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Madness and the city

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

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Publication date

2019

Document Version

Other version

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Citation for published version (APA):

aan de Kerk, M. A. (2019). *Madness and the city: Interactions between the mad, their families and urban society in Amsterdam, Rotterdam and Utrecht, 1600-1795*. [Thesis, fully internal, Universiteit van Amsterdam].

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CHAPTER FIVE

FRAMING MADNESS

The changing conceptions of madness and their strategic use in the urban system of care

‘In some ways disease does not exist until we have agreed that it does, by perceiving, naming, and responding to it’, wrote Charles E. Rosenberg in the introduction to the collected volume *Framing disease*.⁴⁷⁵ In this work, several historians have reflected on how illnesses were framed and how social and cultural perceptions influenced ideas of them. ‘In our culture, the existence of a disease as specific entity is a fundamental aspect of its intellectual and moral legitimacy’, Rosenberg argued. ‘If it is not specific, it is not a disease, and a sufferer is not entitled to the sympathy [...] connected with an agreed-upon diagnosis.’⁴⁷⁶ In the process of defining illness, many different actors, including the person in question, doctors, families, friends, neighbours, social institutions, employers and government, have all looked for ways to frame the (biological) event in terms that made sense to them and served their own ends. Many physical – but also mental – diseases therefore came to be defined, redefined, and renamed over the course of several centuries. Tracing this process of framing madness can consequently help to understand how illnesses were viewed, defined, changed and used in the past.

How madness was framed in the seventeenth and eighteenth centuries and if, how and why this changed during this period, is the focus of this final chapter. Assessing these shifts is, to some extent, speculative because of the limited quantity of sources for the seventeenth and eighteenth centuries.⁴⁷⁷ However, as this thesis has demonstrated, we can ascertain some important foundational points of departure. Firstly, in previous chapters of this thesis, it has been identified who the mad were and what type of care was provided for them in the urban environment and by whom. Secondly, by placing the daily reality of care for this group on the centre stage, it becomes clear that many different parties became involved and had to work together to arrange the proper care. How madness was framed was an essential component in understanding how madness was viewed in the early modern period and these frameworks were used to arrange the proper care for the mad. In concurrence with Rosenberg’s arguments, interaction and consensus between all the different parties

⁴⁷⁵ Rosenberg and Golden (eds), *Framing disease*, xiii.

⁴⁷⁶ *Ibidem*, xvi.

⁴⁷⁷ See also: Introduction, 15-16.

was essential in this process of defining and using the framing of madness strategically. This interaction between the different parties involved, however, was not a static, top-down process; rather, the interaction was, for a large part, conducted from bottom-up initiatives.

To answer the main question of how did the framing of madness change and why, this chapter is divided into three parts. The first two sections reflect on two distinct changes in the general understanding of madness during the early modern period: the process of the medicalization and the growing expression of compassion. These two shifts can be identified as important points of debate and interest in research into the history of madness. Moreover, as we have seen in the course of this thesis, they are also evident in the sources from Amsterdam, Rotterdam and Utrecht. By examining these two trends and understanding how people framed and viewed madness, a more comprehensive image of the position of this group in the urban environment can be discerned. In the third part of this chapter, I assess how the framing of madness was used by people in the urban care system. In this final concluding section, I also reflect on analyses from previous chapters and bring them together to answer the main question of this thesis, what and who the driving forces were that instigated the growth of the urban care system for the mad.

Medicalization of madness

Medicalization has been a long and ongoing process in which human conditions and problems have come to be defined and treated as medical conditions and, thus, become the subject of medical study, diagnosis, prevention and treatment. This process has been studied extensively in the history of medicine. In this regard, historians of psychiatry have traditionally emphasized the importance of the nineteenth century as a turning point, when asylums became places of cure instead of care and the discipline of psychiatry was born. Yet, long before this shift took place, doctors, patients and families likewise tried to explain, cure and predict the outcome of mental afflictions. Their methods were not always standardized or always based on science but were rather founded on a combination of theories and folk cures. The early modern period was characterized by great changes in science, medicine and medical mentalities. New ideas about how the body worked and what caused illnesses emerged, changing the way in which people thought about madness.⁴⁷⁸

⁴⁷⁸ Porter, *The Cambridge illustrated history of medicine*, 139-152 and 244-249.

Medicalization spread through a complicated process, which was not only instigated top down but also bottom up: by developments in the medical marketplace and by ordinary men and women. In addition, as this chapter explores, broader social and cultural factors also influenced medicalization.⁴⁷⁹ Traditionally in historiography, the process of medicalization has been studied by focusing on the changes in the ideas about illnesses in medical treatises and the development of new treatments. In this section, this dominant focus will be reviewed in multiple ways; firstly, by reflecting on the medical ideas about madness in two medical treatises that are exemplary for a shift in medical thinking in the early modern period; secondly, by looking at the actual involvement of the medical professions in treating and diagnosing the mad; third and finally, by researching the changing, more medical terminology used for madness and the people suffering from it. Focusing on all three key aspects will provide a more complete view of these changes and their significance in daily life.

Early modern medical ideas about madness

The early modern period marks a much-studied shift in the way that the body was probed, examined, charted and diagnosed by scientists and medical practitioners.⁴⁸⁰ In the seventeenth and eighteenth centuries, medical knowledge did not yet have the exclusive character it acquired from the nineteenth century onwards; many people had access to some kind of medical knowledge.⁴⁸¹ But, even though medical knowledge was constantly developing and was more accessible to a larger number of people in this period, ancient and popular beliefs about sickness and health remained fairly constant among the broader population.⁴⁸² For example, the Galenic humoral theory long remained the most influential medical theory and also shaped public mentalities about madness.⁴⁸³ Galenic theory worked from the idea that the state of the body was correlated with the state of the mind. This meant that, in treating people for illnesses, the physical symptoms needed to be equated with a mental or moral state of being.⁴⁸⁴ Medical writers therefore also echoed ideas about the need to resist and restrain the passions for the good of one's mental, moral and physical health, on the one hand, and about their potential use in the relief of diseases, on the

⁴⁷⁹ Mellyn, *Mad Tuscans and their families*, 131.

⁴⁸⁰ Raber, 'The common body', 99-124, p. 99.

⁴⁸¹ Frank Huisman, 'Gezondheid te koop', 117.

⁴⁸² Raber, 'The common body', 99-124, p. 99.

⁴⁸³ See also, Introduction, 13-14.

⁴⁸⁴ Raber, 'The common body', 99-124, p.105.

other.⁴⁸⁵ And although new ideas and explanations for sickness emerged in this period, the transition process from one idea to the other was very complex and the boundaries between ‘old’ and ‘new’ notions were not distinct.⁴⁸⁶

In many ways, madness was (and had remained) a condition that was difficult to define by the medical professionals. Since antiquity, doctors had written about its occurrence and reflected on its origins and the possibilities for cure. In the medical treatises from the Dutch Republic discussing madness, the general Galenic medical discourse of this period can be found; however, we can also find a particular shift from a Galenic-inspired model to a moral treatment cure model. To show how this medical discourse about madness in the Dutch Republic shifted, two medical books – one from the seventeenth and one from the eighteenth century – will be discussed in detail. Even though these works were very different in character, (one became a bestseller written by a famous physician, the other a more limited print edition from a professor of philosophy, mathematics and astronomy) the two works exemplify the transition process from one medical tradition to the other.

The first book was called *Schat der Ongesontheyt* (Treasure of unhealthiness), written by Johan van Beverwyck in 1642.⁴⁸⁷ Van Beverwyck was a famous physician in the city of Dordrecht, where he was employed by the urban government as city doctor and teacher of anatomy. Van Beverwyck showed a keen interest in the changes and new developments in medical science and was widely regarded, and indeed presented himself, as a modern physician of his time.⁴⁸⁸ Van Beverwyck wrote the *Schat der Ongesontheyt* as part of a trilogy. The goal of this series was to educate a large audience on how to prevent sickness, maintain health and cure illnesses. This noble cause probably also explains why he wrote the book in the vernacular (and not in Latin): something uncommon in medical scholarly literature at the time. The book became immensely popular and was reprinted eight times between 1642 and 1660. For this reason, his work is often used to indicate the general medical view of the seventeenth century.

Of interest for this research is the section that Van Beverwyck specifically dedicated to illnesses of the head. Here, he first explained the anatomy of the brains and then discussed more common ailments, such as headaches. A rather large section, 113 pages, was dedicated to different forms of madness. He divided these in several distinct categories including forgetfulness, rage (a subsection of rage was

⁴⁸⁵ Dixon, ‘Patients and passions’, 22-52, p. 34.

⁴⁸⁶ Raber, ‘The common body’, 99-124, p. 100.

⁴⁸⁷ Van Beverwyck, *Schat der ongesontheyt*.

