

Medical Psychology, Madness, and Melancholy

By Angus Gowland

The cultural history of medical psychology in Renaissance Europe as yet barely exists. In social history, by contrast, the medical treatment of madness has been a well-established feature of the scholarly landscape, at least since the influential studies of early modern England by Michael MacDonald and Roy Porter (MacDonald, 1981a; Porter, 1987a; 1987b); and there are now a number of substantial intellectual histories of this territory, following in the wake of the monumental study of melancholy by Raymond Klibansky, Erwin Panofsky and Fritz Saxl (1964; Schleiner, 1991; Brann, 2002; Bigotti, 2012). Cultural historians, however, have been mainly interested in exploring the religious and social aspects of madness in this period (Midelfort, 1999; Scull, 2016: pp. 86-121), and their discussions of medical discourse and practice have tended to be piecemeal or subordinated to such concerns (but for the eighteenth-century see Stolberg, 2011, pp. 163-95). Why so? Partly, I believe, because of the reaction of historians of medicine to the works of Michel Foucault. For Foucault, one of the most influential figures for recent practitioners of cultural history and a key figure in the ‘antipsychiatry’ movement that developed from the 1960s onwards, the medicalisation of madness in the modern era was not, as traditional histories of psychiatry had suggested, a story of progressive understanding and liberation. Rather, it expressed the workings of institutional power upon the human subject, and was part of the larger process of the growth in the West of ‘disciplinary’ knowledges and social technologies (Foucault, 1961; 1963; 1975; cf. Zilboorg, 1941; Hunter and McAlpine, 1963). Whilst historians of medicine could agree with Foucault that the traditional emphasis on the steadily enlightened progress of modern psychiatry was an inadequate oversimplification, they could not agree with many of his other claims. In particular, they initiated a protracted quarrel about the so-called ‘Great

Confinement' of the mad, said in *Folie et déraison* to have taken place across Europe in the course of the seventeenth and eighteenth centuries (Foucault 1961: 56-91; Midelfort 1980; Porter 1990; Scull 1990; Still and Velofit 1992).

One of the unfortunate side-effects of the controversies over the 'Great Confinement' – which became, to my mind, a problematic fixation on one of the least durable and interesting elements of Foucault's oeuvre – is that they distracted historians of pre-modern Europe from serious consideration of what a Foucauldian cultural history of medicine might look like. Foucault's later works, which moved away from large-scale interpretations of the modern scientific and social institutions and towards a chronologically wide-ranging concern with the role of discourse in the production of subjectivity (Foucault 1976–1984 and 2001), are actually much more valuable for cultural historians than the earlier writings on madness. This later work has had a profound influence on historians of sexuality and the body, but historians of pre-modern psychology have left the exploration of the cultural workings of early modern medical discourse, and its role in the historical formation of subjectivity, largely to literary scholars and practitioners of the cross-disciplinary history of emotions (for example Paster, Rowe and Floyd-Wilson, 2004).

My main purpose in this essay is to suggest how we might fill this gap, by outlining a cultural history of medical psychology in Europe in the period *c.* 1500–1650. My hope is also that this type of approach will help to mediate the resources of intellectual and social history, which have often collapsed into opposed perspectives (the physician's theory *vs.* the patient's 'experience'), by attending to the content and effects of 'medical discourse' – understood as related sets of medical ideas and practices. I make the assumption that medical discourse in this period furnished a set of linguistic and conceptual resources which constituted distinctive 'ways of being', establishing physical and psychological patterns that structured the ways in which physicians conceived and treated their patients, and also the

ways in which subjects thought about, inhabited, and expressed themselves. More specifically, by furnishing descriptions of the human body, articulating relationships between the body and the soul, giving definitions of health and disease, and prescribing regimens for physical and psychic health, medical sources established normative conceptual frameworks and fields of possible experience. To say this is not to retroject a modern interpretation of the historical environment: medicine in this period was conceived not only as the gift of God to ease human suffering, but also as propagating a physiological and psychological knowledge of the self that grounded its care (Ficino [1489], 1998: pp. 216-17; Vesalius, 1543: sig. *4; Crooke, 1615: pp. 12-16; generally see Harkness, 2006: pp. 171-92).

To proceed, I focus on the formation of medical subjectivity, following the suggestion of Foucault in his essay 'Qu'est-ce que les Lumières?' (1978) that the historical constitution of the subject can be analysed along three intersecting axes of knowledge, power, and ethics (Foucault, 1984: pp. 48-9; see also Hacking, 2002: pp. 1-26); but I adapt this to consider the formation of an early modern rather than modern subject, in which the axis of ethics also incorporates spirituality. I then outline the ways in which medical physiology and psychology formed a 'medical subject', before turning to the ways in which this subject was constituted as suffering from psychological and mental pathologies, focusing in detail upon the species of madness known as melancholy. Where space permits, I also consider relevant aspects of the relationship between medical and non-medical discourse, and some of the ways in which medical knowledge in this field circulated between the relatively rarefied worlds of learned medicine and the social contexts in which it was interpreted and applied by medical practitioners.

First, however, a few words about the concentration here mainly on Galenic medicine. Whilst this was a largely stable system of knowledge and practice, it was not a static, rigid, or closed monolith, but was multilayered, regional, and dynamic in various ways. It was

broadly continuous with the medicine of the later middle ages and prevailed until at least *c.* 1630; but in the course of the sixteenth century, it incorporated substantial innovations from medical humanism, anatomical dissection, Neoplatonic philosophy, and various occult sciences, all of which provoked discussion and dispute, and exerted varied influences across Europe. It was challenged and infiltrated by rivals, most directly and conspicuously by Paracelsus, Van Helmont and their followers, but also by Aristotelian natural philosophers and by ‘Hippocratic’ revivalists. It was geographically variegated, for whilst the universities of Northern Italy remained the centre of European learned medicine, distinctive traditions were recognisable particularly in France, Germany, Switzerland, Spain, England, and the Low Countries. With the progress of the Protestant and Catholic Reformations, it was increasingly inflected by religious concerns. And it was not the preserve of a learned elite, being, as the other essays in this volume show, subject to adaptation and modification not only across space and time, but also as it circulated through the various layers of early modern society and culture, and permeated the worlds of spirituality, literature, politics, and domestic life. Nevertheless, the Galenic medicine of the Renaissance was not radically unstable or heterogeneous. It was structured by a generally agreed set of core doctrines and principles, mostly inherited from late-medieval interpretations of the surviving works of Galen and other Greek and Arabic physicians and philosophers, which provided the conceptual framework for the discussions conducted in a community of medical authors, as well as for the activities of medical practitioners of different kinds, all across Europe. Given this general stability, whilst noting the caveats listed above, it is possible to continue now with a condensed synoptic account of the Galenic medical psychology that prevailed in this period.

