Making Sense of Pain: Delusions, Syphilis, and Somatic Pain in London County Council Asylums, *c.* 1900

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I
Introduction

On 28 June 1901, a 46-year-old French wood carver named Eugene N. was admitted to the London County Council's (LCC) Hanwell Asylum singing the Marseillaise at full throttle. In addition to boasting about his vocal talent and great riches, he repeatedly demanded to see the Queen, insisting it was his right as king. He was diagnosed with general paralysis of the insane (GPI), a disease associated with tertiary syphilis, which he had contracted as a young man. Scars believed to have been caused by syphilitic lesions were found on his body, confirming the diagnosis. According to his wife, who furnished the asylum authorities with details of her husband's history, Eugene had been 'a steady, temperate man, thoroughly moral, very industrious'. He had begun to suffer from dyspepsia and dilation of the stomach, poor eyesight, and 'sharp shooting pains in the legs' eight or nine years prior to admission. The 'extravagant ideas' had begun around six months before he arrived at Hanwell. Just two months after admission, Eugene was reported to have been 'pale and emaciated, continually talking to imaginary persons, making lunges at the wall, or jerking his hands in the air as if throwing off some imaginary objects on his body'. He frequently rubbed the skin on his knees and feet, all the while muttering 'electricity'. In November, five months after he was admitted, Eugene died. A post-mortem examination confirmed that he was 'tabo-paretic', suffering from tabes dorsalis and GPI, both of which could present during the tertiary stage of syphilis.[1]

Eugene's 'case' was included in a study of tabes dorsalis conducted by London pathologist Frederick Mott and published in 1903. In it, Mott claimed, among other things, that it was not uncommon for tabo-paretic patients to suffer from persecutory delusions or hallucinations that related to their bodily pain, writing:

> These patients often believe they are being tortured by unseen agencies, that electricity has been turned on by their enemies; they have been given poison which has gone into their legs and feet. They may associate the pains experienced with dreams or visual hallucinations; and they may tell you […]

> that lions and wolves came and gnawed their limbs by night, and will beg you not to let them be tortured again. (*AoN2*, p. 44)

Mott was not the first to have commented on this phenomenon. In his dictionary entry on locomotor ataxy, another diagnostic label for tabes, the Physician Superintendent at Bethlem Royal Hospital, George Savage, wrote that

> there may be **insane interpretations** of the **ordinary crises** […]. One man may attribute the pains and weakness in his legs to poisoning, or to 'influence' — electricity or mesmerism; while another will say the pain and thickening about his ankles are due to diabolical possession, and that the bullae […] are marks of the devil's grip.[2]

Mott believed that these accounts were illusions, defined as 'a false interpretation of a sensation actually perceived', rather than delusions which the eminent Scottish alienist Thomas Clouston described as 'a belief in something that would be incredible to people of the same class, education, or race as the person who expresses it, the belief persisting in spite of proof to the contrary'.[3] Because reports in asylum case notes were recorded as 'delusions', I shall use this term. Technically speaking, however, I agree with Mott. I believe that these accounts were, indeed, illusions, that is, erroneous interpretations of painful and bewildering bodily sensations and the agencies that caused them. As such, they can be analysed as pain narratives. This article asks, therefore, what delusional themes can tell us about the subjective experience of pain in asylum patients with tertiary syphilis.

The historiography of syphilis is considerable but little work has been done on GPI and even less on tabes dorsalis.[4] Substantive studies tend to focus on the more frequently diagnosed GPI. Psychiatrist Edward Hare produced a lengthy essay on its epidemiology, attributing its sudden rise in Europe during the nineteenth century to the proliferation of 'a special neurotropic strain of the syphilitic virus'.[5] Juliet Hurn's doctoral thesis charts medical attitudes towards GPI in Britain from 1830 to 1950.[6] The most recent and by far the most comprehensive work has been produced by social historian Gayle Davis whose monograph *The Cruel Madness of Love* traces the evolution of GPI as a disease category in a changing social, moral, and medical climate in Scotland during the late nineteenth and early twentieth centuries.[7]

None of these studies addresses pain because GPI was, in itself, rarely painful. Yet, tabes dorsalis, which often preceded GPI or coexisted with it as tabo-paralysis, affected the nervous system causing agonizing pain in virtually any part of the body, but

particularly the legs, viscera, and head. Indeed, the broader topic of somatic pain in nineteenth-century asylum patients has received very little attention from historians, which is surprising given the lamentable physical and mental condition of so many inmates.

By arguing that delusions relating to bodily sensations can be construed as pain narratives, this article will add to the growing number of voices, including those of literary scholar Lucy Bending and cultural historian Joanna Bourke, who refute the much quoted claim by Elaine Scarry (1985) that 'physical pain does not simply resist language but actively destroys it'.[8] While pain narratives do exist in myriad forms — often fractured accounts in diaries, letters, case-books, and medical journals — the voice of the historical patient-in-pain, particularly the socially disadvantaged patient, remains elusive. Following his clarion call to 'do history from below' in 1985, Roy Porter drew attention to delusional writings in a number of publications, thus demonstrating their historical value and ability to provide insights into the preoccupations and subjective world of people deemed to be insane.[9] Porter was intrigued by 'mad writings', commenting that 'there is no more splendid cache of psychopathological material than the delusions recorded over the centuries by the insane'.[10] In *The Madhouse of Language*, literary scholar Allan Ingram has produced a sophisticated analysis of the language of madness drawn from accounts produced by the so-called mad, as well as the 'sane', recorded in medical records and texts, and in more literary works. He analyses language within the framework of linguistic and medical discourses of the long eighteenth century to gain a deeper understanding of how today's critic or historian might understand the experience of madness. Drawing on the Lockean notion that madmen have wrong ideas but reason correctly, he writes that

> once the power of reason is granted, the articulations of madness can no longer be regarded as ravings or ramblings, but become available as linguistic acts to be read and understood within a system of grammar, and within a social system, just like any other.[11]

Ingram also connects language to the somatic experience of pain and, for this reason, his work has been particularly useful.

