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Madness and the city

Interactions between the mad, their families and urban society in Amsterdam, Rotterdam and Utrecht, 1600-1795

aan de Kerk, M.A.

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CHAPTER THREE

INTERVENING WITH MADNESS

Private care: community of care and treatment options

‘Madness is the most solitary of afflictions to the people who experience it; but the most social of maladies to those who observe its effects.’²⁶² This quote from Michael MacDonald reflects the enormous impact madness has on the family, friends and neighbours of a person afflicted. This is still true today, but was most certainly also true for the family members of a certain Jannetje Anseaux living in Amsterdam in 1701.²⁶³ Jannetje’s husband, brothers and children declared in a notarial testimony that, to their great grief and deep sadness, Jannetje had been afflicted with a gloomy personality and an illness of the brain after giving birth four years earlier. Ever since, she had had a terrible temper, did not want to talk to anybody, locked herself in her home, suffered from various delusions, abused her husband and prevented him from doing his work. The abuse and obstruction affected his breadwinning abilities, causing great harm to the whole family.²⁶⁴ This testimony is significant in that it reveals the voices of the caregivers who dealt with and cared for Jannetje during her episode of madness. But, equally important, it also shows that the document was drawn up to both address the problems caused by Jannetje’s behaviour and to explain how this affected the daily living situation of her caregivers. The caregiver’s voice can therefore help to understand how the mad were cared for outside the institution and the impact their behaviour had on the people close to them.

In the early modern period, madness was primarily dealt with in a private setting. Care in the community existed long before the establishment of institutions for the mad; in addition, these institutions also had a limited capacity – only being able to provide care for the worst and most dire cases. Private care was thus the rule and institutional care the exception. Despite its prevalence, this important intricate system of private care has been and remains an understudied area of the history of madness. In their edited volume, *Outside the walls of the asylum*, Peter Bartlett and David Wright have argued that three factors have contributed to this neglect: firstly, that for a long time, practicing physicians dominated the historiography; secondly, that the focus of researchers has been on the institutional and anti-institutional discourse; and thirdly, the fact that sources laying bare this phenomenon were hard

²⁶² MacDonald, *Mystical Bedlam*, 1.

²⁶³ Example published previously in: Aan de Kerk, ‘Strategic voices of care’, 66-67.

²⁶⁴ SAA, 5075 *Archief Notarissen*, inv. nr. 6473, 1461 (2 May 1701).

to find.²⁶⁵ In the Netherlands, little to no research has been done into this type of care in the early modern period.²⁶⁶ What we do know about private care in the early modern care system in the Dutch Republic can be derived from research that has focused on physical, and not mental, illnesses. Despite this lack of research, edited volumes on the task of healing and care and cure in the early modern period have shown the importance of care within the domestic environment.²⁶⁷ Indeed, historians have agreed that sickness and dying were social occurrences in this period that directly and intimately involved family and the social network.²⁶⁸ These conclusions have consequently triggered the thought that this type of care and social involvement must also have been essential in dealing with madness. Yet, mainly because madness was associated with stigma and thus mostly considered a more private matter, researchers assumed that sources revealing this phenomenon were not available. Nevertheless, by reading between the lines and using multiple source types, the world of private – extramural care – for the insane does disclose itself.

By reaching beyond the narrative of the institutional story alone and further, by integrating the institutional story with that of the extramural, this thesis offers insight into the daily reality of this type of care in three Dutch cities in the early modern period. The aim of this chapter is, therefore, to show how private care for the mad was organized. Firstly, I examine the groups that were involved and what their role was in this involvement. Secondly, the chapter explores the different care and cure options that were available to the early modern inhabitants of Amsterdam, Utrecht and Rotterdam. Finally, the chapter concludes with an analysis of the development of madness from a private to a public problem: significantly, identifying the circumstances that would eventuate into the request for admission into an institution and expose the delicate balance between the behaviour of the mad and the coping skills of the caregivers.

Community of care

In early modern cities, the sense of community and its involvement with problems such as poor relief, sickness and death was high. In the case of private care for the mad, the support was organized within a broad community of care, in which different people participated and multiple care options existed. The term ‘community of care’

²⁶⁵ Bartlett and Wright, ‘Community and its antecedents’, 1-19, p. 2-3.

²⁶⁶ For the modern period, there is more research into this phenomenon. For example: Vijselaar, ‘In and out’, 277-294.

²⁶⁷ For example: Marland and Pelling (eds), *The task of healing* and Gijswijt-Hofstra (ed.), *Op zoek naar genezing*.

²⁶⁸ Dekker and Roodenburg, ‘Sickness, healing and death’, 69-82, p. 79.

has been used in many different contexts but has generally indicated a type of care that was organized in the community.²⁶⁹ In this research, the community of care will be defined as the group of people who were involved with the care of the mad in urban society and the different care options they provided. The people who were involved with this system of private care can be found in the sources as both initiators and witnesses testifying about a particular situation. This group consisted of family members, friends, neighbours, employees, tenants and even professional carers (either paid or unpaid). Considering the fact that these groups were, in most cases, typically the ones who were directly affected by the behaviour of the mad (and had to deal with it as a result), this was not surprising.

Everybody in the community of care played their own part. It is important to stress that they also had their own intentions and goals when putting their voices to paper. Because people had different goals in mind when they drew up or testified in the sources, it is essential to take this into consideration when analysing the stories. To increase our understanding of this extensive caregiving community, the main objective of the first part of this chapter is to analyse who belonged to this group, why they got involved, and how.

Family care²⁷⁰

Madness was mostly dealt with in a family setting (at home). This was not remarkable, given that the family was the primary social unit for people to fall back on in times of need. As economic, social and emotional units, families were an essential part of the social fabric of the early modern city.²⁷¹ Yet, who was considered family and which family members were involved in the care of the mad? Over the last few decades, different ideas about what the term ‘family’ entailed in the early modern period have been discussed.²⁷² Terminology such as the nuclear family, the extended family and the household unit have all been used to indicate the different compositions of a family. To begin, the nuclear family, consisting of a (married) couple and their dependent children, was – and still is – regarded as the basic social unit. This concept differs from the extended family, which includes (aside from the

²⁶⁹ Horden and Smith (eds), *The locus of care*, 2-3.

²⁷⁰ The importance of family care and the different parties involved were also previously discussed in: Aan de Kerk, ‘Strategic voices of care’, 68-69.

²⁷¹ Spierenburg, *Zwarte schapen*; Schmidt, *Overleven na de dood* and Kooijmans, *Vriendschap*, have all demonstrated that, during the early modern period, the family was a force to be reckoned with in society and that it was both part of a system based on charity as well as a disciplinary network that defined behavior, either moral or immoral.

²⁷² Tadmor, *Family and friends*, 1-17.

nuclear family) other relatives such as aunts, uncles, grandparents and cousins. This differs again from the idea of a household unit, which refers to a house (residence) and its occupants, who may or may not be related to each other by blood or marriage. For instance, a household unit might encompass a merchant, his family and their employees (servants, workers etc.). To bring together the different definitions of family and also to connect them to the practice in which they were used in this period, Naomi Tadmor has coined the term, 'household-family'. This household-family consists of the head of the household and all his dependents, thereby including both family members and household staff in the unit.²⁷³ Tadmor adopted this term to explain the custom of extending familial care to those who lived under one roof in this period.

Although multiple definitions can be used, for the purposes of this study, primary care was mostly in the hands of the nuclear family: usually parents and spouses. However, a broader range of relatives can also be found in the sources such as: children, siblings, aunts, uncles, cousins, nieces and nephews. These sources indicate the involvement of the extended family in the caregiving process. Although Tadmor's concept of the household-family is certainly applicable, it will not be used to define family in this thesis. Rather, this group would be better classified as part of the larger social network for two reasons: first, because they did not have the same legal agency as family members; and second, because they fulfilled a different role in the care of the mad. As the following paragraphs will reveal, sources show that there were important differences between the nuclear family and the extended family, with the former playing a more active role and being more closely involved than the latter.²⁷⁴

Parents and spouses

Parents and spouses were the family members who were primarily concerned with the care of the mad: around 40 per cent of the notarial documents were drawn up on their initiative. As key players in the nuclear family, it does not seem odd that parents took this initiative. Children were the legal responsibility of their parents and as long as they lived in their household, these parents functioned as the main caregivers. Providing for children until they were deemed sufficiently responsible to attend to their own affairs and earn their own living was normal. Consequently, parents

²⁷³ *Ibidem*, 22-24.

