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The origin of psychiatry
The alienist as nanny for troublesome adults*

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> Once . . . insane asylums exist, there must be someone to sit in them. If not you – then I; if not I – then some third person.
>
> Anton Chekhov[1]

At the beginning of the seventeenth century, there were no mental hospitals, as we now know them. To be sure, there were were a few facilities – such as Bethlehem Hospital, better known as Bedlam – in which a small number, usually less than a dozen, of pauper insane were confined. By the end of the century, however, there was a flourishing new industry, called the 'trade in lunacy'.[2]

To understand the modern concept of mental illness, one must focus on the radically different origins of the medical and psychiatric professions. Medicine began with sick persons seeking relief from their suffering. Psychiatry began with the relatives of troublesome persons seeking relief from the suffering the (mis)behaviour of their kin caused them. Unlike the regular doctor, the early psychiatrist, called mad-doctor, treated persons who did not want to be his patients, and whose ailments manifested themselves by exciting the resentment of their relatives. These are critical issues never to be lost sight of.

Unconventional behaviour must have existed for as long as human beings have lived together in society. Psychiatry begins when people stop interpreting such behaviour in religious and existential terms, and begin to interpret it in medical terms. The fatal weakness of most psychiatric historiographies lies in the historians' failure to give sufficient weight to the role of coercion in psychiatry and to acknowledge that mad-doctoring had nothing to do with healing.

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The origin of the madhouse

Higher mammals, especially humans, remain dependent on their parents for some time after birth. Because only women can bear children and because caring for infants is a time-consuming job, societies have adopted the familiar gender-based job differentiation, females caring for the young and tending the shelter, males providing food and protection for the family.

Once a society advances beyond the stage of subsistence economy, mother surrogates often replace the nurturing role of the biological mother. For centuries, parents who could afford household help delegated the task of child-care to servants – governesses for infants and young children, tutors for older ones.

The belief that every parent passionately loves his child and would like nothing better than be able to take care of him is a modern fiction and self-delusion. Taking care of children, day in and day out, is not a very interesting activity. Many adults dislike being merely in the company of a small child. Most people feel similarly disinclined to care for an insane adult, that is, for a person who is selfish and self-absorbed, demanding and dependent, intemperately happy or unhappy, perhaps even threatening and violent. Stripped of three hundred years of psychiatric-semantic embellishments, the fact is that a mad person appears to his relatives as an unpleasant individual whose company they would rather avoid. To deny their embarrassing lack of love for their lunatic kin, people burdened by a crazy relative now call him their 'loved one', especially when they enlist a psychiatrist to dispose of him.

It is clear that delegating the care of an insane adult to hired help, especially if he resists being cared for, presents a very different problem than delegating the care of a child. A young child has neither the physical strength nor the political power to resist being controlled by his parents and their deputies who have lawful authority over him. Adults have no such rights *vis-à-vis* their adult relatives or other grownups. Before an adult deemed to be insane can be treated as a madman, he must therefore first be divested of his rights.[3] Reframing the political status of the insane adult as similar to that of a child accomplishes this task.

Insanity as an infantilizing illness

Historically, the first order of business in psychiatry was to establish insanity as a genuine disease, that is, as neither malingering nor an (immoral or illegal) act carried out by a responsible adult. The next business was to distinguish insanity from other diseases and assign to it the singular characteristic of having the power to deprive the patient of his higher mental faculties, rendering him childlike, and justifying controlling and caring for him against his will. Hence the close association between severe head injury, brain disease (neurosyphilis), and insanity. This whole package was required

by the political character of seventeenth-century English society, where, for the first time in history, a people dedicated themselves to honouring the values of liberty and property. It is not by accident that the ideas of limited government, the rule of law, and insanity as an infantilizing illness all arose and developed in England. Both the medicalization of madness and the infantilization of the insane were, and are, needed to reconcile a society's devotion to the ideals of individual liberty and responsibility with its desire to relieve itself of certain troublesome individuals by means other than those provided by the criminal law.

The idea of insanity as a condition requiring the mad-housing of the insane was invented by those who needed it, the members of the dominant classes of seventeenth-century English society. It was they who had to carry the burden of being responsible for their mad relatives by having to provide for their needs and who, at the same time, had to conform their behaviour to the requirements of a social order that placed a high value on the liberty of persons and the ownership of property. What was a man to do with his spouse, adult child, or elderly parent who flaunted convention and perhaps neglected his own health, but who was considered to possess a basic right to liberty and property? The time was past when such a troublesome individual could be treated as a clan member, responsible to the group, devoid of individual rights in the modern sense. The rule of law liquidated the autocratic prerogatives of elders *vis-à-vis* deviant adults. From the seventeenth century onward, the adult members of families were held together more by co-operation and compromise, and less or not at all by direct coercion. Regrettably, co-operation and compromise are useless *vis-à-vis* persons who are unable or unwilling to co-operate and compromise.