⁴⁸⁸ Van Gemert, ‘Johan van Beverwijck als instituut’, 100.

drunkenness, which he saw as voluntary madness), frenzy, melancholia (with a subsection dedicated to folly love), lunacy and lunacy caused by wild animals (rabies).⁴⁸⁹ His grouping of madness thus shows that these subcategories were thought of as different in their indication and origin.⁴⁹⁰ For all these categories, Van Beverwyck explained the symptoms, speculated on their possible origins, and explained different treatment options. For this, Van Beverwyck used a Galenic-inspired medical model. For example, he claimed that the main cause of madness was a lack of balance between the body and the four humours.⁴⁹¹ The treatments he prescribed also consisted of classic Galenic cures and included nutritional advice, purging, and bloodletting: all designed to restore balance within the body. Strikingly, Van Beverwyck diverges from this traditional Galenic perspective in his discussion on melancholia: he noted: ‘When every other treatment option has failed and strict admonitions have had no effect, one should try to follow the deranged lines of thought of the afflicted and then deceive them’.⁴⁹² The treatment option of following the ‘deranged lines’ of thoughts of the mad, which Van Beverwyck mentioned here only briefly, was seen as one of the main cure options proclaimed in the new, moral treatment theory, which can be found in the second book.

This second book is called *Eudoxus over de krankzinnigheid* (Eudoxus about madness), which was written anonymously and published in 1791.⁴⁹³ The choice for this book requires some additional explanation, as, in comparison with Van Beverwyck’s best seller, this 172-page treatise may seem less relevant.⁴⁹⁴ However,

⁴⁸⁹ Van Beverwyck, *Schat der ongesontheit*, 328-441.

Original: ‘*In haer geheugenis geslagen werden*’, ‘*verstant in rasernye verkeert*’, ‘*uutsinnigheyt*’, ‘*melancholye*’, ‘*dulligheyt*’ and ‘*dulligheyt door dulle beesten veroirsaeckt*.’

⁴⁹⁰ See also: Chapter two, 57-61.

Reflecting back on the section about terminology in the second chapter, these divisions made by Van Beverwyck also show that, even though the difference is difficult to divine for us modernists at this moment, the different terminologies used in the sources could tell us more about the underlying thoughts about the conditions and their characteristics. Still, because it is impossible to say whether people knew the work of Van Beverwyck and referred to his terminology in their documents, it remains difficult to implement it.

⁴⁹¹ Van Beverwyck, *Schat der ongesontheit*, 345-347.

⁴⁹² *Ibidem*, 398-399.

Original: ‘*Maer alsoo men tot de verandering van inbeeldinge niet wel en kan komen ende dat soodanige door ernstige vermaningen dickwils noch hartneckiger werden; soo en isser niet beter, als dat men hare gedachten in volghet, als ofte sij soo wel waren, ende dat men haer niet-te-min na de konst bedrieght.*’

⁴⁹³ Niehoff, *Eudoxus over de krankzinnigheid*.

⁴⁹⁴ *Eudoxus* was not widely available in this period. It was only printed once, with approximately 500 to 1000 copies and was originally published as an addendum to *De proeve van de hoofdzwijmel of duidezigheid* from the German physician Marcus Herz in 1791. This would suggest that Nieuhoff’s work was not very popular and also not widely known.

in one of his articles, Joost Vijsselaar has shown the importance of this work as evidence for the existence of a ‘management of the mind’ theory in the Netherlands in the late eighteenth century: something that other scholars have traditionally placed much later.⁴⁹⁵ Significantly, Vijsselaar has argued that the writer of *Eudoxus* was Bernardus Nieuhoff.⁴⁹⁶ Nieuhoff was a respectable scholar of his time, a Spinozist and a representative of the Dutch Enlightenment movement. He was appointed professor of philosophy, mathematics, and astronomy at the University of Harderwijk in 1774 and, even though Nieuhoff had no formal medical training, he expressed some strong opinions about dealing with and treating the mad. Nieuhoff’s goal was to inform people about how the mad experienced their illness and establish more empathy and compassion for them.⁴⁹⁷ This explicit appeal for compassion was something still unusual at that time; in this sense, Nieuhoff could even be called a pioneering ‘sympathy entrepreneur’.⁴⁹⁸ In his book, Nieuhoff argued that madmen were not without sense or reason, as was believed in earlier times. Rather, they were people who reasoned in the right way but whose reasoning was based upon false assumptions.⁴⁹⁹ Therefore, the afflicted were not raging beasts but people who needed (and were entitled to) help to rid them of their false preconceptions.⁵⁰⁰

According to Nieuhoff, there were two treatment options that could enable this cure. The first one consisted of a gentle form of guidance provided by a professional physician. During the treatment, the bond of trust between patient and physician was of the utmost importance because the physician first needed to try to engage in the world of thoughts of the mad. When a level of trust and understanding was established, the physician had to slowly replace these irrational and false assumptions with different ones and thus change the patient’s reasoning back to

⁴⁹⁵ Vijsselaar, ‘Eudoxus over de krankzinnigheid’, 128-129.

In the article by Joost Vijsselaar, he emphasized that more physicians were involved in establishing this change of thinking in the medical world: for example, Hieronymus Gaubius, Lambertus Bicker, Gijsbert Swartendyk Stierling, Gerbrand Bakker and Schroeder van der Kolk, who eventually reformed the care for the mad in a practical sense in the Netherlands. Nevertheless, Nieuhoff was special in this context because, in his book, several crucial aspects are brought together.

⁴⁹⁶ Ibidem, 113.

⁴⁹⁷ Nieuhoff, *Eudoxus over de krankzinnigheid*, 3-5.

⁴⁹⁸ Clark, *Misery and company*, 84-93.

With this term, people were labelled as such when they indicated cultural definitions of sympathy-worthy bad luck and actively encouraged and instructed societal members to take a particular emotional stance toward those they define as victims of bad luck.

⁴⁹⁹ This in the line of thought with the idea of physician John Locke.

See also: Chapter two, 59.

⁵⁰⁰ Vijsselaar, ‘Eudoxus over de krankzinnigheid’, 111.

normal.⁵⁰¹ The second form of treatment he distinguished was a form of coercive manipulation in which an element of shock was implied. In order to illustrate this treatment, in which the threat alone of inflicting physical pain was usually enough to bring someone back to their senses, he gave multiple examples of physicians who had successfully used this coercive technique; amongst them, the famous Herman Boerhaave (1668-1738).⁵⁰² In both treatment options, Nieuhoff emphasized that the focus needed to be on the interaction between the patient's body and mind. The ideas of Nieuhoff related and (to some degree) preceded the moral treatment that was made popular by and regarded as the invention of the French physician Phillipe Pinel (1745-1826).⁵⁰³ Therefore, this work is of great interest because it contradicts the common narrative about the medicalization process of madness in Dutch historiography, which maintains that these types of changes in thinking about madness – clearly present in Nieuhoff's work from 1791 – only emerged in the Netherlands in the first half of the nineteenth century.⁵⁰⁴

Van Beverwyck and Nieuhoff indicate a change in medical scholarship and thinking in the Dutch Republic. In line with international tendencies, they demonstrate a clear shift in the way of thinking about madness and the medical treatment of the mad: from a Galenic medical view to an interpretation in which madness was increasingly seen as an condition requiring understanding and a different approach. No longer were humoral treatments and locking up the mad in the hope of recovery the dominant methods; instead, reasoning with the mad and understanding their thoughts was seen as the key to their treatment. Combining this trend with the increasing call for empathy and compassion eventually resulted in the first signs of the moral treatment method in the Dutch Republic.⁵⁰⁵ In many European countries and in North America similar shifts took place.⁵⁰⁶ Most commonly mentioned in relation to this shift, in which the moral treatment was implemented and the chains of the insane were supposedly broken, were two physicians: the

⁵⁰¹ Nieuhoff, *Eudoxus over de krankzinnigheid*, 146-153.

⁵⁰² *Ibidem*, 153-165.

⁵⁰³ See: Vijselaar and Bolt, *J.L.C. Schroeder van der Kolk*, 32-39, for more about the role of Pinel and an explanation of how this moral treatment idea developed in different European countries.

⁵⁰⁴ Vijselaar, 'Eudoxus over de krankzinnigheid', 109-110 and 129 and Vijselaar and Bolt, *J.L.C. Schroeder van der Kolk*, 40-41.

Niehoff was however not the first or only Dutch scholar who became interested in these different treatment options: also physician Lambertus Bicker (1732-1801) and the Dutch-German physician Hieronymus David Gaubius (1705-1780) amongst others published works about this. However, the originality explicitly portrayed in the work of Niehoff was unique.

⁵⁰⁵ I will elaborate on this link between compassion and empathy for the mad in the next section.

⁵⁰⁶ Scull, *Madness in civilization*, 159.

