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6

FRAMING PSYCHIATRIC SUBJECTIVITY

Doctor, patient and record-keeping at Bethlem in the nineteenth century

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Introduction

In November 1859, Sarah Rebecca Thorley, a 28-year-old governess, was admitted to the Middlesex County Asylum at Colney Hatch. A letter, written by one Dr Fraser, accompanied her, which stated some extra information about the cause of her disease:

> Yesterday I signed a certificate of insanity in the case of Miss S.R. Thorley, previous to her removal to Colney Hatch – There is one circumstance connected with her condition which you ought to know, as it will guide you in adopting the treatment most likely to be beneficial – The fact was hinted to me by Mr Heally, in consequence of which I questioned Miss Thorley's sister, and learnt from her that at an early age (9 or 10 years) the patient, being under the evil influence of the worthless maid servant, contracted vicious habits of self-indulgence which have increased with her years. An operation (probably excision of part of the clitoris) was performed, but without any apparent benefit. You will probably have a visit from the sister, who can give you further information respecting your patient's antecedents, the family are strangers to me, but I promised the sister (a rather superior young lady, but straitened in circumstances) that I should write to you on the subject, as she might otherwise feel indelicacy in alluding to it.[1]

This is a graphic example of how complex and delicate a task a psychiatric practitioner needed to perform when he attempted to identify the cause of madness a patient of his was suffering from: the aetiology of insanity, as well as the disease itself, was often located in an intensely private realm of family secret, hard to tell and harder to ask. Sheer technical difficulty aside, negotiating one's way to the true cause of the disease, through the intricate web of secrecy, etiquette and protocols was obviously a daunting piece of detective work. Besides with the stigma associated with mental disease and the sense of shame the family felt over the madness of its member, one of the major reasons for the complication lay in the distinctive characteristic of psychiatric clinical encounter. Dr Fraser's letter exemplifies the fact that the psychiatric doctor–patient relationship was normally a triangular one: the patients did not typically report their illness to the doctor, the accounts of the disease being normally given to the doctor by the third party, who did not experience the disease subjectively but knew the patient and their illness well enough – usually members of the patients' family, or their relatives, neighbours and so on. (For the sake of convenience and historical correctness, below I shall refer to the third party in general as 'friends'.)

The doctor–patient relationship, especially in an institutional setting, has attracted the keen interest of historians of medicine in general, many of them utilising the rich resource of hospital case records.[2] These studies have paid special attention to the power structure of the clinical encounter in charitable settings and showed that complex power relations were going on, between the doctor and the patient, between lay governors and medical staff, and so on. Between the patient and the doctor, there existed a contest for interpretative authority over the act of decoding and defining disease, or what Katherine Hunter has called 'a silent tug-of-war over the possession of the story of illness'.[3] Moreover, the relationship at the bedside was affected in crucial ways by the pattern of control of the whole institution, often characterised by the doctors' quest for medical hegemony over the charitable institutions and their bypassing lay governors' power.[4] Historians of medicine have found that such power relationships were embodied in hospital case records. The most famous and important among historical investigations of the role of case record is that of Michel Foucault. In his *Discipline and Punish*, Foucault famously observed that the practice of keeping case records was not merely record-keeping but the cornerstone of modern human science: 'The examination, surrounded by all its documentary techniques, makes each individual a "case": a case which at one and the same time constitutes an object for a branch of

knowledge and a hold for a branch of power.'[5] So far, however, relatively little attention has been paid to the structure of the psychiatric bedside and its embodiment in case records by historians of British psychiatry, and this chapter aims to show that careful scrutiny of the shifting ways in which case records were kept yields unique insights into the nature of psychiatric enterprise in the past and to examine whether Foucault's characterisation of case record as a vehicle of objectification of patients is an accurate one.[6]

With such historiographical concerns in mind, this chapter attempts to investigate changing practice of keeping patient's case records at Bethlem in the nineteenth century and shifting patterns of the distribution of power in the triangular relationship between the doctor, patient and friends. To put it briefly, my argument is that a quiet but definitive change took place in 1852, the year of an important reform of Bethlem. Before 1852, the friends of the patient had relatively unchallenged authority over identifying the cause of the attack. After 1852, their authority was routinely impugned not only by the doctor, but also by the patient. At the core of this shift was the struggle over the power to define the identity of the patient. What kind of life had he or she really led? What had really driven him or her to madness? Who knew the best about his or her private secret, and who could best identify him or her? I shall argue that after 1852, the patients were increasingly defined in the light of what the doctor observed in the institution, and, more interestingly and importantly, what the doctor heard from the patients. Put in another way, the doctor framed the patient's subjectivity into their attempt to understand the real identity of the patient, hidden by or unknown to his or her family members.

Charitable narrative: Bethlem under the old regime

In Bethlem, the practice of keeping patients' case records seems to have started in 1815, no doubt in response to the Parliamentary inquiry in the year before.[7] After 1815, there were two visiting physicians, Edward Thomas Monro from that year up to 1852 and Sir George Tuthill, who was in 1835 replaced by Sir Alexander Morison who remained until 1852. They visited the hospital two or three times a week, each visit lasting about two hours.[8] At first, they were nominally responsible for filling in the case books with the information provided at the admission, but the actual business of putting in entries was increasingly performed by one resident apothecary.[9] The format of each case is an ordinary one. At the beginning of each record, there is a long paragraph

including information taken at the admission of the patient, consisting of the patient's mini-biography and pathography: patient's name, sex, age, occupation(s), place(s) of residence, marriage status, number of children and the progress of the disease from its beginning up to the point of admission. From around 1832 there came into use a hand-written standardised format with fixed sections to be filled in, and in 1837 there appeared its printed version.[10] Information gathered at the admission is followed by subsequent entries about treatment, remarkable changes, general observation, major events such as attacks on other patients and so on.[11] There is therefore a neat division of each case record into two parts, one containing information about the patient's pre-institutional life, taken at the admission, the other recording episodes after the institutionalisation of the patient. This chronological division overlaps with the different sources of the account in the case book. The doctors usually obtained the pre-admission information from those who brought the patient to the hospital, or the 'friends' of the patient. Whereas the events recorded in the post-admission entries were normally observed first-hand by them.

