Institutionalizing Gender

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Institutionalizing Gender: Madness, the Family, and Psychiatric Power in Nineteenth-Century France.


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HE FIRST FRENCH ASYLUM DOCTORS aimed to cure patients of mental alienation and professionalize their medical subspecialty at a time when change represented the only constant, working against a backdrop of political turmoil, fluctuating class norms, and the rapid expansion of the centralized nation-state. These alienists, like their patients, experienced the early decades of the nineteenth century as if it were a new world—one in which doctors themselves helped define French society’s core values while attempting to impose order amid chaos. In the process, they formulated theories of the mind that intertwined with and gave force to emergent class-based standards regarding gender and family life.

Psychiatric assumptions about healthy families often served to reinforce bourgeois gender values by treating them as normative. Like postrevolutionary legislators, doctors believed the relationship between the individual and the state was mediated through the family and that the home ideally served as a bedrock against the frightening changes afflicting French society as a whole. The familialist thrust of French law and medicine held strong throughout the nineteenth century despite considerable differences between various governments (which included three republics, two empires, and several monarchies). Indeed, the dramatic political shifts that occurred from 1789 to 1871 help explain why the source of social stability would have to come from outside the realm of politics proper. The (re)creation of seemingly happy families—economically productive, loving, and secure—had the power to stabilize the individual as well as the nation. Asylum doctors considered the professionally successful married bourgeois the rational man par excellence. His happily domesticated wife represented the ideal woman, and bonds of genuine affection supposedly linked husband to wife and parents to children.

It is tempting to interpret early alienists’ efforts to enforce these values among their patients as attempts to discipline the popular classes and reinforce restrictive norms among their own. Yet, psychiatric understandings of the home—and
the gender- and class-based social expectations it came to symbolize—were de-
doubtedly ambivalent. The most significant stresses during the nineteenth century,
particularly for bourgeois and middle-class people such as asylum doctors, re-
volved around family life. Early alienists therefore suggested mental patients had
the greatest chance of regaining sanity when they were far from their relatives.
They likewise never tired of pointing out that the sources of mental alienation
often resided in the “breast of the family.” Asylum doctors nevertheless argued
a patient’s resumption of his or her familial role constituted the end goal of all
treatment measures and even proof of cure. In other words, doctors recognized
that social pressures related to home life often contributed to mental collapse,
but they also implied a rational person would not appear to struggle with these
challenges at all. In the meantime they traversed this unsettled gender landscape
and began to construct their own identities as professional men.

This chapter explores the early history of French psychiatry and serves as an
introduction to themes that will be picked up in later chapters. Each section rep-
resents a stage of the patient experience, from the onset of mental illness, to the
patient’s arrival in the asylum, to the actual enactment of the moral treatment.
The first decades of the nineteenth century established doctors’ hopes for the
asylum system and their own place within it, and early alienists clearly linked
the incipient specialty to the perpetuation of family and gender norms associ-
ated with the middle classes. Nonetheless, their theories and actions presaged
irresolvable contradictions between the practice of asylum psychiatry and the
maintenance of bourgeois class distinction.

Inventing the Patient

The insane became human sometime in the late eighteenth century—that is, at
least, according to their self-appointed caregivers within the nascent psychiatric
profession. Whereas those considered mad had once been enchained like “fe-
rocious beasts” and treated with “violence and blind brutality,” Philippe Pinel
and his disciples sought to approach asylum inmates with firmness and kind-
ness. This alteration in perspective represented a central element of the moral
treatment, a method of care first theorized by Pinel during the revolutionary era
that asylum doctors continued to refine throughout the first several decades of
the 1800s.

Although those considered mad had long lived within institutions, their in-
carceration did not serve a medical function until the eighteenth century. Rel-
atively few prerevolutionary practitioners believed in the curability of mental
illness, and the absolutist state had little interest in reintegrating mad people into society. Pinel, like his predecessors, believed those who behaved irrationally should be separated from their communities, especially their families. Yet he also advocated the removal of physical restraints in all but the most dangerous situations and insisted that insanity could be overcome by regimenting and supervising patients’ lives within asylums. In time, through a series of strategically planned interactions between doctor and patient, he expected the symptoms of madness to dissipate. The moral treatment was an individualized but routinized method of care intended to bring patients back into the community of citizens by redirecting their emotions in a normative fashion. Doctors left little to chance within their institutions, seeking instead to purposefully cultivate an atmosphere that would disorient their patients’ senses and lead them toward the path of recovery.

The first alienists believed everyone possessed a sense of reason, even those experiencing symptoms of insanity. The flip side to this professed faith in human rationality was their assumption that all people—men and women of all social backgrounds—were liable to bouts of madness under the right circumstances. Pinel suggested as much in his writings on the Revolution. He pinpointed situations that triggered extreme emotional response when discussing the causes of mental alienation among the male patients of Bicêtre during that time, including various reactions to the Terror; the reversal of fortunes; and domestic distress. These particular inspirations for the onset of mental illness were eminently relatable to Pinel’s readers, who had themselves witnessed and experienced the same turmoil as had the asylum’s patients. Far from labeling the insane as outside the bounds of the community, Pinel implied that those driven to the brink by the vicissitudes of political and social change were perhaps all too human, rather than the supposedly incomprehensible animals of the Old Regime.

Even during less dramatic historical interludes, psychiatry’s founders emphasized the distortion and exaggeration of universal emotional states when discussing the onset of mental illness. Pinel and his influential student Jean-Étienne-Dominique Esquirol both cited unchecked emotions as especially relevant sources of insanity, Pinel going so far as to ask how any doctor could remain ignorant of the “the most lively human passions” when “they are the most frequent causes of alienation.” Esquirol wrote his doctoral thesis, “Des passions considérée comme causes, symptômes, et moyens curatifs de l’alienation mentale,” on the passions, using a combination of Pinel’s case notes and his own as principal sources of evidence. He focused on how particular emotions—from tenderness and the desire for love to hate, fear, and anger—might wreak havoc
on the minds of the mad. Both Pinel and Esquirol acknowledged that physical states such as lesions on the brain could cause psychological turmoil, but they consistently foregrounded the emotional dimensions of insanity in discussions of diagnosis and treatment. Madness represented a distortion of everyday “passions,” an extreme and unhealthy manifestation of the feelings experienced by all people. As such, both doctors began their attempts at cure with the belief that everyone had access to the same emotional register, arguing that if the passions constituted symptoms of mental illness, then they could inspire cure when properly manipulated. Far from merely replacing passion with reason, the founders of French psychiatry considered emotion the key feature of the human condition, connecting those diagnosed as insane to the rest of society.