Frenchman Phillippe Pinel and the Englishman William Tuke (1732-1822). In reality, while these men were at the forefront of the movement, it was a much more complicated process, involving many more people.⁵⁰⁷

Involvement of medical professions

Another important indicator of the process of medicalization was the involvement of medical professionals or medical associations, such as the *Collegium Medicum*, in the treatment and judgement of the conditions of the mad. In her book, Inge Mans has stated that, already from the sixteenth century onwards, medical professionals in the Dutch Republic became more involved in the process of curing, explaining, and judging the necessity of incarceration in the case of madness.⁵⁰⁸ This increased involvement of medical professionals can be explained by several developments, the most significant being the growth of medical interest in madness and the growth of the medical profession as a group on the medical market. These developments combined – that is, the increased interest of this new, specialized group – also illustrates the position of medical professionals in the process of diagnosing and, consequently, how other people now saw madness as a sickness. In this research, the archives showed an increase in this medical involvement from the mid-seventeenth century onwards, which correlates with the start of this trend in other European countries.⁵⁰⁹

In the Dutch sources, three specific changes can be distinguished in this regard. The first is that medical professionals were more frequently asked to help cure the mad. In the Dutch Republic, there existed a rather diverse and flourishing medical market in which consumers had a variety of options when seeking care or cure. This also meant that the involvement of the medical world in the daily life of the inhabitants of Amsterdam, Rotterdam and Utrecht was considerable. For example, if we recall back to chapter three, both the medical contracts of Dr Joseph van Celle and healing arrangements with some unschooled healers demonstrate that families and the social network looked for medical help and different cures on the

⁵⁰⁷ Ibidem, 161.

For more information about the different countries developments concerning this shift see also chapter 7 of this book: *The great confinement*.

⁵⁰⁸ Mans, *Zin der zotheid*, 37 and 73-75 and Lindemann, *Medicine and society*, 43-44.

During her research of the Italian archives, Elizabeth Mellyn also affirms this idea stating that she found medical explanations for madness from the mid-sixteenth century onwards. Mellyn, *Mad Tuscans and their families*, 129.

⁵⁰⁹ For example, Andrew Scull however thought that the medical distinctions and the involvement of medical professionals had become more prominent from the late seventeenth century onwards. Scull, *The most solitary of afflictions*, 178.

medical market.⁵¹⁰ The extent of the involvement of these medical professionals in the cure of the mad is difficult to determine since only 26 documents, plus five healing contracts, can be found in which medical treatment is mentioned explicitly. From this number, 23 documents were drawn up in the eighteenth century and eight in the seventeenth century. The main reason why medical treatments were mentioned in the sources was to prove that everything had already been done in the quest to cure the mad but without the desirable effect. In the admission request for Pieter Berenger in the Rotterdam asylum, his brother Henry declared that ‘Pieter had already been treated by a doctor of medicine, a surgeon and a apothecary but that it had all been in vain.’⁵¹¹ The surgeon and apothecary also separately declared that they have given him ‘several medicines and used many treatment options to instigate recovery but that his frenzied state had not diminished.’⁵¹² Unfortunately, the sources do not reveal the types of medical treatments these people received, which leaves us guessing as to what the popular cure options were.

The second trend that can be discerned – and proves the growing involvement of the medical professionals – concerns the many testimonies in which doctors, surgeons and apothecaries testified about the condition of the person in question. From the end of the seventeenth century, an increase in the sources with medical professionals that testified can be established: this trend continued into the eighteenth century. Sometimes, this involvement went hand in hand with medical statements about the treatments previously implemented or accompanied a statement that someone had been examined and found to be mad. What this visitation process entailed can be found in a testimony from Utrecht drawn up in 1679.⁵¹³ In this source, three doctors declared that they had visited Francois Wilhelmi (on the request of Pieter la Burch) and had found him ‘in an upset and baffled state in his senses and often even delirious.’⁵¹⁴ They had come to this conclusion after a conversation with Francois, lasting about two hours, in which they had found him repeating himself,

⁵¹⁰ See also: Chapter three, 83-86.

⁵¹¹ SR, 230-01 *Archief van het Pest- en Dolhuis*, inv. nr. 178 Requesten met appointement inzake opnemng van krankzinnigen 1654-1712, Admission request for Pieter Berenger (2 October 1708). Original: ‘Hij wijders al bereids door een dokter in de medicijnen en door den chirurgijn en apotheker met veel zorgen getracteerd geweest doch tot nu toe ter vergeefs.’

⁵¹² Ibidem.

Original: ‘Verscheijde medicamenten en hulpmiddelen tot genezing van den persoon van Pieter Berenger zijn geapplianceerd geweest doch zonder dat tot nu toe deszelfs uitzinnigheid heeft kunnen verminderd worden.’

⁵¹³ UA, 34-4 *Notarissen in de stad Utrecht*, inv. nr. U078a003, akte nr. 66 (30 June 1679).

⁵¹⁴ Ibidem.

Original: ‘Alwaar zij comparanten hebben gevisiteerd de persoon van Francois Wilhelmi ende deszelve bevonden zeer gealtereerde en verbijsterd in zijn verstand ook doorgaans delirerende.’

talking incoherently and often contradicting himself as senseless people do. This rather elaborate evaluation about Francois's specific condition and the fact that it was made by no less than three medical professionals show that this group played an important role in judgement over someone's state of mind.

The judicial archives also confirm the important role of medical practitioners in judging madness. In the Court of Holland archive, medical practitioners were involved in five out of 13 extant cases: one from the seventeenth century and four from the eighteenth. In the case concerning Martinus Wilhelmus Laurentius Schaap, a certificate signed by three doctors was presented as evidence of Martinus's simple and innocent state of mind.⁵¹⁵ Medical doctors Bojer, Van Bronkhorst and Gaubius declared that they had visited Martinus Schaap 'multiple times in the previous year and had found him in the same simple state. He was without sense and was forgetful in answering questions that were asked just before and he had made many ridiculous gestures.'⁵¹⁶ It is striking that in this certificate the doctors also speculated on the cause of Martinus's state of mind, diagnosing his ailment as 'natural or stemming from his birth, unless it becomes apparent that after his birth he had been subjected to a strange change, such as fever, a strike or musings about a certain thing of which his mental state was the immediate effect.'⁵¹⁷

The third trend that becomes evident from the sources was that the medical practitioner connected to the institutions and the city doctors had a more prominent task in evaluating the conditions of the mad. Chapter four explained that the asylums had both a surgeon and a doctor in their employment: from the second half of the eighteenth century, we can also identify an increasing involvement of the institution physician in determining whether a person was eligible for admission or release. Most of the assessments about the decision of admissions were written down in the margins of the admission requests, stating that a consultation and judgement by the physician had been requested. In general, these statements were relatively short and

⁵¹⁵ 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, Certificate from three *medicina doctores* from Amsterdam (11 January 1730).

⁵¹⁶ *Ibidem*.

Original: 'Meermalen de visitatien hebben gegeven aan de heer Martinus Schaap en denzelve kwaad statum prasentem naar iteratieve vragen innocent en simpel hebben bevonden zo dat niets prudent ter zaak geantwoord heeft en vergetig was omtrent het geen kort tevoren was gevraagd met vele ridicule gesticulatie van innocentie.'

⁵¹⁷ *Ibidem*.

Original: 'Wij zouden oordelen dat deze kwaal in Schaap natuurlijk of uit zijn geboorte is ten ware dat er bleek dat er na zijne geboorte was geweest een notabel voorwerp van alteratie koortsen, slagen of mijmering over een zaak waar op zilks immediatelijk was gevolgd.'

sparse. Still, they do signal an altering in the admission process, which now needed a medical assessment. This change began at the end of the seventeenth century and became increasingly common in the eighteenth century.

In addition to the institution's physician, the city's physician and the *Collegium Medicum* became more involved in reporting on and deciding about the need for admission in the eighteenth century. For example, in the annex of the admission request for 30-year-old Catharina Thomas, the city physicians of Rotterdam declared to have visited her and deemed it absolutely necessary that she be incarcerated in a silent and dark room if there was to be any hope of improvement of her suicidal state. This statement resulted in the order on 16 July 1668 from the burgomasters to admit her to the asylum.⁵¹⁸ In the archives, we can find proof of how meticulous this process of admission was and that, in some cases, the medical professionals also advised against an admission. In a recommendation from June 28 1762, attached to a request made for the admission of Hendrikje Kemmen by the bailiff and several neighbours, the physician of one of the quarters of Rotterdam, Van Stuivezand, stated that he had examined this woman and found no signs of madness; but, to the contrary, she had answered his questions in a very civil manner. The process continued, however, because of the manifold complaints made by neighbours. Consequently, the full *Collegium Medicum* (probably meaning the board) also examined the woman: again, they found no signs of madness. They concluded by advising that she was not suited to be confined in the city's asylum and this advice was followed by the city government.⁵¹⁹

The three trends have shown that, even though the medical professions had always been involved in dealing with madness, their engagement in dealing with this madness, both in cure and advising about admission or release, increased significantly from the late seventeenth and eighteenth centuries onwards. This increase indicates that *something* changed in how people thought about their status and expertise in handling the problem of madness on multiple levels. Looking further into why this was the case is the focus of the next section, which concentrates on the changing (medical) terminology used for madness and people inflicted with madness.

