DISORDERED EATING AS A LEITFADEN THROUGH LATE EIGHTEENTH-CENTURY PSYCHIATRY

by

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ABSTRACT

My thesis expands the histories of insanity, psychiatry and eating disorders. It explores the myriad intersections between the diagnoses of ‘insanity’ and ‘disordered eating’, using the latter as a guide to changing conceptualisations about the former. The parallels between the relabelling of disordered eating as a manifestation of psychological disorder and the reimagining of insanity as mental illness are complex but illuminative. Disordered eating cases show that, from 1750 to 1830, somatic signs were usurped by sociobehavioural, emotive and cognitive symptoms. This thesis argues that psychiatry evolved when geographic, cultural and intellectual groups adopted that position.

This thesis treats medical knowledge and practice as independent but interdependent. The years 1750-1830 were seminal, transitory years. Hospitals and asylums reshaped not only the basic dynamics between practitioners and patients and the rate at which practitioners encountered the poor and the insane.¹ Psychological types developed in print

¹ For physicians this was often for the first time. For the development of the hospital within this period see Erwin H. Ackerknecht Medicine at the Paris Hospital, 1794-1848 (Baltimore: John Hopkins Press, 1967), C.E. Rosenberg The care of strangers: the rise of America’s hospital system (New York: Basic Books, 1987), Susan Lawrence Charitable knowledge: hospital pupils and practitioners in eighteenth-century...
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but evolved into clinical categories as asylums changed the face of medical practice.

Although this period has long interested historians of medicine it has been neglected by historians of eating disorders. But disordered eating was among the most commonly accepted indications of insanity, abnormality and irrationality. Varying in intensity and form, disordered eating symptoms documented a spectrum of illness. This was critical for the broader acceptance of psychiatry as a legitimate discipline and mental illness as a valid medical condition.

Finally, my thesis presents the American medical world as, in essence, a subset of English culture. This is qualified in four ways: asylum strategies; (re)publications of medical texts; newspapers reports; and legal decisions. American psychiatrists constantly referenced English colleagues and encountered individuals akin to English examples. In practice and theory, they developed the efforts of their English counterparts to formulate a new idea of mental illness.

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INTRODUCTION

------- The Contributions of this Thesis -------

My thesis expands the history of psychiatry in two key areas. First, its novel exploration of disordered eating cases offers a new interpretation of the earliest years of psychiatry. Despite acknowledgement that “food refusal was a commonly reported phenomenon” and that “Dietary abuses and abnormalities figured again and again as symptom and causes,” the intimate relationship between the history of disordered eating and the emergence of psychiatry has never been detailed. Using disordered eating as a guide, my thesis shows that the concept of mental illness emerged when traditionally physiological complaints were reconceived as symptoms of psychological disturbance. On both English and American soil theories were forged into psychiatric practice as ‘moral management’ and ‘moral treatment’. Although both approaches have been dismantled into medical, benevolent and organizational motivations, historians have yet to demonstrate how they were applied across space and time to a particular group of symptoms. By highlighting the fact that food relationships and patterns of consumption were important therapeutic determinants, the final chapters of this thesis illustrate how therapeutic theories translated into daily asylum experiences.

This thesis makes a second contribution in its trans-Atlantic purview. I argue that English and American practitioners built an intellectual and therapeutic community around their shared reimagining of disordered eating as a manifestation of mental illness. This community’s homogeneity arose from knowledge sharing networks and personal

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relationships rather than state interventions.¹ My thesis further demonstrates that, largely unhindered by the Revolutionary Wars or Independence, American practitioners were continuously influenced by their English counterparts. Tracing a trans-Atlantic history, I highlight the largely shared experiences of the early English and American psychiatric community. Generally American practitioners consciously followed and built from the works of their English and continental counterparts. This thesis subsequently largely highlights the similarities rather than differences between the two medical cultures. That assertion is shaped by wider historiographies about the philosophical, cultural and social relationship between the American territories and England.² Using disordered eating as a guide, this thesis shows that shared case notes, narratives, theories and practices bridged colonial, state and national boundaries.

My thesis further suggests that the psychiatric community achieved lasting legitimacy and authority only once wider communities accepted the premise of mental illness. Disordered eating cases are extremely instructive as to this major transition for they highlight the many ways psychiatrists introduced non-medical audiences to their idea of insanity. The earlier chapters in particular show that psychiatry evolved through affirmations that the psychiatrist alone was equipped to treat and cure mental illness. The years 1750-1830 saw a sharp increase in the number of publications about insanity and mark the early psychiatrists’ determined entry into the growing medical literature marketplace. They also mark the steady transformation of the insane narrative into the case study of insanity. Included over the course of this thesis are medical and psychiatric publications, lecture notes, hospital case reports, domestic health manuals, newspaper

articles, newspaper editorials, periodical articles, court transcripts, clerical treatises and pamphlets. I employ this wide range of sources as a valuable method of tracing the spread of psychiatric ideas: all genres advanced the idea that mental illness was a subject suitable for the format of a medical case study. Thus, by analysing varied sources and descriptions of disordered eating, I highlight the fact that this was a transformation advanced by medical and non-medical authors alike.

In addition, this thesis analyses disordered eating in order to discuss how ‘insanity’ was both experienced and witnessed. Chapter five makes an innovative contribution to historiographical attempts to uncover what it truly meant to experience insanity. It shows that many patients gave meaning to their imagined and emotional realities through their relationships with food. The middle chapters demonstrate that, at the same time, friends, families and broader communities constantly drew upon the behavioural, verbal and somatic symptoms of disordered eating when describing and diagnosing insanity. Crucially, the language surrounding disordered eating shows a widespread sociocultural acceptance of the premise that mental illness was insanity’s root characteristic.

Finally my thesis makes important contributions to the historiography of eating disorders. First, through its focused study of the late eighteenth and early nineteenth centuries it uncovers a period often overlooked in these histories. Caught between medieval fasting saints and later nineteenth-century anorexics, the years 1750-1830 have drawn little attention. For example, Eugene Bliss and Charles Hardin Branch moved into the nineteenth century by page thirteen of their *Anorexia Nervosa: its History, Psychology, and Biology*, whilst the eighteenth century forms but a part of chapters in seminal works by Joan Jacobs Brumberg and Walter Vandereycken and Ron Van Deth. For these authors, and many other scholars, the mid nineteenth century represents the

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period of fundamental cultural shift. Demonstrating that descriptions of disordered eating as a manifestation of mental illness existed a century earlier than they ascribe, I insert this key period into the heart of this longer narrative.

I offer another new direction by focusing on the cultural context of disordered eating cases. In this I reject the tendency to approach historical examples of eating disorders through either the explanations of modern-day sufferers or nineteenth- and twentieth-century realities. The interpretation of the past through the lens of the present arose, in part, from the fact that many early scholars of eating disorders were themselves either health care professionals or from non-historical disciplines. Such investigations into the “value of slenderness,” “the appropriate shape for women,” and claims that “women have [always] been expected to look and dress in ways that immobilize them” tend to use the past primarily as a mirror for the present. These are histories of female fasting rather than histories of food relationships or interpretations of historical consumption behaviours. My work expands this scholarship through its determination to detail how changing theories about a full range of disordered eating evolved across time-specific medical, legal and broader socio-cultural climates.

------ Historiography ------

I argue that psychiatry did not evolve solely within the walls of the public asylum. The following pages thus move into the institution only at the end of their narrative. That approach separates this thesis from many other histories that have interpreted the early years of the psychiatry squarely through the lens of the nineteenth-century asylum and the “failure of institutions.” These histories are dominated by attempts to explain the rise of the asylum and the dichotomy between treating the sick and the “social organization of

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5 For a comparative literature perspective see N.A. Gutierrez ‘Shall She Famish Then?’ Female Food Refusal in Early Modern England (Aldershot: Ashgate, 2003) and A. Krugovoy Silver Victorian Literature and the Anorexic Body (Cambridge: Cambridge University Press, 2002). See also Jacobs Brumberg Fasting Girls, chapter one.


deviance.” This scholarship expanded significantly in the 1960s, very much the product of concurrent movements that questioned and discredited both the psychiatric profession and medical arenas of practice. As Charles Rosenberg put it “suddenly, it seemed in the late 1960s, the American hospital became a problem. It has remained one.”

The psychiatrist Thomas Szasz propelled this movement at the start of the 1960s when he roundly denounced the confinement of the ‘insane’ and questioned the medical legitimacy of psychiatry. Szasz’s argument was supplemented by Thomas Scheff who relabelled mental illness as a category of deviance rather than a marker of biological reality. By calling into question the very nature of psychiatry these early scholars invited debates about the historical experiences of the confined.

The reinterpretation of insanity as a problematic label for deviance drew further fuel from Michel Foucault’s seminal 1961 work *Madness and Civilization*. Foucault’s vision of a state-sponsored segregation and confinement of the delinquent or abnormal has informed repeated narratives that interpret the asylum and psychiatric profession as agents for social control. As he would later expand upon in his *History of Madness* (1972), Foucault contextualised late eighteenth- and nineteenth-century madhouses and asylums within a longer history of the ritual exclusion of the insane. Foucault argued that fear was the predominant motivator and presence within the asylum, and that morality, truth and reason were almost synonymous rhetorical masks for organising the physical and metaphorical separation of the insane from the rest of humanity.

At the turn of the 1980s Andrew Scull encouraged a reexamination of this narrative by pointing to the disconnect between the “intentions” [emphasis in original] of the early

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13 Ibid., pp.187, 233 and 248.
asylum builders and the “damned” results of the nineteenth century. Scull saw the early nineteenth century as a period of promise, bracketed by sweeping institutionalization in the later nineteenth century, and the brutality of eighteenth-century mad-doctoring. Informed in part by “the nineteenth century’s deep contempt for the eighteenth,” a vision of the almost charlatan mad-doctor, blindly experimenting on and depleting their ‘captives’ has subsequently informed both anecdotal and academic visions of the early eighteenth-century asylum. Scull and Max Byrd, for example, have portrayed the eighteenth-century “madman in confinement [as one] treated no better than a beast” and the cells of Bethlem as “in reality the cells of a human zoo.” The eighteenth century thus became a period of paradox, when enlightened rhetoric failed to guarantee humane treatment but, rather, when the insane were treated as threats to peace and rational society, to be corralled and controlled.

Although Foucault’s arguments were grounded in the seventeenth century, his interpretation was further advanced by historians of late eighteenth-century institutionalization, urbanization and nineteenth-century welfare. A parallel interest in the commercialization of the medical industry, and “the growing, though still unsettled, role of corporations and the state” has also been influential. In the 1990s and 2000s this scholarship was revised by histories that saw later eighteenth-century medical endeavour as theologically inspired charitable work. Revisited in chapter four, both interpretations

16 Scull Museums of Madness, p.64 and M. Byrd Visits to Bedlam: Madness and literature in the eighteenth century (Columbia: University of South Carolina Press, 1974), p.45. For more on this see Foucault Madness and Civilization, p.68.
have been particularly well developed for America, where scholars have connected institution building to efforts to metaphorically and physically reshape the newly independent territory.  

David Rothman and Gerald Grob’s efforts to contextualise changing practices of welfare and the rise of the asylum within a “broad social and political framework” have also had lasting influence.  

Class-infused visions of a movement enacted on (rather than with) pauper, delinquent and insane populations thus inspired a return the narrative of control and societal missions.  

The idea that the early asylum was an agent for social organization raised questions about the power-dynamics underpinning the application of terms such as ‘madness’, ‘insanity’ and ‘mental illness’. George Rosen’s 1968 *Madness in Society* was an early attempt to explore how insane individuals were manufactured within their time-specific sociocultural climates. Subsequent scholars suggested that the label ‘insanity’ was itself a sociocultural construct. In 1994 Roy Porter and Mark Micale addressed this scholarship when they argued that histories of psychiatry and insanity reveal a greater degree of discord than any other medical histories because of the continuing uncertainty as to the nature and etiology of mental illness. 

The nineteenth and twentieth centuries’ discoveries of biomedical mechanisms and etiologies have strengthened arguments that there was an inherent biological reality to the historical experience of insanity, but the debate is ongoing. Recent scholars have questioned how far the label ‘insanity’ was

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reflective of lived and witnessed realities and whether or not asylums were merely “cultural construction[s] in medical form.” In contrast, this thesis subscribes to Roy Porter’s declaration that histories of insanity must treat it as a physical fact but interpret it primarily as a socially constructed experience.

This thesis contends that, whilst the label ‘insane’ carried many meanings, they all derived from lived and witnessed conditions. Chapters four and five portray public asylums first and foremost as medical institutions. They are shaped by the acknowledgment that practitioners and attendants always presented themselves as therapeutic workers. Within the asylum and beyond its walls, the idea of mental illness was advanced because psychiatry was presented so as to be as similar to traditional medical disciplines as possible. Moral treatment, for example, organized insanity at the same time that Cullen and Linnaeus were ordering and structuring material medica, diseases and the natural world. It also employed traditional medicants and heroic therapies alongside psychobehavioural conditioning. I move away from the social control model because it can reduce the motivations of the many other groups who supported the advance of psychiatry. The individuals who constructed, subscribed to or presented patients to the asylums clearly believed that these institutions were capable not just of caring for but actively curing insanity. Those labelled insane were not permanently segregated from rational society: they were committed to asylums because those institutions promised to help and to heal.

Although historians have differed as to the exact nature of early psychiatry, there is a general consensus that early psychiatrists used their voices as much as their hands. Disordered eating cases demonstrate that, far from silencing the insane, the early

psychiatric community relied on both explanations and behaviours when reaching a diagnosis. In addition, it appears that insanity and the insane voice gained an increasing public presence in the years 1750-1830 through a variety of print genres. In my study of those discourses I build from the work of historians such as John Mullan, Michael DePorte, Thomas Dixon and Allan Ingram who have contextualised ‘insanity’ within enlightenment philosophical-psychological discourse. These scholars made significant contributions to debates about the intellectual climate of insanity within the long eighteenth century.

Whilst ‘the Enlightenment’ has been deconstructed into various strands, its relationship(s) to the insane remains a major point of contention. Mullan, for example, argued “To describe ‘the dark side of the Enlightenment’, the seething realm of ‘unreason’, is to accept the myth of Enlightenment, the positivity of Reason.” Lynn Gamwell and Nancy Tomes disagreed:

The driving principles of the Enlightenment - that reason is the essence of human nature, that science can explain the universe, and that society can be continually improved through human effort - reshaped the conception and treatment of madness over the course of the eighteenth century in England and the American colonies. Loss of reason came to be seen as equal to loss of humanity; madmen were seen as little better than animals. The first hospitals were established to protect citizens from the threat to social order posed by violent lunatics.

The key point of dispute is whether or not the ‘insane’ were alienated from a sociocultural climate that promoted rationality and faith in the human initiative. The cases explored in the following pages demonstrate the latter.

A further effect of this debate has been to position the medicalization of mental illness within this broader climate of human industry and secularizing endeavor. Chapters two and three touch upon a major subset of this debate: the medicalization of behaviours previously considered moral or divine by nature. As Michael MacDonald has

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33 Chakravarty “Medicalisation of Mental Disorder”, p.271.
argued, practitioners benefited from rather than led the cultural changes that enabled this reconceptualization. But the emphasis on the joint advance of secularization and rationale endeavour over spiritual tradition must not be overestimated in either English or American contexts. As chapters four and five demonstrate, asylum patrons, practitioners and patients all approached insanity and disordered eating through the filter of religious and salvation sentiment. Whilst it is possible that psychiatry provided a convenient alternative to religious delinquency, it is also the case that moral treatment was almost universally premised upon a vision of God’s grace. Disordered eating manifestations thus provide a new way of thinking about historical relationships between medicalization, secularization and the insane self.

Indeed, my thesis reveals a period filled with changing perceptions about the mind-body relationship. It has also been shaped with reference to the works of Joan Jacobs Brumberg and Walter Vandereycken and Ron Van Deth, historians of eating disorders who traced “the transition from sainthood to patienthood.” Jacobs Brumberg’s argument that “eating disorders appear ultimately to be cultural productions, no matter what biological mechanisms they provoke” was influenced heavily by social constructionism and its emphasis on “symbolic language.” Vandereycken and Van Deth’s scholarship is more definitely connected to histories of medicine. But their interest in the medicalization of fasting behaviours was also premised upon the declaration that “the creation of illness is a sociocultural process” and thus more complex than mere biological or behavioural realities. Their joint vision of the nineteenth-century annexation and subjugation of the

34 M. MacDonald “The Medicalization of Suicide in England: Laymen, Physicians, and Cultural Change, 1500-1870” in Rosenberg and Golden (eds.) Framing Disease, p.98.
35 For more regarding clerical influence see Hempton “Enlightenment and faith”, pp.72 and 99. For more on Methodism and madness see Andrews and Scull Customers and Patrons of the Mad-Trade, pp.82-85.
36 This was especially true for the Quaker-led York Retreat, the Friend’s Asylum in Frankford, the Pennsylvania Hospital and the Hartford Retreat. For more see Charland “Benevolent theory”, pp.61-80. See also Anon Report of the Physician of the Connecticut Retreat for the Insane from the opening of the Institution on the 1st of April 1824, to the 1st of April 1825 (Hartford, CT: P.R. Goodsell, 1825).
37 Jacobs Brumberg Fasting Girls, p.4.
39 Vandereycken and Van Deth From fasting saints, p.13. For more works focused on the intersections between food behaviours and the medical construct of eating disorders see Joseph A. Silverman “Louis-Victor Marcé, 1828-1864: anorexia nervosa’s forgotten man” Psychological Medicine, Vol.19 (1989), pp.833-835, Brenda Parry-Jones “Historical terminology of eating disorders” Psychological Medicine,
feminine body by the male-dominated medical world has spurred additional scholarship into this era.40 The following pages address these parallel interpretations.

Eating-disorder scholars encouraged the idea that whilst present-day eating disorders cannot be traced through the historical record, it is possible to trace symptoms by exploring both changes in medical theory and the language sufferers used to describe their eating. In 1992 Tilmann Habermas addressed these approaches and argued “an anachronistic reading of historical texts, in the sense of judging them with present day diagnostic concepts, is legitimate when the aim is…the description of historical change in syndromes.”41 His argument unites numerous scholars whose histories of eating disorders equate, in reality, to the history of anorexia nervosa or bulimia nervosa.42 The vast majority of the scholarship into the history of eating disorders has been constructed around attempts to trace the historical precedents of anorexia nervosa behaviour before it was named in 1873.43 Both streams ground their historical investigations in medical theory and “the principal eating disorders identified in the…DSM” as they try to mould historical stories to fit our definitions of bulimia nervosa or anorexia nervosa.44

This thesis breaks with the vast majority of the histories of eating disorders, which tend to reduce the history of eating disorders to the history of female fasting behaviour and the anorexic female body. It is near impossible to find a history of eating disorders unshaped by gendered analysis. Hilde Bruch’s seminal 1979 work The Golden Cage


inspired interpretations of the history of eating disorders as a history of the female self. This scholarship echoes wider attempts to uncover whether or not women have ever been treated neutrally by medical practitioners, families and societies at large. For example, in Susan Bordo’s exploration of the body (and she included masculine bodies) as a historical agent, eating disorders were and remain “at least in part a defense against the “femaleness” of the body, and self-loathing.”

Bruch’s influence is also evident in additional arguments that eating disorders have meaning as expressions of resistance to and rejection of both familial relationships and wider patriarchal impositions. My thesis highlights the problems with that perspective. Individuals who manifested disordered eating in the years 1750-1830 almost never explained such using the language of idealized body types, familial oppression or patriarchal suppression. Any attempt to retroactively diagnose this would be speculative at best. Furthermore, historical instances of disordered food relationships were neither gender-specific nor universally expressed through abstinence. Nor were they perceived as such by medical practitioners. The crux of this thesis lies in the attempt to reshape narratives premised on the idea that diet offers women a philosophy of self into a narrative of disturbed selves and more gendered-balanced realities.

But the history of eating disorders expanded significantly with rising interest in the history of food and the meanings attached to the act of eating. This scholarship, from a largely anthropological perspective, has stressed the thought processes and cultural preconditions that shape an individual’s food habits and has, at times, appropriated Foucault’s message that social behaviours evoke struggles for authority. Scholars such as Sidney Mintz, for example, have interpreted anorexia and bulimia as “food-related

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pathologies…[and] a clear if extreme sign of human ambivalence about eating” in the face of consumption-related power dynamics. ⁴⁹

Mintz’s suggestion that food plays a role in communication and identity was expanded by Carole Counihan and Penny Van Esterik who, in 1997, argued, “Eating is an endlessly evolving enactment of gender, family, and community relationships.” ⁵⁰ Counihan and Van Esterik aligned with two 1985 publications that explored the role food and consumption patterns played in medieval female expressions of spiritualism. Carol Walker Bynum’s *Holy Feast and Holy Fast* and Rudolph Bell’s *Holy Anorexia* both attempted to locate meaning in patterns of abstinence. They offered two different (but emblematic) interpretations of those meanings. Using Tilmann Habermas’ terminology Walker Bynum employed the “discontinuity approach” [emphasis in original] to disconnect historical food behaviour from modern-day anorexia nervosa and argue that the meanings the women attached to their food behaviours were specific to their particular cultural context. In contrast, Bell employed the “continuity approach” [emphasis in original] and emphasised the similarities between extreme fasting behaviours across different temporal periods. ⁵¹

Through these interpretations, histories of eating disorders have come closest to sociocultural histories of insanity. Those who were classified as insane ascribed detailed, lengthy and even spiritual meanings to their food relationships. In turn their disordered eating was translated in numerous ways that spoke to their emotional or imagined realities far more than the state of their physical frame. This thesis points to how psychiatrists’ diagnoses relied on behaviour and discourse, not one or the other. It therefore uses historical examples not to trace a history of a syndrome but, rather, as insight into contemporaneous conceptualizations of disorder behaviours and disturbed minds.

Critically, it traces the intersections between how people experienced disordered eating and how those experiences were translated (by communities with various interests) into symptoms of a larger illness. That marks a major contribution to the current field.

---- Terminology ----

I employ the terms ‘psychiatrist’ and ‘psychiatry’ throughout my thesis. Both indicate authors and practitioners who grounded their diagnosis and treatment of insanity in a joint combination of psychological analysis and physiological exploration. The label ‘psychiatrist’ has sometimes been used to denote a class of practitioners who shared professional apparatus and a common philosophy. These descriptions of the professionalization of the medical practitioner have been heavily shaped by investigations into the ‘progressive’ accumulation of professional markers in the nineteenth century. The use of the term throughout this thesis speaks instead to changing doctrines about insanity. This was a period of community building more than a period of professionalization, when individual authors and institutions both published cases and treated patients according to their own disparate sense of what insanity looked and sounded like. To refer to either as psychologists, or their treatment simply as ‘psychology’ would be misleading.

I am also careful to differentiate between physicians and medical practitioners. Historians of the hospital have pointed to the nineteenth century as the moment at which scientific progress was marked by the professional triumph of the physician over other practitioners and, more importantly, over hospital trustees. Whilst my thesis demonstrates that physicians gained prescriptive authority within the asylum, it is also clear that any authority within the institution was derived from asylum committees and

52 For the latter see Henry Burnell Shafer The American Medical Profession 1783 to 1850, 1st ed. 1936 (New York: Ams Press, 1968) and Starr The Social Transformation.


patrons. Chapters one to three indicate that the public accepted the premise of psychological disturbance before they accepted physicians’ monopoly over the insane. In tandem, chapters four and five acknowledge that physicians never held absolute authority over the diagnosis or treatment of insanity, within or without asylum walls.

In addition the term ‘patient’ is used deliberately. ‘Patient’ is normally a self-identified label we apply to ourselves for a transitory period of time. In contrast, the individuals discussed over the course of this thesis often lacked control over their diagnosis. Nor were their treatment periods of short duration. The realities of these patients often existed quite separate to – and sometimes in spite of – the judgements of those around them. I use the term ‘patient’ nonetheless because it is emblematic of the annexation of insanity by medical practitioners and, more importantly, because it recognises how broader groups classified these individuals. Furthermore, my use of the term ‘patient’ is heavily shaped by my research decision to focus predominantly on public asylums. It is to be acknowledged here that the patients discussed over the course of this thesis do not represent the full range or experiences of the many individuals judged insane in this period.

This focus of course also encourages questions as to the nature of the words ‘public asylum’. Admittance to various public asylums was shaped by myriad factors. St Luke’s Hospital, for example, seems to have drawn patients based more on requests received from individual patrons rather than geographical proximity, whilst the Quaker-led asylums in York and Frankford, Pennsylvania, were designed initially for the Society of Friends. In 1760s Philadelphia, the anti-slavery board at the Pennsylvania Hospital made the decision to charge fifty percent more for black patients, perhaps explaining why cases involving slaves are almost nonexistent in their records.55 I use the term ‘public asylum’ throughout however because it denotes the fact that, in spite the above limitations, many asylums quickly admitted all types of patients across sectarian, geographic and federal boarders, opening to the lowest paying patients regardless.56 In this sense they truly did provide for a new sort of ‘public’ patient.

56 See, for example, “Asylum for Insane Persons” Daily National Intelligencer, Washington DC, Issue 2638 (26th June, 1821), Column B.
My thesis also uses medically loaded terms such as ‘insanity’ and ‘mental illness’. The former replaces madness or lunacy although with full acknowledgment that that choice is unusual in the broader historiographical approach. In this period ‘madness’ was used predominantly but it tended to denote violent or delusional mania. It was not synonymous with the full spectrum of states and manifestations experienced by the individuals studied here. Furthermore ‘lunacy’ denoted a periodical complaint rather than a continually experienced condition. By contrast, the term insanity provides a relatively neutral method of labelling symptoms that, to this day, generate spirited debate. ‘Mental illness’ is employed with more circumspection. The term illness implies, of course, an interpretation grounded in medical or biological theory. It is applied in reference to this period’s construction of psychological disturbance as a documentable medical fact. Describing disordered eating as a symptom of ‘mental illness’ is deliberate. It is used to evoke efforts to link insanity to sanity and psychological ‘sickness’ to healthy cognitive and emotional states.

‘Disordered eating’ also encapsulates a variety of phrases. The term ‘disordered eating’ is used to separate the period 1750-1830 from our modern perceptions of eating disorders. Most of the related terms used in the course of this thesis are drawn directly from sources and are applied in the same manner. Anorexy and bulimia are therefore only described as symptoms, whilst abstinence and food refusal are both used to denote food relationships rather than the physical inability to retain ingested items. That was the most frequent form of disordered eating but the terminology was extensive – the 1802 A Medical Glossary, for example, listed almost twenty items associated with disordered eating. References to pica and voracious eating are drawn directly from the period whilst synonymous types, such as canine appetite, ox-like appetite, polysarcia and fames, are subsumed within broader categories. The term ‘disordered eating’ thus refers to many ‘abnormal’ patterns of food consumption and food related behaviours and discourses. These could be either active or inactive. Their importance for early psychiatry lay in the fact that they offered multiple ways to frame and explain mental illness.

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57 W. Turton A Medical Glossary: in which the words in the various branches of medicine are deduced…. 2nd ed. (London: Dewick, 1802).
--- Methodology ---

I explore a variety of sources because I am interested in tracing disordered eating beyond the experiences of a few medical practitioners and because I am concerned with demonstrating the extensive reach of early psychiatric principles. Works written by non-medical authors (or those who did not identify primarily as practitioners) evidence the position of psychiatric theory within broader sociocultural conceptions of insanity. The predominance of these different sources changes over the course of the thesis. Chapter two, for example, draws significantly from domestic health manuals (or largely prescriptive works, published by practitioners for private household use) and wonderous reports of fasting women. Chapter three relies heavily on medical jurists as well as legal sources and newspaper reports, especially for America where newspaper reports provide key evidence of legal decision-making. Chapter four, though focused on the medical institution, was composed with constant awareness that many asylum manuscript and printed records were the products of non-medical men. All these sources provide a parallel or contrast to the medical authors.

I thus interpret a range of sources as case studies. Because I believe that the case study was not a homogenous entity but, rather, was shaped by many considerations, I include the wider market of medical and semi-medical literature. In keeping, I use the terms ‘case study’ and ‘case notes’ to refer to largely detached, observation-driven records of practitioner-individual interactions that include both diagnosis and prognosis. But the exact shape of that record took many forms. This thesis subsequently applies Charles Rosenberg’s description of the diagnosis and prognosis elements of the case study as “the intellectual and social framing of disease” to the many individuals who encountered and then attempted to describe insanity.58

As an example of this principle, this thesis draws upon multiple works by clerical authors in the attempt to trace the spread of psychiatry. As educated men, divines could take up medicine: important seventeenth-century medical authors such as Richard Morton and Robert Burton were ordained and many eighteenth-century clerics published on and

58 Rosenberg “Introduction” in Rosenberg and Golden (eds.) Framing Disease, p.xvii.
engaged with a variety of scientific and medical fields. I recognise that clerical descriptions and discussions of insanity were shaped by their training, objectives and broader sectarian divisions. But there is no doubt that, in certain contexts, clerics were at the heart of the movement to relabel both insanity and disordered eating using the language provided by psychiatric discourse. Ordinarys attributed their imprisoned flock’s disordered eating to delusions and emotional distress. Reverends denounced a fasting woman as an imposter whose claims to abstinence were less spiritually inspired than the result of her corrupted morality. And, finally, clerics were involved in many stages of the asylum process as critics, distributors of the parish funds, patrons, and as workers in asylum chapels where they attempted to reinstall self-control and sober rationality.

It is clear therefore that clerics had a foothold in the medical world. In tandem, the decision to include newspaper reports and articles builds from the determination to trace the evolution of psychiatric theory and psychiatric practice across as wide-reaching a spectrum as possible. It appears to be the case that both English and American newspapers reported, reprinted and retold not just individual cases of insanity but, also, the messages promoted by asylum workers. Aiming for an upmarket and literate audience, newspapers shared cases of insanity as public interest pieces but they also editorialized content and form. Certainly late eighteenth- and early nineteenth-century articles show not just the spread of psychiatric theory but also support for the psychiatric endeavour, as their form and content reflected the formalized insane case study.


belief that they served as important channels for public education and outreach can be seen through the repeated advertisements placed in newspaper columns by early nineteenth-century public asylums. The same can be measured in medical periodical articles and general interest magazines. As with newspapers, periodicals reprinted and shared cases across the Atlantic and, often, over considerable stretches of time as part of their educational mandate. Chapter one in particular addresses the evolution of their articles about the insane.

My work has been further shaped by uneven asylum and hospital source material. The fluidity of patient movement between private and public institutions explains the decision to include case records by physicians such as Benjamin Rush and William Battie. Although it is impossible to verify that their manuscript and printed case notes were born of their work in the Pennsylvania Hospital and St Luke’s respectively, it is reasonable to deduce that their experiences in private practice shaped their practices within those public institutions. Given that Rush worked at Pennsylvania Hospital for thirty years (1783-1813) and Battie was physician to St Luke’s for thirteen years (1751-1764), their notes offer insight into the experiences of a large number of patients. The decision to draw from their work was also shaped by the fact that we lack case records for St Luke’s asylum and that the records for the Pennsylvania Hospital remain sealed under Health Insurance Portability and Accountability Act. Other hospital and asylum records are rare for this period. They are limited by issues of survival, restricted access and a contemporary professional ethos that demanded that the practitioner avoid “reveal[ing] occurrences in the hospital, which may injure the reputation of any one of his colleagues.” Such scarcity was especially true for the eighteenth century but it was also a reality for the early nineteenth century: American public asylum records are almost non-existent, in England record keeping was not mandatory until the end of this period.

My decision to include certain asylums, authors and sources was shaped primarily by these issues of survival and access. In discussing trans-Atlantic communities and changes

62 For the latter see Sylvanus Urban “A Narrative of the extraordinary Case of George Lukins, &c.” The Gentleman’s Magazine and Historical Chronicle (July, 1788) p.609.
64 Thomas Percival Medical ethics: or, a code of institutes and precepts, adapted to the professional conduct of physicians and surgeons…. (Manchester: S. Russell, 1803), p.14.
I try to draw on a divergent range of sources but I have been limited to a degree by archival realities. Wherever possible due reference is paid to as many practitioners, asylums, patient types and non-medical authors – including, when necessary, lone references – so as to paint as rich a portrait as possible. That reality explains, in the later chapters, a heavy reliance on certain asylums, although I consider the ability to include so much source material from the hugely influential York Retreat to be a real advantage. I incorporate a range of sources wherever possible, but the cases referenced in chapters four and five in particular are drawn primarily from English public asylums. There are limits to the range of material available and the stories told over the following pages must be read with these restrictions in mind.
This chapter examines the medical community’s understanding of the relationship between the symptoms of disordered eating and other illnesses. It begins by arguing that late eighteenth and early nineteenth-century medical practitioners repositioned disordered eating symptomologies by moving their etiologies from physiological to somatopsychic, then psychosomatic categorisations. This chapter contextualises those changing explanations about disordered eating within a wider and longer movement to validate psychological theory in conversations about the nature of insanity. The evolution through these doctrines, as experienced in both England and America, heralded the advent of psychiatry. This chapter thus uses the story of the symptomology of disordered eating as a direct window into the larger process of redefining insanity as an illness – first corporeal, then mental – and psychiatry as a medical discipline.

This chapter argues that psychiatry was gradually legitimated as a specialist branch of medical practice through claims to authority over complaints such as disordered eating. The second section shows that the late eighteenth and early nineteenth centuries witnessed a burgeoning delineation of many new forms of insanity. But it demonstrates that these were commonly explained through vague or ill-defined categories and terminology. This confusion proved an obstacle, not just to the development of an international psychiatric community, but also to the promotion of such within the broader medical and then socio-intellectual world. Disordered eating provided the illusion of cohesion as its symptoms could be attributed to a whole variety of explanations about the insane condition. Discussions of these behavioural manifestations gave a greater sense of purpose to otherwise disparate arguments and publications, thus creating a framework for an international psychiatry.

This chapter proves that disordered eating was an important medium through which largely theoretical conceptualizations about the mental processes, and their role in an individual’s overall health, were made tangible to ever-increasing intellectual groups. That is absolutely central to the premise of this thesis: the advancement of psychiatric
thought relied heavily on its correlations with, not isolation from, other medical fields. The particular symptomology of disordered eating, which came to be an important diagnostic feature of insanity, encapsulates the practical enactment of that process perfectly for two key reasons. First, its ongoing connections to other forms of illness meant that early psychiatrists could engage with other practitioners about a topic that all recognised as inherently abnormal. It was known to many and thus made abstract theories accessible. Second, disordered eating provided psychosomatic theory with the quantitative markers of success necessary for its eventual acceptance as medical doctrine.

The final section of this chapter argues that how practitioners shared their information and ideas was as fundamental to the promotion of this new vision of insanity as the actual content shared. Examples of insanity manifested through disordered eating evolved from mere narrative stories to case studies with all attendant medical convention by the early decades of the nineteenth century. It was in the shared knowledge of case studies and specialised monographs – often taken directly from asylums or madhouses – that the insane became medical subjects. And this knowledge was repeatedly shared across the Atlantic. Redefined, the format of presenting the insane as medical case studies quickly spread through other media genres, as will become clear below. And so psychiatry gained ground as international networks of information about the insane were rapidly expanded through a wide community of print. Commentary on disordered eating underpinned that sense of community, as seemingly inexplicable cases allowed a range of authors to debate and to engage with a host of different ideas about the mind and body. Channeling a new psychosomatic and then psychological language through the conventional format of the case study, the early psychiatric community legitimated their ideas to their literate peers.

----- I: Changing Theories -----
as diabolical or divine intervention, to be conquered with prayer and faith, but as a physiological complaint to be treated with actively bracing and reactionary natural remedies. The insane thus entered the latter half of the eighteenth century not as possessed vessels of divine activity but as ill individuals.

In their reconceptualization practitioners and wider communities drew on two main philosophical strands. First, the Greco-Romano distinction between ordinary and divine insanity provided a canonical precedent for separating the insane from the supernatural realm. Whilst Plato and Homer argued that insanity was periodically the result of supernatural activity, the Hippocratic corpus firmly situated causation in the brain.\(^1\) Ancient philosophers bequeathed an insanity that was primarily defined by the excess of passion and appetite and conquered by medicine not worship.\(^2\) Second, the seventeenth- and eighteenth-century movement to relabel religious visions, mortifications and inspiration as manifestations of insanity encouraged investigations into corporeal causations. When Robert Burton dedicated sections of his 1621 *Anatomy of Melancholy* to religious melancholy he reignited the opportunity to connect discourses of dissent, enthusiasm and heresy to the mind and body, rather than just the soul.\(^3\) In addition, John Locke’s assertion that religion was inherently reasonable encouraged early eighteenth-century clerics to measure all spiritual experiences against rational deduction.\(^4\) Medical practitioners acquiesced. In his 1729 *A new system of the spleen*, for example, the widely-read physician Nicholas Robinson described “religious melancholy Madness” as a state whereby “the immediate Intercourse between the Mind and Body, is by some Means or other greatly disconcerted…owing to the temperature of the Body” rather than religion

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\(^3\) See Robert Burton *The Anatomy of Melancholy, what it is. With all the kindes, causes, symptomes, prognostickes, and severall cures of it. In three maine partitions with their severall sections, Members, and Subsections….* (Oxford: John Lichfield and James Short, 1621), section four pp.706-783.

itself. Thus by the mid eighteenth century at least, the idea that the supernatural had a direct or determining role in insanity stood at odds with religious and medical cultures.

The medical world underwent a further fundamental shift over the seventeenth and eighteenth centuries as humoural and Galenic theories lost ground to localised explorations and a quest for specificity. The Hippocratic corpus traditionally provided preventative and therapeutic guidelines through a humoural system whereby bodies were inclined one way or another towards certain constitutions and, later, temperaments (or personalities). Hippocratic divisions were based on key fluids in the body (blood, gastric juice, lubricants) except for melancholic black bile, which seems to have been an expansive term for a blackening, thickening substance. Galen’s description of the heart, brain and liver as the seats of sickness provided an alternative doctrine but, and as with humoural theory, he saw the body and mind as so connected as to be indivisible. His theories retained their influence, especially his description of how animal spirits, originating from the brain, animated insanity. With the rise of localised explorations in the seventeenth and eighteenth centuries, and as humoural theory lost preeminence, it was Galen’s animal spirits that provided a channel to discuss the role of the mind in the progression of insanity.

Searching for new narratives and as dissections sought to unearth the body in all its minutiae, physicians turned their attention to the role of the brain. Mid- to late-eighteenth-century physicians directed their efforts towards exact tropes and categories, as much as attempting to pinpoint the pathogenesis of insanity. Such investigations into

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5 Nicholas Robinson A new system of the spleen, vapours, and Hypochondriack Melancholy: wherein all the decays of the nerves, and lownesses of the spirits, are mechanically accounted for. To which is subjoin’d, A discourse upon the Nature, Cause, and Cure, of Melancholy, Madness, and Lunacy…. (London: Samuel Aris, 1729), pp.234, 236 and 124. See also Thomas Chubb An enquiry into the ground and foundation of religion. Wherein is shewn, that religion is founded in nature. That is, that there is a right and wrong, a true and false Religion in Nature…. (London: Tho. Cox, 1740), pp.2 and 4 and Jonathan Edwards Some Thoughts Concerning the present Revival of Religion in New-England, And the Way in which it ought to be acknowledged and promoted, Humbly offered to the Publick, in a Treatise on that Subject…. (Boston: S. Kneeland and T. Green, 1742), pp.160-161.


7 See Ibid., p.38 and Simon Mind and madness in ancient Greece, pp.218 and 228.

8 Many still offered both options. See, for example, William Coward The grand essay: or, a vindication of reason, and religion, against impostures of philosophy Proving according to those Ideas and Conceptions of Things Human Understanding is capable of forming to it self…. (London: P.G., 1704), pp.130-131.
insanity’s etiology and pathology incorporated new types of systems. Led especially by the late seventeenth-century physician Thomas Willis, neurological explorations looked to the central nervous system for evidence that the enacted elements of insanity were caused by brain disease.\(^9\) His work was furthered by Robert Whytt in 1751. Whytt argued that reflexive, or ‘vital’, activity stemmed from the nervous system, hinting at, but not detailing, the unconscious mental operations as separate to these motions.\(^{10}\) In the latter years of the eighteenth century these precedents translated into dissections focused on the brain and its meninges.\(^{11}\) Because a major pillar of somatopsychic theory was that, as with other organs, the insane brain must exhibit lesions and physical changes, these dissections sought to provide a detailed anatomical portrait of insanity.

This theory, promoted well into the nineteenth century, rested upon the three broad cornerstones of the vitalist, mechanist and cerebalist doctrines. Following a wider and earlier movement that built from an ever-growing elevation of anatomy, these localised the Hippocratic and Galenic systems and relocated the pathogenesis of insanity from the reproductive system to the digestive organs. All sought to trace the pathology of insanity and uncover its mechanisms in increasingly minute detail. These doctrines, respectively, saw the abdomen or stomach, blockages in the body’s fibres (following Herman Boerhaave) or the nervous system as the basis of all complaints.\(^{12}\) They thus offered three separate and distinct paths of exploration and analysis, creating a degree of factionalism within the still juvenile psychiatric community that would linger well into the nineteenth century.

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\(^{11}\) For a key example see John Haslam *Observations on Madness and Melancholy: Including Practical Remarks on those Diseases; together with Cases: And an Account of the Morbid Appearances on Dissection*, 2nd ed. (London: J. Callow, 1809).

\(^{12}\) For further information see Elizabeth A. Williams “Neuroses of the Stomach: Eating, Gender, and Psychotherapy in French Medicine, 1800-1870” *Isis*, Vol.98, No.1 (March, 2007), pp.54-79.
The later 1760s would see William Cullen’s influential nosology develop Thomas Willis’ work into the ‘nervous diseases’. This category took root and played a major role in the character of both British and American debates for the following duration of our period. In essence Cullen’s description of ‘nervous energy’ replaced the four humours but did not stray from the idea that health was dependent upon a carefully balanced internal state, with the cause of any type of ill health lying in unbalanced nerves. Cullen’s further conviction that “from the brain… all the nerves of the body are derived” meant that his nervous diseases offered a new pathological discourse for the traditions that united brain and body under the banner of neurology. By the early decades of the nineteenth century references to animal spirits or humoural doctrines were thin on the ground on both sides of the Atlantic: Cullen’s doctrine of the nerves provided a popular successor to Hippocrates humoural decay and Galen’s animal spirits.

It was, however, a slightly earlier, 1758 printed debate between William Battie, the physician to St Luke’s Asylum, and John Monro, the physician to Bethlem Hospital, that represented the triumph of somatopsychic etiology. Both leading metropolitan ‘mad-doctors’ defined insanity as an abnormal mental function that was the result of changes in the bodily system. But, crucially, Battie and Monro alike focused overwhelmingly on disordered, disturbed or abnormal mental processes as the true hallmark of insanity. It was not so much the etiology they provided but, rather, the very concept of what insanity truly was, that ensured that their works were still quoted widely over eighty years after publication. Battie and Monro, for the first time, expressed their ideas in a manner designed to persuade the broader medical and literate public to a vision of insanity that intimately combined mind and body and that offered a detailed portrait of both. They laid

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13 William Cullen Clinical Lectures delivered in the years 1765 and 1766 (London: Lee and Hurst, 1797), pp.8 and 40-47.
the groundwork for the rest of this period as their speculations about psychological processes gradually became recognised as the very essence of insanity and mental illness.

Battie built directly from the works of author and physician Richard Mead when he argued that insanity was epitomized by deluded imagination.\textsuperscript{16} He connected this defining characteristic to what he saw as the most frequent insane states of anxiety or insensibility. These he attributed, in turn, to either an excess or deficit of sensation.\textsuperscript{17} He minutely traced insanity through the effect of these abnormal sensory states on the nervous system, via the altered arrangements of nervous “filliments” [sic] or “the medullary substance” within them, especially those around the brain.\textsuperscript{18} Monro, in contrast, was unwilling to speculate about the pathological history of insanity and argued that deluded imagination, as sometime periodical and fleeting, did not always mark the condition.\textsuperscript{19} He defined this instead as “a vitiated judgment” [emphasis in original] where by the insane would “see right, but judge wrong.”\textsuperscript{20} Both men separated impaired intellect from insanity. The debate’s major contribution was, however, in their definitive rebranding of insanity as mental illness, not just brain disease. This separation largely dispelled a lingering confusion of the two and offered new opportunities for those who would attempt to define insanity as a distinctive category of illness.

Despite their disagreements, the very existence of Monro and Battie’s debate would kick start a protracted effort to describe the pathology of insanity as both internal and largely autonomous of other types of illness. For the first time, self-identified specialists publically engaged in debates about the true nature of insanity. Their intricate analyses served to align the study of insanity with all other branches of internal medicine as Battie’s choice of organ-centric terminology in particular intimately connected insanity to several other fields of medical enquiry:

\begin{quote}
al tho’ the brain is undoubtedly the principal seat of delusive sensation, nevertheless it is not the only one…the stomach, intestines, and uterus, are frequently the real seats of
\end{quote}

\textsuperscript{17} Battie \textit{A treatise on madness}, p.33.
\textsuperscript{19} John Monro \textit{Remarks on Dr Battie’s treatise on madness} (London: John Clarke, 1758), pp.3-4.
\textsuperscript{20} Ibid., p.4.
Madness…[as]…nervous part[s] of the body…[and capable of]…exciting false ideas as well as in the brain.\textsuperscript{21}

Furthermore, their works provided researchers with avenues of etiological explorations in which the stomach and mind (or the processes of the brain) loomed large. Disordered eating, in this conversation, served as a potential indicator of the insane condition and disturbance. And thus Battie deliberately aligned his vision with a much broader community for whom the body-mind connection lay at the heart of all somatopsychic schools of thought.

The stomach was intricately linked to the brain in an etiological continuum from Cartesian and medical philosophies that saw the mind and stomach as engaged in a reciprocal relationship.\textsuperscript{22} The stomach played a crucial role as the nucleus through which an individual could absorb, digest, correctly sense or decipher the non-natural elements that underpinned general corporeal health. As food and drink were leading non-naturals disordered eating disturbed the careful balance of health. Early psychiatrists explored this principle, facilitating somatopsychic theory’s transmission and eventual acceptance within the broader community. Food and drink had, for an extremely lengthy period, carried the attribution of both positive and negative mental influence, altering the very functioning of the brain.\textsuperscript{23} Food and drink acted not only as triggers for insanity but, also, affected the progression of the insane condition. Disordered eating symptoms, intimately tied to the potency of such external forces, affirmed and translated somatopsychic doctrine into familiar, holistic rhetoric. This doctrine held firm well into the nineteenth century as internationally renowned French psychiatrists Philippe Pinel and his pupil Jean-Etienne-Dominique Esquirol continued to argue that food and drink exerted a major degree of influence on the insane patient.\textsuperscript{24}

\begin{thebibliography}{99}
\bibitem{note1} Battie A treatise on madness, pp.48-49.
\bibitem{note2} Richard Brookes The general practice of physic; extracted chiefly from the writings of the most celebrated practical physicians…, Vol.1, 2\textsuperscript{nd} ed. (London: J. Newbery, 1754), p.60 and p.3. See also John Hunter, A Course of Lectures on the Principles of Surgery & the Diseases connected therewith, 1783, MS 363, Royal College of Physicians, p.11. See Kathleen Anne Stewart The York Retreat in the Light of the Quaker Way (York: William Session Ltd, 1992), p.5 in opposition.
\bibitem{note3} See Bartholomaeus Anglicus “De proprietatibus rerum (1535)” in Hunter and MacAlpine (eds.) Three Hundred Years, p.4.
\bibitem{note4} Williams “Neuroses of the Stomach”, p.61.
\end{thebibliography}
method of medical analysis, subsequently gave academic credence to the inclusion of disordered eating symptomologies in the horde of insane symptoms.\textsuperscript{25}

In contrast, Monro and Battie opened a different explanatory avenue when they implied that external factors, so crucial to those other versions of somatopsychic theory, played a role only as capable of triggering the onset of entrenched physiological and neurological change.\textsuperscript{26} Their ideas directed physicians to pay attention to erroneous delusions or perverted sensation over the intake of the stomach and to look primarily for traumatic rather than organic or external causations. When their theory of sensation was combined with other discourses that prioritised the role of the stomach, a key investigative focus became the relationship between the emotive passions and the stomach. In parallel, dissections failed to evidence lesions in the stomach or, indeed, the brain whilst insane patient presentations failed to confirm the absolute dominance of (or even consistent) somatic change. Practitioners consequently turned to alternative explanations and a largely psychological rhetoric entered late eighteenth-century debates.