These political and legal developments placed family members faced with a disturbing relative in a difficult situation. Though embarrassed and victimized by their (mad) kinfolk, the (sane) relatives could not control him by means of the informal, interpersonal mechanisms normally used to harmonize relations in the family. They had only two options, both useless. One was to set the engine of the criminal law against the offending family member (provided he broke the law), a course that would have led to the social or physical death of the mad relative and the abject humiliation of the family. The other was to expel him from his home, a course that would have required them to possess more power than the party they wanted to expel and would therefore have been most impractical when it was (felt to be) most necessary. It was an intolerable impasse. Sane (or perhaps merely scheming) family members had to come up with a socially acceptable arrangement to enable them to control, by means of a non-criminal legal procedure, the unwanted adult relative (who was senile, incompetent, troublesome, or perhaps simply in the way). That was the need that generated the concept of mental illness and that is the reason why the concept of mental illness differs so radically from the concept of bodily illness. The point is that the physically

ill person can be cared for without requiring that he first be subjected to coercive social control, but the so-called mentally ill person cannot be cared for in this way, because he (rightly) rejects the patient role.

In what way did a property-owning madman in England in, say 1650, endanger his relatives? He did so in one or all of the following ways: personally, by embarrassing them; economically, by dissipating his assets; and physically, by attacking his relatives. In this connection, it is necessary to acknowledge that a person who spurns our core values – that life, liberty and property are goods worth preserving – endangers not only himself and his relatives but, symbolically, society and the social fabric itself. The madman's embarrassing behaviour gave his family impetus for hiding him; his improvidence, which provided an important conceptual bridge between the old notion of incompetence and the new idea of insanity, gave them an impetus for dealing with him as if he were incompetent. The law had long recognized mental retardation as a justification for placing the mentally deficient person under guardianship. Now the law was asked to do the same for the mentally deranged person. Medieval English guardianship procedures lent powerful support to the emerging practice of madhousing. Both procedures grew from the soil of English political-economic and legal tradition, grounded in the value of preserving landed wealth and ensuring its stable transmission in the family. As far back as the thirteenth century, common law recognized two classes of incompetents: Idiots, mentally subnormal from birth, who were considered to be permanently impaired; and lunatics, normal persons who went mad, who were considered to be capable of recovery. The procedure for declaring a person a lunatic was similar to that of declaring him incompetent: 'Commissions examined such persons before a jury that ruled on their sanity . . . Physicians played essentially no role in the certification process itself.'[4] Before pauper lunatics were exiled to madhouses, propertied persons considered to be mad were managed in a manner that presaged the practice of mad-doctoring:

> Physical supervision and care of the disabled party was commonly handled by retaining a live-in servant, the so-called 'lunatics keeper', a person usually of the same gender as the disabled individual. . . . Boarding out the lunatic or idiot at a private dwelling, in the company of a servant, was also commonplace; this practice in some respects anticipated the development of private madhouses in the eighteenth century.[5]

Madness and the metaphor of war within the self

Although some special facilities for housing lunatics existed before the seventeenth century – for example, in ancient Greece, in medieval England, and in Islamic societies – these were isolated arrangements for looking after a few unwanted persons. They were not instances of an institutional

arrangement serving the explicit purpose of incarcerating persons categorized as insane. The history of mental hospitalization, as we know it, began in seventeenth-century England, when and where, for the first time in history, the care of the insane was systematically delegated to persons outside the family. Forcibly removed from his home, the mad person was forcibly re-housed in the home of a surrogate caretaker.

The self divided against itself

Who wants to deprive us of life, liberty and property? Enemies abroad, criminals at home, and the state to which we entrust the power to protect us from them. These threats are external to our selves. Our lives, liberties and properties may also be threatened (metaphorically speaking) from within, by the self acting in opposition to its conventionally defined interests. In fact, the metaphor of the self divided against itself is as central to psychiatry as the metaphor of the Trinity is to Christianity. The 'split personality' of schizophrenia is only the most familiar example. Psychiatrists have managed to infect the Western mind with many other examples of 'divided selves', such as the true versus the false self, the authentic versus the inauthentic self, the sane or healthy versus the insane or sick self, and so forth. To be sure, we all harbour diverse desires, some at odds with others, but we have only one self per person. The force of the maxim, 'Actions speak louder than words', lies largely in its power to prevent the disuniting of actor and action. However, it is precisely the 'reality' of that disunion that we desire to legitimize when we assert that a person who neglects himself or his property, whose economic behaviour is injudicious, or who harms or kills himself is 'not himself'. People have always engaged in such behaviours. In religious societies, they were viewed as martyrs, sinners, or persons possessed by demons. In the West since the Enlightenment, they have been viewed as mentally ill.