⁵¹⁸ SR, 230-01 *Archief van het Pest- en Dolhuis*, inv. nr. 178 Requesten met appointement inzake opneming van krankzinnigen 1654-1712, Admission request for Catharina Thomas (20 July 1668).

⁵¹⁹ UA, 703-a *Stadsbestuur van Utrecht*, inv. nr. 456 Requesten aan burgermeesters en vroedschap, houdende verzoeken om opneming van verschillende personen in het dolhuis 1678-1769, Request for Hendrikje Kemmen (1762).

From object to patient

The terminology used to describe the mad was varied and complex.⁵²⁰ From the sources in the eighteenth century, we can observe an increase in the use of medical terminology in cases of madness by both the medical professions and the lay population, testifying or requesting. This demonstrates an important change in the way madness was framed. One of the most telling changes was the increase of the term ‘patient’ when indicating the mad. Looking into the connotation of the word patient, the early modern dictionary (the *Middelnederlandsch Woordenboek* by Verwijs and Verdam) defined the word to mean ‘sufferer’ and was often linked to illness: a patient was thus someone suffering from an illness.⁵²¹ We see the word patient used especially in the documentation from the asylums but also in the notarial testimony from Rotterdam about the innocent Jacobus de Voogd.⁵²² In this document, a doctor and surgeon both make declarations about the changing state of Jacobus from innocent to mad and dangerous for his environment. They concluded with the statement ‘that this patient needed to be incarcerated in a competent institution in order to prevent disasters as much as possible and for the sake of his cure and improvement’.⁵²³ The fact that the term patient was specifically used in this testimony meant that his mental state was seen and/or framed as suffering from an illness. Thus, medical professionals were the ones who decided that Jacobus’s condition required medical treatment.

When reviewing the terms used for mad people, it was remarkable to see that, contrary to the word patient, terms such as ‘object’ and ‘subject’ were also used regularly in the sources – well into the second half of the eighteenth century – when referring to the mad. These terms indicate a more distancing approach in addressing this group, not relating to any medical meaning. An unusual case from 1770, even shows that the term ‘unhappy creature’ was used by the doctor and city-employed surgeon, Van Cuijlenborg, to indicate the mad Hillegonda Vroeijesteijn who, in a fit of rage, had wounded her own neck.⁵²⁴ The great variety of terms used, subsequently,

⁵²⁰ See also: Chapter two, 57-59.

⁵²¹ Instituut voor de Nederlandse Taal,

<http://gtb.inl.nl/iWDB/search?actie=article&wdb=MNW&id=41927&lemma=patient&domein=0&co nc=true> [13 February 2019] and Instituut voor de Nederlandse Taal,

<https://ivdnt.org/zoeken-in-woordenboeken?w=patient> [13 February 2019].

⁵²² SR, 18 *Archieven van de Notarissen*, inv.nr. 3901, akte nr. 87, p. 353 (29 May 1770).

⁵²³ *Ibidem*.

Original: ‘*Attestanten zodanig voor kwam dat denzelve patient tot voorkominge van andere resulterende onheilen zo veel doenlijk is in een daartoe bekwaam huis ter tijd en wijlen zijner genezinge of herstellinge zeer nodig dienen te werden overgebracht en geconfineerd.*’

⁵²⁴ UA, 709-4 *Archief van regenten van het Krankzinnigengesticht*, inv. nr. 2635-2

requires some caution when reflecting on the overall shift in terminology. Implicating that just the use of the word patient was indicative of a major change in the way people viewed madness would be jumping to conclusions. Indeed, the use of both patient and object to address people with mental problems illustrates that the reality was much more complicated and many different perspectives on madness co-existed in the eighteenth century. All the same, the growing use of the term patient showed that the definition of madness was becoming more nuanced and more related to the notion of suffering from an illness.

Many specifically medical or medically inspired terminologies were used, not only for the person in question, but also for ailments. Medical terms such as melancholic, frenetic and hypochondriac were used in the sources to describe the conditions of the mad.⁵²⁵ A similar development can be observed in the aforementioned book by Van Beverwyck, where different types of madness were indicated by different medical terms. The use of these terms in the testimonies and requests establishes that the meaning and characteristics of these conditions were familiar to the people who used them. Moreover, this usage demonstrates that a simplified version of academic medicine was mainstream medical knowledge to urban inhabitants, reflecting the way they wanted to frame the problem of madness, namely, as something that had a medical origin. In a couple of other documents, the person afflicted was described as visited by a brain disease or as having suffered from a indisposition of the brain.⁵²⁶ The word disease clearly implies that the person was suffering from an illness: again, this correlates with the increased use of the word patient.

The use of medical discourse by laymen and women to try and explain how madness had come about was another notable change. Several sources state that the madness had been the result of an evolving physical illness. This development is illustrated by the case of the 26-year-old maid Catharina Coenraads. In 1789, her employer drew up a notarial testimony to have her admitted to the Amsterdam asylum. The employer, a certain Maria Eedberge, testified that Catharina had fallen

Requesten, vonnissen, overeenkomsten enz. betreffende de opneming van krankzinnigen in het gesticht 1770-1789, Admission request for Hillegonda Vroeijesteijn (29 October 1770).

Original: *'Ongelukkig schepsel.'*

⁵²⁵ For example: SAA, 5061 *Archieven van de Schout en Schepenen*, inv. Nr. 1259 Register der door schepenen geconfinieerden met de requesten 1686 -1695, Admission request voor Maria van der Lip (14 January 1687) and ibidem, 5075 *Archief Notarissen*, inv. nr. 6476, 733 (23 September 1703).

⁵²⁶ For example: SR, 18 *Archieven van de Notarissen*, inv.nr. 588, akte nr. 104 p.165 (8 December 1654) and UA, 703-a *Stadsbestuur van Utrecht*, inv. nr. 460 Requesten aan het vroedschap houdende verzoeken om machtiging om personen in een verbeterhuis op te sluiten 1700-1712, Request for Maria Boesere (18 October 1709).

ill but, in the last week, this illness had caused Catharina to be troubled in her brain and put her in such a state that she no longer could be left alone.⁵²⁷ This explanation of how Catharina's madness came about links both mental and physical ailments and reinforces two notions: firstly, that mental and physical ailments were connected; and secondly, that the condition was seen as an illness.

Notwithstanding the changes in terminology for the mad and their ailments that can be found in the sources, it was still a specific choice to use either one or the other. The question that arises therefore is why were people more inclined to use this medical terminology from the eighteenth century onwards? I would like to suggest that medical terminology and reasoning were used as a strategy to affirm that madness was an illness because of the benefits this had for the people who drew up the document as well as for the afflicted themselves. Using medical terminology was beneficial for the family and social network for two reasons. First of all, by using such terminology, they could make an eligible claim that the behaviour of this person was the result of an illness and, thereby, prevent reputational damage. Secondly, medical terminology enabled them to appeal to the government for help with their caregiving tasks. The admission request drawn up for Jannetie Jans van Heukelum in 1708 can be used to exemplify both reasons.⁵²⁸ In this testimony, Jannetie's husband, mother and neighbours all stated that she had been subjected to the illness of rage and madness for about a year and that the only reason no disasters had yet occurred was because of the help of the neighbours in watching her and the will of God. Furthermore, her behaviour deteriorated daily and she had attempted multiple times to murder her children and to hang herself, drown herself, or jump out the window: several neighbours even had to remove the pantyhose or rope from her neck. She had, consequently, caused much unrest in the neighbourhood and a growing fear arose of her starting a fire.⁵²⁹ Because Jannetie's behaviour was also brazen and morally problematic, the family and neighbours tried to prevent public shame and loss of reputation for themselves and for her by distinguishing her as ill.

⁵²⁷ 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 Catharina Coenraads (January 1789).

Original: *'Welke enige dagen geleden met ziekte bezocht zijnde die ziekte te gevolgen heeft gehad dat sinds het laatste passerende week zij getroubleerd is geworden in de hersenen met welk van dag tot dag zodanig verergerd.'*

⁵²⁸ SR, 230-01 *Archief van het Pest- en Dolhuis*, inv. nr. 178 Requesten met appointement inzake opneming van krankzinnigen 1654-1712, Admission request for Jannetie Jans van Heukelum (2 July 1708).

⁵²⁹ *Ibidem*.

Simultaneously, they tried to get help from the government in providing the proper care for this victim of a mental illness.