Although distorted passions represented a seemingly universal source of insanity, doctors argued that emotional life was itself historically and socially determined. For Esquirol, primal emotional responses concerning self-preservation and reproduction—notably love, anger, terror, and vengeance—could easily be taken to excess. But he additionally linked mental illness to the advance of civilization and the multiplication of wants that defined modern life, explaining that needs engender desires and that desires “represent the most fertile source of the moral and physical disorders that afflict man.” No less treacherous for their comparative lack of urgency, new needs “attached themselves to the first,” thereby increasing the possibilities for the excitation of the passions. The feelings furthest removed from the instincts concerned those “born of our social ties,” such as ambition, greed, glory, celebrity, and honor. Like baser passions related to reproduction or survival, these so-called secondary needs related to the individual’s relationship to his or her family, whose reputation hinged on that of each individual member. Opportunities for the aggravation of such passions were especially numerous in a nominally meritocratic society such as that of postrevolutionary France, where class identities were in the process of replacing corporate ones and where one might move down the social hierarchy as readily as one might climb up. In elucidating this historically informed conception of the passions, Esquirol gave voice to a tendency already present in Pinel’s writings: emotion was universal, but its expression and its potential for unhealthy distortion was intimately tied to an individual’s social and familial role. This meant that a patient’s class and gender background inevitably influenced their diagnosis and treatment.

Psychiatric conceptions of the passions nonetheless resided at the nexus of nature and culture, where physical inspirations for insanity worked in concert with situational ones. Asylum doctors most obviously perpetuated notions of
gender difference in their discussions of the relationship between the body and the emotions. The relative weight attributed to physical versus emotional causes of mental illness depended on a number of factors, the most important being the patient’s sex. Whereas the founders of French psychiatry found myriad chances for a woman’s body to betray her mind, puberty was the only moment in a man’s life when biology alone left him open to excessive or distorted passions. Doctors consistently identified male patients as more constrained by social norms than by physical states.

Esquirol’s interpretation of the role of age in the onset of insanity is a case in point. Childhood constituted the only life stage in which individuals were truly shielded from the stirrings of mental illness, presumably because the passions had the fewest objects to attach themselves to at this time, while puberty in both boys and girls could lead to an excess of emotion owing to physical changes taking place in the body. Esquirol and his contemporaries viewed masturbation as especially pernicious proof that the emotions had been disturbed. Yet although age represented a series of physical states, it additionally implied a particular set of social and familial expectations that changed over the course of one’s lifetime. In men, Esquirol thought mental illness more likely to originate in adulthood than in old age or even adolescence because those in the prime of life were especially focused on the outward trappings of success. In a similar vein, he often cited thwarted ambition as the source of madness in professional men, whereas “instinctual” emotions such as love and fear more often aggravated the minds of his working-class patients.

Felix Voisin, one of Esquirol’s students, expanded on his mentor’s discussion of madness in men, noting that particular lifestyles and their attendant cultural norms helped determine the form of mental alienation. Voisin insisted that physical causes were far more significant than mental ones, yet he still cited the passions—especially pride and vanity—as central “sources of our misery,” and echoed Pinel by stating doctors should seek to “combat the passions with the passions.” More cynical than his notable contemporaries, Voisin argued that the lifestyles of rich and poor alike led vulnerable individuals almost inevitably toward mental breakdown. The dissolute upbringing of working-class children created a class of immoral men ruled by their passions: they became madmen or criminals. The emotional lives of so-called “superior” men, however, could also be carried astray. A man of great intelligence might go mad out of boredom; the indolent lifestyles of the financially secure proved especially fraught. Soldiers likewise found themselves vulnerable to aggravated passions. In their case, an excess of excitement—and numerous opportunities for pride and vanity
to find outlets on the field of battle—created difficulties when attempting to adapt to civilian life. Middle-class and bourgeois men were also at risk, as Esquirol had insisted, and insane merchants who could not help succumbing to the psychological pressures of their unstable occupations supposedly proliferated in the opening decades of the nineteenth century. Expectations for success had risen in the postrevolutionary decades, alongside new opportunities, and some men reacted to the uncertainty of professional life with emotional outbursts and mental collapse. The importance of the family to bourgeois class identity, as a means of both cultural distinction and wealth creation, must be understood in the context of these social and financial pressures.

Doctors were less likely to consider insanity in women as a psychological reaction to cultural expectations despite the notoriously rigid requirements of bourgeois domestic ideology. Alienists partook in the spread of particularly insidious attitudes regarding women and irrationality by presenting their theories concerning the female body’s effect on the mind as scientific inevitabilities rather than acknowledging them as historically situated products of culture (as they were so willing to do in the case of men). All doctors in postrevolutionary France conceived of the typical body as a male one and the female body as an aberration from the norm, and the first alienists fixated on biological differences between the sexes when developing their approach to insanity in women. This was certainly the case for Voisin, who treated many women patients as the co-founder of a private maison de santé outside Paris; his first major work, dedicated to his mother of all people, examined the subject of erotic alienation in women.

Pinel and Esquirol similarly claimed the passions were more animated, and often more sexually tinged, for women than for men. The onset of menses supposedly provided the first chance for madness to appear, and a woman’s period would continue to offer a key to her mental state during her entire life. Throughout the nineteenth century, asylum doctors cited an irregular cycle as one piece of evidence among many that a woman patient’s constitution had been disturbed by insanity. They claimed the return to rationality generally coincided with the regulation of a woman’s period and that pregnancy and childbirth represented moments of danger in a woman’s life because these physical states aggravated the passions to a potentially pathological degree. Menopause brought similar concerns.