Over the course of the latter half of the eighteenth century, and as the processes of the mind continued to draw the attention of practitioners, another doctrine emerged. Widely developing Galen’s hypothesis that the passions directly affected mental and physiological health, investigations into the passions (or emotions) aligned more squarely with the indivisible mind-body doctrine.\textsuperscript{27} As with Battie and Monro, other practitioners used the language of passions to further the idea of a psychosomatic form of insanity. Distinguished practitioners such as John Leake, who wrote in 1781 about his uncertainty as to whether the stomach or the mind were “originally affected,” argued that it was always the case that melancholy (or grief) had an “immediate” effect on the appetite and held the ability to alter digestion.\textsuperscript{28} Leake found support across the Atlantic when the widely-respected physician Benjamin Rush rhetorically asked “Who has not seen the effect of sorrow in destroying the appetite, and reducing it to the state of anorexia, far

\textsuperscript{25} See Culverwell Indigestion: its causes, consequences, and treatment, p.23.
\textsuperscript{26} Battie A treatise on madness, pp.46 and 82-84.
\textsuperscript{28} John Leake Medical Instructions towards the prevention and cure of Chronic Diseases peculiar to Women, 5\textsuperscript{th} ed. (London: R. Baldwin and H. Payne, 1781), pp.189 and 204.
below the hungry point” as part of an explicit reminder to his students of “the effect of the passions on the appetite.”

In tandem, practitioners divorced this appetite from the reflexive or nervous hunger, so that the former became a product of the mind and incorrectly filtered sensation. Appetite, in short, acted through and was not led by the stomach. Terminology changed accordingly. Words such as ‘longing’, ‘loathing’ and ‘deranged’ emerge in publications and a loss of appetite was described with more frequency as subject to sensory and emotional responses rather than the physical functionality of the stomach. In a reversal of somatopsychic theory, disordered eating became the symptom of, not precursor to, psychological distress.

For maniacs the positioning of sensation in the progress of insanity underwent greater change. Slowly, but by end of the eighteenth century at the latest, the stereotypical portrait of the maniac as extremely durable and able to weather all physical hardships came under attack. This was made possible when the association of insanity with corrupted imagination and judgment overrode speculations that the insane’s extreme robustness was derived from perverted sensation. The trend can be traced back to Richard Mead, whose wonder that the insane “sometimes take it strongly into their heads to do things which give the greatest pain and uneasiness to the body... [for] nothing is more contrary to human nature” stressed the psychosomatic genesis of this otherwise purely physiological characteristic. His interpretation started an important amendment of a century’s old equation of insanity with a blanket and concomitant “great insensibility to [the physical sensation of] hunger.” Over the following decades American psychiatrists joined their English counterparts and crystallised the reinterpretation. Slowly, associated

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29 Anderson, Notes taken from Benjamin Rush’s lectures, p.32.
31 In reverse see A Friend to Improvements The Philosophy of Medicine: or, Medical Extracts on the Nature of Health..., Vol.1, 4th ed. (London: C. Whittingham, 1799), p.519.
32 See Monro Remarks on Dr Battie’s treatise, p.6.
33 Mead Medical Precepts and Cautions, p.62
34 William Buchan Domestic medicine; or, the family physician..., (Philadelphia: John Dunlap, 1772), p.304. See also Horatio Jameson The American domestick medicine or, Medical admonisher..., (Baltimore: F. Lucas, 1817) p.282.
symptomologies – such as abstinence – became emblematic of a momentary mental state and not a characteristic of the generic insane condition.

The dominant thread in all these narratives was the gradual ascendancy of the psychological state as the true and constant marker of insanity. As disordered eating became associated with the mental processes it offered up a new group of case studies that could be reworked to validate the idea that the mind could influence a largely unaltered body. The strength of these cases lay in the fact that they did not set insanity on this course alone. Cullen, for example, had included an important subset to his category of nervous disease in the shape of what he termed neurosis. This category did not initially gain as much traction as other descriptions but it set an important precedent in that it could not be explained purely physiologically. With this category Cullen essentially gave nosological order to the doctrine that insanity was illness, validated through psychological symptomology rather than physiological change.36 The benefits of such a perspective lay in the use of behaviour to build symptomatic classifications of a hidden illness. This came to be epitomized by disordered eating. Because insanity was most commonly recognised by behavioural traits, relabelling and categorising these as manifestations of internal disturbance, as symptoms of mental illness, was crucial to the promotion of psychiatry as a medical field.

Over this period a quantifiable body of behavioural and language-based evidence slowly emerged into a rough database of psychosomatic illness. Of great import was the relationship between melancholy and disordered eating. A spectrum of specific and frequent manifestations was developed by practitioners working on both sides of the Atlantic. This included cases whereby the individual believed: that their internal organs had undergone some fundamental change as to be incapable of processing food; that their external physiognomy could not support the act of consumption; and, most frequently, that they were the subject of concerted efforts to murder them by poisoning. All normally resulted in emaciation, via self-restrictive behaviour. But they also generally incorporated some form of body-dysmorphia whereby the sufferer perceived and imagined a change in

their physiology that was not apparent to any other observer. These cases represented the epitome of Battie’s mostly speculative theory that deluded imagination was the true mark of insanity:

that man and that man alone is properly mad, who is fully and unalterably persuaded of the Existence or of the appearance of any thing, which either does not exist or does not actually appear to him, and who behaves according to such erroneous persuasion [emphasis added].

As chapter five will explore further, all three abstinence behaviours made theories about the imagination palpable because practitioners could observe and record disconnects between the patient’s belief and their physiological or environmental reality. As such they became instruments of instruction as to how behavioural symptoms were windows into abnormal psychological states.

A patient’s belief that their internal state had altered was the hardest to disprove or dislodge. These cases continued, therefore, to be treated with physically bracing treatments, and a “boldness of practice” supported by the still influential somatopsychic schools. These efforts can be interpreted as a partial attempt to placate and then counteract such beliefs. And yet, although some practitioners continued to describe all attendant feelings as merely the byproducts of physiological conditions, case studies were dominated by descriptions of changes in behaviour and actions, not the body of the individual. Instead, practitioners used the language of the insane to insist that the imagination was the primary causal agent:

THIS disease then entirely consists in the strength of the imagination… For what is more wonderful, than that a man should persuade himself…that he is actually dead and conversing with the dead, while he is full of life and strength; that he wears a head of glass or clay.

Further references to patients who imagined that they were made of glass and thus capable of “being broken to pieces” or whose persistent abstinence stemmed from the conviction that their stomachs were so small as to be permanently and dangerously overloaded, were remainders that insanity could be discerned from otherwise logical

37 Battie A treatise on madness, pp.5-6. See also Mead Medical Precepts and Cautions, p.59.
38 Thomas Percival Medical ethics: or, a code of institutes and precepts, adapted to the professional conduct of physicians and surgeons…. (Manchester: S. Russell, 1803), p.xxxi. For the nineteenth century see Thomas Eddy Hints for introducing an improved mode of treating the insane in the asylum; Read before the Governors of the New-York Hospital, on the 4th of Fourth-month, 1815 (New York: Samuel Wood, 1815), p.4.
39 Mead Medical Precepts and Cautions, p.59.
behaviour premised on what was shown to be an imagined physiological change. By the nineteenth century the patient who was persuaded that their internal, often digestive, organs had undergone changes provided one of the greatest clinical proofs of the “perverted” insane imagination.

Other insane individuals believed that it was the external façade of their bodies that had changed, either in purpose or design. Detailing and then proving the fallacy of their convictions was critical to the advancement of psychosomatic theory but, also, to new speculations that the mind alone was affected. In short, the advance of psychological theory. For, as these individuals actually exhibited no physiological change, they could only be designated as suffering from a purely imagined disorder. A focus on repeated disconnects between insane descriptions and the reality of their external bodies circumvented the dearth of knowledge about the actions of the mental processes. As we will see elsewhere, the creation of a distinct genre of insanity via manifestation was disordered eating’s most common contribution. Thus case studies, until at least the second decade of the nineteenth century, expended much more energy on the external manifestation of insanity rather than what might possibly be occurring internally.

Again, descriptions of just such cases had a long ancestry and would have been familiar to the whole medical community through canonical authors. By the early nineteenth century, patient language was transcribed as very localised and often specific to the organs of digestion. One example, taken from the 1823 Sketches in Bedlam, a text designed for public instruction as a ‘novelty’, spectacle-laden tour through the

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40 de Kanifeld The institutions and practice of medicine, Vol.4, p.246.
41 See Samuel Farr “Elements of Medical Jurisprudence: or, Succinct and compendious description of such tokens in the human body as are requisite to determine the judgement of a coroner and of courts of law, in cases of divorce, rape, murder, &c. To which are added, directions for preserving the public health (1788)” in Thomas Cooper (ed.) Tracts on Medical Jurisprudence. Including Farr’s Elements of Medical jurisprudence. Dease’s Remarks on Medical Jurisprudence, Male’s Epitome of Judicial or Forensic Medicine, and Haslam’s Treatise on Insanity (Philadelphia: James Webster, 1819), p.68
42 For nosology see Philippe Pinel A Treatise on Insanity (Sheffield: W. Todd, 1806), section 4 and Samuel Argent Bardsley Medical reports of cases and experiments, with Observations, Chiefly derived from Hospital Practice. To which are added, an enquiry into the origin of canine madness; and thoughts on a plan for its extirpation from the British Isles (London: W. Stratford, 1807), p.268.
44 See Anglicus “De proprietatibus rerum”, p.2.
“characteristic traits of insanity,” demonstrates.\textsuperscript{45} The patient, admitted in 1822, “would be induced to take no part of his provisions but by dint of force.”\textsuperscript{46} This refusal was however derived from an oscillating belief that his mouth was either in “quite an opposite part of his person” or that “he had neither eyes, nose, mouth, tongue, nor teeth. While feeding him, his keeper would desire him to open his mouth. ‘‘‘Mouth!’’ he would answer, ‘I have got no mouth; I had a nice large one once, but I have got none now.’”\textsuperscript{47} The author’s argument that this case demonstrated “perception and all its natural organs…at open variance with each other” stands as a prime example of the psychological doctrine adopted at this most notorious of asylums.\textsuperscript{48}

A third form of disordered eating demonstrated the importance of removing the patient from all aspects of their former life and placing them under the total command of the psychotherapeutic physician. As chapter four will explore in more detail, spaces for psychiatric practice arose in the context of primarily familial based forms of care. They built their appeal on the premise that they were, in contrast, able to offer both therapy and cure. But the argument that psychiatry offered such a unique opportunity expanded far beyond the institution. Throughout our period the case was made in print that the psychiatrist-practitioner was an essential player in the path to sanity. This was considerably strengthened in cases where the insane condition manifested through either a rejection or suspicion of friends, family and standard environments. In particular, when individuals “refuse[d] food, from an apprehension of being poisoned.”\textsuperscript{49} This particular trope formed part of a much broader wave of manifestations that represented a “total perversion of the affections and of all common opinions,” as epitomized in the rejection of “nearest relations and best friends” as “their worst enemies.”\textsuperscript{50} Evidence of the overwhelming strength of the imagination, such symptoms were major components of

\textsuperscript{45} A Constant Observer \textit{Sketches in Bedlam; or characteristic traits of insanity} (London: Sherwood, Jones,1823), p.vii.
\textsuperscript{46} Ibid., p.213.
\textsuperscript{47} Ibid., p.214.
\textsuperscript{48} Idem.
\textsuperscript{49} Theodric Beck \textit{An Inaugural Dissertation on Insanity: submitted to the public examination of the trustees of the College of Physicians and Surgeons, in the state of New-York, Samuel Bard, M.D. President, for the degree of Doctor of Medicine, on the 14th day of May, 1811} (New York: J. Seymour, 1811), p.20.
discussions of melancholy well into the nineteenth century. Easy refutation by reference to their locale, questioning their friends and, within the asylum, by examining their environ, combined with the absence of physical deterioration further confirmed that this was entirely a psychological complaint that demanded specialist intervention.

One final genre represented the pinnacle of the deluded imagination doctrine in printed form. Disordered eating entered this category most frequently when the insane laboured under “the supposition that they are dead” and absolutely rejected provisions on the basis that “Food could be of no service” in their deceased state.\(^{51}\) By the early nineteenth century most physician-authors saw this form of disordered eating as psychogenic, or as caused by this delusional belief which, perverting the desire to eat (the appetite), overrode the physical sensation of hunger. Therapeutic efforts subsequently included elaborate staging of funerals, dressing individuals up as the illustrious dead, or an initial indulgence of this belief so as to facilitate the later assertion of practitioner control.\(^{52}\) A wide-reaching practitioner subscription to the delusional genesis of these behaviours underpinned these attempts to treat the delusion primarily, rather than the manifested act (or inactivity) of consumption.

Printed, shared cases of disordered eating substantiated the portrayal of insanity as a psychological illness because they often lacked physiological evidence. As we shall see again in chapter five, symptoms described by patients as physiological were often not made manifest as such. Thus disordered eating cases, where a patient’s behaviour did not match either an assignable physiological cause or change, encouraged practitioners to look to psychological theory for explanations. At the turn of the nineteenth century, those working in both England and America encountered and recorded these cases as evidence that insanity was marked by such. Using shared manifestations practitioners established different forms of insanity that, whilst under the banner of deluded imagination, derived from different mental disturbances and manifested in different ways. As individuals who engaged in disordered eating frequently demonstrated very clear and noticeable aberrations, these cases gave psychological theories more authority. By the nineteenth

\(^{51}\) de Kanifeld *The institutions and practice of medicine*, Vol.4, p.246 and Anon *A view of human nature: or, select histories; giving an account of persons who have been most eminently distinguish’d...* (London: S. Birt, 1750), pp.92-3.

century those behavioural manifestations were frequently classified in a manner that entirely excluded any change in physiognomy.

----- II: Delineating Spectrums and Types ------

All the descriptions of the above cases substantiated the very late eighteenth-century conceptualization of ‘partial insanity’. This moniker, made famous by the trial of would-be regicide James Hadfield in 1800, had broader application when it made sense of the otherwise rational behaviour and discourse of individuals the early psychiatrists insisted were insane.\(^{53}\) These included those whose insanity was fixated upon one topic – such as when indicated by a refusal to eat either a type or all categories of food – but who otherwise exhibited ‘normal’ behaviour. As fixed on one topic only, partial insanity was harder to discern than other insane categories and so relied heavily upon the skill of the practitioner to isolate the particular point of insanity. It became an important psychiatric diagnosis because it was premised on the idea that only specialist, well-trained individuals could unearth a lurking, hidden insanity.

But these explanations also entered an arena defined, above all, by still relatively untested hypotheses. Certainly emphasis increasingly lay on the mental processes, whereby ‘imagination’ and ‘judgment’ became vital to the most frequent definitions of insanity as a delirious state in which one or both were in error. But, for all the causes attributed to either, these terms all remained elusive throughout our period. As John Gregory’s 1770s lecture indicated, “The proximate cause of Madness is not understood & dissections throw little light upon it…it may arise either from ye mind or body, but seldom from a material Cause” [\textit{sic}].\(^{54}\) Almost twenty years later, the provincial psychiatrist Thomas Arnold’s lament that “universally adopted…[Delirium] is, however, very differently defined by different writers;—by many it is not defined at all;—and by none so perfectly as might be wished” illustrated the ongoing negotiation of the parameters of insanity.\(^{55}\)

\(^{53}\) This case will be explored in depth in chapter three.
\(^{54}\) John Gregory, Lectures, c.1770, MS.L43, Wellcome Trust, p.1.
Because of this lack of precision in either proximate causes or even the exact boundaries of insanity’s symptoms, specific forms of manifestations and clearly delineated groups of symptoms became instruments of clarity. Disordered eating, as we have seen, became a core component in discussions of delusional insanity because it provided clear and definitive manifestations that practitioners could both engage with and actively treat. This created a sense of unity in understanding how insanity normally manifested, a unity vital to the spread of the psychiatric discipline both within countries and across the Atlantic. Grob has argued that symptoms were critical to the nosological construction of illness as “no other alternative was available” and, to a degree, that sentiment is applicable to the reconfiguration of insanity as mental illness. Disordered eating gave cohesiveness to the various strands of thought as a set of behavioural symptoms that could be aligned to various and discordant descriptions of the brain and its internal, mysterious processes. The façade of cohesion was central to the engendering of psychiatry as a respectable branch of medical doctrine and practice.

But disordered eating had another role to play: it made both psychosomatic and psychological theories accessible to those practitioners long accustomed to a plethora of these symptoms from the classroom and broader practice. The reinterpretation of symptoms firmly within the medical remit was central to the legitimatisation of psychiatry. The inclusion of disordered eating symptoms in published monographs, at an ever increasingly rate, encouraged physicians otherwise unfamiliar with either theory or practice to study the pages of insanity case studies. For the symptoms of disordered eating or extreme voraciousness or abstinence did not ‘belong’ to the (nervous) melancholic alone. A cursory glance at the following table, composed from Richard Brookes’ patient observations and compiled from his 1754 *The general practice of physic*, demonstrates the vast range of complaints that were traditionally associated with these behaviours:

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<table>
<thead>
<tr>
<th>Symptom: Appetite</th>
<th>Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>decayed sometimes, at others strong,</td>
<td><em>Hypochondriac Passion</em></td>
</tr>
<tr>
<td>for Chalk, Coals, Lime, &amp;c.</td>
<td><em>Chlorosis or Green-illness</em></td>
</tr>
<tr>
<td>depraved,</td>
<td><em>Diarrhaea or Looseness</em></td>
</tr>
<tr>
<td>false,</td>
<td><em>Catarrhal Fever; Melancholy</em></td>
</tr>
<tr>
<td>enormous,</td>
<td><em>Bulimus, or canine Hunger.</em></td>
</tr>
<tr>
<td>Loss of,</td>
<td><em>Empyema, Head-ach, Inflammation of the Bladder, Measles, Rheumatism; continual Fever.</em></td>
</tr>
<tr>
<td>lost totally,</td>
<td><em>Malignant or spotted Fever.</em></td>
</tr>
<tr>
<td>Loss of, with Difficulty of hearing, without a Fever,</td>
<td><em>Madness</em></td>
</tr>
<tr>
<td>unnaturally voracious,</td>
<td><em>approach of the Gout.</em></td>
</tr>
<tr>
<td>Want of, or weak,</td>
<td><em>American Poison, Consumption from Abscesses and Ulcers, Empyema, Fluor albus, malignant Fever, nervous Consumption, Suppression of the Menses</em></td>
</tr>
</tbody>
</table>

Table 1.1. Richard Brookes *The general practice of physic.*

This table saw little changes over the next fifty years and is a clear and immediate reminder that psychological illness categories continued to be conflated with physiological diseases. Requisitioned, the symptoms of disordered eating became an increasingly explored sign of insanity but at no point in this period was disordered eating completely severed from the world of somatic medicine.

Indeed, for most practitioners the labels ‘anorexia’ and its sister digestive complaints ‘dyspepsia’ and ‘dysorexia’, provided a means of reconciling what was not yet understood, namely whether the loss of appetite was due to “disrelish for life, or…a mechanical instinct” rather than a rubber stamp on psychological theory. Anorexia, a “want of appetite, without loathing of Food,” for example, was described as the extreme of a wide spectrum of physiological reactions, even whilst others attributed it to the

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58 Lewis Mansey *The Practical Physician; or, medical instructor Pointing out remedies for the various diseases of mankind: Adapted to the use of private families; Together with observations on diet, air, and exercise* (London: W. Stratford, 1800), p.41. See also Brookes *The General Practice of Physic, Vol.1*, p.226.
effects of “the depressing passions.” Thus in his 1792 *Synopsis and nosology* Cullen classified anorexia and bulimia as “always symptomatic,” arranging them neatly into a physiological system under “Order. II. Dysorexiae, error or defect of appetite.”

Likewise, although John Aiken listed thirteen different species of anorexia in 1783, he classified them all under dyspepsia. Bulimia received even less analytical attention although it was consistently and increasingly referenced in eighteenth-century medical texts and dictionaries. Finally, although some practitioners saw anorexia and nausea (a sister of bulimia) as physical symptoms of mental distress, for most leading authorities they remained primarily somatic reactions.

Given this divergent range of complaints, the early psychiatric community chose to utilise the symptoms of disordered eating as psychological indicators because of their diagnostic visibility and thus clinical reliability. The impression that any disturbance could generate a descent into insanity produced an enormous range of indicators for melancholy, mania and even the lesser conditions of hysteria and hypochondria, which made detailed and accurate diagnosis difficult to succinctly and confidently articulate.

Stability and medical productivity therefore lay in concrete symptomology strands, such as disordered eating, which could create a continuum of mental illness and incorporate the mildest to the severest of symptoms. In addition, the ability to recognise and then actively counter a manifestation repositioned insanity as a temporary and curable illness, on a spectrum of sanity and health. This, more than anything else, led arguments that insanity required specialist attention. From the temporary rejection of food, for example, to the complete refusal of all food as a resolute practice of mortification, aspects of disordered eating suited all types of degrees of mental illness. The road to psychiatric advancement

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60 William Cullen *Synopsis and nosology, being an arrangement and definition of diseases* (Hartford, CT: Nathaniel Patten, 1792), pp.64 and 66.


63 This would include Sauvages conception of *anorexia melancholia* for example. See Francois Boissier de Sauvages *Nosologie Méthodique, ou distribution des maladies en classes, en genres et en especes Suivant l'Esprit de Sydenham, & la Méthode des Botanistes, Vol.5* (Lyon: Bruyest, 1772), pp.230 and 235.

lay in the almost paradoxical route that, on the one hand, stressed the distinctiveness of insanity (namely a psychological pathology) whilst, simultaneously, being careful to locate it at the extreme end of a universal and extensive spectrum of health to illness.65

Practitioners here echoed broader philosophical trends. With the advent of enlightened thinking, fueled by a rapidly expanding print and consumer market, a new sense of one’s relationship to the world emerged. Philosophical treatises, newspaper reports and pamphlets encouraged the ‘enlightened’ man to look upon the opportunity to think rationally and actively engage with the world around him not just as a gift from God but, rather, as part of one’s duty to God, society and, ultimately, oneself. This philosophy underpinned a growing sense of socio-political responsibilities (especially in the newly established United States) and natural philosophical endeavours to order and chart the world through observation, experiment and experience correctly filtered.66 With this approach those unable to wrestle with and control their own passions or irrationality became distant from the norm. But they were not lost forever: rather, the insane were simply ill and could, in fact, be returned to sanity (cured). In that sense insanity was but the far end of a spectrum that concluded in reason.

The success of such a spectrum was, of course, only achievable when a significant amount of cases with shared patterns provided the conditions upon which a populated catalogue or framework could be created. Disordered eating enabled the creation of just such a framework. Included were an abstinence from and loathing of aliment commonly associated with hypochondria and hysteria, pica – a disease defined by the consumption of extremely unhealthy substances – voracious appetites and obesity. This wide range of complaints underpinned a developing scale that terminated in asylum-certified insanity and suicidal propensities. The material change was the emphasis that the insane individual was connected to sanity. By the nineteenth century this connection centred on the mind rather than the body.

For the late eighteenth and early nineteenth-century medical practitioner therefore disordered eating, as a spectrum of behaviour, did not always need to be an extreme manifestation in order to be classified as psychosomatic or psychological in nature. This

65 Anon A view of human nature, p.228.
66 On insanity as a potentially socially destructive act see “The Prostitution of the Pulpit” National Intelligencer, Vol.11, No.1661 (4th June, 1811), p.2, Column D.
approach was promoted through multiple channels that packaged both theories through the format of the case study. American and English newspaper reports bore all the hallmarks of this format, as English medical cases were reprinted almost verbatim on both sides of the Atlantic. A British newspaper, for example, described how one man, “resolved to imitate the austerities of the ASCETICS of former times...took no other sustenance than water, slightly flavoured with oranges, for sixty days!” The effect, according to the publisher, was that “he became highly maniac, and expired, amidst all the horrors of a confirmed lunacy!” This succinct and cautionary tale traced the natural history of the insane condition, tracking an initial determination to adopt a punishing lifestyle, the enactment of that determination through a behaviour, and the termination of such in a complete insanity. His physical appearance clearly epitomised psychosomatic principles, highlighting the effects erroneous conviction could have on the corporeal frame. Thus his “gradul emaciation” [sic], to the point that “his whole appearance suggested the idea of a skeleton,” was described as a “change produced” by his “gloomy superstitions.” Through form, content and terminology, newspapers echoed the efforts at work in psychiatric publications.

By the end of our period such individuals, standing at the precipice of insanity, also littered the pages of prominent practitioners who did not work predominantly with the insane but who, nevertheless, reiterated the dependency of the corporeal form on mental health. William Wadd, surgeon extraordinary to George IV, included a case study with what he described as “a little twist” [emphasis in original] in his 1829 *Comments on Corpulency Lineaments of Leanness.* The gentleman under examination, complaining to Wadd “his skin pinched him,” began a rhetorical conversation over the course of which he self-affirmed that he was missing his stomach and “went on with his queries, most of

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68 “Abstinence” *Diary or Woodfall's Register*, Issue 558 (8th January, 1791), p.3.
69 Idem.
70 Idem. For an alternative rationale see also William Wadd *Comments on Corpulency Lineaments of Leanness Mens on Diet and Dietetics* (London: J. Ebers & Co., 1829), pp.116-117.
71 For a diagnosis that aligned with the new terminology see “To the Public” *Columbia Telescope*, Vol.15, No.48 (27th November, 1829), p.3, Column E.
72 Ibid., p.76.
which he kindly answered himself: “‘Now I want to know about diet - what should I eat?” – “Nothing.” – “What should I drink?” – “Nothing.”” From this “reductio ad absurdum” [emphasis in original], and in an act that indicated his familiarity with psychosomatic theory, Wadd very clearly labelled this the result of “imaginary disease” that manifested in the individual’s speech, “long face and gloomy looks.”

The above case sat at the start of a spectrum that interpreted myriad forms of disordered eating as insane behaviour. At no point did Wadd indicate that this individual actually proceeded to abstain from all food or drink nor, indeed, did he diagnose the individual beyond the comments given. On the other hand, once an insanity diagnosis was given and the individual became patient the most severe disordered eating behaviours could become the sole premise for ongoing diagnosis. Neither degrees nor forms of insanity were fixed or permanent classifications: a progression of the insane condition was illustrated through changing patterns of disordered eating. In the asylum ongoing disordered eating provided justification for ongoing confinement. Even when disordered eating behaviour changed upon admission, an overall diagnosis of insanity remained constant.

Published, these cases justified the importance of specialist arenas and practitioners. By detailing a therapeutic course of action and a well-developed relationship with their patients, the early psychiatrists instructed their colleagues in the manner of psychiatric practice. Combined, asylum and private cases reaffirmed calls for the deferral to the psychiatrist from the onset of such symptoms.

In print a range of disordered eating behaviours were marshaled to create a continuum of progressively dangerous symptoms that reflected worsening degrees of insanity. This was an important asset of disordered eating, as practitioners tried to demonstrate that insanity was a medical complaint with degrees and shades of mental affliction. Over the course of our period physicians moved away from a ‘universal madness’ approach which saw mania and melancholia as blanket terms, but “a higher degree” of each other, expanding rather than completely rejecting these divisions.

In particular the 1760s work of Giovanni Battista Morgagni demonstrated the fallacy of a

73 Ibid., p.77.
74 Ibid., pp.76-77.
75 See Constant Observer Sketches in Bedlam, pp.176-178.
76 A Friend to Improvements The Philosophy of Medicine, p.326. For more see Hunter and MacAlpine (eds.) Three Hundred Years, p.441.
singular therapeutic course of action, critical to arguments about the need to tailor and individualise therapy in specialised institutions. Hinting at the delineation of insanity into several types, Morgagni’s work complemented larger quests for quantifiable data in medical theory in general and, combined, subsequent practitioners attempted to achieve specificity in charting the individual pathogenesis of insane subclasses.

Disordered eating symptoms continued to fall under both: it was through their exact and individual manifestation that this separation was marked. It was therefore the attendant behaviour and verbal expressions that determined the exact diagnosis. As chapter five will explore further, a violent but oscillating rejection of all food almost universally guaranteed a maniacal verdict, whilst a fixed and determined rationale tended to lead to a diagnosis of melancholy. The particular degree, nature or content of these manifestations also underpinned the further development of subsets or forms of insanity. Thus a focus on what those illnesses looked like and how they differed in their appearance to the clinical observer was prioritized. In form, terminology and narrative, striking similarities across various print genres and in asylum decision-making, imply a degree of trans-Atlantic uniformity in these diagnoses. This trend became even more concerted when printed and asylum case studies provided opportunities to study and measure therapies against significant numbers of patients.

In this practitioners on both sides of the Atlantic were influenced particularly by leading physicians who, at an unprecedented level, wrote texts focused exclusively on the problem of insanity. As more was done to chart and clinically dissect the vast category of insanity the two stalwarts of mania and melancholia were expanded and supplemented with a variety of complaints given newly independent status. These were at their most concrete when common symptoms could be explained through varied psychological terminology. And so delusion, derangement, alienation, partial and periodical versions of insanity joined degrees of illness such as hysteria, hypochondria and anxiety. It was the attribution of all these various illnesses to mental states that marked the triumph of the psychological model over the course of our period. It also explains the obvious disconnect between the traditional and limited terminology of the asylum and the expansive vocabulary of the printed text. Subsumed under the categories of mania and melancholia

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77 See Hunter and MacAlpine (eds.) *Three Hundred Years*, p.441.
within the asylum, disordered eating was repeatedly referenced in print because of the opportunities it provided to create a measurable family of illness.

For spectrums require markers, moments at which to measure the position of an individual. Disordered eating symptoms, as diagnostic indicators, provided the tools to separate types of mental illness. This role was facilitated further by disordered eating’s long-standing association with two other complaints: the predominantly feminine hysteria and the largely masculine equivalent, hypochondria. Battie referred to this when he referenced the frequency with which “patients truly hypochondriacal or hysterical refer that load of uneasiness they feel in their bellies to some imaginary object” [emphasis added] as part of his discussion of the role of the stomach in facilitating the onset of insanity.78 Indeed, “an irregular appetite, sometimes loathing, and sometimes craving” and a belief that “The digestive organs oftener show disease in insanity, than the brain, particularly before and during hypochondria” [emphasis in original] were establishing indicators before the mid eighteenth century.79

With the later eighteenth-century reclassification of hysteria and hypochondria as diseases of the nervous system, these gendered diagnoses were brought together and a bridge was created between the traditional stomach-mind dynamic and attempts to clinically classify and analyse degrees of insanity.80 By the nineteenth century these would be reclassified again as psychogenic conditions. Others, such as anxiety and delirium a potu would follow. The nineteenth century added hypochondriasis, described as “a symptom of an advanced or aggravated stage” of melancholy and a frequent enough diagnosis to become an asylum classification in its own right by the 1820s.81 Most of these began life as “very often preced[ing] Madness like its cause, or accompany[ying] it like its symptoms.”82 The key for the expert in both a medical and broader socio-intellectual setting was to be able to differentiate, to classify at which stage a patient

78 Battie Treatise on Madness, p.49.
80 For more see Lopez Pinero Historical Origins of the Concept of Neurosis, p.1 and Henry Manning A treatise on female diseases, in which are also comprehended those most incident to pregnancy (London: R. Baldwin, 1775), p.201.
81 Geo. R. Pitts “Hints on Melancholy” The American Medical Recorder, of original papers and intelligence in medicine and surgery, Vol.6, No.4 (1823), p.597.
82 Battie Treatise on Madness, p.89.
laboured, given that all these illnesses differed “more in degree than kind.” One way to diagnostic confidence, when working to such a spectrum, lay in the use of a symptom that could be attributed to all stages. That explains the ongoing importance of disordered eating in the evolution of classificatory work.

Over the course of the eighteenth century therefore, far from being “one species of disorder,” insanity was understood to exhibit “as much variety with respect to its causes and circumstances as any distemper whatever.” Medical interest in insanity grew when some of those forms were demonstrated to be ‘curable’, at least by the standards of surface improvements. One of those states was “Madness consequential to gradual or chronical congestions occasioned by gluttony” [sic] and marked by its similarities to the frequent diagnoses of gout and corpulency. Under Battie’s nosology, this particular type of insanity was incredibly rare, and thus important, not for its mechanisms but, rather, because it apparently “easily yields to medical care, if seasonably and properly applied.” Placed within a broader range of complaints all the above combined forms of disordered eating and insanity, as treatable or therapeutically responsive, aligned psychiatry with other types of medical practice.

---- III: Shaping and Sharing Information ----

The cases, practitioners and texts discussed above collectively created medical categories of insanity, evolving from physiological, to somatopsychic and then psychosomatic. The 1758 printed debate between Battie and Monro marked a new era in the legitimization of this medical study of insanity as, for the first time, distinguished practitioners in charge of the two leading metropolitan insane asylums marked themselves as specialists in this field and drew on clinical evidence to validate their discussions. Publishing their treatises gave mad-doctoring a degree of respectability. But it is speculative to brand their works as the start of a designed movement. Over the coming

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83 George Baker “De affectibus animi et morbis inde oriundis (1755)” in Hunter and MacAlpine (eds.) Three Hundred Years, p.400.
84 Battie Treatise on Madness, pp.93-94.
85 Ibid., pp.44-45.
86 Idem.
87 Ibid., p.66. Monro disagreed: Monro Remarks on Dr Battie’s treatise, p.29.
88 For more see Hunter and MacAlpine (eds.) Three Hundred Years, p.233.
decades the majority of ‘psychological’ case studies were provided by disparate practitioners working in a range of circumstances. Throughout our period insanity remained a fringe discipline: the constant instructional and vehement tone adopted by self-identified psychiatrists hints at their enduringly ambiguous professional status.

These early psychiatrists remained, for the most part, a group who drew on individual publications rather than a professional collective. Although there was no shared agenda, there is evidence of intent in how they shared information. Born directly from the lack of engagement with insanity in the classroom and lecture halls, the utilisation of a multitude of publication types indicates a body of practitioners who turned to print media as a method of promoting their idea of the psychological nature of insanity. Certainly, earlier eighteenth century works were largely theoretical discussions of all that insanity might encompass, not databases of patient presentations. Nonetheless they set an explanatory discourse that, moving into the nineteenth century, gained further weight. And so narrative tales designed to shock, amuse and document the novel slowly gained the hallmarks of the medical case studies. These formed new psychiatric traditions; they did not represent the apex of an ongoing culture.

Disordered eating symptoms repeatedly played a part in these new discourses. They allowed the practitioner to engage with and then describe a range of theories and practices in a manner familiar from other areas of medical research. These efforts would only gain lasting legitimacy when institutional arenas strengthened the clinical authority of the psychiatrist and strengthened the transformation of insanity into mental illness. But it was underway from at least the mid eighteenth century. Practitioners mimicked the standardized format of the medical case study, employing methods and formats established by medical convention and shaping parameters through an exchange of knowledge between patient and practitioner. Hence the inclusion of supplemental information such as age, occupation, and status alongside the more directly influential fields of inquiry: the length of the complaint, medical history, physical symptoms, discourse and behaviour.

Disordered eating behaviours and discourses were also constant features in comparative accounts of insanity, inviting readers to make deductions as to the nature and manifestation of insanity. Disordered eating as behaviour and discourse, rather than as
somatic change, represented the point at which this symptomology was most commonly recorded and printed as insanity. Disordered eating symptoms were, after all, always enacted and very frequently involved a form of physical or verbal resistance to friends, family, practitioner, instruments or discourse that was then shaped into a case study. But this insight must be tempered with the knowledge that the information throughout was edited by the practitioner for whom the case study represented an apologia for lost chances or a commemoration of triumph far oftener than it represented the deliberate promotion of a particular doctrine.

A late eighteenth century creation, the medical journal proved a largely unprofitable instrument for the advancement of psychiatric literature. A vast rise in the number of English and American journals in our period did not really change the fact that stories concerning insanity tended to be narrative at best.89 The same held true for American journals. Neither type demonstrated large-scale or consistent engagement with insanity. Indeed, such cases often represented individual and brief interludes in careers marked by otherwise general practice. In the early years of the medical journal the repetition and reprinting of individual cases or reports over many decades or centuries suggests that editors were not concerned with the immediacy of the report or the currency of the techniques employed but, rather, that the curiosity of individual and unusual cases did not lose its poignancy over a lengthy period.90

Moving into the nineteenth century psychiatrists started to challenge those editorial decisions, arguing that, “by selecting the most striking cases… chiefly, because they are more easily described, make a more interesting picture, and are the most curable” article authors and journal editors “contributed” to the erroneous view that all the insane were violent and vociferous.91 In that sense the content and shape of journal articles about both insanity and disordered eating changed to a degree in the early years of the nineteenth century and practitioners began to actively elicit opinions from their colleagues.92

Asylums, especially American asylums, also began to issue reports and publish through

journals, suggesting that they saw journals as a fruitful tool of dissemination. But as late as the 1830s some articles continued to demonstrate minimal levels of analytical engagement with insanity or disordered eating.93 Both remained, for the most part, subject to anatomical and narrative detachment in the pages of journals.

The development of a more psychosomatic and analytical discourse thus fell predominantly to a new form of specialised monographs. Drawn from private madhouses and public hospitals alike, and authored by a practitioner self-identified as a specialist in insanity, these would cement the determination to make psychiatry a permanent part of the medical arena. Mirroring exactly the doctors case book in form and content, these were published in ever increasing numbers and represent a change in approach from stories and narratives to quantitative case studies.94 Battie and Monro had led the way but it was the 1780s on that would really see the presentation of insanity via this succinct, detailed and rational format. That format alone allowed for the creation of a natural history or pathology of insanity as a medical and clinical category and the validation of the insane as potential patients. These later monographs were not simply theoretical works but, rather, compilations of clinical data relayed in a manner designed to highlight the likeliest symptoms presented while maintaining an interest in individual narratives. They represent the medical community’s clearest indication of a growing interest in insanity as a specialist discipline.

An engagement with the insane condition was then marked by the ability to communicate, at some level, with the insane and then detail those communications in a standardised format. This was made easier, or even possible, in cases with disordered eating symptomologies for it was over the course of such episodes that the practitioner could engage with both body and mind through a behaviour that immediately resonated with a broader medical and literate public. Abstinence in particular was, by its very nature, immediately identifiable, its effects relatively easy to track. But anyone could

94 See Battie Treatise on Madness, p.49 for an early example. See also Perfect Methods of Cure in some particular cases of insanity, Andrew Harper A treatise on the real cause and cure of insanity: in which the nature and distinctions of this disease are fully explained, and the treatment established on new principles (London: C. Stalker, 1789) and Haslam Observations on Madness and Melancholy for just a few more examples.
recognise the act of refusing food or consuming none-nutritious produce and could measure the degree to which those acts were undertaken. They thus conformed to the broader cultural expectation that insanity was defined by its visibility.⁹⁵ And it was the public who continued to initially recognise insanity. As chapters four and five will further demonstrate, parish and family decisions to commit, from the mid eighteenth century on, those who exhibited disordered eating symptoms to asylums rather than general hospitals, show that the ascendancy of the mind over the body was recognised and secured.

The range of theories this chapter has explored drove therapeutic efforts within asylum walls. The internalization of such theories was only achievable when practitioners were equipped to map such ideas onto the bodies and minds of their own patients. Asylums provided the chance to collate databases of insanity but it was the printed page that created a sense of collective momentum in the promotion of psychological theory. This occurred at exactly the same time that private madhouse owners, not just medical practitioners, began using the printed press to advertise their establishments, cure-alls, methods of treatment and, even, particularly unusual cases.⁹⁶ Case studies originating from institutions of all sizes and mandates, from local and individual practitioners and from the pages of popular magazines, hospital notes and self-published theses played a part in the steady promotion of insanity as mental illness. Their trans-Atlantic kinship lay in their adherence to that new doctrine, their connections to other medical branches in the format of the record. For, early psychiatry’s novelty lay not in the methods employed but, rather, in the categories of symptoms that would reoccur across time and space, and the descriptions and explanations attached to their narratives. As English publications frequently gained American editions, these encouraged trans-Atlantic engagement with psychological conditions.

Ultimately early mad-doctors, practitioners working with the insane in the asylums and in private practice, represented no collective movement to consistently or even confidently promote these new ways of thinking about insanity. The connections between them can be drawn from references to numerous authors and their disparate ideas over the course of a publication, or in the asylum publications that alluded to fellow institutions.

⁹⁵ See Buchan *Domestic Medicine*, p.305.
⁹⁶ For a very early example see Thomas Fallowes *He Cratiste Ton Melancholonton kai Mainomenon iatreia; or, the best method for the cure* (London: n.p., 1705).
The study of insanity continued to attract relatively few students until the middle decades of the nineteenth century because, despite the case studies used throughout this chapter, its position as a clinically distinctive and treatable illness remained insecure until then. Opportunities to engage with the insane in such a setting, as chapter four will indicate, remained largely elusive. Indeed, Bethlem only admitted students in 1843, almost one hundred years after St Luke’s and far behind the almost conventional practices at work on American soil. And that is why the printed monograph became so important: it presented mental illness as a very real, very treatable but very complex condition when other options were lacking.

Psychiatry’s authority and thus lasting stability, even with the advent of the large-scale asylum, could only be achieved when theory met approved formats of medical engagement. Medical practice, especially when at work and recorded in large-scale and institutional settings, marks the success of that engagement by ‘cure’, or a codified and measured return to health. For that quantifiable evidence of change was required. Disordered eating symptoms proved productive for these early practitioners for, as this chapter has demonstrated, they created a framework through which to discuss psychological theories of insanity in a concrete manner. This framework included a comprehensive exploration of all forms and manifestations of illness as, through the symptoms of disordered eating, body, language and behaviour aligned. The case studies explored throughout this chapter and in the pages to come thus prioritize these latter forms of patient expressions for exactly the same reasons other practitioners devalued them and focused on the body: of secondary importance elsewhere, here they were fundamental evidence of illness.

In printed records the language patients used to describe their behaviours, their justifications, remained of primary diagnostic and prognostic concern for the majority of practitioners. As Allan Ingram has pointed out, conversation was a core part of medicine and the ability of the practitioner to negotiate patient language was central to their practice:

\[97^\text{St Luke’s Hospital, General Court Book 1750-1779, H64/A/01/001, London Metropolitan Archives, entry dated 12th February 1753 and Benjamin Franklin Some account of the Pennsylvania Hospital; from its first rise to the beginning of the fifth month, called May, 1754 (Philadelphia: the office of the United States’ Gazette, 1817), p.53.}\]
Part of what marked off the skillful physician was in fact his ability to draw out his patient, and by subtle and sophisticated inquired and inspired reading between the lines of what he was told, to elicit and interpret the evidence considered crucial to rendering an informed judgment about the nature of the malady in front of him.\(^{98}\)

With the insane this negotiation took on even more import and required even higher skill levels. Patient discourse illustrated both the highly individual nature of each case and, simultaneously, the importance of developing a body of specialised experts in order to translate and then categorize these individual presentations into broader nosological forms. Valuing the reasons patients provided for their actions including, for example, the refusal, or over consumption, of food, produced absolute indicators of a flawed imagination or perverted judgment.

In numerous cases, including those used throughout this chapter, the patient’s own descriptions of their mental health was either directly quoted or paraphrased. This was true of all formats, indicating that the patient’s voice was a central component in an insanity diagnosis. But the rather more obvious examples of flawed judgment or imagination were not the only manifestations encountered. By the start of the nineteenth century periodical insanity had joined partial insanity as “the most common form of [insanity].”\(^{99}\) Both relied on the conviction that insanity was hidden under a flurry of rational conduct and discourse, discovered only when the sufferer was pressed on the particular subject of their disturbance.\(^{100}\) Because the language of insanity was evidence of a particular delusion, so too ‘cure’ could be measured when the subject of that delusion no longer formed a part of the patient’s discourse. That factor explains the frequency with which case studies reprinted the words used by patients themselves: in the late eighteenth century this level of practitioner-patient interaction took precedent.

The debate about the nature of psychiatry as a medical practice is still ongoing. One of its most famous defectors was Thomas Szasz who argued in 1961 that as psychiatry is based on principles of communication rather than biology it cannot be classified as a medical discipline.\(^{101}\) But his argument is ahistorical: it was in the manipulation of language and behaviour (as patient-practitioner communication) that psychiatry first

\(^{98}\) A. Ingram The Insanity of Place/The Place of Insanity (Abingdon: Routledge, 2006), p.60.

\(^{99}\) Pinel A Treatise on Insanity, p.5.

\(^{100}\) See Ibid., p.146.

gained grounds as a medical field. By combining behavioural with spoken language these early practitioners duplicated medical models onto the insane. Indeed, this chapter has shown that psychiatric practitioners relied on disordered eating symptoms for their variety: from violence to inertia, acts of consumption, dining etiquette and language, behaviours were critical outward signs of the delusional progression.

Behaviour and language were joined by the physical frame. The changing tone in discussions about this latter category provides the clearest evidence of a shift in the ascendancy of somatopsychic, psychosomatic and then psychological definitions of insanity. This was rarely explicitly stated but, rather, was implicitly conveyed through the form and content of case studies. But physical changes, as the most visible record of delusions, were duly noted. It was the body that, despite all psychological rhetoric, remained the entry point for the medical practitioner. Some asylums would list somatic consequences of mental illness whilst others would detail the physical affects only. This split characterised both England and America. One case, from Virginia’s Western State Hospital in 1829, noted merely that the individual “Had been deranged ten or twelve years before her admission,” that “She would take but little food and no medicine” and that “Her constitution wasting much debilitated when admitted and she appeared to sink from debility alone.” In the absence of notes about her psychological condition it is the deterioration of her body alone that offers testimony as to her commitment and, by extension, offers clues that American practitioners also marked disordered eating as a consequence of mental illness.

----- Conclusion ----- 

Whilst retaining the idea that insanity could be explored anatomically, new theories rooted it firmly in the turmoil of the mind. Battie’s work hinted at this possibility, Cullen’s category of nervous diseases encouraged these somatopsychic theories further. Their efforts found final fruit in these specialised publications, especially as we move into the nineteenth century. Works that dedicated large portions of their pages to dissections

102 Register of the maniacal cases in the New York Asylum Bloomingdale, Bloomingdale Records 106A, Medical Center Archives of New York Presbyterian or Weill Cornell, entry dated October 4th 1824, p.56.
103 Case Book (No.1), 1828-1830; 1841-1846, Western State Hospital, Series IV, Patient Records, Subseries C, Vol 273, Library of Virginia, unnumbered page, entry 33d.
and anatomical observations, attempting to locate insanity definitively in mechanical changes in the brain were unable to prove such.\textsuperscript{104} With no lesions or organic change to draw on, the possibility of corrupted imaginations and judgements became more and more attractive and plausible. Thus practitioners were forced to redesign insanity as a primarily psychological condition. As ideas about psychological processes were worked out, reitered and seemed to bear therapeutic fruit, these would transition from symptoms of a somatic complaint, to the very essence of insanity.