From Jannetie's case, we can thus surmise that people classified and framed madness quite deliberately as an illness because they benefited from its effect on social discourse. This social context dictated to what extent the family and the mad were held accountable for their actions, whether they were entitled to help, and to what extent people felt compassion for them. As a result, people such as Jannetie's family helped to bring about the medicalization of madness.

Emotions expressed⁵³⁰

A second development that demonstrates a shift in the framing of madness was the increase of emotions and compassion expressed in the sources from the eighteenth century. Because the sources in this research revealed the voices of the mad and their caregivers, these documents not only deal with practical motivations, but also with the sentiments of their makers. As such, they offer the opportunity for a collaboration between the fields of medical history and the history of emotions. The sources capture the intimate reality of dealing with madness: hence, it is not surprising that they also contain emotional expressions. What causes major challenges when analysing these emotional expressions is the differences in use of terminology of emotions, emotional etiquettes, explanations for emotions and thoughts about emotions in the pre-modern period when compared to our current interpretation. Many scholars have been dealing with these problems; for instance, Steven Mullaney in his work on the subject has observed that the word 'emotion' did not become a term for feeling until about 1660.⁵³¹ Instead, words such as 'passion' and 'affection' were used, although these could (in fact) have multiple meanings, depending on the context in which they were used.⁵³² Furthermore, ideas about emotions were totally different to modern notions and highly influenced by the humoral theory, which tied someone's humoral constitution to certain emotional and personal characteristics. In addition to this problem of terminology, working with sources primarily in their textual form poses a challenge because these words are not a direct reflection of emotions, but are rather the representations of emotions. Nevertheless, these expressed emotions do have a particular meaning and reflect social and cultural

⁵³⁰ Re-edited version of part of an article published in *History of psychiatry*: Aan de Kerk, 'Strategic voices of care', 66-78.

⁵³¹ Kern Paster, Rowe and Floyd-Wilson (eds), *Reading the early modern passions*, 2.

⁵³² *Ibidem*.

mentalities. Looking into these emotions can tell us more about the use and meaning of their expression in cases of madness.

When people talked about madness, different types of emotions were expressed. Expressions of fear were found most frequently in the sources and can be relatively easily elucidated in the explanations given for the behaviour of the mad. Fear was usually expressed in recounts of the extreme levels of violence used and during the speculation on potential disasters such as causing fires and suicide. An example of this is seen in the admission request for Susanne Consul from 1742. In this document, it was explicitly stated that, due to her long-lasting heavy melancholic and sad state, which had devolved into complete insanity, ‘her whole family constantly feared for and lived in anguish of the possible disasters that could happen.’⁵³³ This is just one of the many examples of this type of direct expression of fear that could be found in abundance in the notarial documents and admission requests.

A second emotion expressed was shame. This was, however, mostly expressed much more subtly and indirectly and can be explained within the context of (potential) reputational damage as a result of the behaviour of the mad. One of the few cases in which shame was directly expressed was the admission request made for the mad Cornelis Vergeer. Multiple admission requests were made by family members and guardians to confine (and keep confined) Cornelis for many years: first in the leprosarium of Dordrecht and, later, in the asylum, section *Kleyn Padua*, in Rotterdam.⁵³⁴ In one of the admission requests from July 1741, Cornelis’s stepmother and uncles stated that, even though treated by a medical professor, he still had fits, during which he made no sense and made offensive gestures as if he was simple in the head. Besides this, he also laughed without reason or became extremely angry, swearing and cussing at people without cause. His behaviour had already lasted for months and worsened daily, forcing them to declare that they ‘were very worried that Cornelis in his fit of rage would, to the family’s sadness and shame, kill or wound a family member or somebody else who was forced to interact with him or that he would set a fire that would lead to the total ruin of his friends and fellow citizens’.⁵³⁵ This case is striking both because the documentation about

⁵³³ RA, 230-01 *Archief van het Pest- en Dolhuis*, inv.nr. 180 Requesten met appointement, bijlagen en vonnissen inzake opneming, continuering en betaling van het verblijf, en ontslag van krankzinnigen in resp. uit het Pest- en Dolhuis 1713-1819, Admission request for Susanna Consul (2 April 1742).

Original: ‘*En die gehele familie met gedurige vreze en angstvalligheid is aangedaan door de onheilen die te duchten zijn.*’

⁵³⁴ *Ibidem*, Admission request for Cornelis Vergeer (17 July 1743).

⁵³⁵ *Ibidem*.

Cornelis's case was very elaborate but also because his family members explicitly stated that his madness and the behaviour he displayed could cause them shame.

Reflecting more on the expression of shame, we can tentatively conclude that, by documenting and labelling the behaviour of these people as the result of madness, the community of care tried to avert public shame for themselves. By having a notarial testimony or an elaborate admission request drawn up, the family or social network could distance themselves from the behaviour of the mad. This desire also relates to the previous section about the use of medical terminology. To explicitly label someone as afflicted with an illness, his or her behaviour could be causally linked to the illness, guaranteeing that the family, social network or the person afflicted could not be held accountable: madness was a problem that could happen to anybody and, thus, made them entitled to help. Often, underlying these expressions of shame, was the desire to limit reputation damage. Because someone's greatest good in the early modern society was her or his reputation, people did everything in their power to be proclaimed honourable citizens and avoid any form of public shame.⁵³⁶ Since the mad lost their sense of cultural and social convention, their socially unaccepted actions could inflict severe and irrevocable reputation damage. Causing hindrance and commotion in the neighbourhood – especially displaying the naked body or engaging in promiscuous behaviour during fits of madness – could evoke this shame and loss of reputation, which tainted everyone close to the afflicted.⁵³⁷ Still, naming the behaviour as medical and (in a way) 'airing out the dirty laundry', helped to reduce reputational damage because the stigma was now linked to madness and not to the individual(s). Openness about the shameful behaviour of the mad combined with a *re*-framing of the behaviour as the result of a condition could therefore be seen as an effort to move past the shame and stigma of madness and strategically putting the focus elsewhere.

Expressions of compassion can also be found in the sources. Even though utilized less frequently, the use of terms indicating compassion increased during the eighteenth century. The emotional expression of compassion in the sources can be discerned in the use of specific emotionally charged words. The most important of these words include terms such as sadness, unfortunate, wretched, commiserate,

Original: 'Dat de supplianten ende hun verdere bloedverwanten ten uiterste beducht zijn dat denzelve Cornelis nu of dan in zijn kwaadaardigheid de een of andere van zijn familie tot droefheid en schande van dezelve of andere die met hem noodzakelijk moeten omgaan wel mochten te neer leggen of andere werkelijke wonden toebrengen ofte wel enige tijd brand stichten tot totale ruine zo van zijn vrienden als medeburgers en inwoonders van de plaatse.'

⁵³⁶ Van de Pol, *Het Amsterdams hoerdom*, 67- 84.

⁵³⁷ Van der Heijden, *Misdadige vrouwen*, 67-68.

grief, and sorrow.⁵³⁸ In this thesis, over 300 notarial testimonies and about 2,000 admission requests were researched; only a small percentage, namely 157 of the documents from Utrecht, Rotterdam and Amsterdam, contain these expressions of compassion. Despite their rarity, they remain remarkable for their emotive power. Families and the social network directly incorporated these expressions of compassion into the testimonies when they made statements about the ‘great sadness’ they felt for the person in question and her or his situation. Identifying this kind of compassion is very interesting and resonates with the ideas of philosopher Martha Nussbaum, who studied compassion extensively in her book, *Upheavals of thought*. In Nussbaum’s work, she concluded that compassion was present when a situation was thought of as severe, befallen upon someone and the person in question was deserving. Therefore, to deserve compassion, one needed to be innocent to one’s faith.⁵³⁹ Other early modern historians have also researched compassion in this specific period and have come to the conclusion that this emotion stemmed from a spiritual foundation and displaying compassion was an act of charity.⁵⁴⁰ The distinction between deserving and undeserving instigated by Calvinist and humanist visions was especially important in this regard because it determined not only who got help but also what kind of help.⁵⁴¹ These are interesting conclusions because it tells us something about the thoughts people had regarding the origin of madness. By showing compassion to the ones afflicted with madness, people recognized that it was a condition that emerged separately from the guilt or sin of the afflicted person. In other words, madness was not thought of (in these cases) as punishment for sinful or unvirtuous behaviour.

Still, most of the testimonies were made without any emotional expression and seem quite formal. To illustrate the difference between the documents with emotional expressions and those without, two examples will be given, both from parents who requested admission for their mad son. The first example occurs in 1772: Jan Schouten declared that he had the ‘bad fortune’ that his son Jan Schouten junior had gone out of his mind several weeks ago and that this state of mind was accompanied by frenzy and even malice. The situation had escalated to such an extent that, to prevent disaster, he needed to be guarded by at least two men. His father therefore concluded that it was extremely necessary to incarcerate his son and

⁵³⁸ In Dutch: *droevig, bedroefd, ongelukkig, smart, deernis, leedwezen* and *betreuren*.