Most historical work on delusions has focused on first-person narratives in edited volumes and anthologies. These include Dale Peterson's anthology (1982), as well as a number of interpretations of the writings of London tea merchant James Tilly Matthews (1770–1815) and the German judge Daniel Schreber (1842–1911).[12] Clinician and

historian Allan Beveridge has drawn on accounts of delusions to provide insights into the psychological preoccupations of individuals through his study of patients who were admitted to the Royal Edinburgh Asylum between 1873 and 1908.[13] Beveridge referred to these letters as 'bulletins from the front line', which are 'less tidy, less polished productions than published works [which][…] arguably […] give a more authentic picture of the nature of mental illness a hundred years ago' ('Voices of the Mad', p. 907). I will be making a similar point in relation to records in asylum case notes.

Few social and cultural historians have, however, tapped the rich seam of delusional content that was recorded in asylum case notes. There are good reasons for this. Literary scholar Carol Berkenkotter has shown how shifting psychiatric epistemology shaped the construction of asylum case notes, while social historian Jonathan Andrews has drawn attention to the potential pitfalls around working with these accounts, particularly relating to issues of inconsistency, omission, bias, and censorship.[14] Case notes were usually written by doctors who might have been informed by nursing staff, the patient's relatives, or the patient, all with his or her own interests. The degree to which notes provide an insight into clinical 'reality' is, therefore, questionable because each will have been subjected to at least one stage of interpretation before the historian adds her own layer of reflexive interpretation to 'the mix'. Because we are trying to get closer to the patient's subjective experiences, rather than to that of the doctor, I will focus on the meaning of delusional *themes*, such as electricity, rather than provide a close textual analysis of the delusional accounts. Such themes, which are replete with symbolism, can be understood within a similar framework to that used for analysing metaphors, which imbue delusions with meaning, both describing and constructing experiences.[15] While we can never really know for sure whether anomalous sensations were the result of tabes or neurological damage caused by other factors, we can be reasonably sure of the GPI and/or tabes diagnosis because they were among the few, if not the only, conditions treated in mental institutions where lesions could be found at post-mortem.[16]

To summarize, this article sets out to ask what recorded delusions can tell historians about the subjective experience of pain in asylum patients with tabes dorsalis, thus exploring the complex relationship between culture, the body-in-pain, and the disordered mind. In terms of the structure, I will provide a brief overview of syphilis and GPI/tabes, and their symptoms, followed by a methodology for understanding delusional themes, applying this approach to that of 'electricity'. Finally, I will suggest the meaning

given to pain by patients, how it was constructed, and some of the psychosocial consequences of these interpretations. First, however, it is important to understand tertiary syphilis within its social and historical context at the end of the nineteenth century.

II
Syphilis, GPI, and Tabes Dorsalis

Painful, horribly disfiguring, and incurable, few diseases were as socially freighted or feared as syphilis in Victorian Britain. Particularly prevalent in men, especially those who had served in the army or navy, it was cloaked in shame and stigma. Often referred to as 'the secret disease' or 'a social evil', syphilis was associated with 'sin'. During the latter decades of the nineteenth century, around five to seven per cent of those infected with syphilis developed diseases of the tertiary stages, which usually manifested as GPI, tabes dorsalis, or tabo-paralysis.[17] At the time, a significant number of 'alienists', as nineteenth-century psychiatrists were called, believed that GPI and tabes could be caused not only by syphilis but by other pernicious effects of modern life; these included excessive alcohol consumption, tobacco, sexual indulgence, and over-work. By the end of the century, with degeneracy theory in the ascendency, most — but not all — alienists believed the underlying cause of GPI/tabes to be a faulty heredity, activated by syphilis. The aetiological link between syphilis and GPI/tabes was not proven in the laboratory until the early twentieth century following a chain of discoveries that began with the identification of the *treponema pallidum* as the causative agent of syphilis in 1905. A year later the Wasserman test was introduced to detect the bacterium in the blood and, in 1907, in the cerebro-spinal fluid. In 1913, it was found in the brain of a patient who had died from GPI.[18]

Incidences of GPI and tabes were particularly high in urban areas, with London numbers exceeding those of anywhere else in England and Wales. In 1901, no fewer than 17 per cent of male asylum admissions to LCC Asylums were diagnosed with GPI, compared to 11 per cent across England and Wales in a similar period. Death rates were even higher. General paralysis accounted for 38.5 per cent of male deaths in LCC asylums compared to 27.4 per cent nationally in 1901. The socio-economic consequences were significant, with most deaths occurring in men aged 35 to 54 when many were at their most productive. The wealthy — and it was common in men from all social classes —

could afford to be looked after at home or in a discreet private nursing establishment, thus evading the social stigma associated with asylums, as well as the statistics. Tabes and GPI were diagnosed far more infrequently in women: 3.3 per cent in London compared with 2.4 per cent nationally in 1901, although this percentage did begin to rise in the early twentieth century.[19] Some contracted it through prostitution, others from their husbands.