The admission procedure, in which the doctors obtained information about pre-institutional episodes, was essentially a process of petition and charity-giving.[12] The decision over admission was one of the duties of the so-called Bethlem sub-committee, which consisted in seven, mostly lay, governors who met weekly. At the sub-committee meetings, the patients were brought in by their friends, who made formal petition to the governors, explaining the distressed situation of the patient.[13] Since Bethlem was very choosy about the suitable subject for admission on the basis of the patient's medical condition, the visiting physicians were asked to attend the committee to offer advice. But their function was explicitly stated as that of *assistance*, and their opinions were sometimes overruled by governors.[14]

Surviving evidence suggests that the petitioner's presentation of the case prevailed over the ideal of medical interview at the admission committee. It seems that doctors filled in a sheet called 'Memorandum upon admission of patients into Bethlem Hospital'. Many surviving memoranda were inserted into the relevant pages of the case books, into which was transcribed the information in the memoranda. Its format shows the doctors' aspiration for the ideal of systematic information-taking, with printed columns, specifying the type of information to be put in. The actual practice of taking notes was, however, messier. Take, the example of the memorandum for John Bool, admitted on 10 March 1825. The entry into the section 'when this attack commenced' reads as follows:

> Caught cold working in a Hothouse at Montacute in Somersetshire when exposing himself to the cold air in the garden 2 months ago, then about 5 weeks ago his mind became affected. being then restless melancholy, violent towards his wife, wandering about the country leaving his work & crying 'lost man'. Then refused his food, would have destroyed his wife and himself; confined by the parish at home.[15]

The important point is that this entry not only contains much surplus information about the cause, symptoms and other episodes which should not be put here, but also physically spills over the two sections below, unrestrained by the printed format. This seems to suggest that the medical staff of Bethlem were incapable of imposing the pre-established order on what they heard at the admission of a patient, unable to process and neatly pigeonhole the data they received. I shall later come back to this point and explore its wider implications: here suffice it to say that the doctors, in practice, did not possess the power to reconstruct the individual as a 'case', which, as I have mentioned above, Foucault believed, was exercised in prisons, schools and hospitals in the nineteenth-century West.[16]

The entry in the memorandum was unbroken not only because of the doctor's lack of control over the material presented by the friends of John Bool, but also because of its internal integrity. The story of his mental disease is well told: major episodes are arranged chronologically, the cause of the disease is implied at the beginning, and symptoms are described clearly, with emphasis on a piece of eye-catching stereotypical mad behaviour ('crying "lost man" ').[17] Indeed, the case books of Bethlem contain numerous very well-told narrative of madness. One of the best is the entry made by Tuthill in the case note for Sarah Hartley, a 36-year-old wife of a picture-frame maker in London:

> Her present disorder is reported to have begun in August last and to show itself on the death of one of her children. She positively refused to suffer the body to be buried and continued in a distracted state persisting in her refusal till at the end of a fortnight the parish officers were obliged to remove her to the Workhouse in order to make the family to proceed with the funeral. She has remained in Whitechapel Workhouse to the present time and when she first went thither she raved in search of her lost child and could only be removed without very great violence by suffering her to carry with a pillow which she nursed and caressed and called it her child. Since that time she

has remained tolerably quiet but her manners and observations have been very constantly irrational.[18]

Again arranged chronologically, this story traces the disease of the mad mother to its origin and cause and narrates the symptoms of her mad grief, culminating in the intensely dramatic delusion about her lost child – a literary and visual topos being established at that time.[19] The story of Sarah Hartley is a gripping mini-biography of a mad mother, written with highly effective dramaturgy which seems to have compelled the reader/listener into charitable sympathy.[20] Small wonder, Tuthill put down the entire story in one breath.

The obvious question is: who was the author of this story? Almost certainty Tuthill exercised some editing on the story told by the friends. All the material for the entry, however, must have come from the presentation of the case given by the friends at the admission procedure, for obviously Tuthill was not able to witness any episode contained there. Without running the risk of speculating on the extent of medical editing process, one can certainly say that lay people did provide extremely rich and commanding raw material.

Numerous other entries testify to lay people's ability to make sense of the madness of those whom they knew well and to tell dramatic stories about their downfall into madness. Particularly remarkable was their readiness to provide causal explanation: *why* did this man or woman become insane? The majority of the cases include the attributed causes of the present attack of madness of the patient, usually explicitly stated as given by the patient's friends. In some cases there is evidence which suggests that the lay people conducted somewhat elaborate enquiry about possible causes.[21] The friends gave their own causal explanation partly because the doctors and the governors expressed their desire to know the cause, but also because there existed strong lay cultural frameworks which enabled them to detect and understand the origin of the madness. There is a plenty of evidence from other types of material such as private correspondence which show that people were ready to search for causes when their family members or relatives became insane, without being asked or helped by doctors.[22] Rather than seeing it as a mysterious visit or an esoteric and technical question, lay people frequently expressed their own opinions about the causes of the mental diseases of their acquaintances. Entries for 'cause' section were dominated by this kind of lay cultural understanding of madness rather than medicalised aetiology.