²⁷⁴ This cooperation between the nuclear and the extended family can be found in multiple societies, such as those found in the Americas, continental Europe and even Taiwan according to Peregrine Horden in: Horden, 'Household care and informal networks', 21-67, p. 51.

remained important because children with mental problems either never reached this state of independence or fell back into incapacity during an episode of madness.²⁷⁵ However, parental responsibility did have its limits. Akihito Suzuki has stated that, even though parents cared for their mad offspring, they rarely helped lunatic children who had gotten married.²⁷⁶ Suzuki's conclusions would suggest that, when children left their parental house to marry, they distanced themselves from their original nuclear family and started a new one with their spouse. Hence, one nuclear family precluded the other. By marrying, these children (in a way) also proved their independence 'enough' to warrant parental distance.

Of course, the bond of marriage was strong in the early modern period, which explains why the engagement between man and wife was of great importance when we look at the care for the mad.²⁷⁷ It should be noted that the Dutch sources also contain combined statements from parents and spouses *together*, meaning that the rigid division suggested by Suzuki does not fully apply here. Instead, both parents and spouses were involved in the day-to-day care for the mad and their voices were the most prominent ones in the sources. They typically acted as initiators of the notary documents, consequently showing their agency and revealing stories about their private lives, struggles and home care.

The importance of parents in caring for the mad becomes particularly clear in the extensive corpus of notarial wills, as these documents include specific regulations to ensure that mad offspring would remain cared for after their parents' death. For instance, in her testament from 1603, Jannetje Jacobsdr. appointed two testamentary executors who needed to guarantee that all her beneficiaries (her children) received 92 guilders each and that all her other possessions would be sold and invested in annuities to support her simple-minded son Jacob until his death.²⁷⁸ Another will reveals that Heijndrick Evertsz. even arranged for his 'innocent' daughter Geertgen Heijndricks to be cared for by her cousin for a certain sum – still to be agreed on.²⁷⁹ These two examples do not necessarily signify, however, that family care was present in every family or available to everyone.

²⁷⁵ In the Dutch Republic, the family unit was often small and during the Golden Age, a new fascination with children and childrearing emerged. The outpour of publications on the topic and the many artworks featuring children displayed this. Also, in comparison to other countries, it has been said that the children were raised in the Dutch Republic with much freedom and were even classified by some foreign visitors as spoiled and well behaved.

Roberts, *Sex, drugs and rock 'n' roll*, 22-24 and De Mooij et al. (eds), *Kinderen van alle tijden*, 16-21.

²⁷⁶ Suzuki, 'Lunacy in seventeenth- and eighteenth-century England', 455-456.

²⁷⁷ Suzuki, 'The household and the care of lunatics', 153-175, p. 157.

²⁷⁸ SAA, *5075 Archief Notarissen*, inv. nr. 4, 479 (4 September 1603).

²⁷⁹ *Ibidem*, inv. nr. 16, 101 (28 March 1620).

In the sources, we find not only migrants who lacked the support of their family, but also ‘locals’, such as the Amsterdam-born and raised, Selena Arnouts, who could not count on her family network.²⁸⁰ In Selena’s case, the testimony drawn up by her neighbours narrated that a couple of months after Selena’s mother had died, her father left Amsterdam, leaving her alone and penniless. According to the testimony, she was a ‘simple-minded young woman’ who was unable to take care of herself, wandered the neighbourhood like a (stereotypical) town lunatic, and slept in improper places such as lavatories and doghouses.²⁸¹ She quickly became a victim of mockery and abuse: ‘Almost on a daily basis her clothes were ripped from her “full-grown woman’s body” by local boys and rabble, causing great turmoil in the neighbourhood’.²⁸² The testimony was made *pro deo*, which meant that these neighbours collaborated as a community to arrange shelter in a government institution for Selena, paid for by the government, thus showing the involvement of a broader social network. It is unclear as to whether this initiative was taken out of compassion for Selena or because they wanted to take her off the streets and end the upheaval in their neighbourhood. Nevertheless, this example shows the crucial role parents and spouses played in looking after the mad; for Selena, their absence clearly had a detrimental effect. Selena’s case also tells us about importance of focusing on the larger social network, which will be discussed later in this section.

What is remarkable in the sources made by both parents and spouses was the significant time people invested in managing the madness of their child or partner privately, before undertaking other steps. A case in point was an admission request made for Jacob Buijs.²⁸³ In this request, Jacob’s parents, Barend Buijs and Louisa Pfeiffer, declared that their 20-year-old son had become troubled in his brain four years after a severe illness. In the past years, ‘they had, as far as their limited economic means allowed this, invested their money in order to cure Jacob but without any results so far.’²⁸⁴ During the four years of Jacob’s ailment, he had also

²⁸⁰ See also: Chapter two, 52-53.

²⁸¹ SAA, 5075 *Archief Notarissen*, inv. nr. 6050, 977 (5 February 1710).

Original: ‘*Dat zij simpel en onnozel is.*’

²⁸² *Ibidem*.

Original: ‘*Dat Selena dagelijks als een gek en mal mens langs de straat loopt en zo door de jongens als andere kwaadaardige mensen werd geplaagd, getrokken en gesleurd met als gevolg dat dit dikwijls uitmond tot een schandaal in de buurt.*’

²⁸³ SAA, 342-6 *Archief van het Dol- of Krankzinnigenhuis*, inv. nr. 955 Stukken over opneming, staten van verplegingskosten en van eigendommen van verpleegden 1581-1792, Admission request for Jacob Buijs (22 January 1789).

²⁸⁴ *Ibidem*.

Original: ‘*Dat de supplianten voor zo verre hun gering vermogen heeft toegelaten hebben*

become more aggressive and less manageable at home; subsequently, Barend and Louisa had to ask for help more and more frequently. The duration of this situation – four years – in which both Jacob's condition and his parents' ability to help deteriorated, was not uncommon for this period. Nor was the statement Jacob's parents made about having employed all their economic means at their disposal before finally asking for institutionalization.

The fact that spouses fulfilled the task of initiator of action in a substantial number of the sources shows their commitment as main caregivers alongside the parents. High spousal involvement was not uncommon at this time. Perhaps, this was a consequence of a strong sense of marital responsibility or simply the intimacy that came from the close proximity that marked all social relationships in this period. That both husbands and wives played the same role in this process is noteworthy because it says something about the relationship between the genders and their authority. In this regard, research about the role of women in early modern Dutch cities has often classified women as relatively independent and able to provide for themselves.²⁸⁵ When it came to the care of their mad husband, the power and responsibility of these women is clearly revealed by the sources: both in that they were the main initiators of action and that they took over certain legal tasks from their mad spouse. For example, there is the case of Maria Ben, wife of surgeon Joannes Boshuijsen, who acted as the seller in a sale contract because her husband was without his senses.²⁸⁶ Another example is the case of Maertien Cornelis van der Knap, who negotiated with her neighbour about estate boundaries because her husband had been admitted into the Rotterdam asylum.²⁸⁷ One final instance that reveals the extent to which women could take over traditional male roles is that of lime vendor Aegje Simons. She gave permission to her daughter to marry Jan de Marree because her husband (whose task this would normally be) had been mad for several years.²⁸⁸

*gecontribueerd en te kosten gelegd wat tot herstelling van hun zoon konde dienen, vooralsnog te vergeefs.*²⁸⁵

²⁸⁵ Van der Heijden, *Misdadige vrouwen*, 35-38; Van der Heijden and Van den Heuvel, 'Sailors' families and the urban institutional framework', 296-309 and Phillips, *Well-being in Amsterdam's Golden Age*, 118.

²⁸⁶ SAA, 5075 *Archief Notarissen*, inv. nr. 6200, 305 (8 May 1704).

²⁸⁷ SR, 18 *Notarissen te Rotterdam*, inv. nr. 656, akte nr. 86, p. 150 (16 July 1654).

²⁸⁸ SAA, 5075 *Archief Notarissen*, inv. nr. 7255, 333 (13 April 1707).

Extended family

In his article on lunacy in seventeenth- and eighteenth-century England, Akihito Suzuki commented that, ‘outside the immediate family, the help of kin was almost non-existent.’²⁸⁹ The sources from Amsterdam, Rotterdam and Utrecht, offer a rather different picture of family care and the involvement of the extended family. Even though the extended family was less involved than either parents or spouses, other family members do appear regularly in the sources. Siblings, aunts and uncles, even children initiated the drawing up of documents, testified in them, and took on the care for a mad family member. In the case of the notarial will of Johanna Jacoba Ploos van Amstel, she had insisted that her inheritance was used to provide her mad sister Isabella with ‘the proper care for a lady of her standing’.²⁹⁰ She also explicitly stated that her sister could not be confined in one of the houses commonly used in such cases, which implies that she wanted to make sure that her sister remained cared for in a private setting.²⁹¹ Another revealing case is the contract from 1702 between Daniel Chabain, his wife and two their adult daughters on the one side and a certain Marc Bellanger on the other. In this contract, the care of the hypochondriac and mad Margaretha Chabain, who was Daniel’s sister and Marc’s wife, was arranged for the duration of her life. Her brother and his family committed to care for Margaretha in their household for a set amount of 35 soldis per week: all paid for by her husband.²⁹²

Other family members, such as nieces, nephews and cousins, were also involved when they testified about the situations of the mad. Here, the difference between initiating action and testifying in the sources provides us with a useful distinction in the roles people played. In the case of extended family, their involvement as initiators mostly occurred when the mad could no longer count on the help of a parent or spouse. These cases usually included people who were single, widowed, or when the parents passed away or were otherwise unable to care for them. In these situations, the caretaking responsibilities shifted to the extended family also as a result of the shifting of legal roles: being next of kin, they now became the legally responsible parties. The role of testifier was different to that of initiator, but no less significant. Indeed, the act of testifying was of great importance because the voices of these witnesses reflect the gravity of the situation and added weight to the document. Testifiers differed from initiators in the sense that they did

²⁸⁹ Suzuki, ‘Lunacy in seventeenth- and eighteenth-century England’, 450.