This movement would find its greatest evidence in behavioural symptoms. Even then psychiatrists still had to account for physiological symptoms that continued to riddle the insane condition. These provided a much stronger point of comparison for the broader medical community for whom early psychiatric thought was defined by its disparities and divisions rather than its uniformity. And this is where disordered eating was especially instructive and fruitful. The changing analyses of this symptomology indicate the manner through which a familiar and thus accessible complaint was reconditioned. The story of disordered eating is the story of the promotion of psychosomatic theory through the medium of a traditionally physiological condition. Repositioned as a behavioural manifestation of mental processes, this in turn would underpin a further rebranding of insanity as, first and foremost, mental illness.

With that shift mercurial, behavioural symptoms drew more attention than physical changes. This cemented the importance of detailed case studies and descriptions of patient types, as well as the need for ongoing, measured and authoritative care. It encouraged the management and restorative therapeutic techniques that will fill the pages of chapters four and five. This chapter has therefore argued that it is possible to trace a deliberate incorporation of food-refusal as a mental behaviour into all these categories far before the 1873 definition of anorexia nervosa by William Gull and Charles Lasègue. Those practitioners represented a moment in a continuing evolution of thinking, not the beginning of a wholly new endeavour.

That is not to suggest that somatic changes were no longer of interest – they just required additional consideration and further expertise to unravel their hidden meanings and irrational foundations. Both are indicative of a cautious but growing trend, rather than

\textsuperscript{104} In contrast see Williams “Neuroses of the Stomach”, p.64.
a protracted push, towards a situation whereby insanity would merit more attention both within the print marketplace and, ultimately, in the classroom. This was not to be realised in our period and it was the English printed page and American teaching hospitals that led theoretical momentum. For, the ability to study large numbers of the insane together and the determination to then share clinically validated information was fundamental to the legitimation of ‘mad-doctoring’ within the medical community. Chapters two and three will transition that legitimisation onto broader, external arenas.

This chapter has traced the growing preeminence of disordered eating in the creation of a continuum of insanity in both form and degree. This spectrum, in turn, encouraged practitioners to think about insanity as mental illness. These included Francis Willis’ (1718-1807) 1823 work *A Treatise on Mental Derangement*, which included reference to some form of food aversion or refusal in all its case studies, and John Haslam’s 1809 *Observations on Madness and Melancholy*, which listed food refusal as a symptom for nearly all of the patients he discussed. Their works, hugely influential within the field and in both England and America, are but a small part of the evidence that speaks to a forgotten chapter in the history of late eighteenth- and early nineteenth-century psychiatric theory.
Kathryn Segesser

**CHAPTER TWO:**
**DISORDERED EATING IN THE PUBLIC REALM**

------ Introduction ------

Chapter one explored increasing attempts to relabel insanity as a disturbance and dysfunction of the mental processes. This chapter seeks to trace that transition within a wider socio-cultural and literary world through the histories of three forms of disordered eating. It highlights an alternative, more traditional vision of insanity as passion or emotion-based. This concept, widespread amongst both English and American audiences, built from popular belief in the potency of the non-naturals. Offering a mirror to chapter one, this chapter explores three distinct categories of disordered eating in order to trace various psychiatric theories within broader public debates. This was a period when competing but increasingly psychological ideas about insanity began to shape wider literary discourses. Focusing on specific types of disordered eating, this chapter engages with the competing worldviews and philosophical currents that evolved in discussions about the root cause of these behaviours and discourses. At the heart of all debate lay questions as to the ability of individuals to shape their illness experience through their lifestyle and choices.

The first section looks at a range of literature about consumption and digestive complaints. It introduces the passions, and shows that they were increasingly considered the agents behind a spectrum of disordered eating. This section begins with private manuscripts and domestic health guides, both of which show a general public familiarity with the mechanisms of the appetite, stomach and consumption, as well as a concern with regulating eating behaviour. By tracing general prescriptions to moderate behaviour from the household out, it demonstrates that disordered eating became a marker for a wide spectrum of psychological states. In particular, and as shown through specific trans-Atlantic cases, voracious eating transitioned from an abnormal reflex of the stomach into a manifestation of moral failure. As physicians and non-experts alike described voracious eating as a chosen behaviour they recast disordered eating as a psychological symptom.

The second section examines a fasting woman who gained transatlantic fame in the years 1809-1814. From salvation to physiology and psychology, Ann(e) Moor(e)’s story
encapsulates the diagnostic arguments at work in all other branches of disordered eating. This case marked a transition in this widely popular and longstanding genre, from divinely inspired mortification practice to willfully deceitful behaviour. In a rare instance of unification between religious and medical practitioners, both rejected superstitious explanations in favour of physiological and psychological theorems. Documenting details and focusing on symptoms rather than etiology, practitioners and clerics alike explained away what would previously have been classified as miraculous. Her case thus represents a theological as much as a medical shift. Now a symptom, descriptions of fasting women’s abstinence took on the explanatory hallmarks seen in other types of disordered eating: their behaviour was described using a language of passions, desire and loathing, all of which could be rationally tested and minutely traced.

The final section unites the discourses of imagination, desire and physiology in its exploration of two particularly feminine disorders. Chlorosis and malacia were listed in numerous feminine health books, midwifery courses and general medical textbooks as complaints defined by the act of consuming deleterious products, known as pica. Specific to feminine life stages, discussions about chlorosis and malacia were permeated with gendered discourse and analysis. Building from those gendered characteristics, historians of eating disorders have mentioned chlorosis in passing, noticing its prevalence and a correlation with anorexia nervosa in terms of patient type, an often-shared refusal to eat more common foodstuffs, and its nineteenth-century subsumption under anemia.¹ This section argues instead that it was the incorporation of ideas about the mind rather than judgments about the gendered body that took precedent by the end of this period.

Constructed around disordered eating, this chapter will trace the promotion of psychiatric thought beyond the medical textbook, part of a wider channel of information that flowed predominantly from England to America. Whilst some early psychiatrists drew explicit connections between disturbed judgment and dangerous choices, the development of an almost entirely separate stream of psychological language was critical to the advancement of psychiatry as a whole. Critical, because it provided another route to explain the centrality of psychological disorders when encountering range of visible

manifestations and ‘abnormal’ behaviours. Furthermore, the three types of disordered eating explored in the coming pages provided a well-delineated spectrum of psychosomatic illness, from the extreme to the nearly normal. By placing widely different disordered eating behaviours upon that same spectrum and connecting the extreme to the everyday, early psychiatry made further inroads into the public consciousness, building a whole discipline of medical practice with social standing.

----- I: Eating and Health -----

Keith Thomas has described the eighteenth century as an era when “new faith in the potentials of human initiative” and an idealised vision of rational and productive members of society pervaded. Moderate and temperate behaviour was widely considered an important foundation for achieving this rational and productive living, informing social commentaries and a range of pamphlets on healthy living. In particular advice about food and patterns of consumption allowed authors to translate the idea of moderate living into prescriptions for daily life. On the continent and in the Anglo-American territories medical authors drew on this principle repeatedly, publishing frameworks of moderate consumption behaviour and proscriptions regarding the quantity and quality of food to be consumed. They built a platform of authority by reflecting broad philosophical and social currents. Private manuscripts, essays published by members of the clergy and popular texts alike indicate that moderation was considered the best way to prevent illness and that disturbed eating was a sign of an upset body. The late eighteenth and early nineteenth centuries witnessed the point at which all these works also began to describe disordered eating as a behavioural complaint rather than the outward sign of a disturbed stomach. Tracing those narratives, this chapter will demonstrate that psychiatry advanced


\[\text{See, for example, John Fallowfield Miscellaneous Essays, Divine and Moral. Designed to discourage vice, and to promote virtue, 3rd ed., with additions (Carlisle: M. Dennison and Son, 1790), p.253.}\]
in large part because a range of authors promoted that idea.

In the print market several works built around dietary prescription became popular guides to moderate living. Initially written in the sixteenth century, Luigi Cornaro’s autobiography *Sure and Certain Methods of Attaining a Long and Healthful Life* was a bestseller on both sides of the Atlantic. His pleas to “eat only to support life [as] every thing that is more than necessary for our nourishment, sows the seeds of sickness and death” aligned with the cause of moderate consumption.\(^5\) Cornaro claimed that it was the change of his diet *alone* that effected a ‘cure’ of both his vital and mental spirits. The dual promise of longevity and health, through simple changes in habit explains his enduring appeal. An example of the fluidity between general proscriptive works and the medical arena is found in John Abernethy’s reference to Cornaro’s work. In his early nineteenth-century surgical lectures Abernethy advised future practitioners;

> If people would follow [Cornaro’s] example, & not put more food into their stomachs than that organ is fully competent to digest, they might live as long as he did…Patients will come to say “I don’t care what I take, if you will but let me eat”. I, for one, will never disgrace the medical profession by a compliance with the whims + caprices of such patients.\(^6\)

In his statement Abernethy suggested that the proscription of moderate consumption was a fundamental practitioner *duty*. When individuals indulged imagined needs or emotive whims and failed in their duty to discipline their own bodies, it was the medical practitioner who alone possessed the understanding to diagnose such and then steer them right.

Simultaneously, domestic recipe books and manuscripts recorded a broad familiarity with disturbed if not pathologically disordered eating. References to partial abstinence from meat and drink were very common and a transient loss of appetite seems to have been treated as a regular symptom of general illnesses. Several private eighteenth-century recipe books include entries for a brief “loss of appetite” and recommended easily accessible garden products.\(^7\) These took their place alongside a plethora of recipes for weak stomachs, disordered stomachs and “stomack[s] that canot Digest” [*sic*].\(^8\) Few of

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\(^6\) Notes from John Abernethy’s surgical lectures, 1802-1821, MS2, Royal College of Physicians, p.31.

\(^7\) A Book of physick made June 1710, MS.1320, Wellcome Trust, pp.6 and 27, Johnson Family Recipe Book, 1694-1831, MS.3082, Wellcome Trust, p.76, and Receipts of Different Things, 1780, MS 511, Royal College of Physicians, pasted inserts.

\(^8\) Anne Nevile, Recipe Book, mid eighteenth century, MS.3685, Wellcome Trust, p.12.
these short, dry records offer any detailed insight: they are ingredient lists first and foremost. But some suggest a slight pathologisation of disordered eating complaints within the household. One mid eighteenth-century example included a cure for “one that loatheth meate” [sic], whilst another included “warming ye brain” as part of the cure for an upset stomach. Both, in very different ways, portrayed disordered eating as potentially psychosomatic. They show – albeit in a rare and limited manner – a belief that mental health played a role in the journey to physical restoration.

Specialist publications also described a range of disordered eating symptoms as psychological complaints. Dictionaries had a plethora of terms dependent solely on consumption, including but not limited to “POLYSARCIA…fatness, or corpulence…FASTIDIUM…an aversion to aliment…DYSDYS and CYNOREXIA…the canine or greedy appetite, that is not easily satisfied” [sic]. Dictionaries developed spectrums of disordered eating symptoms, separating nausea and anorexia, for example, by degree rather than nature or origin. But from the early years of the eighteenth century even these most prosaic of texts associated appetite and hunger with the motions of the brain. By the mid eighteenth century disordered eating complaints including bulimia, pica and abstinence were described in terms of loathing, longing and lifestyle rather than stomachic or general physiological change. For practitioners and interested parties, these dictionaries provided the seeds of an important association between disturbances of the brain as cause and disordered eating as behavioural manifestation.

Aligned with these other genres, by the late eighteenth century many practitioners were moving away from traditional depictions of the stomach as simply a physiological gatekeeper and searched, instead, for alternative paths to illness. Indeed, many practitioners argued that excessive consumption was a leading cause of ill health precisely because they subscribed to the principle that non-naturals such as food had the ability to

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12 For example see Richard Brookes An explanation of the terms of art in the several branches of medicine…. (London: Newbery and Carnan, 1769) pp.501 and 509.
alter not just physiological but also psychological states. As it became clear that the reflexive actions of the stomach alone could not account for observed disordered eating behaviours, practitioners began to describe the stomach not so much as malfunctioning but, rather, as depraved or deranged. This simple linguistic change indicates an important shift: it was the result of practitioners focusing on the behaviour of consumption rather than the physiological performance of the stomach. Instead, practitioners suggested connections between disordered eating as a symptom and a disturbed mind as a condition.

And so the ideal of self-discipline continued to dominate. It was with this stricture that medical authors stepped beyond merely describing how external agents affected the frame of the body. Instead, another non-natural was introduced to discussions about consumption and disordered eating: the passions, or emotions. This non-natural, increasingly important, would represent one of the greatest inroads of psychological ideas about disordered eating. The passions were linked to disordered eating behaviours on two fronts: first, because food and drink influenced the passions and, second, because disordered eating behaviours were manifestations of aberrant passionate states.

Eighteenth-century authors had created a very general platform, offering sweeping descriptions of how “Hope, fear, joy, grief, are well known to display their signs externally,” [emphasis in original] attributing a vast array of complaints – both chronic and intermittent – to the passions. Practitioners of the later eighteenth century however increasing argued that passions affected behaviour as well as the physiological functionality of the body. And so disordered eating behaviours provided a prime opportunity to elucidate on the role of the passions as made manifest by applying the principles of psychosomatic action. By the early decades of the 1800s the American physician James Ewell described “Errors and irregularities in the mode of living” or the “depressing passions” as the cause of even the most physiological of complaints.

The passions were all encompassing and could be turbulent, violent, depressing or

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14 See Ibid., p.113.
revitalizing. Over the course of our period they increasingly meant emotional and moral turmoil whereby external influences triggered internal reactions.\textsuperscript{17} In medical journals contributors contrasted passionate destruction with the exemplary reasonable mental state: “From the influence of the passions upon the system, when they are allowed to escape from under the control of reason, a large proportion of the most dreaded diseases…originate.”\textsuperscript{18} Medical practitioners’ belief in the influence of the passions on mental health should not be underestimated: this became as important a strand of psychosomatic theory as the cognitive disturbance explored in chapter one. These two strands of psychiatry complemented rather than weakened the other, as exemplified in Thomas Reid’s statement “I allways took Reason and the Moral sense to be good Friends” [sic].\textsuperscript{19} But the sufferer who was either unable or too weak to control their passions was very different to the individual tormented by delusional imaginations or deranged judgments. The language of the passions was applied sweepingly: to social behaviour as well as physical complaints. Thus any mental illness that was characterised by passions was treated as the climax of a more general disposition towards excess. Hence the individual was partly to blame.

Physicians also directly correlated excessive consumption with the remoter causes of mental illness, applying a model that saw excess as a precursor to physical illness. Subsequently, it followed that mental illness was the result of excessive behaviour.\textsuperscript{20} That deduction encouraged several physicians to lay the pathogenesis of many chronic complaints – including insanity - very squarely at the feet of those who chose to indulge their metaphoric and literal appetites.\textsuperscript{21} This was especially important in the context of a late eighteenth- and early nineteenth-century cultural milieu that, on both sides of the Atlantic, valued refined manners and genteel restraint. Over-eating subsequently garnered indignant censure in the early years of the 1800s, condemned as “unnatural or

\textsuperscript{17} J.G. Spurzheim Observations on the deranged manifestations of the mind, or insanity (Boston: Marsh, Capen and Lyon, 1833), p.113. On the wider transition see Thomas Dixon From Passions to Emotions: the creation of a secular psychological category (Cambridge: Cambridge University Press, 2003).
\textsuperscript{18} Anon “Tranquility of Mind” Journal of Health conducted by an Association of Physicians, Vol.1, No.13 (March, 1830), p.205.
In keeping, the performance of an individual as a social being was intimately connected to his or her ability to discipline their own irrational and gratuitous inclinations. Physicians such as John Thornton, for example, argued, “Gluttony is so ungentlemanlike a vice, that it would be an affront to suppose that persons of polished manner...could be capable of it.” Thus voracious eating was framed by a discourse that focused on choices made. Once described as a chosen act of self-destruction, the door was opened to discuss the role the mind played in the wider context of this behaviour.

Around the same time, forms of ‘excess’ became closely aligned to ‘passionate excess’ and, as such, became emblems of psychological abnormality. It is possible to argue that these suggestions gained ground in discussions of the excessively corpulent. But there is a caveat: the effectiveness of such an argument was moderated considerably, hidden in the purely narrative accounts of the heavily corpulent normally printed in medical journals and generic newspapers alike. These stories were mostly instructional in tone, a mix of medico-social commentary designed as lessons in sober and healthy moderation, rather than diagnostic or therapeutic models. Taken in the context of the historiography of disordered eating they are unusual, for they predominantly described males who, as a rule, rejected moderation in favour of over-indulgence and excess. They were generic interest pieces but also cautionary tales. There was a lesson to be learned and it was a familiar one. To be kept in mind at all times was that “the passions have less influence, and cause less disorder, in a body that is regular in its diet, than in another which follows the cravings of an inordinate appetite.”

Voracious eating as behaviour was crucial in the construction of this explanatory framework because of its physical effects. “[E]nfeeble[ing] both mind and body,” it was not just disgraceful, bringing “poverty and want” and destruction on a scale that extended beyond just the body, but those who engaged in such were described as “sinful waster[s].” Strong moral overtones were accompanied by additional warnings that “The victim of this unhappy vice becomes heavy, idle, and eventually good for nothing...“the

22 John Reid Essays on Hypochondriacal and other Nervous Affections (Philadelphia: M. Carey and Son, 1817), pp.85-86.
23 Thornton The Philosophy of Medicine... Vol.2, pp.114-115.
24 Cornaro Sure and Certain Methods, p.20.
The voracious eater thus carried the double failure of disturbing the balance of nature and wasting the chance to be a productive member of society. In contrast to scholars’ descriptions of a later Victorian “cross-class attempt to deny fat” [emphasis in original] as a body-form standard, in the lecture halls students were warned that whilst “Theer is some foundations in nature for those cravings…they are greatly increat by Indulgence” [sic].

Corpulency became physical evidence of a lack of self-control.

The condemnatory rhetoric reflected an ongoing and lengthy attempt to reconcile the relationship between the free will and the passions in cases of excess. As early as the seventeenth century it appears that the decision to engage in excessive eating was understood as distinct from an inability to eat or to stop eating. Those who chose, of their own free will, to engage in disordered eating behaviours were therefore subject to a condemnatory rhetoric missing in other cases. A focus on the vagaries of free will gained ground when the eminent early eighteenth-century physician George Cheyne tied free will to self-governance. Cheyne’s vision of the human experience was grounded on the principle of an ever-engaged dialogue between the soul and the body with the soul residing in the brain and the passions as either the affects of the body on the mind or the affects of the mind on the body.

Free will, within that dialogue, was the manifestation of a self-determining, active principle, not necessarily “conformable to the settled laws of nature,” that separated “rational and intelligent beings” from passionate creatures. Well into the nineteenth century, Cheyne’s decision to connect both free will and the passions with insanity, via his warning that “Some of these passions, as love, grief and pride, when very intense and long indulged, terminate even in madness,” underpinned central dichotomies in psychiatric theory and influenced psychiatric texts on both sides of the Atlantic.

Cheyne’s ideas were made tangible through case studies of corpulent individuals that

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26 Ibid., pp.1-2.
30 Ibid., p.126.
31 Ibid., p.133.
were shared in popular, non-expert literature on both sides of the Atlantic. In the 1790s a magazine report about John Love of Weymouth, “the most remarkable Man in all England for his Weight and Corpulence,” was described as a cautionary warning to those who gave “full scope to [their] desires.”

Love’s journey began when he became “remarkably thin” following the death of his friend and protector. To combat this state, and following the advice of his physicians, he “had every kind of delicious nutriment, which gave him such a habit of ease and indulgence…[that] he gave full scope to his desires.”

Ridiculed as an object “for boys to point at,” Love eventually died a dangerous example of the “general opinion” that when “indulgence is continued” at the expense of temperance and moderation, “the antidote becomes a poison.”

Love’s warning about indulging oneself built upon a 1772 case printed on both sides of the Atlantic. It concerned an extremely corpulent fifty-three year old Thomas Wood who “Soon after he entered into his forty fourth Year…began first to be disturbed…had constant Thirst, great Depression of Spirits, violent Rheumatism, and frequent Attacks of the Gout.” The full list of Wood’s complaints was extensive and blurred physiological ailments with psychological disturbances. Although periodicals and newspapers noted that “His Parents were intemperate,” Wood’s corporeal bulk was attributed to his deliberate decision to “indulge…himself to Excess in eating voraciously.” This phrasing inferred a degree of culpability and moral failing that was only rectified when, in imitation of Cornaro, Wood made changes to his diet and lifestyle. The significant part of the report was his biographer’s closing statement that Wood subsequently achieved “a Tranquillity of Mind which he never enjoyed before” [sic], suggesting that whilst his complaint manifested physically, the true root of his condition was psychological.

In the twenty years between Wood and Love the message was clear and unchanging: over-indulgence had a negative effect on both body and mind. But magazine and

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33 Idem.  
34 Idem.  
35 Ibid., p.223.  
37 Idem.  
38 Idem.
anecdotal reports about Daniel Lambert’s case, published in 1806, offered up an alternative explanation. In their articles it is possible to see the adoption of the psychiatric doctrine of the power of the imagination. Even at his heaviest, Lambert’s food and drink apparently differed “in no respect from that of other people” and, in contrast to Wood and Love, his eating habits were described as the very essence of “moderation.”[^39] What set Lambert’s story apart then, was that the only explanation offered as to his condition was that “at the age of nineteen, he began to imagine that he should be a heavy man.”[^40] This comment, through brief and subsequently followed by a series of extraordinary events, was the only concrete explanation offered by the publisher as to his “excessive corpulence.”[^41] With Lambert’s case the tripartite explanation for corpulency was complete: desires and the imagination alike were held to affect the functionality of the stomach.

The description of Lambert’s imagination was, however, unusual. Instead, as Wood and Love demonstrate, a focus on the choice to over-indulge became more and more common, to the point that moral culpability became a leading point of debate. At the heart of this lay ongoing negotiations between the will and the passions. The leading American psychiatrist-physician Benjamin Rush, for example, described “moral derangement” as “When the Will becomes the involuntary vehicle of vicious actions through the instrumentality of the passions.”[^42] In their actions and behaviour, Love, Wood and Lambert stood at the very start of a spectrum of passionate excess that, at its far end, degenerated into insanity.[^43] This ambiguous intersection, between the passions and the mental processes, continued to populate discussions of insanity and debate as to the accountability of the insane and the corpulent well into the nineteenth century. A prioritizing of the passions marks the separation of psychiatry from the anatomical branches of medicine but it is a mistake to attribute that to the early decades of the nineteenth century: even with these developments varied and competing theories

[^40]: Ibid., p.5.
[^41]: Idem.
[^42]: Benjamin Rush, Facts and Documents as exemplified chiefly in murder including newspaper but not Judges’ Opinions, Rush Family Papers, Benjamin Rush Section, Yi2 7400 (Box 7), f.20, Historical Society of Pennsylvania, p.21 [facing].
[^43]: A case study is found in Reid *Essays on Hypochondriacal and other Nervous Affections*, p.85.
Discussions of voracious eating and corpulent bodies thus came to be dominated by questions of free will, choice and indulging passionate appetites. At the opposite end of the disordered eating spectrum stood abstinence. And yet there was one case that asked similar questions of this form of disordered eating. It raised the question of whether or not abstinence was a chosen behaviour. This case, first brought to light in the 1809 *Edinburgh Medical and Surgical Journal*, garnered a plethora of debate across spiritual, physiological and psychological lines.\(^{44}\) Highly publicized on both sides of the Atlantic, the story of Ann Moore epitomises the protracted reclassification of disordered eating behaviours as essentially psychological. As with voracious eating, it also offers an insight into the progress of psychiatry within a very public setting. As this section will demonstrate, it was a progress marked by ongoing ties between spiritualism and fasting, a reliance on physiological explanations and, finally, a discordant range of psychiatric opinions.

A labouring woman from a small village in Staffordshire, Ann Moore lived on the fringes. A servant and mother to two out-of-wedlock children, she was derided as “a notorious immoral character” whose “extreme poverty…excited but little pity in the breasts of her neighbours.”\(^{45}\) Ann’s medical complaints began in 1806 with difficulties eating and pain in the stomach. By November she was confined to her house, consuming only bread. Her poverty and rural location meant that Ann endured five months of illness before consulting a physician. He prescribed an extensive if ineffective course of medicine and within two weeks, on the 17\(^{th}\) of March 1807, she “entirely relinquished

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\(^{44}\) By 1810, for example, shortly after her story first came to light, the English presses produced a fourth edition of her case. One year later the American presses were onto their third editions.

\(^{45}\) John Sharpless *An account of the extraordinary abstinence of Ann Moor of Tutbury, Staffordshire….* (Philadelphia: John Sharpless 1810), p.10 and J.E. White *The history of Ann Moor ; with a statement of the evidence substantiating the fact of her long abstinence….* (Savannah: Seymour and Williams, 1812), p.9.
nourishment.” From that date until the summer of 1813 (a period of over six years) her medical narrative was one of continually abortive attempts to eat.47

Ann’s was a very public fast from the beginning, drawing hundreds of visitors over the course of her complaint. All were apparently astonished by the fact “that whilst the term of abstinence has, month after month, been extending, no effects have been produced by it on the system.” The public saw her as yet another fasting woman “supported by the supernatural power of God” alone.49 But Ann’s story was not to be a celebrated wonder of the age. In the summer of 1812 Dr. Alexander Henderson, a member of the Royal College of Physicians and physician to the Westminster General Infirmary, published An examination of the imposture of Ann Moore, comparing her to other ‘fasting women’ and denouncing her abstinence as “an imposition she had practiced on the public, for the purpose of obtaining a comfortable living” [emphasis in original].50

By April 1813 a watch was underway. Led by Henderson, it lasted a mere nine days before an obvious deterioration in Ann’s health brought it to a halt. On the 4th of May 1813 Ann signed (with a cross) a confession admitting to deceit and fraud. The profitable adventure, which had earned Ann in excess of £400, was over and those who had declared her to be “a living miracle” had to retreat in the face of her exposure by medical practitioners.51

For the many years of her ‘abstinence’ the wider medical community used Ann’s natural history to debate a variety of ideas about the workings of body and mind. When Charles Turner Thackrah explored Ann’s case in an 1824 lecture, she was but the highlight of a plethora of “extreme abstinence” [emphasis in original] cases he argued fell under the medical establishment’s professional remit.52 But it was not always clear that the medical community could claim ownership over fasting women. Communal acts of

46 Benjamin Granger “Some Account of the Fasting Woman at Titbury, who has at present lived about two years without food” Edinburgh Medical and Surgical Journal, Vol.5, No.19 (July, 1809), p.320.
47 She stopped taking any form of food or drink by September 1808.
48 Granger “Some Account of the Fasting Woman at Titbury”, p321.
51 Legh Richmond A Statement of Facts, relative to the supposed abstinence of Ann Moore.... (Burton-on-Trent: J. Croft, 1813), p.43.
52 Charles Turner Thackrah Lectures on Digestion and Diet (London: Longman, Hurst et al., 1824), pp.41 and 33.
fasting had a lengthy history, performed on both sides of the Atlantic in imitation of biblical examples.\textsuperscript{53} Well into the eighteenth century members of the Anglican clergy portrayed fasting as an act of communal supplication, “a Means or Discipline necessary to qualify or equip both Soul and Body for the Discharge of the moral Duties of Love and Charity in social Life.”\textsuperscript{54} This social remit was especially revitalized in revolutionary America where a flurry of pamphlets promoted public days of fasting, humiliation and prayer. National days were designated by both the Continental Congress in July 1775 and President John Adams in May 1798, as well as at the state and town level. Following Ezra VIII.23 “so we fasted and besought our God for this, and he was entreated of us,” these were directed expressions of penitent piety that speak to the enduring belief in the potency of consumption-based mortification as worship.\textsuperscript{55} But they were also communal expressions of thanks designed to knit together a people divided by politics, faith and loyalties. Their spiritual purpose was but a part of more protracted political attempts to awake a national consciousness.

Whilst communal acts of fasting carried important strategic purpose, individual fasting was categorized as acts of devotion and promoted as an “essential duty of all who wish to serve GOD.”\textsuperscript{56} Fasting traditionally disciplined the corporeal frame so as to improve the health of the soul but late seventeenth-century theologians went further, stipulating that fasting was also a rational method of making the mind more receptive to the work and word of God. Fasting therefore tamed the fleshy demands of the body and the unruly desires of the mind, a “Mortification of a Lust and ill Habit” that united “Both Grace and Reason…in the practice of this difficultest piece of Self-denial” [sic].\textsuperscript{57} Within this cultural milieu individual fasting women served as exemplary spiritual models for English and American audiences.\textsuperscript{58} In the 1660s, for example, the English fasting girl

\textsuperscript{53} For biblical examples see Exodus 34: 28-29 RSV, 1 Kings 19:7-9 RSV and Matthew 4:1-11 RSV.
\textsuperscript{54} Thomas Cooke An essay in two discourses (London: J. & J. Rivington, 1753), p.11.
\textsuperscript{55} As quoted in Ebenezer Bradford The nature of humiliation (Boston: Adams & Larkin, 1795), p.5. Abraham Lincoln was to revive this tradition as late as April 1863.
\textsuperscript{57} Richard Kidder Of fasting. A sermon preached before the Queen at White-hall, on May 23. 1694.... (London: J.H., 1694), pp.20-21 and Herbert Palmer Memorials of Godliness and Christianity...., 8\textsuperscript{th} ed. (Boston: Timothy Green, 1713), p.10.
\textsuperscript{58} See Thomas Robbins Newes from Darby-shire or, the Wonder of all Wonders.... (London: T.P., 1668), pp.2-4 and Robert Plot The Natural History of Staffordshire (Oxford: printed at the Theater, 1686), p.288.
Martha Taylor described her abstinence as “the manifestation of Infinite Power, for the benefit an[d] advantage of them that fear God” [emphasis in original].59 On the other hand, in 1690s America, Margaret Rule was described as having been prevented from eating by the tricks of “her tormentors.”60 Both women, although diametrically opposed, offered a shared vision of abstinence as forcibly imposed by the spiritual realm. Martha and Margaret were spiritually-edifying “chosen Vessels” who expiated the sins of all humanity through their suffering.61 If the words attributed to the women were correctly recorded, they saw their fasts as theological interventions, not symptomologies. Of course, the depiction of these women as passive vessels was coloured by gendered concepts about female susceptibility to the supernatural. But it is important not to overstate this: fasting men were also well known.62 All saw themselves as wholly beyond the reach of the most skilled physicians.

Into the early nineteenth century men and women continued to describe both self-denial and higher spiritual awareness as central reasons for their abstaining behaviour.63 But eighteenth-century theologians generally moved away from extreme acts of mortification, supplication and fasting. Indeed, and as we have seen already in this chapter, moderation became the spiritual mantra. In the mid eighteenth century a range of authors united around the argument that

nothing can be more absurd or impious, than to make Abstinence from Food or Pleasures meritorious, any farther than it conduces to Health, or qualifies us for Business. Almighty

59 As quoted in H.A. Mirabile Pecci, or, The non-such wonder of the peak in Darby-shire: discovered in a full, though succinct and sober, narrative of the more than ordinary parts, piety and preservation of Martha Taylor... (London: T. Parkhurst, 1669), p.31.


62 See, for example, Thomas Umfreville The case of Mr. John Ferguson, of Argyleshire in Scotland, who hath lived above Eighteen Years only on Water, Whey, or Barley-water; together With Observations thereon: Wherein are laid down The Possibility of Truth of the said Case, attested to the Royal Society, on Thursday the 9th Day of December 1742.... (London: W. Reason, 1743).

63 Rudolph Bell argued that the numbers practicing this increased. R.M. Bell Holy Anorexia (Chicago: University of Chicago Press, 1995), p.151.
God reserved but one Tree in all Paradise from our first Parents; but the Priests would keep them all for their Posterity [emphasis in original].

Indeed, manifest pious mortification became a target of public ridicule, with those who “carried the business of Abstinence and mortification [too] far…put in the catalogue of heretics” [emphasis in original]. The later eighteenth century thus differed from earlier periods because of the way others positioned the fasting women. Starkly different from before, no mention of Ann’s religious allegiance was made beyond one publication, which claimed she was in “a state of true repentance.” In a climate noted for a “prejudice…very prevalent” where “few were willing to argue God from witches or miracles,” fasting women were redundant entities. Thus one of Ann’s more prolific biographers, the Reverend Legh Richmond, began by arguing “that there was no necessity to resort to the hypothesis of a miracle, in order to resolve the supposed difficulty of the case.”

Walter Vandereycken and Ron Van Deth have argued that it was only when such “connection[s] between fasting and religion became more and more loose [that] physicians succeeded in transforming food abstinence into a medical problem.” The hundred years or so between Martha Taylor and Ann Moore had predominately recast these women as bearers of physical pain rather than subjects of divine workings. They

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64 John Trenchard “Of Fasting” The Independent Whig: Or, A Defence of Primitive Christianity, And of our Ecclesiastical Establishment, against The Exorbitant Claims and Encroachments of Fanatical and Disaffected Clergyman. In Two Volumes, Vol.1, 5th ed. No.27 (30 July, 1720), p.216. See also George Benson Sermons on the following subjects. The resurrection of Lazarus. The unchangeable difference between good and evil. The absolute necessity of holiness, in order to salvation. The case of the prophet, who was slain by a Lion. The spiritual (not the natural, or animal) man, disposed to receive the gospel…. (London: J. Waugh, 1748), p.394.

65 Ephraim Chambers A supplement to Mr. Chambers’s Cyclopaedia: or, universal dictionary of arts and science, Vol.1 (London: W. Innys and J. Richardson et al., 1753), p.ABS. See also William Davy A System of Divinity, in a course of sermons, on the First Institutions of Religion; On the Being and Attributes of God; on some of the most important Articles of the Christian-R eligion, in Connection; And On the several Virtues and Vices of Mankind; with Occasional Discourses..., Vol. 12 (Lustleigh: William Davy, 1801), p.401.

66 Sharpless An account of the extraordinary abstinence, p.10.


68 Richmond A Statement of Facts, p.11. This argument found a prolific proponent in David Hume. See Dorothy Outram The Enlightenment (Cambridge: Cambridge University Press, 2003), p.42. For debate about a specific case see Joseph Easterbrook An appeal to the public respecting George Lukins, (called the Yatton demoniac.) containing an account of his affliction and deliverance; Together with A Variety of Circumstances which tend to exculpate him from the Charge of Imposture (Bristol: T. Mills, 1788) and “Bristol Demoniac” Morning Herald, Issue 2401 (2 July, 1788), p.2, Column D.

69 Vandereycken and Van Deth From Fasting Saints, p.47.
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were turned from spiritual examples into case studies through a shared system of recording information. The miracle of fasting woman was refuted through the medium of ordered, physiological description and clinical diagnosis. In turn this gave way to speculation as to how much control these individuals had over the course of their abstinence. The minutely recorded physiological details, the first recourse of all the medical commentators, were important empirical stepping-stones for opinions as to how passive or active the fasting women were. For, it was only by emphasizing the physiological nature of their extreme abstinence that physicians would open the possibility of discussing their psychological control.

Later narratives thus began with details of the women’s previous and ongoing ill health. Ann, for example, was described as a noted “valetudinarian of the last ten years, having never been, in that time, entirely free from pain” whilst Mary Thomas, first recorded in the 1770s, suffered repeatedly from measles, before becoming “insensible” and taking “no manner of nourishment” for “seven years and a half.” Janet McLeod, also from the late eighteenth century, suffered two epileptic fits followed by a “fever of several weeks continuance” before relinquishing all food. Natural histories thus positioned their abstinences within a physiological narrative. Biographers accordingly then noted the women’s present external size, countenance, figures, movement and responsiveness, all of which they shared with the reader in minute detail. A shade of the spectacular lingered, but the arrangement of facts encouraged the belief that these fasts were inherently biological and could thus be solved using the tools medicine provided.

In reference to late nineteenth-century cases, Joan Jacobs Brumberg has argued that medical practitioners were only interested in aggressively instructing the public about fasting women once they had attained a certain degree of celebrity. Certainly medical practitioners published widely and made public claims about their intimate knowledge of the fasting women. Janet McLeod, for example, was “carefully examined” in both 1767 and 1772 by a Dr. Alexander Mackenzie whilst Ann’s earliest proponent, the surgeon

72 See Ibid., pp.6-7.
73 Jacobs Brumberg Fasting Girls, p.73.
Benjamin Granger, took pains to inform his readers that he “repeatedly visited the patient” to fully assess her condition before submitting his article. One of the most public ways medical practitioners claimed control was by directing testing the fasting women. Ann, for example, underwent two watches in 1808 and 1813, both led by medial men “of strict scrutiny” who took her community through clinical-like trials. In the first instance Ann herself “consented to be removed to a neighbour’s house,” away from her carer-daughter and was watched for sixteen days and nights. “[N]o person was allowed to attend, but such as discredited the fact” and placards were “struck up in different parts of the town, announcing, “This is to maintain, that Ann Moor has taken no nourishment since Tuesday afternoon at three o’clock, and is truly and constantly watched”” [sic]. It was Ann’s body, not her soul, which was tested and it was her body that provided the wider community with results “most convincing.”

These watches stood in stark contrast to an otherwise inability to solve the riddle of lengthy abstinence. Benjamin Granger’s admittance “With regard to the proximate cause of this disease…I have nothing to offer” set the tone for a printed plethora of opinions rather than diagnostic statements. Two main lines of thought dominated, both of which echoed anecdotes about the endurance of the insane. As abstinence became a symptom rather than a sign the first pieces of evidence used were drawn from the animal kingdom, specifically from animals thought capable of living on air alone. As a non-natural, air’s harmful and beneficial vapours were broadly believed capable of altering both the internal organs and systems of the body.

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75 These tests were key to later nineteenth-century cases. See Sian Bushy “A Wonderful Little Girl”: The True Story of the Welsh Fasting Girl (London: Short Books, 2003), pp.83 and 110-111.
76 Sharpless An account of the extraordinary abstinence, p.vi.
77 “Abstinence from Food” Maryland Gazette, Issue 3252 (10th May, 1809), p.4, Column C.
79 White The history of Ann Moor, p.38.
80 Granger “Some Account of the Fasting Woman”, p.323. See also Anon “A most Extraordinary Circumstance of a Girl who Subsisted near Four Years on Water alone” The New Wonderful Magazine, and Marvellous Chronicle, Vol.3, No.29 (1793-1794), p.188.
81 Anon A view of human nature: or, select histories; giving an account of persons who have been most eminently distinguish’d (London: S. Birt, 1750), p.228 and Woolley The benefit of starving, p.31. See also Richmond A Statement of Facts, p.ix and Plot The Natural History of Staffordshire, p.288.
that air could provide enough sustenance for Ann to survive without the need for normal consumption. But the ability to survive a lasting abstinence was only possible when the stomach itself changed. Thus this first idea developed into claims that the fasting women’s bodies had somehow evolved so as to capable of surviving on air alone.

The premise that these women’s bodies had actually changed was supported by the women’s own testimony. For example, one of their most common complaints was that attempts to consume anything caused physical pain: “any greater quantities [than a few drops of water] or different liquors, have always made her sick.” Ann Moore apparently begged, “not to be urged to take anything, as the attempt to swallow gives her grievous pain.” This implied that their bodies had changed so that abstinence, rather than harming their health, was actually the most salubrious practice. The fasting women’s “natural…[or] good colour” and bodies “no[t] so much emaciated as might be expected” were recorded so as to confirm this proposition. From these empirical details medical practitioners structured the argumentative explanation that “emaciation does not necessarily follow abstinence” [emphasis in original]. The repetition of this argument by several commentators gives credence to Shorter’s argument that many, before the creation of the term ‘anorexia nervosa’, “justified their inability to eat on the basis of pain and misfunctioning body parts.” These women supplied (or were furnished with) a physical reason for refusing to eat: pain offered a rational, medical excuse for their consumption behaviour.

And yet the later eighteenth- and early nineteenth-century cases also show the start of a psychological discussion surrounding the fasting women. Although there was no accord, proponents of all theories explored the possibility that these fasting women reacted not just physically but emotionally towards food. For example, in 1793 The New Wonderful Magazine told the tale of a sixteenth-century girl whose initial physical

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83 Plot The Natural History of Staffordshire, p.288. See also H.A. Mirabile Pecci, p.12. We will see this again in chapter five.

84 Dr. Allen as quoted in White The history of Ann Moor, p.16.


86 Granger “Some Account of the Fasting Woman”, p.322. It is worth noting that it is the body as an entity (not the specifically female body) that was considered capable of such a transformation.

complaint triggered “an aversion to victuals” and a loathing of “all food to such a degree, that if any one suddenly put a bit of sugar into her mouth she immediately fainted.”

Almost twenty years later one American publication declared that Ann had “entirely lost her appetite”, “lost all desire for food” [emphasis added] and suffered from “the imagination of her stomach being diseased.” Likewise Janet Mcleod, who suffered from locked jaw for almost a full year in the late eighteenth century, was described as having neither “desire” nor “craving” for food. Such repeated conflation of psychological and physiological rhetoric is a further reminder that the women’s own words were treated as important clues. Ann’s biographers took pains to stress that her “mental faculties are entire” and her statements, consequently, to be respected. The women’s behaviour and public persona were all under scrutiny. Their rational discourse, at odds with stereotypical ideas about the character of insanity, made their cases even more confusing for their observers.

In fact the women’s mental states were only really subject to analysis when some commentators suggested that extreme abstinence could be the result of deliberate deception. This was very different to other spiritual or physiological explanations and recast the women’s disordered eating as a symptom of misplaced faith, disturbed morality or delusional conviction. With this suggestion historical cases of remarkable abstinences were dismissed as riddled with “error[s] in the report,” their subjects condemned as “grossly deceiv[ing]” and their expressions “strange and contradictory.” Those cases, republished as accompaniments to Ann’s story, served instead as evidence that her medical symptoms had long and natural histories. This is an important caveat that separates these cases of abstinence from the traditional historiography of eating disorders. That historiography is dominated by gendered divisions that equate body-dysmorphia with deliberate resistance. The texts that survive offer no such insights. They suggested that deliberate abstinence could reflect willful self-starvation but they did not give voice

88 Anon “The following Wonderful and Extraordinary Cases”, p.479.
89 Sharpless An account of the extraordinary abstinence, pp.13-14.
90 Mackenzie “An Account of a Woman in the Shire of Ross”, pp.3-4.
91 Granger “Some Account of the Fasting Woman”, p.321.
93 See Bell Holy Anorexia, p.xii.
to the women themselves. The change in description came, instead, from those who wrote about them.

Lacking from all their reports however was a psychological history prior to the onset of abstinence. This was only really deployed for a category of individuals who shared the same behaviour as the fasting women but were labelled differently: the religious melancholics. This medical category of abstainer represents the greatest overlap between the fasting women’s stories and the more general psychiatric model. Portraying abstinence as a primary symptom of religious melancholy allowed practitioners to exercise their own particular brand of psychology and apply that to abstainers of various temperaments. These included passionate excess, erroneous judgment and deluded imagination so that, by the later eighteenth century, spiritual abstinence was a major psychiatric symptomology. For the fasting women this translated into a commentary that described the women as possessing minds “hardened in sin and moral insensibility” whilst, at the same time, suggesting that their abstinence had a deliberate irrational purpose.

However, religious melancholic abstinence had a role in a debate much broader than that surrounding the fasting women. Early eighteenth-century authors had deliberately positioned the enlightenment as a force for freedom from the sort of dangerous spiritual superstition embodied by mortification behaviours. In these discourses practitioners labelled as ‘delusional zeal’ that which patients continued to describe as penance for their “wonderings.” But practitioners were not alone. In sectarian attacks, acts that for some remained important forms of spiritual practice were relabelled through the language of melancholic insanity. And this motif had a lengthy history. In seventeenth-century England the philosopher-scholars Henry More and Meric Casaubon portrayed Puritan practice as the “natural result of vapors or overheated melancholy” and their being

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94 See Walker Bynum *Holy Feast and Holy Fast*, p.151.
95 Richmond *A Statement of Facts*, p.45.
97 Avis Binney, Diary, MSS 9001-B Box 13, Rhode Island Historical Society, loose leaf page.
victims of “the delusion of being inspired.”\textsuperscript{98} In parallel Roman Catholicism was attacked as a haven for “gloomy, splenetic, half-distracted people”.\textsuperscript{99} In the eighteenth century similar themes were recycled and applied to Methodists, whose focus on inner revelation and a highly personal, emotional spirituality incited repeated accusations of enthusiasm and heresy.\textsuperscript{100} A host of sermons, treatises, and newspaper articles sought to undermine their focus on individuality-lived spirituality as enthusiastic insanity.\textsuperscript{101} By our period, and on both sides of the Atlantic, newspapers carried tales of suicides committed and attempted in “a fit of religious despair” and satirical conversion stories that began with “deep dejection” and sense of sin.\textsuperscript{102} Despair and melancholy crossed sectarian lines, threatening all who lost their spiritual way.

In this sense clerics furthered the psychiatric cause by reshaping experiences of the soul into disturbances of the mind. By the late eighteenth century psychiatrists returned the favour, arguing that “the enthusiasm of religion” was merely a particular form of maniacal insanity.\textsuperscript{103} Individual experiences of the miraculous were subsequently dismissed as irrational and subversive at best, delusional at worse. As potential dangers were emphasised, religious enthusiasm became almost a synonym for extremism. No longer associated with heightened spiritual awareness, religious enthusiasm was described by ministers as unnaturally burdensome.\textsuperscript{104} Now the focus was on the extreme nature of enthusiasm. Extreme practices such as abstinence were likewise tarnished: multiple psychological parallels between the symptoms of melancholy and superstition allowed for a neat and quick theological rebranding of a swath of individuals and practices previously


\textsuperscript{101} John F. Sena “Melancholic Madness and the Puritans”, p.300.

\textsuperscript{102} “London” \textit{London Evening Post, Issue 6207} (17\textsuperscript{th} June, 1766), p.5, Column C and “The Persecuting Husband and his pious wife” \textit{Western Intelligencer, Religious, Literary and Political}, Vol.3, Issue 9 (20\textsuperscript{th} September 1828), p.1, Column E.

\textsuperscript{103} See, for example, Andrew Harper \textit{A treatise on the real cause and cure of insanity; in which the nature and distinctions of this disease are fully explained, and the treatment established on new principles} (London: C. Stalker, 1789), p.44.