Yet despite alienists’ seemingly deterministic understanding of the relationship between biology and insanity in women, they also emphasized cultural attributes of the female life cycle when identifying the moments in which a woman’s emotional state might cross the boundary from normal to pathological. For
example, Esquirol explained that the education of young women dangerously excited the passions. This had supposedly not been the case in antiquity, an era in which he claimed women were actually less likely than men to go mad. Esquirol found bourgeois habits especially jarring to a girl’s senses. Music, balls, and dancing all primed the female brain for emotion, and thus mental illness, at the precise moment when their adolescent bodies already encouraged passionate feelings. Moreover, reading novels could “inspire ideas of imaginary perfection” in young women, setting them up for disappointment when life failed to live up to their fantasies. Biological facts thus combined with cultural habits to make women especially vulnerable to mental alienation.

Case notes and treatises describing women patients implicate psychiatric professionals in the promotion of attitudes that had been used since the Revolution to deny women the rights of citizenship. The writings of early alienists, however, also reflect the very real concerns of women at an historical moment when legal and cultural strictures focused their emotional lives on marriage and family. In contrast to their discussions of bourgeois men, Pinel and Esquirol never cited frustrated professional ambitions as a source of insanity in women (it never would have occurred to them that women might hold professional ambitions at all). Instead, they tied women’s insanity most closely to aggravations within the home; a child’s birth or death, disruptions of household routines, the dissipation of familial affections, and complications in the process of courtship could all inspire madness in women. Women whose reactions to their families appeared out of line with bourgeois understandings of femininity were often labeled insane, as were those who took such norms to apparently unhealthy extremes. Those who became “lovesick” and obsessed with the objects of their affection rather than simply attached, concerned, and devoted were judged to need their passions redirected and controlled.

For early asylum doctors this state of affairs was only natural, for marriage and family constituted the loci of women’s emotional lives, and madness was above all a reflection of emotional distress. This tendency is seen most clearly in the writings of the celebrated young alienist Étienne-Jean Georget, another doctor who insisted that all people—regardless of class or gender—were susceptible to feelings that “wound our sense of self by contradicting our needs or wants.”10 Georget was one of Esquirol’s most promising students before he died in 1828 at the age of thirty-three. His major work, titled simply De la folie, bore the imprint of Esquirol’s teachings, yet he focused more sustained attention on the relationship between the body and the mind than had his mentor. Georget believed madness was an illness of the brain and even called the moral treatment
“direct cerebral treatment” for this reason. He also claimed bodily distress led to psychological disturbance and vice versa. Georget thus emphasized treating the emotional aspects of madness alongside the physical ones—such as insomnia or digestive difficulties—because new bodily symptoms would inevitably arise if the affliction’s psychological cause was not discovered and overcome.

As was the case for Pinel and Esquirol, Georget’s conception of the passions led him to create a class- and gender-based understanding of insanity and its treatment. Although feelings such as jealousy, love, hate, fear, sadness, and anger were comprehensible to all people and could serve as triggers for mental illness, the circumstances that aggravated such emotions in each individual patient differed. As a physician working at the Salpêtrière, Georget dealt with women patients of a variety of class backgrounds. Most women, he argued, experienced madness owing to frustrations in their family lives, but those of the popular classes dealt with more regular and more extreme forms of domestic distress. Poverty, of course, made it difficult to support a family and also compounded daily tensions between husbands and wives. Domestic violence (“brutality in marriage”) received special mention by Georget as a source of mental alienation in working women.

Conversely, he emphasized emotional responses to scandalous love affairs, thwarted marriage plans, and secret jealousies (of their brothers, sisters, and prettier friends!) when assessing the origins of women’s insanity more broadly. He believed madness struck women of the lower classes most often but that these patients were also more readily cured. In their case, he found it appropriate to use physical labor as a method of distraction, whereas he argued that the diversions associated with middle- and upper-class lifestyles actually contributed to the aggravation of the passions. Still, he considered the reincorporation of women patients into the family home—regardless of class—the end goal of psychiatric treatment. Sentiments supposedly held by all women would aid in this result: “The mother,” wrote Georget, “will desire to care for her children, the wife to return to her household routine.” Georget’s understanding of women and madness undoubtedly reinforced the ideal of domestic motherhood, although one wonders why a woman’s supposedly natural condition would bring about so much psychological turmoil.

Psychiatry’s founders also linked insanity in men to disordered behavior in family life, beyond the already mentioned pressure to assure the family’s well-being through professional success. The perversion of what doctors considered normal affections constituted one of the clearest signs a man had gone mad, and Esquirol and Pinel both provided numerous examples of men whose
love for their parents and wives seemed to transform into hate or indifference for no apparent reason. A male patient, for example, who had long been considered a “respectful son” began to “ignore the entreaties of his dear father.” The “tears of his lover” left him equally unmoved. As was the case for their women patients, the behavioral repertoires doctors associated with sanity in men conformed to the family ideals of the bourgeoisie, a class that promoted self-possessed yet sentimental relations between all members of the family. Men who did not adapt to nineteenth-century expectations of fatherly and husbandly behavior, in particular, risked being seen as insane. The disturbance of affective ties therefore represented a symptom of insanity in men and women both. What differed was the comparative emphasis doctors placed on male and female biology in the diagnostic process, in that they found cases of mental illness in women more likely—although not exclusively—to be connected to physical states unique to their sex.

In sum, doctors’ attitudes toward the passions perpetuated bourgeois values concerning family life by identifying gender and class nonconformity as a sign of mental illness. They additionally reflected middle-class assumptions regarding the popular classes, whose expressions of insanity were supposedly less complex than those of their bourgeois counterparts. Yet, the ways that doctors utilized these class- and gender-based notions in the treatment process suggested they held integrative potential. Pinel believed all people—even those deep in the throes of madness—held inside of them a kernel of rationality. Their sense of self remained, even if it was hidden. Accordingly, any patient could gradually attain self-mastery by redirecting the aggravated passions that acted as source and symptom.