To see through the confusions embodied in the image of the mentally ill person as 'not himself' we must be clear about the connection between behaviour and disease. Every part of our body influences our behaviour. If we have arthritis, we cannot move normally. If we have glaucoma, we cannot see normally. The organ affecting behaviour most directly is the brain. If it is seriously damaged, we die; if less seriously damaged, we lose a wide range of bodily functions, such as the ability to see or speak. The question we must keep in mind is: when and why do we attribute a person's behaviour to brain disease, and when and why do we not do so? Briefly, the answer is that we often attribute bad behaviour to disease (to excuse the agent); never attribute good behaviour to disease (lest we deprive the agent of credit); and typically attribute good behaviour to free will and insist that bad behaviour called mental illness is a 'no fault' act of nature.[6]

Madness, malady, and morality

The disease model of derangement is soundly based, of course, in the illness

now known as neurosyphilis or paresis. In seventeenth-century England, syphilis caused many people to become mad. But many mad people did not have syphilis. The paucity of medical knowledge at the time made it virtually impossible for people to know whether a particular person's abnormal behaviour was or was not due to brain disease. However, even then, there was a simple and reliable method for distinguishing persons whose brains were being destroyed by syphilis from those who went mad for other reasons. The syphilitic madmen died, usually within a year or two after admission to hospital, whereas the healthy madmen often outlived their sane mad-doctors.

Although a person may behave abnormally because he has a brain disease, the typical madman behaves the way he does because of his particular adaptation to the events that comprise his life. Examples abound in Shakespeare's tragedies. King Lear goes mad because of his poor choice for retirement. Lady Macbeth is driven mad by guilt and remorse over a criminal career. Hamlet breaks down under the stress of discovering that his mother and uncle murdered his father. Yet, none of these persons is relocated in a madhouse. Why? Because there are no madhouses. A century later, the practice of resolving such family conflicts by letting the stronger party psychiatrically dispose of the weaker one was well on its way of becoming accepted in principle, established in practice, ratified by law, and embraced by the public.

Some people have always found it difficult to grow up and assume the responsibilities of adulthood. Formerly, the person who failed to meet this universal challenge – who remained unskilled, unmarried, unemployed, and unemployable – was cared for in the family, or became a vagrant, leading a marginal existence. His relatives, if they were educated, might have called him a 'tatterdemalion'. Now they call him mentally ill, usually schizophrenic. Regardless of such a person's medical condition, there is a clear and critical connection between the value we attach to life, liberty and property and the idea of insanity or mental disease. The 'misbehaviour' of a prostate is not a moral issue, but the misbehaviour of a person is. The distinction is useful for the observer-respondent: if he accepts the moral dimension of insanity, he is faced with an ethical-political problem, whereas if he rejects it, he is faced with a medical-technical problem.

Finally, I want to acknowledge the rationale, though not the validity, of bracketing the insane with infants. There are similarities between the behaviour of an adult who does not eat or sleep properly, neglects his possessions, perhaps even attacks his relatives, and the behaviour of an unruly child.[7] That analogy forms the basis for the legal-psychological strategy of treating the insane as if they were (like) infants. Correlatively, the relatives of a misbehaving adult (madman) feel compelled to protect him as well as themselves from his embarrassing and destructive behaviour. That similarity forms the basis for the legal-psychological strategy of letting

psychiatrists act as the guardians of their mental patients, as if they were parents and the patients were (like) children.

The madhouse as surrogate home

When the trade in lunacy began, the individuals incarcerated as insane were members of the propertied classes who posed a problem to their families. The sane relatives' problem was not finding a home for a homeless person, but finding a justification for removing the lawful occupant of a home from his residence and relocating him in someone else's home. Although the historical record is clear, Michel Foucault constructed a history of psychiatry that has confused the matter. Influenced by his Marxist bias, he traced the origin of the practice of incarcerating madmen to the segregation of lepers and, more specifically, to the large-scale confinement of urban indigents in France in the seventeenth century.[8] Some of what Foucault described happened. But it was not the way the systematic confinement of persons diagnosed as mad came into being. Individual rights were virtually non-existent in seventeenth-century France. They were assuredly non-existent for the propertyless French masses. Hence, imprisoning the rabble in 'general hospitals' did not require the pretext of insanity as an illness. Moreover, it is simply not true that institutional psychiatry represented the beginning of a new mode of warfare between the haves and have-nots, the former resorting to the tactic of labelling the latter as insane in order to remove them to the madhouse. The incarceration of rich persons in private madhouses came first and was followed, considerably later, by the incarceration of poor persons in public insane asylums. Roy Porter emphasizes that psychiatry was *not*:

> a discipline for controlling the rabble ... Provision of public asylums did not become mandatory until 1845. . . . Even at the close of the eighteenth century, the tally of the confined mad poor in Bristol, a town of some 30,000, was only twenty . . . [Whereas] about 400 people a year were being admitted to private asylums.[9]

The clergyman as mad-doctor

Except for some historians of psychiatry, few people realize that the early madhouses were not hospitals, but were simply the keepers' homes into which they took a few, often only one or two, madmen or mad women as involuntary boarders or house-guests; or that the keepers, who owned and operated these private madhouses, were lay persons, principally clergymen; and that the connection between religion (the cure of souls) and mad-doctoring (the cure of minds) made good historical sense.