²⁹⁰ UA, 34-4 Notarissen in de stad Utrecht, inv. nr. U242a003, akte nr. 75 (2 March 1764).

Original: ‘Tot het behoorlijk alimenteren van gemelde haar zuster als een ordentelijke juffrouw toekomst.’

²⁹¹ Ibidem.

²⁹² SAA, 5075 Archief notarissen, inv. nr. 6476, 733 (23 September 1702).

not initiate action but assisting the initiators in the process, thus having a different agency.

Besides the family, a much larger group of people could get involved in the care of the mad. The social network, consisting of neighbours, friends, employees, tenants, employers and (professional) carers was also regularly involved in these situations. Distinctions between initiator and testifier can in these cases also help to categorize and distinguish the roles of the different people in the social network.

Social network

As already mentioned in the first chapter, the growing urban community was a place in which people lived closely together and were therefore part of each other's lives.²⁹³ Such close proximity created a strong sense of community and, hence, the nuisances caused by the mad were very much present in the public sphere. Consequently, madness – just like illness and death – was also seen as both a private and a social problem and the larger social network inevitably became involved. In this regard, the social network functioned both as a system of social support and of social control. More specifically, these groups assisted in a variety of situations but they also dictated certain social and cultural conventions. Hence, this network decided what types of behaviour were (and were not) acceptable in society and, together with the family, formed a disciplinary network guarding these boundaries.

Within this social network, neighbours and friends were the two groups that were most frequently represented in the sources in the roles of initiator and testifier. This tells us that these social groups exercised a certain authority. Indeed, the structure of early modern Dutch cities meant a strong neighbourhood connection and, in many cases, also a strong social network. Both conditions were essential for survival in this period; more importantly, these conditions also dictated the norms and values of these cities. Interestingly, it is especially the neighbours who were influential in this context. In her book, *Civic duty*, Manon van der Heijden has stressed the vital role of neighbourhoods in civic matters. For example, in some cities, neighbourhoods became formalized organizations with responsibilities such as keeping the peace and acting as intermediary between urban government and citizens. However, most of the help from this group was based on unofficial rules and unwritten moral standards.²⁹⁴ In cities where there was no official structure, neighbourhoods served on an informal level to regulate conflicts, preserve public

²⁹³ See also: Chapter one, 26-27.

²⁹⁴ Van der Heijden, *Civic duty*, 65-66.

order and deal with all kinds of irregular behaviour.²⁹⁵ Individual neighbours also helped each other in cases of illness and financial disaster: Hilde van Wijnwaarden, has even suggested that help from neighbours had more meaning than that of the family in this period.²⁹⁶ In her study, Van Wijnwaarden has shown that neighbours played both a significant part in providing primary support and in the judgement of who was entitled to poor relief.²⁹⁷

How this dual role of ‘support and control’ was practised is illustrated by the testimony made on the initiative of the neighbours of Amsterdam surgeon, Joannes Rentmeester, dated 1704.²⁹⁸ They declared that, ever since the preceding winter, Joannes had suffered from a saddening accident in his brain that had affected his intellect and caused him to lose his mind and the ability to conduct his own affairs. After the accident, he caused major disturbances to his neighbours, especially at night because he ‘raged and yelled like a mad person, keeping the whole neighbourhood awake’.²⁹⁹ He was also a threat to himself and had attempted suicide. It became apparent that he was completely incapable of taking care of himself when, on multiple occasions, his neighbours had found him in bed covered in his own urine and faeces and had to clean him up and put him in dry clothes.³⁰⁰ This example showed the duality of the role played by neighbours. Firstly, we see that Johannes’s neighbours are genuinely concerned for *his well-being* and, as caregivers, the neighbours exhibit support. Secondly, we also see the neighbours apply rules and boundaries, wanting to put a stop to the nightly disturbances, which reflects concern with *their well-being*: an explicit show of control.

When it comes to discussing the second social group – that of ‘friends’ – using this term in the early modern context requires some explanation. The word ‘friend’ had many different meanings in the seventeenth and eighteenth centuries and could therefore refer to multiple styles of relationships.³⁰¹ In his research about friendship and survival in the early modern period, Luuc Kooijmans has argued that friendships were of key importance due to the way early modern society was organized and how social cohesion was established.³⁰² This conclusion suggests that an overlap between the function of friend and neighbour existed and Kooijmans even

²⁹⁵ Ibidem, 66.

²⁹⁶ Van Wijnwaarden, *Zorg voor de kost*, 252.

²⁹⁷ Ibidem, 229-230 and 252

²⁹⁸ Example published previously in: Aan de Kerk, ‘Strategic voices of care’, 69.

²⁹⁹ SAA, 5075 Archief Notarissen, inv. nr. 7207, 997 (17 June 1704).

Original: ‘*Hij raast en tiert zo dat de getuigen van hun nachtrust worden beroofd.*’

³⁰⁰ Ibidem, inv. nr. 7207, 997 (17 July 1704).

³⁰¹ Tadmor, *Family and friends*, 167.

³⁰² Kooijmans, *Vriendschap*, 14.

went so far as to claim that both terms were used synonymously. The sources, nonetheless, seem to show that the reality was more complex.³⁰³ In the documents researched for this study, the relation between people and the mad were described rather precisely and the distinction between friends and neighbours was made regularly. Typifying someone as friend or neighbour did mean different things; neighbours could also be friends who lived in close proximity and friends could fulfil the same role as neighbours but lived elsewhere. Just like neighbours and family members, friends also took the initiative to have documents drawn up and thus could have certain authority in the care for the mad.

Other groups that belonged to the community of care included employees and tenants who, by living with the mad person or resided in the same house, had a close involvement with the situation. These groups also acted regularly as witnesses and are represented in the sources. However, unlike other groups mentioned above (family members, neighbours and friends), these groups never took the initiative to draw up a document. Speculating on why this was the case, it seems most plausible that the dependent financial position of this group played a significant part in this decision.

Other smaller, but influential groups in the social network were also found in the sources. Medical professionals were also part of the community of care in that they testified about the treatment they administered or gave their professional opinion about someone's condition. Once in a while, employers also pop up in the sources, mostly to testify to the incapacity of someone to work for them.³⁰⁴ In the literature on dealing with the mad in England, parishes were also mentioned as active agents in coping with the problem of lunacy. They were typified as part of a grey area between domestic and institutional care: 'Lunatics who could not be coped with by a household did not automatically suffer institutionalization, and parishes often played an important role in keeping lunatics out of institutions, by making use of parish nurses and boarding people out.'³⁰⁵ Research into the organization of poor relief in several Dutch cities has also indicated similar involvement by different religious communities.³⁰⁶ However, the extent of their involvement remains hard to

³⁰³ *Ibidem*, 15.

³⁰⁴ For example, in the cases of the simple-minded Hermanus Doornebosch who could not work as a baker's assistant and Wiggert van Schie who was unable to keep his job as a blacksmith's assistant. SAA, 5075 *Archief Notarissen*, inv. nr. 7216, 61 (5 July 1708) and SR, 18 *Notarissen te Rotterdam*, inv. nr. 3870, akte nr. 11, p. 30 (27 April 1709).

³⁰⁵ Suzuki, 'Lunacy in seventeenth- and eighteenth-century England', 446.

³⁰⁶ For example in: Van der Vlis, *Leven in armoede*, 38-40; Van Wijngaarden, *Zorg voor de kost*, 17 and Spaans, *Armenzorg in Friesland*, 228.

define from the sources as these communities mainly appear when payment was needed for a mad person within their community and only in some cases, when they provided other types of care such as boarding out.

Why were these parties involved?