The most striking feature of the lay observation is that it understood madness in relation to the life events and their psychological impact on

the patients in question. The events that were regarded as having prompted insanity are usually acute and painful ones. Perhaps reflecting so-called affective individualism, the death of a family member was believed to have driven many into insanity. Influenced by romanticism in general and by the 'Crazy Kate' figure in particular, disappointed love was one of very common attributions made by the friends of insane women as the cause of their insanity.[23] For men, anxiety and stress over business and economic-related matters loomed large. The ideology of self-help and respectability came into play here. Sometimes the petitioning party showed elaborate observation and causal speculation, exercising some empathic reasoning and seeing things from the patient's view. Mary Solomon, for instance, gave birth to an illegitimate child and fell insane soon after. The parish officers reported that 'it is believed that the pregnancy and consequent loss of character have so dwelt upon her mind as to increase her present disease'.[24]

The lay narrative at the Bethlem was, therefore, centred around well-articulated and more or less clearly defined incidents, and their psychological effects, mainly painful emotions such as grief, anxiety, shame, etc. The attribution of madness to drastic and emotion-shattering life events made the madness of the patient *understandable*, something with which one could feel empathy and sympathy. Little doubt the sympathetic framing of madness of the patients was due to the protocol of asking for charity and the strategy of petitioners to present the case as one deserving charity. By representing the disease of a patient as a result of misfortune over which the patient had little control, the friends could depict him or her as a victim. Moreover, there was a striking absence of cases in which the blame was put on the patient, which is abundant in other types of sources.[25] The Bethlem case records presented more or less a sanitised version, putting the patient in a favourable or at least neutral light.

The important question is: what was the doctors' attitude to these lay accounts of the cause of the attack of madness? Of course, the doctors were not nodding their approval to everything presented at the admission committee. Knowing the 'causes' of madness, however, involved a tricky epistemological problem: by reason of chronology, the doctors were denied direct access to observing the patient's transition from sanity to insanity. The family members, relatives, neighbours and Poor Law officers of the patients had a clear epistemological advantage over the doctors, because they usually observed the crucial transitional process first-hand. Take, for example, a letter written by Mr James Ogle, of the Oxford Asylum, accompanying the admission document for Ann Sparkes who was admitted as Morison's patient:

> I was requested to visit Mrs Ann Sparkes about a month time and found her labouring under a paroxysms of mania.... There did not appear any very evident cause of the paroxysm but her neighbours said she had long suffered considerable anxiety respecting her domestic affairs and did not hesitate to ascribe her malady to that origin.[26]

This is a very graphic example of psychiatric inability *vis-à-vis* lay ability to identify a cause of insanity. The neighbours, who were familiar with her personal situation, had no problem in finding why she became insane, while the doctor was clueless about the cause. The crucial point here is that the doctor could not offer his own opinion. He seems to have been aware that he should not trust the lay practice of aetiological reasoning, but he did not possess a lever to overturn the confidently expressed lay opinion.

This pattern dominates the entries of 'causes' in Bethlem case books. The doctors were aware that they had learned the causes from 'dubious sources'. Some accounts in the case books indicate that the doctors were aware of the indirect or second-hand nature of the information they had: the phrases 'it appears', 'it seems', 'the cause is attributed', etc. abound, showing the reservation tacitly expressed by the doctors. Occasionally, they expressed explicit doubt, but they rarely attempt to correct lay attributions and offer alternatives. The case books of Bethlem under the visiting physicians do not reveal any systematic undertaking to appropriate the power to decode the cause of a patient from his or her lay friends into the hands of the medical profession.

The reasons for this lenient attitude to lay interpretation of madness are manifold. Apart from the built-in structural obstacle of chronology and epistemology and the sheer lack of technical sophistication, there are signs that the doctors were often convinced by the powerful, cogent and poignant representation of the madness of the patient narrated by the friends. The friends were playing the game with very strong cards, capitalising on the resourceful and compelling ideologies of romanticism, self-help and affective individualism. One could safely argue that the lay decoding of the aetiology of madness, capitalising on the current cultural understanding of human emotional life, made its way into Bethlem case books, relatively unblocked and often sanctioned by the doctors. This paradigm essentially continued up to 1852, when William Charles Hood assumed the responsibility of resident physician. In the next section, I shall examine the new game started by him.

Voyeurism or empowerment of the patient?

In 1852, due to pressure from the Commissioners in Lunacy, Bethlem went through a large-scale reform.[27] The Commissioners finally secured a right to inspect items in Bethlem: the patients, the staff, the building, devices for restraint and, most importantly, for the purpose of this chapter, the case books. Although stated as one of the duties of physicians or apothecary, keeping case books before 1852 was not always taken seriously and performed attentively. As early as the beginning of the 1820s, the business of record-keeping was rather irregular. For some years around 1822, case books were entered by a person who was obviously not up to the task: entries were written in an extremely clumsy hand, and the author often missed or misspelled medical terms and occasionally did not understand what he was putting down.[28] In the 1830s, the committee inquiring into the misconduct of Edward Wright, the apothecary to the hospital from 1819, learned from him that he could not produce recent case books and the cases of the patients had not been regularly entered.[29] While the 1830 insider committee was not particularly concerned about Wright's failure to keep case books, the 1852 inquiry by the Commissioners in Lunacy repeatedly pointed out the unsatisfactory state of the hospital's record-keeping.[30] The case books of Bethlem now became public record, to be scrutinised by the central government's inspectors. Second, they succeeded in convincing the governors of Bethlem to get rid of the Byzantine system of line-management with two visiting physicians at the nominal top and with day-to-day management left to the apothecary and matron. The new system installed by the end of 1852 was one that had already become the norm for county asylums, centring around one all-powerful resident medical superintendent. The visiting physicians, Monro aged 62 and Morison 73, made a rather ignoble exit, and the superintendentship was taken by William Hood, a 28-year-old Dublin MD, fresh from the job of the resident physician of the Middlesex County Asylum at Colney Hatch.[31]

It appears that there were not great changes in the basics of the admission procedure. Neither was there a drastic change in the format of the case book, although they were kept more regularly, reflecting the fact they were now inspected by the Lunacy Commissioners. On closer scrutiny, however, it turns out that Hood utilised the old formula for a different strategy. One can detect this by looking at how he filled in the 'causes' sections. A hand different from Hood's, perhaps that of the clerk, filled in all sections except 'causes', which were entered by Hood himself. Internal evidences suggest that the 'causes' sections were

systematically left open at the time of admission, to be filled in later by Hood. From what Hood wrote in the monthly observation pages, it is clear that he spent a few weeks or a month in observing, examining and interviewing the patient and comparing the result with the information presented at the admission, trying to discover the real cause of the disease. Sometimes Hood deleted earlier 'causes' entries written in a different hand by strikeout double lines, making new ones by himself. For instance, the initial 'exciting cause' entry in the case note of Angus Mackay's was 'disappointment and drink'. About three weeks later, Hood recorded additional and crucial information:

> Since he has been a patient at this hospital it has been stated that he is a man of most temperate habits and that he has not indulged at all lately in that respect, but the cause of this illness can be traced to anxiety of mind and over study, he having made music his ruling thought lately, endeavouring to set to written notes music adapted for the pipes.