The practice of healing began as an undifferentiated religious-medical enterprise. Later, as the social world split into sacred and profane parts, the practice of healing also split, one part remaining a sacred, religious activity, the other becoming the secular profession of medicine. In the West, this

separation occurred twice: first, with respect to the body, in Greece, two and a half millennia ago; second, with respect to the mind, in England, less than four hundred years ago. Since the Enlightenment, spiritual and scientific healing have become, and have been perceived as, distinct and separate enterprises.

There is a long Western tradition of interpreting insanity in religious terms; treating it as due to demonic possession, by means of exorcism; and, most importantly, viewing clerical coercion as morally laudable and politically legitimate. When people believed that eternal life in the hereafter was more important than a brief sojourn on earth, torturing the possessed person to improve the quality of his life after death was regarded as an act of beneficence. Hence the long history of lawful clerical coercion.

In contrast, before the seventeenth century, there was no historical tradition justifying the use of force by physicians. Unlike the doctor of divinity, the doctor of medicine had no right (as yet) to imprison and torture his patients. In fact, when Englishmen first tried to enlist the doctor in the service of diagnosing and disposing their problematic relatives, the physician, as Shakespeare showed in *Macbeth*, declined the invitation. This rejection was consistent with the physician's historical mandate. From ancient times, his help was sought by suffering persons on their own behalf, or by healthy persons on behalf of relatives too disabled to seek help for themselves. The clergyman laboured under no such tradition, which explains his role as pioneer mad-doctor and madhouse keeper. Subsequently, as the clergyman's power diminished, the mad-doctor's increased, and theological coercion was replaced by psychiatric coercion.[10]

The private madhouse: a 'home' for paying guests

The trade in lunatics must be understood in economic and social terms. The enterprise satisfied the existential needs of the lunatics' relatives, and the economic needs of the entrepreneurs who supplied the demanded service.[11] The madhouse keeper's retainers were wealthy, able and willing to pay him to relieve them of the company of their unwanted relative. The keepers were relatively impecunious, eager to please their paymasters. Contemporary observers recognized what was happening. Thomas Bakewell, himself the proprietor of a madhouse, observed: 'The pecuniary interest of the proprietor and the secret wishes of the lunatics' relatives, led not only to the neglect of all means of cure, but also to the prevention and delay of recovery.'[12] Another madhouse keeper wrote: 'If a man comes in here mad, we'll keep him so; if he is in his senses, we'll soon drive him out of them.'[13] The practice of involuntary mental hospitalization thus began as a private, capitalist enterprise. Like chattel slavery, psychiatric slavery of course had to be sanctioned by the state.

Because madhousing was soon transformed into a largely statist programme of confining troublesome poor people, the entrepreneurial origin of

psychiatry as a form of private imprisonment merits re-emphasis. In the seventeenth century, England was essentially a two-class society, consisting of those who owned property and those who did not. Because wealth, especially land, generated income, members of the propertied classes did not have to work to procure a livelihood for themselves and their families. The poor, whose only property was their labour, had to work or face destitution. Because they had no 'real' property other than their daily labour, their relatives had nothing to gain, and much to lose, by having them declared mad. The very poverty of the poor thus protected them from the ministrations of the early mad-doctors.

Ironically, long before the misery of poorly paid factory workers generated denunciations of private profit, the early critics of madhouses blamed the abuses of the trade in lunacy on the profit motive. It was an important factor, to be sure, but it was merely a symptom. Forbes B. Winslow, the proprietor of two private asylums, denounced the practice of patients being 'brought into the market and offered for sale, like a flock of sheep, to the highest bidder'.[14] He was referring to the practice of madhouse keepers advertising for 'guests'. A typical advertisement ran as follows: 'Insanity. Twenty per cent. annually on the receipts will be guaranteed to any medical man recommending a quiet patient of either sex, to a first class asylum, with highest testimonials.'[15] *Plus ça change* . . . Today, private mental hospitals not only advertise their services but encourage their staff to double as psychiatric bounty hunters. It hardly needs adding that the madhouse keepers hawk their wares not to the so-called patients but to their relatives who are eager to get rid of them. Since government and insurance programmes now pick up the tab, this tactic has become more tempting and more popular than ever.

Unfortunately, the early critics of the madhouse business aimed their fire at the wrong target. The root problem was not profit but power, the mad-doctor's power to lawfully transform a sovereign British subject from person into mental patient and thus deprive him of liberty.

Madness: an 'English malady'?

My thesis is that, like limited government, the free market and the workhouse, mad-doctoring was also an English invention. This interpretation is supported by the writings of seventeenth-and eighteenth-century English physicians, who maintained that mental illness was a peculiarly English malady.