Neither Pinel nor Esquirol sought to replace emotion with reason because they believed rationality existed under the surface all along, and because they considered emotion an essential part of the human personality. Controlling and redirecting emotion, not eliminating it, would allow individuals to prosper within the community, the polity, and the home. After all, as the title of Esquirol’s dissertation made clear, the passions were not simply causes and reflections of mental alienation, but they were moyens curatifs as well. This belief in the healing properties of the emotions applied equally to men and women of all class backgrounds. For if the diagnosis of mental illness appears to have simply reproduced dominant assumptions related to men, women, and class, the treatment methods theorized and enacted by psychiatry’s founding fathers made use of nineteenth-century gender values in order to heal all patients—in so doing, they undermined the very same class and gender distinctions they helped to create.
Isolating Madness

Psychiatry’s founders spent the start of the nineteenth century trying, under less than ideal political conditions, to institutionalize legally their positions as the rightful guardians of the insane.\(^\text{15}\) Those whose conceptions of individual liberty had been influenced by the French and North American revolutions began to view the humane treatment of mad people as essential. Yet without a specific government policy dictating the terms of the treatment process, there was no way to enforce new styles of patient care. The establishment of the conservative Restoration monarchy—ushered in by victorious European powers after the defeat of Napoleon in 1815—proved hostile to the creation of such a system. The regime of Charles X, which strongly linked its own authority to that of the rehabilitated Catholic Church, was particularly disinclined to support the liberal, anticlerical alienists in their efforts to standardize psychiatric treatment.\(^\text{16}\) As Esquirol noted in 1819 after surveying numerous private and public institutions, many patients still lived in conditions much like those criticized by Pinel nearly three decades earlier.\(^\text{17}\) Patient abuse remained a distinct possibility without passage of a law outlining the rights of patients and the exact legal mechanisms regulating the commitment process; unscrupulous family members, in particular, could still commit relatives with ease until legislators put safeguards in place. Furthermore, even well-meaning families could prove dangerous to those experiencing the symptoms of insanity.

Psychiatric attitudes toward the family—especially the belief that all patients should be “isolated” from their families in order to be cured—proved central to doctors’ conceptualizations of asylum reform and to the performance of the moral treatment. The asylum served as a source of seclusion from all the cares of work and home, a space apart from public and private sphere alike, where doctors controlled all aspects of their patients’ daily lives, including their interpersonal interactions. The promotion of familial isolation conveniently legitimated the alienist’s professional services; for example, someone such as Esquirol served as director of the public facility Bicêtre and also operated a private institution dedicated to the treatment of wealthy patients. Professional self-interest cannot fully explain the emphasis doctors placed on isolating madness, however, for it was possible to imagine the deployment of psychiatric expertise in settings beyond the asylum (by sending patients to general hospitals and convalescent homes with an alienist on staff, by encouraging doctors to make house calls, or by having patients visit doctors on an appointment basis in private offices). Members of the psychiatric profession at the start of the nineteenth century
nonetheless championed sequestration in specialized institutions as the only way to cure individuals of insanity.

Doctors’ faith in the utility of isolation logically stemmed from their belief that the passions could be useful in the treatment of mental alienation. As shown, Pinel considered “domestic distress” one of several typical causes of mental illness; he further claimed that living in the family home represented an “eternal obstacle” to a patient’s recovery. Citing various British sources, including the “mad” King George’s physician Willis, he insisted that a patient would be best served by the moral treatment if he or she were kept away from their relatives for its duration. Pinel thought the presence of loved ones could lead to the interruption of the treatment process, inspire feelings of irritation in the patient, disturb the calm atmosphere of the institution, and even cause a relapse. In short, family life aggravated the passions, familiarity often bred contempt, and only a stranger would be able to effectively shift the orientation of a patient’s emotional state. Early alienists aimed to restore what they considered normalcy to the household, but doing so depended on the cultivation of spatial and emotional distance between patients and their families. Thus, much like their gendered formulation of the passions, doctors’ reliance on isolation simultaneously propped up bourgeois family values and indicated some ambivalence toward the family itself.

That said, doctors’ actions tended to undermine authoritarian manifestations of familial power reminiscent of the Old Regime rather than the sentimental relations more firmly associated with the rising bourgeoisie. Bourgeois families celebrated affective relationships between relatives, especially within the nuclear family. Marriage strategies continued to revolve around economic security and the development of family alliances in the nineteenth century, but the ideal marriage was one that accomplished these goals while maintaining genuine friendship between spouses, especially because the bourgeois home represented a site of tranquility in a chaotic world. As infant mortality rates declined, closeness between children and parents became increasingly central to family routines, and domestic architecture encouraged a sense of intimacy and privacy through the use of individual bedrooms, nurseries, and separate family wings where outside guests rarely if ever congregated. Furthermore, although fathers still held ultimate authority within the home, there were many signs that members of the middle classes expected this authority to be wielded more justly and less violently than in previous centuries. As Loftur Guttormsson notes, “the mood was shifting away from beating as a routine punishment (except in schools) towards the application of moral and emotional pressures developing in children
a capacity for self-government." Novel approaches to child-rearing paralleled new attitudes toward the mentally ill, who were likewise now expected to learn how to control themselves rather than merely submit to physical compulsion.

The work that ultimately had the greatest long-term impact on the practice of asylum psychiatry in nineteenth-century France reflected the profession’s alignment with bourgeois family values, although it did so in a way that often drew attention to the dangers posed by the family to a patient’s mental health. Esquirol wrote *Memoire sur l’isolement d’aliénés* in 1832 in order to convince lawmakers of the recently established July Monarchy to create national regulations concerning the construction and administration of insane asylums, and the comparatively liberal atmosphere of the new regime proved conducive to the alienist’s plans. In his memoir on isolation, Esquirol insisted that doctors, rather than families, knew what was best for the patient. He nevertheless built his case for professional intervention around the notion that family life represented the most essential element of a person’s identity—an assumption bourgeois families would certainly have shared. Sequestration in a mental institution was a traumatic process, and Esquirol argued that the terms by which someone might find himself in such a place should be tightly regulated:

The question of isolation attaches itself to the interests most dear to man, considered as a patient, as a member of the family and of society. Herein lies the gravity of an illness that puts [the] affected at risk of being deprived of the objects of his most dear affections, of being thwarted in his desires and in the exercise of his civil rights and his liberty.

In other words, madness threw a patient’s world into disarray by destroying his sense of self, disrupting his family relations, and splintering his social bonds. Isolation could restore not just a person’s sanity, but their familial, communal, and civic identities as well.