\textsuperscript{104} Joseph Lathrop \textit{Two sermons on the atrocity of suicide} (Springfield, MA: Henry Brewer, 1805), p.20.
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uncensored. Orthodox approval of this rebranding of previously ‘good’ Christian expressions of duty and love – such as fasting – into the direct result of delusional or frenzied passion must not be underestimated. Religious melancholy developed as a medical category in part because of the shared objectives of the psychiatric and clerical communities.¹⁰⁵

Religious enthusiasm enraged clerics because it stood as an affront to their truth. For general medical practitioners enthusiasm, in contrast, represented an affront to their prescriptions of “proper conduct and moderation in the pursuits of life.”¹⁰⁶ But the leap to a diagnosis of full insanity required more than accusations of enthusiasm. Philippe Pinel, experienced with the French Revolution’s de-Christianization policies, directly associated superstition and enthusiasm with insanity. Pointing to shared food-refusal behaviours and over-active imaginations, Pinel drew a parallel between religious enthusiasm and the insane, implying strongly that the former was a branch of the later.¹⁰⁷ A parallel discourse used imagined romance or love-sickness as a tool for explanation, whereby disordered notions of spiritual or temporal love drove fasting behaviours.¹⁰⁸ But most, including those who wrote about Ann, utilised Pinel’s framework, to argue that the imagination could produce “Effects equally wonderful” so as to support a lengthy abstinence.¹⁰⁹ The abstainers’ spiritual discourse and convictions were, therefore, trumpeted not as rationale for religious practice but, rather, as evidence of their deluded judgements. Fasting women and spiritual penitents, who saw their abstinences as part of “the duty...a Christian oweth to God,” were now widely disconnected from medical practitioners who pathologised their extreme abstinence.¹¹⁰

¹⁰⁶ Harper A treatise on the real cause and cure of insanity, p.44.
¹⁰⁷ See Philippe Pinel A Treatise on Insanity (Sheffield: W. Todd, 1806), p.73.
¹⁰⁹ Sharpless An account of the extraordinary abstinence, p.13.
¹¹⁰ Robins The wonder of the world, p.8. We will see this disconnect again in Chapter Five.
By at least the mid eighteenth century then the extreme abstinence associated with religious melancholy most commonly resulted in a psychiatric rather than spiritual diagnosis. For those tormented by “Inward Sorrows…[and] reproach and Temptations” fasting was a method through which they hoped to revitalize their soul; for medics it became a sign of mental illness to be treated by men.\textsuperscript{111} From the early eighteenth-century individuals such as Reverend George Trosse, who saw the “Starving of [his] Body…as the Way to save [his] Soul,” faced commitment in the asylum.\textsuperscript{112} Although asylums admitted the religious maniac throughout our period, it was the religious melancholic who overwhelmingly dominated both sides of the Atlantic by at least the turn of the nineteenth century. In a unique combination, religious melancholy perverted both emotive and irrational brands of mental illness. The story of a 1788 patient at London’s Westminster Hospital (the same institution that employed Ann’s biographer Alexander Henderson) is emblematic. The case notes give the determining cause of diagnosis as the fact that she “once fasted three weeks in obedience to a vow she made to God” and “had great anxiety for the fate of her soul.”\textsuperscript{113} These acts alone now provided validation that she was to be fashioned as a patient, to be treated rather than applauded. Diagnosed as insane, she was a long way from the fasting girls of the previous century.

\section*{III: Chlorosis and Malacia}

The association of extreme abstinence with religious melancholy positioned the fasting women on a spectrum of behaviour that moved from sober rationality to insanity. As with voracious eaters, it was never the case that those who engaged in a form of disordered eating would necessarily be labelled insane. But the connection between disordered eating as a behaviour and insanity as a condition certainly became stronger in this period. In part this was because various psychological explanations were advanced in

\textsuperscript{111} H.A. Mirabile Pecci, p.15.
\textsuperscript{113} S. Sawrey (ed.) The morbid anatomy of the brain in mania and hydrophobia with the pathology of these two diseases, as collected from the papers of the late Andrew Marshal, M.D.... (London: Longman, Hurst, Ress, Orme, Brown and Green, 1815), p.161.
response to unproven physiological hypotheses. The very diversity of early psychiatry meant that there were many avenues for including disordered eating within its remit. This final section turns to another category of disordered eating which witnessed perhaps the most varied range of psychological speculations. Chlorosis, or ‘the green-sickness’, a complaint of pubescent girls, and malacia, a disease of pregnant women, were described as so “innumerable” “Every practitioner must have met with instances of these.” Indeed, non-practitioners such as John Wesley recognised “The Green Sickness” as a standard disease and prescribed for its cure, whilst domestic recipe books included chlorosis in their receipts. Both were diagnosed by behaviour not physiological change. Both represent one of the most developed categories of disordered eating as mental illness precisely because they could be adapted to suit multiple hypotheses.

Chlorosis and malacia were defined by pica, or the consumption of “such things as their own reason must tell them cannot be agreeable to the Constitution of their Bodies,” including “unripe Goosberries, Currants, Apples” “chalk, tobacco pipes” and other deleterious substances. As consumption behaviour, practitioners looked at the individuals’ current actions as much as natural history. As with voracious eating, physicians and lay authors associated lifestyle choices with both consumption habits and the ability to digest food. For chlorosis in particular this had longstanding ties to descriptions of innate feminine weakness and susceptibility. From Greco-Romano authors early modern commentators developed the doctrine that pica was caused by a disturbance in the regular functioning of the (predominantly) female body. Galen described a form of pica when he wrote that the suppression of the menses could cause patients to “vomit their food, and eat earth or cold ashes or similar things.” Pica thus formed a parallel to

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117 As quoted in Plinio Prioreschi History of Medicine: Roman Medicine, 1st ed. 1998 (Horatius Press: Omaha, 2001) p.479. For a brief reference to Galen’s familiarity with the complaint see John Quincy Lexicon physic-medicum: or, a new medicinal dictionary; explaining the difficult terms used in the several branches of the profession, and in such Parts of Natural Philosophy as are introductory thereto….., 3rd ed. (London: J. Osborn and T. Longman, 1726), p.31.
hysteria, caused or at least aggravated by the retention of semen or a “stoppage of the menses” in women.¹¹⁸ In the mid eighteenth century pica as malacia was still widely attributed to “a Perversion and Depravation of the natural Menstruum,” but physicians also began to consider various other possible explanations.¹¹⁹ The physician Charles Perry, for example, gave a long list of potential etiologies in 1741, speculating that malacia could be the product of the suppression of the menses, or “a preternatural, vitiated Ferment in the Stomach…or possibly the like Passion, Perception or Appetite [or it] may be excited by some capricious Action or operation of the animal Spirits, in and upon the Stomach.”¹²⁰

In the late eighteenth and early nineteenth centuries further commentaries were added. These broke with the overwhelmingly gendered interpretation of pica and, instead, suggested alternative preconditions grounded upon character and circumstance, rather than flaws inherent to the female form. For example, popular magazines wrote scathing commentaries on “the present race of young invalitudinarians, and their puny pigmy progeny” who, as “spurious, effeminate, mushroom breed… mistake their food, and impose upon themselves.”¹²¹ This lifestyle, contrary to masculine ideals, could also be enforced:

Neither is it unusual to see young lads who have received from Nature, and from their Parents, a sort of feminine constitution, education, &c. affected with much the same symptoms as chlorotic young women.¹²²

In addition, the physician John Gregory told his students that malacia was a class-based lifestyle, seldom found “among ye common people who cant afford to greattify theer

¹¹⁸ Peter Shaw A new practice of physic; wherein the various diseases incident to the human body are orderly described, their causes assign’d, their diagnostics and prognostics enumerated, And The Regimen proper in each deliver’d; With a Competent Number of Medicines for every Stage and Symptom thereof..., Vol.1 (London: J. Osborn and T. Longman, 1726), p.179.
¹¹⁹ Charles Perry A treatise of diseases in general. Wherein the true causes, Natures, and Essences of all the principal disease incident to the Human Body, are mechanically accounted for and explain’d, and their respective Intentions of Cure assign’d upon the same Principles..., Vol.2 (London: T. Woodward and C. Davis, 1741), p.70.
¹²² A. Hume Every woman her own physician; or, the lady's medical assistant. Containing the history and cure of the various diseases incident to women and children.... (London: Richardson and Urquhart, 1776), p.7.
appetites” [sic]. Combined, these commentaries furthered the idea that it was lifestyles practiced and decisions made that engendered this form of disordered eating.

Nonetheless, commentaries on lifestyle and disordered eating continued to predominantly target women. Here two broad doctrines intersected. Firstly, that young, virginal women were predisposed to engage in disordered eating. Chlorosis in particular showed significant overlap with fasting women when it came to patient type. For example, with the exception of Ann Moore, all the fasting women were virginal. Ann was therefore a difficult aberration for a medical community who regarded puberty and pregnancy as the prime medical and mental ‘risk’ periods in the female life cycle. Indeed, the late eighteenth-century English and American presses often ran accounts of “Wonderful abstinence[s] from Meat and Drink” which invariably listed girls of prepubescent or pubescent age. Though a different type of disordered eating, chlorosis affected the same demographic groups. Indeed, it was so much associated with unmarried women that it was known as the “cachexy of virgins” from at least the mid-eighteenth century. Combined, fasting and chlorotic girls created a database of complaints specifically centred upon the relationship between pubescent girls and consumption.

The second contention was that women exercised choice and free will when they engaged in these disordered eating behaviours. To this must be added a caveat. This literature contains very little that points to the current interpretation of teenage disordered eating as reaction to a socio-cultural idealization of the slender feminine form. But the idea that these types of disordered eating were chosen behaviours was central. The diagnosis of ‘choice’ implied that they had no physiological root. Rather, mental exertion or ‘decision’ lay behind the manifestation. By the late eighteenth century some commentators suggested that pica was the manifestation of unhappiness with either one’s family or one’s wider environment. This suggestion became a fully blown principle when the French physician Ernest-Charles Lasègue described anorexia nervosa in 1873. His

123 Gregory, Lectures, p.214.
124 For more see J. Jacobs Brumberg Fasting Girls, p.70.
126 Brookes An explanation of the terms of art, p.509.
conceptualisation of consumption behaviour as the nucleus of a wider familial conflict thus echoed and adapted the work of his precursors.\textsuperscript{127}

The proposition that individuals chose to enact disordered eating behaviours is a familiar one. But chlorosis offered a new direction: the possibility that disordered eating was an elected method of achieving thinness.\textsuperscript{128} Medical practitioners on both sides of the Atlantic associated this type of pica with the aesthetic pursuits of teenage girls. The widely read practitioner William Buchan, for example, rebuked those who indulged in “absurd practices such as drinking vinegar to produce what is called a genteel or slimmer form.”\textsuperscript{129} Likewise, a trans-Atlantic publication by the physician Anthony Willich noted not only the drinking of vinegar but, also “Eating chalk” in destructive attempts to “beautify their persons.”\textsuperscript{130} Practitioners always listed these patterns of consumption as part of a spectrum of lifestyle choices.\textsuperscript{131} This was a constant theme of chlorosis and one that, moving further into the nineteenth century, was developed further. In the nineteenth century medical practitioners expanded their overview to condemn “fashionable maxims” as leading women to “the greatest of all absurdities – that of valuing themselves upon the delicacy and tenderness of their constitutions.”\textsuperscript{132} Through all they attacked women’s decisions, breaking with suggestions that they were simply victims of their body’s ill health. This theme would only expand further throughout the nineteenth century.

But by far and away practitioners were most concerned that women could potentially further the development of their chlorosis or malacia. This garnered considerable attention and prescriptive efforts, both of which had a lengthy history in the literature. As has been a theme throughout, such debates continued to draw on the idea of behavioural choices. From the early eighteenth century, these illnesses were described as ones of grades and degrees. Prolific physicians such as Bernard Mandeville claimed that chlorotic

\begin{itemize}
\item J. Jacobs Brumberg \textit{Fasting Girls}, pp.128-134 and 142.
\item For more on this see Vandereycken and Van Deth \textit{From Fasting Saints}, p.241.
\item William Buchan \textit{Advice to Mothers, on the subject of their own health : and on the means of promoting the health, strength, and beauty of their offspring} (London: A. Strahan, 1803), pp.9-10. See also Ewell \textit{The Medical Companion}, p.395.
\item W. Birch \textit{American lady’s medical pocket-book, and nursery adviser...}. (Philadelphia: James Kay, Jun and Brother, 1817), p.28.
\end{itemize}
women “brought themselves to like what at first was indifferent to them, and tasted by them only out of Wantonness.” Wanton longing, unchecked by rational restraint, was understood to have a far-reaching psychosomatic effect. But even that was measured and graded: women could be subject to both “the violent Eagerness of Longing” and the less severe “fanciful hankering[s].” Their subsequent descent into more extreme pica reflected their overall mental stability and health. The mid eighteenth-century English physician John Colbatch accordingly labelled pica “a degenerate Taste, which perpetually covets and longs for Things that are both improfitable and hurtful” [sic].

Chlorosis and malacia thus became diagnostic tools for the early psychiatrist. Using their shared behaviour, as early as the eighteenth century practitioners treated the two as simply different degrees of the same psychological condition. This led to two further theoretical developments. First, the belief that there were degrees of emotional states that needed to be categorised circumspectly by the practitioner. For example, by attributing chlorosis and malacia to longing, early psychiatrists placed them at the opposite end of a shared spectrum with disordered eating complaints defined by loathing of food. Second, that because these behaviours originated in the mind the women were, to some degree, capable of controlling their disordered eating behaviours and prognoses. Both removed chlorosis and malacia from the purely physiological realm. Thus, in medical dictionaries physicians such as Robert James associated pica and “Deprevations of the Appetite” with psychological distress first and foremost.

Medical practitioners stepped into the therapeutic market by asserting that they alone were able to truly gain command over these longings. Just as a malacic or chlorotic woman chose to indulge in a certain lifestyle, so too she was urged to conquer her “unaccountable” longings “as much as in her lies.” Some went further, describing chlorosis and malacia as the unfortunate by-products of feminine desires unrestrained by medical reason. This was of particular concern in malacia, which was such a dominant

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133 Mandeville A treatise of the hypochondiack and hysterick diseases, p.241.
134 Idem.
136 For loathing see John Ritson An essay on abstinence from animal food, as a moral duty (London: Richard Phillips, 1802), p.43
137 See Buchan Advice to Mothers, p.13.
139 Salmon A family jewel, p.9.
complaint that Dr. Lowder, in his lectures on midwifery, declared it to be “one of the best signs” of pregnancy.\textsuperscript{140} Because of concerns about the potential dangers for the foetus, malacia cravings or longings were treated as detrimental if not indulged to a certain degree, but catastrophic if humoured beyond educated sense.\textsuperscript{141}

There certainly appears to have been a popular belief that the mental as well as bodily health of a pregnant woman affected her unborn child, a belief that lingered especially in America. For example, in 1760 the Massachusetts practitioner John Perkin recorded the case of a former “Lover of Clams” who suffered a “pica pregnauticum” when made “very angrie” \textit{[sic]} and had, since that time, had “an aversion to ye.”\textsuperscript{142} In an illuminating addendum the report ended with the claim that “likewise a son of hers…has a steady abhorrence to them.”\textsuperscript{143} Well into the eighteenth century a common argument remained that a degree of indulgence was necessary, albeit “as moderate as possible,” lest unsated, perhaps natural longings caused the unborn child to “be lost or disfigured with strange Marks.”\textsuperscript{144} Benjamin Rush seemed to concur: in the early years of the nineteenth century he recorded in his notebook that “a child when born has perceived & willed from internal impressions: It has impressions from the passions - appetites &c of its mother” [emphasis in original].\textsuperscript{145}

But the early 1800s witnessed debates about this very point. As late as 1815, for example, Massachusetts medical students were introduced to an “idea which prevails very commonly…[that if the]…mother longs for any particular food while pregnant that the child must be gratified with that or it will die.”\textsuperscript{146} But, simultaneously, both American and English texts replaced indulgent tones with strictures and disclaimers. Whilst some authors chose a moderate tone, reminding readers that pregnant women need not “fear, if such absurd longings be not gratified, that her child will incur the risk of blemish or

\begin{footnotes}
\item[140] Lukyn, Midwifery Lectures by William Lowder, 1786, MS 7789, Wellcome Trust, p.76 [facing].
\item[141] For a case study in this see John Perkins, Medical Papers, June 1760, Folio Volumes P, American Antiquarian Society, p.27. See also Perry \textit{A treatise of diseases in general… Vol.2}, p.71 and Lesel Dawson \textit{Lovesickness and Gender in Early Modern English Literature} (New York: Oxford University Press, 2008) p.178.
\item[142] Idem.
\item[143] John Perkins, Medical Papers, p.27.
\item[144] Salmon \textit{A family jewel}, p.9. See also Townsend \textit{A guide to health}, p.386.
\item[145] Benjamin Rush, Medical Notes 1804-1809, Rush Family Papers, Benjamin Rush section, Yi2, 7265 v.87, Historical Society of Pennsylvania, p.39.
\item[146] B.F. Heywood, Notes on medical lectures 1814-1815, Octavo Volumes H, Heywood Family Papers, Octavo Vol.1, American Antiquarian Society, Lecture 2d.
\end{footnotes}
deformity. [For] Such an apprehension is neither warranted by reason, nor confirmed by experience,” others mocked the idea that the mother’s mind had the power to alter the future of the foetus.\textsuperscript{147} When reassurances failed, the practitioners’ role was to be “the force of the ridicule, of argument, or of authority” in the face of ridiculous folly.\textsuperscript{148} For all, only the expert and skilled practitioner could achieve the careful balance between accommodating symptoms and indulging irrational desires.

That skill lay not so much in medicines applied but, rather, the psychiatric therapies adopted. John Colbatch had earlier pointed to the important role the mind played in conquering these illnesses. He argued that the complaints only abated when the individual was able to consume “unnatural Stowage” which, “no sooner eagerly devour'd, than the Mind detaches a sufficient Troop of animal Spirits, to enable the Stomach to dislodge the Enemy.”\textsuperscript{149} This seed grew over the eighteenth century as psychiatry expanded its remit of care over these patients. It is of course important to acknowledge that, for all the developing psychological and psychosomatic propositions, the stomach remained, as with all other disordered eating symptoms, a central etiological agent. As we move into the later eighteenth century however, even those who maintained that malacia derived from “a Disease of ye Constitution in general, or ye stomach in particular,” described the complaint through the rhetoric of a depraved appetite.\textsuperscript{150} And, as attempts to trace the physiological progression of chlorosis and malacia made little progress medical authors built their therapeutic strategies around the impulses spurring the observed consumption behaviours.

The notion of desires and passions (longing and loathing) reinforced psychosomatic thinking and practice.\textsuperscript{151} Indeed, the rhetoric of the passions would be an extremely influential part of the literature on all female pica and abstinence in the early nineteenth century. References to longing or loathing provided women with, essentially, a justification for their disordered eating; they simply chose to “give way to the depraved

\textsuperscript{147} Birch \textit{American lady’s medical pocket-book,} p.123. See also Buchan \textit{Advice to Mothers} p.45.
\textsuperscript{148} Buchan \textit{Advice to Mothers}, p.42.
\textsuperscript{149} Colbatch \textit{The generous physician}, p.50.
\textsuperscript{151} See Hooper \textit{A Compendious Medical Dictionary}, p.PIM.
Feelings or emotions now shaped consumption behaviours. Using Ann Moore’s case, for example, one author argued that these could not only shape illness, but even actively change physiognomy: “an exemption from passions…[was]…one of the means of her existence being so long maintained.” In this the patients’ verbal statements aligned with the medical belief that that the passions could impair or destroy not just the physiological function of the stomach but, also, the appetite or very desire to eat.

Both passion and appetite remained of central concern for those discussing these particular complaints. This explanation connected with another evolving theorem that associated the depraved appetites of chlorotic girls with depraved sexual appetite. Several historians of eating disorders have equated the suppression of the appetite with sexuality and as an expression against patriarchal sterility. This is impossible to judge from an almost total silence on this issue in this period. What can be gleamed is that the term ‘appetite’ often associated the consumption appetite with appetites for other potentially harmful behaviours. For example, one physician argued that chlorosis “most commonly proceeds from a longing desire after the enjoyment of some particular person, or from a violent inclination to exchange a singly life for a state of matrimony.” The therapeutic advice was simple: “when this is the case, the parents should either let her have the man she longs after…or otherwise endeavour to provide her a suitable match as…the most natural and most radical cure.”

Disordered eating was then, but one expression of a plethora of unhealthy desires.

There was one final alternative practitioners turned to when describing the genesis of pica-type longings. This, a heightened interest in the role the imagination played in shaping the potency of the disease and controlling the bodily desires of these women, tied more directly with broader discussions of insanity and mental illness. In 1733 John Colbatch wrote that pica “takes its Rise rather from a blundering Imagination than any

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153 White The history of Ann Moore, p.43.
156 Idem.
Defect in the Juices of the Body”. His work was supplemented by later eighteenth century physicians who, even at the most general of level, acknowledged “An agitated mind is productive of inappetency, or indigestion, and a depraved chylification” \[sic\]. In 1788 William Rowley, a leading London physician, argued that the primary indicators to look for when observing pregnant women were the “strange fancies [that] have possessed their imagination, in desiring absurd things for food.”

By Rowley’s time debility of the stomach remained the root cause but its role over the entire course of the complaint was pathologised. Even Rowley, committed to the idea that the stomach was the entrenched precondition for malacia, would concede that “Whatever the stomach has repeatedly rejected, impresses the mind, and occasions future dislike; so that the bare mention of certain things create disgust, nausea, or vomiting.”

Finally, it is important to note the other complaints associated with chlorosis and malacia. As might be expected, these split along psychological and stomachic lines. For the first practitioners gave chlorosis and malacia a psychological symptom (not cause) by labelling anxiety as a by-product of both conditions and providing a prognosis that argued that when “The Irregularity of the Idea ceases” the pica would end. Descriptions of the imagined cravings of the patient further linked this explanation to other illnesses defined by disordered eating, including bulimia and hydrophobia. It was however hysteria that seems to have been most associated with the conditions. Indeed, pica was described often as a precursor to the hysteria: “Before young Girls come to be Hysterick, you shall always observe, that their Blood has been much depauperated by Agues, Green-sickness, or other Cachexies” \[sic\]. But, as has been the story throughout this section, by the end of the eighteenth century, even those who attributed chlorosis to the obstruction of the menses would argue that its manifestations were ultimately derived from “The Effects of

157 Colbatch The Generous Physician, p.50.
160 Ibid., p.139.
161 Edward Strother An essay on sickness and health ; wherein are contain’d all necessary cautions and directions....., 2nd ed. (London: Charles Rivington, 1725) p.104.
163 Mandeville A treatise of the hypochondriack and hysterick diseases, pp.239 and 241. See also Dawson Lovesickness and Gender, p.61.
Imagination in Causing longing."

Remodelled along the lines of the other conditions, as intellectually or emotively provoked complaints that acted on the digestive organs, chlorosis and malacia added to the growing database of psychogenic diagnoses.

----- Conclusion ----- 

The complaints under discussion in this chapter differ significantly from those explored in chapter one. The rhetoric that surrounds them also differed, opening up a new line of psychosomatic thinking on both sides of the Atlantic as the American presses reprinted English cases and texts. Because individuals who exhibited the signs of these three types of disordered eating did not often talk about their motives in a way that could clearly be attributed to an imagined delusion, the connections between their behaviours and mental illness were less tangible than for those who filled the pages of chapter one. This explains, partially, why early psychiatry made less inroads and held less claim over these three types of disordered eating.

But it also explains another phenomenon: the development of an even larger spectrum of mental illness than was created through the medium of disordered eating in chapter one. As discussions about voracious eating, lengthy fasts and pica attempted to trace their etiological roots beyond the physical body, the ancient category of passions was expanded significantly. By the early decades of the nineteenth century it came to incorporate a range of terms such as loathing, longing, cravings and fancies, that, when taken as a whole, informed a slow but steady movement that located disordered eating in the mind rather than the body. As we shall see in chapters four and five, this movement, the creation of a second way of thinking about mental illness, would be critical in the development of different strands of asylum practice.

These complaints, surrounded by an accusatory discourse of failed self-discipline and passionate excess, suggested that those who descended into insanity carried a burden of blame at some intrinsic level. More generally, that any individual who ignored the right practices, lifestyle and mental exercises was at risk of disturbing their mental and thus

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164 Lectures By Doctor Young Professor of Midwifery in The College of Edinburgh, Delivered in Winter, Vol.1, 1769, MSS 03042 Rb112171 c.1, Thomas Fisher Rare Book Library, pp.133 and 191-192.

165 For a caveat see Anon “On Hypochondriasis and Suicide” The American Medical Recorder, Vol.6, No.3 (1823), p.567.
physical health. This is a very different category of sufferers than those in chapter one. They were framed differently accordingly. Ultimately these particular disordered eating behaviours were treated and described in a manner that suggested connections rather than made firm links to psychosomatic etiologies. In particular the complaints that seem to have been almost the exclusive preserve of women – chlorosis, malacia and the women fasting for spiritual relief – continued to be clouded by a medical doctrine that saw women as inherently weaker. But this weakness was increasingly reshaped as a weakness of mind rather than body and, furthermore, of the imagination rather than merely emotional state.¹⁶⁶ The nineteenth century would further develop a range of complaints attributed to a general inability to control passionate volatility rather than an aberration in physiological functioning. The significant point is that the former came to dominate these disparate disordered eating cases.

¹⁶⁶ On the latter see Skultans English madness, p.15.
Kathryn Segesser

CHAPTER THREE:
DISORDERED EATING AND THE LAW

----- Introduction ------

Dana Rubin notes that, under eighteenth-century law, “arguments for insanity rested on two kinds of evidence: the offender’s history of peculiar behaviour and the inexplicable nature of the crime itself.”¹ Those two qualifiers continued to inform early nineteenth-century law at all levels. This chapter reexamines both through the medium of disordered eating. It explores specific cases to illustrate how disordered eating became important qualifying evidence in legal judgments of insanity for both English and American judges, juries and witnesses. The previous two chapters have introduced disordered eating symptoms within the context of psychosomatic theories. This chapter instead looks primarily at disordered eating as behaviour and action. It is interested in the way law courts on both sides of the Atlantic – and with a remarkable degree of similarity – used disordered eating behaviours as both evidence of long-standing insanity and markers of temporary mental disturbance. This chapter argues that disordered eating provided an important tool through which medical practitioners, eyewitnesses and lawyers alike were able to translate psychological theories into practical realities that juries could then identify as legally valid evidence.

This chapter explores legal procedure and the lived reality of the legal system rather than institutions or statutes, the focus of most historiographical research. Both English and American civil and criminal courts approached insanity very much on a case-by-case basis, constructing varied definitions of insanity rather than following a clear precedential rubric.² This rather divergent approach was partly born out of their application of common law and localised judicial authority, but was also the product of a system where inexpert juries were presented with opposing testimonies from myriad witnesses. In addition, American courts turned to the limited strictures of the English Chancery court

and Privy Council before independence and became more regionalized and individualistic post revolution, precluding any standardised national approach. The legal world possessed a series of litmus tests through which to determine and then treat (or, more often, detain) insanity, but acquittals, convictions, and diagnoses alike were often shaped by the instructions judges gave to juries, and by lawyer-led definitions that guided witnesses to specific evidence. Medical practitioners always entered the courtroom as invited participants: the questions and classifications of the courtroom shaped their testimonies.

The late eighteenth- and early nineteenth-century legal worlds serve as important barometers for measuring the extent to which the psychiatric theories discussed in the previous chapters affected an extraneous professional arena. It was only right towards the end of our period that established medical authors began to seriously encourage their colleagues to look to the courtroom and other legal processes as tools for social and professional advancement. Indeed, the historiography of both psychiatry and the nineteenth-century medical world in general has located the issue of professionalization in this period within similar attempts. It is better instead to see the courtroom as a changeable marketplace in which practitioners of various descriptions were called upon to compete in an unfamiliar and very public setting. The courtroom became but one more site for the advancement not necessarily or primarily of medical authority but, rather, of medical interaction. Thus, and in continuation of chapter two, this chapter is essentially the story of the promulgation of psychiatric theory – specifically psychological doctrine – rather than a body of professional psychiatrists.

This chapter begins by using the medical practitioner’s entry into the courtroom as a case study in translating psychological theories into tangible, convincing realities. This was the focus of a growing body of medical jurisprudence texts that attempted to build a

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model for practitioners based on the expectations of the judicial system. It opens this chapter because the central thrust of those attempts lay in ongoing efforts to convince courts to prioritize qualitative opinions and expertise. These were gained from quantitative exposure not just to the insane individual, but also to insanity as a condition. Under this design, disordered eating behaviours were important pieces of evidence that could be verified by other witnesses but only properly explained by the medical practitioner. They were thus a key part of a broader range of symptoms used to argue that practitioners were to be treated as the voice of authority in insanity pleas. Easily recognised and recounted, disordered eating helped practitioners of all types navigate the complexities of insanity.

Next it looks in detail at trial cases where disordered eating was used to promulgate this newer model of insanity. This section includes case reports, trial records and, especially for America, newspaper articles to access the legal experience. These cases epitomise attempts to implement and demonstrate the model of insanity as fundamentally a discovered rather than manifest condition. By exploring suicide inquests, contractual disputes and criminal trials, it shows how psychological theories gained traction. This was led by lawyers attempting to convince juries expecting to see and hear quantifiable evidence as much as by practitioners. That is where disordered eating played such an important role. By the late eighteenth century the standard for insanity required it be demonstrated as “a habitual Fact, a Disposition, a personal Affection of the Mind.”

Disordered eating behaviours provided evidence of all three. As it was broadly acknowledged that “nothing is more difficult than to prove the fact of insanity…to render an invisible and interior quality sensible and visible,” disordered eating symptoms provided important qualifiers for a natural history of insanity, allowing courts to grade an individual’s insanity within a varied spectrum. Thus recounting behaviours or actions transitioned into explaining what those actions meant via the language of mental

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disturbance. These cases represent the advent of a legally sanctioned psychological model of insanity.

The final section looks at how legal personnel and commentators developed that momentum still further. By tracing cases of the convicted and acquitted alike both during and after the moment of trial it is possible to see a steady reshaping of the insane so that they were defined by their specific form of mental distress, rather than an all-encompassing criminal nature. This stands in contrast to the 1800 Criminal Lunatics Act and later legislation that are often seen as a return to draconian, permanent and punitive confinement. These would have more lasting influence into the nineteenth century. It is better to read that Act as a specific response to a shock acquittal and one that highlights the separation between the tone of the English legislative body and the actions of the wider English and American legal systems. Courts, as a rule, were unwilling to label any individual as either permanently or absolutely insane.

The texts under consideration in this final section highlight that separation and can be seen as evidence that legal officers were influenced by psychiatry in a manner not paralleled by their legislative or even judicial colleagues. Disordered eating symptoms grounded their commentaries that were, usually, founded on the premise of spectrums and changing degrees of insanity. This was the case even when the insanity plea had not been raised or had been rejected in the courtroom. It is possible to argue that the development of psychological continuums of insanity called into question the ‘facts’ of legal insanity, forcing a reexamination of even the most basic types of abnormal behaviours. As longer-term explorations, these works were able to trace disordered eating symptoms over lengthier periods. It is therefore significant that most of the authors under examination in this section increasingly described disordered eating as emblematic of a clinically refined and narrow mental distress.

------ I: Medical Practitioners in Court ------

Over the course of the eighteenth century courts transitioned from what Rubin has

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described as the “accused speaks” to the “adversarial trial.”

With the addition of sworn testimony of witnesses for the defense, the emergence of a stronger prosecution counsel and the creation of a defense counsel, trials became more uniform. Simultaneously courtrooms enshrined enlightened principles of equality on the basis that the right to defend oneself against all charges needed to be promoted and then protected. Although often instigated against the wishes of the defendant, the growing deployment of the insanity defense was born of this atmosphere: attempting to protect individuals from their own self-destructive inclinations whilst, simultaneously, tightening safeguards against those who saw the insanity defense as a means to escape punishment.

These new sensibilities demanded new standards of exactness in the delineation of an insanity defense or suit. It was that atmosphere that encouraged medical jurists to assert the importance of experience and expertise. This was both prompted and reinforced by lawyers who started laying emphasis on the particular qualifications of the individual witnesses they called to the stand. Expertise often meant interaction with the defendant or individual under examination, but it relied more generally on experience with a wide range of forms and types as well as a career in a specialist branch of medicine. For insanity pleas, jurists thus stressed that only dedicated clinical familiarity, or “daily communication…and attentive observation” of a whole range of insane patients, could enable the practitioner to conquer the “very difficult to define…invisible line that divides perfect and partial insanity.”

It was however neither obvious nor expected that the call to court would result in a clear projection of medical authority. In language, behaviour and deportment, the medical

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10 Rubin Identity, Crime, and Legal Responsibility, pp.29 and 33. For an American narrative see Meranze “Penality and the Colonial Project”, p.199.
practitioner in the legal arena was very much a reflection of legal standards, a reality the medical community only belatedly sought to modify. In his 1824 doctoral dissertation, James Webster reprimanded the American medical community for what he described as an historic neglect of medical jurisprudence; “Until within the last few years, this important branch of medical science seemed to be almost entirely neglected in this country.”¹⁴ He echoed concerns expressed by his English counterparts whose promises that “feeling[s] of inferiority and humiliation” would be rectified stood in stark contrast to a continued lack of formalized instruction in medical jurisprudence.¹⁵ As medical practitioners were increasingly called to court and as judges and juries alike showed increasingly willingness to indulge insanity pleas, the early nineteenth century witnessed growing momentum for this particular branch of practice on both sides of the Atlantic.

Obstacles were raised on two fronts: divisions within the medical community and the particular demands and biases of the justice system. In response, medical jurists imagined and instructed a new standard of enlightened and ultimately ennobling professionalization. This was to be projected onto rather than shaped by the courtroom and demonstrated a remarkable degree of accord across the Atlantic.¹⁶ In particular texts drew comparisons between an idealised standard of deportment and testimony and what they perceived to be the disingenuous offering of “hastily promulgated” opinions.¹⁷ Medical jurists understood that the practitioner’s central role remained as a narrator of facts. Indeed, courts explicitly reminded practitioners that they “must state facts, as well as other witnesses” [emphasis in original] and that their opinions were “not to be received as evidence of insanity…unless predicated upon facts, testified either by them or by others.”¹⁸ This point explains how far psychiatrists were able to shape courtroom verdicts: at no point was the practitioner set as remote from other witnesses. Nor were they excused the task (as, for instance, with disordered eating) of recounting behaviours and

¹⁶ For more see Haslam “Medical Jurisprudence, as it relates to insanity”, pp.288-289.
¹⁷ William Dease Remarks on Medical Jurisprudence ; intended for the general information of juries and young surgeons (1793) in Cooper (ed.) Tracts on Medical Jurisprudence, p.86. See also Haslam “Medical Jurisprudence, as it relates to insanity”, p.289.
¹⁸ Dane A general abridgment and digest of American law, Vol.2, p.602 and Daniel Appleton White A view of the jurisdiction and proceedings of the courts of probate in Massachusetts with particular reference to the County of Essex (Salem: J.D. Cushing and Brothers, 1822), p.65.
actions.

For, whilst medical jurists envisioned a time when the medical practitioner would become a vehicle for opinion—rather than narrative-based testimony, the reality was that medical practitioners continued to enter the courtroom as one witness amongst many. For the most part they were relative strangers to the accused, called upon to supplement the testimony of friends, neighbours and co-workers more familiar with the individual and their recent history. In insanity pleas the medical profession essentially served what Moran has called a “rubber-stamping” function only.\(^{19}\) Insanity pleas were won and lost on eyewitness testimonies, not expert opinions. Lay witnesses were instructed to recount patterns of behaviour that were permanent and absolute, and detailed natural histories of insanity that were structured around the visible and the recordable.\(^{20}\) The reality however was that witnesses often described just how abnormal the individual seemed, measuring their experiences with the individual against broad, sweeping and often highly visible and shared Anglo-American cultural expectations of insanity. Medical jurists and lawyers alike understood this, and chose instead to promote an image of the practitioner as one capable of untangling the confusing symphony of other witness testimony in order to present a clear, description-based diagnosis.

Reliance on testimony about behaviour and conduct was shaped by the ongoing difficulties of verifying the ‘facts’ of insanity. Still described as “possibly the easiest disease to imitate,” this remains a point of debate today.\(^{21}\) Certainly late eighteenth- and early nineteenth-century authors were aware of the dangers of potential miscarriages of justice.\(^{22}\) Medical jurisprudence texts addressed this by providing detailed and lengthy lists of insanity manifestations practitioners and juries were most likely to encounter. These invariably relied heavily upon descriptions of physical symptoms and behaviours most immediately visible and recognisable with a short amount of exposure to the individual.\(^{23}\) These texts, designed for every level of practitioner and often reprinted on American shores, blended old stereotypes of furious maniacs and dull, depressed melancholics with more recent theories about partiality and fluctuations. This explains

\(^{19}\) Moran “The Origin of Insanity as a Special Verdict”, p.488.
\(^{21}\) Watson Forensic Medicine in Western Society, p.77.
\(^{22}\) Romeyn Beck Elements of Medical Jurisprudence, Vol.1, pp.350-351. See also p.361.
\(^{23}\) See Male “An Epitome of Juridical or forensic Medicine”, p.256.
repeated references to behaviours with somatic manifestations such as disordered eating: they were a quick and immediately documentable tool for gauging and then explaining insanity.

Abstinence in particular drew a lot of attention in the context of separating genuine from feigned insanity. But this was shaped by the demands of the legal system rather than clinical ideals. Older arguments that the insane could endure “extreme bodily tortures, without expressions of pain” such as “intemperance in diet” and “extremities of heat and cold” were recycled, but these were to be treated as evidence of insanity’s ‘true’ but otherwise unprovable hallmark, namely “strong prepossessions of the mind.” Authors warned that “Abstinence for a great length of time, is the most frequent, as well as the most successful of these deceptions…[because] the most constant and minute attention is requisite to detect the falsehood." Thus testing food aversion was a tool for discovering the ‘truly’ insane. Practitioners were therefore instructed to distrust the proclamations and immediate behaviours of those under their examination and rely instead on their diagnostic practices. It was these that could then be offered as factual evidence within the courtroom.

Testing insanity “called into exercise…the entire skill of a medical man” who had to diagnose a condition otherwise “characterized by little or no change in the external appearance.” That, of course, was what the practitioner could offer above and beyond eyewitnesses and character witnesses. But juries and practitioners still had to rely heavily on behaviours and conversations introduced as evidence by other witnesses. Disordered eating behaviours provided a window into insanity that could be codified and verified by legal officers and the public alike and made to fit legal standards of demonstrable proof. Because disordered eating behaviours were easily recounted by other witnesses medical practitioners could use them to persuade the courtroom that their idea of mental illness

27 Ibid., p.337.
28 Ibid., p.2.
was valid. Providing quantifiable evidence, disordered eating allowed the psychiatrist to use a behaviour verified as ‘fact’ by both themselves and other witnesses and then translate that into a commentary on the broader but subtler mental illness.

But criminal and civil courts also had to determine the degree to which the individual was insane before absolving them of a crime or invalidating a legal document. Disordered eating was part of a range of behaviours that implied the existence of degrees of insanity and opened up questions as to where to diagnose an individual at any given time. As late as 1834 James Simpson, a Scottish lawyer with a trans-Atlantic readership, argued that the legal system still needed to move further away from demands that the defendant “prove insanity enough.” For Simpson, the more just course of action was to “presume irresponsibility” when “the proof generally of diseased manifestations of the intellect or feelings” were presented. This proof was supplied through the medium of behaviour. In support he offered the eighteenth-century case of John Howinson, whom Simpson believed was unfairly executed in the face of evidence that he was insane. Simpson drew strongly upon the evidence presented by witnesses about Howison’s eating habits to make that retrospective diagnosis, arguing that a man who “had an almost incredible appetite for food,” who “sucked the blood from his own wrist after every two or three mouthfuls of his food” and whose “voracious appetite for food ceased only with his breath” could not be considered a morally responsible agent.

Taking Howison’s false perceptions as his foundation, Simpson claimed “nothing more important has been determined by the more enlightened views of insanity, which are beginning to prevail in a legal setting, than the existence and nature of distinctive monomanias.” Using Howison’s disordered eating, Simpson made those connections, contextualising Howison’s habits within the broader, insane condition and arguing “Of this [disordered eating] many instances of the insane could be furnished.” Simpson thus sought to exonerate Howison post execution. His purpose was clear and part of a broader argument about the necessity for specialist experts to be present in all trials involving the

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30 Simpson Necessity of Popular education as a National Object, p.223.
32 Ibid., p.226.
33 Ibid., p.225.
insanity defense. His method was echoed by other medical jurists who saw medical practitioners as the only witnesses truly able to distinguish between true insanity and mere eccentricity:

the ordinary observer can hardly be convinced of the existence of insanity, without some turbulent expression, extravagant gesture, or phantasmic decoration; while on the other hand he is too apt to infer a state of insanity from those whims and eccentric habits between which the medical practitioner, from daily communication with deranged persons, can alone know how to discriminate.\(^{34}\)

The arguments of medical jurists were founded on the preexisting acceptance of the idea that insanity was not always a merely surface or manifest experience. Medical jurists pushed beyond that, focusing on who was in court not just on how cases were presented and deliberated. They were united in the insistence that surface manifestations required translation, so that courts faced with insanity verdicts could be guided to just decisions about otherwise hidden psychological conditions. Practitioners were to be the conduit for that translation, exactly placing an individual within a much broader and complicated insane spectrum. Courts increasingly reflected this argument, comparing one criminal with a body of behaviours and manifestations and drawing on behaviours such as disordered eating to validate those judgments. The questions lawyers and judges asked indicate that they were relatively quick to adapt the idea that the condition of insanity could manifest itself upon specific subjects, through specific behaviours or at specific moments in time but was to be measured against a psychological continuum. Nonetheless, at least for this period, that was only effective when the direction and testimony offered by these two groups correlated with the evidence provided by general character witnesses and eyewitnesses.

------ II: Discovering Insanity, Discovering Mental Illness ------

Disordered eating behaviours thus offered medical practitioners and legal officers alike multiple avenues to translate the intangible psychological realm into tangible and legally valid evidence. Law courts, of course, had long considered cases through considerations of the separate cognitive faculties of the individual.\(^{35}\) Because those who

\(^{34}\) Paris and Fonblanque Medical Jurisprudence, Vol.1, p.316.
\(^{35}\) See Pennsylvania Supreme Court Reports of cases adjudged in the Supreme Court of Pennsylvania..., Vol.1 (Philadelphia: John Bioren, 1871), p.110.
were on trial were often those caught in the act, judges and juries sought motivations for crimes, deliberating about responsibility rather than guilt and focusing on whether the individual was “incapable, from natural defect of understanding, to judge of what is right or wrong.” This was important in civil courts also, where contracts and wills were examined against a standard of ‘normative’ moral and rational dealings and relations. The opinion as to whether or not someone knew right from wrong required the deepest contemplation of legal officers and medical personnel alike. It was an ongoing negotiation because it required both juries and judges to suspend their own moral compasses in the face of clearly criminal behaviour. In the late eighteenth and early nineteenth centuries juries – and instructions to juries – demonstrated a willingness to create a new precedent and challenge the idea that determined behaviour was always evidence of rational capability.

As Joel Eigen has pointed out, the ability to determine an individual’s understanding and their knowledge of right from wrong relied on a familiarity with a whole class of people, not just the individual under question. The argument that insanity could be a very specific, focused complaint thus served as an indirect reminder of the importance of the expert. As extremely active and vocal manifestations could no longer be relied upon as obvious signs of studied intent, opinions became as important as statements of fact. This was especially true with regards to delusions and focused, rather than universal insanity. For example, in the 1812 trial of Thomas Bowler a Dr. Ainsley, carefully described as someone who had “seen a great number of persons deranged,” extended his testimony beyond Bowler when he explained that the insane were “subject to various acts of violence where there is a delusion on the subject; on all other subjects [they] can act as well as any person.” Ainsley’s position and testimony exemplified how medical witnesses were asked to draw on their experience not just with the defendant in particular

39 The verdict was guilty but with a recommendation to leniency. Old Bailey Proceedings Online (www.oldbaileyonline.org, version 7.0, 19 September 2013), July, 1812, trial of Thomas Bowler (t18120701-11).
but with the behavioural, emotional and psychological characteristics of many. It was the complete insane condition that was now of interest to the court.

This was echoed by a changing attitude to what insanity should look like over the course of a trial. The 1760 conviction of Lord Laurence Ferrers’s is emblematic of the vestiges of earlier legal precedent that only accepted an insanity defense when a total want of all understanding and reason was demonstrated. Ferrers’ history of fits of passionate rage and witness testimony that he had long been considered insane were not enough when weighed against his premeditated behaviour and sober discourse whilst on trial. That is because traditionally jurors were instructed to look for an insanity exhibited through raving and often violent behaviour. Just a few decades later these “coarse” expectations of insanity previously imposed by the legal system were eroded, facilitating a movement away from jury expectations of “prominent and strongly marked features…caricatures of [the] disease.” As medical categories and “degree[s] of insanity” were increasingly recognised, the legal definition of insanity fractured into many different conditions and states of mind. It was only under these conditions that the medical practitioner could hope to gain an authoritative voice.

The question of intent, prosecuted and defended through the narrative of deliberate, premeditated organisation, most often proved the biggest obstacle to successful insanity defenses. In the late eighteenth and early nineteenth centuries insanity defenses challenged the convention that demonstrated planning and deliberate behaviour were always to be translated as evidence of rational capabilities. Criminal courts witnessed some of the biggest changes, adopting the principle that the insane as a rule lost control of their willpower – and by extension control of their bodies and conduct – due to derangement or deluded imagination. The requirements for acquittal subsequently transitioned from a total want of all understanding to a focus on the particular

derangement of the individual. This was measured against a standard that compared their behaviour not just to their previous habits but, rather, to the collective psychobehavioural predispositions of the mentally ill.

One case in particular brought this question into the spotlight. The 1800 defense of alleged traitor and would-be regicide James Hadfield, eloquently conducted by Thomas Erskine, legally encoded the idea that insanity took on many more faces than merely raving, violent, or detached lunacy. Erskine’s brilliance lay not so much in advocating a wholly new position, but, rather, in constructing an insanity defense that withstood the litmus test of intent, premeditation and a plethora of eyewitness accounts. In this, surpassing any medical practitioner, he advanced psychiatric interpretations and allowed the presiding judge to set a precedent that would inform English and American verdicts for many years to come. Erskine directly challenged the convention that the will to act was akin to rational intent by focusing not on “the commission” of the crime but, rather, “the imputed motives of his [Hadfield’s] conduct.” His argument rested on the fundamental premise that behaviour – indeed a whole pattern of behaviours in the days leading up to the crime – could be misleading.

Instead, Erskine incorporated the late eighteenth-century theories explored in chapter one. It was his argument that a particular delusion was the true hallmark of insanity and could stand apart from otherwise rational thought that persuaded the judge, Baron Kenyon, to direct an acquittal. Erskine argued that Hadfield’s body and character, even after the exposure of the error of his “unfounded and erroneous opinions,” continued to be governed by his delusional beliefs. Under this argument, the effect of an utter conviction in a delusion could affect an individual’s ability to truly separate right from wrong and their will to act on the basis of the former. It also underpinned their behaviours and actions, suggesting that protracted behaviours such as disordered eating were, in fact, indicative of an all-encompassing delusion. Erskine made direct use of this, presenting Hadfield as a man whose entire sense of right and wrong was skewed, directly

44 Anon. *High Treason. A Full Report of the proceedings against James Hadfield at the bar of His Majesty's Court of King's Bench, in England, on the 15th of May, for shooting at the King, with Mr. Erskine's speech* (Dublin: J. Stockdale, 1800), p.22.
45 Channing, *Legal medicine lectures: insanity.*
compromised by his delusional beliefs. Under English law therefore he could not be considered a moral agent nor responsible for his actions.