In 1672, Gideon Harvey, physician to King Charles II, wrote a treatise titled, *Morbus Anglicus*, a term he used for 'hypochondriacal melancholy'.[16] Fifty-one years later, George Cheyne popularized this notion in his classic, *The English Malady*. That antique work remains of considerable interest because it already clearly exemplifies the confusion, still characteristic of psychiatry, of metaphorical maladies of the soul with literal diseases of the body.[17] 'The Spirit of a Man', wrote Cheyne, 'can bear his Infirmities, but a

wounded Spirit who can bear? saith a Prophet. As this is a great Truth in the Intellectual World, so it may allude to the *Human* machine . . .'[18] To what 'conditions' did Cheyne refer when he categorized them as instances of the 'English Malady'? They were 'Spleen', 'Vapours', 'Lowness of Spirits', 'Hysterical Distemper' and other similar 'ailments'. Despite naming 'it' 'Lowness of Spirits', he explicitly identified that 'condition' as a bodily disease, and recommended treating it with mercury, antimony, and other arcane compounds and concoctions, as well as dietary regimens and purgatives.[19]

Pioneer critics of the practice of madhousing

Madhousing the unwanted family member was a novel method for coping with age-old familial and social problems. Since every solution of a human problem creates a new set of problems, protests against the novel practice typically arise in the same cultural milieu as the reforms. The Industrial Revolution and the Luddite revolt against the machine both began in England. And so did the protests against what we now term 'psychiatric abuses'.

False commitment: the wrong target

Insofar as insanity is accepted as a justification for depriving a person of liberty, the basic risk inherent in involuntary mental hospitalization becomes analogous to the risk inherent in imprisoning criminals. In each case, a person might be wrongfully identified, as suffering from insanity or being guilty of a crime, and wrongfully deprived of liberty.

Preoccupation with the wrongful confinement of sane persons in insane asylums, called 'false commitment', is a leitmotif that runs through the entire history of psychiatry. The history of this protest movement is characterized by the stereotypical claims of incarcerated mental patients that they are sane and have been misdiagnosed as insane, while at the same time enthusiastically supporting the diagnoses of their fellow victims as insane and applauding their incarceration as just and proper. Evidently it never occurred to the protestors to challenge the legitimacy of psychiatric slavery itself. The mad, no less than the sane, accepted the principle that the illness called insanity justifies incarcerating the patient.

However, madmen and mad women claiming to be sane were not the only critics of the madhouse system. Their impeached pleas were amplified and supported by the unimpeachable voices of journalists and men of letters. These critics alerted the public to the fact that individuals were often committed not because they were insane but because they were the victims of scheming relatives and greedy madhouse keepers. These accusations were supported by anecdotes of philandering husbands committing their innocent wives, and greedy children confining their harmless elderly parents.

Obsession with false commitment thus obscured the fundamental issue of the freedom-and-responsibility of the so-called mad person, and reinforced the belief that incarcerating the truly insane was in the best interests of both the patient and society.

Daniel Defoe

Daniel Defoe (1660–1731), famous as the author of *Robinson Crusoe*, was what we would now call an investigative journalist. As such, he was also a pioneer critic of the business of mad-doctoring. Like other madhouse reformers, Defoe objected only to the confining of sane persons, an abuse he attributed partly to the selfishness of the relatives initiating the commitment process, and partly to the rapacity of the madhouse keepers. He wrote:

> This leads me to exclaim against the vile Practice now so much in vogue among the better Sort, as they are called, but the worst sort in fact, namely, the sending their Wives to Mad-Houses at every Whim or Dislike, that they may be more secure and undisturb'd in their Debaucheries . . . This is the height of Barbarity and Injustice in a Christian Country, it is a clandestine Inquisition, nay worse. . . . Is it not enough to make any one mad to be suddenly clap'd up, stripp'd, whipp'd, ill fed, and worse us'd? To have no Reason assign'd for such Treatment, no Crime alledg'd or accusers to confront? ... In my humble Opinion all private Mad-Houses should be suppress'd at once.[20]

Note that Defoe speaks only of the practice of locking up persons of 'the better Sort', as he called members of the propertied class. The large-scale commitment of the poor in public madhouses lay still in the future.

Because they never questioned the idea of mental illness or the legitimacy of incarcerating persons diagnosed as insane, the critics of false commitment accomplished less than nothing. By shaming the madhouse keepers and society into prettifying the psychiatric plantations, they preserved and strengthened the system of psychiatric slavery.[21] Psychiatrists became more sophisticated, concealing incarceration as hospitalization and torture as treatment. After 1800, the persistence of psychiatric abuses is attributed to a succession of fashionable scapegoats, such as untrained or sadistic doctors, inadequate government funding, the severity of the patients' diseases, the inadequacy of available treatments, and, today, to the overuse or underuse of psychiatric drugs.

Anton Chekhov

One of the most moving criticisms of involuntary mental hospitalization is Anton Chekhov's novella, *Ward No. 6*. Written in 1892, it is a veiled, but none the less powerful, attack on the entire system of psychiatric incarceration. The gist of the story is this.