Galenic medical psychology

How did Renaissance Galenism constitute the subject as an object of medical knowledge?

Most basically, knowledge of the human being consisted of knowledge of the body and of the soul, and of their interactions with each other and the external environment. The body was typically ordered Hippocratically (Crooke, 1615: p. 30), as an arrangement of material elements into parts that were ‘containing’ (such as bones, arteries, and organs) and ‘contained’ (such as the humours and the natural, vital and animal spirits). The soul, in line with the Aristotelian ‘hylomorphic’ understanding to which most learned physicians subscribed, was the intelligible ‘form’ or ‘actuality’ of the living body; the human being was therefore understood as a composite of immaterial form – soul – and matter – body. As the principle of vitality in the human organism, the soul in its different aspects was used to explain the ‘vegetative’ operations of bodily nourishment and growth, the ‘sensitive’ operations of sensation, perception, emotion and movement, and the ‘rational’ operations of thinking and willing (Fernel, 1578: pp. 80-3). Accordingly, body and soul were held to be tightly bound together in a relationship of mutual interaction and influence which contributed to health or sickness. The constituents of the healthy organism included in the traditional category of the *res naturales*, for instance, contained not only the physical elements, complexions, organs, spirits, and humours, but also the faculties of the soul deemed necessary for the basic activities of the living body. Similarly, in the *res non naturales* – factors which could influence the *res naturales* and therefore defined the scope of medical aetiology and intervention – the ‘passions of the mind’ were placed alongside air, food and drink, sleep and waking, motion and rest, and evacuation and repletion. Although the immaterial and immortal rational soul was excepted from direct material influence, the vegetative and sensitive operations of the soul could be affected by modifications of the physical body which they inhabited, and also themselves prompt physiological changes.

Here the crucial mediating role was played by the subtle spirits, often characterised as the ‘instrument’ of the soul in the body, which were integral to accounts of the causes, symptoms, and cures of many diseases (Fernel, 1578: pp. 68-9, 78-80; Lemnius, 1561: fols 6r-18r).

The interactions of body and soul were also integrated within the Galenic theory of complexion or temperament. The complexion, sometimes identified with the ‘substantial form’ of the living being, was derived from the qualities of the natural elements, whose mixture in the body yielded one theoretical condition of perfect balance, and eight distinctive patterns of relatively stable imbalance (Fernel, 1578: pp. 55-6; Lemnius, 1561: fols 23v, 80v-83v). These imbalanced patterns were either simple (hot, cold, moist, dry) or compound (hot and dry, hot and moist, cold and moist, cold and dry), and each could be identified by the interpretation of sets of physical and psychological signs. This theory enabled doctors to place the unique individual mixtures (‘idiosyncrasies’) of their patients into complexionate categories and ascertain which type of healthy imbalance was to be therapeutically restored (Lemnius, 1561, fols 30r-v), and it also undergirded a sexually differentiated pathology and therapeutics (the bodies of women were taken to be generally cooler and moister than those of men). More broadly, it provided the framework for the learned medical art of ordering and interpreting psychic and physical signs in accordance with the Galenic mantra that ‘the manners of the soul follow the temperament of the body’.

Whilst descriptions of the various complexions had long been incorporated within popular characterologies, their influence was substantially increased in the sixteenth century with the proliferation of vernacular medical works that laid out the connections between the physical conditions of their readers’ bodies, their psychic and emotional predispositions, and their characteristic forms of behaviour. One example, which I take to be broadly representative of medical literature of this kind, is the *De habitu et constitutione corporis*

(1561) by the Dutch physician Levinus Lemnius, a work translated into English by Thomas Newton (Lemnius [1576], 1633; for works in the English vernacular with similar concerns see Elyot, 1547; Boorde, 1547; Cogan, 1588; La Primaudaye, 1589; Clever, 1590; Vaughan, 1600; Walkington, 1607). A repository of useful self-knowledge, the *De habitu* advertised itself as a manual for readers to identify and understand their bodily dispositions and mental inclinations, and repeatedly iterated the value of so doing for the maintenance of physical health and moral ‘continency of life’ (Lemnius, [1576] 1633: p. 1). As works of this kind make clear, Galenic medicine furnished a distinctive model of self-scrutiny and self-management: medical self-knowledge, constituted as knowledge of how one’s complexion shaped the workings of one’s own body and soul, was the necessary condition for identifying and measuring one’s physical and moral defects, establishing whether and how they had a basis in nature (the *res naturales*), and for amending them (by the *res non naturales*), thereby restoring oneself as closely as possible to a condition of ‘good and sound disposition, or integrity of temperature’ (Lemnius [1576], 1633, pp. 52-3). For Lemnius as for many other physicians, the key agent in this therapeutic process was the *spiritus*, which was to be maintained and cherished as ‘the chiefe and principall instrument’ mediating the operations of both body and soul, and so the cause of the psychological and moral virtues and vices (Lemnius, [1576] 1633: pp. 12-13).

We can now make some general observations about the medical constitution of the human subject. In the first place, although the humours were commonly adduced as a primary internal cause of the individual’s physical and psychological dispositions, it is misleading to describe this as a form of ‘humoral’ subjectivity (Paster, 2004). This description not only forecloses consideration of the other *res naturales* as constituents of the healthy or sick body, but also conveys a materialistic determinism which cannot be squared with the consensus

about the interdependence of the body and the soul. Even the humours themselves had associations that extended beyond their immediate physical function in the body, being linked not only with the four qualities, elements, and bodily constituents (fluids, homogeneous parts, spirits, innate heat), but also with the four seasons, the four ages of man, and with the external 'climate' and astral bodies. In any case, far from being rooted in the material substances of the humours, the medical subject was constituted as a complex multitude of potentially interacting and overlapping physical, psychic, and external natural and supernatural elements and causes (Lemnius, [1576] 1633, p. 209; Cardano, [1557] 1663: pp. 146a-154b). As a conjectural art Galenic medicine constituted the body as the site of a practically infinite number of signs and significant relations – between different parts of the body; between body, spirit, and soul; and between man, the natural world, the cosmos, and God – to be interpreted and therapeutically manipulated. Semiologically, it was therefore continuous with, and in some cases permeated by, other arts concerned with the discovery, interpretation, and manipulation of the physical, psychological and celestial aspects of the human organism – astrology, chiromancy, metoposcopy, physiognomy, and dream-interpretation (Maclean, 2006: pp. 79-109). These arts considerably expanded and enriched the discursive space within which medical subjectivity could be elaborated. To know oneself medically, then, was first to know one's idiosyncrasy, but this was constituted not simply in terms of the absolute predominance in the body of particular qualities or humours, but in relation to age, sex, mode of life, and other variables, and invited consideration of the various ways in which one's body and soul were together subject to an array of beneficial or detrimental environmental and celestial influences.