People got involved in the care for the mad for multiple reasons and these reasons were usually closely related. First and foremost, people cared for the mad not only because they felt the responsibility to do so, but also because they had (in some way) a social connection to the afflicted person. Again, it is pertinent here to distinguish between people who were involved through the initiation of action or by testifying. The former group undertook action to change or handle a situation. They did so, for instance, because they could be held legally responsible for the actions of the mad – as was true for parents and spouses. The latter group – the testifiers – were those who took no action but were prepared to support those who did. They did so for various motivations; but most often to help strengthen the weight of the documents by emphasizing the severity of the situation.

People also got involved for more practical reasons: especially the disruptive and dangerous situations caused by the behaviour of the mad was the primary motivation behind involvement. As seen in the second chapter, the behaviour of the mad could cause many social problems, particularly damage, not only to the relatives' reputation, but also the neighbourhood's.³⁰⁷ People thus became committed to keeping the mad safe and to guard the social and moral boundaries of the urban environment. The prominent presence of all the caregivers can (to a large extent) be explained by their personal interest in handling the situation, either practical or emotional. Moreover, by addressing the behaviour and taking the proper measures to help the mad, they were able to deal with this private and yet social problem, by curbing any negative social consequences deriving from it.

The people who never initiated a document to be drawn up but only testified, did so on the request of someone else who needed these statements to support a case. This was often the situation when medical professionals or household staff and tenants testified. The importance of their voices becomes clear when looking at the testimonies given by a tenant and several household employees, a maid and two wet-nurses in the notarial document concerning Rica de Souza Britto (first mentioned in the preceding chapter).³⁰⁸³⁰⁹ Made on the request of Rica's husband, the witnesses

³⁰⁷ See also: Chapter two, 59-61.

³⁰⁸ SAA, *5075 Archief Notarissen*, inv. nr. 6053, 565 (14 July 1710) and 601 (15 July 1710).

³⁰⁹ Example published previously in: Aan de Kerk, 'Strategic voices of care', 69-70.

testified to her behaviour in the house. All stated that they were aware of Rica's situation because they lived or worked in her house. Rica was afflicted with a violent form of 'evil madness' and her anger was mainly directed at her own husband and children. Rica had, for instance, sworn to slit her husband's throat, hit him over the head with a stick, threatened to burn down the house and had delusions about the devil who had taken possession of her body. The real breaking point however, happened in the middle of the night when Rica had come out of her bed and banged on the door of her husband's room, screaming that she wanted to kill him. He did not open his door and she left. In her rage, she went to the room shared by the maid, the wet nurse and Rica's children and threatened to do the same thing to them if they did not open their door. When the maid opened the door, Rica called out to her: 'Give me a butcher's knife, I will knock down his door and slit his throat with it'.³¹⁰ After the maid gave her the knife, she again tried to enter her husband's chamber but, after this proved unsuccessful, she eventually calmed down. Rica's condition thus resulted in a clearly unsafe situation in which everyone in the household feared for their lives. The staff members and tenant all stated that it was no longer possible to live under the same roof as Rica. The witnesses further emphasized this by stating that precautions needed to be taken to prevent a great disaster.³¹¹ Undeniably, these voices were instrumental in assisting the family to change a dangerous and unsustainable situation. In this specific case, Rica's husband took the initiative but the testimonies from the tenant and his employees were crucial in the undertaking of concrete actions.

How were the mad cared for?

How a mad individual was cared for and managed depended on many factors: to a considerable extent, these were family factors. Decisions were made based on the financial resources of the carers and those of the deranged person, the deranged person's age, marital status, domestic arrangement and the behaviour of the individual: all factors which restricted the options available.³¹² Yet, as a rule, care consisted of keeping the mad at home for many years. During this time, the family tried to fit him or her into the 'normal' daily routine for as long as possible. The sources tell many stories of people being kept at home during their fits of madness

³¹⁰ Ibidem, inv. nr. 6053, 601 (15 July 1710).

Original: '*Geeft mij het hakmes [...] ik zal de deur van mijn mans kamer openslaan en mijn man met het mes de hals afsnijden.*'

³¹¹ Ibidem, inv. nr. 6053, 565 (14 July 1710) and 601 (15 July 1710).

³¹² Suzuki, 'Lunacy in seventeenth- and eighteenth-century England', 440 and Houston, 'Not simple boarding', 19-44, p. 34.

for longer periods of time that range from weeks to years. We also read about the simple-minded being cared for by their parents for the duration of their whole life. The testimonies that describe the struggles of families reveal that keeping the mad at home was not always the best solution. In many cases, the situation gradually escalated: madness became a serious social problem when the caregivers were no longer able to handle the care charge within a domestic setting.

Since the documents were drawn up when care in the domestic context failed, families that could boast successful home care do not (or to a limited extent) have a voice in the sources. Consequently, the voices most often relate stories of precarious situations and breaking points. Another difficulty of the limitations of the sources was that they (in general) say little about day-to-day care and focus on the moments of escalation. Only in a few cases can a glimpse be caught of the daily interactions. To take one example, the testimony made about Willem van der Voort on the request of his wife, Maria Ros, sheds some light on this. The witnesses recounted the story of Willem in the period from September 1706 until January 1707 in which he was typified as ‘not completely in control of his senses, not behaving as a human being who had his senses’.³¹³ The witnesses, consisting of a friend, a tenant and an employee, stated that Willem had been sitting in a chair shivering, drooling and crying at everything anyone said to him. On another occasion, Willem was sitting in the kitchen wanting to smoke his pipe but, because his pipe was empty, had trouble lighting it. He then stuffed his pipe with lettuce and again tried to light it – without success. The witnesses also declared that his simple-mindedness often resulted in rage, cursing and threatening his children and wife. These half-comic, half tragic glimpses into home care explicitly demonstrate the reality of such a commitment: it was unpredictable, perilous and heartrending.

Even within the home, multiple options for care were available and the mad who were kept within the private care system were not all cared for in the same manner. Home care was the option most often used to begin with and for longer periods of time, if the situation allowed for it. Other care options were then explored if the behaviour of the mad person required more attentive supervision. In these cases, the first step was usually supervision by a carer, either paid or unpaid. When researching this option of extended home care, it was striking to see that many people mentioned in the sources the assistance they had from others in guarding the mad in their house. Extended home care could come from other family members,

³¹³ SAA, 5075 *Archief van notarissen*, inv. nr. 6773, 1215 (24 June 1707).

Original: ‘*Willem niet volkomen bij zijn verstand was, doende het geen van een mens die zijn verstand had niet te verwachten was.*’

neighbours, friends or household staff. For example, in the notarial testimony from Amsterdam made on the initiative of the blood friends (*bloet vrienden*) of Nicolaes van Renselaer: these two men declared that they had been guarding Nicolaes in shifts during his stay in his mother's house on the Keizersgracht.³¹⁴ During these shifts, they noticed the condition Nicolaes was in, described as 'without senses' and dangerous because he tried to escape the house on multiple occasions.³¹⁵ People were also paid for guarding the mad, as becomes clear in an admission request for the correction house in Amsterdam. Here, the wine merchant Wouter van Tijsen revealed that he had hired a man to constantly watch his mad wife, Maria Laurens. Maria had lost her senses six weeks prior and displayed such behaviour – tearing apart her clothes, attacking other people and making it impossible for him to earn a normal living – that he was forced to hire paid help to keep her safe.³¹⁶

Guarding the mad was not the only way people tried to keep the mad safe within the home. Locking people up in their homes, or in a room, and constraining them was also employed to manage the mad. In Rotterdam, Jacob Casteleijn asked for permission to keep his son, Jan, in his home. Jan 'had been visited by a major fit of which medical professionals judged that this would worsen and lead to raging madness. Because of his madness Jan needed to be locked up and his father asked permission to, for as long as possible, first lock him up in his own home.'³¹⁷ Locking someone up or constraining them was used in the home as a last resort to keep people from hurting themselves and others. What is striking about this story is that permission was asked from the authorities before reverting to incarceration within the home. Clearly, madness did not immediately allow infringement of one's personal rights of freedom. In fact, constraining and binding someone by the hands and feet was a major step; in 1781, Marcus van Seventer explained why he felt he was forced to physically constrain his daughter Marianna. Two witnesses testified that Marianna had been robbed of her senses for a long time and that this caused great rage and evilness to such an extent that Marcus had been obliged to bind her

³¹⁴ The term blood friends (*bloet vrienden*) refers to relatives.

³¹⁵ SAA, 5075 *Archief notarissen*, inv. nr. 3610, 293 (17 September 1670).

³¹⁶ SAA, 5061 *Archieven Schout en Schepenen*, inv. nr. 1259 Register der door schepenen geconfinieerden met de requesten 1686-1695, Admission request for Maria Laurens (26 November 1692).

³¹⁷ SR, 230-01 *Archief van het Pest- en Dolhuis*, inv. nr. 178 Requesten met appointement inzake opneming van krankzinnigen 1654-1712, Admission request for Jan Casteleijn (26 April 1706).