Andrew Ephimich Raghin, an aimless young doctor, takes a job at a provincial mental hospital. After he assumes his post, it is made clear to him

that he is expected to play the part of a feudal master, leaving the care of the patients to the brutal hospital attendants. Although warned against mingling with the inmates, to relieve his boredom he drifts into engaging one of the patients in conversation. Soon, the patient appears to be quite sane to him, and he, the doctor, appears to be increasingly more mad to his acquaintances. As the story nears its climax, Ephimich is declared insane and imprisoned in the same cell as Ivan Dmitrich, the patient he befriended. This appalling scene follows:

> 'But suppose I were to go out of here, what harm would that do anybody?' asked Andrew Ephimich . . .'I can't understand this! Nikita, I must go out!' . . .
>
> 'Don't start any disorders, it's not right!' Nikita [the attendant] admonished him.
>
> 'This is the devil and all!' Ivan Dmitrich suddenly cried out and sprang up. 'What right has he got not to let us out? How dare they keep us here? The law, it seems, says plainly that no man may be deprived of liberty without a trial! This is oppression! Tyranny!'
>
> 'Of course it's tyranny!' said Andrew Ephimich, heartened by Ivan Dmitrich's outcry. 'I've got to, I must go out! He has no right to do this! Let me out, I tell you!'
>
> 'Do you hear, you stupid brute?' Ivan Dmitrich shouted, and pounded on the door with his fist. 'Open up, or else I'll break the door down! You butcher!'
>
> 'Open up!' Andrew Ephimich shouted, his whole body quivering. 'I demand it!'
>
> 'Just keep on talking a little more!' Nikita answered from the other side of the door. 'Keep it up!'
>
> 'They'll never let us out!' Ivan Dmitrich went on. . . . 'They'll make us rot here! . . . Open up, you scoundrel, I'm suffocating!' he cried out in a hoarse voice and threw his weight against the door. 'I'll smash my head! You murderers!'
>
> Nikita flung the door open, shoved Andrew Ephimich aside roughly, using both his hands and one knee, then swung back and smashed his fist into the doctor's face.
>
> Ivan Dmitrich let out a yell. Probably he, too, was being beaten. . . .
>
> Toward evening Andrew Ephimich died from an apoplectic stroke.[23]

And so the story ends. Chekhov, himself a physician, knew whereof he spoke.

English literature and the origin of mad-doctoring

When Shakespeare wrote his great plays, there were no private madhouses in England. One hundred years later, the trade in lunacy was a flourishing industry. Shakespeare's tragedies thus provide a superb, and surprisingly neglected, source for tracing the origin of mad-doctoring.[23]

Are Shakespeare's tragic heroes mad?

The longer I have pondered Shakespeare's portrayal of madness, the more impressed I have become with how psychiatrists, psychoanalysts, historians of psychiatry, and literary critics alike have distorted Shakespeare's depiction of madness. They have done so by concentrating on the behaviours of the persons denominated as mad, ignoring the behaviours of the persons who so denominate them, and imposing psychoanalytic interpretations on the *dramatis personae* instead of letting the playwright have the last word.

From among a multitude of psychiatric studies of Shakespeare, I shall comment on one only, Sir John Bucknill's (1817–1897) *The Mad Folk of Shakespeare*, first published in 1859 as *The Psychology of Shakespeare.*[24] Bucknill, one of the founders of British psychiatry, took for granted that Shakespeare's tragic heroes were ill, in the literal, medical sense of the term. The psychiatrist's task, as he saw it, was to identify precisely what ailed them. To Bucknill, who knew that there were no insane asylums in England in 1600, this meant only that there was an unmet need for such institutions. He wrote:

> In his [Shakespeare's] time the insane members of society were not secluded from the world as they are now. If their symptoms were prominent and dangerous, they were, indeed, thrust out of sight very harshly and effectually; but if their liberty was in any degree tolerable, it was tolerated, and they were permitted to live in the family circle, or to wander the country.[25]

Bucknill acknowledged that the absence of mental hospitals in Shakespeare's time might signify that there was more tolerance for personal eccentricity in Elizabethan than in Victorian England, but failed to pursue this lead. Instead, he continued:

> That abnormal states of mind were a favourite study of Shakespeare would be evident from the mere number of characters to which he has attributed them, and the extent alone to which he has written on the subject . . . The consistency of Shakespeare is in no characters more close and true, than in those most difficult ones wherein he portrays the development of mental unsoundness, as in Hamlet, Macbeth, and Lear . . . It is on the development of insanity . . . that the great dramatist delights to dwell.[26]

In Bucknill's view, then, Shakespeare described the development of mental diseases. In my view, Shakespeare painted imperishable literary portraits of life as tragedy. Let us briefly reconsider, without psychiatric prejudgements, some of Shakespeare's mad/tragic heroes and heroines.