In the most general sense, isolation could be used as a synonym for confinement or sequestration, and sometimes Esquirol did just that. The term isolation is more historically useful than these alternatives, however, for it raises the question: isolation from what? Although “sequestration” emphasizes the space where a patient might be confined, isolation forces one to think of the space—and in this case, the people—he or she is being taken from. Esquirol defined isolation as “removing the mad person from all his habits, taking him far from the place he lives, separating him from his family, his friends, and his servants while surrounding him with strangers and changing completely his manner of life.” Treatment entailed a complete break from the home because its familiarity
inhibited the patient’s return to rationality. While Esquirol considered the asylum a curative space in which material surroundings and human interactions represented two complementary aspects of the same rehabilitative process, he suggested a similar sense of harmony between architecture, social relations, and individual recovery could not exist inside the family home owing to “the presence of individuals who awaken or irritate the . . . passions, [who] provoke the disturbance of reason and are insurmountable obstacles to its reestablishment.”

Shocking, confounding, and redirecting a patient’s senses required separation from everything and everyone he or she found familiar and familial.

Strangers therefore played a special part in the moral treatment. The presence of unfamiliar people in an unfamiliar environment encouraged a novel interplay among the patient’s senses, which constituted the first step on the path toward recovery. Discombobulation and distraction presented doctors with an opportunity to start the healing process, to teach the patient how to resume their expected familial role. If patients expressed intense anger toward those closest to them, lashing out or becoming indifferent when in contact with the source of their rage, doctors claimed that a sense of pride encouraged them to act agreeably when meeting new people. Esquirol reported having witnessed patients interacting with their physicians in a very calm fashion while simultaneously cursing their family members under their breath. The company of other patients could also prove beneficial because the example of other madmen encouraged self-reflection.

Ordinary people and situations no longer made much of an impression on the insane person. The “extravagances of their peers,” however, would prove shocking and distracting. The strangeness of their new situation forced patients to momentarily forget themselves, to interact with others, and to live outside their minds. In the process, their former “mad desires” would eventually be replaced by ennui and hopes to go back home—the purpose of isolation in the first place.

Esquirol presented numerous examples meant to prove the indispensability of isolation, most of which emphasized the negative influence of close family and friends on his patients’ emotional states. Through his descriptions, the renowned alienist suggested the performance of behaviors one would reasonably expect within any middle-class home were precisely those that caused insane people the greatest disturbance. He noted that wives of depressed men sometimes could not hide the sadness they felt over the progression of their husbands’ conditions. For many a head of household, “the tears of his wife (and) her sad countenance, are new motives that persuade the unfortunate that there is nothing better to do than to destroy himself.” Already depressed, such men
viewed the suffering of their wives as further proof they had not lived up to societal expectations regarding their husbandly duties. Esquirol noted that one patient in particular, a twenty-seven-year-old man who had become depressed after losing his fortune, attempted suicide when faced with “the despair and the cares of his wife.”

It was only when taken into Esquirol’s asylum that the man ceased his self-destructive activities owing to enforced isolation from his family and friends, as well as his relocation to a ground-floor room where it would be impossible to jump to his death. An example of a young man who had recently displayed signs of depression is similarly revealing. According to his doctor, the man purportedly exclaimed, “Ah! My mother, how you torment me! I will never heal near you.” He had grown impatient with his mother’s questions about the state of his health and her constant requests for him to follow the treatment regimen prescribed to him. Esquirol presented these cases and others as proof that patients should be kept away from their families—even, and perhaps especially, from those with good intentions.

Still, the reintegr ation of the patient into the seemingly natural workings of the household represented the primary goal of the moral treatment, and all commentators recognized that families held intense interest in the treatment of their loved ones regardless of the doctor’s recently enhanced role. Although doctors went to great lengths to prove the damage that might be caused if an insane person lived in the family home instead of entering a specialized institution for treatment, they never blamed families for the psychological distress of their intimates even if they insisted that family life could aggravate the passions. As seen in the above example of the meddlesome mother, Esquirol did not cite pathological family relations as the justification for isolation. It was not her behavior that he considered unhealthy. Instead, it was the son’s response to seemingly innocuous and unremarkable mother-child interactions that needed to be identified, contained, and redirected. The son’s perceived inability to react to his mother in a normative fashion labeled Esquirol’s patient as irrational; removal from her company would be the first step in his recovery process. Isolation thus propped up sentimental family relations while nonetheless drawing attention to the fragility of the nineteenth-century construct of the bourgeois home as a place of refuge.

In a century that emphasized the tranquility of the bourgeois home and the familial relationships articulated therein as primary elements of class distinction, the suggestion that the family might be a source of mental illness would have been controversial. Esquirol thus framed his assertions carefully and rarely mentioned patients whose relatives’ behaviors could be construed as cruel or
even atypical. The only family members he depicted in a negative light were people who attempted to incarcerate sane relatives. Such individuals behaved in a fashion more akin to families of the Old Regime, a time when parents could institutionalize children without due process and husbands wielded greater legal power over wives, rather than those of a liberal era more reflective of psychiatric principles.34 Doctors attempted a precarious balancing act by drawing attention to the dangers of family life. Implementing their theories of psychiatric treatment necessitated them doing so. Yet securing alienists’ roles as the rightful caretakers of the insane also depended on their ability to preserve bourgeois class distinctions—the cult of domesticity ranking high among them.

The profession managed to walk this tightrope, at least at first, by pathologizing authoritarian household dynamics and celebrating benevolent ones.35 Not only did doctors condemn families who attempted to institutionalize relatives without cause but they also implied that “unsentimental” behavior actually constituted evidence of insanity. Esquirol’s discussions of heads of household afflicted with mental alienation were often indicative of this tendency. The above example of the suicidal husband involved a patient whose love for his family intensified his depression and who seemingly fared best when kept away from them. Esquirol also worried, however, that men were particularly needful of isolation because they were used to considering themselves “master(s) of the land.”36 These husbands had previously inspired the obedience of their families “through respect or through affection” and would become infuriated when their demands were not met in the same fashion following the onset of insanity.37 Esquirol argued the man of the house should be forced to cede his authority if deemed insane, even though he had once reasonably expected his wife, children, and servants to bend to his will.