Accordingly, he deleted the former entry and replaced it with 'overstudy of music'.[32] For Hood, the 'causes' sections were not something to be simply filled in at admission: rather, they should be completed only after observation of the institutionalised patient. In other words, he made retroactive use of his own institutional observation: reasoning backward from the direct observation of the patient to the causes of disease, which he could not witness first hand.[33] There was no sign that his predecessors ever did this. Even if one makes concession to the possibility of their retroactive inferring of the cause of the disease without recording it in the case books, one can still argue that Hood made an innovation, by *systematically* using post-institutional data to infer pre-institutional events as causes of madness. Hood made it a *routine* work to infer the unobservable from the observable.

This involved a more critical attitude to lay report on the causes of the disease: now the lay aetiology presented to the doctor was systematically suspended until it was confirmed or rejected by him. Hood exercised elaborate detective work in the case of Emma Riches, a 25-year-old wife of a broker. The 'exciting cause' entry was 'grief at loss of the eldest child', a typically acceptable lay aetiological representation asking for charity. Hood did not entirely deny this attribution, but his further inquiry led him to downplay the role played by the event. Learning that 'there is no particular distressing occurrence about the death of her child that could account for this attack', he emphasised a more important part played by hereditary nature of the disease.[34]

Rather than being content with the cause given by the friends of Mrs Riches, Hood inquired into details and found that the explanation was not convincing.

This systematic discredit of the lay aetiology and illness narrative certainly involved the imposition of professional and scientific authority, which has been the major historiographical focus for the last twenty years.[35] In the case of Emma Riches, Hood was medicalising and somaticising aetiological identification in a rather straightforward way, refuting lay attribution with his negative finding and somatic aetiology of heredity. Simple dichotomy of the physical and the moral and one-sided emphasis on the former was, however, obviously an untenable attitude in the context of day-to-day practice at Bethlem, given the lack of zeal for scientific and somatic psychiatry in Hood. Sophia Sell's case, in which Hood wrote '[this] case may be fairly considered one of puerperal mania, though the circumstance of the child being illegitimate would probably increase the liability to mental disturbance', is a typical mixture and compromise of the moral and the physical.[36]

Hood's critical attitude to lay narrative of disease is in itself not surprising to any medical historian studying the nineteenth century, when the combination of physical examination and pathological anatomy was making doctors less dependent on what patients told them. What is interesting here is the means he utilised to discredit the lay aetiology and the ramification of the new strategy on the psychiatric doctor–patient relationship.

An obvious lever for Hood to counter the lay narrative of the cause of madness was *the patient*, which had been a relatively unexploited resource before. It is not that medical staff at Bethlem before Hood had not listened to the inmates. The entries in the case books reveal, however, that they had been more concerned to detect fraud in terms of the duration of the disease from the conversation with the patients. Five months after the admission of Jeffrey Muggridge, whose derangement had been reported to have lasted for 'five or six months', Tuthill wrote: '[he] is certainly more quiet and tranquil. He will converse freely on the nature of his disorder and from that conversation it has manifestly existed for years.'[37] Another prominent concern of theirs is to record 'interesting' delusions.[38] Light-hearted interest in the content of amusing delusions had long been established in medical and lay culture, and given the occasion to travel in the exotic terrain of numerous insane minds, Bethlem doctors during the old regime assumed the attitude of armchair ethnographer collecting curious stories.[39]

Hood made more active use of the patient. He introduced the patient into the scene, hitting a new balance in the triangular relation-

ship of doctor–patient–friends, increasing the power of the former two parties, at the cost of the friends. A most striking example is that of Mary Ann Musard. Before Hood was appointed, she was admitted first as Monro's patient on 31 July 1851, at the age of 23. The 'cause' entry says that the disease was caused by 'anxiety and distress of mind on account off some supposed frivolous misunderstanding between her self, her mother and her husband'. In December 1853, she was readmitted, this time under Hood. The 'cause' section was apparently left empty at the admission. Two weeks after the admission, Hood thought he had discovered the real cause:

> There are quite sufficient causes for this attack. Her husband is a [skirmish] and not only beats her but keeps another woman. He excuses his conduct by accusing her of forming intimacies with other men, and declares he will never live with her again, but it is not considered that his tale is worthy of credence and if it is the weakness of mind induced by his cruelty, is a sufficient excuse and cause for a crime she may have committed.

Perhaps at this time, he entered 'ill-treatment of husband' in the 'exciting cause' section. In February next year, he recorded in his monthly observation in a similar vein: 'If her story is true her husband is one of the most unmitigated brutes that ever lived.'[40]

The crucial thing about Mary Ann Musard's case is that Hood listened to the patient's own narrative about her domestic situation (she was 'very fond of talking'), and in effect discredited the husband's story of her adultery, which had probably been told at the admission. Note that he preferred the insane wife's version to that of her sane husband. The same pattern repeated itself in the case of Fanny Tebay, whose column for cause was apparently kept blank at admission. Less than a month later, Hood apparently thought he had discovered the true cause, both by listening to her story and observing the husband: 'Her husband has all the appearance of being a bully, and ill-treating her as she represent to be the case she declared now she will not live with him again, and that his brutality has been the cause of these attacks.'[41]

A crucial aspect about Musard's and Tebay's cases is that Hood was aware that domestic disagreement, dispute and cruelty could cause the madness of a family member, and he was fond of detecting domestic cruelty as the cause. It is true that the domestic conflict or cruelty had been recognised as a cause of insanity by the physicians of the previous regime, their reports occasionally listing 'familial troubles', 'domestic unhappiness', 'unkindness of the mother', 'father's misconduct', as the

cause of the disease.[42] Hood's innovation again lay in his active and systematic attempt to reveal domestic problems as the cause of the disease, which were likely to be hidden or suppressed by the family, for they were trying to represent the case as one deserving sympathy and charity. The other members of the family thus became a suspect and biased source.