Recording a diagnosis could be a vague and arbitrary affair. On admission, most patients with both tabetic as well as paretic symptoms were given a primary diagnosis of GPI, as in the case of Eugene N. As the disease progressed, tabetic symptoms might diminish while paralysis and dementia associated with GPI became more pronounced, ultimately leading to death. Mott circumvented the GPI/tabes distinction by using the term 'tabo-paralytic', claiming that many of the leading authorities on the subject believed that 'etiologically and pathogenetically the two diseases were identical'. He maintained that 'there is one tabes which may begin in the brain […] or in the spinal cord […] or in the peripheral nervous structures' connected with different parts of the body (*AoN2*, p. 3). By the 1920s, all forms of tertiary syphilis that affected the nervous system, including tabes dorsalis and GPI, were included within the umbrella category of neurosyphilis (Davis, p. 16). Not only was the prospect of an accurate diagnosis confused by myriad symptoms, it could also be influenced by a patient's social class due to the delicate nature of his condition. While county asylum patients were diagnosed with general paralysis, Mott wrote that 'when a noble or distinguished patient suffers from grandiose delusions and other signs of the progressive brain disease which in a few years will terminate fatally, it is given out that he is suffering from locomotor ataxy' (*AoN2*, p. 3). Whatever the diagnostic label, those suffering from these forms of tertiary syphilis faced an incommutable death sentence. Months or years of excruciating and debilitating pain in the case of those with tabes were often followed by the gradual deterioration of body and mind that required intensive nursing care in the GPI wards of a mental establishment.[20]

Not only did confusion around diagnostic categories prevail, so, too, did symptoms. Syphilis was often referred to as 'the great imitator' or 'great imposter' because it could so easily be confused with other conditions. Many sufferers believed for years that the pains in their legs were sciatica or rheumatism, or that they suffered from gout (*AoN2*, pp. 42–43). Indeed, it was not uncommon for tertiary syphilis to be diagnosed fifteen or twenty years after the initial infection, having remained latent in the body during the intervening period. In the case of tabes or tabo-paralysis, the syphilitic spirochaete

caused degeneration and inflammation of the dorsal, or posterior, column of the spinal cord, giving rise to a number of symptoms. Mott enumerated the main ones as reflex pupil rigidity (Argyll Robertson pupils); lightning pains, absence of deep reflexes; visceral disturbances, bladder troubles, and gastric crises; motor disturbances; and mental disturbances (*AoN2*, p. 30). He wrote how patients with tabes dorsalis suffered from agonizing pain with pin-point pupils, citing the case of one woman for whom 'even the light of the windows was so painful she would bury her face in the pillow' (*AoN2*, pp. 31, 43). Abdominal or 'girdle pains' were common, described by Mott as a 'tightness compared to an iron jacket or the constriction of a tight belt', and by one of his patients as if 'something was squeezing him in a vice' (*AoN2*, pp. 43, 122). Another patient experienced a burning pain in the larynx and felt he was going to be suffocated (*AoN2*, p. 57). A common early symptom of tabes was lancinating pains which Mott likened to 'stabbing, shooting, boring or lightning, or to hot wires thrust into the flesh' (*AoN2*, p. 42).

GPI tended to be associated with dementia and paralysis of virtually any part of the body. In itself, it does not cause pain. Even when pricked by a needle, GPI patients were reported to feel — or, at least, complain — very little due to the partial destruction of the cerebral cortex, which processes sensory information (*AoN2*, p. 312). However, while a patient may have been diagnosed with GPI, he may also have suffered from the painful symptoms of tabes, even at the advanced stages of the disease. Mott wrote that

> many of the tabetic cases of very old standing still suffer with the lightning pains and visceral crises. All the while there are any rootlets left undestroyed by the disease, pains may occur and radiate all through the sentient grey matter, each decaying fibre serving as a fulminating agent. (*AoN2*, p. 79)

Not all tabetic patients developed GPI and its associated mental symptoms, which invariably resulted in admission to an asylum. Patients who escaped this fate were usually treated in general hospitals.

As is so often the case with hallucinations and delusions, whatever their aetiology, those associated with the pain of tabes were frequently frightening, persecutory, and condemnatory. Mott cited the experiences of a male patient, referred to as F. W. R., who was a 35-year-old clerk, admitted to Claybury Asylum in 1899, believing two nurses were following him around, talking about him, turning on electricity, and pulling his legs at night. The patient reportedly associated the lightning pains and cramp-like spasms with the voices. He claimed one nurse caused him

> to have electric shocks in his limbs, body, and face. They pull his bowels about, and caused him to have pains at his heart; some time ago they continually put poison into his rice pudding, which burnt the inside of his stomach. (*AoN2*, pp. 82, 118–19)

Mott recounted another case of a musician who suffered from lightning pains and heard an orchestra which

> he associated with the electric wires and electric currents in his body […] and being a professional flute player, he whistled very accurately the melody he heard in his mind, and was quite surprised that I did not hear it also. (*AoN2*, p. 83)

Another case was a dock labourer who was admitted to Claybury aged thirty-five having suffered for years from what he believed to be pains caused by rheumatism and indigestion. 'After three years he had delusions of persecution, that unseen agencies turned on electricity and blew up his stomach', Mott wrote (*AoN2*, p. 56). In 1901, Elizabeth H, a 51-year-old woman, was admitted to Hanwell tied to a stretcher and in a maniacal state with conjugal paralysis. She claimed to 'see Old Nick' and that 'Burglars came into the house, they boiled the pot and then poured it down her throat' (*AoN2*, pp. 242–43). Her case notes record that she believed her 'arms, knees & legs are diseased and that she has the "black pox"'.[21] George Savage explained how one patient would claim that his bowels had been twisted by his persecutors, while another stated that red hot irons had been thrust into his feet and eyes. Other tabetic patients have been recorded as saying that worms were eating their insides out, that lions wanted to devour them, or that snakes were living inside them. These delusions clearly signified extreme psychic distress as well as physical pain. Sufferers were in the grip of an existential crisis as they grappled with the symptoms of a painful and socially stigmatized disease that would almost certainly end in an ignominious asylum death. The next section looks, therefore, at how recorded delusions might provide us with deeper insights into the patients' experience of bodily pain.