Erskine heavily relied on Hadfield’s somatic condition – his earlier brain injury – to give his insanity a physiological etiology. This physical reality allowed his jury to confidently excuse him from his criminal act as medical ‘evidence’. The bigger trick was to remove the necessity of a somatic etiology and explain, in clear and precise language, that insanity was in fact defined by delusion and only made manifest through actions. That explanation was only definitive if the lawyer or medical witness was able to distinctly describe the patterns of the whole insane condition and – crucial for criminal guilt – locate the individual within the broader spectrum of that condition. In short, using behavioural symptoms as exactly that, symptoms that pointed to a degree of lost understanding, rationality, mental faculty, emotional intelligence and so forth. This enabled the jury and court to absolutely place the individual on either side of culpability.

Disordered eating behaviours were therefore read as merely the outward manifestation of an otherwise inaccessible mental disturbance, reshaped from signs of intent to symptoms of a long-standing delusion. Two jurists, separated by over three hundred years but both referenced by trans-Atlantic jurists in the early nineteenth century, highlight this evolving but significant shift. In 1592 Richard Cosin described the 1591 trial of Edmund Coppinger, William Hacket and Henry Arthington, three men tried as traitors after they condemned Elizabeth I and declared Hacket to be Christ the revenger returned to earth. Cosin expended considerable energy describing and then dismissing Coppinger’s failed insanity defense, arguing that Coppinger demonstrated “no defect at all of reason, memorie, wit, or understanding” [sic] and that his particular “absurditie and follie of the fansie, wherein he was led” [sic] was not enough to acquit on insanity. 46

More specifically, Cosin used Coppinger’s post-conviction death from “want of sustenance” as his strongest piece of evidence, arguing “Such resolution or obduration of mind, can hardly so long together remaine with him, that is madde.” [sic] 47

Cosin thus saw Coppinger’s enduring abstinence as proof of a focused intentionality and control that invalidated his insanity defense. By contrast, the physician-jurist George

47 Idem.
Edward Male drew directly from late eighteenth-century theories about partial and focused insanity when he argued that disordered eating across a range of spectrums actually revealed insanity. For Male a long-standing and deliberate abstinence was merely one manifestation of the insane person’s ability to “carry into execution plans, which require subtlety and long-continued dissimulation to mature.” This spoke to both tasks at hand for those who worked within the legal system: to both discover and measure the “peculiar hallucination” of the individual whilst, simultaneously, comparing that specific form with wider knowledge about the general behaviours and manifestations of insanity.

Male’s work, published and often referenced on both sides of the Atlantic, set a new working standard for legal diagnoses that was at complete odds with Cosin: now the determination to maintain a course of action or set of behaviours (such as abstinence) was evidence for, not against insanity.

Disordered eating also provided incontestable evidence when opposing explanations of insanity were offered. One case, premised on the idea that behaviour over a considerable length of time indicated a hidden and otherwise latent insanity, demonstrates the important role played by defense lawyers in constructing such pleas. But it also shows the centrality of practitioner opinions that, in the course of a single trial, offered various explanations for insanity. These would be revived post trial in the context of self-starvation. This particular case focused on the death of Dr. John Elliot[1] who was acquitted, in July 1787, of attempted murder. Commentators framed his insanity as a form of “unhappy passion” but prosecution witnesses differed, testifying to his melancholy predisposition, offering two different visions for the jury to deconstruct. Both strands and the insanity defense in general were only really tested when Elliott’s barrister, Mr. Silvester, called two ‘expert’ medical witnesses to diagnose his state of mind.

The first, a Dr. Simmons, was at the forefront of psychiatric practice. A physician to St Luke’s Hospital, Simmons told the court that he had, “for some time past looked upon [Elliott] as a man somewhat disordered” but drew on a particular letter in which Elliott argued “that the sun, so far from being a hot place, is a very comfortable and habitable

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49 Ibid., p.251.
spot” to give evidential support to his opinion that Elliott’s “mind was deranged.” Simmons used a variety of language to frame Elliott as insane, contextualising his mental state by drawing on characteristics of the broader monomaniac condition: “Mr. Silvester. Have not you met with a great deal of ingenuity on some subjects amongst those persons that you have known to be afflicted in this way? - Yes, a great deal.” [sic]

John O’Donnell, partner and apothecary to Elliott, echoed Simmons’ portrayal of a melancholic, withdrawn Elliott, but interspersed his testimony with descriptions of Elliott’s tendencies to “improper and dangerous” behaviour. As with Dr. Simmons, O’Donnell was called upon to translate Elliott’s behaviour into an opinion as to his state of mind:

What state of mind was he in? - In a very irritable state of mind, excited to strong passions from very little causes…my opinion given of him to others has been, that he was mad, and on a very slight provocation, he would go out of his mind and kill himself [sic].

Like Simmons, O’Donnell also stressed that Elliott’s insanity was of a particular nature so that he was able to function in certain parts of his life: only “in particular points” was he “always insane.” In the 1780s this definition was not yet established as a legally valid explanation of insanity and the judge himself intervened to question O’Donnell:

Court. I am a little at a loss what to understand from you…You describe this man as capable of going about his business, and prescribing for his patients, and as a man of a philosophical well turned mind; yet you say you considered him as a madman.

O’Donnell rebutted with a more standardized and general description of Elliott’s distractedness, detailing and using his conduct to support his opinion as to his psychological state. Thus O’Donnell and Simmons, led by Silvester, presented the jury with a number of options, drawing on disparate definitions of insanity to strengthen the chance of an insanity acquittal.

O’Donnell, Simmons and Silvester ultimately failed in their efforts – John Elliott was acquitted but not for insanity. Of more import however was the fact that their groundwork unquestionably laid the way for Elliott’s sister to then use his subsequent self-starvation

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51 Old Bailey Proceedings Online (www.oldbaileyonline.org, version 7.0, 19 September 2013), July 1787, trial of John Elliott (t17870711-41).
52 Idem.
53 Idem.
54 Idem.
55 Idem.
56 Idem.
as but further evidence of long-standing psychological distress. Returned to Newgate after his acquittal to await trial for assault, Elliott was dead less than two weeks later. Whilst one publication attributed his death to “a broken heart,” The World and Fashionable Advertiser was clear that he had “obstinately persevered in a refusal to partake of any nourishment.”

Thus the actions of the medical practitioners in the courtroom – using a natural history of behaviour to form opinions – were echoed in later commentaries. Elliott himself certainly seemed determined to end his life, previously attempting to “destroy himself by poison” so that a history of destructive behaviour was evident. That historical evidence of a behavioural pattern, coupled with the opinions offered in the courtroom, was enough for his sister to lodge a case “against any will which he may have left behind him” via a plea of insanity.

In parallel, the trial of John Chaplain illustrates the importance of disordered eating in establishing not just patterns of behaviour but also patterns of criminal behaviour. Described as one who “was deranged” Chaplain was portrayed as a man who not only had a history of self-harm but had also made repeated attempts to take his wife’s life before succeeding in 1812. Over the course of many witnesses a picture was constructed of Chaplain as one who was so violent as to require constant supervision and the use of the “straight waistcoat…frequently.” Although no medical witnesses were called, the keeper and owner of the madhouse Chaplain had previously been admitted to joined his friend in pointing to his “tak[ing] no food for several days…[and that] He refused his victuals.” By attributing this behaviour to his delusional belief that “there was a black man behind him waiting to take him to hell,” these witnesses established a history of Chaplain’s psychological health. This was critical to the success of the insanity defense: his keeper was able to explain away his subsequent calm and ordered behaviour as a common but misleading episode in a long-term insane condition.

One final case serves as an emblematic example of how disordered eating was used

58 Elliot A narrative of the life and death of John Elliot, p.5.
60 Old Bailey Proceedings Online (www.oldbaileyonline.org, version 7.0, 20 August 2014), December 1812, trial of John Chaplain (t18121202-32).
61 Idem.
62 Idem.
63 Idem.
as part of a wider public commentary on patterns of violent behaviour in the English civil courts. Settled in 1792, though originally tabled in December 1780, in Panther and Wife the validity of a letter executed by Mrs. Panther in favour of transferring 800l. per annum in stocks to her husband came into question. The prosecution hinged upon the “extremely outrageous” actions of the lady for whom abnormal eating formed part of a wider spectrum of extreme behaviour.\textsuperscript{64} Her past record formed an integral part of the insanity evidence as lawyers worked hard to nullify an otherwise legally binding document. Mrs. Panther’s aggressive conduct to others was explicitly and fully detailed; “she…beat her domestics most unmercifully, and concealed knives under her stockings. She was often extremely outrageous, and always had on a strait waistcoat.”\textsuperscript{65} Significantly however the initial three symptoms listed all revolved around issues to do with consumption; witnesses “had seen her swallow a half crown; that she sometimes tore the hair off her head and eat it: she once swallowed three guineas and a half,” all enacted over a significant length of time.\textsuperscript{66} The priority of these disordered eating behaviours is but further reminder of the central role patterns played in creating an overall impression of a mental state.

But there was another vision of insanity that influenced the courts and left more evidence in the American courtroom. It is a vision that we encountered in chapters one and two: rooted in a passionate dimension and based on the feelings of the individual rather than their mental faculties. Both criminal and (more especially) civil courts measured acts against a standard of emotional (or moral) insanity that was influenced by particular moments or relationships, much more than cognitive disturbance.\textsuperscript{67} This interpretation relied heavily on reading behavioural ‘facts’ in such a way as to build individual actions into connected symptoms not always immediately apparent. Thus, for example, a violently changeable relationship with food in fact indicated the periodical fluctuations of insanity and was indicative of its special ability to “artfully avoid” a court’s attempts at discovery.\textsuperscript{68} Those connections became the foundation when forming an opinion as to the entire mental health of the individual and seem to have especially

\textsuperscript{64} “Law Report” \textit{The World, Issue 1727} (12\textsuperscript{th} July, 1792), p.[2] of unnumbered pages.\

\textsuperscript{65} “Court of King’s Bench – The Attorney General \textit{versus} Panther and Wife” \textit{Oracle, Issue 977} (13\textsuperscript{th} July, 1792), p.[4] of unnumbered pages, Column B.\

\textsuperscript{66} “Law Report”, p.[2].\

\textsuperscript{67} For more see Pitts \textit{Family, Law, and Inheritance in America}, pp.13-14.\

\textsuperscript{68} Ibid., p.256.
informed the verdicts of both English and American civil courts. By the late eighteenth century those “incapable of bridling [their] passion” were to be considered as insane, their outbursts and singular acts interpreted as merely the surface manifestations of a broader, deep-set predisposition or derangement.\(^69\)

Rabin has termed such criminal defenses “the language of mental excuse,” arguing that the eighteenth century saw an amplification of this form of legal interaction.\(^70\) Two cases, tried in the same court with the same principle actors but three years apart, demonstrate the varying degrees of success such pleas achieved in the early decades of the nineteenth century. In New York in 1829, Richard Johnson’s defense counsel read directly from English and continental psychiatric treatises when, in opposition to prosecution arguments that Johnson did not show “any traces of deep passion,” they attempted to establish a history of long-standing insanity manifested through a moment of homicidal “Maniacal frenzy” [emphasis in original].\(^71\) In summation Judge Edwards addressed this directly, instructing the jury that “A mere influence of the passions…were not of themselves sufficient to constitute a defence.”\(^72\) Johnson was subsequently convicted when the court failed to discover a long-term mental affliction.

This was despite repeated witness statements about a very recent and very extreme change in both conduct and demeanour. Most witnesses discussed this in as extraordinary a manner as they could, stating that Johnson “appeared as though he was distracted in his mind” and claimed “his appearance indicated insanity.”\(^73\) Both the prosecution and defense alike asked their witnesses repeatedly not just to relate Johnson’s behaviour and conversation but to also speak to the question of just how far Johnson was “troubled in mind.”\(^74\) This was where Johnson’s disordered eating behaviours became evidence, introduced by the second defense witness, Alexander Hays, as part of his attempt to

\(^{72}\) Ibid., Column D.
\(^{73}\) Ibid., Column B.
\(^{74}\) Ibid., Column D.
describe Johnson’s recent descent into more serious mental illness. Hays described Johnson’s actions in the days leading up to the murder by focusing very specifically on the change in Johnson’s pattern of consumption: “He was pale, haggard, and his eyes wild. It was generally spoken of. He took his place at the table, but once after his return – did not come to his meals as usual.”75

Hays drew no points of comparison between Johnson and other insane individuals: as Johnson’s border he would have little authority were he to do so and he was not pressed on the point. Nor was a medical practitioner asked to qualify Johnson’s insanity. It is on this point however that the operations of the law can be seen, for it was Judge Edwards who made the connection explicit, comparing Johnson’s “not attending his meals regularly” with how it was “not customary for persons insane to care for food.”76 Echoing the instructions medical jurists laid out for practitioners, Edwards attempted to gauge Johnson’s alleged insanity by drawing on an entire category of individuals and offered his jury not just a verdict but also a diagnosis. It is instructive that he felt the best method for doing so, indeed the only point at which he alluded to specific testimony, was via the medium of disordered eating behaviour.

In contrast a case heard three years earlier in the same court circuit used disordered eating as part of a wider construction of insanity developed over many months. In the 1826 trial of Nathan Gilbert, also for murder, Gilbert’s insanity was described as the result of external circumstances, caused by both a physical injury and a protracted breakdown in the relationship between the defendant and the victim. The defense argued such so as to challenge his apparent deliberate and malicious planning of the act of murder and, instead, reframe it as merely a moment of passionate rage, the apex of a longstanding insanity. Gilbert was described as one whose insanity was first enacted on himself (including via the method of abstinence), prior to any acts of violence against the victim. Thus the act of murder was presented as but part of a wider and much lengthier history of his being “weak in body and mind.”77 His defense counsel used testimony of many years standing to supplement accounts of his more immediate behaviours. In

75 Ibid., Column C.
76 Ibid., Column D.
contrast to Johnson’s case, the defense counsel found success when they were able to convince the judge that Gilbert’s actions in the days leading up to the murder merely represented a period when his insanity was “made…manifest by a change in conduct,” and that his “extraordinary,” “wild” and “incoherent” conduct should be considered as part of his overall mental ill-health.\(^{78}\)

One of the ways in which this was delineated was through a focus on Gilbert’s disordered eating behaviours in the days and hours immediately before the crime was committed. Witnesses recounted that Gilbert declared, “he could not” eat and “refused food the whole of that day [of the murder]” saying that “he was choked and could not swallow it.”\(^{79}\) This demonstrable evidence was critical to the attempt to prove that Gilbert’s crime was committed during a period of affliction and not “during a lucid interval.”\(^{80}\) Because other witnesses had attested to the fact that they knew Gilbert both when lucid and when insane, the defense had to establish firmly that he was “not competent to the perpetration of the crime” at the particular moment that it was undertaken.\(^{81}\) This was enshrined in legal precedent on both sides of the Atlantic where judges demanded, “the evidence in such case…ought to go the state and habit of the person” [emphasis in original] at the moment of contract or crime, rather than the later and rehearsed opinions of their nearest associates.\(^{82}\) Using his disordered eating, the defense was able to ‘prove’ his mental illness at the point of the murder. The judge concurred, drawing (as had the defense) from both jurists and English precedent before instructing the jury that the prosecutor had failed to demonstrate that the crime was committed under a period of lucidity. The jury dutifully acquitted on the grounds of insanity.

In both cases the judges drew on medical and legal authorities alike. Disordered eating provided a link to other cases, contextualising an individual’s behaviour, validating any diagnosis and verdict by virtue of the broader category and common forms of insanity. But disordered eating behaviours also provided a chance to detail the illness

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\(^{78}\) Ibid., Columns C, D and E.

\(^{79}\) Ibid., Column B.

\(^{80}\) Ibid., Column E.

\(^{81}\) Ibid., Column C.

history of the individual under examination. This was critical to the success of a defense plea and these behaviours operated both to verify long-standing mental illness and to validate changes in habit that suggested the onset of insanity. Disordered eating behaviours worked so well for juries and judges alike because they were acted and lengthy patterns that contextualised the solo act not just as a moment of passionate phrenzy but, rather, as the climax of a long-term mental illness. They situated the criminal act within a broader course of insanity and taught juries to look beyond their own immediate observations and deductions. By the late eighteenth century, for example, extreme abstinence created the impression of abnormality that was critical in courtroom deliberations. As the insanity defense essentially meant that insanity itself was on trial, this would prove crucial: disordered eating gave evidential context to the criminal act under consideration.

The above cases, though separated by the Atlantic, are united in the attempts to establish a natural history of insanity. These attempts also spoke to the shared conceptualization of insanity as a periodical, oscillating illness. This was a long-established and enshrined part of the law’s approach to insanity, fundamental to both criminal and civil court measures. Whilst this description was not new to the late eighteenth-century jurist it was obscured in rather vague rhetoric and was often very difficult to delineate in the context of courtroom drama. Disordered eating was but one of several behaviours used by courts to pinpoint periods of lucidity and periods of insanity, both of which were seen as part of an overall condition of insanity. This in particular also reaffirmed the importance of separating judgment about the moment of the action from any subsequent descent into insanity. In this documents such as wills and contracts were artifacts of a particular state of mind at any given moment but they, as with criminal acts, needed to be considered against a broader picture and history of behaviour.

There is one category where this was even more relevant. In suicide inquests behaviours such as disordered eating served to give a momentary act an etiological history, allowing jurors to declare a suicide as *non compos mentis*, absolved of his actions

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and, thus, sparing his family any penalties.\footnote{84} In both America and England, by the nineteenth century, it was “a general practice to consider those who kill or destroy themselves as being insane.”\footnote{85} This was rooted in the eighteenth-century transition of suicide, from a spiritual and legal crime to evidence of insanity, which has been well studied by many historians. In keeping with the overall tone of this chapter, most subscribe to the opinion that such legal decisions were the reflection of a more tolerant and secular society, “medicalized by default” and not at the instigation of the medical community.\footnote{86}

Nonetheless these verdicts were guided by two separate psychological theories. The first relied on the notion that rationality and understanding could be temporarily suspended under a phrenzy, a momentary insanity. This interpretation drew on prolific jurists such as Matthew Hale who framed a “temporary frenzy” as an instance where passion overtook reason but not judgment.\footnote{87} Describing suicide as a “fit of insanity” was but one way in which other legal commentaries framed suicide as passionate outbursts.\footnote{88} Anthony Highmore, another early nineteenth-century leading authority, warned against merely adopting the idea that suicide must, by its very nature, be considered insane but argued that “it cannot be punished without punishing the effects of madness.”\footnote{89} Highmore offered this observation as a positive comparison with French jurists such as Charles-Louis Montesquieu, who saw suicide as merely “connected with the physical state of the machine, and independence of every other cause.”\footnote{90} For American and English juries, in contrast, suicide absolutely indicated a mind at odds with reason, nature and sense.

The second doctrine was a more radical departure. In this the individual act of suicide became the apex of a long-standing melancholia. Contrary to more recent narratives of

\begin{footnotesize}
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\item[84] Until 1822 the possessions of someone declared a suicide could be forfeited to the crown or state. See J.G. Spurzheim \textit{Observations on the deranged manifestations of the mind, or insanity} (Boston: Marsh, Capen and Lyon, 1833), p.139 and Rev. Solomon Piggott \textit{Suicide and its antidotes: a series of anecdotes and actual narratives, with suggestions of mental distress} (London: J. Robins, 1824), pp.121-122.
\item[85] M. MacDonald “The Medicalization of Suicide in England: Laymen, Physicians, and Cultural Change, 1500-1870” in Rosenberg and Golden (eds.) \textit{Framing Disease}, p.98.
\item[86] Hale \textit{Historia placlitorum coronae}, p.31.
\item[87] “Deaths” \textit{Aurora and Franklin Gazette, Issue} 2582 (27\textsuperscript{th} July, 1826), Column D, accessed 24\textsuperscript{th} November 2014, http://www.infotrac.galegroup.com.myaccess.library.utoronto.ca.
\item[88] Highmore \textit{A treatise on the law of idiocy and lunacy}, pp.204-205.
\item[89] Idem. See also John Brydell \textit{Non compos mentis: or, the law relating to Natural Fools, Mad-Folks, and Lunatick Persons, Inquisited, and Explained, for Common Benefit}, (London: Richard and Edward Atkins, 1700), p.78.
\end{enumerate}
\end{footnotesize}
suicide, this conceptualization was not the most immediate recourse for the inquest jury. But it did make considerable inroads in this period. Echoing discussions of temporary frenzies, under this consideration a permanent – even if periodically manifested – melancholia created a predisposition to self-harm. Because melancholia was often described as “an attachment of the mind to one object, concerning which the reason is defective, whilst, in general, it is perfect in what respects other subjects,” it allowed juries to return non comos mentis verdicts in the face of very little circumstantial evidence of long-standing insanity.\(^91\) Following that principle, suicide was merely the manifestation of a delusional mental illness, rather than a moment of passionate excess.\(^92\) Thus the decision to label suicides insane rested entirely on a psychological basis, that as “the Will of Man being set apart, all his Deeds are indifferent, neither can the Body offend, without a corrupt or erroneous Mind.”\(^93\) Juries subsequently followed criminal precedent by using the insanity verdict as a way of absolving the suicide from culpability for self-murder and all resultant penalties.

Certainly coroner’s juries and inquests were far from averse to returning insanity verdicts in cases whose “prevalent symptom” was a belief in poisoned food and where a resultant refusal to eat demonstrated a suicidal inclination.\(^94\) They had a wide variety of symptoms to draw from, including beliefs that associates were attempting to poison food and instances of voracious, non-nutritional eating and cannibalism.\(^95\) But they also had the use of medical practitioners who warned “insanity facilitates the commission of suicide, by removing in some degree and in some cases the barrier opposed to it by the dislike of bodily pain [such as starvation].”\(^96\) Joining such to declarations that “IT must not be denied that there are natural as well as mental causes of suicide,” most medical commentators found their strongest voice by correlating physiological and psychological

\(^92\) See Watson *Forensic Medicine in Western Society*, p.100.
\(^93\) Brydell *Non compos mentis*, p.79.
\(^95\) For a failed 1824 French case see William A. Hammond *Insanity in its relations to crime, a text and a commentary* (New York: D. Appleton & Company, 1873), pp.11-24.
\(^96\) Thomas Mayo, *Elements of the Pathology of the Human Mind* (London: John Murray, 1838), p.70
causes.\textsuperscript{97} Using these to trace longer patterns, judges and juries alike found the groundwork for their attempts to trace a history of insanity from a momentary act.

These opinions were given concrete reality through the testimonies of friends, relatives and neighbours. That more than anything explains the incorporation of these ideas into legal verdicts: witness testimony echoed jurisprudence publications. By thus testifying to patterns of past, destructive behaviours, witnesses gave suicide a natural history. Some authors continued to argue that the decision to abstain from food represented an "awful resolution…voluntarily encountered as the means of suicide."\textsuperscript{98}

But by the nineteenth century they acknowledged that their views were in the minority as jurymen increasingly automatically associated suicide with an insanity that knew not what it did. Note, for example, how one inquest was carefully informed that the deceased man “had attempted to destroy himself divers times, by hanging, and drowning, and striving to starve himself.”\textsuperscript{99} Disordered eating symptoms were a means of verifying a diagnosis and, ultimately, a verdict about a mental predisposition in the absence of the individual concerned. They were another piece of evidence for irrational and destructive behaviour, the embodiment of the true nature of insanity. Thus absolved, the suicide became another case study in psychiatry to be clinically quantified and studied.

----- III: Disordered Eating and Insanity outside the Courtroom -----  

Much has been written about the growing penal movement born of the late eighteenth and early nineteenth centuries. On both sides of the Atlantic the outlook of the legal system significantly shifted, turning to the reforming possibilities of penitentiaries rather than the immediate physical retribution of capital or corporeal punishment.\textsuperscript{100} The relationship between the judicial collective and the individual was shaped by a different sense of responsibility and parameters than the relationship between practitioner and patient but there is evidence of genuine concern and pity expressed by these authors. In

\textsuperscript{97} Piggott \textit{Suicide}, p.121.  
\textsuperscript{99} Old Bailey Proceedings Online (www.oldbaileyonline.org, version 7.0, 19 September 2014), April 1767, trial of Richard Greenwood (t17670429-50).  
the cases – those whose records extend beyond the courtroom or long after trial – legal and medical officers alike focused not so much on the nature of their act but, rather, the nature of their insanity. As with psychiatric textbooks, these sources quote liberally from interactions with the individuals and their nearest associates. They were born of a general interest not just in the conduct and conversation of prisoners at the point of crime, but also after the fact. Although the following examples are all drawn from London, they are included as suggestive of a wider trans-Atlantic approach to the significant of disordered eating within the entire legal process. The material result was an increase in records detailing the life of the jailed individual and the birth of the insane criminal narrative genre.

As the “first point” for both criminal and civil courts was to decide “where eccentricity ended, and derangement commenced,” so too these accounts indicate attempts on the part of the author to uncover the true and ongoing mental health of their subjects.101 In deciding whether or not an accused was insane, for example, juries were expected to consider whether or not the individual “act[ed] like a man who was unconscious of what he had done” post crime.102 Legal officers embodied this – willing to frame convicted felons as insane even when such a plea had not been originally entered. Thus, post trial, disordered eating served as an emblem of wider mental distress: this symptomatic group was used by legal officers to construct a portrait of mental illness, even when that sat at odds with courtroom decisions.

Whereas medical practitioners sought to contextualise the individual within the broader spectrum of the insane condition, witnesses and legal officers sought to contextualise the individual act within the broader history of the person through their trial and then conviction. The early dates of the examples used below are important. They indicate that those working in the legal system adopted not just the tone but also the rhetoric of early psychiatry as early as if not earlier than lawyers, judges and even general medical jurists. Those working in the justice system – beyond those who worked in the courtroom – understood that individuals were defined by a type of insanity that was not

always manifest over the short course of a trial. The efforts of all, witnesses, practitioners and legal officers alike, united when groups of symptoms or behaviours could be recounted.

The behaviour and state of mind of post-trial prisoners drew commentary from a range of individuals who saw this as part of the negotiation between guilt and clemency. Early ‘spectacular’ cases, recycled in nineteenth-century texts, were essentially anecdotal tales of miscarriages of justice. The leading medical jurists John Paris and John Fonblanque, for example, cited an undated Corsican case in which the convicted resolved to die through the medium of “star[ing] himself to death” in protest against his condemnation.¹⁰³ In 1802 Joseph Ritson cited the case of “John Scot, a Scottish man, [who] being cast in a suit of law…took sanctuary in the abbey of Holyroodhouse, where, out a deep discontentment, he abstain’d from all meat and drink thirty or forty days” as verified by a strict watch.¹⁰⁴ Within this context disordered eating was merely a tool to protest injustice, a way for prisoners and convicts to demonstrate their innocence: only the mention of Scot’s ‘deep discontentment’ and the Corsican’s “awful resolution” indicates their mental state amongst otherwise total diagnostic silence.¹⁰⁵

But by the late eighteenth century post-conviction acts of self-starvation were not just recorded but analysed. Commentaries now portrayed disordered eating as a manifestation of melancholic distress rather than protest, particularly within the context of suicidal intent. They drew directly from leading medical practitioners such as Benjamin Rush who wrote about their institutional encounters with insane patients who “seek for death in this mode of suicide.”¹⁰⁶ But legal officers and clerics had recognised this connection in advance and very early in the eighteenth century, suggesting the frequency with which such behaviours were seen within prison walls. One 1721 sermon, delivered to six condemned men, associated mental distress with “secret Sins [and faults], which a Man acts, yet knows not that he acts them” by drawing in particular on “Self-Murder…an unobserved Kind of it may be; the wasting our Bodies by too great an Abstinence and

¹⁰⁴ Joseph Ritson An essay on abstinence from animal food, as a moral duty (London: Richard Phillips, 1802), p.67. See also p.66.
¹⁰⁶ Benjamin Rush Medical Inquiries and Observations upon Diseases of the Mind (Philadelphia: Kimber and Richardson, 1812), pp.132-133.
Fasting…as Abstinence may be Suicide.” In addition ordinary’s accounts bear repeated witness to at least the penned creation of fasting as a means of atonement and preparation for death: their accounts contain language better suited to medical rather than religious texts. As prison ordinaries associated fasting with grief and regret, rather than deliberate malice or protest, they explained these acts using the framework of fragile and guilt-ridden minds.

An early Newgate case, described using the language of delusion, encapsulates all these points. It concerned Jacob Romert who was ultimately convicted and executed for murder in 1758 after his victim’s wife testified to his acting with “intent” and being “in his senses as much as any one here.” At no point in the transcript was a medical practitioner asked about Romert’s possible insanity, with all evidence provided by lay witnesses. For example, the prosecutor asked former foreman Paul Deingraman (or D’Ingrement) about Romert’s state of mind over a lengthy period of time. After stating that he had been told that Romert was once inflicted with “what we call madness,” Deingraman’s answer rested entirely on Romert’s eating habits: “Since he has been with me, about Lent-time he would not eat. If I asked him to eat, he would say he would not eat; and desired I would not ask any questions about it.”

It was that focus on Romert’s disordered eating, more than any other evidence, that echoed in later commentaries. When constructing his account of Romert post conviction, for example, the Newgate ordinary Stephen Roe relied heavily on stories of Romert’s previous and repeated disordered eating behaviours. After conversations with Romert’s wife, Roe recorded in detail Romert’s imprisonment for debt in Marshalsea in spring 1757 and the birth of his child shortly thereafter. Described by Roe as “the wonder,” Romert undertook a fast four days after the birth, refusing “all manner of sustenance for forty four days, except pumb water only…refus[ing] with indignation…all his wife’s

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110 Idem.
offers and interties” [sic] to eat.\textsuperscript{111} The abstinence, reducing Romert “to a skeleton,” secured his release.\textsuperscript{112} But Roe drew further significance from the fact that Romert also exhibited the same \textit{outside} prison walls:

The same kind of fast she asserts he kept during last Lent...he pretended that he would eat at home in the evening with his wife, while to her he pretended he had eat breakfast and dinner abroad [sic].\textsuperscript{113}

Roe’s records offer the one of the earliest detailed instances of manipulative consumption behaviours, structured to imply that Romert’s actions at Marshalsea formed part of a long-standing behaviour. Roe seemed to suggest so when he labelled Romert as one “under a delusion strong,” clearly attributing his disordered eating to a delusional rather than somatic disturbance.\textsuperscript{114} Though the court rejected witness testimony that followed these lines, it was this narrative of periodical fasts alone that convinced Roe, a member of the legal profession, that Romert was indeed insane.

Some commentators went further, drawing more explicitly from psychiatric theory to create a connection between disordered eating behaviour and internal mental disturbance. In these descriptions prisoners were presented as innocent, but innocent because of their insanity, rather than because they had not committed a crime. Francis David Stirn, a post-conviction suicide, serves as an example. During the course of his 1760 trial for murder, witnesses were asked to locate Stirn on a spectrum of insanity but, demonstrating universal reluctance to give their “absolute opinion that he was a madman,” Stirn was convicted.\textsuperscript{115} Nonetheless, the testimony as to his history of melancholy must have influenced those who had interactions with Stirn post conviction. Described as a man whose “[melancholic] passions were too strong for the hands of reason and religion to rein in,” the ordinary’s account indicates that both prior to and during his trial Stirn planned to commit suicide by starvation.\textsuperscript{116} This was attributed directly to his imagined and irrational despair as well as his determination to deny the justice system the chance to

\textsuperscript{111} \textit{Old Bailey Proceedings Online} (www.oldbaileyonline.org, version 7.0, 25 July 2013), \textit{Ordinary of Newgate's Account}, 1\textsuperscript{st} July 1758 (OA17580701).
\textsuperscript{112} Idem.
\textsuperscript{113} Idem.
\textsuperscript{114} Idem.
\textsuperscript{115} \textit{Old Bailey Proceedings Online} (www.oldbaileyonline.org, version 7.0, 04 October 2013), September 1760, trial of Francis David Stirn (t17600910-19).
\textsuperscript{116} \textit{Old Bailey Proceedings Online} (www.oldbaileyonline.org, version 7.0, 25 July 2013), \textit{Ordinary of Newgate's Account}, 15\textsuperscript{th} September 1760 (OA17600915). The case was also reported across the Atlantic.
take his life:

So fruitful was his mind of imaginary affronts, that he might be stiled the Self-Tormentor...so strong was his conviction of his crime, or rather his despair and pride combined, that he seemed determined...of starving himself to death [sic].

Stirn would eventually succeed in committing suicide after taking poison smuggled into the prison. Through all this concerned acquaintances and members of the public visited and attempted to change his mind. All the therapeutic steps in place at asylums were employed in this endeavour; persuasion, tricks and, finally, threats of physical intervention. Thus Stirn was compared not to his fellow convicts but to those committed to Bethlem. Of addition importance was the association made by the ordinary, visitors and lawyers alike that, even in the face of his objections, his refusal to eat should be brought forward as part of the “defence of lunacy set up for him” as they were convinced that his disordered eating was sufficient to justify an insanity verdict. But their observations never made it to the courtroom and Stirn’s conviction for murder accelerated his suicidal determination. For his brief moment in court, the jury was unable to access the scope of his insanity in a manner observed and then recorded by those who worked in the penal system. That, as we have seen, would come in the following decades. The mid eighteenth-century groundwork was laid in those longer and more detailed observations where legal officers, visitors and reformers alike relied on very recent psychiatric rhetoric to conceptualize and then explain relentless abstinence.

------ Conclusion ------

When faced with an insanity plea both civil and criminal courts focused on protecting both the individual and society at large from potentially devastating actions. In many ways, the story of this period is the increasing attempts – led by the legal as much as the medical communities – to more clearly delineate insanity whilst, simultaneously, stressing its hidden and subtle nature. Behaviour, conduct, physical manifestations and the state of the body continued to play an important role in giving the intangible

117 OBPs, Ordinary’s Account, 15th September 1760 (OA17600915).
118 Idem.
119 Idem.
120 See Highmore A treatise on the law of idiocy and lunacy, pp.104 and 201.
psychological state an evidentiary basis. But these were increasingly translated as the outward, temporary manifestations of a longer and more permanent mental disturbance. By stressing the psychological cause of behavioural manifestations, medical practitioners and lawyers together furthered the idea that the individual under examination in the courtroom or on trial could in fact be legitimately and absolutely graded on a spectrum of insanity.

That was achieved through the medium of varied forms of insanity that allowed judges and juries to connect one individual’s particular behaviour or conversation to a whole category of patient. For example, to posit one person’s refusal to eat as an example of delusional belief by tying that delusion – rather than the simple behaviour of starvation – with new but wide-reaching psychological categories. Thus the courts could judge insanity even when faced with surface measured, protracted and deliberate behaviour. For medical practitioners it was neither a smooth nor universal transition, and debates about how to confirm whether or not an individual knew right from wrong, or good from evil, continued throughout the early decades of the nineteenth century. These debates sat at odds with the fact that, by the late 1820s at least, judges on both sides of the Atlantic relied heavily on psychiatric texts, directly referencing William Battie, Francis Willis and John Locke amongst others when instructing juries that “the true criterion was this-where there is delusion of mind, there insanity is to be found.”

Of course disordered eating was just one example. But it was an important one. First, it was a behaviour that all witnesses could track and measure. This was critical given that all manners of medical practitioner and lay witness were increasingly asked not just to describe but to make judgments as to where individual under examination lay on a spectrum of insanity. It was no longer enough to measure how far an individual was insane by describing general behaviours – these were now refined, measured and, increasingly, repackaged as hallmarks of specific mental disturbance. At the same time, because disordered eating was trackable and could be turned into measured evidence, its range of symptoms were accepted by the legal world as demonstrable and – critically –

121 In contrast see Rubin Identity, Crime, and Legal Responsibility, p.96.
123 “Prerogative Court - April 12”, p.2.
verifiable facts. In short, at a time of hidden etiologies, disordered eating made psychological theories legally 'real'.

As nineteenth-century courts incorporated a range of forms and types into their definitions of insanity new questions were raised as to the importance of selecting the correct medical witness. This was especially true when insanity defenses required that the correct man spoke to the defendant on very specific topics. But that is not to suggest that practitioners were able to dictate the tone or even focus of the courtroom. This chapter has encapsulated the bent of most recent historiographical research by demonstrating that it was legal personnel as much as medical practitioners that furthered the influenced of psychiatric theory on both sides of the Atlantic. In the Elliott case, for example, Silvester established his witnesses’ expertise by detailing not just their general status as medical practitioners, but also emphasising their experience of working with the insane. As early as the 1780s the individual’s credentials were an important part of their role in court. With that established, the lawyers then made it very clear that they required not just a recounting of facts but their opinion as to the defendant's mental state. It was that opinion that guided the jury to the real cause of the ‘facts’ of behaviour.

Conversely, that explains the ongoing importance of symptoms such as disordered eating. When justice was at stake it was not enough to make vague or half-formed references to psychological distress: behavioural and physical symptoms were absolutely critical to any courtroom decision. That required a body of evidence that could be measured against legal standards, easily described, or ‘witnessed’. Demonstrable evidence therefore remained the foundation of all branches of the justice system and it is important to stress that at no point did the medical practitioner fully transition from being a reteller of facts to being an opinionated expert. Legal personnel guided them instead into their world but it was a world that, increasingly as we move into the nineteenth century, became less alien to medical practitioners of all types.

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125 *OBP*, July 1787, John Elliott (t17870711-41).
This chapter discusses moral management and moral treatment by analysing their relationship to food and patterns of consumption. The previous three chapters traced the advance of psychiatry, first within the medical community and then broader occupational groups. The next two chapters focus on experiences within the early years of the public asylum. This chapter argues that asylum administrators and attendants focused on controlling both food and patient patterns of consumption because they considered both to be critical to the success of psychiatric therapy. Both moral treatment and moral management aligned this therapy around the practice of regulating the behaviour and physiological state of the body so as to effectively reorder the mind. Simultaneously, medical practitioners monitored eating behaviours in order to measure the progress of insanity in both individuals and psychological patient categories. Indeed, food and consumption informed daily experience within the asylum. Mealtimes and the dining hall were important components of therapeutic management but all aspects of patient access to food were prescribed. Finally, the traditional practice of dietetics played a leading role in early psychiatry as physicians used the clinical experiences provided by the asylum to experiment with and adapt the principles of moral treatment to contemporary standards of medical practice.

From the mid eighteenth century public asylums were constructed by small corporations of “public-spirited” “humane and charitable Persons.” Merchants and artisans united in establishing asylums in London (St Luke’s 1751), Philadelphia (1752) and Manchester (1765). With the support of private subscriptions, local governments expanded preexisting institutions in Virginia (1773), Yorkshire (1817) and Massachusetts (McLean 1818). Finally, individual bequests encouraged further support in both London (Guy’s 1723) and New York (Bloomingdale 1821). By the end of the 1820s America

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boasted seven dedicated public asylums, England nine. In both countries asylum administrators saw themselves as part of a broader, trans-Atlantic movement. They often referenced their counterparts as well as the lessons they had drawn from earlier establishments. This was especially true in America where Frankford, Pennsylvania (1813) and Harford, Connecticut (1824) explicitly mimicked the spiritually inspired Quaker-Tukean model of the York Retreat (1796). As we saw in previous chapters, Americans did not seek to develop their own vision of therapy or commitment. Rather, they reveled in the idea that they were responsible for transplanting the successes witnessed in England onto American soil.

The first part of this chapter briefly introduces the socio-economic roots of these asylums. It argues that food was a fundamental consideration in the move to the public asylum. This was principally because of two reforming ideals. First, that other institutions lacked the capacity to either productively or humanely cater to their inmates. Second, that the asylum could be an economically expedient method for charitably distributing food. This section establishes that the asylum was heralded as a benevolent and effective site of therapy through contrasts with other institutions. It demonstrates that, as spaces to distribute food and regulate mealtimes, asylums were used to enact benevolent therapies or medical charity. These efforts grew not just from early psychiatric theories but, also, from a wider movement to perfect institutional care.

The second section argues that control of both food and patterns of consumption were important tools in the evolution of moral management. This therapeutic approach, new to the latter half of the eighteenth century, attempted to restructure and regulate patients’ habits so as to reorder their minds, both in terms of cognitive and emotional disturbance. Both food and patterns of consumption were critical to intricate operational

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procedures and were at the heart of broader methods of reinstruction. By examining the patient at the table, this section illustrates how food and patterns of consumption (or mealtimes) were constant tools of negotiation between staff and patients. Food was, simultaneously, a source of reward, a channel for sociobehavioural therapy and a means of structuring the day. In addition, tight controls over consumption patterns show constant concern with both quantity and quality of produce. They also indicate that asylum attendants used food to jointly exert influence over the physical and psychological health of their charges.4

Physicians and medical personnel were the beneficiaries of both institution building and changes in methods of managing the insane. The third section examines their role in the advancement of moral (or psychological) treatment. In particular, it uncovers how asylums created spaces for experimenting with and assessing the role of food as therapy. Moral treatment relied heavily on regimens such as dietetics so as to further the discipline of both body and mind. This section illustrates that directions from physicians as to the diet of patients were amongst the earliest and most frequent instructions provided to asylum staff. By tracing the increasingly psychological categories that underpinned dietary prescriptions, it shows that the traditional practice of dietetics was repurposed: it became a building block of psychiatry, used to create physiological conditions favourable for psychological treatment. Control of both consumption patterns and food confirmed the physician’s authority and grounded interactions between medical personnel and their patients.

------ I: Asylum Builders and Patrons ------

The earliest public asylums were built on the premise of charity and economy. In psychiatry’s infancy the asylum’s great advantage lay in the promise of caring for the insane by providing them with food and shelter and treating them with dignity. They arose in the context of alarmist reports about increasing numbers of pauper insane and authors who wrote with growing unease about the reality of living with or witnessing

insanity on urban streets. Although Andrew Scull claims that urbanization had “little or no relationship” to the development of these buildings, Gerald Grob argues that population growth in America “forced [the] alteration in the pattern of welfare” and drove the creation of socioeconomic institutions. Asylum literature indicates that the early recognition of urban migration patterns stimulated the mid eighteenth-century construction of hospitals in Philadelphia, New York and Boston. The board of the trustees of the Massachusetts General Hospital (and affiliated insane asylum), for example, argued “The persons, most likely to stand in need of its benefits, are those who resort to the metropolis, from remote parts of the Commonwealth.” The same was true in England although at a slightly later date. These migrants, unaided by parish welfare, were most reliant on private donations of a monetary or substantive nature.

In both America and England this period subsequently experienced an “unprecedented” level of charitable and medical institution building for indigent populations. But the construction of asylums was complicated by the madhouses and wards that continued to operate. It would be erroneous to imply that the public asylum provided a solution for the entire population of the pauper insane: well into the nineteenth century reports on both sides of the Atlantic relayed stories of the insane kept in “degraded and brutalizing” conditions in local gaols, almshouses and madhouses.

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5 See John Reid Essays on Hypochondriacal and other Nervous Affections (Philadelphia: M. Carey and Son, 1817), chapter 15.
8 Massachusetts General Hospital Address of the Board of Trustees of the Massachusetts General Hospital to the public (Boston: J. Belcher, 1814) p.11.
9 Newcastle (1764), Bedford (1812), Nottingham (1812), Lancaster (1816), Lincoln (1820) and Gloucester (1823) were all such examples.
10 Ole Peter Grell and Andrew Cunningham “Health Care and Poor Relief in 18th and 19th Century Northern Europe” in Ole Peter Grell, Andrew Cuningham and Robert Jutte (eds.) Health Care and Poor Relief in 18th and 19th Century Northern Europe (Bodmin: Ashgate, 2002), p.3. For America see Baugher “Visible Charity”, p.175.
Nonetheless, reformers continually insisted that the institution represented the greatest opportunity to provide restorative discipline to the maximum number of beneficiaries.\(^\text{12}\) They questioned what they saw as neglectful and punitive confinement rather than the idea of institutional care and repeatedly stressed the potential of specialist institutions to reform bodies, minds and morality. Historians have also tempered the reformers’ tableau of universally ‘unspeakable’ conditions in other institutions by pointing to the self-justifying nature of their claims.\(^\text{13}\) Still, although wider institutional reforms did not lead to the creation of the asylum they certainly drove momentum for it.

Public asylums thus arose in the context of a philanthropy that presented itself as humane because it was medical and restorative rather than punitive in its outlook. And so, the early asylums of the 1750s, St Luke’s Hospital, London, and Pennsylvania Hospital, Philadelphia, explicitly condemned other institutions as “very unfit Places” “by no means fitted for…proper Management” of the insane.\(^\text{14}\) They were joined by the Massachusetts General Hospital, which argued “The cure of the sick is, almost necessarily, a secondary consideration in an Alms-house” [emphasis in original].\(^\text{15}\) This literature associated the lack of proper provision for diet and nursing with these institutions’ inability to either care for or cure the sick.\(^\text{16}\) Both informed the move to the asylum. Simultaneously reforming societies like the Prison Discipline Society of Boston described the fate of insane individuals held in small prisons whose cell doors “had not been opened in


\(^{15}\) Massachusetts General Hospital *Address of the Board of Trustees*, p.7

eighteenth months” and whose food “was furnished through a small orifice in the door.” Such isolation stood in increasingly stark contrast to the social reconditioning enforced through the communal dining and living experiences offered by the asylum. That contrast would drive several decades of construction, as providing the insane with higher standards of communal care shaped the language of helping and healing.

For the early asylum builders the insane were, primarily, philanthropic objects. Their collective efforts demonstrated that the traditional association of food with charity remained one of the most intrinsic parts of almsgiving. Medical theory and charitable endeavour also aligned around the distribution of food. Late eighteenth-century practitioners such as John Ferriar, a resident physician at the Manchester Infirmary, described how food was supplied alongside nurses and clothing to the sick poor during an epidemic. The asylum patrons copied these efforts and applied them in a collective if disjointed manner. Their promises to benevolently tend to the insane further represent a wider socio-cultural acceptance of the early psychiatric community’s insistence that the insane were not subjects of divine punishment or beyond the reach of humane intervention. If the insane retained a semblance of their former sanity it became both a sin and an injustice not to attempt to help to restore them. Food-distribution and other traditional acts of medical charity were now simply channeled into an institutional setting.

The asylums also reflected contemporary organisations that built collective charity around the distribution of food. By the late eighteenth century these organisations took their charitable remit beyond mere relief: instruction became their most important endeavour. Contemporaneous kitchen charities, for example, modeled themselves in the form of teaching institutions, appealing for public support by arguing that they could “teach and instruct” the deserving poor the most salutary methods of preparing food. It was no longer enough to simply supply food – knowledge was dispensed alongside provisions. The reinstruction of the pauper population around methods of consumption directly influenced approaches to the pauper insane: the asylum administrators envisaged

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their role, in part, as one of reeducating the insane in social behaviours such as consumption. From necessity however in the asylum positive reinstruction was joined by attempts to break dangerous behaviours. Thus, for example, the fourth rule of government in the Manchester Lunatic Hospital was that “no Knives and Forks shall be used by any of the Patients.”20 American asylums echoed the same strictures.21 Public asylums thus adapted and refined contemporaneous charitable techniques into management therapies suited to their specialist populations.

Moreover, theirs was an assistance aligned to economic expediency. The asylum was designed to ensure that patients could access a level of medical care and expert practitioners otherwise beyond their reach. Indeed, the ability to lessen expenses “by providing for a Number together” was declared “The Principal End of establishing [these] Hospitalls” [sic] and asylums.22 This principle was often expressed through the ability to limit the costs of food and medicine. Asylums such as the York Lunatic Asylum drew explicit connections between the provision of food and the provision of medicines: “parish-paupers are taken in at a price equal to what they cost in diet and medicines. This was the relief originally intended” [emphasis in original].23 But for all classes of patients, the indigent poor, the parish poor, and those in “easy or superior circumstances,” the justification that fees paid went directly to patient sustenance informed asylum discourse.24 Leading practitioners such as Philippe Pinel echoed the administrators, noting with pride a system of “culinary management” whereby “patients were provided with excellent fare at little expence” [sic].25 St Luke’s provides material testament, paying in 1751 an average of just 21d. per stone, against a street price of c.41d. for beef and c.36d.