Original: 'Is bezocht met een zwaar overval dat na het oordeel der doctoren Helvetuis en Spegt ende chirurgijn Asbergen van tijd tot tijd erger werd tot een razende dolheid van dat hij met langer kan werden bewaard maar dient te werden opgesloten dat hij suppliant eerst geerne zouden proberen in zijn huis en dat niet kunne te boven komen ja een publiek huis.'

by hands and feet and keep her locked in the house to prevent hazards.³¹⁸ The fact that permission was sometimes requested (and granted) for the physical constraint of the mad contradicts the image of random cruelty that has perpetuated notions about handling of the mad in the early modern household for years.³¹⁹ Indeed, these measurements to ensure both the mad person's safety and personal rights points to a more nuanced understanding of madness.

Boarding out: non-medical, medical and private institutions

If keeping someone at home and providing care in that setting was no longer an option, the mad were sometimes boarded out either to non-medical or medical carers. In most cases, this care was provided within a household atmosphere, but there was also the option of admission into private or semi-private institutions (houses of correction).³²⁰ The type of care strategy chosen depended on several factors, such as the behaviour of the mad and the resources of the main caregivers and the mad themselves. The larger the financial resources, the better the chances that the care for the insane remained in the household sphere. Providing lodging and care for the mad was also regarded as an acceptable way of earning a living and a regular practice for people. A good example of this can be seen when, in 1767, the city doctors from Utrecht were evaluating the situation of the mad Grietje Boll and stated that 'she should not be admitted to the asylum, but was more an object that needed to be boarded out with people who took in such simple subjects.'³²¹

A noteworthy part of the history of boarding out of the mad in the Low Countries can be traced to the Belgian city of Geel, whose own community of care had evolved over a period of 700 years.³²² Already in the thirteenth century, people had come to Geel with their mad family members to implore the city's patron saint, Saint Dymphna, for assistance. Soon the increasing numbers of pilgrims who came

³¹⁸ UA, 34-4 *Notarissen in de stad Utrecht*, inv. nr. U248a016, akte nr. 16 (11 July 1781).

³¹⁹ For example, in his influential book, *A history of psychiatry*, Edward Shorter stated that: 'Home care in the world we have lost was a horror story.' He backs up this statement with a couple of stories about abuse, incarceration and neglect by the family, showing (in my opinion) only a small part of the spectrum. I do not want to claim here that these terrible cases of neglect did not happen at all; however, I do believe that these were anomalies instead of the norm as regards this type of care. Shorter, *A history of psychiatry*, 2-4.

³²⁰ See also: Chapter one, 38-40.

³²¹ UA, 702-1 *Archief Stad Utrecht, secretarie 1577-1795*, inv. nr. 456 Requesten aan burgermeesters en vroedschap, houdende verzoeken om opneming van verschillende personen in het dolhuis 1678-1769, Admission request for Grietje Boll (July 1767).

Original: '*Zodat dezelve meer een voorwerp is die ergens dient te worden besteed en door mensen die dergelijke onnozele subjecten in huisvesting en kost innemen.*'

³²² Roosens and Van de Walle, *Geel revisited*, 13.

to Geel could not be accommodated and people in the village and county began to provide shelter. From the seventeenth century onwards, more and more people began to be boarded out in these 'boarding families', which had gathered fame, providing care and shelter to the mad.³²³ In the Dutch Republic, no such village existed but people were transported to Geel from the Netherlands.³²⁴ The sources from Amsterdam, Rotterdam and Utrecht do, however, provide a better understanding about the widespread system of boarding out in this period, even though, they also leave many questions unanswered. In most sources, the information about boarding out was often limited to one sentence, which simply stated that someone had been boarded out, making it more complicated to determine how this care was organized than the fact that it happened. Sometimes, further details could be gleaned, such as where the person had been boarded or to whom, but often these details themselves lead to more questions than understanding. Even simple information about the precise costs for this type of care and what the day-to-day life of a lodger looked like remain hard to establish with only limited information.

Non-medical care

The history of boarding out of the mad reveals a story of both coincidence and convenience. In the Utrecht archives, sources about private care were more extensive than for the other two cities. This source material allows us to delve into non-medical care of the mad, which consisted of boarding someone out with a private person. This person then had the task of watching over and caring for the mad. In a notarial testimony of 1783 about a certain Leendert Sonnenberg, a declaration was made by Adrianus Nijpoort, who had taken Leendert as a boarder for the last year and a half.³²⁵ He stated (on the request of Leendert's guardians) that Leendert had been unable to use his senses for several years but, in the last six months, his condition has worsened and he had become completely mad, displaying aggressive and dangerous behaviour. Therefore, Adrianus deemed it necessary that Leendert would immediately be placed under careful supervision and be detained. This example demonstrates that boarding someone out could last for a long period (in this case, a year and a half), but also that boarding out in the private setting was not necessarily suitable for the raving mad.

Church communities and the poor-relief organizations in the cities only interfered sporadically and, as the sources indicate, mainly when payments had to be

³²³ Ibidem, 17-20.

³²⁴ Ibidem, 20.

Still, in the Dutch sources used in this research no traces of boarding someone in Geel could be found.

³²⁵ UA, 34-4 *Notarissen in de stad Utrecht*, inv. nr. U272c006, akte nr. 14 (6 February 1783).

made for the care of the mad. Still, these religious communities occasionally became involved with boarding people out in the homes of individuals, as the following example demonstrates. In the admission request for Maria Jansen, made by the regents of Utrecht's Almoners' Chamber (*Aalmoezenierskamer*), it was stated that she was boarded out by the widow Mansvelt who lived at den Achterweg. Since Maria's behaviour deteriorated and she had become completely enraged, the widow was compelled to bound her hands and feet. The regents decided it was no longer possible to keep her in private care and requested admission into an asylum.³²⁶ Several incidences can also be found in Rotterdam's archives that show a preference for non-medical private care. For instance, Catharina Vettekeuken – who had been mad and incarcerated for three years in a house of correction (*Kleyn Padua*): her uncle Cornelis Rees asked for Catharina's discharge with the intention of boarding her out to a good and capable home of a resident.³²⁷ This last case is of specific interest to us because it not only demonstrates a preference for private care when possible, but also that people could return to urban society after confinement in an institution.³²⁸

It is important to state here that there seemed to be a difference between boarding someone out and having someone locked up with a private person or in a private institution. With boarding out, people were put under someone else's care and supervision, which did not mean that they were locked up. If it were deemed necessary to confine someone, it would seem that special authorization was needed by the town council.³²⁹ Whether this strict division was always kept in practice can be called in question; yet, especially in the second half of the eighteenth century, the burgomasters of Utrecht tried to enforce more supervision regarding practice of incarceration by inspecting the institutions and implementing regulations.³³⁰ Again,

³²⁶ UA, 709-4 *Archief van regenten van het Krankzinnigengesticht*, inv. nr. 2635-2 Requesten, vonnissen, overeenkomsten enz. betreffende de opneming van krankzinnigen in het gesticht 1770-1789, Admission request for Maria Jansen (21 November 1785).

³²⁷ SR, 230-01 *Archief van het Pest- en Dolhuis*, inv. nr. 192 Requesten met appointement en bijlagen inzake opneming, continuering en betaling van het verblijf, en ontslag van personen wegens wangedrag in resp. uit het Beterhuis 'Malta', gericht aan het College van de Weth 1725-1795, Multiple admission requests for Catharina Vettekeuken (28 October 1732, November 1732 and October 1733).

Original: '*Catharina bestellen in een goede en bekwame burgerwoning*.'

³²⁸ See also: Chapter four, 114-116.

³²⁹ UA, 34-4 *Notarissen in de stad Utrecht*, inv. nr. U087a001, akte nr. 174 (28 August 1719) and 702-7 *archief van het gerecht*, inv. nr. 3279 Rapporten, besluiten, reglementen en verslagen van visitation betreffende de verbeterhuizen, het toezicht daarop en de formaliteiten, nodig voor het plaatsen van personen daarin 1749-1767, Extract from the resolution of the burgomasters and magistrate of Utrecht (1 February 1768).

³³⁰ *Ibidem*.

this counters the image of an arbitrary system of care in which the mad could be randomly locked up by family or legal guardians without any oversight or control on this practice.

Medical care

Hiring a medical professional in the form of a physician, surgeon or ‘irregular healer’ to cure and care for the mad was also possible in the early modern Dutch Republic.³³¹ These medical professionals usually took in the mad, which was not odd because patients staying at the doctor’s house during treatment was common practice in this period. In the sources, there was often mention of one or several cure options being exercised but, unfortunately, none of the sources provide much information about the precise way the treatment was administered and whether the treatment was successful. What the different sources do show was that medical professionals were part of the private ‘mad’ business and that the options for care and cure were much more elaborate on the medical market than might be expected in this period.