III

Delusions and their Meanings

What, then, can delusional themes tell us about the meaning given to pain by tabetic patients? First, we know that the experience of pain is formed by the embodied

consciousness and theories of the body and mind in any given culture at any given period of time.[22] 'The subjective character of experience (its phenomenological content)', Joanna Bourke has written, 'does not simply arise from interactions in the world but is constituted by those interactions' (*Pain and the Politics of Sympathy*, p. 14). People's experiences of their bodies are shaped by a range of cultural and societal influences from 'language and dialect, power relations, gender, class and cultural expectations, climate, and the weight and meaning given to religious, scientific and other knowledges' (*Pain and the Politics of Sympathy*, p. 18).

In his ground-breaking book, *The Illness Narratives*, cultural anthropologist and psychiatrist Arthur Kleinman states that 'cultural meanings mark the sick person, stamping him or her with significance often unwanted and neither easily warded off nor coped with. The mark may be either stigma or social death.' He adds: 'The cultural meanings of illness shape suffering as a distinctive moral or spiritual form of distress.'[23] So, whether or not somatic pain is triggered by a physiological event, such as a lesion caused by disease or injury, the experience is constructed in a complex web of social, cultural, psychological, and physiological interactions. 'Even when suffering, people adhere to societal norms, rituals, and stories', explains Bourke (*Pain and the Politics of Sympathy*, p. 6). This is where metaphors play such an important role. Making conceptually elusive physical sensations, such as pain, more psychologically tangible enables individuals both to understand their subjective experiences within their own terms and to communicate them.[24] Metaphors expand the systems of knowledge and belief from which they evolve, creating new meanings and experiences. For example, new findings in the field of bacteriology in the late nineteenth century gave rise to metaphors relating to the 'invasion' of the body by recently discovered pathogens. War metaphors became common in the early twentieth century. Salvarsan, the first chemical treatment for syphilis, discovered in 1909, was referred to as a 'magic bullet' (Brandt, p. 40).

Like metaphors, delusions are culturally constructed in terms of both their form and their content.[25] The psychologist Brendan A. Maher hypothesized in 1974 that 'many paranoid patients suffer not from a thinking disorder but from a perceptual disorder' and that in the case of experiencing an unusual bodily sensation 'the patient is not presenting a delusion in any technical sense. He is describing an experience.'[26] Maher continued: 'A delusion is a hypothesis designed to explain unusual perceptual phenomena and developed through the operation of normal cognitive processes' (Maher, p. 103). This takes us closer

to the notion that somatic delusions can be misperceptions of bodily sensations. Broadly speaking, Mott and his late nineteenth-century colleagues were saying the same thing. Tabetic patients encountering the unannounced, the abrupt, the short sharp shocks, and the long sharp shocks of tabes dorsalis created narratives that were intended to be literal descriptions, yet were imbued with metaphor that helped them to make sense of their pain, thus shaping their phenomenological experience.[27] Attributing painful sensations to electric currents, the work of devils, or attacks by wild and untamed animals transformed bewildering and frightening sensations into experiences that could, as Bourke has contended, be understood by the patient within his or her world view. This is not to say that this process enabled the patient to control their pains, even though they tried to by lashing out at the imagined attacker. But it did help them to understand them better, to comprehend that they could *not* restrain or manipulate these forces because, like electricity, devils, and wild animals, they were beyond human control. In his study of 'mad writings', Ingram has written that to find meaning in their pain, pain sufferers might develop a language that will allow them to 'negotiate' it (Ingram, p. 106). Maher commented that

> when a coherent explanation is ultimately developed, it should be accompanied by a strong feeling of personal relief […] even if the explanation is […] threatening to the patient: the kind of relief associated with 'Now I know the worst,' may temper the ominous implications of the explanation itself. (Maher, p.104)

There is a crucial distinction between how those with and without delusions respond to metaphorical associations. This lies in the system of belief surrounding them. The person who is not experiencing delusions consciously employs metaphor as a linguistic device to describe and give meaning to a sensation; the individual with delusions describes — and might act on — what he or she *believes* to be a real event. Asylum superintendent W. Julius Mickle, who wrote extensively on GPI, described one patient who,

> when walking quite alone, and when absolutely unmeddled with, was accustomed to shriek suddenly at times, and when questioned on the subject declare that someone had that moment kicked or injured him, or that his back was broken.[28]

This draws attention to another difference between delusional and non-delusional narratives of pain. Tabetic patients with delusions provide an insight into somatic pain *as they were experiencing it*, rather than after the event.[29] The French novelist Alphonse

Daudet (1840–1897), who suffered from tabes dorsalis without mental symptoms, made extravagant use of metaphor in his notebook *La Doulou* where he described in detail his excruciating pains.[30] He wrote that 'words come only when everything is over, when things have calmed down. They refer only to memory, and are either powerless or untruthful' (Daudet, p. 15). Ingram reinforces this point: 'The here and now is […] a vital ingredient of this kind of mad language. Madness is in a perpetual present, and makes of the past only what can contribute to the chosen explanation for the reality of pain' (Ingram, p. 117). Delusions that are triggered by somatic sensations do, therefore, provide narratives of pain that are not self-consciously mediated by the sufferer, providing deeper insights into direct experiences.