⁵³⁹ Nussbaum, *Upheavals of thought*, 304-327.

⁵⁴⁰ Broomhall (ed.), *Ordering emotions in Europe*, 146-160.

⁵⁴¹ Lindemann, *Medicine and society*, 197 and Steendijk-Kuypers, *Volksgezondheidszorg*, 101.

asked permission to confine him in the asylum.⁵⁴² Permission was granted and his son was confined in the asylum of Utrecht. The second example is the request of Arij Kleij and his wife Annetje van der Maen, drawn up in 1761. In contrast to Jan Schouten, they began their request by stating that, ‘with intense grievance of their soul, it had pleased the almighty God to deprive their youngest son Jan, who lived with them, of his senses’.⁵⁴³ Jan Kleij had been in this state for over a year and because of their own old age and there was no one else to guard and take care of Jan (apart from a daughter who also lived with them), they requested authorization ‘to confine their son until God had relieved him of his ailment’.⁵⁴⁴ Their request was approved and Jan was confined in the workhouse of Gouda in 1761 but transferred to the Utrecht asylum in 1767 where he became a ‘patient’ because of his persistent madness.⁵⁴⁵ The difference in expression of both parents when they talked about the conditions of their sons is striking to say the least. Where Jan was quite straightforward in his testimony, Arij and Annetje expressed grief, made repeated references to God’s will and elaborated on their own situation. Looking at both cases raises questions about why these expressions of emotion were used in one case but not in the next, especially because both get the same authority to confine their sons.

The increasing frequency of expressed compassion in the notarial documents and admission requests from the eighteenth century requires some further explanation. To begin, several factors may have played a role. One explanation could be that, due to the fact that the source material was more elaborate for the eighteenth century, it compromises the image we have of the preceding seventeenth century for

⁵⁴² 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 Jan Schouten (February 1772).

Original: ‘Dat den suppliant het ongeluk heeft dat zijn zoon Jan Schouten sedert enige weken zinneloos is geworden welke uitzinnigheid gepaard gaart met grote boosaardigheid zodanig dat hij om voor ongelukken bewaard te blijven door twee a drie mensen moet worden bewaard dat het ten uiterste nodig zijn dat de gemelde persoon op een verzekerde plaats werde gebracht.’

⁵⁴³ *Ibidem*, inv. nr. 2635-1 Requesten, vonnissen, overeenkomsten enz. betreffende de opneming van krankzinnigen in het gesticht, 1609-1766, Admission request for Jan Kleij (23 May 1761).

Original: ‘Tot haar grievende droefheid hunnen zielen bij requeste hadden te kennen gegeven dat het god almachtig na zijne aanbiddelijke en souveraine vrijmacht beliefd hadde haaren jongsten zoon Jan Kleij bij hun lieden en wonende en te voren gehad hebben de het gebruik van zijn verstand en zinnen.’

⁵⁴⁴ *Ibidem*.

Original: ‘Verzoekende dat zij hun zoon mogen confineren ter tijd toe dat het god genadig mochte believe hem het gebruik van zijn verstand en zinnen weder te geven voornemens zijnde het te Gouda off elders in een daartoe gedestineerd huis te plaatsen.’

⁵⁴⁵ The term patient was used here in the source and connects to the medicalization process discussed in the previous section, in which these terms became increasingly more common.

which less information was available and therefore a comparison not possible.⁵⁴⁶ The increase in expressions of compassion could also be seen in the context of changing mentalities and customs in the eighteenth century. With the birth of Enlightenment culture, the way people thought about social problems in their society and the secularization of the world changed and brought different types of rhetoric and reasoning into fashion. The aforementioned idea of showing compassion to indicate that madness was an affliction that anybody could get is an example of this change in reasoning. Interesting to note at this point was that the same rhetorical reasoning and emotional expressions used in the notarial documents and admission requests were also present in the admission requests to get people admitted into houses of correction.⁵⁴⁷ This could possibly indicate that this formulation of emotion was a type of rhetorical strategy that had come into fashion in this period. A final factor for the increase in emotional expressions could be the increase in the number of government institutions available for the mentally disturbed. This availability combined with a growing role of the urban government to act as a problem solver for these types of social issues could have influenced people's willingness to request their help.⁵⁴⁸ By using emotional expressions, they proved that they deserved help and appeal for compassion from the public and government to receive help.

In short, by looking at the development of emotional expressions in these sources, it is possible to propose that emotional expressions – especially framing and formulating the testimonies in a certain way – were employed as a rhetorical strategy. Families and the social network may have utilized these emotions to obtain outside help and secure an understanding of their situation. They did this because they benefited from the effect this had on the social discourse, which dictated the extent to which the family and the mad were held accountable for their actions, the extent to which they were entitled to receive help, and the levels of compassion that other people felt for them. How these developments in the framing of madness and the

⁵⁴⁶ See also: Introduction, 15-16.

⁵⁴⁷ These institutions provided confinement for both the mad and people who had strayed from the righteous path, had given in to sins of the flesh and alcohol abuse. In their calls for admission, the families of the men and women conducting this unacceptable behaviour mostly reflected on the situation and stated that (to their utmost grief) the behaviour was uncontrollable and the only solution was confinement.

SAA, *5061 Archieven van de Schout en Schepenen*, inv. nr. 1259-1285 Register der door Schepenen geconfineerden met de requesten 1686-1811. In addition, Pieter Spierenburg wrote on this private confinement in houses of correction and reflects on the reason for confinement in: Spierenburg, *The prison experience*, 238-248.

⁵⁴⁸ I will elaborate on this further in the next section.

corresponding rhetorical strategies were used in dealing with and arranging care for the mad will be discussed in the next section.

Using the urban care system

The final section of this chapter reflects on how the system of urban care was used by the inhabitants of Amsterdam, Rotterdam and Utrecht in dealing with madness and the mad in their city. Applying the knowledge about how the framing of madness was strategically utilized in organizing and asking for care will show with even greater clarity how the intricate system of care worked and depended on the collaboration and consensus between the different parties that have been discussed in this thesis. To begin, the discussion in the third chapter about the private system of care showed that the *family* was the main driving force in arranging care for the mad; however, sometimes, they needed a larger social network, thus creating a *community of care*. Subsequently, when people asked for care in the public system, the *urban authorities* also became part of this community of care.

If we recall back to the discussion of this urban care system in the first chapter, it was established that this system grew significantly in the early modern period and was sparked by several different factors.⁵⁴⁹ During this time, the urban government became increasingly involved in the care for its citizens; consequently, the options available in the urban care system grew. The most prominent sign of the expansion of this system for the mad was the rising availability of places for this group in urban institutions, especially in the asylums. Additionally, the increasing admission requests and population numbers in the asylums in the eighteenth century not only show the growth of the system in terms of the literal expansions of these institutions, but they also indicated that people knew their way in and around the system *and wanted* to make use of this urban system. But what and who were the driving forces behind this increased demand on the system of urban care?

To answer this question, the many different factors that have already been discussed separately in the preceding chapters now need to be considered as a synthesized whole. The first factor was the identification of who the mad were; namely, mostly men and women from the lower and middle strata of society who lived (generally) in the cities under study. If we combine these details with a second factor – the terminology and behavioural characteristics that were used to describe this group – a general idea of who were labelled as mad can be ascertained. This information further helped to identify a third factor: which types of behaviour or

⁵⁴⁹ See also: Chapter one, 24-30.

circumstances instigated the need for care and help. From all the individual examples used in this research, some general conclusions can be drawn. For example, people who were not able to take care of themselves, caused nuisance on a regular basis, and who needed to be protected for the sake of themselves and/or others formed the largest group of mad that required care. At first, the options in the private care system were explored and utilized by the community of care in searching for help for their mad loved ones. These options included caring for someone at home, arranging future care in wills, getting someone medical treatment, organizing guards or restraint within the home to guarantee safety. How long this care could be kept within this private setting depended (for a large part) on the balance between the coping capacities of caregivers and the behaviour displayed by the mad. At some point, however, the private care system was unable to cater to the needs of the community of care or the more extreme cases of ‘raving’ madness. This left a gap in the provision of care for the mad, which – to a great extent – the urban care system would fill. Nevertheless, this alone does not explain the increase of the use of the care system in the eighteenth century. To determine the driving forces behind this increase, it is necessary to explore two points: what circumstances in society increased the use of the urban care system, and who instigated the use of this system.

Driving forces: What?