Another salient feature of the model of subjectivity theorised in Galenic medical psychology is what we could now call its behavioural dimension, which bestowed it with morality and spirituality via the establishment of patterns of connected emotions, thoughts,

and actions. The hot and dry complexion, for example, was typically accompanied by emotional irritability, arrogance, and unruliness (Lemnius, [1576] 1633: pp. 210-11). Such behavioural patterning connected the idiosyncrasy to social being, for when bad customs and education supervened upon the complexion, ‘peevisish manners’ and vicious modes of life would commonly follow (Lemnius, [1576] 1633: pp. 208-10; for further elaboration see Huarte, 1575). Medically constituted subjects were moreover moral and spiritual subjects in more substantive ways. Whilst Galenic physicians did not explicitly present themselves – unlike their Paracelsian rivals – as practitioners of an overarchingly spiritual art, they often emphasised the spiritual aspect of the medical duty of care for the body, whose neglect would have perilous consequences for the soul (Lemnius, [1576] 1633, pp. 2-4; see Corneanu 2017). Subjects could also be held ethically and spiritually responsible for their own vicious or sinful actions, even whilst those actions were rooted in their physical mixtures, or indeed in the ‘occasion’ given by those mixtures to malign demonic forces; medical therapies could provide appropriate remedies (Lemnius, [1576] 1633, p. 37). As doctors sought to position their art within the spiritual frameworks being elaborated by Reformation and Counter-Reformation movements in the later sixteenth century, models of ‘spiritual physic’ seeking to integrate the care of body and soul along similar lines became increasingly prominent and substantial (Lederer 2006; Grell 1993; Harley 1993).

From Soul to Mind: Mental Illness and Madness

I turn now to the ways in which Renaissance Galenism created more specific configurations of subjectivity that were constituted as pathological forms of madness and mental illness along the axes, first, of knowledge, then of power and ethics/spirituality.

In learned medicine, where the human organism was regarded as a unified composite of soul and body, what we now call the ‘mind’ – *mens* or sometimes more traditionally

animus ('rational soul') in the Latin terminology – was ontologically not fully distinct from either soul or body. The operations of the mind were usually described as the faculties of the soul in the brain, particularly of the sensitive soul – whose functions were typically subdivided into perceptual faculties of the external senses and the internal senses (common sense, fantasy, imagination, cogitation, and memory), and 'motive' faculties which produced physical movements and appetites or emotional inclinations) – and of the rational or 'intellective' soul, usually comprised of the powers of will and understanding or intellect. Within this framework, there was no diagnosis and treatment that was applied to the mind separately from the body, and conversely the operations of mind or soul were drawn into the aetiology, diagnosis, and therapy of a wide variety of diseases. Diseases of the mind were in this sense diseases of the whole organism. This holds even for Neoplatonist philosopher-doctors who maintained a dualistic theory of matter and immaterial soul, such as Marsilio Ficino (Giglioli 2011), and for Paracelsians, for whom the spiritual-demonic, psychological and corporeal aspects of disease intertwined (Paracelsus, [1531] 2008: pp. 720-936; Webster, 2008: pp. 142-68). In Galenic medicine and beyond, then, it is not possible to talk of a distinct branch of the art exclusively concerned with 'mental illness' that can be identified as the forerunner of psychiatry. Rather, discourse about mental pathology was integrated within the complex and variegated world of discourse about the health and disease of the human organism in general. In Galenic medical literature, discussion of mental disorders was dispersed across all five of the branches of medicine – physiology, pathology, hygiene, semiotics, and therapeutics – and within the genres of both *theoria* and *practica*. Treatments for diseases with predominantly mental symptoms included the same range of pharmacological, surgical, regiminal, and astral or magical remedies as those for conditions with predominantly somatic symptoms (Plater, 1602-3: vol. 2, pp. 123-69; Burton, [1621-51] 1989-2000: vol. 2, pp. 1-266).

Nevertheless, we can detect in the late Renaissance a growing tendency amongst learned doctors to group and analyse ‘diseases of the mind’ together. The first Galenic treatise explicitly restricted to mental diseases, the *De cerebri morbis* by the Dutch physician Jason van der Velde, was published in 1549, although a distinct trend began only in the early seventeenth century with the appearance of the *Praxeos medicae* (1602) by Felix Plater. In the first volume of the *Praxeos*, the renowned Swiss physician discussed the various forms of sensory impairment, including afflictions not only of the external senses, but also of the principal internal senses of imagination, reason, and memory. Plater labelled the latter together as ‘mind’ (*mens*), and proceeded to describe how their functions were affected by various categories of affliction: *mentis imbecillitas*, *mentis consternatio*, *mentis alienatio*, and *mentis defatigatio* (Plater, 1602-3: vol. 1, pp. 1-179). Other learned treatises followed, including the *De cerebri et capitis morbis internis spicilegia* (1612) by the German doctor, historian and poet Franz Hildesheim, the *Archipathologia* (1614) by the Portuguese converso Elijah Montalto, and two books published in 1615 by the Venetian physician Curzio Marinelli (1615a; 1615b), *De morbis nobilioris animae facultates* and *De malis principem animam vexantibus*. Yet whilst such works contained a specific focus on the ‘mind’, they were advertised primarily as disquisitions on diseases of the head or of the soul (Burton, [1621–51] 1989–2000: vol. 1, p. 130). As in natural philosophy, the long-term shift from soul to mind within learned medicine was piecemeal, and at this stage radically incomplete (Vidal, 2011; Mengal, 2005).

Galenic discussions of diseases of the mind, soul, or head in the Renaissance, as with other areas of medicine, were generally continuous with their late-medieval predecessors. Conditions which were considered to be seated primarily in the brain, and which also seriously affected the faculties of imagination, reason and memory, were commonly allocated to the pathological genus of *delirium* (madness); in accordance with ancient medical doctrine

this was divided into three principal species, frenzy, mania, and melancholy. But a large number of other afflictions were routinely included in the category of ‘mental diseases’: apoplexy, vertigo, sopor, coma, lethargy, carus, memory loss, catalepsy, epilepsy, lycanthropy, incubus, rabies, stupor, tremor, conditions affecting the operation of the external senses such as blindness, deafness, tinnitus and glaucoma, and also those often thought to be of preternatural origin such as St. Vitus’s Dance and demonic possession or obsession. Different typologies and aetiologies can be found in the works of Paracelsus and his followers, but there are also substantial overlaps: in his treatise on diseases that ‘rob the reason’ (*Von den Krankheyten, so die Vernunfft berauben*), Paracelsus included epilepsy, mania, ‘true insanity’ – subdivided into lunacy induced by the moon, insanity inherited from the womb, fury caused by toxic foodstuffs, melancholy, and demonic obsession – St Vitus’s Dance, and the *suffocatio intellectus* (Paracelsus, [1567] 1941: pp. 135-212). In popular medical practice, however, the taxonomies were less stable. The notebooks of the English astrological physician Richard Napier grouped the mental abnormalities of his patients into various kinds, some of which were drawn from traditional learned doctrine (melancholy, madness, lunacy) but others derived from popular stereotypes, and mapped only indirectly on to the categories of learned discourse (‘mopishness’, ‘light-headedness’, being ‘troubled in mind’) (MacDonald, 1981a: pp. 115-25; cf. Kassell, 2005: pp. 128, 150, 168-9, 188, 202). In these typologies there is also a notable absence of hysteria, traditionally seen as a uterine rather than a mental disease. In the course of the seventeenth century, however, physicians increasingly tended to identify hysteria as a mental pathology seated in the brain (Boss, 1979; Arnaud 2015).

