774 Madhouses Act, which arose from a growing concern among the public about the treatment of the insane. This early movement toward government regulation supports

\footnote{109} Practical Remarks on Insanity, in Three Hundred Years of Psychiatry, 660.  
\footnote{110} Three Hundred Years of Psychiatry, 769.  
\footnote{111} Alexander Morison, Outlines of lectures on mental diseases, 1825, in Three Hundred Years of Psychiatry, 772.
Porter’s contention that the changes in “appropriate” ideas of asylum regulation and management were not a sharp break from the eighteenth century, as Scull had argued. The Madhouses Act, a “reluctant and ineffectual intervention by the Government”\(^{112}\) which created a committee for inspecting private madhouses but gave them no power to take away licenses, also mandated “that every Certificate upon which any Order shall be given for the Confinement of any Person…shall be signed by Two Medical Practitioners except ‘Pauper Lunatics’ or ‘Parish Patients’ for whom only one medical certificate was required.”\(^{113}\) The idea had first been proposed to the College of Physicians in 1754, but they rejected the responsibility on the grounds that “the Execution of That Trust will be attended with such Difficulties as will make it very inconvenient to the College to perform it.”\(^{114}\) In the nineteenth century, however, this assumption that physicians were most qualified to determine insanity provided an inherent authority and kept doctors involved in the running of both traditional and moral management asylums.

As these doctors were so firmly connected with asylums and the experiences of the insane, it is useful to explore their assumptions about the institutions and people with which they worked. The physicians of Bethlem diagnosed their patients according to contemporary standards of sanity, which included specific judgments on correct behavior according to class, gender, and religion. Evidence of these assumptions can be found interspersed throughout their writings. These references, although rarely overt, provide valuable insights about the medical mindset and, by extension, the treatment received by the inmates of Bethlem.

\(^{112}\) The History of Bethlem, 417.

\(^{113}\) Three Hundred Years of Psychiatry, 454-5.

\(^{114}\) Ibid., 452.
Several sources indicate that poor and moneyed lunatics were perceived very differently. A now-infamous exchange between Dr. Monro and a member of the Committee on Madhouses during the 1815 hearings illustrates this attitude (italics are the words of the interviewer):

\begin{quote}
What are your objections to chains and fetters, as a mode of restraint?

They are fit only for pauper Lunatics; if a gentleman were put into irons, he would not like it…

What idea do you fix to the words, that a gentleman would not like irons?

In the first place, I am not accustomed to gentlemen in irons; I never saw anything of the kind: it is a thing so totally abhorrent to my feelings, that I never considered it necessary to put a gentleman in irons.

Do you or not think that a man in a superior rank of life is more likely in a state of insanity to be irritated by such a mode of confinement, than a pauper Lunatic? Most assuredly.\textsuperscript{115}
\end{quote}

Given that Dr. Monro, in this excerpt and elsewhere in his testimony, displays no moral objection to the use of mechanical confinement, his belief that he “never considered it necessary to put a gentleman into irons” is an unusual statement. Taken as a whole, however, this sentiment betrays a strong class consciousness and a belief that class and background not only shapes a man while sane, but also while in the grips of insanity.

Immediately prior to this statement, Monro testifies that the function of irons is to prevent madmen “from being riotous and mischievous.”\textsuperscript{116} The implication, then, is that gentlemen, even insane gentlemen, are less prone to this sort of behavior. In addition, Monro betrays a belief that it is inherently wrong to put a gentleman in chains, although he has no objection to chaining paupers. This distinction carries an unspoken

\textsuperscript{115} Committee on Madhouses, 703.
\textsuperscript{116} Ibid.
acknowledgment of the idea that paupers and gentlemen are entirely different species of men, and as such must be treated differently.

This belief in the intrinsic difference between social classes may be rooted in the civilizing power of education. In Alexander Morrison’s *Outlines of Mental Diseases*, the author notes that “education conducted with too great severity may lead to insanity; but the opposite extreme is the more common cause of it—an education not conducted on the principle of bringing the inclinations and affections under the control of religious and moral principles, and of repressing ideas of hurtful tendency.” Education served a psychological as well as an intellectual function, training the person to function under socially-espoused “religious and moral principles.” A greater degree of this type of education would contribute to the more tractable nature of gentlemen portrayed by Monro.

The inability to use one’s education was recognized as a fact legitimately noted in case histories of the period. *Outlines of Mental Diseases* includes, in a section on the physiognomy of insanity, the picture of a man who “had received a good education, but indulgence in solitary vice brought on a state of general imbecility.” There is a definite cause-and-effect relationship established between his imbecility and his “solitary vice,” implying that moral turpitude is a gateway to madness. This is not the only example of moral or religious interpretations of madness by doctors. Bryan Crowther explicitly links religious devotion with sanity in *Practical Remarks on Insanity*. He describes a “furiously deranged madman” who, when he realized that he was about to die, “requested a person to sit down and pray with him…he earnestly joined in the devotion. Which

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118 Ibid., 76.
circumstances, I think, fully justify the conclusion, that had his insanity been occasioned by the diseased appearances, manifest on opening the head, such *lucid interval* could not have taken place [emphasis added].”¹¹⁹ A proper sense of Christian piety, then, is taken as a definite sign of lucidity.