A special find in this research was a group of five medical contracts from the notarial archive of Amsterdam. These were made between the physician, Joseph Celle, and the relatives of five mad people.³³² While analysing these contracts, all from the 1740s, a few things stand out. First, all patients were categorized as suffering from a brain disease and no details were given about how this manifested itself. The most obvious explanation for this was that the contract was not perceived as the proper place for noting this detail. Usually, before doctors entered into a contract with patients, a consultation took place so the doctor could assess the patient and decide whether he wanted to take this patient into his care.³³³ The actual contract was a formalization of a positive outcome of this first consultation and was, therefore, perhaps not the place to describe the affliction in detail. The contracts further stated that Celle would treat, care for and keep the patient at his home during the period of treatment. A second interesting feature of these contracts was the payment. Payment arrangements varied, but often an amount of approximately 5

³³¹ The term irregular healer is derived from other studies on the history of medicine in which the early modern medical market was described as consisting of a regular market, within which the officially trained specialists, physicians, surgeon and apothecaries worked and the irregular market, in which non-officially trained healers and quacks operated.

³³² SAA, 5075.X *Archief Notarissen*, inv. nr. 10700, 210 (23 December 1739), inv. nr. 10702, 228 (22 June 1740), 314 (19 August 1740), 372 (19 September 1740) and inv. nr. 10703, 463 (17 November 1740).

The documents about Joseph Celle were previously used in: Aan de Kerk, ‘Strategic voices of care’, 71.

³³³ Steendijk-Kuypers, *Volksgesondheidszorg*, 278.

guilders was paid weekly with an additional payment ranging from 160 to 300 guilders.³³⁴ The first half of this amount was paid on entering into the contract and the second half after the patient was cured. These prices establish that Celle's clientele came from the more affluent classes because such amounts could not be afforded by the lower or even middle classes. The third and most remarkable aspect of these contracts was the agreement that, if the patient had been cured but during his or her life would relapse, Doctor Celle was obliged to treat the patient once again without receiving any additional payment. The fact that this relapse 'danger' was calculated into the cost and the contract tells us something about ideas held concerning the nature of these 'brain diseases'.³³⁵

Not only physicians were involved in the care and cure of the mad: surgeons, too, were found regularly in the sources. We see, for instance, in the judicial archive of the *Schout* and *Schepenen* in Amsterdam, a request made by the guardians of the mad Henricus Bott to transport him to Maarssen and have him board with and treated by a local surgeon there 'for his frenzied state'.³³⁶ The two most plausible explanations as to why the guardians wanted to move Henricus to Maarssen could be that they either wanted to move him from sight to prevent stigma, or, the expertise of this surgeon was renowned and sought after.

On the medical market, yet another group was involved; the irregular healers. These 'healers' claimed to be specialized in taking care of and curing the mad but were not officially trained and registered at the *Collegium Medicum* or surgeons' guild. This group is only rarely mentioned and just two examples were found in the sources to confirm their existence. In a notarial document from 1639, we discover that Nicolaas Agges, described as a 'master of the mad', was in the business of curing the mad. For this purpose, he had built several 'dark houses' on his property located on the Engelse Pad in Amsterdam, where the mad could be held.³³⁷ In the rest of the testimony, a story about the baker, Wessel Wesselsz., was

³³⁴ Luiten van Zanden, 'De economie van Holland', 566. He calculated that the average wage of a labourer in Holland in the early modern period was between 250 to 300 guilders a year, thus not leaving much scope for extra expenses.

³³⁵ SAA, 5075.X *Archief Notarissen*, inv. nr. 10700, 210 (23 December 1739).

Original: 'hersens ziekte'.

³³⁶ SAA, 5061 *Archieven van de Schout en Schepenen*, inv. nr. 1259 Register der door schepenen geconfinieerden met de requesten 1686 -1695, Request for Henricus Bott, p. 56 (5 April 1692).

Original: 'Hendrick Bott is te Oude Maersen ten huise van zekere chirurgijn omme aldaar enige frenesie te werden gecureerd.'

³³⁷ SAA, 5075 *Archief Notarissen*, inv. nr. 706B, 59 (26 November 1639).

Original: 'Meester van krankzinnigen' and 'Dat Nicolaes Agges curerende personen die krankzinnig zijn waarvoor hij donkere huisjes heeft bij zijn huis op het Engelse Pad waar

told: he had become mad and was brought to Agges to be cured. Wesselsz. was described as mad and aggressive and he was brought to Agges, his hands and feet bound in shackles. Once he was placed in the little house, he remained chained to a pole for the duration of a month.³³⁸ This example reveals much about the existence of this type of ‘medical’ help and how it was arranged. Not only do we garner information about the circumstances in which Wesselsz. was kept, but also the location of these little houses, built outside of the original city walls. These points are quite significant: cases of mad people being cared for *outside* the cities walls and in this *type* of care can also be found in Utrecht and may also suggest that removing someone from the urban centre was one form of harm prevention.³³⁹

The second example of the involvement of this group of healers was a source in which an octroy was granted to Hendrik de Graaf by the provinces of Holland and West Friesland so that he could sell his medicine to cure ‘people, who because of illness, epilepsy, or angry imagination, were being touched in the senses in such a way that they had lapse[d] into lunacy and madness’ in these regions.³⁴⁰ This document specifically stated that he was neither a doctor nor a surgeon; nevertheless, he was granted permission to sell his medicine anyway. He was also allowed to cure the mad in his home in Beverwijk. What makes this document even more extraordinary was that it also specified that he could lock the patients in his care in his home for the purpose of cure – as long as the magistrates of the city or village were informed and had complied with the incarceration. Again, the knowledge and requisite agreement of government bodies in the confinement of patients contradicts the horror image of random incarceration in the early modern period. The position of irregular healers in the medical market in the Dutch Republic was a special one: they were only allowed to practise with permission from the local authorities; although, in many cases, they also knew how to get around these regulations.³⁴¹

mensen kunnen logeren.’

³³⁸ Ibidem.

³³⁹ Another example of care outside the city walls: UA, 709-4 *Archief van regenten van het Krankzinnigengesticht*, inv. nr. 2522-1 Resolutiën van de broeders van het Dolhuis (sedert 1820 huismeesters en regenten) 1593-1737, Transfer of Anna Gouslijn (17 January 1647).

³⁴⁰ SAA, 27-1 *Archief van het Collegium Medicum*, inv. nr. 65, Akte van octrooi door de Staten van Holland en West-Friesland verleend aan Hendrik de Graaf voor de behandeling van zwakzinnigen, 1722.

Original: ‘*Waardoor hij genas zodanige menschen die door siekte, toevallen, of quade imaginatien of verbeeldingen in het verstand waren geraakt so dat dezelve in meijmeringe sinnelooshijt ja selfs in dolligheijt waren vervallen.’*

³⁴¹ De Waardt, ‘Op de grens,’ 29-46, p. 30.

Private confinement

Locking someone up in the private care system for the mad could either be done in the household, by individuals or in private or semi-private institutions for the mad (houses of correction). As noted in chapter one, two types of these institutions can be distinguished: municipal houses of correction and private houses of correction. The difference between the two is that the municipal houses were managed or rented out by the city government and the private ones were privately owned.³⁴² The private madhouse business was rather significant in England and Scotland; in the Netherlands, only patchy information about this type of practice can be uncovered. The houses of correction in the three cities were monitored by either the burgomasters (mayors), the *vroedschap* (city council) or the *schepenen* (aldermen) and can best be described as semi-private institutions. Most information about these institutions was found in the archive of Utrecht; unfortunately, the archives of the house of correction in Amsterdam and Rotterdam yielded little information due to the former's lack of transmission of archival material and the latter's integration with the city's asylum. The sources from Utrecht, which all dated to the eighteenth century, were diverse; however, combining them with the limited information from the other two cities does give insightful information about how these houses worked and the clientele they catered for.

In Utrecht, not anyone could start up a house of correction or keep people locked up. Special permission was necessary for this and regulations needed to be obeyed by the wardens of such establishments.³⁴³ The sources from Utrecht disclose that the city had multiple private institutions and the government took the initiative to inspect these houses of corrections to ensure that all ran smoothly. As a result, the sources contain information on the organization of the houses and who was allowed to be admitted. In a 1749 visitation report on the institutions, it was specifically stated that the houses were also meant for 'people who missed the proper use of their senses and reason and, as a result of this, were unable to govern themselves or were a danger to the people around them'.³⁴⁴ In the same account, the aldermen made it very clear that one of their greatest concerns was the fact that the houses were frequently used

³⁴² See also: Chapter one, 38-40.