The case of Emma Nichols, a single 26-year-old waistcoat maker, graphically tells how different the two versions could be. Soon after she was admitted to Bethlem, Hood wrote in his monthly entry that 'her family have to strive hard for a living and she has exerted herself to the utmost to maintain a respectable appearance'. Then she started to recover and started to talk, and Hood learned from her that the situation was more complex than this sanitised version. He recorded: '[it] appears, in addition to the privations she has had to undergo…a brother has on several occasions behaved in a very brutal manner to her and her mother has thrown obstacles on two or three occasions in her way to prevent her marrying when she had the opportunity for fear she should thus lose the labour of her daughter who supported her'.[43] The pattern is the same in the case note for William Day, a 56-year-old widower and infant school master. Hood learned from Day himself that he had to break off an engagement against his will due to his family's objection, and 'this preyed much on his mind'.[44]

The mode of the patients' narrative listened to and recorded by Hood is that of confession. The patients told their own life histories, riddled with calamity and psychological agony, and sense of guilt and shame. They were often centred around the innermost secret of their private life. Hood was, of course, not the first medical figure who started to take the confessional story of the mad seriously. One Mr George Harcourt, who had attended Michael Walker before he was admitted to Bethlem in 1830, wrote a letter to the governors of Bethlem about Walker, in very similar language to Hood:

> At the request of his friends I continued my visits in consequence of the great depression of his nervous energies and by degrees draw from him the cause of his sufferings. He had been living for some years in a gentleman's family and had engaged to marry a young woman but…had connection with a female and caught a gonorrhoea. His mother being a very religious character & it coming to her knowledge, lectured him on…the punishment that would surely await him. This he took so much to heart that he soon fancied himself a ruined man (altho' the disease had long ceased to exist) and incapable of

performing the matrimonial duties. He therefore broke off the engagement and thereby added much to his disease.[45]

The secret sense of shame and guilt of getting gonorrhoea from a prostitute while engaged to a woman, the fear of the punishment for the sin preached by the mother, the anxiety of transmitting it to his future wife – all these private agonies were confessed to the doctor. The remarkable thing about Hood was, as I mentioned above, that he made this a routine aspect of his duties.

Another avenue which he used to explore the secret life of the family and patient was his investigation of masturbation, which was gaining greater importance in contemporary explanations of insanity. William Mason, aged 30 was admitted on 9 October 1854, apparently with the 'exciting cause' column left empty. On 26 October, Hood triumphantly wrote that '[there] is no cause stated by his friends or known to them at all to account for the present attack. He has told an attendant that from a very early age he has practised masturbation and not even given up the habit since his marriage' and entered 'masturbation' in the section. (Note the crucial use of the information provided by the patient.) The case note of Thomas Burgess indicates that Hood was bold enough to ask his father whether the son practised onanism: 'He is thin and unhealthy looking and has the appearance of a person emaciated from masturbation, but his father considers he has not indulged in such practices.'[46]

Conclusion

It is rather difficult to tell how typical Hood was – whether he was just an isolated figure with voyeuristic curiosity about other people's secrets or whether he represented a new culture in psychiatry. Certainly it is highly unlikely that medical superintendents of country asylums, overburdened with bureaucratic paperwork and demoralised with low cure rate, shared Hood's vigorous interest in identifying the 'true' cause of the disease, and the case books of Colney Hatch Asylum, which Hood himself was responsible for keeping, are no exception in their minimal account.[47] Nevertheless, I would like to extend my argument and maintain that Hood's new practice signals the coming of modernity in psychiatry, in three aspects, all related with each other: 1) disfranchisement of the family as a proper component of psychiatric discourse, 2) the penetration of psychiatry into the private realm, and 3) the framing of individual psychiatric patient as subject.

It is fairly obvious that Hood entertained an *a priori* distrust for the narrative of the friends of a patient, especially about the cause of the disease. Although he did not entirely abandon the information given by the family, he did not let their aetiology make an easy way into case books. The aetiological judgement and report made by the family was systematically suspended until the medical superintendent detected the real cause. This built-in suspicion against the family might be a remote echo of the concern against wrongful confinement, stereotypically represented as a conspiracy between scheming family members of the alleged lunatic and an unscrupulous doctor.[48] Or his powerful status as the single head of the hospital boosted his confidence into conducting detective work by his own initiative. Whatever the reason, Hood represents a doctor with modernised professional ethos, who was relatively independent from his client's view when making his judgement. This was achieved at the cost of the family, or lay people who had known the patient much more closely than the doctor. Their long, personal and intimate knowledge of the patient, especially at the crucial time of the beginning of the disease, no longer gained them the status of the best judge about the cause of the disease. The direct access to the innermost privacies of the institutionalised patients, Hood seems to have believed, enabled the psychiatrist to 'discover' the secret life of the patient in the past, hidden even to his or her family. About James Aransolo, a 15-year-old youth, Hood wrote '[he] probably practised masturbation a considerable time though his father has only recently become aware of the fact, for although during the last two years his parents have tried him in several trades yet he would not take to either but on each trial ran away and refused to continue in that or any other occupation'.[49]