The Case of Melancholy

Renaissance medicine thereby constituted a substantial variety of forms of madness and ‘diseases of the mind’, which as a rule were taken to afflict the body, soul, and mental faculties altogether – in different ways, depending on the particular condition – and which could accordingly be treated by physical, psychological or spiritual remedies, or by some mixture of these. Orthodox Galenists tended to divide their attention in works of *theoria* roughly equally between the different species of madness and other psychological or mental diseases. From the sixteenth century onwards, however, there was growing concern with the condition of melancholy, the theory of which had expanded substantially since antiquity, and can be regarded as the most important – and in some contexts almost a ‘catch-all’ – category of madness in the Renaissance (Gowland, 2006). In the remainder of this essay, I focus on melancholy as a useful encapsulation of the character and scope of the medical discourse on mental illness, considering it as a form of medical subjectivity in terms of knowledge, power, and ethics.

Knowledge

There was a strong consensus in learned Galenism about the main aspects of the explanation, diagnosis, and treatment of melancholy. Knowledge of the disease was predicated in the first place upon knowledge of the melancholic complexion, since the principal material cause of both, as their etymology indicated, was black bile (μέλαινα χολή). A melancholic complexion, as Lemnius explained, was the least desirable, because its qualities of coldness and dryness were directly opposite to the heat and moisture required for ‘the maintenance and conservation of life’ (Lemnius, [1576] 1633: p. 215). This complexion commonly resulted from the failure of the spleen to purge the body of an excess of black bile, which affected the mood and psychological disposition by darkening and clouding the spirits, and was to be recognised by such familiar signs as a person being surly, anti-social, sorrowful, fearful, and

distrustful (Lemnius, [1576] 1633: pp. 221, 224, 225). Following natural-philosophical discussions of the Aristotelian *Problemata* XXX. 1, however, the melancholic complexion was also said by some physicians to yield symptoms of intellectual ingenuity and creativity, when adust black bile was moderately warmed and mixed with blood (Du Laurens, 1599: pp. 85-6; see Klibansky, Panofsky and Saxl, 1964; Brann, 2002). Theories of the disease of melancholy extended the explanatory framework of the melancholic complexion by focusing on the potential of an excess of black bile to hinder the operations of the faculties of both body and soul. In line with a long tradition of medical discussion extending back to Rufus of Ephesus, melancholy was usually divided into three main subspecies according to the site of the humour's preponderance – head, hypochondrium, or the whole body – and although each subspecies had its own distinctively identifiable groups of causes and symptoms, their central characteristics were given by the common definition of the species, namely as a type of chronic *delirium* without fever, and primarily affecting the imagination in the brain (Burton, [1621–51] 1989–2000: vol. 1, pp. 162-5).

In the later middle ages, the pathological category of melancholy had gradually increased in size and complexity as Galenic theorising absorbed influences from Arabic medicine. Astrological accounts of planetary influence were particularly significant, leading to the common identification of Saturn and Mercury as the main celestial causes of the disease (Klibansky, Panofsky and Saxl, 1964: pp. 82-102). Further subspecies also became widely recognised. Incorporating Arabic doctrines of erotic disease, medieval Galenists theorised the condition of love melancholy, and their discussions accordingly came to incorporate concatenations of external, psychological, and physical causes, in which black bile remained important but could also be described as only a prerequisite for the disease (Ferrand, [1623] 1990: pp. 242-51). In the later sixteenth century, these theories of love melancholy then formed the basis for the recognition and discussion of a distinctively

spiritual group of affective melancholic symptoms (Sassonia, 1603: p. 89). Physicians had also long noted the peculiar severity of some of the melancholic symptoms experienced by women (Mercuriale, 1602: p. 31, quoted in Calabritto, 2011a: p. 70), sometimes regarded as more susceptible to psychological and emotional disturbance, and also as more susceptible to illness because of the influence of the uterus and the putative malignancy of menses. Some learned doctors argued that women were subject to specifically female forms of melancholy, such those said to afflict virgins and unmarried women in the *De mulierum affectionibus* by the Spanish physician Luis de Mercado (1579: pp. 162b-169b; see also Castro, 1604: vol. 2, pp. 116-24).

The physical symptoms of the three traditional forms of melancholy, which were continuous with those of the complexion but varied according the three subspecies of the condition, included darkened, pale, or ruddy skin, leanness, hollowness of eyes, flatulence, dizziness, sluggishness, and sleeplessness. Their principal psychological symptoms were, according to the frequently quoted Hippocratic aphorism (VI. 23), prolonged fear and sorrow without manifest external causes, to be traced to the effects of dark, atrabilious vapours that had risen into the brain and affected the faculties of imagination and reason. Such symptoms were also said to be often accompanied by anxiety, delusions and hallucinations, misanthropy, love of idleness and solitude, and the desire for death. Erotic melancholics shared many of these, with the addition of others associated with the passion of love, such as sighing, erratic pulse, and distraction; religious melancholics typically expressed extreme fear of damnation and passions associated with despair. Prognostics for all kinds of the disease depended on the severity of the affliction, ranging from the restoration of the healthy idiosyncratic imbalance to death by suicide. The diversity of therapies matched the diversity of potential causes in the category of the 'non-naturals', and included psychological as well as physical measures; these were usually presented as redressing the qualitative physiological

imbalance of the melancholic sufferer through measures to increase heat and moisture, thereby working according to the orthodox therapeutic principle that ‘opposites are cured by opposites’, and as counteracting the cognitive aberrations involved in melancholic passions by working on the imagination and the reason. But medical authors who adhered less strictly to Galenic principles or rejected humoral theory also recommended chemical, magical and popular folkloric remedies, many of which had no explicit theoretical justification, or which were thought to cure by similarity, as in the Paracelsian medical doctrine of ‘signatures’ (Burton, [1621–51] 1989–2000: vol. 2, pp. 217-18, 260-1).