The doctor explained that a mad husband often failed to come to terms with his new role in the family:

Like a despot, he is ready to punish with the greatest severity whomever will dare make the least remonstrance; whatever he demands is impossible; it doesn’t matter . . . the affliction of his family, the sorrow of his friends, the eagerness of everyone, their deference to his will . . . all serve to support this madman in his ideas of power and domination.38

Men like this misunderstood the cultural basis of paternal power in the nineteenth century. Although his patients acted as if their authority naturally stemmed from their sex, Esquirol reasoned that the demands of male heads of household should be respected because men were the most rational members
of the family. These capricious “despots” would therefore need to regain their sanity before their expectation of familial obedience was once again socially acceptable. The act of isolating an irrational husband—“outside his empire, far from his subjects”—would humble him and thereby help reorient the tone of his social interactions.39

Esquirol aimed to eventually return patients to their former lives. Accordingly, he did not envision asylums as permanent living spaces, but as necessary sites of repose and rehabilitation. While the household might serve as a source of respite from the outside world, mental patients needed respite from the home itself. The fact that they did not experience home life in the same way as their “normal” counterparts signaled their irrationality to a great degree. Isolation, in and of itself, did not produce a cure. It is better understood as a necessary precondition for the cultivation of new, healthy social relations between the mad person and other members of the community, most importantly their family. In order for a healthy family dynamic to reemerge, alienists insisted, an entirely new and equally significant relationship must be cultivated between the patient and the doctor himself.

Performing Treatment

Most descriptions of early French asylums come from the doctor’s perspective and therefore tell us much more about the assumptions undergirding the behaviors of professional men than those of the people over whom they held power. The moral treatment was nonetheless a two-way—if always heavily imbalanced—process that occurred between doctor and patient. Doctors focused considerable care on formulating treatments they thought might appeal to their patients’ hidden, rational selves and on developing personae they believed patients would respond to in a rehabilitative fashion. Psychiatric theories concerning the passions and familial isolation heavily influenced asylum doctors’ step-by-step formulation of the treatment scenario, as well as their own behaviors, in ways that placed gender at the heart of every asylum interaction.

The first stage of the treatment process always involved shocking the patient’s system in order to redirect their emotional state; as shown, the necessity of such surprise constituted the raison d’être of familial isolation, since familiar sensations supposedly kept patients from reconsidering their pathological behaviors. After having instilled what he considered the proper degree of shock (through isolation from family and interaction with new people, but also through more obviously repressive means), the doctor began to more fully immerse his patient
in the mutual performance of the moral treatment by drawing on shared understandings of proper feminine and masculine comportment. The development of gendered treatment scenarios stemmed from the importance doctors placed on the passions in the origins and the presentation of mental illness: although all people were capable of experiencing the same sentiments, and were susceptible to mental collapse if those feelings somehow went awry, the precise circumstances that aggravated the passions were highly individualized. Each case of madness depended on a person’s temperament, their upbringing, and their class and gender background. Furthermore, doctors believed that certain codes of conduct—such as those related to masculine honor or feminine virtue—remained comprehensible to all patients despite their symptoms.

Alienists staged elaborate scenes in which they used pertinent aspects of patients’ gender and class identities to convince them to return to rationality. For example, Esquirol thought a man’s occupational background and past experiences could be used as an entry point for treatment, as his interpretation of a case of madness in a former soldier shows. Numerous fighting men found themselves incarcerated in asylums during the 1790s and the decades that followed. After becoming depressed after losing his fortune during the Revolution, one such individual moved to Paris from the countryside at his wife’s urging. Apparently growing bored with his new location, he became increasingly stubborn, succumbed to delirium, and eventually ended up in Esquirol’s institution. The man met each of Esquirol’s efforts to shift his emotional state with increased resistance; he reportedly refused food, would not leave his bed, and reacted with violence to the doctor’s attempts to disrupt his senses with sprays of cold water to the face. The only tactic that seemed to make any impression involved Esquirol’s assignment of a new servant to the patient’s quarters: a former soldier, like the man himself. The attendant reminisced with his new charge, talking to him about “war, the countryside, and military service.” Nostalgia and kindness distracted the patient from his frustration; he immediately began to eat and two weeks later regained his reason entirely. Esquirol claimed that recollecting shared wartime experiences with a stranger led to the replacement of a pathological passion with something far more benign: in this instance, burgeoning comradeship conquered self-destructive stubbornness. Furthermore, a bit of male bonding had encouraged the return of sanity, thereby solidifying the perceived connection between manliness and rationality that doctors both relied on and helped to perpetuate.

Women also responded to gendered treatments according to Esquirol, although the role of the family in the redirection of a woman’s passions could be
complex. All doctors agreed family life could aggravate the passions and that a return to the household too early might even inspire a relapse in an apparently healthy person, but the promise of going home could also inspire hope—an especially useful emotion—in melancholic patients. Since doctors believed women focused their emotional lives on their families, they took this predisposition into account when devising plans for emotional redirection. For instance, Esquirol cited the case of a woman who harbored intense love and devotion for her husband and children yet felt profoundly depressed. At first, she reacted positively to a stay in the asylum, but she soon became bored and the depression returned. Esquirol thought that surprise would prepare her mind for hopes of recovery, so he orchestrated a series of visits between the patient and her loved ones. These visits intensified the woman’s desire to return home. But Esquirol refused to let her leave; he even cut off all communication between the patient and her family. Then, when she least expected it, he arranged for them to visit again. In toying with her emotions in this fashion, the alienist claimed to have his patient’s best interests at heart. She supposedly became reasonable after this bit of theater and happily resumed her role as wife and mother.41

Assumptions about gender and family life likewise shaped the self-presentations of doctors, whose writings reveal as much about shifting meanings of professional manhood in postrevolutionary France as they do the process of psychiatric treatment. Early alienists such as Pinel envisioned asylums as temporary stand-ins for their patients’ homes and, accordingly, imagined their own roles in paternal terms. “In a word,” explained the founder of French psychiatry, “the general governance of the hospital resembled that of a great family, consisting of turbulent and impetuous individuals, who must be repressed but not exasperated.”42 The doctor himself oversaw this “great family,” for only he possessed the wisdom and patience such responsibility demanded.