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20 Anon An account of the Rise...in Manchester, p.17. See also W.C. Ellis A treatise on the nature, symptoms, causes, and treatment of insanity: with practical observations on lunatic asylums, and a description of the pauper lunatic asylum for the county of Middlesex.... (London: S. Holdsworth, 1838), pp.342-344.
21 See Fletcher Little Early years of the McLean Hospital, p.110.
22 St Luke’s Hospital, General Court Book 1750-1779, p.11. See also the calculations in “Report from the Select Committee on the State of Lunatics” The Edinburgh Medical and Surgical Journal, Vol.4, Part I (1st April, 1808), p.137 and Franklin Some account of the Pennsylvania Hospital (1817), p.38.
24 See Anon An Account of the Rise...in Manchester, p.9 and Gloucester Asylum An abstract of proceedings, p.11.
for mutton.\textsuperscript{26} This was a point of pride: asylum administrators repeatedly and very publically made explicit the connections between the cost-effective supply of food and the productivity of their therapeutic institutions.

Administrators organised not just the distribution of food but also the quality of the produce itself. On both sides of the Atlantic claims about the high quality of the food supplied to patients were designed to appeal to the middle-class patrons who supported both individual patients and the asylum as a whole.\textsuperscript{27} The politician Robert Waln’s description of the Frankford Asylum, Pennsylvania provides a clear example: “Their food is of the most wholesome and substantial kind, and such as may be found on the tables of the middle class of society…there are no meagre-days.”\textsuperscript{28} Waln’s vocabulary was deliberate, designed to appeal to patrons and elicit donations and would be echoed later by other American asylums.\textsuperscript{29} Indeed, concern with the quality of produce became a constant thread in both American and English asylums. It was an issue that united patrons and administrators and informed their activities. In Massachusetts, for example, patrons directly participated in these measures through bodies such as the visiting committee, which was instructed to frequently “examine…whether the food be of good and wholesome quality and sufficient in quantity.”\textsuperscript{30} The repeated appointments of patrons to examine and admire the quality of their produce imply that administrators saw this as a fruitful method of attracting and retaining support.

One way to control the quality of food was to grow it within asylum grounds. This was especially applicable for nineteenth-century asylums which, following the example of the Tukean York Retreat, were built in rural surroundings. With sufficient land they

\textsuperscript{27} These were also more reliable than the state. See Anon \textit{A letter from a subscriber}, p.8 and L.B. Goodheart \textit{Mad Yankees: The Hartford Retreat for the Insane and Nineteenth-Century Psychiatry} (Boston: University of Massachusetts Press, 2003), p.33.
\textsuperscript{29} Vermont Asylum for the Insane \textit{First Annual Report of the Trustees of the Vermont Asylum for the Insane; presented to the legislature, October 1837} (Montpelier, VT: E.P. Walton and Son, 1837), p.17.
\textsuperscript{30} The Massachusetts General Hospital \textit{By-laws of the Massachusetts General Hospital : with the rules and regulations established by the Board of Trustees for the government of the Asylum for the Insane in Charlestown and the Hospital in Boston} (Boston: Charles Croker, 1821), p.12.
developed another economical measure: the asylum kitchen garden. By the second decade of the nineteenth century these were common asylum features. For patients they became productive sites of work therapy and employment, serving to preoccupy them and to fill and organize the day in a way aligned, as we shall see below, to other management efforts. Saving costs, such activities also taught the insane to work, a habit of benefit to the greater community, and thus served a double purpose. Their importance only increased as we push into the nineteenth century and as the employment of patients in “useful occupations” became a key therapeutic pursuit on both sides of the Atlantic. But asylum publications presented them primarily as a cost-saving exercise. Potential benefactors of the Frankford Asylum, for example, were reassured that it’s kitchen garden and nursery “plentifully supplied” food to the patients. Kitchen gardens further provided asylum apothecaries with the herbs and plants necessary to complete prescriptions. Once asylums could grow both food and medicines upon their own grounds the two major points of fiscal interest were managed.

In a way, providing meals regularly and ensuring the quality of produce was, in and of itself, therapy. It was certainly a marker of care and essential for the many malnourished bodies that passed into asylum walls. Brockliss and Jones have argued that seventeenth- and eighteenth-century French hospitals provided little more than “food therapy” for the poor. It is possible to trace that tradition to the early efforts of asylum administrators. Because their pauper clients were defined as those at risk of dependency, asylum proprietors argued that cured patients could “become [again] useful to the Community” rather than “burden[s] upon the public as long as they live.”

33 Waln Jr “An account of the Asylum for the Insane”, p.232. See also Ellis A treatise on the nature, symptoms, causes, and treatment of insanity, p.304. On similar efforts in other institutions see Baugher “Visible Charity”, p.176.
compared themselves favourably to the abilities of other institutions. Restoring bodies, even if minds proved beyond reach, was therefore a clear way to validate their version of economically ordered medical charity. Asylum publications constantly turned to this principle, connecting the provisions they provided with the standards of care their clients enjoyed. In this way charity and therapy united around food.

-------- II: Asylum Attendants and Moral Management --------

Asylum administrators attempted to institute economically efficient medical charity. They charged their staff, the non-medical asylum attendants, with managing daily regimen. Although the public asylum physically and emotionally removed the insane from their friends and family it sought to reflect normative experiences as much as possible. Everything about the early asylum, from its architecture to its daily routine, was designed to instill rational order. This section examines the attendants’ attempts to control food and patterns of consumption so as discipline their charges and retrain them in ‘normative’ or rational social behaviours. Their actions fell under the umbrella of moral management, a new therapeutic practice that attempted to psychologically recondition the insane through social interaction and management techniques. In this asylum attendants again drew on the model of contemporaneous general hospitals that also organised their patients through paternalistic but rigid orders.

Moral management pushed asylum staff to assert authority over minds as well as bodies. In the latter decades of the eighteenth century and early decades of the nineteenth century it was believed that this could only be achieved through uninterrupted control over the entire environment. That control would guarantee that staff could command the necessary authority over their patients’ troubled minds. This included all aspects

36 See Appendix One. For a contemporary argument about architecture’s therapeutic importance see Report of Commissioners appointed under a resolve of the Legislature of Massachusetts, to superintend the erection of a Lunatic Hospital at Worcester, and to Report a System of discipline and government for the same (Boston: Dutton and Wentworth, 4th January 1832), p.2.
38 St Luke’s Hospital, General Court Book 1750-1779, p.2. See also Thomas Percival Medical ethics: or, a code of institutes and precepts.... (Manchester: S. Russell, 1803), pp.213-214.
connected to food and dining: controlling the environment, the body and exposure to non-naturals such as food and drink was an essential precondition for therapeutic attempts to re-instruct the mind. In the early years of clinical psychiatry conformity in habit and deportment was considered the outward marker of inward conformity and self-restraint. The latter were the true pursuits of moral management. In particular this was to be realised through the steady reshaping of habits, rather than reactive and singular corrections that showed little long-term psychological benefits. Moral management thus presented the social conditioning of the insane by their attendants as therapeutic pursuit. Teaching patients to restrain extreme consumption behaviours and regulate their relationship to food exemplified moral management’s approach.

Staff and patients had to work together to achieve such regulation. Asylum attendants were meant to provide ordered and sober examples for their volatile and passionate patients. Furthermore their kind but regimented discipline provided a positive contrast to the owners of private madhouses, described as “Mercenary Keeper[s]…who could lay so small a Claim to Medical Abilities.” Indeed, throughout this period ongoing madhouse scandals continued to shape the standards imposed on caregivers in all their contact with their patients. Although legislators had shaped their first tailored statue in the Madhouses Act of 1774, this act was applicable on English soil only and was extremely limited in both geographic and regulatory scope. In the American territories there was no real regulation throughout our period. That is why descriptions of staff as “of good moral and religious characters” sat alongside assurances of their experience and skills. As late as

40 Parkman Proposals for Establishing a Retreat for the Insane, pp.5 and 9.
42 The Act was designed to last for five years initially but, through the Madhouses Law Continuation Act 1779 (19 George 3 c.15) and then the Madhouses Law Perpetuation Act, 1786 (26 George 3 c.91) it remained in effect until 1828. For details see Percival Medical ethics, pp.69-71.
43 “Asylum for Insane Persons” Daily National Intelligencer, Washington DC, Issue 2638 (26th June, 1821), Column B.
1813 Samuel Tuke declared, “The utility and excellence of all Institutions…must depend…upon the immediate managers.”

The attendants’ ability to daily regulate what was placed at the dining table was a further point of contrast to the madhouses. Although madhouse keepers advertised the “Goodness and Quantity of the Patient’s Food” [emphasis in original], by the late eighteenth century asylum personnel highlighted “spare diet[s]” when condemning madhouses as spaces of universal “corporal and physical punishments.” Their attacks were echoed in memoirs that associated the withholding of decent food with neglectful madhouse practices. The scathing 1825 publication A Description of the Crimes and Horrors in the Interior of Warburton’s Private Mad-Houses, for example, painstakingly detailed disparities in the quality of food supplied to clients at different periods. In this portrait the quality of the food supplied varied, used by the attendants as a tool for systematic punishment and humiliation. Whilst some author-physicians also advocated the withholding of food as a means to correct “mischievous and unruly” patients unresponsive to remonstrance, most asylums focused instead on the consistent standards of their provisions as a point of contrast to madhouses. When they did change diets they would mark the distinction by presenting their efforts as short-term management techniques rather than punitive responses.

In all asylums therefore the careful selection of staff was echoed in exacting and lengthy duties issued according to station and the demands of particular charges. In keeping with accusations against madhouses, from the earliest days of the public asylum the monitoring and caliber of food provisions often ranked highly in staff instructions. In 1752 the very first rule for the male keeper at St Luke’s, for example, was to “weigh in all the respective Provisions ordered for Daily Diet of the House and keep an Exact Account

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45 Thomas Fallowes He Cratiste Ton Melancholonton kai Mainomenon iatreia; or, the best method for the cure (London: n.p., 1705), p.20 and Pinel A Treatise on Insanity, p.64. See also David Irish “Levamen infirmi: or, cordial counsel to the sick and diseased (1700)” in Hunter and MacAlpine (eds.) Three Hundred Years, p.280.
47 Ibid., p.3.
thereof.”

Even earlier, in 1728, Guy’s Hospital instructed its attendants to prevent food from being unduly “alienated by Sale or Gift.” By the nineteenth century the careful instructions to staff had evolved into a broader concern with monitoring patients. Thus Bloomingdale governors assured the public that great care was taken “to sever the servants of the house who attend the kitchen and laundry from all communication with the patients” in order to create a barrier between patients and provisions. By this point asylum instructions sought to regulate not just the quality of the provisions but, also, the degree to which patients could access supplies and create their own dining experiences.

A related point of management was the keeping of the wrong sort of food out of the asylum and away from patients. The attempts of many late eighteenth-century asylums to restrict access to external food products translated most often into the tightening of visitor access. This was motivated by concerns that they were conduits for food and drink, unchecked by asylum personnel. From at least the 1750s restrictions were applied to “Provisions of any kind to be brought into the house to the Patients from their Friends or any person whatever.” These directives were the practical expression of an overwhelming trans-Atlantic concern with the potential dangers of outside influences.

In tandem asylum attendants daily oversaw each patient’s allocated diet and provisions and sought out illicit or unprescribed produce. Guy’s Hospital attendants, for example, were required to “Examine Every Patient’s Locker Every Morning” so as to prevent the accumulation of “more than is Proper for their Breakfast” and make sure that patients

49 St Luke’s Hospital, General Court Book 1750-1779, entry dated 12th February 1752, p.33.
51 “The new Lunatic Asylum in New York” The National Intelligencer and Washington Advertiser, Issue 1402 (4th October, 1809), Column B. See also Report of Commissioners appointed under a resolve of the Legislature of Massachusetts, pp.6-7 and Fletcher Little Early years of the McLean Hospital, p.72. In contrast, and regarding the employment of patients in the kitchen, see Ellis A treatise on the nature, symptoms, causes, and treatment of insanity, pp.296 and 343.
52 St Luke’s Hospital General, Committee Minute Book 1775-1804, H64/A/03/002, London Metropolitan Archives, entries dated 3rd February 1790 and 7th April 1790.
53 St Luke’s Hospital, General Court Book 1750-1779, entry dated 12th February 1752, p.33.
received only “such Proportions as shall be Ordered.” As with checking the food supplied, restricting access to unchecked food had both a management and therapeutic purpose: it guaranteed the stable environment required for moral management.

Although staff regulations focused on the distribution of food, the daily lives of the patients were more directly affected by patterns of consumption. From the outset asylums and hospitals minutely regulated the role consumption played in staff-patient dynamics. Asylum attempts to reshape and reform “habits and deportment” relied heavily upon open, shared spaces where the conformity of individual patients could be simultaneously ‘tested’ and developed. And so organizing where patients ate became crucial. Central dining halls were, from the earliest years of the asylum, an integral architectural feature and, along with the chapel, represented rare areas within asylum walls where large numbers of patients came together. In addition, fixed hours and regularly scheduled mealtimes featured in all asylums. Such order and consistent rhythm helped normalize and structure the day whilst ensuring that smaller numbers of attendants could supervise a larger number of patients. Attendants always strove to bring their charges to the dining hall tables. From very early on the dining hall was, therefore, a focal point for moral management. When Guy’s hospital ordered, in 1728, that their insane patients were “Obliged to dine at Table” en masse and at the hours appointed they set the tone for later asylums in both England and America.

The centrality of the dining hall(s) was yet a further point of departure for the new institutions. One of the accusations leveled against madhouses was their inattention to the proper dietary routines. John Wilson Rogers, for example, declared that he had “heard a keeper confess, that it was so impracticable at the hour of dinner to attend to every patient, that some were often totally forgotten” [emphasis in original]. In contrast, practitioners affiliated with public asylums were keen to stress the sociobehavioural importance of the dining hour. In America it appears that by the 1820s the decorum achieved in the dining hall became a marker for the success of the overall operation.

55 Guy’s Hospital, Minutes of Committee for taking in Lunatics, entry dated 27th August 1728, p.261 and St Luke’s Hospital, General Court Book 1750-1779, entry dated 31st October 1750, p.17.
57 Guy's Hospital, Minutes of Committee for taking in Lunatics, entry dated 27th August 1728, p.261.
Thus, for example, in 1822 Matthew Clarkson, president of the New York Hospital, reported that patient “deportment at meals is more orderly than might be expected.”\(^{59}\) Likewise, Samuel Theobald, an attending physician at the Lunatic Asylum of Kentucky, commented in 1830 that “superintended during their meals by the keeper and matron or their assistants...It is rare that any indecency or impropriety of conduct occurs at table.”\(^{60}\)

Within the dining hall patients were therefore segregated not so much by class or gender but, rather, by their ability to conform to the consumption behaviours expected of them. Training these behaviours allowed asylum attendants to reward behavioural normalcy. These rewards were a critical method of encouraging self-esteem, a fundamental part of the Tukean management model. For example, Samuel Tuke asked his female visitors to “take tea with the patients, who are much gratified with the attention” as part of his strategy to reinstate self-esteem and encourage the desire to gain further respect.\(^{61}\) Tuke also argued that the decision to bring lower-class convalescents into the higher-class dining room was “found essentially to promote their recovery.”\(^{62}\) Others, including Pinel, followed. The therapeutic benefits were also recognised by stakeholders. In his description of the Frankford Asylum, for example, Robert Waln described how mealtime privileges were:

> highly gratifying to the feelings of the patients: they find themselves, in a degree, placed upon an equality, with those who are labouring for their restoration...Their almost uniform exemplary and quiet conduct during meals, is the best pledge of the respect and affection.\(^{63}\)

Sharing meals or drinks thus became a core part of a ritualized management method whereby patients were treated respectfully and “as much in the manner of a rational being, as the state of [their] mind[s] will possible allow.”\(^{64}\)

Furthermore, the ritual of communal mealtimes was used to reinforce the familial model. Tuke’s description of the collective patients and staff of the York Retreat as a “family” spurred other asylums to model themselves “as much as possible, [on] that of a

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60 Theobald “Some Account of the Lunatic Asylum” p.82. See also Fletcher Little *Early years of the McLean Hospital*, p.73.
61 Tuke *Description of The Retreat*, pp.112 and 101.
62 Ibid., p.65.
64 Tuke *Description of The Retreat*, p.100.
private residence.” Opportunities for patients to share not just meals but the dining table with superintendents and their family inferred a degree of respect and familiarity. It was believed that this would, in turn, perpetuate the performance of ‘correct’ consumption behaviour as part of what Leonard Smith has called a “behavioural modification programme.” Education through example required communal arenas and group interactions enabled by the dining hall. This was a conditional privilege, dependent on the patients being “in the proper condition,” and connected to wider privileges, such as attending chapel. Communal mealtimes shared with the patients created the impression that they were considered equal to their attendants and “members of [the] family.” Using the dining hall to build that environment allowed attendants to apply a fundamental principle of moral management: social conditioning through parental instruction. Dining halls were thus more than sites of social interaction. They became sites of instruction.

And yet the privileges of dining halls were not extended to all. Some asylums adjusted their policy of communal meals in recognition of the demands of a particular patient population. These adjustments tended to follow the lines of segregation from the broader patient community. Thus, for example, female visitors to the York Lunatic Asylum in 1814 recommended the “removal of a small [dinner] table into the Back day room, for the better patients who sit at it in common amidst some others who must prove a great annoyance to their comfort.” Asylum managers and physicians also adjusted seating arrangements so as to reward or correct individual patients. Segregated eating,

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65 Ibid., p.33 and Parkman Proposals for Establishing a Retreat for the Insane, p.4. See also Ellis A treatise on the nature, symptoms, causes, and treatment of insanity, p.305 and Andrews et al. The History of Bethlehem, p.244.
67 Vermont Asylum for the Insane First Annual Report, p.17.
68 Idem.
69 Just a quick note on this: the asylum was designed to mimic the ‘family’ rather than the father. Female patients would have had little interaction with male attendants (beyond their medical practitioners) and the asylums were designed to foster the idea that a communal endeavour was at work, not a singular authority.
70 York Lunatic Asylum, Female Visitors Book, BOO 1/8/4/1, Borthwick Institute for Archives, York University, entry dated 3rd November 1814.
as in cells or day-rooms, was generally reserved for those who could not be trusted to eat in the orderly fashion prescribed for the hall. Those who could not or would not conform to the standards imposed by the communal dining hall challenged moral management’s carefully constructed regimen. Furthermore they threatened the psychosocial conditioning enacted on other patients. Adjustments and segregations are therefore best translated through the lens of potential disturbances to other patients’ ability to relearn consumption behaviours, rather than as individually punitive measures.

Some patients, especially voracious eaters, were prescribed their individual portion to be consumed alone in an attempt to prevent the consumption of an excessive quantity of food or other’s portions. The Frankford Asylum, for example, provides an example of the frequency with which patients were denied access to both the dining hall and “management of their own diet.” In 1825 the doors to patients rooms were described as constructed with “Small doors, about seven inches square…[which] serve for the purpose of conveying food, &c. to violent patients.” This appears to have been a universal standard. One year later the same asylum reported that only “about two-thirds of the whole number” were listed as able to “assemble at meal-time in the refectory, and eat together.” This figure indicates the degree to which confined insanity manifested around food. It also illustrates the frequency with which management techniques were adapted around issues of consumption. Concern with food and consumption thus informed the practical application of moral management and the physical reality of daily life in the asylum. Three cornerstones of psychological reconditioning (social interaction, respectful treatment and tailored discipline) came together as control over food and patterns of consumption informed moral management strategies.

------- III: Practitioners and Dietary Prescriptions -------

For both administrators and attendants, control of access to food and patient consumption patterns was informed by economical and management operations far more than the complexities of individual cases. But public asylums also provided the medical

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community new environments and physical spaces within which they could test psychological treatment. This section looks in particular at how practitioner prescriptions for diet and consumption, united under the banner of dietetics, informed their broader psychological therapies. Dietetics was premised on the regulation of the quantity and quality of food and drink consumed. As moral management techniques began to ensure regulated environments, practitioners gained the opportunity to align their vision of moral treatment with the dietetic and therapeutic strategies employed in general hospitals. This was critical to the medical community’s acceptance of psychiatry as a legitimate medical discipline, a leading objective in the early years of asylum. The public asylum thus became a medical patron because it provided clinical opportunities that aligned psychiatry with other specialisms. Drawing from the example of contemporaneous hospitals, social and professional networks spread both within Britain and America but also – and unhindered by the Revolution – across the Atlantic. These exchanges furthered a shared therapeutic philosophy. It would however be a mistake to see these institutions merely as springboards for the triumph of the physician over other practitioners. Rather, asylums organized the authority of all medical practitioners over all other workers.

Physicians claimed authority on all points of admission and prescription. One of the largest preconditions for their assertions lay in changes to commitment papers. These papers recorded formal legal diagnoses of insanity amongst the poorer populace and are artifacts of a change in the primary purpose of commitment from protecting others to actively shaping the custody of the insane. Over the course of the eighteenth century these developed into a formalized system. But it was an ongoing transition: as late as 1821 New York’s Bloomingdale Asylum required only that the information about the potential patient be provided “where it is practicable” by a physician. Bloomingdale was however

76 In contrast, but with regards to the general hospital system, see Rosenberg *The Care of Strangers*, p.9. On the role of other medical practitioners see Percival *Medical ethics*, p.53.
exceptionally lax. The majority demanded that these certificates be filled in by physicians or surgeons who first examined and then testified that the individual was in a “state of insanity.” These were then verified by those directly responsible for the enactment of the law and the distribution of parish funds. Their translation of anti-social behaviours into medical conditions strengthened the psychiatric community’s claims to authority over the pauper insane.

Commitment papers were designed to ensure that any potential patient was both eligible for and likely to respond to the therapeutic regime of the asylum. They subsequently demanded a vast array of standardised and quantitative information that effectively guaranteed a natural history of insanity. Crucially, they show the ongoing concern with the reciprocal nature of psychological and physiological health. Commitment papers indicate that asylum administrators and medical practitioners alike were consumed by their concerns about the bodies of potential patients. Their queries had a manifest purpose. Asylums screened admittees because they required that all patients were able to withstand heroic intervention and work- or exercise-based activities. In addition, because these asylums operated constantly under the public eye the pressure for staff and administrators to ‘perform’ medically was ever constant. Publications compared asylums not just on the basis of their operational ethos but, more directly, by statistically listing their cure rates. That did not mean, for example, that asylums rejected the weak or those emaciated from abstinence outright. But it is a further explanation as to why physiological health was assessed even before patients entered asylum walls. The position of those who were either unable or refused to participate in the various components of asylum life was consequently precarious.

Commitment papers supplied information as to the onset of insanity, its precedents, a history of physiological disease and the mental and bodily condition of the individual. They focused as much on long-standing habits as a recent change in behaviour or physical

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81 See, for example, William Farr On the statistics of English Lunatic Asylums (London: Sherwood, Gilbert and Piper, 1838?), p.6. See also J.G. Spurzheim Observations on the deranged manifestations of the mind (Boston: Marsh, Capen and Lyon, 1833), p.250. See Appendix Three.
82 This included regular dining habits. St Luke's Hospital House Committee, Minute Book 1765-1771, H64/A/04/003, London Metropolitan Archives, entry dated 17th October 1766.
state. It is in this area that dietary assessment played a more direct role. The Asylum for Pauper Lunatics, West Riding, provides an illustration of the variety of ways disordered eating formed a part of preliminary assessments. Their 1820s commitment papers (called reception warrants) asked about sober and temperate living habits as standard. This question was answered at times with singular consumption-related words such as “gluttenous” or “voracious,” and at times with more definitive descriptions about the consumption of non-nutritious substances. All stood as markers for intervals of insanity and lucidity as the papers traced the history of an individual’s insanity. Other submissions portrayed disordered eating as part of a wider pattern of refusal-behaviours. Finally, a recent descent into abstinence was, at times, the only information supplied to justify a commitment. The entire details provided on one 1822 paper, for example, consisted only in the information that the individual had “refused to take any other food than a little biscuit & water for the last 4 days.” This lone asylum illustrates the myriad ways in which a wide spectrum of disordered eating symptoms were marshalled and recorded as justifications for the commitment of individuals.

Commitment papers were also therapeutic blueprints. As such they detailed information as to previous therapeutic attempts, including dietetic treatments. In a contemporary example, Virginia’s Western State Hospital specifically asked whether a “low diet” had been employed in previous efforts to treat new patients. In tandem, a York Retreat casebook indicates that, in the years 1827 to 1830, some 15 out of 62 cases (or 24 percent) of those admitted had exhibited past tendencies to refuse food. It proves small surprise then that asylum records were littered with references to the dietary habits of patients upon admittance and previous therapeutic interventions in that area.

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83 See West Riding Pauper Lunatic Asylum, Reception Orders: Warrants 1818-1819 Folder, C85/195, West Yorkshire Archives Wakefield, Warrant no.67, 2nd February 1819.
84 West Riding Pauper Lunatic Asylum, Reception Orders: Warrants 1822 Folder, C85/197, West Yorkshire Archives Wakefield, Warrant no.369/66, 27th August 1822, and West Riding Pauper Lunatic Asylum, Reception Orders: Warrants 1818-1819 Folder, Warrant no.64, 2nd February 1819, and Warrant no.67, 2nd February 1819.
85 See West Riding Pauper Lunatic Asylum, Reception Orders: Warrants 1818-1819 Folder, Warrant no.34, 8th January 1819.
86 West Riding Pauper Lunatic Asylum, Reception Orders: Warrants 1822 Folder, Warrant no.393/90, 2nd November 1822.
87 Western State Hospital, Commitment Papers, Western State Hospital Collection, Series IV, Subseries D, Box 215, Folder 10, Library of Virginia, Elizabeth Jones’s case.
88 York Retreat, Case Book 2, RET 6/5/1/2, Borthwick Institute for Archives, York University.
addition, this reliance on dietary habits when diagnosing insanity was matched by the prescriptions listed in admission records. Some asylums attempted to structure a dietary plan according to an individual’s particular manifestations and history. Bloomingdale Asylum’s admission records indicate just how central dietetics was. These records include prescriptions for every new patient categorized and tabulated: diet forms an entire category. From the start the dietary habits of the patients were under minute assessment. Providing windows into natural histories and periodical fluctuations, consumption behaviours and dietary information were both fundamental pieces of historical information.

The weight given to consumption behaviours and dietary information further explains the prioritization of dietetic prescription. Indeed, instructions as to what and how much food patients ate was as important a medical intervention as pharmaceuticals or other heroic interventions. Asylum managers and physicians united in their belief in the efficacy of diet as a treatment and that, as treatment, diet fell under the physician’s purview. Physicians were thus expected to take control of all provisions that supplied the institutions. Pinel considered this to be such an important aspect that he dedicated a whole section to the preparation and distribution of provisions, claiming “one of my most sacred duties…was, immediately upon my appointment, to inspect the management and services of the kitchens.” But the use of dietetics in the treatment of the insane predates either Tuke or Pinel’s versions of moral treatment. As early as 1751, and immediately upon his appointment to St Luke’s Hospital in 1751, Dr. Battie was “desired to prepare a List of such Drugs and Medicines as will be proper to be got ready for the Use of this intended Hospital and also to consider of a Diet proper for the Patients” well in advance of many other operational decisions. Battie supplied diet lists three weeks before his requests for any drugs or medicines, more confident in dietetics than other therapeutic options.

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89 See Register of the maniacal cases in the New York Asylum Bloomingdale, Bloomingdale Records 106A, Medical Center Archives of New York Presbyterian or Weill Cornell.
90 Pinel A Treatise on Insanity, p.207.
91 St Luke’s Hospital, General Committee Minute Book 1750-1774, entry dated 7th November 1750. Battie presented his list on 21st November, adding a full catalogue of drugs and medicines on 28th November.
Walter Vandereycken and Ron Van Deth’s argument that dietetics had fallen out of favour by the end of the eighteenth century is thus at odds with hospital records. In fact, dietetics proved an important common ground between the asylum and the more general hospital. Dietetic prescription also provided both a theoretical and a practical link between psychiatry and other branches of medicine, strengthening claims that psychiatry amounted to an ‘authentic’ branch of medical science. Dietetics, although an ancient therapy, withstood changing schools of thought and was a core therapy under both academic medicine and quackery. Cases books and reports from physicians working in leading hospitals make regular reference to both the eating habits of and the diets prescribed to patients presenting with a variety of physical complaints. Dietetics entered the asylum because moral treatment also worked on the basis that the body and mind were engaged in a reciprocal relationship. The prioritizing of psychological therapies did not mean that asylum practitioners ignored the physiological sphere.

In this practitioners transplanted a long-held doctrine of dietetic prescription into hospital walls. Throughout the eighteenth century physicians published guides to health that focused on the role aliment and beverages played not just in prevention but, also, as remedies to sickness. Earlier works owe more direct influence to the ancient doctrines of humours and temperaments but it is clear that, even when practitioners were unwilling to absolutely dismiss the theories of the ancients, they pushed for a new degree of specificity. The physician John Arbuthnot’s 1731 *An essay concerning the nature of aliments*, for example, divided constitutions into five categories and provided dietary directions accordingly. Arbuthnot included “Aliments of hard Digestion, as dry’d and salted Flesh, unripe Fruits, [and] farinaceous Substances unfermented” as part of his wider list of physical and psychological causes of the melancholic state because of their ability to thicken and suspend the blood. In addition, physicians also moved away from the Galenic principle that food was endowed with humoural qualities. Instead, they

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93 See Cases and Reports from Doctor Steadman, 1773, MS 566, Royal College of Physicians and Cases and Reports from Drs Gregory and Cullen, 1771-1773, MS 469, Library Company of Philadelphia.
94 John Arbuthnot *An essay concerning the nature of aliments, and the choice of them, according to the different constitutions of human bodies. In which the different Effects, Advantages and Disadvantages of Animal and Vegetable Diet are explain’d* (London: J. Tonson, 1731), p.146.
95 Ibid., pp.201-202.
sought to chart the direct effects of food on various components of the physical frame and prescribe accordingly.\textsuperscript{96}

In both English and American asylums food and drink were assessed for their stimulating and depressing qualities because of the enduring belief that “emotions are felt at the stomach.”\textsuperscript{97} Medical practitioners united around the belief that the selection of produce was crucial to the efficacy of dietetic prescriptions. Meat was of particular concern because of its stimulating nature and because it was considered most likely to irritate the stomach. Building on the work of earlier eighteenth-century authors such as George Cheyne, later eighteenth-century practitioners continued to caution that “Beef, and especially beef from older animals, made ‘ill juice’ and ‘grosse bloude’, engendering melancholy,” whilst William Battie informed the St Luke’s Hospital General Committee that “Veal was unnecessary and Pork improper for the Patients.”\textsuperscript{98} Sausages, anchovies, oysters, smoked beef, ham and salmon were held to “excite appetite” and were thus seen as productive for those who ate little, but to be avoided for those who had voracious appetites.\textsuperscript{99} For maniacs meat was to always be distributed “in less proportion that that of vegetables…[and] of the tenderest sort.”\textsuperscript{100} Finally, and because the main focus was on prescribing foods that were easy to digest, steaming or boiling meat seems to have been the preferred method of preparation. In the 1820s, for example, all victuals were cooked by steam in the McLean Asylum.\textsuperscript{101}


\textsuperscript{97} Charles Webster \textit{Facts, tending to show the connection of the stomach with life, disease, and recovery} (London: J. Murray, 1793), p.40.

\textsuperscript{98} Steven Shapin “‘You are what you eat’: historical changes in ideas about food and identity” \textit{Historical Research}, Vol.87, No.237 (August, 2014), pp.387-389 and St Luke's Hospital, General Committee Minute Book 1750-1774, entry dated 11\textsuperscript{th} September 1751. See also A.F.M. Willich \textit{Lectures on diet and regimen: being a systematic inquiry into the most rational means of preserving health and prolonging life: together with physiological and chemical explanations…..}, 2\textsuperscript{nd} ed. (London: T.N. Longman and O. Rees, 1799), p.43.

\textsuperscript{99} George Parkman \textit{Management of Lunatics: with illustrations of insanity} (Boston: John Elliot, 1817), p.18. See also William Forster \textit{A treatise on the cause of most diseases incident to human bodies, and the cure of them. First, by a right Use of the Non-Naturals chiefly by Diet. And secondly, by Medicine} (Leeds: James Lister, 1745), p.6. and William Buchan \textit{Domestic medicine or, The family physician: being an attempt to render the medical art more generally useful, by shewing people what is in their own power both with respect to the prevention and cure of diseases…..} (Philadelphia: John Dunlap, 1772), pp.40 and 305.

\textsuperscript{100} Andrew Harper \textit{A treatise on the real cause and cure of insanity; in which the nature and distinctions of this disease are fully explained, and the treatment established on new principles} (London: C. Stalker, 1789), p.58.

\textsuperscript{101} Fletcher Little \textit{Early years of the McLean Hospital}, p.72.
Vegetables were considered generally to be a safer choice, easy to digest, unlikely to inflame the spirits and able to “diminish…the irritability and sensibility of the system.” Vegetables, fruits and water were commonly prescribed under the banner of a refrigerating diet, which, from at least the earliest decades of the eighteenth century, was considered especially productive in cases of mania. In their dietary prescriptions practitioners found support in a wider literature that advocated vegetables and water as the best possible choice for the insane. The Methodist leader John Wesley, for example, in his widely read Primitive Physick prescribed “nothing but apples for a month…Or, nothing but bread and milk” in the case of “Raging Madness” [emphasis in original]. There seems to have been more debate as to the most effective dietetic regimen for cases of melancholia: some prescribed excitants such as distilled vinegar, whilst others recommended small meals of a maximum of four ounces or “Living entierly upon fruit” [sic].

The choice of beverages was as fundamental as the choice of food. Eighteenth- and early nineteenth-century authors grappled with the decision to serve their patients water, wine, beer or liquor. Early and mid eighteenth-century authors continued to view wine (and white wine in particular) as an important therapeutic tool for suspending or weakening the perverted appetites. However wine was generally considered unsuitable except for the sake of easing digestion: by the later eighteenth century wine was to be used circumspectly, as the consumption of too much wine ran the risk of weakening the

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102 Willich Lectures on diet and regimen, pp.43-44.
103 See John Quincy Lexicon physico-medicum: or, a new medicinal dictionary; explaining the difficult terms used in the several branches of the profession, and in such Parts of Natural Philosophy as are introductory thereto: with an account of the Things Signified by such Terms..., 3rd ed. (London: J. Osborn and T. Longman, 1726), p.259.
105 Notes from John Abernethy's surgical lectures, MS 2, Royal College of Physicians, pp.31-33 and John Gregory, lectures, MS.L43, Wellcome Trust, p.4. See also Arbuthnot An essay concerning the nature of aliments, p.115, Wesley Primitive Physic, p.75 and Benjamin Rush, Medical Notes 1804-1809, Rush Family Papers, Benjamin Rush Section, Yi2 7265 v.87, Historical Society of Pennsylvania, p.171.
106 See Charles Perry A treatise of diseases in general. Wherein the true causes, Natures, and Essences of all the principal disease incident to the Human Body, are mechanically accounted for and explain'd, and their respective Intentions of Cure assign'd upon the same Principles..., Vol.2 (London: T. Woodward and C. Davis, 1741), p.71.
stomach and depressing the spirits.\textsuperscript{107} For practitioner and lay commentators water became an important part of dietetics in the middle decades of the eighteenth century. In 1726, for example, the cleric John Hancocke claimed not only that “I believe Water used outwardly, or inwardly, or both, is good for all those Distempers that seize the Body with that Violence, as to make People for the present mad” but also that he found that “almost all Physicians in the Cure of Phrensy or Madness prescribe cooling and diluting Drinks, simple or compound.”\textsuperscript{108} Similarly, the physician John Arbuthnot’s remedies for melancholy included “Water impregnated with some penetrating Salt” so as to try and dissipate the overheated state and, finally, John Wesley argued that water drinking could prevent “Hysteric Fits, Madness” and a host of other illnesses.\textsuperscript{109}

Dietetic prescriptions were therefore shaped not just by the dangers of individual food items but, also, by their potential for therapeutic efficacy. Individual food choices could also act as therapeutic conduits. Porter (a strong beer) and “medicated wine” were used as medication designed to stimulate appetites in those who refused to eat.\textsuperscript{110} Tuke advocated supplying a patient “freely with meat, or cheese and bread, and good porter” as a means to induce sleep without resorting to opium, whilst beef-tea broths and milks were other popular methods of providing nutriment to those with weak stomachs or low appetites.\textsuperscript{111} Furthermore, diets could be tailored not just to a particular form of insanity, but also to the disordered eating type. As early as 1726, for example, the physician Peter Shaw prescribed various diets for different disordered eating manifestations. Thus anorexic patients were to be fed “Relishing sauces,” those suffering from voracious eating (or fames canina) were to be fed food that was “fat, the sauce rich and unctuous, or well

\textsuperscript{107} See Buchan \textit{Domestic medicine} (1776), p.486. See also Peter Shaw \textit{The Juice of the Grape: or, Wine preferable to Water. A treatise wherein wine is shewn to be the Grand Preserver of Health, and Restorer in most Diseases.....} (London: W. Lewis, 1724), pp.8 and 12, Albala “Insensible Perspiration and Oily Vegetable Humor” p.31 and Shapin “‘You are what you eat’”, p.383.

\textsuperscript{108} John Hancocke \textit{Febrifugum magnum, mor bifugum magnum: or, the grand febrifuge improved. Being An Essay, to make it probable, that common Water is good for many Distempers that are not mentioned in Dr. Hancocke’s Febrifugum Magnum} (London: J. Roberts, 1726), pp.34 and 15.


\textsuperscript{110} West Riding Pauper Lunatic Asylum, Medical Case Book 1821-c.1823, C85/3/6/96, West Yorkshire Archive Service Wakefield, p.76 and West Riding Pauper Lunatic Asylum, Medical Case Book 1823-c.1826, C85/3/6/3, West Yorkshire Archive Service Wakefield, p.5. In tandem see Anne Nevile, Recipe Book, MS 3685, Wellcome Collection, p.7 [facing] and Shaw \textit{The Juice of the Grape: or, Wine preferable to Water}, p.7.

\textsuperscript{111} Tuke \textit{Description of The Retreat}, p.76. See also Arbuthnot \textit{An essay concerning the nature of aliments}, p.113.
stored with butter...gellies and rich sweet wines,” whilst those suffering from pica to be restricted to a “nutritional diet.”

Eighteenth- and early nineteenth-century private recipe and commonplace books prescribed similar remedies for weak, disordered or loathing stomachs: asylums merely built upon and expanded an expansive pre-existing tradition of using food as a pathway for therapy.

Asylum practitioners used dietetics for two main therapeutic reasons. First, to create a regulated physiological context best suited to the reordering of the mind. Second, to complement the management of the external body (and behaviours) with an internal balance. Both reasons rested on the dominant belief that, inflamed by dietary choices, the passions were, in effect, the conduits for the actions of the mind on the body. They thus needed to be forcibly held in check and balanced. This philosophy took root particularly in America where it informed both asylum and hospital dietetic practices.

James Johnson, a Philadelphia physician, summarised the therapeutic strategies at work: “the physicians cannot cure the moral cause that preys upon the mind, and through that medium injures the body, but he can, in a great measure, prevent the re-action of the body on the mind.” Dietetics provided the physician his most productive tool for preventing such disruption. Asylums surpassed the opportunities available in general hospitals when, for the first time, they provided spaces to experiment with dietetics as part of psychological reconditioning. The broad dietary categories of house, low and high were adopted but adapted as required. And so, taking their direction from an established treatment as well as a newer psychological doctrine, early psychiatrists tested the effect of various foods and diet on different categories of patients.

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112 Peter Shaw *A new practice of physic; wherein the various diseases incident to the human body are orderly described, their causes assign’d, their diagnostics and prognostics enumerated, And The Regimen proper in each deliver’d; With a Competent Number of Medicines for every Stage and Symptom thereof..., Vol.I* (London: J. Osborn and T. Longman, 1726), pp.3 and 178-179.

113 See A Book of physic Made June 1710, MS 1320, Wellcome Collection, pp.61 and 120, Anne Nevile, Recipe Book, MS 3685, Wellcome Collection, p.72 [facing] and John Neilson Recipes, BV Neilson, New York Historical Society, n.p.


The early asylums thus provided new spaces to experiment with the application of dietetics to psychological conditions. In the early years, it was experiment rather than experience that guided the use of dietetics under the umbrella of moral treatment. That explains emerging and then ongoing disputes about the most effective dietary prescriptions. By the end of the eighteenth century several leading psychiatrists questioned the efficacy of the widely used moderate diet. In tandem, Tuke listed the York Retreat’s diet tables, noting that many who subscribed to the low diet method would be “startled at this account” of a more liberal diet, arguing that the superintendent, physician and himself were united in agreeing that they had “seen very few cases, in which a low diet has produced a good effect.”

As a direct result of such trial and error, late eighteenth-century physicians did not prescribe dietary regulations as a fixed or one-off prescription. Nor did they prescribe on the premise that such a course would provide a cure all by itself.

Tuke highlighted a major point of departure for late eighteenth-century treatment: the decision to subscribe diets based on psychological categories rather than social station. This became a guiding principal, and a manifestation of the new commitment to segregate patients by their “capacity of rational enjoyment” rather than social status. His decision was widely copied by other asylums so that, from the 1790s on, asylums implemented a system whereby an individual’s diet was almost completely determined by their particular psychological complaint and their stage in recovery: “The diet of the patients is of course regulated by their peculiar symptoms…the diet is made comfortable to the particular curative plan adopted towards each individual” [emphasis in original]. Asylums and physicians concurred on this point. Some, such as the author-physician Borsieri de Kanifeld, followed the general trend but tailored diets based only on the broader categories of melancholia and mania. Increasingly though leading hospital and asylum

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116 Tuke Description of The Retreat, pp.79-80.
117 For the broader roots of this see Andrew Harper “A Treatise on the real cause and cure of insanity; in which the nature and distinctions of this disease are fully explained, and the treatment established on new principles (1789)” in Hunter and MacAlpine (eds.) Three Hundred Years, p.522.
118 Tuke Description of The Retreat, p.65. In contrast, the Pennsylvania Hospital allowed patients to add delicacies if they could afford to do so, although this had to be approved by the physician. See Krumbhaar “The Pennsylvania Hospital”, p.241. For Scotland see Houston “Institutional care for the insane”, p.178.
120 Borsieri de Kanifeld The institutions of the practice of medicine; delivered in a course of lectures, Vol.4 (Edinburgh: Cadell and Davies, 1800-1803) p.263.
practitioners such as Benjamin Rush prescribed dietetic regimes and the regimen of food consumption to patients according to their specific psychological complaint. Building directly from their new experiences, asylum physicians reacted to changes in their patients and adapted diet and medications prescriptions accordingly.

The precondition for this refined approach was the transition in the categorization of patients for therapeutic purposes. The sheer numbers of patients encountered within public asylums meant that the practitioner encountered not just a wide variety of manifestations but, simultaneously, was able to observe several examples of similar symptoms side by side. It was this novelty that enabled a move from categorizing patients by the state of their bodies to classifying them because of their particular type of mental illness. This transition also affected how asylums approached various disordered eating symptoms. Wresting control of meals and consumption was more than just a demonstration of authority: by curtailing disordered eating behaviours physicians attempted to re-inform the deranged imagination and disordered emotions in a much more tailored manner than the application of medications. The public asylum provided an arena for the evolution of this principle into differing plans refined to suit the underlying psychological complaint. For example, canine appetites became markers of hysteria and mania whilst, concurrently, it was observed that hypochondriacs liked to weigh their meals prior to consumption. Although it was recognised that these different disordered eating behaviours denoted different mental illnesses, the principle that food was an agent remained consistent.

Removing patient control over their portions was therefore a therapeutic strategy designed to break both their imagined somatic complaints and their habitual behaviours. As with management techniques, this was a constant struggle that could only be played out within the isolated environment provided by the asylum. One case highlights this. Admitted as a melancholic “with a determined refusal to take food” and instructed to be watched “with great attention,” one female patient in the York Retreat was recorded as

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121 For an example see Benjamin Rush, Correspondence, Volume 31, No.42, Rush Family Papers, Benjamin Rush Section, Y12 7247.F, Historical Society of Pennsylvania.
122 See, for example, West Riding Pauper Lunatic Asylum, Medical Case Book 1827-1830, p.2. For changes to dietary regulations see St Luke's Hospital, General Committee Minute Book 1775-1804, entry dated 13th October 1790.
123 See Rush, Medical Notes 1804-1809, p.335.
exhibiting a refusal to eat on the 2nd, 6th, 10th, 15th and 20th of April 1805. The fact that most of the entries for this patient (indeed for many patients) were either dominated by or solely about her disordered eating behaviours reveals two things. First, that the manifestations of disordered eating symptoms were central considerations when physicians formulated ongoing therapeutic strategies. Second, the high level of activity and awareness required when dealing with disordered eating patients. These notes, and the notes of many other patients on both sides of the Atlantic, are the records of practitioners concerned with more than just the physical health of their charges. They mark the tracking of an individual’s disordered eating so as to best trace and regulate all aspects of their insanity.