To sum up, medicine constituted melancholic subjects with a variety of characteristics, but there were a number of distinctive and relatively stable patterns that channelled their recognition and thereby their therapy by the physician: a patient exhibiting chronic passions (especially fear or sadness) without a manifest external cause, accompanied by delusions, poor appetite, and sleeplessness, would be almost certainly be diagnosed as suffering from the melancholic disease, which would then be differentiated into one of its subspecies according to other observable symptoms and treated accordingly. Here, however, a question of practical diagnostics arises: how was the melancholic subject to be known as pathological, rather than a complexionate melancholic who might exhibit very similar symptoms? According to the Galenic theory, a preponderance of black bile could become pathological when the black bile had become excessive in the extreme, corrupt, or burnt into its hot and dry ‘adust’ form, which could occur when it was supervened upon by any of a number of potential ‘non-natural’, preternatural or celestial pathogenic causes. But the close similarity between the signs of a settled melancholic complexion and that of a chronic disease, based on their common material cause, posed a problem for physicians and patients alike. One solution, proposed by André du Laurens, physician to Henri IV and professor of anatomy at the university of Montpellier, was to argue that melancholic complexions were

healthy insofar as they did not perceptibly hinder or damage the faculties of body or mind, especially imagination and reason (Du Laurens, 1599: pp. 84, 87). Another was given by Burton, who distinguished between ‘transitory’ and ‘fixed’ or habitual melancholy. To know oneself as a diseased melancholic began with the recognition that one’s condition would ‘hardly be removed’ (Burton, [1621–51] 1989–2000: vol. 1, pp. 136-9).

Case-studies give suggestive, though hardly conclusive, answers to the question of how this issue was negotiated by medical practitioners and patients; the same can be said about the more general issue of how consistently the Galenic theoretical distinctions relating to melancholy were applied. In England the classificatory schemes employed by physicians such as Napier, who distinguished between being ‘troubled in mind’ and being fully ‘melancholic’, do suggest that there was at least a general correspondence between the Galenic theory and diagnostic practice outside of learned circles (MacDonald, 1982). Considerations of social status, gender, and changes in pathological taxonomies all exerted intertwining influences upon the ways in which melancholy was perceived and treated. Medical diagnoses and patients’ self-perceptions were seemingly skewed most substantially by the common association of idleness with nobility, buttressed perhaps by the perceived link between the melancholic complexion and creative genius. The casebooks of the eminent Swiss doctor Théodore Turquet de Mayerne abound with melancholics from courtly circles, and Napier was similarly predisposed to see the well-to-do as ‘melancholic’ and the less socially elevated as ‘mopish’ or ‘dumpish’ (Nance, 2001: pp. 134-6; MacDonald, 1981a: pp. 150-3). Throughout Europe, letters and life-writings by or about philosophers, artists, and poets also suggest that the theory of ‘genial melancholy’ encouraged a degree of (mostly male) melancholic self-identification amongst the social elites (Wittkower and Wittkower, 1963: pp. 98-124).

Perceptions of the disproportionately fragile physical and psychological disposition of the female sex could also come into play. The casebooks of the Yorkshire practitioner Nathaniel Johnston suggest that later in the seventeenth century women of high social status, especially if they were virgins or unmarried, were seen to be especially susceptible to melancholy, and Johnston was predisposed to diagnose more women than men with melancholy, but more men than women with the closely related condition of hypochondria (Williams, 1990). But the theoretical expectation that women would be more likely to suffer from melancholy, either because of psychological weakness or because of their commonplace association with witchcraft and disordered sexuality, is not well-supported by the evidence that has been studied so far. Women were obviously thought to be susceptible to exclusively female conditions such as ‘Nun’s melancholy’ (Strocchia, 2011), and some physicians considered women more difficult to cure than men of certain forms of melancholy (Burton, [1621–51] 1989–2000: vol. 1, p. 429; Calabritto, 2011a: p. 71; Midelfort, 1999: p. 78); but the contents of learned practical *consilia* cut against the gendered stereotypes found in medical theory, and suggest that men were just as vulnerable to most melancholic afflictions as women (Calabritto, 2011a: pp. 75-80). Similarly, physicians’ adjudication of the truth or falsity of claims about diabolical interference depended on their assessment of the patient’s credibility, and that in turn seems to have issued less from ideas of sexual difference *per se* than from views about the malign agency of demons and the influence of supernatural forces upon the body (MacDonald, 1981a: pp. 198-217; Kassell, 2005: p. 150).

Power and ethics

How was the melancholic constituted as someone who acted and was acted upon? And what were the moral and spiritual implications of these aspects of melancholic subjectivity? Here we must first return to the psychological core of the Galenic theory of melancholy: as a

disease of the imagination, it affected the relationship between perception, thought and action, specifically disordering the way in which sense-data were processed by the powers of the soul. In the imaginatively deranged mind of the melancholic, sensory *species* were amplified and distorted by the damaged imagination, changing their form in ways that provoked extreme passions and perturbations and also delusions and hallucinations – to the extent that many physicians claimed that the power of reason or understanding could also be affected by the disease. Medical authors recycled a catalogue of common melancholic delusions – thinking oneself to be a shell-fish, to have swallowed a snake, to be made of glass, butter, and so on – whose evident irrationality was frequently adduced to support the claim that the operations of the rational soul were secondarily depraved (Montalto, 1614: pp. 224-8). However, doctors typically thought that the rational powers were not completely alienated. This enabled them to distinguish melancholy at least theoretically from mania, which generated more violent raving. The symptomatic actions of melancholics were held, accordingly, to emanate principally from the derangement of their imaginative-rational powers, and from the emotional disturbances that accompanied this derangement. This resulted in more extreme forms of the behavioural patterns associated with complexionate melancholics, varying according to the severity and the particular subspecies of the disease. In Burton's summary, 'far gone' melancholics talked and laughed to themselves; some, afflicted with irrational fear, could not tolerate solitude, whilst others craved it; some, suffering anxiety and discontent, tried to kill themselves, but others were suspicious and jealous of their companions. Above all, melancholics were emotionally unstable, irresolute and impulsive in their actions, and predisposed to fixate on unimportant matters and objects (Burton, [1621–51] 1989–2000: vol. 1, pp. 382, 385-6, 389-94).