Pinel’s own son, Scipion, expanded on this familial metaphor and insisted that working with mental patients required a very specific fatherly disposition. The asylum doctor must have “a special vocation to pass his life among the alienated, to attach himself to their unhappiness, to find charm in that existence, so seemingly empty and at the same time so full of great lessons. . . . He must identify fully with [his patients’] pain, their joys, and all their interests.” The younger Pinel also claimed that when a doctor suited for asylum management saw his patients following a short absence, he would feel joy comparable to that brought on by a reunion with “family long separated.” “This type of man,” Pinel fils famously wrote, “is more than a doctor, he is a consoler and a father.”43 The prototypical version of the doctor-father was, in this case, the writer’s actual
father as well, which might help to explain why he found the similarities between the household and the asylum so salient. All early practitioners of the moral treatment, however, believed that patients—like children—required education, and that the success or failure of the educative process would depend not only on their instructors’ methods but on their personalities as well. The key was to convince the patient-child that it was in their best interest to obey the doctor-father—to inspire each patients’ filial respect and devotion through a variety of strategies, some gentler than others.

Doctors cultivated and constantly reaffirmed their personae through the process of social interaction. Like early psychiatric conceptions of mental illness itself, the therapeutic persona did not exist in a vacuum and depended on the validation of others to a great degree. The projection of authority was the most important aspect of the alienist’s self-presentation and, simultaneously, the one most in need of outside affirmation. Pinel considered the ability to “exude authority” a necessary attribute for a doctor because there were certain patients who could only be cured if they were suitably impressed by medical power. Esquirol also asserted “the physician should be invested with an authority from which no one is exempt.” He thought even the representatives of local governments should take care to aggrandize psychiatric power because social respect outside of the asylum would add to the doctor’s authoritative mystique when dealing with patients. Likewise, authority should never be divided between doctors and families, or among members of the asylum staff. Instead, “everything should be controlled by the chef.”

As shown, practitioners of the moral treatment believed each element of a patient’s daily life should work in concert and contribute toward the goal of mental recovery. This included everything from the design of the room a patient inhabited, to the food he ate, to the diversions that filled his time. Yet the perception of control was nearly as important as its existence because both encouraged the patient’s eventual submission. The creation of an authoritative persona would allow the doctor to foster dependence, which alienists believed would make patients compliant and eventually lead to their cure. Isolation from family helped to aggrandize medical authority because it proved to the patient that he was truly alone and had no one to turn to but the doctor. As Esquirol explained, “from that first moment when the madman is isolated, surprised, disconcerted, etc., he feels a precious relaxation . . . finding the patient without barriers, [the doctor] can more easily acquire his confidence.” Family visitations were discouraged in most cases so that patients would depend on their doctor for all their needs and see him as the sole source of the eventual improvement
of their situation, as the above case of the young mother implies.\(^49\) This train of thought extended to the activities of the asylum’s staff, who were expected to model correct behavior for the patients. Esquirol argued that “the doctor must give impetus to everything” and employees “must give the example of deference” in order to “show the madman that resistance is in vain.”\(^50\)

The first asylum doctors apparently saw no conflict between feeling genuine compassion toward their patients and enacting domineering performances of medical authority (although, as we will see in the following chapter, there was much debate within the profession when doctors appeared to cross the line from treatment to abuse). Because each patient’s treatment regimen was individualized, it is easy to imagine the doctor changing his persona like a mask from one patient to the next—or even doing so vis-à-vis the same patient at various points in the treatment process. Pinel was acutely aware of the performative dimensions of psychiatric power, noting that the “appearance of repression,” usually in the form of trickery, was a necessary evil justified only when other methods had proven futile and when practiced without malicious intent on the part of the doctor.\(^51\) As Jan Goldstein has conclusively demonstrated, doctors sought to “console” their patients, not simply intimidate or frighten them—which itself speaks to the transition from an authoritarian conception of family life to something more benevolent. The tack a doctor chose to pursue depended on the specifics of a given case and how readily he thought the patient might respond to a particular treatment scenario. Doctors nonetheless agreed certain personality traits were more conducive to cure than others, especially since they considered patients’ respect for medical authority essential in every case.

Pinel addressed the traits embodied by the ideal asylum overseer by using his assistant, Pussin, as an example. Pussin had no specialized medical training, but he served as the superintendent of Bicêtre before Pinel arrived and continued to work under him thereafter. He eliminated physical restraints in that asylum, although the credit for this action has often been attributed to Pinel himself. The role played by gender in Pinel’s discussion of Pussin is noteworthy and suggests that only a man could run an asylum in the therapeutic fashion promoted by psychiatry’s founder. Some traits championed by Pinel could arguably be understood in gender-neutral terms; he writes, for example, that Pussin exhibited “alongside the most pure philanthropic morals . . . an indefatigable diligence in his [duties of] surveillance.”\(^52\) Yet Pinel soon transitioned to a list of characteristics associated more obviously with manliness, noting that the overseer’s “unshakeable firmness [and] reasoned courage” helped him manage the asylum.\(^53\) If it was unclear that such sure-mindedness and savoir-faire were personality traits
that Pinel classified as masculine, he erased any doubt by linking them to physical features. Pinel even titled the relevant section of his treatise “The Physical and Moral Qualities Essential to the Surveillance of the Alienated,” suggesting the asylum overseer’s physicality was inseparable from his authoritative character. Pinel claimed Pussin’s courage was “supported by physical qualities best suited to impose [his will upon patients].” Notable were his “well-proportioned body” and “limbs full of strength and vigor.” Furthermore, “in stormy moments his voice is thunderous, his attitude proud and intrepid.” When taken all together, the various traits Pinel associated with successful asylum management point to a conception of psychiatric authority that was masculine by definition.

This did not mean Pinel denied the possibility of a more feminine style of psychiatric self-presentation—a fact that points to the incompleteness of psychiatry’s professionalization at this time. Pussin lived with and worked alongside his wife, Marguerite Jubline, when he managed Bicêtre. Although Pinel alluded to Jubline only in passing, it was always with admiration for her character and for the work she performed as the surveillante. As in his depiction of Pussin, Pinel described his wife as someone who used gender to her advantage when interacting with the asylum’s patients. Pussin used his authoritative demeanor and physicality to encourage respect and obedience. Jubline, on the other hand, tended to appeal to her male patients’ belief in feminine virtue and their desire to protect vulnerable women. Most of Pinel’s descriptions of the surveillante appear in a section related to the art of “directing the mad, while appearing to assent to their imaginary ideas.” It should perhaps come as little surprise that it was Jubline who proved most adept at this particular tactic; a woman of the popular classes in a patriarchal society such as hers likely had considerable experience avoiding direct confrontation with men while seeking to get her way.