IV
Interpretation

Understanding the subjective meaning patients gave to their pain experiences requires a deeper exploration into why particular themes gained traction and agency within delusional systems. An obvious starting point for embarking on an interpretative analysis of the delusional themes is, therefore, to briefly outline prevailing cultural attitudes in Britain towards syphilis. Primary stage symptoms include painful ulcers and chancres, particularly on the genitals, as well as boils and buboes filled with foul-smelling pus. Unsurprisingly, biblical tropes abounded. As did references to other stigmatized diseases such as plague, which was associated with transmission by rats and fleas, and, in turn, with filth and defilement. In March 1891, a *Daily Telegraph* editorial famously commented on the one and only performance of the first British production of 'Ghosts', in which the Norwegian playwright Henrik Ibsen confronted social attitudes towards syphilis. The review was excoriating, describing the play as 'an open drain; a loathsome sore unbandaged; of a dirty act done publicly; or of a lazar-house with all its doors and windows open'.[31]

Syphilis had, therefore, become a powerful metaphor in itself. Historian Lesley A. Hall has suggested that by the end of the century 'the "guilty" sufferer […] was more often perceived as male, conveying disease to his innocent family, as opposed to a contaminated prostitute infecting healthy young male bodies' (Hall, p. 123). Similarities between the social meaning and clinical manifestation of AIDS and syphilis have received

a great deal of attention from scholars across disciplines. Susan Sontag's essay, 'AIDS and its Metaphors', is among the most notable. Here, she explains how, historically, epidemics such as plague were often believed to be inflicted by God as a punishment, writing: 'Thinking of syphilis as a punishment for an individual's transgression was for a long time, virtually until the disease became easily curable, not really distinct from regarding it as retribution for the licentiousness of a community.'[32] Parallels were drawn, both implicitly and explicitly, between the syphilitic spirochaete infecting the body and the notion of a social pathology in which the carriers of syphilis contaminated society. Gayle Davis has noted how one paretic patient in a Scottish asylum would stay clear of other patients lest he might infect them with syphilis, commenting how 'a number of those patients who knew or at least believed themselves to be venereally infected were said in their case notes to feel similarly dirty and infectious' (Davis, pp. 101–02). This explains the alienating effect of syphilis, which, in the tertiary stages, conflated social with mental isolation as patients descended towards madness and death, ministered to by asylum 'alienists'.

Returning to the punishment theme, the notion of 'pain as torture' has commonly been evoked by pain sufferers, whatever the cause of their pain and whether or not they were psychotic. Tabetic patients were no exception. Mott remarked on how the insane tabetic might believe that 'enemies are torturing them with electricity', or with 'hot irons and pincers before electricity was in general use' (*AoN2*, p. 37). Hot irons and pincers did, therefore, retain their symbolic value as instruments of torture, even though the practice had been outlawed in England more than two centuries earlier. Yet, as in the case of patient F.W.R., who believed nurses were turning electricity on in his legs, clinical staff were not always seen as benign. Indeed, it is possible that the notion of pain-as-punishment was psychologically appropriated by patients because hot irons had been used by physicians to cauterize syphilitic chancres in an agonizing and invasive procedure (Quétel, p. 117). Other potentially punitive 'treatments' included mercury, which could make symptoms worse and result in a number of unpleasant and painful side effects.[33] Cultural historian Judith Walkowitz has pointed out that 'despite the new humanitarian spirit in medical practice […] mercury application was very painful, it remained an appropriately punitive method of treating syphilitics'. She suggests that treatments may have continued after the subsidence of the symptoms to discourage the sufferer from 'further immoral activities' (Walkowitz, p. 55). Indeed, American actuarial tables from the

early twentieth century show that the mortality rates of people who were untreated for syphilis was lower than those who had been treated with mercury.[34] Other medical interventions that could have led to misinterpretations of bodily sensations were sensory tests in which patients were pricked with needles or subjected to electrical currents to see whether or not they would respond to pain (*AoN2*, p. 243). It is no wonder, then, that delusions of persecution implied a threat of attack from an agency that worked either directly on the body, such as electricity, or that was inflicted by an external force, be it a doctor, a nurse, or the devil.

Electricity was a common delusional theme expressed by asylum patients suffering from a range of mental and physical conditions, including tabes and tabo-paralysis. From the latter decades of the eighteenth century and during the course of the nineteenth century, electricity gained increasing purchase on descriptive language and delusional themes. From the late-Georgian era, it was used to describe the body's biomechanical systems, as well as somatic sensations. Similarities between physiology and electrical events began to be investigated, and experiments in electrophysiology were conducted.[35] Wider curiosity among a lay readership was piqued in 1818 by the publication of the highly popular novel *Frankenstein*, in which the author Mary Shelley 'shocked' her creature into life using the force of electricity. As a discipline, neurology emerged during the second half of the nineteenth century in tandem with the growing understanding and application of electricity brought about by the Second Industrial Revolution. Not only did electricity provide a fertile source from which new metaphors — 'current', 'shock', 'spark', 'pole', 'circuit', 'plug', 'energy', etc. — could be created, enabling experiences and events to be conceptualized differently, but it shaped ways in which the body was understood. Cultural historian David Nye has written how during the nineteenth century 'Americans internalized a new psychology in which the human personality was an electrical system that could be "switched on", "overloaded", "short-circuited", "shocked" and "burned out"'.[36]