Medicine did of course constitute the melancholic as a subject to be acted *upon* in various ways – not just therapeutically in encounters with physicians or in hospitals

(Henderson, 2006; MacDonald, 1981b; Andrews *et al.*, 1997: pp. 111-29), but also by those who encountered melancholics in social life, and particularly within legal and religious contexts. Learned Galenists tended to circumscribe the forms of therapeutic intervention for melancholy, as with other diseases, strictly within the categories of the non-naturals, and aimed to counteract pathological causes by various kinds of regiminal, pharmaceutical, and surgical treatment. But medical writings aimed at wider audiences also drew on moral and spiritual principles to make suggestions about how melancholics ought to be regarded, responded to, and indeed judged, in extra-medical environments. The most far-reaching moral and spiritual implications of melancholy were derived from the sufferer's psychological inability to subject his or her violent passions to rational control: as an irrational subject, the melancholic was a negation of the definitive philosophical status of man as *animal rationale* (Gowland, 2013). But negative assessments of this kind could be balanced by the consideration that no matter how morally or spiritually deviant the behaviour of melancholics appeared to be, because the corruption of their faculties of the soul had been 'constrained and violently inflicted by diseases', as Du Laurens argued, then 'it deserveth to bee weighed of every one with a tender and charitable compassion' (Du Laurens, 1599: p. 81; see also Lemnius, [1576] 1633: p. 231). The symptoms exhibited by some melancholics could also be seen to be so excessively irrational, especially their 'strange imaginations', that these became legitimately the subject of ridicule, to the extent that witnessing them could give 'delight' and generate contemptuous laughter; but they might also elicit sympathy and pity (Du Laurens, 1599: p. 103; Bright, 1586, p. 114; Burton, [1621–51] 1989–2000: vol. 1, p. 272).

The medical argument that melancholics should not be censured for evidently vicious behaviour because it proceeded from a kind of pathological madness, affecting their imagination and in some accounts also their reason, also had implications for their legal

personality (Midelfort, 1999: pp. 182-227; Mellyn, 2014: pp. 58-93; Robinson, 1996). In Roman civil law, which in combination with canon law formed the basis for the legal codes adopted in most of medieval and early modern Europe, if a subject could be demonstrated to be *furiosus*, *mentecaptus*, *fatuus*, or *demens*, this established mental incapacity and the grounds for what we now call an ‘insanity defence’. To say that someone suffers *furor*, for example, is to say, in the words of Justinian’s *Digest* (1. 18. 13-14), that they are ‘in such a state of madness, that from continuous aberration of mind they lack all understanding’; from this point of view, the attribution of malign intent (*dolus*) for voluntary actions, and therefore also traditional legal punishment, were deemed inappropriate. Following Roman law, late medieval legal commentators argued that the mad were only to be confined in prison if they could not be placed in the care of family, since the *furiosus* was ‘punished enough by the madness itself’ (Justinian, 1985: vol. 1, p. 36 [translation modified]; see also de Ubaldis, 1575: consil. 347). In applying this principle, however, the judge would need to consider whether the subject was ‘really and truly not *compos mentis*’ (*Digest* 1. 18. 13. 1), and subsidiary questions then became relevant: whether the *furor* was feigned, and whether the madness was of a kind that permitted the subject to enjoy ‘lucid intervals’ which might affect the interpretation of witness testimonies (Calabritto, 2008: p. 143).

Forensic medicine had become well established in the legal systems of most of continental Europe by the sixteenth century (Crawford, 1994: pp. 93-5; de Renzi, 2007), and in its later decades learned physicians became increasingly involved in establishing and explaining the details of different forms of pathological irrationality in criminal trials; at the same time, legal *consilia* were infiltrated by Galenic learning. Initially this seems to have been stimulated by public controversies over witchcraft prosecutions, especially following the provocative and influential critique mounted in the *De praestigiis daemonum* (1563) by the physician Johann Weyer, which argued that those accused of witchcraft were not guilty of

undertaking a Satanic pact, but had rather been deceived by malign demonic forces, and were possibly just imaginatively deranged melancholics to be regarded as *furiosi* under Roman law (Weyer, [1563] 1998: pp. 180-6). Distinctions between forms of madness differing in kind and degree of severity, either imported from learned medicine or issued directly by physicians, were subsequently considered in the context of criminal law. The prolific Italian jurist Giacomo Menochio, for example, drew on medical authorities to argue that a Paduan septuagenarian accused of heresy was not only legally ‘*insanus & stultus*’, but suffering from frenzy with lucid intervals (Menochio, [1572] 1609: p. 218v). The use of medical arguments to distinguish between those who were truly sick and those who were feigning illness was also extended to different kinds of madmen and melancholics. For the trial in 1588 of the Bolognese aristocrat Paolo Barbieri for the murder of his wife, a number of learned doctors, led by the eminent professor of medicine at Padua Girolamo Mercuriale, gave their formal opinion that Barbieri had long suffered from hypochondriacal melancholy, and that his condition – as indicated by Barbieri’s violent ‘imaginationes and bad thoughts’ – had turned into adust melancholy of the whole body. When, as the doctors explained, he failed to keep to their prescribed therapeutic regimen, and the arrival of autumn intensified the effect of the malign humours in his body, he fell into a state of extreme *furor* that occluded his reason and caused him to attack his wife, before running into the street, raving, in his nightgown. Although Barbieri subsequently regained control of his mental faculties and expressed regret for his actions, according to the doctors this occurred in a lucid interval: he was thus a melancholic *furiosus* under the sway of a ‘burned and wild humour’ (Calabritto, 2008: pp. 152-3).

In court, however, medical authority was not decisive. Judges were advised to have recourse to physicians in considering cases of *furor*, but the testimony of physicians was not intrinsically superior to that of other witnesses, and medical evidence was sometimes

regarded as weak: as the eminent papal physician and jurist Paolo Zacchia conceded, ‘the judgement of doctors ... is often fallacious, as experience demonstrates’ (Zacchia, [1621–51] 1661: p. 420, though cf. the claims at pp. 365, 398, 417). All parties tended to exploit the flexibility of the vocabulary of ‘madness’ and ‘melancholy’ to promote their own interests, and irrefutable proof of *furor* was notoriously difficult to produce (Mellyn, 2014: pp. 93, 132, 145). In the case above, Barbieri was condemned and sentenced to death by the judge, who probably viewed his flight from Bologna after committing the murder as a sign of guilt rather than as a lucid interval (Calabritto, 2008: p. 141). Indeed, whilst all agreed that melancholics were sufferers of *delirium*, some questioned whether they were medically or legally *furiosi*. Zacchia, who devoted an entire book to the conditions of impaired rationality in his influential *Quaestiones medico-legales* (Zacchia, 1651; see Foucault, 1961: pp. 139-40, 153, 283, 293), observed that melancholics, being affected by black bile in its natural state, were typically quiet and sorrowful; but *furiosi* – identified as sufferers from mania, caused by black bile in its unnatural adust form – were aggressive and excitable. According to Zacchia, whilst both diseases generated irrational, impaired behaviour, it was characteristic of melancholics that they lacked prudence and so were prone to erratic judgements and actions. But when their imaginative derangement referred to a single object, their testimony was admissible, and they could also be held responsible for criminal acts (Zacchia, 1651: p. 26). Other jurists further distinguished between melancholics and *furiosi*, arguing that the former, unlike the latter, were capable of voluntary acts and so were responsible for their actions (Midelfort, 1999: pp. 220-3).