Aided and abetted by his loyal wife, Macbeth destroys his rivals and reaches the pinnacle of political power. Unable to relish the role she so hungrily coveted, Lady Macbeth becomes unhinged by guilt. She is

tormented by anguish, cannot rest or sleep, and 'hallucinates' blood on her hands that she cannot wash away. Macbeth summons a doctor to cure her. He does not ask the doctor to discover what ails Lady Macbeth; he just wants him to restore her to her 'premorbid' condition. However, the doctor quickly grasps the meaning of Lady Macbeth's madness and her husband's reasons for wanting to deny its meaning. He tells Macbeth that his wife is 'Not so sick, my lord / As she is troubled with thick-coming fancies / That keep her from her rest.'[27] Macbeth is not satisfied. He presses the doctor with these immortal words:

> Cure her of that:
> Canst thou not minister to a mind disease'd,
> Pluck from the memory a rooted sorrow,
> Raze out the written troubles of the brain,
> and with some sweet oblivious antidote
> Cleanse the stuff'd bosom of that perilous stuff
> Which weighs upon her heart?[28]

The doctor, conscientious and wise, remains unmoved. His exemplary reply is: 'Therein the patient / Must minister to himself.'[29] This answer leaves the disturbed and disturbing persons to their own devices, to cope with their problematic lives as best they can. With neither divorce nor commitment being available to Macbeth, both his and Lady Macbeth's options were limited – to murder and suicide.

In my reading of this play, part of its message is that personal misconduct is not a disease; that the troubling consequences of moral failure do not constitute a treatable medical condition; that the mad person needs moral, not medical, guidance; and, in the final analysis, that the patient must 'cure' himself. When this formula is inverted – when madness is accepted as a disease over which the patient has no control, and when the (mad)doctor is empowered to control him by force and fraud – then, and *only* then, can mad-doctoring as a profession arise and coercion begin to masquerade as cure.

While in *Macbeth* Shakespeare presents a 'nervous breakdown' as morally merited punishment for the actor's evil deeds, in *Hamlet* he exhibits the duplicity intrinsic to mad-doctoring. After Polonius realizes that Hamlet's erstwhile friends, Rosencranz and Guildenstern, have been enlisted as Gertrude's and Claudius's agents, Polonius ponders aloud:

> Tis too much proved, that with devotion's visage
> And pious action we do sugar o'er
> The devil himself.[30]

The metaphor of the 'devil sugared over' alludes to the pretence that foe is friend, that the effort to silence a person who suspects crimes in high places is an attempt to protect a madman from his madness. Hearing Polonius's words, Claudius acknowledges that his concern is not for Hamlet's mind but for his own soul:

[*Aside*] O, 'tis too true.
How smart a lash that speech doth give my conscience!
The harlot's cheek, beautied with plast'ring art,
Is not more ugly to the thing that helps it
Than is my deed to my most painted word.
O heavy burthen![31]

The scenarios of both *Macbeth* and *Hamlet* point to a powerful, albeit latent, demand for alternative housing for certain upper-class persons, a demand generated not by those to be rehoused, but by their relatives seeking to rehouse them. We touch here on some similarities between madhouses and prisons on the one hand, and homes and hotels on the other. In the former domiciles, individuals are rehoused involuntarily; in the latter, individuals rehouse themselves voluntarily. Because no such service existed, the would-be buyers turned to physicians, in effect asking them to expand their professional repertoire by providing madhousing. It was a reasonable proposal. Physicians were in the business of helping healthy people care for their sick, and therefore problematic, relatives. Lady Macbeth was a problem to her husband. He called for the doctor to help him. This triangular relationship – comprising a disturbing man or woman, his or her dissatisfied spouse, and a doctor – remains the main engine of psychiatry.

For Shakespeare and his contemporaries, it must have still seemed self-evident that the individuals who act madly as well those who define them as mad are responsible for their behaviour. No one's (mis)behaviour is excused as due to demonic possession, mental disease, or any other duress. Lady Macbeth is responsible for her crimes and her guilty conscience; Macbeth, for denying the meaning of his wife's dis-eased mind and trying to enlist a doctor in an immoral collusion; Claudius and Gertrude, for covering up their villainous deeds and trying to incriminate Hamlet as mad; and, perhaps most interestingly, Othello is responsible for becoming and being mad. Here is Shakespeare's affirmation of the central role of personal responsibility for our character and conduct:

Iago.
'tis in ourselves that we are thus, or thus. Our bodies are our gardens, to which our wills are gardeners; so that if we will plant nettles or sow lettuce, set hyssop and weed up thyme, supply it with one gender of herbs or distract it with many, either to have it sterile with idleness or manured with industry, why the power and corrigible authority of this lies in our wills.[32]

At the very moment when the idea of insanity as non-responsibility is developing in its mother's womb, Shakespeare presciently declares it a monster unworthy of life. Hamlet, Lear, Lady Macbeth, Othello, none is mad when he or she first enters the stage. They go mad before our very eyes. For Shakespeare, madness is the consequence of one's freely chosen

conduct, fated perhaps (in the classic Greek sense), but neither an excuse for evil nor an illness that requires medical attention. On the contrary, everything connected with madness is motivated action: Claudius and Gertrude attribute madness to Hamlet as a weapon of aggression; Hamlet feigns madness as a defensive ruse; Lear and Othello go mad because they have trusted imprudently or were immoderately jealous.