This type of religious or moral judgment is particularly evident in discussions of homosexuality. In *The Physiognomy of Mental Diseases*, Morison includes a particularly virulent discussion of “monomania with unnatural propensity,” describing it as a variety of partial insanity, the principal feature of which is an irresistible propensity to the crime against nature. This offence is so generally abhorred, that…the punishment…is death, formerly rendered more dreadful by burning or burying alive the offender. Being of so detestable a character, it is a consolation to know that it is sometimes the consequence of insanity; it is, however, a melancholy truth, that the offence has been committed in christian countries, by persons in full possession of their reason and capable of controlling [sic] their actions, and it is said to be still more prevalent in countries where the purifying and restraining influence of the christian religion does not prevail.¹²⁰

Here Morison decries homosexuality while reaffirming the rationalizing influence of Christianity. He does not, however, establish an absolute correlation between homosexuality and insanity. This loophole allows for judgment of homosexuality without confining oneself to the language of treatment and cure.

In addition to the poor, the uneducated, and those of unorthodox sexual orientations, women were also uniquely paired with insanity in the minds of physicians. Although it is probable that Showalter’s case is exaggerated, there is certainly evidence that women were considered uniquely susceptible to certain illnesses due to the nature of

¹¹⁹ *Practical Remarks on Insanity*, in *Three Hundred Years of Psychiatry*, 660.

their constitutions. Morison’s *Outline of Mental Diseases* outlines three phases in a woman’s life that were considered likely to bring about insanity: “the efforts of the constitution in establishing the menstrual discharge, … the puerperal [or postpartum] state, [and] the critical period of female life,”¹²¹ or menopause. Haslam corroborates this idea, noting that “in females who become insane the disease is often connected with the peculiarities of their sex.”¹²² He goes on to use women’s supposedly innate sense of decorum as a justification for the necessity of medical involvement in the field of mental illness, stating that “the education, character, and established habits of medical men, entitle them to the confidence of their patients: the most virtuous women unreservedly communicate to them their feelings and complaints, when they would shudder at imparting their disorders to a male of any other profession; or even to their own husbands.”¹²³ These impressions combined paint a picture of women as the victims of their own unpredictable biologies, hesitant to impart the unsavory details of their illnesses to any but the most qualified of men.

The medical staff of early nineteenth-century Bethlem had strong preconceptions about their clientele based on their class, gender, sexuality, and propriety of religious devotion. Specific groups were made insane by specific defects in their makeup, defects not present in upper-class men. Their attitudes reveal a definite grounding in the beliefs and value structures of their time period, which in turn influenced their approaches to treatment. The works surveyed here demonstrate an unwillingness on the part of doctors to empathize with their patients, preferring instead to view them as distinctly separate and generally inferior beings. John Haslam’s treatment of John Tilley Matthews is

¹²¹ *Outline of Mental Diseases*, in *Madness and Morals*, 32.
¹²³ Ibid.
particularly instructive. Rather than attempting to disillusion Matthews, Haslam used his patient’s account of his experiences in order to further his own ideas about the discipline, abusing his status as Matthews’ doctor in the process. Haslam’s *Illustrations of Madness* objectified Matthews as a raving madman with no internal logic, undeserving of sympathy. Although an extreme case, the relationship between Haslam and Matthews is in many ways typical of the interaction between doctors and patients at this time in the history of psychiatry. Rather than attempt to rehabilitate Matthews and return him to the community as a functional human being, Haslam used his privileged position in order to witness and profit from Matthews’ insanity. As a result, the story of psychiatry in the early nineteenth century can be viewed as two distinct narratives, those of keeper and kept, each of which held markedly different views of madness and madmen.

This situation, in which doctors were comfortably ensconced in a position of power over a marginalized group that was viewed at best as experimental subjects and at worst as reasonless creatures who were to be kept in cages in the least troublesome matter possible, was challenged in the nineteenth century by reformers, the moral management movement, and the patients themselves. At first glance these challenges appear to have failed—moral management was unsupportable, restraint continued to be employed to some extent, and mental patients still lacked a viable psychiatric community intent on finding workable treatment methods—but the changes in both administration and attitudes that took place at this time laid a significant portion of the groundwork for the psychiatric revolution of the next century. Insanity had been recognized as a societal issue, varying gradations of madness had been acknowledged, and the internal logic of unreason had become largely accepted, allowing for a view of madness as an individual
and ultimately manageable problem rather than a dehumanizing experience. On a more practical level, the legislation enacted in response to the reform movement and legal crises such as the Hadfield and McNaughton trials did improve the situation of madmen in real terms, although the effect was hindered by the overall growth of asylums and the resistance of doctors to changes in treatment. The principles of the moral management movement redirected therapeutic efforts toward changing behaviors and effecting psychiatric change rather than attempting to cure the mind by dosing and chaining the body. Although this approach ultimately failed, it did greatly reduce the use of mechanical restraint and introduced the notion that treating the mind rather than or in addition to the body could have a positive impact on cases of madness. This era in psychiatric treatment was a time of substantial change in England, providing a bridge between the hostile atmosphere of the past and the twentieth century movements of psychoanalysis, out-patient therapy, and psychiatric medication.
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