In continental Europe, then, to be a melancholic in court was to be a site of potential struggle between medical and legal interpretations of *furor*. In England, where proceedings followed its common law and where there was no system of forensic medicine comparable to that on the continent (Crawford, 1994: pp. 105-7), it is harder to discern the substantial

incorporation of medical learning within legal discourse. Insanity defences drawing on the Roman concepts of *non compos mentis* and *actus non facit rerum nisi mens sit rea* had been mounted well before the first recorded acquittal on these grounds in 1505 (Walker, 1967–73: vol. 1, p. 19), though according to Sir Edward Coke, the exculpatory force of the principle that the *furiosus* is ‘punished enough by the madness itself’ had traditionally been qualified by the requirement not only that ‘it must be an absolute madnesse’, but also that it must involve ‘a totall deprivation of memorie’ – which according to the physicians occurred in frenzy but not melancholy (Coke, 1644: p. 6; see further Coke, 1628, pp. 246–8). Reflecting in 1592 on the recent treason convictions of the puritan prophet William Hacket and his associates Edmund Coppinger and Henry Arthington, the ecclesiastical lawyer Richard Cosin listed the ‘divers degrees’ of irrationality as ‘*Furor sive Rabies: Dementia sive Amentia: Insania sive Phrenesis: Fatuitas, Stultitia, Lethargia, & Delirium*’, but his sources here were legal and philosophical, and Cosin eschewed contemporary medical arguments about melancholy in his argument that none of them could be excused of malign intent on grounds of madness (Cosin, 1592, pp. 73, 75; Walsham, 1998). However, public controversy over possession and witchcraft did sometimes provoke the introduction of medical authority to English legal considerations of insanity. Galenic ideas about madness and melancholy were employed for sceptical purposes in the later decades of the sixteenth century by Reginald Scot and Samuel Harnset, and prominent trials brought doctors into the court. In the infamous case of the London teenager Mary Glover, whose alleged bewitchment by Elizabeth Jackson led to the latter’s conviction in 1602, doctors testified on both sides of the case, with the learned physician Edward Jorden arguing unsuccessfully that Glover was actually suffering from the natural disease of hysteria, and then – on the encouragement of the Bishop of London, Richard Bancroft – elaborating his views at length in a bitter pamphlet

controversy with others who sought to attribute her symptoms to supernatural causes (MacDonald, 1991: pp. xv, xlix).

But whilst medical testimony was often sought in English courts in this period, this was done in a relatively piecemeal fashion, and there was no body of systematic medico-legal discourse in which the diagnostic specificities of different forms of madness could be differentiated with reference to medical learning (Crawford, 1994: p. 108). Melancholics did not have a clearly defined legal identity in England until Sir Matthew Hale discussed their condition in the late seventeenth century under the heading of ‘accidental’ or ‘adventitious’ *dementia* in his unfinished *Historia placitae coronae*. Even then the medical details were vague. According to Hale, ‘melancholy persons’, who mostly ‘discover their defect in excessive fears and griefs’, were to be regarded as suffering from only ‘partial insanity’, a condition which seemed ‘not to excuse them in the committing of any offence for its matter capital’, since they were ‘not wholly destitute of the use of reason’. As for how to draw the ‘invisible line’ between ‘perfect’ and ‘partial’ insanity, Hale made no mention of physicians or medical authority, arguing simply that this ‘must rest upon circumstances duly to be weighed and considered both by the judge and jury’, and offering the opinion that a melancholic should be regarded as having ‘ordinarily as great understanding, as ordinarily a child of fourteen years hath’ (Hale 1736, p. 30; for continental precedents see Midelfort, 1999: p. 189).

As the involvement of doctors in controversies and legal discussions of witchcraft and demonic possession indicates, Galenic medicine also contributed to the formation of the melancholic as a spiritual subject. Here the vectors were constituted by the relations between melancholy and the conditions of superstition, inspiration (or enthusiasm), and atheism. In learned circles melancholics were identified as prone to superstition principally on the

authority of Rufus of Ephesus, Aretaeus of Cappadocia, and the Arabic physician Ishâq ibn 'Imran, whose explanation of the susceptibility of the religiously devout to melancholy as a function of their excessive fear of God and anxiety about future judgement circulated in the eleventh-century translation *De melancholia* by Constantine the African (Rufus of Ephesus, 2008: pp. 37-9, 69; Aretaeus of Cappadocia, 1552: fols 17r, 18v-19r; Constantine the African, 1536: p. 283). In discussions of prophetic inspiration Renaissance physicians had recourse to the discussion of the strange effects of black bile on the mind given by the pseudo-Aristotelian *Problemata* XXX. 1 (Arculanus, 1493: fol. 26r), and it was frequently asserted that the humour – referred to as the ‘devil’s bath’ – attracted demonic forces into the body, where they disturbed the imagination and provoked the melancholic disease (Brann, 2002: pp. 24, 211-12, 342-3). Physicians also began to offer black bile as a potential cause of spiritual despair, which in writings on sorrow and sloth had long been regarded as primarily the territory of the theologian, and of atheistic doubt (Ficino, [1482] 2001-2006: vol. 4, pp. 301;13; Bright, 1586: pp. 190, 197-205).

Whilst spiritual symptoms had long been incorporated within learned medical accounts of melancholy, it was not until the later decades of the sixteenth century that Galenic physicians began to group these symptoms together and theorise a distinctively ‘religious’ subspecies of the disease. As had been shown by the notorious case of the Venetian jurist Francesco Spiera, whose public abjuration of Protestantism and despairing death in 1548 was alleged by Reformed polemicists to have been provoked by his melancholic passions (Overell, 1995), medical discourse about melancholy could easily become enmeshed within confessional religious politics. And indeed, the stimulus for the development of theories of religious melancholy seems to have been provided, at least in part, by the intensification across Europe at this time of post-Reformation confessional controversies over the theology of grace, whose language and doctrinal flash-points are

conspicuous in several medical discussions of cases of religiously inflected melancholy (Midelfort, 1996). In England this is evident in the *Treatise of Melancholie* by the physician and Calvinist divine Timothy Bright, whose account of melancholy exerted strong influence upon works of practical divinity well into the following century (as in Perkins, 1596: pp. 86-7; 1604: pp. 173-80, 182-3). In the lengthy appendix to the *Treatise*, Bright distinguished the melancholic disease from the purely spiritual affliction of conscience, but also explored the ways in which melancholics' inclination to meditate upon the controversial points of predestination drove them to despair (Bright, 1586: pp. 200-201).