³⁴³ UA, 702-7 *archief van het gerecht*, inv. nr. 3279 Rapporten, besluiten, reglementen en verslagen van visitaties betreffende de verbeterhuizen, het toezicht daarop en de formaliteiten, nodig voor het plaatsen van personen daarin 1749-1767, Regulations for the warden of the houses of correction with incarcerated in Utrecht (1771) and Regulations for the process of admission (22 July 1775).

³⁴⁴ *Ibidem*, Report after visitation of the houses of correction (11 October 1749).

Original: '*Dat persoonen, die 't gebruik van hun verstand en reden missen en daar door of zig zelven niet kunnen ernereren, of voor zig en hun mede mensch gevaarlijks zijn.*'

to lock people away for life. However, these houses were not designed for this purpose.³⁴⁵ They therefore advised the city government to keep a stricter eye on this misuse and to ensure the rights of those incarcerated, either via governmental or private channels. These rights were, for example, the ability to write letters to family or friends on a monthly basis and attend a religious service on Sunday (if they were with reason).³⁴⁶

The visitation reports and extracts from the resolutions of the burgomasters and *vroedschap* from Utrecht were insightful in obtaining a better sense of how life in these houses was organized. For instance, in the visitation report of House *Rustwijck*, made in 1749, we read of four women (incarcerated at the time) complaining about some mad fellow residents. These women had trouble getting their night's rest and asked for a solution.³⁴⁷ In another example, an extract from the resolution of the burgomasters and *vroedschap* of Utrecht, dated February 1 1768, specifications of who and how the mad could be kept with other individuals was provided. In this extract, permission was given to the widow of Gerrit van Zwol and her daughter Christina van Zwol to accommodate and keep (in their house in the Groenesteeg) people who 'due to their simpleness and madness (although without fury or rage) were in need of safekeeping'.³⁴⁸ They were, however, responsible of ensuring that their neighbours would not suffer any hindrance from this practice. The Van Zwols also needed to provide a list of people incarcerated and their condition every three months; moreover, at all times they were to allow inspections by the government bodies to check that they maintained all regulations. These last two regulations also applied to the institutions and not only private houses and was a way for the city council and the aldermen to supervise these establishments and keep up to date about who was incarcerated and where. It is interesting to note that, again,

³⁴⁵ Ibidem.

Original: 'Zo was het nogtans aan de andere zijde niet minder zeker dat zoodanige uitsluitinge uit de societeit en behandelinge zulker subjecten die zelfs stilzwingende verstaan kan worden, bij den register maar gedecerneert te worden voor eenen bepaalden tijd, altoos op hoope dat de geenen welke in zulke facheuse omstandigheden komen te geraken wederom in vrijheit zullen worden herstelt zodra zij haar verstand en zinnen magtig geworden. Om alzo 't geene tot herstellingen en beterschap zulker ongelukkige voorwerpen was geordonneert net tot dezelve ongeluk en eene altoos duurende beroinge van haare natuurlijken vrijheit en het aangenaame der menschelijke zamenleving te doen strekken.'

³⁴⁶ Ibidem.

³⁴⁷ Ibidem.

³⁴⁸ Ibidem, Extract from the resolution of the burgomasters and magistrates of Utrecht (1 February 1768).

Original: 'Te mogen huisvesten oppassen en bewaren zodanig behoeftigen personen welke wegens onnozelheid ofte krankzinnigheid (nogthans buiten rasernij ofte dolheid) bij haar besteed mogen worden.'

the sources mention that this private option was not particularly suited for extreme cases of madness.

The cost for incarceration with private persons or in houses of correction was difficult to determine. Only a couple of amounts were mentioned in the sources.³⁴⁹ Sums between 25 and 500 guilders per year were specified, which meant that the lower classes would not have been able to pay for this type of care. And yet, this does not preclude their access to these institutions either. To return to the resolution concerning the Van Zwols, they were also obliged by the burgomasters to take in people who were given into their custody by the Almoners' Chamber or diaconate.³⁵⁰ Even though these 'acts of charity' certainly occurred, the main users of the houses of correction were people from the middle classes. The more wealthy generally did not use these facilities but arranged their own care in private, as was the case with Martinus Wilhelmus Laurentius Schaap.³⁵¹ The simple-minded Martinus Schaap, who had inherited the fortune of his mother Catharina Maria Blauw and a manor in Abcoude, popped up in the archive of the Court of Holland because his stepfather had committed fraud with Martinus's will to obtain his fortune.³⁵² From the documentation about his case, we know that Martinus was cared for privately in the homes of several pastors, by the household staff in the county estate in Abcoude, and at the house he owned in Amsterdam.

An examination of these different private care options – both within and without the home – has shown us that there were many opportunities available. And yet, we have also seen that the raving mad were deemed unsuitable for this type of care. Exploring this boundary, that is, exactly when madness became a public problem instead of a private one, seems to be the next logical step to pursue in this chapter.

Breakpoint and balance: from private to public problem

As a rule, people were kept in private care as long as possible. There were various reasons for this: it was the cheapest, the most socially accepted and the most

³⁴⁹ This was also the conclusion Pieter Spierenburg made in his book *The prison experience*. Spierenburg, *The prison experience*, 231.

³⁵⁰ UA, 702-7 *archieff van het gerecht*, inv. nr. 3279 Rapporten, besluiten, reglementen en verslagen van visitaties betreffende de verbeterhuizen, het toezicht daarop en de formaliteiten, nodig voor het plaatsn van personen daarin 1749-1767, Extract from the resolution of the burgomasters and magistrates of Utrecht (1 February 1768).

³⁵¹ Spierenburg, *The prison experience*, 233.

³⁵² NA, 3.03.01.01 *Archief Hof van Holland*, inv. nr. 5421.7 Stukken inzake Gerard van Otelaar, notaris te Haarlem, wegens het maken van een testament voor iemand die krankzinnig was, ten behoeve van diens stiefvader (1730).

culturally expected option. However, living with a mad person sometimes grew to be impossible and care of this person became a public problem instead of a private one.

To explain how this shift came about and what constituted the ‘breaking point’ for caregivers (which usually ended in a request for admission), Joost Vijselaar has employed the concept of balance between *draaglast* (burden) and *draagkracht* (coping capacity). So, the balance between the behaviour of the mad (burden) and the available coping skills of the caregivers (coping capacity).³⁵³ By using this paradigm, Vijselaar argues that the delicate balance between the two was disturbed when either the condition of the mad worsened or the coping strategies of the family and the community of care deteriorated. This instigated action from the caregiver’s and madness at this point became a public problem instead of a private one. Vijselaar had originally developed this concept to explain the increase of admissions in nineteenth-century Dutch asylums; nonetheless, his idea about the shift in balance is also applicable to the early modern period.³⁵⁴ From the diverse early modern source types, the various behaviours of the mad that disturbed this ‘balance’ can be distinguished. The reasons for such a disturbed balance can be divided roughly into social and economic issues. This division is, however, not a strict one; many of the different problems co-existed and, combined, led to an untenable situation.

Social problems were most frequently mentioned in the sources and could influence both the burden or coping capacity side. Often, this resulted in the claim that it had become impossible and/or dangerous to live with the mad person in question. This claim was usually the outcome of a combination of factors: the level of violence someone displayed, the amount of disturbance they caused in the urban public space, and the fear experienced by the people around them. A combination of all these factors can be found in the testimony made about Jan van Bommel on the request of his brother-in-law in 1702.³⁵⁵ Fourteen people testified and declared that Jan was completely out of his mind. Medical professional physician Anthonij van

³⁵³ Vijselaar, *Het gesticht*, 120-122.

³⁵⁴ It might seem problematic here to use a concept developed for the nineteenth century and apply it to the seventeenth and eighteenth centuries. However, because much of the reasoning of the caregivers was the same, and similar problems can be found in both periods, the concepts of *draaglast* (burden) and *draagkracht* (coping capacity) as used by Vijselaar were particularly suitable. By using them, an order and an idea about the tipping point between the public and private spheres in the early modern time can be established. Speculating even further about why these concepts were applicable for such a long period of time, in my opinion, would therefore also be an interesting exercise.

³⁵⁵ Example published previously in: Aan de Kerk, ‘Strategic voices of care’, 71.

Thiel even declared him ‘untreatable’ and other witnesses elaborated on his behaviour.³⁵⁶ Jan caused great disturbances in the night when he screamed, raged and threw bricks from his window into the street, keeping everybody in his neighbourhood awake. Jan lived with his sister and her husband and had also thrown a brick at her head, who – as a result of this – went into early labour. He also suffered from delusions and acted like a complete lunatic in public and was consequently avoided by others on the street. He started fights in public and even threatened to rob and kill the maid working in the grocery shop during one of his frenzies. Subsequently, everybody in his household feared for their life and nobody in his proximity felt at ease.³⁵⁷ This story reveals the escalating momentum of circumstances over a period of a year and a half. His family tried to get him the usual medical treatment and boarded him out. But, after all else failed and his behaviour deteriorated, his sister and her husband were no longer able to take care of him within the domestic sphere.