Jonathan Swift: 'A House for Fools and Mad'

Barely a hundred years after Shakespeare, the English people were as engrossed with the abuse of reason as madness as we are with the abuse of drugs as addiction. I have remarked elsewhere on some of the cultural and economic reasons for this development.[33] There were other, more subtle stimuli at work as well. Michael DePorte, for example, attributes the growing interest in insanity in the seventeenth century 'to the policy at Bethlehem Hospital of allowing visitors to come and go freely, a practice which not only gave writers a chance to observe madmen at first hand, but which also gave them an audience familiar with the behaviour of the insane.'[34] This is a perceptive and persuasive observation. Indeed, visiting Bedlam as if it were a zoo not only gave artists a chance to observe madmen, it also gave madmen an opportunity to address a more sympathetic audience than their fellow victims, disdainful keepers and hostile relatives.

Swift made many references to madness, almost all satirical. Like Shakespeare, he also took for granted that there is method in it. Specifically, he viewed madness as a tactic the madman chooses to enhance his self-esteem. In *A Tale in a Tub*, for example, he describes a madman as 'a tailor run mad with pride',[35] echoing Hobbes's interpretation of a half a century earlier: 'The passion, whose violence, or continuance, maketh madness, is either great vainglory which is commonly called *pride*, and self-conceit; or great *dejection* of mind . . .'[36] In the same essay, Swift satirizes the view that geniuses are insane and the sadistic practices that pass as mad-doctoring: '. . . *Epicurus, Diogenes, Appolonius, Lucretius, Paracelsus, Des Cartes*, and others, who if they were now in the world ... would in this our undistinguishing age incur manifest danger of *phlebotomy,* and *whips,* and *chains*, and *dark chambers*, and *straw*.'[37]

In his magisterial biography of Swift, Irvin Ehrenpreis writes:

> The theme of madness which runs through Swift's work normally carries the motif of power without responsibility. In Irish affairs it grows into the concept of a nation gone mad: Parliament as Bedlam populated by lunatics who think themselves statesmen, the kingdom as a land of absurdities . . . the machinery of government in Ireland has for its true function that of farcical entertainment, diverting people from their real problems.[38]

Shakespeare always, and Swift most of the time, view madness as a moral and political matter, not a medical malady. Both use the term *madness* as a

figure of speech, an evocation of the turmoil and tragedy of human existence, not as the diagnosis of a disease requiring medical intervention. However, Swift's conduct toward allegedly mad persons, himself included, was inconsistent with some of his writings. Although he characterized Bedlam as a place of 'phlebotomy, whips, chain, dark chambers, and straw', yet he joined the hospital's governing board and tried to commit one of his friends to it, who, Swift believed, 'went mad from thinking too long about the problems of calculating longitude'.[39] At the same time, he suggested that since 'incurable fools, incurable rogues, incurable liars, [and] the incurably vain or envious' qualified for admission to Bethlehem Hospital . . . 'a certificate as an "incurable scribbler" would elect him [Swift] a patient at the foundation.'[40] Said in jest but meant in earnest?

The most interesting evidence of Swift's concern with madness is his last will, in which he bequeathed his estate for the construction of an insane asylum in Dublin, which as yet had none. His poem, 'Verses on the Death of Dr. Swift', written in 1732, ends with this grand double-entendre:

> He gave the little Wealth he had,
> To build a House for Fools and Mad:
> And shew'd by one satyric Touch,
> No Nation wanted it so much.[41]

To his bequest of about eleven thousand pounds, a substantial sum at that time, other gifts were added, enabling the city of Dublin in 1757, 12 years after Swift's death, to open St. Patrick's Hospital, better known as Swift's Hospital.

For Swift, the immortal artist, madness was largely a metaphor for hypocrisy, perversity and stupidity. However, for Swift, the modern hypochondriac afraid of illness, madness was a disease that might even render the patient dangerous and hence justify his segregation. It must be recalled that during much of his adult life Swift suffered from Menière's disease, or labyrinthine vertigo, which was then a mysterious ailment that made him fear for his own sanity.[42] In the poem in which he recorded his bequest, he described his condition thus:

> That old vertigo in his head
> Will never leave him till he's dead:
> Besides, his memory decays,
> He recollects not what he says;
> He cannot call his friends to mind;
> Forgets the place where he last din'd.[43]

Swift's fear of going mad might signify a growing appreciation of the relationship between brain disease and the sorts of behaviours that were becoming understood as the symptoms of insanity.

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