On the continent Pieter van Foreest, the city-physician of Delft, included several case histories of religiously inflected melancholy in his *Observationes et curationes*, whose tenth book was devoted to diseases of the brain. Here fasting, contemplative solitude, and conscientious scruples were implicated in melancholic derangement and atheistic despair. One case-history is especially suggestive: that of two brothers from Alkmaar, whom van Foreest describes returning from studying in Catholic Leuven (where van Foreest himself had trained, and the site of fierce disputes over predestination in the 1580s), the first in a state of total *delirium*, and the second with suicidal melancholy exacerbated by the overzealous study of scholastic theology (van Foreest, [1584–1606] 1653: p. 418a; see Rutten, 2011). According to Felix Plater in his *Praxeos medicae*, melancholy with religious symptoms, such as fear of the final judgement and the despairing belief that one was not predestined to be saved, was 'the most frequent species' of the disease, and one he had found extremely difficult to cure (Plater, 1602–3: vol. 1, pp. 88-9). Catholic physicians such as Ercole Sassonia, professor of medicine at Padua, also gave attention to the spiritual symptoms of melancholics (Sassonia, 1603: p. 89; Sassonia, [1620] 1639: p. 8; for Spanish parallels see Orobítg, 2015). Physicians were here wandering out of their territory on to dangerous ground, so it is not surprising that the seventeenth century the history of 'religious

melancholy’, which was first explicitly designated as a subspecies of the disease by Burton ([1621–51] 1989–2000, vol. 3, pp. 330-1), is largely a history of the appropriation of medical language by non-physicians. In England, the concept of ‘religious melancholy’ was mainly used by philosophers and theologians to attack forms of politically threatening spirituality as pathological forms of melancholic ‘superstition’ and ‘enthusiasm’, and to criticise rival confessions as responsible for melancholic despair, a usage that spread to the continent in the following century (Heyd, 1995; Keitt, 2004; Laborie, 2017).

As these fluctuating theological and political currents suggest, the spiritual dimension of melancholy depended radically upon the context of its designation. To be spiritually melancholic in Galenic medicine was to suffer from the pathology physiologically in ways that were similar to those for other melancholics: for most physicians, the specificity of the condition related to its particular imaginative and derangements, which were distortions or exacerbations of otherwise normal religious preoccupations or feelings, and could be indications of demonic interference; for others, the description of the condition was based in its affective spiritual-psychological origin, the defective or perverted love of God to which everyone was potentially subject after the Fall (Burton, [1621–51] 1989–2000: vol. 3, pp. 334-43). But the reach of Galenic medicine into this domain was constrained by contrasting but widely held religious conceptions of spiritual distress. While some physicians were willing to diagnose those with religiously inflected psychological symptoms as suffering from a melancholic disease with purely physical, non-natural causes, it was more common in practice to identify a combination of these with spiritual causes, and many patients seem to have resisted the Galenic medicalisation of their own spiritual anguish. Studies of English ‘spiritual physic’ in the seventeenth century strongly suggest that when given a choice of self-interpretation that offered suffering from either melancholy or divine affliction of conscience, most opted for the latter, interpreting their suffering as providential and seeking

the spiritual-psychological therapies offered by purveyors of practical divinity (Harley, 1996; Hodgkin, 2007; Schmidt, 2007; Sullivan 2016; Thorley, 2016). In effect, the limited contexts in which the Galenic conception of religious melancholy could take hold restricted its influence in a world where there were alternative, powerful and socially well-established ways of thinking about spiritual selfhood and illness. Beyond the domain of orthodox learned medicine, the boundaries between the natural and the supernatural were more fluid and porous, and here, the experience of disease could be constituted in a way that was permeated and encompassed by its overarching spirituality and heavenly character.

Conclusion

The human subject was constituted in the Galenic medicine of the Renaissance as a site of ordered and causally connected physical and psychical elements and operations, susceptible to a diversity of ‘non-natural’, preternatural and supernatural influences, and imbued with moral and spiritual significance. This discursive framework was of diagnostic use for the physician, but it also traced out passages for self-interpretation: the medical subject was someone to be known about, but also someone who knew themselves, being in possession of self-knowledge of their body and soul, their interactions, and their relationship with the external world and celestial sphere. Within this model of subjectivity, to experience madness, and more particularly experience melancholy, was to suffer a deprivation of the rational powers that were essential to the harmonious functioning of the organism as a soul-body composite, potentially generating a host of extreme passions and perturbations, imaginative derangements, and actions that could lead to the transgression of social, moral and spiritual values.

How culturally significant was this model of subjectivity, however, and how was it expressed? There is little doubt that as medical doctrines and practices circulated across

Europe in this period they had substantial influence beyond medical circles, not only through the interactions of physicians with their patients, but also through the proliferation of medical works aimed at lay audiences. Plotting and measuring this impact is a large, complex and ongoing task for cultural historians of medicine. But although it is not hard to find expressions of distinctively medical subjectivity in literary works – especially in drama and life-writing, where the idiosyncrasies often appear as indices of individual physiology and psychology (Montaigne, [1580–1595] 2007: p. 679; Tasso quoted in Calabritto, 2011b: p. 206; Burton, [1621–51] 1989–2000: vol. 1, p. 7; Aubrey, 1898: p. 347) – these are rarely, if ever, found in pure form outside medical genres. Instead, medical concepts were typically incorporated within broader discursive frameworks that constituted subjects by positioning them in relation to a range of different vectors, of morality and spirituality, and of social, political, and economic norms (for an English case-study see Smyth, 2010). This is particularly evident in the case of melancholy, where as we have seen medicine provided a distinctive mode of understanding which could be combined but also challenged or constrained by other ways of thinking and forms of experience, and which was adapted as it interacted with the world that surrounded it. To be considered mad or melancholic was not only to be seen as treatable by various kinds of medical therapy, but also to experience and traverse through spaces of morality, legality, and spirituality in ways that were shaped and perhaps even ultimately determined by the broader social contexts in which the medical world was embedded. There was of course no one way of being ‘mad’ or ‘melancholic’ in this period, or any other, but the more one zooms out from the medical sources to consider their relationship with the wider social environments where they became relevant, the more flexible and permeable medical subjectivity seems to have been, the more unstable its governing vocabulary, and the more open to influence and reinterpretation by competing forces of – especially legal and religious – authority. To put this another way: in the case of

madness and melancholy, the process of ‘medicalisation’, often taken to be an index of the development of modern scientific culture in Europe, was, at this stage at least, uneven, fragile, and eminently contestable. It was only in the later decades of the seventeenth century, as substantial and sophisticated medical discussions of mental pathology became consolidated within the influential knowledge networks of the ‘new science’, that medical discourse about mental illness would begin to acquire a more robust, pervasive, and invasive authority in the social environments of early modern Europe.