The family, Hood thought, were not only unaware of the true cause of insanity; they actively concealed the key information. The friends most typically framed the cases as cultural stereotypes of madness commanding sympathy. In the process, they sanitised their representation, exonerating both the patient and themselves, consciously and unconsciously suppressing data which would put either party in an unfavourable light. A mother who became mad because of her grief over her dead child, young women seduced and discarded, and a failed businessman were all *presentable* figures for their family. The extensive use of interview with the patient enabled Hood to go beyond these façades and make voyeuristic penetration into the domestic and private secret. Hood discovered people who had become insane from causes which were secret, indecent and embarrassing to tell: a husband who masturbated after marriage, a wife abused by a cruel husband who carried on adultery, a daughter ill-treated by the exploitative mother

and so on. In so doing, Hood often assumed the role of a patrolman of domestic harmony and propriety. About Emmanuel Caronel, Hood found that 'the fact appears to be that he was a bad husband and his wife an indifferent woman, and consequently he drank and then beat her. He had suspicions too of her faithfulness to him, and he certainly did not confine his attentions to her.'[50]

Probably Hood's concern to uncover domestic problems was due to the rise of public health as an attempt to uncover vices in the private realm. It seems significant that this systematic attempt to penetrate into the private and domestic sphere of the patient started when the Bethlem case books became, like other asylum records, public documents under the scrutiny of government inspectors. George Robinson, a public health activist and an owner of a private asylum summarised the view in his *On the Prevention and Treatment of Mental Disorders*, published in 1859. Using analogies with public health, he maintained that:

> the physician must look beyond the precincts of the asylum. He must not rest content with there observing the various forms of insanity, recording their progress and searching for their effects...the veil of conventionalism and routine must be drawn aside, and the light of truth and reason allowed to penetrate into the darker recesses of civilised existence.[51]

The asylum inmates thus became an important window through which the doctor penetrated into the private realm, or the Englishman's castle. There had to be some anomaly or irregularities, or deviancy from the ideal domestic situation, in order for the third party to intervene into the guarded private sphere – for example, marital discord or sexually transmitted disease.[52] Madness could be another justification of assault on domestic privacy and secret.

In his persistent attempt to present domestic cruelty or violence and 'vices' related to sexuality as the prime objects of psychiatric investigation, Hood preceded more 'scientifically' oriented psychiatrists of the early twentieth century.[53] Hood's practice could be interpreted as a signal to psychiatric modernity, or what Elizabeth Lunbeck has called 'the enlightened antithesis to Victorianism', in which allegiance to science and endeavour to find 'truth' were accompanied by frankness on matters related to sexuality and attacks on outmoded propriety.[54] Hood's practice at Bethlem however, did not lead to systematic or scientific research combined with quantification and definition of normalcy. Hood spoke in the language of reform framed around the issue of class

and respectability rather than the language of science. His practice resonated with the contemporary concern for the hidden vices practised in the private realm of the families of the lower orders.

To achieve this goal – and this is my third point – Hood relied on the patient's own story, elicited through interview. He thus created a new pattern of the institutional psychiatric bedside, in which the patient told their life story and were listened to by the doctor, replacing the old pattern that consisted in the doctors listening to other people's story about the patient's past. Hood introduced a new scheme where the patient was not only the object of their friends' report, but also a subject who could and did refute the narrative about him or her, by telling his or her own stories. The patient, in collaboration with the doctor, became a legitimate storyteller about their own life.

This seems to compel us to rethink the way in which we should interpret the development of psychiatric power from the mid-nineteenth century. Historians of English psychiatry, most notably Thomas Szasz and Elaine Showalter, have generally assumed that the development of modern institutional psychiatry silenced the voice of the mad, highlighting the role of psychiatry as a prohibiting power, patrolling the patient's morality and labelling social or morally undesirable or disturbing behaviour as pathological.[55] My findings about the Bethlem under Hood shows that this model of, so to speak, 'tug-of-the-war' between the alienist and the patient is grossly simplistic. It was under the modernised, rationalised and bureaucratic regime of the new Bethlem, with more inquisitive power exercised by the doctor, that the voice of the mad started to be heard. One can certainly say that Hood's new practice represented a new culture, which aimed at more medical power and, *at the same time*, put premium on the stories told by the mentally diseased patient.[56]

Unfortunately, there is no way to tell how authentic the voice of the patient recorded by Hood was. First of all, we do not know how the patients responded to Hood's probe into their privacy. Although Hood naturally did not record any instance of hostile reaction to his investigation, that does not mean his relationship with the patients were entirely a benign one. There is little doubt that Hood made his own use of the patient's report and perhaps sometimes put what he wanted to hear in the patient's mouth – he was so fond of identifying domestic cruelty against the patient as the true cause of the disease and he must have derived satisfaction by fashioning himself as the guardian of the patient against the abuse of the family.

It seems, however, too cynical and simplistic to regard Hood's search for cause as an invention to massage his professional self-image. His use

of the subjectivity of the patient is best understood as the new scheme of psychiatric power described in Foucault's later works. In the light of the new practice of Hood at Bethlem, where the patient could challenge and alter the content of the record about himself or herself, the role assigned by Foucault to the patient in *Discipline and Punish* seems too passive. The case book was a far more dynamic and fluid space than Foucault's account suggests, ripe with struggle for the status of legitimate storyteller between the patient, the doctor and family. Foucault's concept of 'confessional technology', put forward in his *History of Sexuality*, captures the complex dynamics of Hood's practice.[57] Instead of repressing the patient's self, Hood regulated his or her subjectivity, encouraging (perhaps occasionally forcing) inmates to narrate their stories to be incorporated into the case book entries, which now became public property. In that sense, Hood's patients signalled modern individual subjectivity constructed by 'psy' professions, 'in which all the "private" effects of psychological interiority are constituted by our linkage into "public" languages, practices, techniques and artefacts.'[58] We should recognise that psychiatry often regulated patient's subjectivity, rather than simply prohibiting it. Michael MacDonald has succinctly stated that 'insanity has been defined by experts but discovered by laymen'.[59] My findings at Bethlem seem to show that between the definition and discovery there existed a complex process of struggle for the appropriation of power/knowledge and the patient's own voice was a vital component for psychiatric modernity.