Negotiations over consumption were then a continuing means of correcting abstinence. Public asylums provided many practitioners their first “major experience” of patients who refused to eat. But they also, as the York Retreat case indicates, provided multiple opportunities to work with such individuals over a long period of time and within a controlled setting. As physicians subsequently recognised that food refusal was more common when immediately followed by paroxysms so too they recognised that the deployment of diet as treatment had to respond to such rhythms. Pinel provided several studies in adapting diets (and other therapies) to suit the state of patients at various moments in time. His example was mimicked by asylums on both sides of the Atlantic as they increasingly recognised that different manifestations of insanity responded to personalized dietary intervention. The maniacal voracious eater, for example, might not always eat beyond restraint. At times their insanity could display in the refusal of “every sort of regimen with great obstinacy,” rejecting food and all comforts. The early psychiatrist met such varied symptoms with a firmness of purpose. Tailored food therapy was the practical enactment of the belief that “remov[ing] from [the patient] the power of eating in opposition to it,” or enacting complete control over all consumption, represented

124 York Retreat, Case Book 1B, RET 6/5/1/1B, Borthwick Institute for Archives, York University, pp.58-59.
126 See Pinel A Treatise on Insanity, pp.256 and 267 as examples. For implementation see West Riding Pauper Lunatic Asylum, Medical Case Book 1823-c.1826, p.5.
one of their best chances to conquer the underlying conviction that informed such behaviour.\textsuperscript{128}

Often this therapy this translated into negotiations as to where food would be consumed. Tuke’s York Retreat provides another example:

Some patients who refuse to partake of the family meals, are induced to eat by being taken into the larder, and there allowed to help themselves. Some are found willing to eat when food is left with them in their rooms, or when they can obtain it unobserved by their attendants.\textsuperscript{129}

Tuke’s description bore reality in 1824 when a male patient “refused food in the presence of others but not when left alone.”\textsuperscript{130} As a rule however Pinel and Tuke aligned moral treatment with the moral management techniques underway. Both insisted that, wherever possible, the asylum used mealtimes as a time of treatment. Pinel went so far as to describe a regimented schedule as essential to “securing order and regularity,” a “fundamental principle in the treatment of mania.”\textsuperscript{131} It does however seem to be the case that asylums frequently had to depart from strict schedules and catered to a large number of patients unable to match the rigours of mealtimes. The American physician George Parkman, for example, argued in 1817 that the denial of dining hall privileges to certain patients was one of the most effective tools for counteracting their self-starvation: “When a patient shows determination to fast…apparent indifference is likely to arrest it…[the] sight of the family enjoying a good meal, none of it being offered to the sufferer, as if he could not eat, are useful means.”\textsuperscript{132} For physicians such as Parkman, the denial of access to both the dining hall and the common diet, the enforcement of seclusion, was an important tool. It was used to correct abstinence behaviour in favour of rational temperance and social etiquette.\textsuperscript{133}

Ultimately, dietetics represented one of the few non-coercive or heroic therapeutic opportunities for physicians to exert total control and authority over their patients. This authority was, of course, implicit from the start of their relationship for the asylum was a space dominated by the power of staff over the patient. But early psychiatrist-physicians

\textsuperscript{129} Tuke Description of The Retreat, p.106.
\textsuperscript{130} York Retreat, Case Book 1A, RET 6/5/1/1A, Borthwick Institute for Archives, York University, p.288.
\textsuperscript{131} Pinel A Treatise on Insanity, pp.205-206 and 99.
\textsuperscript{132} Parkman Management of Lunatics, p.18. See also Pinel A Treatise on Insanity, p.187.
\textsuperscript{133} Parkman Management of Lunatics, p.18.
cultivated their image as stern, all authoritative but kindly figures, uniting “tenderness with steadiness, and condescension with authority” so as to inspire obedience. In part this formed a deliberate message that the asylum practitioner was benevolent and humane in contrast to their madhouse counterparts. But it also had a therapeutic purpose. As passions such as fear and love often shaped the insane experience, it was essential for the practitioner to engage with their patients on these levels. This engagement furthered the practitioner’s control and thus level of respect from the patient, seen as vitally important to “the result of a medicine” because “the power of imagination” was stirred by the affiliation patients felt for their physicians. Through acts of paternal beneficence the physician and, indeed, all asylum staff, fostered the positive relationships necessary to restore their charges. As, for example, diet decision-makers physicians became providers. In addition, by controlling both food and patterns of consumption physicians subtly exerted their authority over patients whilst, simultaneously, policing behaviour. Shared mealtimes also allowed patients to develop relationships with their medical attendants. Diet and consumption patterns were always constructive parts of patient-practitioner relationships.

Diet and consumption patterns were also fundamental parts of wider negotiations between practitioners and patients. Tuke wrote extensively on the role of diet as a therapeutic medium, drawing strength from his belief in “the general effect of different kinds of food on our mental feelings.” Quoting directly from Pinel, Tuke associated the practice of subscribing scarcity of food with more general neglectful, “practical barbarity” practices at odds both the principles and experiences of the Retreat. Their philosophy directly informed practices in asylums on both sides of the Atlantic. These instructions also represent compete agreement between the two leading architects of moral treatment. Both believed that only the public asylum could hope to conquer food refusal, the disordered eating that, above all others, “precluded the use of internal medicines” and

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134 Percival Medical Ethics, p.9. See also Pinel A Treatise on Insanity, pp.4 and 49.
135 For the long history of this principle see Fay Bound Alberti “Bodies, Hearts, and Minds: Why Emotions Matter to Historians of Science and Medicine” Isis, Vol.100, No.4 (December, 2009), p.806.
137 Tuke Description of The Retreat, p.81.
138 Ibid., p.82.
threatened all other therapeutic strategies. But for all patient types dietetics was designed to complement broader psychotherapeutic efforts and as a tool for ensuring a balanced organic state. Past patients recognised this, associating their diet with a much broader and diverse therapeutic regime. By controlling the food and consumption patterns of their patients, physicians both ensured and furthered the efficacy of moral treatment: they created the environment for rationality to prosper. Dietetics was thus central to the bigger psychological therapies at work, not separate to them.

----- Conclusion ----- 

This chapter has highlighted the remarkable consistencies between the early American and English public asylums. Whilst the American asylums were constantly subject to the public gaze (through their annual publications), this era saw both countries witnesses a new degree of public investment in the care and cure of the insane. Food united the three strands of asylum workers. Administrative staff pointed to their economical but generous distribution of provisions as medical charity at its finest and most efficient form. Attendants managed and rewarded patients for conforming to dining regimes as they reinstructed their charges in consumption habits and social behaviours. Asylums provided the context whereby the management of social behaviours became psychological therapy. Wresting control of food and consumption patterns away from patients enabled the active pursuit of both. Finally, physicians and other medical practitioners used dietetics to impose their authority and regulate their patients’ bodies in order to work on their minds. For all, the asylum provided new spaces and unparalleled opportunities to enact their particular mission on the most amount of beneficiaries.

The asylum was, simultaneously, a force for charitable endeavour and social economy. Repeated messages regarding the food served to asylum patients were designed to appeal to a variety of patrons. They indicate how much the wider eighteenth- and early nineteenth-century public associated the distribution of food with institutional charitable care. And yet it is important not to interpret asylums solely through the context of contemporaneous segregating or confining institutions. For the asylum also represented

139 York Retreat, Case Book 1A, p.67.
the medicalization of the broader public. It was they, not medical personnel, who drove the professional organization of early psychiatry. The asylum epitomizes the point at which communities remodelled economically efficient charity into therapeutic care. Regulations about food and consumption played an important role in that shift.

Clinical instruction paralleled the reinstruction of the patients themselves. These asylums all acted on the belief that their patients suffered from impaired rather than obliterated intellectual or moral faculties. The insane retained some of the attributes of sanity: instruction was, therefore, a potential game-changer. This principle underpinned moral management and moral treatment. All manifestations were considered capable of responding to an order and regimen imposed by skilled but lay attendants. Consumption patterns were a major concern in the daily life of the asylum because they could be worked into the broader ethos of regulation and order. Non-conforming patients threatened the work underway.\textsuperscript{141} This explains the precautionary and expansive regulations that ensured that food was supplied according to strict prescriptions.

The public asylums provided unprecedented spaces where the practice of psychiatry could be tested and allowed to mature. These asylums brought together large numbers of the insane, often for the first time, treating the insane side-by-side rather than in very small houses or their own homes. Although it cannot be claimed that they replaced this primary system of care completely, it does seem the case that public and legislative support drove the move to the institution as a solution.\textsuperscript{142} But they also organised them as objects for instruction.\textsuperscript{143} Asylums provided opportunities to study concentrations of patients in a setting that made psychological complaints clinical entities.\textsuperscript{144} Therapeutic strategies (such as dietetics) could now be ‘scientifically’ tested through experience and then modified to suit different patient groups. Food, consumption patterns and irregular behaviours were all therapeutic considerations. In particular dietetics became a channel to shape mental illness into a medical condition that could be tracked and analysed. It allowed asylum physicians to record improvements in bodily health alongside (or

\textsuperscript{141} For the roots of this see Richard Mead \textit{Medical Precepts and Cautions} (Dublin: W. Smith, 1751), pp.63 and 66.
\textsuperscript{142} For more see Goodheart \textit{Mad Yankees} p.5.
\textsuperscript{143} For the pecuniary benefits of this see Benjamin Rush, Medical Classes of Dr. B. Rush, Rare | AM 1777 Rus (b.w.) 60917.O.29 (Rush), Library Company of Philadelphia, insert at p.30.
\textsuperscript{144} For more see Porter \textit{Madmen: A Social History of Madhouses}, p.220.
separate to) improvements in mental health. As such it made insanity a ‘real’ or treatable illness.
CHAPTER FIVE:
THE SUBJECTIVITY OF FOOD WITHIN THE ASYLUM

----- Introduction -----

This chapter charts the experiences of patients whose insanity manifested through disordered eating. The previous chapters focused on the pathologisation of disordered eating by psychiatrists and other communities. This chapter is interested instead in how the patients confined within the walls of both American and English public asylums expressed their emotional and imagined realities through their food behaviour. It analyses the language and behaviours of disordered eating as a form of patient expression and argues that patients often conceptualized their complaints in terms of their relationships with food and diet. In parallel, it demonstrates that disordered eating was a leading diagnostic indicator for the various individuals who encountered, witnessed and judged insanity. This chapter shows that the early years of the public asylum elevated the significance of patients’ relationships with food in the diagnosis of mental health, as patient realities attained psychiatric and clinical meaning through their disordered eating. These patients confirmed suspicions that insanity was a mental illness arising primarily from emotional and cognitive disturbance rather than organic deterioration. Disordered eating behaviours and discourses thus revealed otherwise hard-to-access psychological disorders and experiences.

The first two sections explore the role food relationships played in the dominant categories of mania and melancholia. The most frequent disordered eating symptom for both was abstinence or food refusal and that type of disordered eating forms the bulk of these sections. Many patients diagnosed under these two banners manifested their realities and their emotional states primarily if not exclusively through their relationships with food. The first part of this chapter explores the various intersections between melancholia and disordered eating. It argues that the disordered eating discourses and behaviours expressed by melancholic patients evidenced the psychiatrists’ hypothesis that melancholy was defined by emotional disturbance. The second section illustrates how disordered eating disclosed maniacal hallucinations, paroxysms and monomania. These
food relationships provided clinical evidence that mania was a complaint defined by emotional and cognitive disorder.

The final section examines patients whose relationships with food changed at various points in their illness. It is focused more predominantly on disordered eating behaviours rather than patient discourse. Building from section two, this section demonstrates that disordered eating behaviours often marked changes in mental states or degrees of insanity. This was evident through both changes in the form of food behaviour and changes in the intensity of the symptoms. This section thus contains various consumption tendencies, including pica and voracious eating. But it also includes patients whose patterns of disordered eating were consistent markers of otherwise fluctuating conditions.

The following pages rely heavily on patient discourse as recorded in case notes and associated records. There are, of course, challenges inherent to these sources. As with all case notes, the following records were shaped by asylum workers. In the public asylums patient case notes were shared entities, subject to the scrutiny of the various practitioners who interacted with patients on different days of the week and, ultimately, were the property and thus under the purview of the asylum committees and boards. Multiple people used and viewed these notes. And yet it is the fact that notes were shared that most strongly suggests that even if patient words may not have been recorded verbatim, practitioners attempted to record the essence of expression. That is because discourse gave practitioners and attendants alike their greatest clues as to the particular shape of any individual patient’s delusional or emotional reality. Discourse provided the explanation as to why disordered eating permeated asylum life and was a critical form of distributed evidence given the often-absent physiological cause. Consequently, this chapter uses patient discourse cautiously but nonetheless draws important evidence from the words recorded.

For whatever duration or to whatever degree, for the patients that engaged in disordered eating their disordered eating informed their identity within the asylum and shaped their therapeutic journeys. The case records provided by both asylums and psychiatrists indicate that disordered eating symptoms became an established aspect of insanity as witnessed within the asylum.¹ Disordered eating was experienced by all

¹ See Appendix Five.
categories of patients and manifested in a variety of forms. As such an analysis of disordered eating offers unique insight into how asylum patients lived and expressed their illness. Simultaneously practitioners recorded the discourses, behaviour and physical changes that marked disordered eating as it became a leading observable symptomology for measuring psychological disorder. In combination, these three types of symptoms confirmed lay diagnoses of mental disturbance and played a leading role in ongoing patient-practitioner relationships. Together they disclosed the degree, type and fluctuations of any patient’s insanity. Thus disordered eating manifestations helped both patient and practitioners make (medical) sense of mental illness.

I: Melancholia

Individuals diagnosed as melancholic represent the majority of those whose insanity was defined by their relationships with food. The intersections between ‘melancholy’ and ‘disordered eating’ were both frequent and sweeping in their nature. Abstinence or food refusal dominates. Many patients described their food refusal as an active and deliberate attempt to correct what they saw as personal failings. Many more rationalized their disordered eating through an emotive rhetoric of fear, grief or remorse. Numerous asylum experiences with such patients meant that by the late eighteenth century melancholic abstinence was generally assigned an emotional pathogenesis. Leading psychiatrists such as Benjamin Rush urged their colleagues to look to “unfortunate love, debt and guilt,” that “they must be extorted by direct or indirect means” for “otherwise the appropriate remedies cannot be applied.” Asylum experiences and clinical observations of disordered eating thus validated the hypothesis that melancholic insanity was primarily an emotional complaint.

Melancholic abstinence often joined a wider range of behaviours that, collectively, signified emotional withdrawal and a rejection of sociobehavioural norms. This category of food abstainers was described as “depressed”, “extremely dull” or suffering from a “want of energy.” Theirs was a passive abstinence, aligned with disinterest in “all that

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2 Benjamin Rush, Lectures on the Practice of Medicine, Yi2 7394 F11, Book 11, Box 1, Rush Family Papers, Benjamin Rush Section, Historical Society of Pennsylvania, p.500 [facing].
3 West Riding Pauper Lunatic Asylum, Medical Case Book 1821-c.1823, C85/3/6/96, West Yorkshire Archive Service Wakefield, pp.2 and 309, J. Andrews and A. Scull Customers and Patrons of the Mad-
nature requir’d,” and forming part of a wider pattern of behaviours that indicated the withdrawal from past pursuits and external stimuli.\(^4\) Traditionally, these collective manifestations symbolized an insanity that was marked by extreme physical endurance and deprivations, those lost to all comfort. But in the late eighteenth century, under the guidance of both Samuel Tuke and Philippe Pinel, such lengthy abstinences were transformed into evidence of emotional insensibility and redefined as potentially treatable.

Both casebooks and printed collections of case studies constructed natural histories of insanity around increasing disengagement. Pinel, for example, chose to publish the case of one melancholic patient whose “Ennui and insurmountable disgust with life, absolute refusal of food, and dissatisfaction with every thing, and every body that came near him, were among the last ingredients of his bitter cup” [emphasis added].\(^5\) In New York the Bloomingdale Asylum also encountered patients whose refusal of food aligned with changes “contrary to [their] usual habits” such as “avoid[ing] society of all kinds” and “seek[ing] to be alone.”\(^6\) These behaviours constituted a natural history. But they were also highlighted as measures of fluctuating psychological states amongst asylum patients. In 1786 the Pennsylvania Packet published an ‘Extraordinary Case’ from York Lunatic Asylum.\(^7\) Reprinted by the asylum in their 1791 annual report, this case concerned a male patient whose restoration from a “state of insensibility” was measured when he started to eat and drink one more.\(^8\) Other asylums also associated ‘cure’ with a return to previous habits so that “normal physical functions and mental health” were evidenced by a “recovery of normal appetite.”\(^9\) Thus, on both sides of the Atlantic, degrees of withdrawal became important markers of mental states.

\(^4\) Andrews and Scull *Customers and Patrons of the Mad-Trade*, p.c-44.
\(^6\) Register of the maniacal cases in the New York Asylum Bloomingdale, Bloomingdale Records 106A, Medical Center Archives of New York Presbyterian or Weill Cornell, entries dated 25\(^{th}\) July 1825 and 10\(^{th}\) November 1822, pp.93 and 22.
\(^9\) Andrews and Scull *Customers and Patrons of the Mad-Trade*, p.79. See York Retreat, Case Book 1B, RET 6/5/1/1B, Borthwick Institute for Archives, York University, p.58.
Whilst the above patients translated their grief or upset into a passive abstinence, many others turned to more active food refusal as a way of giving meaning to their emotional states. Their interactions with asylum staff are recorded more frequently as their discourse often indicated the exact genesis of these emotions. But practitioners also relied heavily upon the testimony of friends and family as guides to causation. Their testimonies pointed to traumatic rather than organic geneses. Very often these were the same groups who uncovered insanity in the individual’s withdrawal from their normal interactions. Associations and practitioners alike most frequently recorded these behaviours as originating in ‘disappointments’ and generally revolving around close, familial relationships. In almost all these cases no physiological details are given: these patients were diagnosed and then identified through their emotional states.

The refusal of food because of “a disappointed expectation of marriage” was emblematic of this type of insanity. Romantic love was a major originating factor in melancholy: when Benjamin Rush recorded the etiologies of fifty insane patients admitted to the Pennsylvania Hospital between May 1784 and December 1787 he listed “disappointed love” or “love” for twelve percent (six) of the cases. Private practitioners also left notes about patients whose food refusal seems to have been an expression of frustrated affections. The narrative of emotional distress and disappointed love was a widely familiar cultural trope for both English and American audiences – as within the asylum, so too outside its walls pamphlets, stories and songs told of lovesick individuals whose broken hearts resulted in melancholy and broken relationships with food. And so

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10 See, for example, York Retreat, Case Book 1A, p.140.
12 York Retreat, Case Book 1A, p.28.
13 Benjamin Rush, List of lunatics admitted from May 1st 1784 to December 1st 1787, Yi2 7247.F No.31, Historical Society of Pennsylvania, Rush Family Papers, Benjamin Rush Section, Correspondence Volume 31.
patients and witnesses alike conformed to broader stereotypes about the meaning of abstinence by ascribing food refusal to frustrated emotional attachments.

Other patients experienced disappointments relating to their wider families and were diagnosed primary through their internalization of grief and guilt. In that same Pennsylvania Hospital list Benjamin Rush recorded another ten percent of patients (five) whose insanity originated in “grief.”16 Most often this grief derived from close familial relationships and, as with disappointed lovers, manifested predominantly through abstinence behaviour. The genders align around this basic precondition – both men and women refused food because of their parental affections. The anecdotal Sketches in Bedlam, for example, included the case of a “victim of maternal fondness and painful anxiety for her child” whose emotional distress about her daughter’s imagined sufferings motivated her food refusal.17 In tandem the apothecary-physician John Haslam drew on another Bethlem case when he described a male patient whose food refusal was symptomatic of his “anxious and miserable” state triggered by his grief over the death of his son.18

For both men and women abstinence was also “occasioned by anxiety respecting Business” and “embarrassing circumstances” in their families.19 George III’s ‘mad-doctor’ Francis Willis relayed the case of a man whose “reverse of fortune” occasioned him to fall “into such a deplorably low state as to excite in his family an alarm for his life.”20 The belief that he failed his family informed his dominant psychological symptom: his delusion “that, if he put food into his mouth, he should be condemned to everlasting perdition” resulted in extreme food refusal behaviour.21 Similarly the English surgeon Charles Turner Thackrah referenced a Hufeland’s Journal case in the mid 1820s when he attributed a German merchant’s “resolution of destroying himself by abstinence”

16 Rush, List of lunatics admitted.
17 A Constant Observer Sketches in Bedlam; or characteristic traits of insanity (London: Sherwood, Jones,1823), p.280.
19 York Retreat, Case Book 1A, pp.269 and 63.
20 Willis A Treatise on Mental Derangement (1843), p.99
21 Idem.
to his being “depressed by severe reverses of fortune, and the consequent slights of his relatives.”

Exaggerated by affections for their families, the food refusal behaviours of all these individuals materialized their emotional distress.

Whilst guilt or grief drove some melancholics to abstinence, the food refusal of many others was the manifestation of their anxieties and fearful suspicions. Concerned with external threats, patients frequently expressed these fears by claiming that their families or friends had “designs” against them and were either poisoning or were planning to poison their food. The case notes of several patients are informed primarily by or composed solely of their reluctance to eat on the “suspicion that poison might be introduced” or their “idea[s] that something…has been added to it.” Many late eighteenth-century authors, drawing from direct interactions with such individuals, subsequently listed “apprehension of treachery and poison” as particularly emblematic of the melancholic condition. Some mid-eighteenth-century physicians, such as Richard Mead, argued that these discourses implied a physiological disturbance whereby the mind was “in some measure…called away from the senses.” But, especially moving into the nineteenth century, many more relied instead on patient discourse in order to substantiate their hypothesis that psychological disturbance engendered this particular form of disordered eating.

Asylum attendants and practitioners alike thus attributed such justifications for food refusal to “foundless fears” and treated them as expressions of disturbed emotional attachments. But, and as for emotional distress, the consequence of such convictions was often a lengthy and extreme abstinence. The physician John Ferriar, for example,

23 Andrews and Scull *Customers and Patrons of the Mad-Trade*, p.c-70
24 York Retreat, Register of Certificates 1819-1827, RET 6/1/1 A/B Retreat, Borthwick Institute for Archives, York University, pp.171 and 200.
27 York Retreat, Case Book 1B, p.54.
recorded how he “once saw a patient who had passed a fortnight without food, and who died of mere inanition” after he suspected “an intention to poison him.”28 These behaviours both altered and remained consistent once they were admitted as patients of the asylum.29 It is possible to speculate that, for the former category, a physical removal from the objects of their suspicions invalidated their food refusal. Those who persisted in their claims adapted their suspicions towards the asylum attendants and practitioners who presented themselves as ‘family’ and ‘friends’. Regardless, both groups were far removed from those classified as insensible – their food refusal was an active pursuit with a defensive purpose. But it was grounded upon errors of judgment and emotional sense: their verbal expressions disclosed a “total perversion of the affections and of all common opinions.”30

The rejection of food on the premise of poison was often the only behavioural manifestation recorded in case notes. The next two melancholic groups are shaped instead around patients whose food refusal was part of a wider pattern of behaviours. Although abstinence was often their most intense or frequent manifestation, their food refusal often aligned with other destructive actions. Self-violence represents the most frequent parallel, for patient records almost universally follow accounts of food refusal with information as to self-injuries. Indeed, admission certificates issued by the York Retreat combined the two into one question: “Has the Patient shown any disposition to refuse food, or to injure himself or others?”31 Furthermore, York Retreat case notes often used variations of the observation that patients had shown “a disposition both to refuse food and to injure [themselves].”32

This information was collected initially from friends and families who interpreted disordered eating as emblematic of these wider behavioural manifestations. Occasionally abstinence was a warning sign for other behaviours that, whilst different in their actions,
achieved similar purposes. But more often self-violence and food refusal manifested concurrently. Together they informed ongoing diagnoses. Asylum casebooks thus record patients for whom the decision to refuse food was part of a wider “disposition to injure [themselves]” by, for example, putting their “hand & arms into the Bucket of Lime & Water used for cleaning the room” or “attempt[ing] to cut her hands with a hatchet.” These patients seem to have descended into disordered eating as merely the most recent manifestations of their judgments that they were “good for nothing.” As a form of violence committed against the self, abstinence to the point that it was “necessary to use force,” was thus an expression of a more entrenched self-directed negativity.

At its extreme, protracted food refusal became a method of suicide. The descent into total abstinence presented such a significant threat to life that some individuals, with a lengthy history of suicide attempts, were admitted to asylums only in response to very recent disordered eating. It is also possible that medical practitioners constructed a relationship between abstinence and suicidal impulses in cases with histories of past suicide attempts but with present symptoms that were simply “Talks incoherently and refuses food.” This category of patients populated records from all asylums. As with self-harmers their abstinence often correlated with previous behaviours that carried the same repercussions. Within the asylum self-harming or suicidal actions seem to have continued unmitigated by the immediate affects of therapeutic or management regimens. In this sense abstinence became a form of patient agency and “perverse self-mastery.” Their lengthy food refusal represented an act of willful control in asylums built and furnished in such a manner as to prevent other opportunities for self-violence.

The food refusal enacted by these patients was clearly a chosen method of achieving their particular objective: their case notes include no physiological causes or explanations. Their insanity was therefore defined by their motivations, rather than simply the

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33 York Retreat, Case Book 1A p.214.
34 West Riding Pauper Lunatic Asylum, Medical Case Book 1819-c.1823, C85/3/6/2, West Yorkshire Archive Service Wakefield, pp.85 and 306.
36 Idem.
38 Register of the maniacal cases in the New York Asylum Bloomingdale, entry dated 6th September 1818, p.4.
39 Dawson Lovesickness and Gender, p.120.
behaviour of food refusal. Practitioners thus relied heavily on patient verbal expressions as well as abstinence behaviour when diagnosing suicidal intent. In these instances disordered eating behaviours often marked the transition from thought to action. Practitioners subsequently took care to record verbal manifestations as, for example, when patients “express[ed] a wish to die” or “shewed an aversion to food, and said [they were] resolved to die” [sic].⁴⁰ The patients who manifested both disordered eating discourse and behaviour were those who most often maintained such a protracted and absolute abstinence that they required drastic intervention.⁴¹ When patients were “bent on self-destruction, and resist[ed] all nourishment for the purpose of starving [themselves]” [emphasis added] practitioners reacted quickly.⁴² At the turn of the nineteenth century a lengthy list of authors cautioned that many of their patients required force-feeding and they developed a range of instruments accordingly.⁴³ But this was a response to the immediate threat to life rather than an different vision of insanity: even when forcibly fed their food refusal was still considered to be the outward reflection of disturbed design.

Religious melancholics were the other major category of melancholics whose food refusal most often was but one aspect of wider behavioural patterns. This remained a dominant subset of insanity both within and outside the asylum. As chapter two discussed, religious melancholy was a commonly accepted category of insanity and it is reasonable to deduce that admissions to the asylum under this category were shaped by the support implicit in wider debates about the correct and reasonable nature of religion. Early eighteenth-century clerics such as Jonathan Edwards lamented that “There are Hundreds, and probably Thousands of Instances...of Persons that have murdered themselves, under religious Melancholy” [sic].⁴⁴ Over the course of the later eighteenth century clerics joined psychiatrists in the categorization of religious melancholy as

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⁴⁰York Retreat, Case Book 1A, p.171 and Haslam Observations on Madness and Melancholy, p.87.
⁴¹See York Retreat, Case Book 1A, p.257.
⁴³William Rowley A treatise on madness and suicide, with the modes of determining with precision mental affections (London: J. Barfield, 1804), p.4. See also West Riding Pauper Lunatic Asylum, Medical Case Book 1830-c.1842, C85/3/6/5, West Yorkshire Archive Service Wakefield, p.2. See Appendix Six.
⁴⁴Jonathan Edwards Some Thoughts Concerning the present Revival... (Boston: S. Kneeland and T. Green, 1742), p.162.
“nothing else but a disordered Imagination.”\(^{45}\) As part of the public asylum experience, this patient categorisation was subject to this much broader movement to relabel religious dissent as insanity. Admissions could be shaped by religious sectarianism and friends and families’ moral judgments. Thus, for example, Methodism was listed as a cause for admission in over ten percent of the patients admitted to Bethlem in the years 1772-1787.\(^{46}\) And, despite Tuke’s claims that “very few cases…at all [were] connected with religious impressions”, his York Retreat admitted numerous such patients who often exhibited lengthy abstinence behaviours.\(^{47}\) It is therefore unsurprising that religious convictions were described by psychiatrists in both England and America as “one of the most frequent and dangerous” sources of melancholy.\(^{48}\)

It is equally clear that many patient realities were infused with spiritual meaning and that debates over the nature of religious practice and affiliation also affected the physician-patient relationship. In his early eighteenth-century scathing and widely-quoted *The London-Citizen exceedingly injured*, Alexander Cruden accused Bethlem’s resident physician James Monro of misrepresenting his words so as to unjustly confine him on the pretense that Cruden “was a great Enthusiast…[who] thought that God would send an Angel from Heaven, or would work some Miracle for his Deliverance” [emphasis in

\(^{45}\) Davy *A System of Divinity, in a course of sermons*, Vol. 16, p.205. See also Charles Chauncy *Enthusiasm described and caution’d against. A Sermon Preach’d at the Old Brick Meeting-House in Boston, the Lord’s Day after the Commencement, 1742…* (Boston: J. Draper, 1742), p.vii.


\(^{46}\) J. Andrews and A. Scull *Undertaker of the Mind. John Monro and Mad-Doctoring in Eighteenth-Century England* (London: University of California Press, 2001), p.91. See also West Riding Pauper Lunatic Asylum, Medical Case Book 1819-c.1823, pp.499-500. See also Pinel *A Treatise on Insanity*, p.73. This was in part because their food refusal tended to be both absolute and prolonged. For examples see West Riding Pauper Lunatic Asylum, Medical Case Book 1819-c.1823, pp.26-28 and Haslam *Observations on Madness and Melancholy*, pp.97-98.


\(^{48}\) Rush, Lectures on the Practice of Medicine, pp.499-500. See also Pinel *A Treatise on Insanity*, p.73. This was in part because their food refusal tended to be both absolute and prolonged. For examples see West Riding Pauper Lunatic Asylum, Medical Case Book 1819-c.1823, pp.26-28 and Haslam *Observations on Madness and Melancholy*, pp.97-98.
Almost sixty years later, in 1797, a New York Hospital case embodied the careful and difficult path practitioners walked between their patient’s worldviews and the diagnoses of religious insanity. The case involved a young girl who, having “suddenly taken insane…had eaten nothing, nor taken any kind of nourishment for a week” prior to admission. Within the hospital, she continued to refuse all food to the extent that “It was forced into her mouth, but instantly rejected,” although she did consume “some dirty suds” from the washing room. Whilst her physician noted that she “divided her time in singing methodistic hymns, and putting up short prayers,” he cautiously concluded that “her disease did not proceed from any insane religious impression.” Ignoring her religious affiliation, his diagnosis built solely from her lack of concern as to the fate of her soul before or during her illness.

For many other religious melancholics food refusal was often a part of wider and lengthy patterns of self-violence that could continue unmitigated by confinement. The admission record of one West Riding Pauper Lunatic Asylum patient provides an example: “imagines God has forsaken her that she must destroy herself. Has several times attempted to hang herself & cut her throat, obstinately refuse[s] food.” Most patients were diagnosed as religious melancholics when they described their abstinence through the language of penance, fear and despair. Overwhelming feelings of sinfulness or failure, combined with fears about imagined torments and future divine judgement, drove their food abstinence. This fear could suspend their interest in or the consumption of food. For example, one male patient “entertain[ed] distressing ideas of having missed his way in a religious sense & that he is to be sacrificed” and materialized his fears by being “very shy at taking food, which, tho he takes a sufficiency, is done with much hesitation.” Some patients justified their abstinence by arguing that, as God had abandoned them, they were

49 Alexander Cruden The london-Citizen exceedingly injured: or a British inquisition display'd, in an account of the unparallel'd case of a citizen of London, bookseller to the late Queen, who was in a most unjust and arbitrary Manner sent on the 23d of March 1737/8, by one Robert Wightman of Edinburgh, a mere Stranger, to a private madhouse….., 2nd ed. (London: T. Cooper and A. Dodd, 1739), p.16.
51 Ibid., pp.181-182.
52 Ibid., p.182.
54 West Riding Pauper Lunatic Asylum, Medical Case Book 1819-c.1823, p.26
55 York Retreat, Case Book 1A, p.253.
both unworthy of and unlikely to respond to nourishment. These patients continually negotiated their relationships with food as part of their ongoing struggles with their imagined fates. Psychiatrists consequently used their discourse surrounding their food behaviour to construct a clinical portrait of religious melancholy.

The key psychiatric development was in the interpretation of their behaviours as melancholic symptoms rather than spiritual practice. Benjamin Rush described religious melancholy as “false and destructive opinions,” deliberately rebranding spiritual mortification as the manifestation of erroneous judgement. His interpretation corresponded directly with whose “extreme terrors of mind…[and] great despondency & fears respecting [their] future state” made it “extremely difficult to prevail with [them] to take nourishment sufficient to sustain life.” But for many other individuals the refusal of food represented a deliberate strategy of atonement as abstinence played a prominent part of their wider attempts to appease an angry or disappointed god. Religious melancholics thus expressed their emotional anxieties about their personal relationship with God through their disordered relationships with food.

But religious melancholy was a rare form of melancholy in that it could be identified through hallucination as well as emotional distress. These religious melancholics were aligned closely with other melancholic patients as asylums translated their descriptions of vengeful spirits into categories of imagined torment and delusional terrors. Bethlem, for example, hosted a male religious melancholic who had a “perpetual suspicion that every person about him intended to assassinate or poison him.” His diagnosis as a religious melancholic derived from the explanation he gave as to why this might be the case: “his mind was engloomed, partly by religious enthusiasm, and partly by imaginary apprehensions…He was affected by a bitter sense of remorse for ideal crimes, [and] a horror of death” [sic]. “Pleading his religious scruples,” the patient’s rejection of food

56 See, for example, Haslam Observations on Madness and Melancholy, p.136.
57 York Retreat, Case Book 1A, p.253.
58 Rush, Lectures on the Practice of Medicine, p.498.
59 York Retreat, Case Book 1A, p.106. See also pp.9 and 93.
60 A Constant Observer Sketches in Bedlam, p.39.
61 Idem., p.39.
deteriorated to the point of total abstinence when he became convinced that his consumption of poisoned food would make him commit the sin of suicide.\textsuperscript{62}

For these patients abstinence effected a purpose: it demonstrated their willingness to acquiesce to God’s judgement and punishment. Because of their focus on the heavenly realm their abstinence was almost entirely beyond the reach of argument or negotiation. Practitioners recognised this and subsequently developed elaborate ruses or play-acting as a method of rebalancing the patient’s conception of their relationship with God. A long established practice, this was very much a therapeutic intervention and represents an early attempt to work \textit{with} rather than \textit{on} the patient. By the late eighteenth century leading physician-authors such as Borsieri de Kanifeld argued that when melancholy was “obstinate and permanent,” as in these cases, a cure could only be achieved “by some fraud.”\textsuperscript{63}

The physician Erasmus Darwin disclosed the purpose of such intervention in his 1796 \textit{Zoonomia}:

\begin{quote}
Miss---said she had seen an angel, who told her, that she need not eat…After fruitless persuasions to take food, she starved herself to death.---It was proposed to send an angel of an higher order to tell her, that now she must begin to eat and drink again; but it was [tragically] not put into execution.\textsuperscript{64}
\end{quote}

Two years earlier the anecdotal \textit{Wonderful Magazine} printed a similar tale under the heading ‘The Prodigious Force of Imagination’. A nobleman, believing “That God would not forgive him his sine” \textit{[sic]} in despair abstained from all earthly comfort, including food.\textsuperscript{65} Eventually, after trying medicants and other strategies, his physicians “let down an artificial angel [from the roof, via the window] into his room” who pronounced that God forgave him his sins and commanded him to resume eating and drinking.\textsuperscript{66} The report goes on; “his physicians, who humoured the artifice…pronounced him a holy man and that soon after he found an appetite to his meat…and enjoyed himself as formerly.”\textsuperscript{67}

Both narratives make it clear that the way to break the abstinence behaviour was to

\begin{quote}
\textsuperscript{62} Ibid., p.41.
\textsuperscript{63} Borsieri de Kanifeld \textit{The institutions and practice of medicine, Vol. 4} (Edinburgh: W. Mudie, 1800-1803), p.264. For a sixteenth-century example see Dawson \textit{Lovesickness and Gender}, p.178.
\textsuperscript{64} Darwin \textit{Zoonomia}, p.357.
\textsuperscript{65} Anon “The Prodigious Force of Imagination” \textit{The New Wonderful Magazine, and Marvellous Chronicle, Vol.1, No.5} (1793-1794), p.217
\textsuperscript{66} Idem.
\textsuperscript{67} Ibid., p.218. See also Pinel \textit{A Treatise on Insanity}, p.61.
\end{quote}
directly address the underlying delusional condition. Thus, through therapeutic experiment, spiritually-motivated abstinence was refashioned into a psychological category.

There is one final category of patients under this banner. These patients aligned the rejection of food with the rejection of medication and were diagnosed with either hypochondriasis or melancholia. The diagnosis ‘hypochondriasis’ began to enter admission records in American asylums in the 1820s. But, for the most part, and certainly in England, patients exhibiting hypochondriacal symptoms continued to be classified as melancholic. That can perhaps be explained by Benjamin Rush’s definition of hypochondriasis as a delusional condition whereby patients experienced “false judgement of his physicians…[and] false judgement of remedies” [emphasis in original]. This conceptualisation provided a psychological connection between melancholia and hypochondriasis. Rush argued that, rather than merely coercing patients, practitioners needed to approach this joint refusal primarily for what it told them about the state of the mind. His argument underlined the key innovation of this period: understanding that symptoms such as disordered eating were melancholic patients’ expressions of their internal realities.

----- II: Mania ----- 

Melancholic patients thus continuously communicated with practitioners through disordered eating. But disordered eating very often also appears to have become the nucleus of negotiation between maniacal patients and practitioners. Verbal expressions about their attitudes to food offered clues as to the specific shape of their delusions or hallucinations and, ultimately, the motivation for their behaviour. Disordered eating not only manifested across a range of maniacal patients but, also, represented a rare opportunity to access what were considered to be the two dominant underlying psychological conditions: “a false perception of things, or a false judgment of the


69 Rush, Lectures on the Practice of Medicine, p.490.
relations of things.” The conviction that mania presented through behavioural symptoms but was defined by imagined realities meant that, as with melancholia, patient discourse became critical clinical evidence. From the 1750s William Battie’s insistence that the ideas of the insane needed to be treated seriously informed asylum practice. By the early nineteenth century the combination of irrational discourse with illogical behaviour were critical to diagnosis. Critically, disordered eating symptomologies included both.

A. Ingram has pointed out that the early psychiatrists took their direction from John Locke’s definition of the madman (or maniac) as one who retained his faculties for reasoning but argued from wrong principles. Latter eighteenth-century physicians such as John Ferriar matched Locke’s definition with clinical experience, claiming “I have seen great exertions thrown away, in attempting to influence lunatics by arguments…I never knew such endeavours answer any good purpose.” Contemporaneous practitioners often lamented “fruitless persuasions” and how “every endeavour proved ineffectual.”

By the 1810s physicians cautioned that “attempts to dissuade” patients from their “determination to fast” could, in fact, “confirm it.” From arguments to negotiations and persuasions, practitioners adapted their therapeutic strategies in direct response to how patients described and enacted their relationships with food. The wider point however is that these almost universally represent initial therapies. Therapeutic strategies thus make it clear that psychiatrists on both sides of the Atlantic treated disordered eating as a symptom of maniacal disturbance.

Many patients explained their disordered eating behaviours by assimilating medical discourse. In this they rationalised their behaviours by drawing on a language of pain, discomfort and physiological disturbance. Their explanations were, as we saw in chapter one, more directly aligned with older conceptualisations that described insanity as the result of a physiological shock or imbalance. Nor did psychiatrist-physicians dismiss this particular etiology altogether. Benjamin Rush listed “unwholesome foods” as a cause of mania whilst John Haslam cautioned that food refusal was sometimes the result of “a state

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70 Idem., p.509.
72 Ferriar Medical Histories and Reflections, p.109. See also Pinel A Treatise on Insanity, p.223.
73 Darwin Zoonomia, pp.327-358.
of disease in maniacs, where the stomach and intestines are particularly inert.”\textsuperscript{75} But it does appear to be the case that both men, and many of their peers, increasingly saw physiological disturbance as a possible precondition rather than the root source of insanity. Their changing perceptions can reasonably be attributed to their experiences within the hospital-asylum.

The casebook of John Monro, Bethlem’s late eighteenth-century attending-physician, documents how these patient narratives unfolded. In the context of patient-practitioner interactions, abstinence became a barometer to measure insane realities against those observed by everyone around them. In one case Monro described how his patient “would willingly not eat any thing if we would permit it” because she “has a notion that she must not eat least she should increase her fever…she thinks herself dying.”\textsuperscript{76} In this sense the patient rationalized her abstinence as a form of therapy or, at the least, a logical method of preventing further discomfort. It was the disconnect between her descriptions and Monro’s observations that served as clinical evidence for her mania and, in turn, verified that her abstinence was the result of a psychological rather than physiological condition.

The psychiatrist’s task was thus to use medical investigation and observation in order to measure the patients’ imagined reality against their true physiological state. This was equally true when patient descriptions aligned with traditional medical doctrines about the somatopsychic etiology of insanity. Monro recorded another case where the patient, also a female, attributed her complaints to having ate “some grapes which chill’d her blood, & afterwards some mushrooms which poison’d her.”\textsuperscript{77} Her descriptions should seem familiar to some of the practitioner theories explored in chapter one. The clue that her self-diagnosis was erroneous however lay in her subsequent insistence that “her inside is decay’d…[and] she…is in danger of…losing her nose.”\textsuperscript{78} With the examples such cases provided, more and more practitioners were exposed to the possibility that, whilst physiological changes or complaints could feature in the insane condition, these were

\textsuperscript{75} Rush, Lectures on the Practice of Medicine, p.517 and Haslam Observations on Madness and Melancholy, pp.325-326.
\textsuperscript{77} Andrews and Scull Customers and Patrons of the Mad-Trade, pp.c-21-c-22.
\textsuperscript{78} Ibid., p.c-22.
often the result of self-inflicted behaviour rather than organic deterioration.\textsuperscript{79} By the 1820s even non-specialist medical practitioners discussed insanity as a complaint where the deterioration of the mind nearly always predated the deterioration of the “bodily powers.”\textsuperscript{80}

Practitioners approached these patients with the full arsenal of their physiological training and reassured themselves that they “could by no means trust to [the patients’] own account[s]” for their complaints were “without foundation.”\textsuperscript{81} This was especially true when patient justifications disclosed imagined somatic realities. In this sense Monro’s cases can be qualified against more extreme examples of patient discourse. In particular, frequent arguments that their bodies had physically altered to the point that the ingestion of food was either no longer possible or worthwhile. These patients substantiated the theory that insanity was defined by perverted imagination: their disordered eating behaviour was the direct consequence of their imaginings. John Haslam wrote about just such a patient. Admitted in 1796, this sixty-one-year-old male

\begin{quote}
    said it was ridiculous to offer [food] to him, as he had no mouth to eat it : though forced to take it, he continued in the same opinion ; and when food was put into his mouth, insisted that a wound had been made in his throat, in order to force it into his mouth.\textsuperscript{82}
\end{quote}

In another Bethlem case, this time from 1822, the patient, a younger gentleman

\begin{quote}
    supposed his mouth to be quite an opposite part of his person, and would call aloud to his keeper when endeavouring to feed him, “don’t! pray don’t put meat and things in there! it’s so unnatural. Nobody ever did that before to any man ; it’s so unreasonable : pray don’t do it!”\textsuperscript{83}
\end{quote}

Finally, the Bloomingdale Asylum admitted a male in 1822 who “imagines he has no stomach – refuses food” and another in 1824 who “refused to eat, said his jaw was broken.”\textsuperscript{84} On both sides of the Atlantic these two asylums used the explanations surrounding disordered eating as clinical evidence of their insanity.

\textsuperscript{79} See Ibid., p.c-44. For a patient admitted with ‘Dyspepsia’ given as etiology see York Retreat, Case Book 1A, p.67.
\textsuperscript{80} George Bacon Wood, Diary 1817-1829, Am. 1924, Historical Society of Pennsylania, entry dated 10\textsuperscript{th} April 1829.
\textsuperscript{81} Andrews and Scull Customers and Patrons of the Mad-Trade, p.c-57.
\textsuperscript{82} Haslam Observations on Madness and Melancholy, pp.114-115. See also Parkman Management of Lunatics, p.12.
\textsuperscript{83} A Constant Observer Sketches in Bedlam, p.214.
\textsuperscript{84} Register of the maniacal cases in the New York Asylum Bloomingdale, entries dates 10\textsuperscript{th} November 1822 and 4\textsuperscript{th} October 1824, pp.22 and 56.
Patient expressions of physiological change directly mirrored the medical and institutional environment they found themselves in. They used a language designed to appeal to their practitioners and attendants but that also reflected their own understanding of how to express ill health. John Haslam provides other key examples in the case of two male patients. The first, many years into his commitment, and after being taken ill with a cough, began to complain that his “victuals were poisoned” before changing tack and arguing that “he had a violent pain in across the stomach, which arose from his naval string at his birth having been tied too short.”

The second, after a lengthy history of commitment, violence and delusions, “complained of pain in his stomach, and said he felt as if he had no intestines. His appetite diminished, and he became melancholic.”

Both men turned to physiological justifications when other behaviours or arguments failed to remedy their situations. In this sense their disordered eating became a new foundation for negotiations with their attendants.

Other maniacs refused food because they “fancied themselves a Corpse.” Their justifications were consequently premised on the contention that there was no physiological reason for them to eat, rather than that ingestion caused physical pain. Most of these patients absolutely “refuse[d] to take nourishment” in consequence.

In the face of their protracted abstinence practitioners turned once again to carefully staged drama. John Conolly, lecturing at University College London in 1830, referenced a famous case of a Bourbon Prince who “imagined himself to be dead, and refused to eat. To prevent his dying of starvation, two persons were introduced to him in the character of illustrious dead like himself, and they invited him…to dine.”

He accordingly ate with a plethora of characters “whilst this fancy prevailed,” the ruse maintained over many nights until he was ‘cured.’ Benjamin Rush, commenting on the same case in his lecture notes, called this therapeutic device “happily suited to the deranged state of his mind.”

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85 Haslam *Observations on Madness and Melancholy*, p.96.
86 Ibid., p.173. See also Register of the maniacal cases in the New York Asylum Bloomingdale, entry dated 4th October 1824, p.56.
87 West Riding Pauper Lunatic Asylum, Medical Case Book 1830-c.1842, p.2.
88 Register of the maniacal cases in the New York Asylum Bloomingdale 1808-1828, entry dated 4th October 1824, p.56.
90 Idem. For another example see Anon *A view of human nature: or, select histories....* (London: S. Birt, 1750), pp.92-93.
91 Rush, Lectures on the Practice of Medicine, p.494 [facing].
and Rush saw the ruse as a means to force the delusion to its apex: disordered eating merely guided them to a productive and practical method for working upon the imagination.

In 1811 the American physician Joseph Mason Cox described some of his patients as follows: “If often happens, from various causes, but most frequently from some mistaken idea or secret vow, that maniacs refuse food” [emphasis in original].92 It certainly appears to have been the case that this form of delusion could result in very specific consumption behaviours. One male patient in Yorkshire claimed that he “has got an order that he is to eat nothing cut with a knife, refuses to take either bread or meat but takes thick oatmeal and water.”93 Another patient continued to undergo force-feeding “tho it gives her much trouble & some pain,” and providing an explanation only “when closely pressed…that she feels she is forbidden to take it.”94 It is possible that the behaviour of another female, at the same asylum, who “refused food in the presence of others but not when left alone” was also a manifestation of a similar delusion.95 Finally, the physician Paul Slade Knight, superintendent at the Lunatic Asylum for the county of Leicester, stated that he had “very frequently known the lunatic refuse food when offered to him at state periods, and yet he would take it readily enough, if permitted to eat when he thought proper.”96 Working along the grain of their patients’ beliefs, these practitioners created the impression that the patient was in control of their consumption choices so as to best facilitate consumption.

The second major category of maniacal abstainers includes those whose food behaviours disclosed a monomania, or partial insanity. These patients’ consistent fixation on one subject was matched by consistent behaviour, such as disordered eating. As ever, patient discourse provided the clues to the motivations for their disordered eating. These most frequently manifested around two themes: fear of injury and religion. At times these aligned with imagined realities. Pinel, for example, described a male maniac who “was perpetually haunted with the fear of being poisoned” but whose discourse “upon every

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92 Joseph Mason Cox Practical Observations on Insanity: to which are subjoined remarks on medical jurisprudence as connected with diseased intellect (Philadelphia: Thomas Dobson, 1811), p.98.
93 West Riding Pauper Lunatic Asylum, Medical Case Book 1818-1820, C85/3/6/1, West Yorkshire Archive Service Wakefield, p.194.
95 York Retreat, Case Book 1A, p.288.
96 Slade Knight Observations on the causes, pp.107-108.
subject, excepting that of his hallucination, was perfectly connected and correct.”97 His was a monomania of suspicion. The Retreat likewise admitted a male diagnosed with monomania because “he imagined poison was given & on his food.”98 Finally one West Riding patient, admitted in February 1821, argued, “that his food was poisoned” but whose claims derived from delusion rather than suspicion: he argued that the poison “was owing to the planets which he can now tread upon.”99

Delusions centred on fear of injury or persecution also informed maniacal food refusal. Pinel, Tuke and Haslam all reference patients who hallucinated that they were “under a sentence of condemnation, for crimes punishable by death, and [strove] to anticipate its execution by the most invincible rejection of food.”100 The West Riding Asylum admitted one female who was terrified that she was in danger of “being devoured by a Bear.”101 Five months after her admittance, and continuing to hallucinate the sounds of an angry bear, she took her food “with great difficulty” before, in June, taking “no food but what is forced down.”102 Although she improved briefly when moved to another ward (away from an engine whose sounds she apparently believed were the noises of the bear grumbling), she quickly became “much more maniacal again & has refused her food.”103 The explanation offered in the notes was only that “she is still in great terror of the bear.”104 Through many months and interactions, the rejection of food was the only method she used to express her reality and her terror.