Jan’s aggressive behaviour was not unique; the sources reveal that the level of violence was often quite severe. Of course, it is not a surprise that this was an important aspect to mention in the testimonies. By emphasizing the level of disturbance and danger, contemporaries tried to convince others of the need for action, often in the form of institutionalization. In most testimonies, it was stressed that someone regularly made or caused a scene in public and subsequently created great disturbances in the urban environment. Being too much of a burden to others was thus classified as unacceptable social behaviour. A perfect example of this can be deduced from the negative reactions of neighbours in the case of Jacob Jacobsz. Kloot. On September 5 1706, Jacob’s neighbours declared, on the request of his wife Lijsbeth Dirks, that they all knew that Jacob had been afflicted with blindness and that he was simple-minded. Further, they argued, he had recently also become insane and that this was accompanied by problematic behaviour. He ripped and tore apart everything he could get his hands on and he tried to escape his home by climbing through the window, which caused great scenes because (probable due to his blindness) he repeatedly fell onto the street: ‘Jacob also regularly walked around the neighbourhood naked with only a sheet wrapped around his shoulders. When this happened, his neighbours – who were appalled by his behaviour – escorted him home. Some even scorned and mocked him on his way, which caused even greater

³⁵⁶ SAA, 5075 *Archief Notarissen*, inv. nr. 6016B, 849 (4 March 1702).

Original: ‘*En dat hij oordeelt dat Jan onmedicabel is.*’

³⁵⁷ *Ibidem*.

scandal.³⁵⁸ In addition to this, Jacob could not be trusted around fire since he messed up the fireplace and threw all sorts of objects into the fire. Because of this last issue, the neighbours feared he would start a fire and cause great harm to others.³⁵⁹

Fear for the safety of the family and environment were not the only reasons to draw up a testimony. The fear, also, that someone would hurt him or herself or commit suicide was reason enough to undertake action. In 43 cases, people mentioned attempted suicides and, in 121 cases, the fact that the mad were a threat to themselves was recorded. An example of this latter issue is the notarial testimony initiated by the two sisters of Abraham Abrahamsz. Meulenaar. The sisters had several of their brother's neighbours testify that Abraham had struggled greatly with dark thoughts for over a year and a half. For some time now, he had locked himself in his room and was living his life as a wild and ferocious man. Sometimes he did not eat or drink for several days and they could only conclude that he was completely insane. Because of his behaviour, he 'could not be trusted to keep himself safe' and they feared that he would shorten his own life.³⁶⁰ In another example, the husband of Magdalena Susanna Mathes also undertook action to protect his wife from harming herself. The maid and a tenant declared that Magdalena 'became afflicted with melancholia and gloominess', ten weeks prior.³⁶¹ This caused her such desperation that she could no longer bear any company or take care of herself. She could not be left alone because she had already tried multiple times to end her life and this had only been prevented because she was monitored day and night. The witnesses thus deemed it necessary that she be secured in a safe place to prevent further accidents.³⁶² Dealing with these threats of suicide must have been a complicated dilemma for families. In the eighteenth century, although moral judgement and legal prosecution of suicide caused by mental illness was softer, a taboo still rested on the issue.³⁶³ The power of such taboos can also be seen in the sources; for example, in a case from the Court of Holland where a document was made up to prove that one unfortunate person's suicide was actually committed

³⁵⁸ Ibidem, inv. nr. 7094, 1287 (5 September 1706).

Original: '*Jacob ook diverse malen naakt en ongekleeed met alleen een deken over de schouder is afgekomen en van de bureu in die staat weder in huis is geleid tot spot en aanstoot van de bureu.*'

³⁵⁹ Ibidem.

³⁶⁰ Ibidem, inv. nr. 6720, 511 (3 June 1701).

Original: '*Zichzelf niet toevertrouwd.*'

³⁶¹ Ibidem, inv. nr. 8892, 269 (31 March 1750).

Original: '*Bezocht met een zware melancholie en een nare droefgeestigheid.*'

³⁶² Ibidem.

³⁶³ MacDonald, 'The secularization of suicide', 83-87.

during a period of madness. As such, the person could be classified as *non compos mentis*, thus avoiding the religious and legal implications of suicide.³⁶⁴

Undertaking action and making use of agency was also employed when economic problems arose. These problems revealed themselves as issues of either income or expenditure and could affect the balance on both the burden and coping capacity sides. The most basic economic problem from the view of household economics can be understood by looking at the appeal made by Annetje Roek to the burgomasters of Amsterdam. In her request, she had asked for free admission into the leprosaria for her husband because he has become afflicted with madness. Because of his behaviour, living conditions had become untenable at home and he could no longer fulfil his duty as the main provider of his family. The family had therefore fallen in financial trouble and she was no longer capable of looking after him all day because she was a poor woman with two children to feed.³⁶⁵ Income was not the only concern: expenditure could also cause economic problems brought about by outrageous purchases by the mad and leading to financial and legal trouble. Contrary to other problems, this excessive spending did not always lead to a request for admission but, more often, resulted in a request for the transfer of administrative control of money and goods to force the person to stop wasting money and save the family from impoverishment.

It is evident that the community of care played a vital role in the care of the mad. In particular, evaluating *who* had the agency to decide on the care of the mad was an important factor in understanding how people dealt with madness in this period. Our distinctions between those who took agency and those who validated that agency have been helpful in discerning the various social expressions of support and control discussed in this chapter. By exploring the factors that instigated the breaking points and by discussing the abundance of care options in the private care market, we find emphatic evidence that the caregivers with agency – the initiators – were the most influential in deciding on the care. They were the ones who determined how the care should be provided when someone was incapable of making choices themselves and when assistance was needed from the urban governments. Significantly, by taking this agency, caregivers took on the position to judge when

³⁶⁴ NA, 3.03.01.01 *Archief Hof van Holland*, inv. nr. 5495.22 Verhoor van een gewezen knecht, verdacht van krankzinnigheid (1769) and inv. nr. 5482.8 Verklaring nopens de zelfmoord van een knecht in krankzinnigheid gepleegd (1764).

³⁶⁵ SAA, 5028 *Archief van Burgermeesters*, inv. nr. 595 Godshuizen in het algemeen, gasthuizen, huiszittenhuizen, Spin- en Nieuwe Werkhuis, Tuchthuis, Leprozenhuis, Burgerwees-, Aalmoezeniers- wees- en Diaconieweeshuis, St. Jorishof, verscheidene hofjes, Zijdewindhuis, Request made by Annetie Jans van der Roek (January 1700).

madness became a public problem and no longer a private one. In doing so, caretakers also decided on the moral and social boundaries that could not be crossed within the private setting.

Conclusion

The private care system for the mad was large and intricate. Families played the lead role in this system. However, besides the family, a much larger community of care – neighbours, friends, employees, employers, household staff and (paid) carers – was involved with the mad in the private sphere. This social network functioned as a system of social support and social control, both assisting in care and laying down boundaries of acceptable and unacceptable behaviour. Within the private care system, many different care options were available for the mad and – as this chapter has shown – these were implemented in multitude of ways. Both medical and non-medical treatment and care options had their place in the market. In many cases, these treatment options were used simultaneously or consecutively by the caregivers. The private care system was not always successful, however. Sometimes, private care options failed, creating a fatal shift in balance between the condition of the mad and the coping strategies of the family and the social network. The breaking point that this shift instigated pushed the problem of madness out of the private sphere and into the public realm.

This chapter has also done much to dispel the notion that private and/or home care for the mad was a horror story. On the contrary, the sources reveal that involvement, prudence and a meticulous search for the right type of care was usually implemented. The careful nature that characterizes the Dutch private care system may be a result of a number of factors. Firstly, in contrast to England, the Dutch private care market outlined a different image than the explosive rise of private institutions that marks the English. In the Dutch Republic, the available care options were small-scale initiatives and houses of correction (often semi-private institutions) that were still controlled by government or judicial authorities. Secondly, the locus of care was mostly in the hands of the family, which was not a passive bystander. Rather, the family was a powerful unit that negotiated with its environment and the authorities over the need for action and the care options – often from a position of power.³⁶⁶ Thirdly, when the family was out of the picture, neighbours or friends – the strong social network – were able to take over this role of power. They also had

³⁶⁶ Bartlett and Wright, 'Community and its antecedents', 1-18, p. 8.

the agency to exert the power of decision and to collaborate with the authorities via unofficial organizations and in the guidance given by those (unspoken) moral norms and values. It is apparent that caregivers always took an active role in dealing with the problem of madness in the urban environment of Amsterdam, Rotterdam and Utrecht. They also kept this role during the process of institutionalization, which will be the focus of the next chapter.