Electricity was also valued for its therapeutic benefits. From the 1830s, galvanism was used to stimulate the nervous system — calming, stimulating, ameliorating pain, and producing contractions.[37] Gout, rheumatism, sexual and urinary dysfunctions, as well as neuralgia and neurasthenia, were all considered treatable by this new technology. Newspapers and periodicals ran advertisements promoting electric belts for men and corsets for women, associating it with life and virility — force, energy, and strength.[38] But

there was also a dark side to electricity. Few people understood how it worked and for many it was silent, undetectable, and potentially deadly. Furthermore, it gradually began to be incorporated into the structures of a growing number of public and domestic buildings, including asylums. Fears around its dangers were stoked by the gas industry seeking to quash the competition.[39] People believed that, like gas, electricity would explode (Gooday, p. 72). In 1881, Irish labourers laying electric cables in New York were terrified of 'the devils in the wires'.[40] Yet these fears were not commensurate with the actual number of electrical fatalities, which were rare. When they did occur, the press had a habit of sensationalizing them.[41]

Perhaps nothing aroused fears around electricity more than reports of the first execution by electricity that took place in New York in August 1890. William Kemmler faced the chair for killing his lover, Lillie Zeiger, under the influence of alcohol. Both Zeiger and Kemmler had been married and were referred to as 'the guilty couple', implying that Kemmler was paying the price not only for murder but for adultery, sexual incontinence, and drunkenness, behaviours that were, incidentally, believed to cause syphilis during that period. The British press had a field day. Headlines such as 'The First Electric Execution. Terrible Scenes' or 'The Electric Death' enticed readers into reports of 'contortions of the body', 'frothing at the mouth', and 'a sickening smell of burning flesh and hair'.[42]

Electricity could, therefore, be perceived in a positive or a negative light. This, as cultural critic Tim Armstrong has explained, created a duality in attitudes to electricity as both a life force and a killing instrument, in addition to being 'part of the emerging technologies of medical control' that provided a '"clean" way of solving the problem of transgressive behaviour' (Armstrong, pp. 14, 32). Electrocution created 'a chastisement of the body which silently and invisibly absorbs the individual into a scientific and technological system', he has argued (Armstrong, p. 34). Electricity is a fatal and silent force: sterile, sterilizing, cauterizing, invisible, causing death without warning.

An analogy can be drawn between popular perceptions (and misperceptions) of the properties of electricity and syphilis, both of which exist or are able to exist in the body undetected. Some patients who developed GPI or tabes may have been surprised to discover that a syphilitic infection had remained in their system years after the primary symptoms had disappeared. Others would have been fully aware that they ran the risk of developing tertiary symptoms when the spirochaete might attack the brain, the nervous

system or both, suddenly and unannounced. The lancinating pains that shot through the limbs were often described as 'lightning' pains; like electrical charges flashing through the sky, they were imbued with their own sense of agency or believed to have been sent as a punishment from God.

When these attacks took place, Mickle commented that male tabetic patients would 'shriek' with pain, a word described in 1911 as 'shrill & usu. inarticulate cry of terror, pain, &c., screech, scream; laugh uncontrollably […] say in shrill agonized tones'.[43] This, of course, was Mickle's term, and one he used frequently, which gives insight into his own perception of the experience and response to pain in male patients.[44] 'Shrieking' in this context implies surprise, shock, an unexpected and frightening event, or 'hysterical' which suggests a female quality. Did this mean that men with tabes and tabo-paralysis felt emasculated by their condition? Mickle commented that the gait of one patient who had previously been in the army had become 'slouching and unsoldierly' (Mickle, p. 62). Daudet commented that his 'resort to anaesthetics is like a cry for help, the squeal of a woman before danger actually strikes' (Daudet, p. 9). Lucy Bending has interpreted this as evidence of a 'kind of failure of masculinity' ('Approximation', p. 133). Indeed, in an era when independence was valorized, the sight of other patients growing increasingly demented, paralysed, and helpless must have caused great anguish in men who had recently been admitted to paralysis wards and were still able to perceive their surroundings. It was a far cry from the hubristic delusions of grandeur many had manifested during their admission to the asylum.

V
Conclusion

This article is predicated on the premise that, in some cases of tabes dorsalis, delusions were misperceptions of bodily sensations and can be analysed by historians as pain narratives, thus providing insights into patients' subjective experiences. In particular, it draws attention to the degree to which somatic and psychic pain are inextricably intertwined, their boundaries hazy and porous. As Mott wrote: 'In tabo-paralysis, in the early stages, there may be an intensification of the pains and sufferings by the subjective attitude of the individual towards the effects produced by the irritation and degeneration of the sensory, somatic, and visceral neurons' (*AoN2*, p. 312). As the patient finds himself

subsumed by an existential crisis of cataclysmic proportions, helplessly and hopelessly 'battling' society's most stigmatized disease, knowing, as far as he is able, that an ignominious and undignified death awaits him, his sense of shame and alienation, in every sense of the word, permeates these fractured pain narratives.

Here, I have drawn on delusions experienced by a small sample of asylum patients who were in the last stages of their life. They were mainly male, living in London *circa* 1900, and witnessing a period of massive change: faith in new powers (science and industry) was challenging old beliefs (God and religion); and when newly identified pathogens became the enemy, purity movements were mobilized to fight them on all fronts. If these delusional themes are compared with those experienced by other patients suffering from the same pathology and symptoms in another time period or culture, we would be confronted with a different pattern of themes and, thereby, experiences of pain. This is a bigger project.