Economic downfall and financial hardship have often been mentioned as one of the driving forces behind the increase of institutionalization, because more people needed the support of the urban government and poor relief.⁵⁵⁰ Likewise, in the sources from this research, one of the reasons frequently given by people to ask for help from the public system of care (mainly institutionalization) was of an economic nature. Indeed, the many admission requests made by the caregivers mention these economic considerations, often alluding to their own (disadvantageous) economic situation.⁵⁵¹ Often these petitioners stated that they had spent all their money on care and cure, that they could not manage financially anymore without the income of the person afflicted, or were limited in their own breadwinning abilities due to the responsibilities they had taken upon themselves. The fact that these government institutions and the city-employed physicians and surgeons were cheaper, was undoubtedly an important aspect in this call for help. Because the research group in this thesis consisted mainly of people from the poor and middle echelons of society,

⁵⁵⁰ For example in: Lis and Soly, *Disordered lives*, 193-195.

⁵⁵¹ See also: Chapter four, 96-101.

they were arguably more prone to economic hardship. This is especially applicable during the eighteenth century, in which economic stagnation made these classes more dependent on the system of care. Still, if we recall from chapter one, not all three cities under study were equally affected by economic downfall. Rotterdam, on the contrary, even experienced a period of growth during the eighteenth century. Nevertheless, even in this city, both the number of admission requests and the size of the asylum grew.⁵⁵² A similar occurrence can be found in England: this country also experienced a growth in the institutions and admission numbers in the eighteenth century and this was during a time of economic prosperity.⁵⁵³ Consequently, while one can conclude that the (generally declining) economic situation most likely contributed to the increase in the use of the urban care system, this factor does not fully account for the increase.

Another reason given for the increase in the use of the urban care system was the growing population number of the cities.⁵⁵⁴ This would seem quite apparent: more people meant that more people would make use of the facilities offered in the urban care system. Additionally, due to increased urbanization and population growth due to migration, more people in the cities lacked a support network (family and community) and therefore became more dependent on the public urban care system. Especially the province of Holland became highly urbanized, evident in the population increase in Amsterdam and Rotterdam. However, the migration influx dropped in the eighteenth century, which also affected the population numbers in the cities. When analysing the population numbers over time, a growth in both Amsterdam and Rotterdam in the seventeenth century can be discerned but – then – a decrease from the second half of the eighteenth century. In Utrecht, no significant population growth took place at all during the period under study.⁵⁵⁵ Therefore, citing population growth as a factor to explain increased use of the urban care system is problematic, especially for Utrecht, since this city showed no major population growth but still an increase in the admission requests made for the mad and multiple expansions of the asylum. So both the decrease in the population numbers in Amsterdam and Rotterdam from the mid-eighteenth century, combined with the stable population numbers of Utrecht throughout the whole period seems to suggest that population increase was not the main driving force for the growing dependence on the urban care system.

⁵⁵² See also: Chapter one, 36.

⁵⁵³ Scull, *The most solitary of afflictions*, 26-34.

⁵⁵⁴ Lindemann, *Medicine and society*, 196 and see also: Chapter one, 24-30.

⁵⁵⁵ See also: Chapter one, 26-27.

Cultural changes cannot be overlooked when we come to consider what the driving forces behind the increase of the urban care system could be. As this thesis has touched upon, these changes in society influenced the way the system was perceived and how it was used. In this context, notions of deserving and undeserving were important. The previous two sections about the medicalization and the expression of emotions showed that madness in the eighteenth century became seen as something that was not necessarily linked to guilt or sin but could happen to anybody. This prompted a new reaction; namely, that this group was deserving of help and care.⁵⁵⁶ This new attitude stimulated an increase in labelling someone as mad; subsequently, more people were open about the problems this caused because asking for government help became more acceptable. Furthermore, the medicalization of madness also enforced the idea that this condition was an illness: one that could be cured if the right treatment was implemented. The image of the institution, explored in chapter four, was also an important aspect in this cultural change. Having established that the asylums in this early modern period were, in fact, seen as institutions of care and cure and not as places of horror, clearly affected the way people thought about them. These changing cultural circumstances and ideas in society about the mad, the origins of madness, and the asylum as a place for the mad all encouraged people to use the urban system of care and, therefore, simultaneously instigating a growing need for it. People became more accepting of the mad and emphasized the shared social responsibility for these people. Therefore, these cultural changes seem to have been the main driving force for the increase of the willingness to call on the urban care system in the Dutch Republic.

Still, looking into the *what* of the question is only one side in understanding the origin of this increase. The next section therefore explores the human side, looking into the agency of the different actors involved and establishing *who* exactly were behind these driving forces asking for care?

Driving forces: Who?

This thesis has shown that, at different times in the process of caregiving, different people have had the primary agency of deciding on the type of care that was provided. Still, it can be concluded that the agency of the family was of paramount importance. This group had the legal power to decide over the person in question and took the initiative to get this person care: either within the private system or in the public system. Their agency is revealed via the admission requests they made.

⁵⁵⁶ Steendijk-Kuypers, *Volksgesondheidszorg*, 101-103.

The family can consequently be seen as both the main caregiver and as a disciplinary network that decided when the behaviour of a mad family member needed to be addressed. In most cases, when the family was absent, the agency shifted to the larger social network consisting of mostly neighbours and friends, who then took over the role of family to arrange care for someone. One of the most striking finds of this research has been the few voices of the mad themselves, revealed when they took control and managed their own illness process, thus showing their own agency as well. However, this could only be carried out as a preventive measure in periods of sanity or lucidity. The urban authorities also had agency, usually when the family or social network was absent or after the request for external help was formulated by the private parties to the public care system. Because the urban government (burgomasters and magistrates) and the legal authorities had the right to make the final decision about admission into institutions, this agency was also considerable.

Still, the family was the main driving force in asking for care and in instigating the use of the urban care system. Nevertheless, various actors took over this role at times and, hence, these groups also needed each other to arrange care in the process of dealing with madness. For example, while the family remained the 'prime mover' in the cycle of admitting a mad family member into an institution, other agents were vital to the process: the social network remained crucial to confirm claims of madness and likewise, urban authorities to grant admission. The very intricate collaboration that this co-dependence created resulted in a more intensive and extensive use of the urban care system, in which each agent was fundamental to the whole.

Besides agency, another way to discern who the driving forces were behind the increased use in urban care is to investigate who paid for the care of the mad. Various agents determined the funding of care and the public facilities in the early modern urban environment.⁵⁵⁷ In chapter four, when discussing the admission process, it became clear that, if the family was in any way capable of paying for the care of its mad family member, it was held accountable for this. This accountability could even come in the form of services; for example, doing the laundry for the people who were institutionalized.⁵⁵⁸ Not only the family was involved in paying for the mad, but the inhabitants of the city were indirectly involved because they sponsored – for a great part – the public system of care via almsgiving.⁵⁵⁹ By facilitating the urban care system, the urban government, too, was involved in the

⁵⁵⁷ Van der Heijden, *Civic duty*, 2.

⁵⁵⁸ See also: Chapter four, 101 and 114-116.

⁵⁵⁹ See also: Chapter one, 28-30.

foundation of the institutional system and thus involved in paying for the costs. The urban government also became concerned with, or even dictated, civic and religious organizations' poor relief to pay for admission costs in the institutions; however, these groups also sponsored the boarding out of their poor mad adherents. When we 'follow the money', it can be concluded that different parties were involved in paying for the care of the mad. Unsurprisingly, in most cases, the families were held responsible for the payment of the care and needed to pay for this when they had the money to do so. It was only when they could not afford to or if they were not involved in the process that the larger community of care (social network, urban government and different religious or non-religious poor-relief organizations) would step in. Again, this revelation confirms the strong position of the family as the main driving force.

The previous two paragraphs strongly suggest that the answer to the question of who the driving force was behind the increase of the urban care system was family. The family was responsible for arranging care, keeping the situation in check and deciding when it was time to institutionalize someone. The family also paid for this if possible, either in money or kind. Still, in the development of the urban system of care, it has been a long-held scholarly understanding that the increase of admission into the institutions was implemented top down by the urban governments and not bottom up as the 'family' answer implies. This top-down theory argues that the foundation of these institutions was part of the larger aim of the government to provide institutional care for its inhabitants in an attempt to pre-empt the disturbance caused by the growing population of unwanted (poor) citizens: the mad were seen as part of this group.⁵⁶⁰ However, to understand the true driving force behind the growth of this public system, one cannot simply look at the notion of 'supply' that this theory encourages: the 'demand' side must also be taken into consideration. This research has shown that institutionalization of the mad was not an arbitrary act and that, in most cases, requests were made for admission. Hence, people *asked* for help from the public system of care. Again, the family was the initiator in most cases, requesting admission into the asylums or other urban institutions. As such, in my opinion, both the bottom-up demand (from family and other social units) as well as the top-down supply (from governmental and urban organizations) need to be addressed by scholars to fully answer the question of who instigated the increase of admissions and growth of the institutions.

⁵⁶⁰ Scull, *Madness in civilization*, 122-129.