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NOTES

1 Greater London Record Office, H12/CH/B11/5 Case Book Females no. 7, a letter inserted at p. 331.

2 For a standard overview of the history of doctor–patient relationship in general, see Stanley Joel Reiser, *Medicine and the Reign of Technology*, Cambridge, Cambridge University Press, 1978; Edward Shorter, *Doctors and Their Patients: A Social History*, 2nd edn, Brunswick, NJ, Transaction Publishers, 1991; Guenter B. Risse and John Harley Warner, 'Reconstructing clinical activities: patient records in medical history', *Social History of Medicine*, 5, 1992, pp. 183–205; Mary E. Fissell, 'The disappearance of the patient's narrative and the invention of hospital medicine', in Roger French and Andrew Wear, eds, *British Medicine in an Age of Reform*, London, Routledge, 1991, pp. 92–109; Fissell, *Patient, Power, and the Poor in Eighteenth-Century Bristol*, Cambridge, Cambridge University Press, 1991.

3 Kathryn Montgomery Hunter, *Doctors' Stories: The Narrative Structure of Medical Knowledge*, Princeton, NJ, Princeton University Press, 1991, p. 13.

4 Fissell, *Patient, Power, and the Poor*, pp.110–70.

5 Michel Foucault, *Discipline and Punish: the Birth of the Prison*, Harmondsworth, Penguin, 1979, p. 191. See also Ruth Leys, 'Types of one: Adolf Meyer's Life Chart and the representation of individuality', *Representation*, 34, 1991, pp. 1–28.

6 See, however, Peter Bartlett, 'The Poor Law of Lunacy: the administration of pauper lunatics in mid-nineteenth century England with special emphasis on Leicestershire and Rutland', University of London, Ph.D., 1993. Sally Swartz, 'Colonising the insane: causes of insanity in the Cape, 1891–1920', *History of the Human Sciences*, 8, 1995, pp. 39–57.

7 Jonathan Andrews, Asa Briggs, Roy Porter, Penny Tucker and Keir Waddington, *The History of Bethlem*, London, Routledge, 1997.

8 Ibid., p. 441.

9 *Standing Rules and Orders for the Government of the Royal Hospitals of Bridewell and Bethlem*..., London, by H. Bryer, 1818, pp. 62–3.

10 Case Books (CB) from 1815 are now kept at the archive of Royal Bethlem Hospital. CB/19 curable patient Monro; CB/22 Curable patients Morison.

11 In theory they should be entered at least once a month, but in practice the entries were extremely irregular.

12 Fissell, *Patient, Power, and the Poor*, pp. 74–93. See also the chapter by Lorraine Walsh in this volume.

13 Andrews *et al.*, *History of Bethlem*, pp. 436–63.

14 *Standing Rules*, 1818 states at p. 63 that one of physicians' duties is 'To attend the sub-committee, at Bethlem Hospital, every meeting, to assist the committee with their advice in taking in and discharging patients'.

15 Memorandum upon admission of patients into Bethlem Hospital for John Bool, inserted in CB/11.

16 Michel Foucault, *Discipline and Punish*, pp. 184–94.

17 See Mary Fissell, 'Readers, texts, and contexts: vernacular medical works in early modern England', in Roy Porter, ed., *The Popularisation of Medicine 1650–1850*, London, Routledge, 1992, pp. 72–96.

18 CB/8, p. 229.

19 Sander Gilman, *Seeing the Insane*, New York, John Wiley and Sons, 1982, pp. 138–9.
20 For powerful linguistic analysis of discourse of charity, see Thomas Laqueur, 'Bodies, details, and the humanitarian narrative', in Lynn Hunt, ed., *The New Cultural History*, Berkeley, University of California Press, 1989, pp. 176–204.
21 In the case of Amelia Lawrence, at CB/2, pp. 97–9, it is stated that the family asked her about the cause of the disease. See also, for example, CB/1, pp. 167–8, 239–40.
22 See American examples in Nancy Tomes, *The Art of Asylum-Keeping: Thomas Story Kirkbride and the Origin of American Psychiatry*, Cambridge, Cambridge University Press, 1894; paperback reprint with new introduction, Philadelphia, University of Pennsylvania Press, 1994, pp. 92–103.
23 For the literary topos of love-sick woman, see Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830–1980*, London, Virago, 1987, pp. 11–14; Helen Small, *Love's Madness: Medicine, the Novel, and Female Insanity, 1800–1865*, Oxford, Oxford University Press, 1996.
24 CB/2, pp. 177–8.
25 See, for example, Alexander Morison, MSS Reports and Notes of Cases, Royal College of Physicians of London, SR/471, 'The case of Miss Mary M – by her sister'.
26 CB/20, p. 3.
27 Commissioners in Lunacy, *The Report of the Commissioners in Lunacy to the Secretary of the State on Bethlem Hospital*, London, Spottiswoodes and Shaw, 1852. About the 1852 investigation and the new regime of Hood in general, see *History of Bethlem*, pp. 464–511.
28 The case book numbered CB/12 (Admissions curable male and female) holds inserted admission memorandum sheets, from which the entries seem to have been transcribed with numerous errors. In a single entry for William Adams, the author missed two terms 'insensible' and 'Rheumatic fever' and wrote 'health week' for 'health weak'. CB/12, p. 33.
29 Bethlem Hospital, *Minutes of Evidence Taken by the Committee, appointed to inquire into the charges preferred against Dr. Wright*, London, by Mills, Jowett, and Mills, 1830, p. 36.
30 Commissioners in Lunacy, *The Report*, 1852, pp. 6, 15, 17, 28, 34 etc.
31 For the Colney Hatch Asylum, see Richard Hunter, and Ida Macalpine, *Psychiatry for the Poor: 1851 Colney Hatch Asylum. Friern Hospital 1973*, London, Dawsons, 1974.
32 CB/64, pp. 45–8.
33 For the retroactive nature of medical reasoning, see Hunter, *Doctors' Stories*, esp. pp. 51–82.
34 CB/61, p. 49.
35 The most forceful and sophisticated proponents of this model are Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700–1900*, New Haven, Yale University Press, 1993; W.F. Bynum, 'Rationales for therapy in British psychiatry: 1780–1835', *Medical History*, 18, 1974, pp. 317–34; L.S. Jacyna, 'Somatic theories of mind and the interests of medicine in Britain, 1850–1879', *Medical History*, 26, 1982, pp. 233–58.
36 CB/61, p. 54. In any way, since heredity belonged to 'predisposing' cause and moral ones largely to 'exciting' one, Hood's concern for the hereditary