Delusions contain metaphors but have different meanings. Metaphors were self-consciously created to describe a physiological event, sometimes for the sake of posterity when used in a personal diary or journal. Even though they shaped experiences, the writer understood them for what they were, linguistic devices, and did not believe them literally to be true. Delusions were intended to be descriptions of real events; they were constructed out of metaphors to help patients make sense of and even negotiate their pain. Tabetic patients were existentially, psychologically, and physically invested in their delusions, fighting for their life, the only group of asylum patients suffering from a known psychopathology with fatal consequences. Mott said as much himself when he wrote that

> the tabetic with delusional insanity […] probably suffers more than the sane tabetic, as he is not only tortured with physical pain, but also with delusions of persecution by unseen agencies — the true pains forming a realistic basis to the delusions around which his whole psychical existence may centre. (*AoN2*, p. 44)

'Pain', according to clinician and literary scholar David Biro, 'is an all-consuming internal experience that threatens to destroy everything except itself — family, friends, language, the world, one's thoughts, and ultimately even one's self.'[45] Through their delusional systems, asylum patients attempted to give meaning to their pain, transforming it into a tangible entity they could fight, or starve, or stifle. And this allowed them to cling to their sense of self for as long as possible — to challenge, to resist, to battle on before the *treponema pallidum* did its worst, rendering them totally helpless.

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[1] These details have been extrapolated from two sources. The first is Frederick Walter Mott, 'Tabes in Asylum and Hospital Practice', *Archives of Neurology from the Pathological Laboratory of the London County Asylums, Claybury, Essex*, 2 (1903), 1–327, (pp. 150–51). Further references to this volume will appear as *AoN2* after quotations in the text. The second source is Hanwell Asylum, Male Case Book 20, case 10,532, ff. 573–74, London Metropolitan Archives (LMA), H11/HLL/B/20/029. Where possible, I have compared Mott's notes with the asylum case notes for individual patients, quoting the latter where discrepancies exist between the two.

[2] 'Bullae' are bed-sores. Geo. H. Savage, 'Locomotor Ataxy, Tabes Dorsalis, Ataxie Locomotrice Progressive', in *A Dictionary of Psychological Medicine*, ed. by D. Hack Tuke, 2 vols (Philadelphia: Blakiston, 1892), II, 750, bold in original.

[3] 'Illusion', in *A Dictionary of Psychological Medicine*, I, 675; T. S. Clouston, *Clinical Lectures on Mental Diseases*, 3rd edn (London: Churchill, 1892), p. 244.

[4] Key texts include: Peter Lewis Allen, *The Wages of Sin: Sex and Disease, Past and Present* (Chicago: University of Chicago Press, 2000); Allan M. Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880 with a New Chapter on AIDS* (Oxford: Oxford University Press, 1987); *Sex, Sin and Suffering: Venereal Disease and European Society since 1870*, ed. by Roger Davidson and Lesley A. Hall (London: Routledge, 2001); John Parascandola, *Sex, Sin and Science: A History of Syphilis in America* (Westport, CT: Praeger, 2008); and Claude Quétel, *History of Syphilis*, trans. by Judith Braddock and Brian Pike (London: Polity Press, 1990).

[5] E. H. Hare, 'The Origin and Spread of Dementia Paralytica', *Journal of Mental Science*, 105 (1959), 594–626 (p. 595).

[6] Juliet D. Hurn, 'The History of General Paralysis of the Insane in Britain, 1830 to 1950' (unpublished doctoral thesis, University of London, 1998).

[7] Gayle Davis, *'The Cruel Madness of Love': Sex, Syphilis and Psychiatry in Scotland, 1880–1930* (Amsterdam: Rodopi, 2008).

[8] Lucy Bending, 'Approximation, Suggestion, and Analogy: Translating Pain into Language', *Yearbook of English Studies*, 36 (2006), 131–37; *The Representation of Bodily Pain in Late Nineteenth-Century English Culture* (Oxford: Clarendon Press, 2000); Joanna Bourke, *Pain and the Politics of Sympathy, Historical Reflections, 1760s to 1960s* (Utrecht: Universiteit Utrecht, 2011); Elaine Scarry, *The Body in Pain: The Making and Unmaking of the World* (New York: Oxford University Press, 1985), p. 4.

[9] Roy Porter, 'The Patient's View: Doing Medical History from Below', *Theory and Society*, 14 (1985), 175–98.

[10] *The Faber Book of Madness*, ed. by Roy Porter (London: Faber and Faber, 1991), p. 131. See also by Porter: *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency*

(London: Penguin 1990), ch. 5; *A Social History of Madness: Stories of the Insane* (London: Weidenfeld & Nicolson, 1987); and John Haslam, *Illustrations of Madness*, intr. by Roy Porter (London: Routledge, 1988).

[11] Allan Ingram, *The Madhouse of Language: Writing and Reading Madness in the Eighteenth Century* (London: Routledge, 1991), pp. 6–8.

[12] *A Mad People's History of Madness*, ed. by Dale Peterson (Pittsburgh: University of Pittsburgh Press, 1982); Mike Jay, *The Air Loom Gang: The Strange and True Story of James Tilly Matthews and his Visionary Madness* (London: Bantam, 2003); Eric L. Santner, *My Own Private Germany: Daniel Paul Schreber's Secret History of Modernity* (Princeton: Princeton University Press, 1996).

[13] Allan Beveridge, 'Voices of the Mad: Patients' Letters from the Royal Edinburgh Asylum, 1873–1908', *Psychological Medicine*, 27 (1997), 899–908; see also 'Metaphors of Madness: Iain Crichton Smith's Journey through the Inferno', *History of Psychiatry*, 7 (1996), 375–95.

[14] Carol Berkenkotter, *Patient Tales: Case Histories and the Uses of Narrative in Psychiatry* (Columbia: University of South Carolina Press, 2008); Jonathan Andrews, 'Case Notes, Case Histories, and the Patient's Experience of Insanity at the Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century', *Social History of Medicine*, 11 (1998), 255–81 (p. 280). See also Guenter B. Risse and John Harley Warner, 'Reconstructing Clinical Activities: Patient Records in Medical History', *Social History of Medicine*, 5 (1992), 183–205.