Food refusal and monomania also aligned around the topic of religion as “erroneous views on religious subjects” informed the diagnosis of religious mania.105 As with religious melancholy, this diagnosis was shaped by wider debates. But religious mania

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97 Pinel A Treatise on Insanity, pp.145-146.
98 York Retreat, Admissions Book 1777-1786, RET 6/2/1/1, Borthwick Institute for Archives, York University, entry no.113.
99 West Riding Pauper Lunatic Asylum, Medical Case Book 1821-c.1823, p.251.
100 See Pinel A Treatise on Insanity, pp.177-178 and Haslam Observations on Madness and Melancholy, pp.92-93.
101 West Riding Pauper Lunatic Asylum, Medical Case Book 1819-c.1823, p.316.
102 Idem.
103 Idem.
104 Idem.
(also called religious insanity) remained a contentious issue amongst medical practitioners. In their 1827 review of leading French psychiatrist Felix Voisin’s *Des Causes Morales et Physiques*, the journal *The Medico-Chirurgical Review* paid a lot of attention to his description of the influence of religion on the mind. Voisin delineated religious insanity into both maniacal and melancholic qualities, describing those who “imagination, constantly dwelling on such subjects…become[s] deranged” and the “histories of suicidal maniacs, urged to the dreadful deed by religious, or rather fanatical impulses” [emphasis in original].\(^{106}\) In the same year, in contrast, Paul Slade Knight boldly proclaimed that “of the nearly seven hundred cases of insanity that I have sedulously treated, I have only *once* ascertained…unquestionable proof, that either a religious or a moral cause produced the disorder” [emphasis in original].\(^{107}\) Instead he argued that “derangement of the mind, though not palpable, had obviously existed, before [the patient] became a raving devotee” although he included one “rare” case of a woman whose religious fixations he described as “the passion of love.”\(^{108}\)

From the mid eighteenth century enthusiasm classified as religious insanity was often discovered through disordered eating. The 1757 *A Dissertation on False Religion* rewrote the hagiography of Saint Theresa as a history of “lunacy” when describing her living “for a considerable time only on fallets” before subsisting “only on such herbs as grow naturally in the fields.”\(^{109}\) The publication denounced her restrictive eating as but an example of wider religious pretense built on “enthusiastic distraction” and “nonsensical incoherent rhapsodies.”\(^{110}\) Several individuals descended into absolute abstinence in the asylum as a means of either imitating or proclaiming themselves Christ. One female at West Riding, for example, “threw her food away” and claimed “that as Christ fasted 40

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\(^{107}\) Slade Knight *Observations on the causes*, p.33.

\(^{108}\) Ibid., pp.33-34. For a cleric writing along similar lines see Richard Graves *An essay on the character of the apostles and evangelists: designed to prove that they were not Enthusiasts; containing the substances of several discourses, delivered in the Chapel of Trinity-College, Dublin* (London: C. Dilly, 1798), pp.4-6 and 93. See also Leigh Wetherall-Dickson “Melancholy, Mad Moon and Marriage: Autobiographical Expressions of Depression” in Allan Ingram, Stuart Sim, Clark Lawlor, Richard Terry, John Baker and Leigh Wetherall-Dickson *Melancholy Experience in Literature of the Long Eighteenth Century* (New York: Palgrave Macmilan, 2011), pp.152-155.


\(^{110}\) Idem.
days she was determined to do the same”.\textsuperscript{111} Another patient at the same asylum began to refuse food and medicine immediately after proclaiming that “there was no Christ upon earth but himself.”\textsuperscript{112} Pinel explicitly classified “superstitious” mania as a form of monomania.\textsuperscript{113} He argued that this class of patient refused food because of their absolute focus on their relationship with God. His therapeutic strategy was to force patients to reason and discern between the two evils of “render[ing] themselves criminal in the sight of God, or to expose themselves to ill treatment” by making decisions as to whether or not to eat.\textsuperscript{114} Pinel’s extreme measure was a response to the fact that, for many of these patients, broken relationships with food realised their unshaken convictions that extreme consumption behaviour was critical to their spirituality. Such convictions necessitated, at times, stronger measures than deployed on other patients.

The final major category of maniacal abstainers involved those for whom disordered eating manifested as a marker of their “paroxysm or periodical...[but] continued insanity.”\textsuperscript{115} Seen as “One of the most dangerous symptoms in some cases of periodical insanity,” “stubborn abstinence” was described as a symptom of acutely heightened passions.\textsuperscript{116} Disordered eating behaviours thus marked periodical oscillations in mental illness. In turn, these behavioural variations were used for insight into the particular degree of derangement that individual was suffering from at any given moment. Because disordered eating behaviours were often recorded by themselves, with little supporting information or discourses, it is reasonable to speculate that behaviour provided the primary pathological evidence for insanity in these cases. By the early decades of the nineteenth century asylum experiences suggested that “maniacs who refused their food have had generally the strongest and most durable paroxysms, and their subsequent depression has been the most deplorable.”\textsuperscript{117}

The onset of abstinence therefore marked the possibility of relapse or degeneration and demanded the most tailored and soothing interventions on the part of all asylum

\begin{footnotesize}
\begin{enumerate}
\item \textsuperscript{111} West Riding Pauper Lunatic Asylum, Medical Case Book 1827-c.1849, C85/3/6/4, West Yorkshire Archive Service Wakefield, p.211.
\item \textsuperscript{112} West Riding Pauper Lunatic Asylum, Medical Case Book 1821-c.1823, p.116.
\item \textsuperscript{113} Pinel \textit{A Treatise on Insanity}, p.23.
\item \textsuperscript{114} Idem., and pp.62-63.
\item \textsuperscript{115} Idem., p.156.
\item \textsuperscript{116} Idem., pp.32 and 96.
\item \textsuperscript{117} ‘The Physician’ as quoted in Tuke \textit{Description of the Retreat}, p.80.
\end{enumerate}
\end{footnotesize}
staff.\textsuperscript{118} These patients required relentless attention: case notes that record the minutest changes in eating behaviours – “has been more maniacal & had refused his food yesterday & to-day” – indicate the consistently high degree of importance placed upon changes in food behaviour by asylum practitioners.\textsuperscript{119} But maniacal paroxysm was also recorded as a facet of resistance. Admission notes often draw parallels between the periodical refusal of food and being “disobedient” to friends or family.\textsuperscript{120} It is further possible to interpret food refusal and “great opposition” to attendants as markers of ongoing patient struggles to resist the new authority of the asylum.\textsuperscript{121} These patients demonstrated the role disordered eating played in patient-practitioner relationships. Disordered eating behaviours gave meaning to patient disorders and shaped therapeutic interactions. Verbal negotiations about disordered eating behaviour allowed both patient and practitioners to navigate imagined and emotive realities. Combined, these patients transformed theories of maniacal illness into a clinical portrait of psychological disturbance.

\textbf{------ III: Changing Behaviours ------}

The previous two sections demonstrated that abstinence accounted for the vast majority of disordered eating behaviours witnessed within the asylum. But many patients experienced disordered food relationships in other ways. Sudden onsets of pica, or the consumption of deleterious substances, account for the most cases in this subset. But sudden changes across all forms of eating behaviours were recorded as clinical evidence. As with abstinence, these behaviours formed both part of wider symptomologies and stood as the primary evidence for diagnosis. The critical difference was that these cases of insanity were generally characterized by the act of disordered eating rather than verbal expressions about that behaviour. But often those behaviours offered clues as to motivations or deliberate purpose. Practitioners thus analysed changes in patient conduct

\textsuperscript{118} See Pinel \textit{A Treatise on Insanity}, p.96.
\textsuperscript{119} West Riding Pauper Lunatic Asylum, Medical Case Book 1821-c.1823, p.189. See also p.39.
\textsuperscript{120} York Retreat, Case Book 2, p.5. See also York Retreat, Case Book 1A, p.25 and York Retreat, Register of Certificates 1819-1827, p.327.
\textsuperscript{121} York Retreat, Case Book 1A, p.44. This frequently manifested via refusal to take either food or medicines. For an example see Allen \textit{Essay on the classification of the insane}, p.71.
because changing or heightening consumption behaviours often proved to be the surface expressions of changing mental states.

In his *Practical Hints for the construction and economy of Pauper Lunatic Asylums* Samuel Tuke described the danger of leaving patients to eat unsupervised by pointing to the consequence that “the strong often devour[ed] the portion intended for the weaker patients.”¹²² His warning drew attention to voracious eaters, a form of disordered eating the asylum physician-superintendent Paul Slade Knight warned, in 1827, defined “Patients in the worst state of insanity [who] absolutely require more than sane persons.”¹²³ Some patients were recorded simply for having “shown an inclination to eat too much.”¹²⁴ For others, described as “addicted to food,” their overeating appears to have coincided with the onset of an attack of insanity.¹²⁵ Still more appear to have eaten with purpose. One female, for example, voraciously consumed food all the while insisting, “mercurial preparations were mingled in [her] food and medicines.”¹²⁶ This contradictory behaviour must however be viewed in the context of the earlier note that she “seemed anxiously to wish for her own dissolution, but had no thoughts of accomplishing her own destruction.”¹²⁷ It is reasonable to speculate that the onset of her voracious appetite reflected her discovery of a new opportunity to realise her plans.

Pica, the consumption of deleterious substances, was a much more common form of disordered eating witnessed within the asylum. As with abstinence, pica represented a degree of patient resistance to both asylum attempts to manage consumption and their prescriptions. One patient, for example, “seized a vial, containing a dram of Argentum Nitrat. [a topical antiseptic]…and at once drank it off,” refusing to swallow an emetic designed to counteract his purpose.¹²⁸ More frequently though the consumption patterns of pica-manifesting patients – predominantly men – revolved specifically around the ingestion of their own bodily products. For example, one twenty-one-year-old male was admitted to Bethlem in 1822 with the notes only that he was “rather silly” and consumed

¹²³ Slade Knight *Observations on the causes*, p.120.
¹²⁴ York Retreat, Case Book 1A, p.269.
¹²⁵ West Riding Pauper Lunatic Asylum, Medical Case Book 1827-c.1849, p.53.
¹²⁷ Ibid., p.100.
“candles, starch, chalk, and other trash, and [drank] urine wherever he could.” Others developed these behaviours whilst staying in the asylum. West Riding attendants faced a male patient who, two weeks after his admission in December 1818, fell into “the habit of eating his own feces.” Four years later the same asylum encountered another male patient who, just under two years into his stay, adopted “the habit...of drinking his own Urine.” In both the latter cases attendants responded by attempting to physically restrict their ability to enact such behaviour. In contrast to the majority of the cases encountered above, no notes are given about patient rationales or arguments concerning their behaviours.

More patients consumed deleterious products whilst exhibiting a broader range of behaviours. One female patient, for example, became “very poorly in consequence of her propensity to bite and swallow things, having swallowed a piece of wood, which stuck in the gullet.” But in her case notes this singular act of consumption became emblematic of a deeper-set “mischievous” demeanour. It was her pica that was highlighted as a specific example of her wayward behaviours and inability to conform to the normative behaviours her attendants were attempting to install. Similarly John Haslam included the case of a “violent and mischievous” individual who was repeatedly confined and constrained on account of his persistent attempts to damage his surroundings. His history of violence extended to attacks on new patients but it was his tendency to use consumption as a weapon that furnished most of the information contained in his case notes:

He was extremely dexterous with his feet, and frequently took off the hats of those who were near him with his toes, and destroyed them with his teeth. After he had dined he generally bit to pieces a thick wooden bowl, in which his food was served, on the principle of sharpening his teeth against the next meal. He once bit out the testicles of a living cat, because the animal was attached to some person who had offended him.

It seems clear that, in these cases, observed disordered eating served as specific clinical

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129 A Constant Observer Sketches in Bedlam, p.250.
130 West Riding Pauper Lunatic Asylum, Medical Case Book 1818-1820, p.120.
131 West Riding Pauper Lunatic Asylum, Medical Case Book 1821-c.1823, p.123.
133 Idem.
135 Ibid., p.148. For a similar case whereby the patient ate their crockery see Nina Fletcher Little Early years at the McLean Hospital…., p.110.
Pica behaviours therefore established and continued to verify insanity. Transitions from one disordered eating behaviour to another served the same purpose. One male patient provides an example. Initially admitted in 1817 as a religious melancholic, he arrived “much emaciated & weak of body,” the result of his “extreme abstemiousness.”

Within two months of admittance his abstinence was joined by self-harming behaviour and a “disponding & mooping” countenance. But it was the change from abstinence to pica that marked his periods of recovery and relapse. The casebook provides the following information:

5th August 1818: About a month ago he swallow’d in the course of a day 43 Dominos made of bone, several large pieces of stone glass & a pine. Some of the pieces stuck in the throat, & were fetched up by an instrument…He takes his food well & appears cheerful, yet still shows a propensity to improper things & requires much watching…

23rd November 1818: He has since made several attempts to injure himself once he suddenly sprung into the prose room fastened the doors within, broke four panes & when the men broke in was laid on the floor eating the glass with all his might which caused much blood to flow from his mouth…seems to enjoy these exploits…

10th February 1819: He still continues to watch for opportunities to injure himself by any means in his power…Sometimes shows an inclination to eat immoderately at others to refuse his food.

These details of his acts of consumption populate the majority of his case history, specific food behaviours playing a preeminent role in the asylum’s assessment of his insane condition.

Changing disordered eating behaviours could also reflect changing delusions. In these instances discourse about consumption patterns played a more central role in the construction of case notes. *Sketches in Bedlam*, for example, published the case of a gardener whose derangement commenced with a strange notion that he was to fall victim of poison…[and thus] three months preceding his transmission to [Bethlem] he refused all other sustenance but milk alone.”

His behaviour changed almost immediately upon admission so that “he took his food without the slightest symptom of doubt or

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136 For a case where the patient’s explanation was provided see Benjamin Gooch *Medical and Chirurgical Observations, as an Appendix to a former Publication* (London: G. Robinson, 1773), p.177.
137 York Retreat, Case Book 1A, p.199.
138 York Retreat, Case Book 1B, p.123.
139 Idem. and p.132. See also York Retreat, Case Book 1A, p.199.
140 A Constant Observer *Sketches in Bedlam*, p.176.
But this new consumption behaviour did not last long and the case study concluded with the comment; “He has latterly imbibe the extraordinary notion of his being filled with frogs, and that all the food he takes goes to their support.”\footnote{Ibid., p.177.} Again, his case was dominated by his disordered eating. His changing behaviour, from extremely selective eating to normative consumption, appeared on the surface to mark a degree of restoration: instead, his expressed motivation for consumption confirmed his ongoing mental illness.

Some patients created the illusion of adapting their food behaviours so as to conform to asylum prescriptions and management regimes. In reality they found new ways of using disordered eating behaviours to enact resistance. In 1818 the West Riding asylum saw such a case in the shape of a young woman who was admitted after several suicide attempts. Force-fed, she appears to have developed a new form of disordered eating behaviours in order to avoid the discomfort of that procedure: “Takes her food rather better but vomits everything as soon as taken, upon careful watching there is reason to conclude she produces it by putting her finger down her throat.”\footnote{West Riding Pauper Lunatic Asylum, Medical Case Book 1818-1820, pp.302-303.} Similar behaviour reoccurred at the same asylum in 1825. In this instance a male patient, initially admitted refusing food, developed a different pattern of disordered eating approximately one year into his confinement when he “produced vomiting by his finger if not under restraint.”\footnote{West Riding Pauper Lunatic Asylum, Medical Case Book 1824-1826, C85/3/6/97, West Yorkshire Archive Service Wakefield, p.39.} The patient offered the rationale that he felt “loaded after eating” but this seems to have been dismissed by the medical practitioners.\footnote{Idem.} It is reasonable to speculate instead that both patients found a new, less combative way to minimize their consumption and upset their dietetic prescriptions.

But disordered eating manifestations could change in intensity rather than form. For example, one West Riding Asylum patient was admitted as a melancholic but just one month later was reclassified as “not so maniacal” any more.\footnote{West Riding Pauper Lunatic Asylum, Medical Case Book 1823-c.1826, C85/3/6/3, West Yorkshire Archive Service Wakefield, p.343.} The reclassification mirrored a change in her relationship with food: admitted refusing “all food,” by May she
took her food although “with great difficulty.”\footnote{Idem.} Whilst the behaviour of abstinence remained the primary symptom of her insanity, the exact degree continued to oscillate through the following months: in July she started “to take some food without force” but by August appeared “to be sinking entirely for want of food, which there is no getting her to take but by force.”\footnote{Ibid., pp.343-344.} Another, a male religious melancholic, was described in 1803 as “shy at taking food, which, tho he takes a sufficiency, is done with much hesitation” before, in 1826, being readmitted close to death when “he took no food…without having his mouth opened to put it in.”\footnote{York Retreat, Case Book 1A, p.85.} At times a fixed pattern of food-behaviour remained the only consistent record in the case of patients reclassified multiple times as suffering from melancholy, hypochondriasis and mania.\footnote{See York Retreat, Admissions Book 1777-1786, entry no.77 and York Retreat, Case Book 1A, p.79.}

Finally, it is worth briefly mentioning those patients whose expressions of disordered eating always fell at the mildest end of the spectrum. This thesis has previously alluded to the important role disordered eating manifestations played in the development of a vision of mental illness that spanned the divide between health and illness. Within the asylum patients appear to have engaged in disordered eating to various degrees. Practitioners were, nonetheless, careful to record even the slightest of dispositions to this symptomology. Some patients were accordingly admitted to asylums with but sparse mentions of how they were “rather reluctant to take food” or showed a “disposition to refuse food” the only clues as to their diagnoses and confinement.\footnote{York Retreat, Register of Certificates 1819-1827, p.302 and York Retreat, Case Book 2, p.7.} Others were recorded simply as “extremely irregular in taking [their] food” or were described as only taking “food occasionally, except she can steal it.”\footnote{York Retreat, Case Book 1A, p.100 and West Riding Pauper Lunatic Asylum, Medical Case Book 1827-c.1849, p.233. See also Allen Essay on the classification of the insane, p.158.} Asylum practitioners also meticulously recorded those who exhibited merely a disposition to refuse food because of the motivations the patients offered. These include patients who took “food shyly from an apprehension that [they] cannot pay for it & that [they did] not deserve it” or had “at times shewn a disposition to refuse food from an apprehension that it was right to restrain herself in the indulgence of her appetite.”\footnote{Ibid., pp.259 and 133.} In
these cases even the slightest manifestation of disordered eating unearthed clues as to this patients’ delusion. There are, furthermore, countless instances, undetailed here, where case notes or admission records mention in passing some degree of disordered eating. A decision not to eat dinner one day did not always indicate a broader pattern and these records have not been included. That does not imply that their behaviours were insignificant but, rather, that those records speak more to the all-pervading interest in patient dietary and consumption patterns than to the role of disordered eating in these individual cases.

------ Conclusion ------

This chapter has demonstrated that disordered eating was a constant feature of asylum life. Within asylum discourse, eating was a key language through which insanity was expressed, experienced and diagnosed. Disordered eating provided recordable, clinical evidence of mental illness as patients and practitioners negotiated from the start around issues of food consumption. Most often this negotiation took the form of persuasion and remonstrance designed to appeal to patients’ emotional attachments to their hosts. For patients, disordered eating symptoms were expressions of their realities. They therefore offer an opportunity to access their innermost thoughts, beliefs and emotional states. Most frequently these patient realities and emotional states were reflected in food refusal, or abstinence, but many other forms of disordered eating manifested within asylum walls.

This chapter is built around the case study and asylum case notes. It does not suggest that these offer the complete picture of what it meant to be a patient in the early asylum. Detailed case records do not survive for all asylums: vague references to discharges for ‘poor bodily health’ are, for example, the only clues St Luke’s Hospital left as to the frequency of disordered-eating cases. The sources used above are, furthermore, shaped by factors other than patient expressions or biological realities. They are limited in the sense

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154 West Riding Pauper Lunatic Asylum, The Medical Case Book 1827-1830, is littered with such references.

155 For an example of this in action see William Pargeter Observations on Maniacal Disorders (Reading: for the author, 1792), pp.58-59.
that the patient’s voice survives translated and edited by practitioners. The above statements about patients’ mental states must be read in light of this consideration.

Different types of disordered eating behaviours presented different threats to both the physiological well being of the patients and the efficacy of the asylum routine. This was especially true in the case of prolonged abstinence but psychiatrists describe forcing patients to eat only when the threat to life required more active measures.\textsuperscript{156} It was a valid concern: in the 1820s Massachusetts Hospital and the Friends Asylum at Frankford, Pennsylvania recorded the deaths of patients from “Abstinence and long and gradual decay” and another “who was greatly emaciated and debilitated by a constant refusal of food previous to admission.”\textsuperscript{157}

Disordered eating symptoms marked diagnoses of insanity prior to, during and even after confinement ended.\textsuperscript{158} In that sense descriptions of disordered eating offer insights into the witnessing of insanity by practitioners and families alike. Drawing on the case of a female patient who refused food, Erasmus Darwin argued that ideas and hallucinations were revealed in behavioural and verbal forms.\textsuperscript{159} For Darwin, and for many asylums on both sides of the Atlantic, therapeutic approaches were at their most “effectual” when they were deployed in response to “the probable designs of the patient.”\textsuperscript{160} These patients’ disordered eating symptoms were deliberately described as either food refusal or an unusual attitude towards eating. For the first time numerous practitioners on both sides of the Atlantic recorded food-related behaviours and verbal expressions almost entirely without resorting to the physiological language of suspended or disturbed stomachs. Their notes, their psychopathological databases, were shaped in direct response to patient attempts to make their internal worlds tangible through behavioural and verbal forms.

\textsuperscript{156} Willis \textit{A Treatise on Mental Derangement} (1823), p.202. See also Mason Cox \textit{Practical Observations on Insanity}, p.98 and Ferriar \textit{Medical Histories and Reflections}, p.91.


\textsuperscript{158} See Elizabeth Evans to William Tuke, 24\textsuperscript{th} February 1797, Correspondence 1797, RET 1/5/1/2/2, Borthwick Institute of the Archives, York University, p.[1] of unnumbered pages.

\textsuperscript{159} Darwin \textit{Zoonomia}, p.358.

\textsuperscript{160} Idem. See also Haslam \textit{Observations on Madness and Melancholy}, p.173.
This thesis has exposed the important role disordered eating played in the development of psychiatry. Exploring the parallel histories of disordered eating and insanity it has offered a new interpretation for the years 1750-1830, a time long considered the formative period for the development of psychological theory. But it has stressed that this was a time when ideas about the etiology, prognosis and best treatment of insanity were still developmental. These were years of experiment. In 1758 Bethlem’s resident physician John Monro lamented “we do not know the true cause of the distemper in one third of those unfortunate persons, who are intrusted to our care” [sic].1 By the close of our period questions remained unanswered. At no point were other worldviews fully abandoned. Well into the nineteenth century the possibility that both insanity and disordered eating were the product of either divine intervention or physiological disturbance lingered on. There was no universal experience or interpretation of either.

Disordered eating cases provide solid evidence that the years 1750-1830 witnessed the steady reclassification of insanity as mental illness. At first this reclassification was premised on the idea that such complaints were purely physical and thus fell under the remit of the medical rather than spiritual healer. In the latter half of the eighteenth century insanity was described through a language of somatopsychic then psychosomatic disturbance. By the nineteenth century, a trans-Atlantic community of practitioners was formed around the premise that disordered eating symptoms were psychogenic. Disordered eating played a critical role in these schools of thought, providing a complete spectrum of what mental illness looked and sounded like. These symptoms transformed theories about mental health and mental illness into a medical discipline according to the standards of the day.

This thesis focused on disordered eating because it played such a large role in contemporaneous experiences of insanity. In tandem, insanity and disordered eating were medicalized and pathologized. The early psychiatrists seem to have found their strongest voice when they were able to explain behaviours and actions that, on the surface, appeared to contradict the idea of mental disturbance. Thus, for example, they attributed

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1 John Monro Remarks on Dr Battie's treatise on madness (London: John Clarke, 1758), p.23.
the willful act of restricting one's food to an error in judgment or a deluded purpose. In the midst of uncertainty, observable symptoms provided common ground and diagnostic confidence for practitioners and communities alike.²

Disordered eating provided practitioners on both sides of the Atlantic with a body of evidence that could be measured and recorded. As a result, the early psychiatrists were able to construct case records of illness and cure in line with both practitioner and public conceptions of what medicine looked like. The specialist tools and training required to carefully diagnose and treat these symptoms consequently became a means of demarcating the psychiatrist from the street quack or everyman healer. These precedents would only develop further into the nineteenth century.

But psychiatry did not develop in the vacuum of the medical arena. As numerous historians have argued, the profession developed when states, families and communities turned to the psychiatrist for answers. This thesis has shown that, for these early years, disordered eating helped other communities shape a discourse of mental illness. As disordered eating helped practitioners to refine their ideas about the mind, so too other groups made sense of emotional and cognitive disturbance when they were able to map both onto witnessed manifestations. The disordered eating cases explored in the previous pages provide evidence of this adoption, even when they suggested disparate ideas of mental illness. Descriptions, legal verdicts and the building and patronage of the public asylum all suggest that, by the turn of the nineteenth century, the general public accepted psychological rhetoric and the authority of the psychiatrist-practitioner.

In 1873 William Gull published an article entitled ‘Anorexia Nervosa. (Apepsia Hysterica, Anorexia Hysterica).’ In the course of this brief paper he described two teenage girls suffering from a range of physiological complaints born of their “extreme emaciation.”³ Gull’s description of their ‘anorexia nervosa’ encapsulated all the characteristics we have seen over the course of this thesis. His case notes included highly detailed descriptions of his patients’ bodies but he admitted that their “repugnance to

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² By observable I include auditory symptoms.
food” commenced “without apparent cause.”4 Gull’s diagnosis and prognosis echoed the psychiatrists we’ve encountered in the previous pages:

The want of appetite is, I believe, due to a morbid mental state... The treatment required is obviously that which is fitted for persons of unsound mind. The patients should be fed at regular intervals, and surrounded by persons who would have moral control over them; relations and friends being generally the worst attendants.5

Gull further explained his decision to use the term ‘anorexia nervosa’ instead of ‘anorexia hysterica’ “since the disease occurs in males as well as females, and is probably rather central than peripheral.”6 As this thesis has demonstrated, his decision matched the almost gender-neutral division of disordered eating cases in the years 1750-1830. Women were more prevalent in the asylum, but that is probably accounted for by the fact that they were often dominated the poorest segments of society, the source of most public asylum patients. In reverse, it appears that men provided most of the case studies published for wider audiences.

Gull’s contribution has defined many histories of eating disorders. Alongside the French physician Charles Lasègue, Gull gave definition to a category of individuals that has only expanded over the past one hundred and fifty years. His classification of his patients as those whose “perversions of the “ego” [was] the cause and determining the...course of the malady” hinted at what has become the dominant feature of present-day eating disorders.7 This was cemented by the 2013 publication of the fifth edition of the Diagnostic and Statistic Manual of Mental Disorders (DSM), which listed diagnostic criteria for eating disorders as disturbed consumption behaviour and food relationships that manifest a self-evaluation “unduly influenced by body shape and weight.”8 The DSM further defined eating disorders by the lack of normative feelings towards either food or the consumption of food and “socially normative practice” with regards to eating behaviours.9

Ultimately eating disorders are diagnosed through behaviour but defined by mental

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4 Ibid., p.313.
5 Ibid., pp.310-311.
6 Ibid., p.311.
9 Idem.
health issues. There are major parallels to be drawn between this modern concept and the period under examination. Modern descriptions of significant weight loss echo the extreme emaciation observed by practitioners, whilst “obsessional traits” and “depressive symptoms” seem to align with the focused attention and melancholia the early psychiatrists witnessed amongst some of their patients. Furthermore, some of the patients the early psychiatrists encountered manifested a form of body-dysmorphia whilst others seem to have used food relationships as a point of negotiation, agency and resistance. It is less apparent that practitioners (or, indeed, any other commentators) connected individual eating choices to reactions against society or culture.

But there can be no certainty in mapping current presentations onto past definitions of terms or past examples of unusual patterns of consumption. This thesis deliberately separated the lived and witnessed experiences of disordered eating in the years 1750-1830 from modern-day concepts of eating disorders. It focused instead on the many ways changing concepts about what caused disordered eating mirrored and furthered changing ideas about what the true character of insanity was. This thesis is not a history of eating disorders. Disordered eating was never the primary determinant or a condition in its own right – it was always a symptom, a leading diagnostic indicator used to access the insane condition.

The difference between the years 1750-1830 and the present lies in the way surrounding cultures and societies interpret motivations. That is what this thesis has traced: a changing conception of why individuals engaged in disordered eating. This thesis is unique in its use of the leading diagnostic indicator of disordered eating as a guide to the way various individuals encountered, witnessed and judged insanity. Its narrative offers groundbreaking insight into the wider development of schools of thought and therapy that, collectively, reimagined what it was to be insane.

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10 Idem.
11 Idem. The DSM lists industrialized nations, genetic predispositions and “cultures and settings in which thinness is valued” as risk and prognostic factors for these impairments to “physical health or psychosocial functioning.”
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Periodical Articles


APPENDIX ONE:
ASYLUM SPACES AND DESIGN

1. An early nineteenth century asylum plan, with designated individual spaces.¹

Numbers for key areas (mirrored rooms is reflective of separation of patients by gender):

4. Committee Room.
6. Apothecary’s shop.
8. Laboratory.

10. Yard.
15. Cells for dirty and noisy patients: “As they are near the attendants, cleanliness will be attended to.”³
19. Strong cells.
21 & 22. Swing, shower bath, cold bath and warm bath.
29. Gravel walk for “free communication of air”.⁴
35. Single cells.
37. Water closets.

Spurzheim added the following further instructions:
– “Both wings of the front building are only on the ground floor, and destined for the dirty, noisy, and dangerous patients.”
– “longitudinal wings may be one or two stories high; they are isolated from all sides for the sake of free circulation of air; they contain the quiet and innoxious patients.”⁵

¹ J.G. Spurzheim Observations on the deranged manifestations of the mind (Boston, MA: Marsh, Capen and Lyon, 1833), Appendix plate 3.
² Ibid., p.259.
³ Idem.
⁴ Idem.
⁵ Ibid., Appendix plate 3.
2. Pauper Lunatic Asylum for Middlesex, built 1831.\(^6\)

\(^6\) W.C. Ellis *A treatise on the nature, symptoms, causes, and treatment of insanity: with practical observations on lunatic asylums, and a description of the pauper lunatic asylum for the county of Middlesex, at Hanwell...* (London: S. Holdsworth, 1838), [insert facing front page].
3. The Retreat, Ground Floor.\textsuperscript{7}

APPENDIX TWO:
COMMITMENT PAPERS AND ADMISSION CERTIFICATES

1. Certificates to be presented at St Luke’s Hospital with the individual for examination, 1777.

This certificate represents a standard format for such documents in both England and America.
Note in particular the new insistence that the practitioner had at least “visited” the patient as well as the requests for information about previous therapeutic attempts.

2. Commitment Paper questions, Western State Hospital, Virginia, 1830.²

1. What is the Patient’s age? Married or Single? Number of Children?
2. Employment and reputed circumstances?
3. What were the first evidences of mental derangement?
4. What change has occurred in mental or bodily condition since the attack?
5. Does the disease appear increasing, declining or stationary?
6. What do friends and neighbors consider to be the cause of derangement?
7. Is deranged mind evinced indifferently on various subjects, or chiefly on a few or a single one? Mention particularly any permanent hallucination or mental deception?
8. Are there any periodical exacerbations or improvements? Any entirely rational intervals? And of how long duration?
9. Has any disposition to self-injury been evinced? Any effort to injure others?
10. Has any restraint or confinement been imposed, and what?
11. Has there been any former attack? When, and of what duration?
12. What connections have been insane?
13. Mention former habits?
14. Also mention the history of any bodily disease, suppression of evacuations, eruptions, sores, injuries, &c., which may have afflicted him?
15. What curative means have been pursued? The effect? Say especially whether depletion by bloodletting, cathartics, low diet, &c. have been employed, and to what extent?

² Western State Hospital, Commitment Papers, Western State Hospital Collection, Series IV, Subseries D, Box 215, Folder 10, Library of Virginia.
APPENDIX THREE: ASYLUM PATIENT STATISTICS

1. Patient Discharge Outcomes at the Lunatic Hospital, Manchester, from opening to 1795.¹

¹ Statistics compiled from Public Infirmary and Lunatic Hospital, Manchester A Report of the State of the Infirmary, Dispensary, Lunatic Hospital and Asylum, in Manchester, From the 25th of June 1794, to the 24th of June, 1795, No.43 (Manchester: G. Neilson and Co., 1795), p.4.
2. Patient Discharge Outcomes at St Luke’s Hospital, London, from opening to 1786.²

3. Patient Discharge Outcomes at the Pennsylvania Hospital, from 1754-1761.\textsuperscript{3}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{chart.png}
\caption{Patient Discharge Outcomes at the Pennsylvania Hospital, from 1754-1761.}
\end{figure}

\textsuperscript{3} Statistics compiled from Benjamin Franklin Continuation of the Account of the Pennsylvania Hospital; From the First of May 1754, to the Fifth of May 1761 (Philadelphia: B. Franklin and D. Hall, 1761), pp.53, 57, 61 and 65 and Benjamin Franklin Some account of the Pennsylvania Hospital; from its first rise to the beginning of the fifth month, called May, 1754, rev. ed. (Philadelphia: The office of the United States’ Gazette, 1817), p.82.
4. Patient Discharge Outcomes at the Pennsylvania Hospital, from 1800-1812.⁴

5. Patient Outcomes at the Asylum for the Insane (or Asylum for the relief of persons deprived of the use of their reason), Frankford, PA, from 1818-1830.\textsuperscript{5}

\begin{center}
\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{graph.png}
\caption{Graph showing patient outcomes at the Asylum for the Insane from 1820-1830.}
\end{figure}
\end{center}

6. Patient Outcomes at the New-York Hospital and Bloomingdale Asylum, 1804-1812.⁶

7. Patient Outcomes at the New-York Hospital and Bloomingdale Asylum, 1813-1820.\textsuperscript{7}

\textsuperscript{7} Idem.
APPENDIX FOUR: DIETETICS AND HOSPITAL PATIENTS

1. John Burges, Lecture notes 1760s-1790s.¹

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<tbody>
<tr>
<td></td>
<td><strong>BREAKFAST</strong></td>
<td><strong>DINNER</strong></td>
<td><strong>SUPPER</strong></td>
<td><strong>BREAKFAST</strong></td>
<td><strong>DINNER</strong></td>
<td><strong>SUPPER</strong></td>
</tr>
<tr>
<td><strong>FRIDAY</strong></td>
<td>See Monday.</td>
<td>A Pint of Plum Broth.</td>
<td>See Monday.</td>
<td>A Pint of Plum Broth.</td>
<td>Two Ounces of Cheese or Butter.</td>
<td></td>
</tr>
</tbody>
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¹ John Burges, Lecture notes, 1760s-1790s, MS 180, Royal College of Physicians, pp.27-28.

(Sunday; Tuesday; Thursday; Saturday)  
Breakfast: A Pint of Milk Pottage or Water Gruel.  
Dinner: A Pint of Plumb Pottage, and four Ounces of Bread Pudding.  
Supper. A Pint of Milk Pottage or Water Gruel.  

(Monday; Wednesday; Friday)  
Breakfast. A Pint of Milk Pottage or Water Gruel.  
Dinner. A Pint of Rice Milk.  
Supper. A Pint of Milk Pottage or Water Gruel.  

The Patients upon Milk Diet shall also have: One Load of Bread per Day and Three Pints of Drink per Day, one Part whereof shall be Milk, and two Water.


|        | **BREAKFAST**                               | **DINNER**                                      | **SUPPER**                                     |
|--------|---------------------------------------------|------------------------------------------------|
| **SUNDAY** | Water gruel with bread, butter, and salt. | Mutton, beef, veal, and sometimes pork, with the best table beer. | Bread and cheese, or bread and butter, with beer. |
| **MONDAY** | See Sunday. | Broth. | Bread and cheese, or bread and butter, with beer – larger allowance. |
| **TUESDAY** | See Sunday. | See Sunday. | See Sunday. |
| **WEDNESDAY** | See Sunday. | See Monday. | See Monday. |
| **THURSDAY** | See Sunday. | See Sunday. | See Sunday. |
| **FRIDAY** | See Sunday. | See Sunday. | See Sunday. |
| **SATURDAY** | See Sunday. | See Monday. | See Sunday. |

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2 John Bayly's Case Book, MS 105, Royal College of Physicians, p.29.
3 Taken from Thomas Dunston's testimony in “Report from the Select Committee on the State of Lunatics” *The Edinburgh Medical and Surgical Journal*, Vol.4, Part I (1st April, 1808), p.140.
4. McLean Hospital (then known as Charlestown Asylum), 1823-1824.4

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<td><strong>BREAKFAST</strong></td>
<td><strong>SUPPER</strong></td>
<td><strong>BREAKFAST</strong></td>
</tr>
<tr>
<td><strong>SUNDAY</strong></td>
<td>Coffee, bread, butter, cheese.</td>
<td>Soup, meat, vegetables, bread; or beans and peas, baked, and pudding.</td>
<td>Mostly broth, bread and vegetables. No cheese.</td>
</tr>
<tr>
<td><strong>MONDAY</strong></td>
<td>Shells, bread, butter, cheese.</td>
<td>Roasted beef or veal, or lamb, pork or mutton. Vegetables, bread and pudding.</td>
<td>See Sunday.</td>
</tr>
<tr>
<td><strong>TUESDAY</strong></td>
<td>See Sunday.</td>
<td>Salt beef boiled, vegetables, bread, pudding, or fresh fish, vegetables and pudding.</td>
<td>See Sunday.</td>
</tr>
<tr>
<td><strong>THURSDAY</strong></td>
<td>See Sunday.</td>
<td>See Tuesday.</td>
<td>See Sunday.</td>
</tr>
<tr>
<td><strong>FRIDAY</strong></td>
<td>Chocolate, bread, butter, cheese.</td>
<td>See Monday.</td>
<td>See Sunday.</td>
</tr>
<tr>
<td><strong>SATURDAY</strong></td>
<td>See Sunday.</td>
<td>Fresh or salt fish, vegetables, bread.</td>
<td>See Sunday.</td>
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5. Description of diets at the Lunatic Asylum of Kentucky, 1830.5

Breakfast: well baked corn and wheat bread, with butter and good coffee or milk, and frequently molasses.
Dinner: meat (usually boiled), but chiefly soup with good vegetables and bread.

“The number of meals and the kind and preparation of food, we think, are well regulated in this institution; but we very much apprehend that a due attention to the quantity allowed is not always sufficiently regarded.”

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4 Compiled from Nina Fletcher Little *Early Years of the McLean Hospital, recorded in the journal of George William Folsom, apothecary at the asylum in Charlestown* (Boston: Francis A. Countway Library of Medicine, 1972), pp.71-72.

APPENDIX FIVE:
DISORDERED EATING: THE MANIFESTATION RATE

This appendix traces the frequency with which disordered eating occurred as a manifestation. It concerns publications about and case notes drawn from public asylums. The percentage of cases which include, in some form, a type of disordered eating, are given on the right, with the author and title on the left. Thus, for example, in John Haslam’s Observations on Madness and Melancholy, 32% of the cases he retold included disordered eating in some shape or form over the course of their histories.

1. York Retreat Case Book 1B, RET 6/5/1/1B, Borthwick Institute for Archives: 7.5%

2. York Retreat, Register of Certificates 1819-1827, RET 6/1/1 A/B, Borthwick Institute for Archives, York University: 12%

3. York Retreat Case Book 1A, RET 6/5/1/1A, Borthwick Institute for Archives: 13%

4. York Retreat Case Book 2, RET 6/5/1/2, Borthwick Institute for Archives. 24%


6. Francis Willis A Treatise on Mental Derangement (London: Longman, Hurst, Rees, Orme, and Brown, 1823): 100%
2. Disordered Eating Cases by Gender and Age at the York Retreat, 1819-1827.¹

![Bar chart showing disordered eating cases by gender and age at the York Retreat, 1819-1827.]

3. Statistics correlating food refusal with forms of violence.²

![Bar chart showing statistics correlating food refusal with forms of violence.]

¹ Statistics compiled from York Retreat, Register of Certificates 1819-1827, RET 6/1/1 A/B, Borthwick Institute for Archives, York University.
² Statistics compiled from York Retreat, Case Book 1A, RET 6/5/1/1A, Borthwick Institute for Archives, York University, York Retreat, Case Book 1B, RET 6/5/1/1B, Borthwick Institutite for Archives, York University, and York Retreat, Case Book 2, RET 6/5/1/2, Borthwick Institutite for Archives, York University.
APPENDIX SIX:
FORCE-FEEDING IN THE ASYLUM

The following quotes are descriptions and accusations regarding the experience of force-feeding in both madhouses and public asylums. Included also are descriptions of new tools and instruments developed to improve patient experiences.

1. 1739: a patient description:

“if Prisoners in this Madhouse refuse to take what is ordered them, there is a terrible iron Instrument put into their mouths to hold down their tongues, and to force the physick down their throats.”

2. 1760: a Newgate ordinary records a reference to force-feeding at Bethlem:

“It was suggested by a sagacious gentleman of the law, to treat him as they do lunatics in Bedlam, who refuse to eat or take medicines, (a common case) by forcing their food, or physic, into them.”

3. 1809: John Haslam describes the process at Bethlem (with picture attached):

“A little address will obviate the determination of the patient to keep his teeth closed: he may be blindfolded at the commencement, which never fails to alarm him, and urges him to enquire what the persons around him are about: causing him to sneeze, by a pinch of snuff, always opens the mouth previously to that convulsion, or tickling the nose with a feather commonly produces the same effect.
With delicate females, where one or more of the grinder-teeth are wanting, the finger may be introduced on the inside of the cheek, which being strongly pressed outwards will prevent the patient from biting, and form a sufficient cavity to pour in the liquid.”

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1 Alexander Cruden The London-Citizen exceedingly injured: or a British inquisition display’d, in an account of the unparallel’d case of a citizen of London, bookseller to the late Queen, who was in a most unjust and arbitrary Manner sent on the 23d of March 1737/8, by one Robert Wightman of Edinburgh, a mere Stranger, to a private madhouse..., 2nd ed. (London: T. Cooper and A. Dodd, 1739), p.7.
4. 1813: Samuel Tuke describes the process at the York Retreat:

“[Force-feeding is]…the most painful duty, which the attendant has to perform…The patient is placed in a rocking chair, which of course allows the height and position of the head to be varied…The most difficult part of the business is…to unlock the mouth. For this purpose, the superintendent, after trying a variety of instruments, generally employs the handle of a small door lock key, and having pressed it between the teeth, he turns it round by the other end, and thereby raises the mouth at his pleasure. Another attendant then introduces the food, which is in a liquid state, and contained in a strong spoon…not, in a single instance, [has there] been the occasion of any injury to the patient…[as the] master and mistress of the mad-house” should alone be entrusted with such a grave task.4

5. 1816: a surgeon’s description of madhouse practices:

“The vehicle commonly employed to convey food, is a sort of tea-pot with a very long spout, in the use of which, unless great care be taken, the danger of strangulation is imminent. The spout is generally too long; no regular method of opening the mouth is thought of; a large key is commonly employed, and used with such impatient that the lips and guns are torn, and the teeth often forced out. An instrument might be regularly used for opening the mouth, of a simple construction, consisting of two metallic plates united at one end, between which a screw acting gradually, obviates all danger, and allows no greater opening than is sufficient for the introduction of nutriment…[one keeper was] in the habit, when feeding [the patient], of forcing down, with every mouthful of food, a tea-spoon-full of salt…[another whose] teeth were completely loosened by the brutal manner of forcing the food, and several displaced ; her gums were putrid.”5

6. 1823: A description of force-feeding in Bethlem:

“At last recourse to the elastic bottle and tube were found absolutely necessary to keep him alive…The bottle was filled with rich broth, to which eggs beaten up and some wine were added. The pipe was passed up his nostril, through the palate of his mouth, by which means the nutriment was conveyed to his stomach; and this operation was performed daily for some time.”6

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6 A Constant Observer Sketches in Bedlam; or characteristic traits of insanity (London: Sherwood and Jones, 1823), p.40.
7. 1826: a surgeon and proprietor of a madhouse:

“I can truly aver, from the experience afforded by an establishment to the duties of which I have been accustomed for many years, that no part of actual and personal superintendence can be more disagreeable or revolting, than the task of forcing food upon a contumacious patient...The utter unfitness of the vessel in common use for this purpose, technically called the “boat,” imposes upon the attendant a duty at all times productive of dissatisfaction, if not disgust, and what is worse, generally involves the patient in a series of unpleasant, and painful efforts, among which, injury to the mouth and teeth is a frequent occurrence...a method which I have now pursued during ten years...[is to build] a hollow metallic pipe, bent at the extremity, into a crescentic curve. Midway between the turn and the point, is an opening communicating with the cavity of the instrument. The other end of the pipe screws into the top of a syringe, and this forms the apparatus and means of introducing liquids into the mouth, without unclosing the teeth...The patient should be placed on a bed, an assistant inclining the head backward, and keeping it steady, at the same time compressing the nostrils with the finger and thumb. The pipe having been screwed to the syringe, its joint is to be immersed in the liquid to be injected, (whether food or medicine) and the syringe charged, by drawing up the piston. It is then to be introduced into the corner of the mouth, and passed along between the teeth and the cheek, the shaft of the pipe parallel to the front teeth; the point inclining downwards towards the gums, and in this direction the extremity slides into the space behind the last molar tooth, and is projected into the mouth by the pipe being brought to a right angle with the lips...the nostrils being closed, the patient is driven to the necessity of breathing by the mouth, previously to which, the fluid must be projected...fluid should be injected in small quantities, not exceeding a tablespoonful at a time” [emphasis in original].

8. 1827: a physician describing his design (with picture attached):

“I cannot call to mind more than one instance, where I thought it expedient to force a deranged person to take food; and I believe in that case I acted wrong. Patient and address seem all that are necessary...the means to compel a patient to swallow either food or medicine should be as constantly in the possession of the practitioner as any other instrument...

THE KEY. The oval part consists of a plate of iron, about a quarter of an inch thick, (the edges being rounded and polished,) and of a size to fill the cavity of the mouth when the jaws are extended : in the centre is a hole about half an inch diameter. In using it, the Key is to be introduced edgewise, and then turned so, that it will fill the whole space, or nearly so, behind the upper and lower

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sore-teeth, and then the food can be introduced by the hole...by means of a convenient sized pump, made on the principle of the stomach-pump, and this Key, either food or medicine may be injected into the stomach in any quantity, without being obliged to resort to the harassing, and very offensive operation of compressing the patient’s nostrils, so as to force him to swallow before he is enabled to breather” [sic].

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