Pinel’s version of Jubline used a combination of charm, flattery, and distraction to persuade patients to behave ways she found desirable. For example, one day a patient entered the asylum’s kitchen, grabbed a knife, and threatened the cooks and servants. As they prepared to physically overpower him, Jubline interceded and asked “why prevent so strong a man from working with me?” She then proceeded to instruct him on the proper way to chop vegetables, subtly taking the knife from his hands. She successfully pacified the patient by making him feel useful and manly. Pinel recounted another time when Jubline played on gender norms in the course of the treatment process, which resulted in a previously willful patient securing his release with her help. The patient arrived in the asylum with symptoms of depression and mania; he soon experienced a brief period of recovery, but then apparently started to doubt the desirability of his
cure. At this point, the *surveillante* convinced him that she would be punished if he experienced a relapse; in order to protect the woman from harm, he remained “cured.” Both these examples suggest that the late eighteenth-century belief in gender complementarity in marriage extended to the workplace as well. Pussin’s wife used gender in her interactions with patients in a very different way than did her husband, but Pinel found both methods worthy of praise. There remained a possibility, albeit often unrealized and always contested, for women practitioners to play a part in the direction of asylums throughout the nineteenth century.

As his discussion of the Pussins indicated, Pinel’s conception of psychiatric expertise was not class dependent. Pussin became Pinel’s employee once the doctor took charge of Bicêtre, and the overseer’s subordinate status within the asylum’s occupational hierarchy despite his commanding persona would certainly have propped up the authority of his superior. Nonetheless, Pinel suggested he viewed Pussin as an equal despite his lack of a formal education, especially by presenting him as a model for students to emulate. It is also significant that Pinel stressed Pussin’s physicality over his mental acuity when outlining his most admirable traits, although he also presented Pussin as very self-possessed. The emphasis on the physical prowess of the ideal asylum overseer would dissipate among those who followed in the founder’s footsteps—men who resolutely sought to safeguard their professional interests and expand psychiatry’s reach. Conveniently for them, alienists’ own theories propped up cultural associations between rational self-control and bourgeois masculinity, thereby legitimating their profession’s takeover as the guardians of the insane.

This tendency can be seen clearly in the writings of Scipion Pinel, the son of Philippe, one of the most vocal proponents for the construction of new asylums during the 1830s. The younger Pinel wrote extensively about the characteristics of the perfect asylum director and helped to spread the false assertion that his father freed the inmates of Bicêtre from their irons, thus giving credit to a bourgeois professional for actions actually initiated by a layman. He parroted many of his father’s descriptions of Pussin when describing the ideal asylum doctor by arguing he should possess a commanding physical presence, a strong constitution, a sense of dignity and calm under pressure, a deep voice, and a kind and well-meaning regard. There was one major difference, though, and it pointed to the professionalization of psychiatry that had occurred between the pinnacle of the father’s career and that of the son. Namely, Pinel *fils* noted that the alienist “by nature of his studies . . . [must] become the natural judge of all that happens in the asylum.” Education, in other words, now preceded character.
This suggests that some of the integrative potential of the psychiatric enterprise began to deteriorate as early as the 1830s, at least with respect to the type of person alienists thought could successfully implement the moral treatment. This shift occurred as asylum doctors became increasingly preoccupied with safeguarding their professional prerogatives and eliminating rivals amid the over-supplied medical job market of the July Monarchy, which offered considerable opportunities for individual advancement but also increased competition. The senior Pinel’s relative openness to lay expertise had not lasted long. Gender-based treatments in which all members of the asylum staff played a part, however, did not disappear—doctors merely began to argue more insistently that the orchestration of such scenes required the trappings of professionalization.

The founding “fathers” of French psychiatry made use of widespread attitudes toward the family and its associated gender roles when identifying symptoms, designing treatment protocols, organizing institutional spaces, and crafting their personas. In so doing, they promulgated increasingly narrow definitions of sanity that reinforced sexist and classist structures of power from which they personally benefited. Yet, although historians have typically viewed the relationship between gender and psychiatry as inherently repressive, the way that doctors imagined their patients as capable of responding to gendered treatment processes indicates that the medicalization of mental illness—at its base—was about the possibility of patients’ inclusion in French society rather than their segregation and stigmatization. The approach of early alienists toward gender and the family aligned with their stated belief in the universality of human emotions and the social experiences that inspired them, and there would remain a therapeutic space for gender inside asylums as long as doctors considered emotion an essential aspect of treatment and cure.

Doctors’ attempts to put these ideas into practice nonetheless appear supremely hypocritical considering how thoroughly the nineteenth-century asylum system failed to live up to the expectations of its founders. Indeed, it is easy to ascribe self-interested motives to the first asylum doctors because they conveniently understood the values of their own class as those to which all French should conform. But their role in the perpetuation of bourgeois gender values—and therefore bourgeois class distinction—was always double-edged. Alienists unwittingly questioned the naturalness of middle-class gender norms in the very act of promoting them by pinpointing women and men’s enactment of their familial roles as key sources of mental illness. The influential theory of familial isolation similarly hints at the threat posed by psychiatry to the image
of the uniquely tranquil bourgeois home: early alienists never outright blamed well-meaning families for a patient’s mental distress, but they nonetheless presented a less than peaceful portrait of family life by insisting that a mad person would only become madder when living at home. Even Pinel’s discussion of the ideal psychiatric persona suggested that medical power could be wielded by a layman—or even a laywoman—thus posing a subtle yet meaningful challenge to the authority of all professional men.

There was always a tension between the ways in which the enactment of the moral treatment promoted notions of natural class and gender difference while simultaneously revealing their flexibility and constructedness. This essential contradiction did not necessarily undermine medical, masculine, or bourgeois power in the opening decades of the century—at least in part because the political situation did not yet fully support the expansion of the psychiatric enterprise. The implications of the moral treatment’s gender dimensions remained relatively limited until the 1838 establishment of the national asylum system, despite the method’s use in individual institutions well before that time. Practical consequences, however, soon emerged. As psychiatry’s influence spread and various professional controversies took hold, doctors’ contradictory relationship to bourgeois values would rise to the surface in ways that constrained the behaviors of doctors themselves, proving that medical men were as beholden to new gender expectations as were their patients.