Arguably, answering this question seems to parallel the proverbial chicken and egg situation: did the increase of the urban care system instigate more requests or did the increase in the number of requests instigate the growth of the system? Still, in the case of madness it was established that the initiative of action generally came from within the community: people living with the mad asking the urban government or judicial authorities for help when the situation was no longer tenable. This relationship could allude to a new way of perceiving the city; perhaps, the population started to ‘imagine’ the city, represented by the city government, as a problem solver and therefore as an important element in their daily lives. This would obviously have had an effect on how madness was dealt with. In particular, the families, social network and (on some occasions) the mad themselves grasped their ‘bureaucratic agency’ to play this governmental system and use it to their advantage, as Tim Hitchcock and Bob Shoemaker called it in their book, *London lives*.⁵⁶¹ These authors have identified this involvement as ‘a creative and imaginative agency of shared intent, composed of individual actions motivated by individual circumstances but exercised collectively and often publicly as a result of common experiences and shared understandings’.⁵⁶² In terms of this thesis, ordinary people could influence social policy through this bureaucratic agency by both playing and confronting the system. Thus, they would bring about an increase of the urban system of care in the process.⁵⁶³ Using bureaucratic agency as a concept for understanding the sources, we see that most initiatives of action came predominantly from the bottom up and entailed calling on urban facilities, government, and society at large to act, innovate, and help in dealing with the mad.

Overall, the family can be identified as the main driving force when it came to the care of the mad. Therefore, the family stood at the centre of the urban system of care.⁵⁶⁴ This was not new, the family always had – and still has – an important role in the care of the mad. The question remains, however, as to why the ‘voice’ of the family became more and more prevalent in the sources from the eighteenth century. The cultural changes that took shape during this time were, in this regard, most influential as they altered the way people thought about madness. Moreover, these cultural changes shifted the way people thought about the entitlement of the mad to healthcare with the result that care for the mad became more of a public health problem.

⁵⁶¹ Hitchcock and Shoemaker, *London lives*, 19-20.

⁵⁶² *Ibidem*, 22.

⁵⁶³ *Ibidem*, 4-21.

⁵⁶⁴ Wright and Digby, *From idiocy to mental deficiency*, 4.

When considering these two driving forces – family and cultural shifts in perceiving madness – the conclusion to be drawn is that the urban system of care was *reactive*. Indeed, the community of care (mainly the family) is found to be the *active* party, taking initiative to put the problem of madness on the public agenda. Still, for these changes in mentality to be implemented in day-to-day life, a consensus among private and public parties had to be reached about who was entitled to help and what kind of help. In fact, consensus over these issues was crucial in determining the use and development of the urban care system because, even though the family was clearly the primary power, many other actors had agency at different times in the process of care for the mad. Subsequently, collaboration at these crucial moments was paramount and, to achieve this, a consensus among the various parties needed to exist. In the final part of this chapter, research into how this collaboration and consensus came into being is explored.

Collaboration and consensus

An essential element in the growth of the urban care system and the use of it was the fact that the different parties involved needed to interact and collaborate to establish proper care. To explain how this worked, the early modern city can be viewed as a micro-organism, consisting of many actors who must work together to overcome certain problems in their society. In her book, *Civic duty*, Manon van der Heijden offers a novel view on public services in the early modern Low Countries and reflects on the way all types of responsibilities were shared by central and local governments, private and public individuals, ecclesiastical and secular groups and individual and corporate initiatives.⁵⁶⁵ Van der Heijden's point of view is central in relation to the argument put forward in this thesis, as seeing these cities as civil societies, in which the shared interest of the different actors involved was crucial for the systems of care to work, helps to understand the intricate relationship between them.

One of the most important of these shared interests between the city government and the urban population was guaranteeing the liveability of the cities and safeguarding its inhabitants. Having researched the breakpoint that instigated the shift from private to public care and the reasons that initiated institutionalization, it has become apparent that these issues were of great significance in dealing with the mad. Although the same pattern of reasoning can also be applied to earlier periods, the increase of urbanization and population levels during the seventeenth and eighteenth century in the three cities studied has made these issues more prominent

⁵⁶⁵ Van der Heijden, *Civic duty*, 36-52.

for this period. In addition, the fact that madness was increasingly perceived as a public health problem was also an interest shared by the city government and the urban population. In this regard, the resulting call for a public need for a solution did not mean a governmental solution, but – as Van der Heijden also seems to suggest – a truly *civic* one: that is, a collaborative solution involving the input of both private and public parties for the benefit of city and citizen.

In order for this collaboration to work, a consensus needed to be established between the different actors about who comprised the group of mad, why they needed (or deserved) care, and what type of care was entailed. This consensus was established by a shared public mentality about these questions. For example, we saw in the previous two sections that both the medical discourse and the use of emotional expressions were identified as rhetorical strategies, used by families and the social network to label madness and to legitimate care for this group. By framing the condition of madness in certain ways, these groups anticipated making use of the growing systems of urban care. For these rhetorical strategies to be successful, however, they needed to be accepted by all the various actors. Additionally, a consensus was also needed regarding which types of behaviour had no place in society and how to deal with those people displaying this conduct. This type of consensus shows the role of the community of care as a disciplinary network. Therefore, both the use of rhetorical (emotive) strategies and the categorization of certain behaviours as social or anti-social reveals much about the public mentality of a society and showed that consensus was essential for the working of the whole care system for the mad. We can [immediately] appreciate the implications of this kind of consensus by recalling the process of institutionalizing a mad person. More specifically, both the family and the urban authorities had to agree upon what constitutes intolerable behaviour. Additionally, the rhetorical strategies used by families had to be understood and accepted by all parties.

Examining the use of the urban system of care for the mad – what and who were the driving forces behind the increased development of this system – has shown that cultural changes and the family were the most important factors behind this push. Nevertheless, because the system involved a variety of actors who (at certain times) also possessed the power to decide on the care for the mad, collaboration and consensus between all those involved in the process of care was of utmost importance. In fact, the urban care system could only work when consensus was reached about who was eligible to receive help and what that help entailed.

Conclusion

This final and concluding chapter has examined two major developments in the framing of madness over two centuries to address the question of why the use of the urban care system for the mad increased. In doing so, and by bringing together conclusions from previous chapters, we have established a more comprehensive and nuanced understanding of how the mad were dealt with in the early modern cities of Amsterdam, Rotterdam and Utrecht.

Using the sources to trace the increase of medical discourse and the use of emotional expressions illuminates how madness was seen, analysed and framed in the early modern Dutch urban communities. In regards to medical discourse, we have seen how the mad were increasingly referred to as patients, which influenced general perceptions of them as victims of their illness. We have also seen how medical ideas about the cure for this disease had changed and how medical professionals became increasingly more involved in dealing with madness. Both these discoveries show how the medicalization of madness was brought about in this period. In the use of emotional expressions – and especially that of compassion – sources from the eighteenth century reveal that madness was increasingly framed as an arbitrary illness that came about without the guilt of the person in question. People benefitted from the effect this had on the social discourse about madness: although still present, the stigma attached to this illness had lessened to such a degree that an empathetic rapport could be established between public and private parties. Thus, families used these emotions to acquire outside help for the mad and gain understanding for their situation.

In reflecting on the use of the urban care system for the mad and the growth of the system in the eighteenth century, the main question of this thesis can be answered. Investigating both *what* and *who* were driving the increase, it was demonstrated that cultural changes in the ideas about madness (and the mad) and the family were the two major motivating forces for the growth of the system. Even though economic downfall and population growth have often been cited as reasons for the increase of admissions, discrepancies and even contradictory evidence in the sources have proven that this cannot be the case for the three cities under study. What the sources do reveal – without any inconsistency – is that the change in the mentality about madness and the mad was most important. Seeing madness as an illness that could befall anyone and seeing the mad as people deserving of compassion, cure and care (at home or in institutions) served to legitimate madness within a (public) social context; consequently, this new mentality instigated an increase in the willingness to ask for help. The people asking for this help were predominantly the family of the

mad, who had the legal right and responsibility to act on their behalf. And while this legal right was not new, the way they exercised it was. Arguably, it was the more prominent use of their bureaucratic agency, which resulted from the interaction between urban organizations and private individuals and their willingness to use the system that really pushed expansion in this period.

From this, it can be concluded that the urban system of care was an intricate entity, in which different types of madness and actors had their own place. The family, which was the main initiator of care, was at times assisted by a social network and the urban authorities. This broader involvement of society shifted madness from being a private problem to being a public one as well; crucially, all the actors – family, institutions, and urban authorities – needed to be in consensus in order to collaborate on matters to handle it. Therefore, identifying the driving forces behind the growth of the urban care system for the mad and its use not only reveals something about how the mad were dealt with, but also shows how people lived together in a city. Having this information goes a long way in improving our understanding of how the urban system of care emerged, showing once and for all, that the urban modern society in the Dutch Republic was not ruled and guided top down but was a result of bottom-up initiatives.