[15] This draws on the ground-breaking work by George Lakoff and Mark Johnson, *Metaphors We Live By* (Chicago: University of Chicago Press, 1980).

[16] There is, of course, also the possibility that their pains were caused by other physical diseases such as tuberculosis, or that they were suffering from psychogenic pain. It is not unusual to find descriptions of tabetic pain described in non-delusional terms, usually at early stages of the disease.

[17] The actual percentage of men with syphilis who went on to develop diseases associated with its tertiary stage is difficult to ascertain. Julian Barnes has suggested that it was five to seven per cent. Alphonse Daudet, *In the Land of Pain*, ed. and trans. by Julian Barnes (New York: Knopf, 2002), p. 82.

[18] Davis, p. 203. GPI was identified following the discovery of cerebral lesions by the French physician Antoine-Laurent-Jesse Bayle in 1822. By the 1860s, it had been accepted as a distinct disease within its own right with an 'identifiable brain pathology, predictable clinical history and a definite correlation between these two elements' (Davis, pp. 84–85). Tabes dorsalis — meaning wasting of the dorsal column of the spinal cord — was identified in the 1840s by the German neurologist Mauritz Romberg.

[19] *LCC Thirteenth Annual Report*, 1902, p. 187, LMA; *Fifty-Sixth Report of the Commissioners in Lunacy to the Lord Chamberlain,* 1902, pp. 130, 152.

[20] Most asylum patients died within two years of admission. Some lived far longer, while others went into remission and were discharged.

[21] Patient details are drawn from the asylum case notes. Hanwell Asylum, Female Case Book 26, ff. 511–12, LMA, H11/HLL/B/19/049.

[22] The Birkbeck Pain Project, 'Rhetorics of Pain: A Transcultural History of Bodily Pain from 1760–1960', in *Pain: Management, Expression, Interpretation*, ed. by Andrzej Dańczak and Nicola Lazenby (Oxford: Inter-Disciplinary Press, 2011), pp. 67–73 (p. 67).

[23] Arthur Kleinman, *The Illness Narratives: Suffering, Healing & the Human Condition* (New York: Basic Books, 1988), p. 26.

[24] Deborah Lupton, *Medicine as Culture: Illness, Disease and the Body in Western Societies* (London: Sage, 1994), p. 55.

[25] Richard P. Bentall, *Madness Explained: Psychosis and Human Nature* (London: Penguin, 2004), p. 130.

[26] Brendan A. Maher, 'Delusional Thinking and Perceptual Disorder', *Journal of Individual Psychology*, 30 (1974), 98–113 (pp. 99, 102).

[27] J. E. Rhodes and S. Jakes, 'The Contribution of Metaphor and Metonymy to Delusions', *Psychology and Psychotherapy: Theory, Research and Practice*, 77 (2004), 1–17 (p. 15).

[28] Wm. Julius Mickle, *General Paralysis of the Insane*, 2nd edn (London: Lewis, 1886), p. 132.

[29] Allan Ingram came to a similar conclusion, drawing on two case studies: one patient complained of violent pain in his stomach 'which arose from his navel string at his birth have been tied too short'; and a woman insisted that her insides were full of vermin and that it often felt as though 'they were crawling into her throat'. Ingram observes that both had generated an image that 'genuinely encapsulates the nature of their experience' (pp. 110–11).

[30] These metaphors were remarkably similar to those found in delusions of tabetic patients: see Daudet.

[31] *Daily Telegraph*, 14 March 1891, p. 5. Cited by Toril Moi, *Henrik Ibsen and the Birth of Modernism: Art, Theater, Philosophy* (Oxford: Oxford University Press, 2006), pp. 92–93.

[32] Susan Sontag, *Illness as Metaphor and AIDS and its Metaphors* (London: Penguin, 1991), p. 132.

[33] Judith R. Walkowitz, *Prostitution and Victorian Society: Women, Class and the State* (Cambridge: Cambridge University Press, 1982), p. 53.

[34] Cited by Walkowitz, p. 53; Louis Lasagna, *The VD Epidemic: How it Started, Where it's Going, and What to do about it* (Philadelphia: Temple University Press, 1975), pp. 67–68.

[35] Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity* (New York: Norton, 1999), p. 252.

[36] David E. Nye, *Electrifying America: Social Meanings of a New Technology, 1880–1940* (Cambridge: MIT Press, 1990), p. 155.

[37] Tim Armstrong, *Modernism, Technology, and the Body* (Cambridge: Cambridge University Press, 1998), p. 15.

[38] Carolyn Marvin, *When Old Technologies were New: Thinking about Electric Communication in the Late Nineteenth Century (Oxford: Oxford University Press, 1988)*, p. 131.

[39] Graeme Gooday, *Domesticating Electricity: Technology, Uncertainty and Gender, 1880–1914* (London: Pickering & Chatto, 2008), p. 65.

[40] From a sketch by Walter Edison Kruesi, approved by Thomas Edison, Edison Pioneer Records, Henry Ford Museum Library, 1929, cited by Nye, p. 152.

[41] Of the sixteen deaths occurring in Europe between 1880 and 1889, ten took place in Britain (Gooday, p. 66).

[42] *The Morning Post*, 7 August 1890, p. 5; *Northern Echo*, 7 August 1890; 'Execution by Electricity', *North-Eastern Daily Gazette*, 7 August 1890, 4th edn.

[43] *The Concise Oxford Dictionary of Current English*, adapted by H. W. Fowler and F. G. Fowler (Oxford: Clarendon Press, 1912).

[44] Mott also used the term 'shriek' (*AoN2*, p. 56).

[45] David Biro, *The Language of Pain: Finding Words, Compassion and Relief* (New York: Norton, 2010), p. 18.