nature of insanity and his desire to find moral cause were *not* mutually exclusive.
37 CB/1 (Tuthill), pp. 99–102, entry on 1 April 1817.
38 See for example, CB/1 (Tuthill), pp. 151–3.
39 Tuthill, for example, once faithfully recorded the popular expression ('according to the expression of a petitioner') 'addiky', perhaps a corrupted form of 'addictive'. CB/1, the entry for Joseph Aves pp. 231–3.
40 CB/63, p. 33.
41 CB/62, p. 5.
42 *The Royal Hospital of Bethlem. The Physician's Report for the Year 1845*, London, G.J. Palmer, 1846, pp. 29–30.
43 CB/62, p. 24.
44 CB/64, pp. 129–31.
45 CB/14, p. 14.
46 CB/64, pp. 213–15.
47 GLRO H12/CH/B/11/1/A, Middlesex County Lunatic Asylum Colney Hatch, Case Book Female Side No. 2.
48 Peter McCandless, 'Liberty and lunacy: the Victorians and wrongful confinement', in Andrew Scull, ed., *Madhouses, Mad-Doctors, and Madmen: the Social History of Psychiatry in the Victorian Era*, London, The Athlone Press, 1981, pp. 339–62.
49 CB/64, pp. 209–11.
50 CB/64, pp. 81–3.
51 George Robinson, *On the Prevention and Treatment of Mental Disorders*, London, Longman, Brown, Green, Longmans, and Roberts, 1859, p. 5.
52 A. James Hammerton, *Cruelty and Companionship: Conflict in Nineteenth-Century Married Life*, London, Routledge, 1992, p. 18. Elizabeth Lunbeck, *The Psychiatric Persuasion: Knowledge, Gender and Power in Modern America*, Princeton, Princeton University Press, 1994, pp. 52ff.
53 Lunbeck, however, observed that psychiatrists at the Boston Psychopathic Hospital failed to 'frame domestic violence as an issue in its own right' (Lunbeck, *Psychiatric Persuasion*, pp. 102–3). The contrast between Hood and Boston psychiatrists is perhaps due to the latter's self-conscious pursuit of 'science', whereas the former tended to use the language of reform.
54 Lunbeck, *Psychiatric Persuasion*, p. 52.
55 Thomas Szasz, *The Myth of Mental Illness*, New York, Dell, 1961; Showalter, *Female Malady*, pp. 121–64.
56 The result of Hood's practice could amount to a free-flowing narrative of enormous scale by the patient. See Forbes Winslow, *On Obscure Diseases of the Brain and Disorders of the Mind*, Philadelphia, Blanchard and Lea, 1860, pp. 69–113.
57 Michel Foucault, *Histoire de la sexualité 1. La volonté de savoir*, Paris, Gallimard, 1976. For the centrality of the 'confession' of the object of study or punishment in the modern power, see Michel Foucault, 'The dangerous individual', in Michel Foucault, *Politics, Philosophy, Culture: Interviews and Other Writings 1977–1984*, ed. by Lawrence Kritzman, London, Routledge, 1988, pp. 125–51.
58 Nikolas Rose, 'Assembling the modern self', in Roy Porter, ed., *Rewriting the Self: Histories from the Renaissance to the Present*, London, Routledge, 1997, pp. 224–48, 226.

59 Michael MacDonald, 'Popular belief about mental disorder in early modern Europe', in W. Eckart and J. Geyer-Kordesch, eds, *Heilberufe und Kranke im 17. und 18. Jahrhundert*, Münster, Burgverlag, 1982, pp. 148–73, 148.

7

'DESTINED TO A PERFECT RECOVERY'

The confinement of puerperal insanity in the nineteenth century

Hilary Marland

'Cases of puerperal insanity appear to afford a better prospect of recovery than any other' (John Conolly, 1846).[1] 'Puerperal patients should always be treated as though they were destined to a perfect recovery' (William Tyler Smith, 1856).[2] 'Many of the cases with the worst symptoms, bodily and mental, made good recoveries' (Thomas Clouston, 1887).[3] Unlike the dreary prognosis for many 'insane' patients during the nineteenth century, the condition which came to be known as 'puerperal insanity' or 'insanity of childbirth' was treated by contemporaries as a temporary, albeit often very serious, aberration, likely to be curable. Hard-pressed superintendents of asylums greeted the disorder, which accounted for large and growing numbers of female admissions during the century, as a potential boost to rates of recovery and discharge. Yet at the same time, there was a striking discrepancy between the number of women said to have been suffering from puerperal insanity and asylum intake under this category. The advocacy of domestic management of such cases, particularly by obstetric practitioners, seems responsible for filling the gap between occurrence and asylum admissions.

Childbirth and puerperal insanity

The phenomenon of erratic, crazy, even violent behaviour on the part of pregnant women or new mothers had been described long before the nineteenth century. A small number of largely uninfluential continental works on the subject had been published from early in the eighteenth century, particularly a run of German dissertations,[4] while various authors on midwifery had made mention of the condition. There was