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‘Queer mind and body’: reflections on the interpretation, communication, and experience of the body in the British Asylum, c.1840-1914.

Cora Salkovskis

History, Classics and Archaeology,

Birkbeck College, University of London

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Abstract

This thesis explores the processes of meaning-making which coalesced around experiences of the body in the nineteenth- and early-twentieth-century British asylum. This is achieved through a consideration of the ways in which supposedly abnormal or insane sensation, movement, perception and belief was embodied, defined, experienced, and given meaning from different positions in or around the clinical encounter. As an approach, it emphasises the importance of practices, processes, and embraces fragmentation or the exploration of boundaries. First, this research explores how insanity is structured, organised, preserved, and represented through multi-layered narratives. It unpicks the roles of historian, institution, doctors, patients, and delusions and hallucinations, in framing and telling these stories about insanity. It then considers how the insane body was encountered (in the world and archive) as moving and expressive, particularly emphasising the disconnection or disruption believed to occur between 'mental action' and the body in particular cases. Finally, the section on sensing the lived body considers how delusion and hallucination could transform understandings of the body and its possibilities, particularly in the invisible and inaccessible bodily interior or visceral space. Foregrounding the lived experience and perception of the body, this thesis takes a phenomenologically-engaged and reflexive approach, drawing from anthropological approaches, queer theory, and disability studies, to consider the stories told about this body, how it was seen and moved, and how it was understood and measured.

Acknowledgements

A thesis such as this does not stay bounded within its own pages. It spills out and leaks into the corners of your life and mind, especially through a global pandemic and my own personal experiences of pain and ill-health.

For keeping me tethered, I must thank my wonderful family. Their endless emotional, practical, and edible support has made this thesis possible. My mum and dad for their discerning eyes, ready ears, and warm hugs; my brother Duncan for his philosophical mind and strong stomach, discussing digestive delusions over Friday beigels.

My friends who know me too well to stop inviting me to things, even when they've heard the words "sorry" and "thesis" more times than they could count. Louise Morgan is my own personal hero, rock, and editor.

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Final gratitude must go to the Wellcome Trust, who not only funded this research in the first place, but whose approach to the global pandemic and researchers with personal health challenges, through which this work was produced, has made the last couple of years a fraction of the nightmare it could have been. In fact, at times, it has been rather pleasant.

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Abbreviations

BH	Bexley Hospital
CB	Casebook
CNL	Conolly Norman Lectures
DSM	Diagnostic and Statistical Manual of Mental Disorders
GPI	General Paralysis of the Insane
HS	Holloway Sanatorium
JMS	*Journal of Mental Science*
LMA	London Metropolitan Archives (London)
RCPI	Royal College of Physicians of Ireland (Dublin)
SPR	Society for Psychical Research
WL	Wellcome Library (London)

Introduction

In January of 1903, Medical Superintendent of Richmond District Asylum Dublin, Conolly Norman, delivered a 'Clinical Lecture on Hallucination.' His talk, subsequently published and distributed for a wider medical audience in *The Lancet* the following year, recalled a case of a fifty-four-year-old man who had spoken to Norman as his doctor five years previously about the torture he was enduring. This man's account of his experiences piqued Norman's intellectual curiosity and surprise and, over a century later, it inspired my own. Norman mused that

> 'when we speak to him we are reminded of Ball's striking remark to the effect that such cases recall to our mind the fundamental principle of the religion of Buddha – namely, that our senses are absolutely deceptive, that we are surrounded by void space, and that the whole universe is only a gigantic hallucination.'[1]

Could one trust the body or mind to tell truths about the relationship between self and world, body and environs, objectivity and subjectivity, or sanity and insanity? Narratives and experiences such as these speak to the ways in which doctors, patients, and publics were asking questions about what it meant to *have* a body; to feel, know, and experience the world through this body.

Previously a butler, this man came to the asylum from a workhouse, his employment having ended due to his mental state. He was married and a father to several children, but

[1] Conolly Norman, "A Clinical Lecture on Hallucination," *The Lancet* 163, no. 4192 (1904): 3.

also known to be a 'steady hard drinker for many years.'[2] Crucially for his testimony, he is described as

> 'a calm, grave-mannered man who expresses himself in measured and generally accurate language. He rarely contradicts himself and seldom exhibits verbal incoherence. His memory is excellent for everything connected with his own case and if he sometimes shows an indifference to current events this seems explicable through his absorption in his own troubles.'[3]

He did not *seem* insane; rather, he could effectively narrate his experiences and seek Norman's help with what tormented him. Throughout the article, Norman relayed the patient's descriptions of his hallucinations of seemingly every sensory field, which began when one night 'he was attacked with pains in various parts of his body and at the same time heard a voice… using injurious and abusive language.'[4] From then on, Norman noted, he was 'constantly subjected to a variety of torments which he designates under the general name of "practice."'[5] Norman filtered his patient's experiences into pre-determined sub-divisions of the 'sensory field', claiming that this was because the case is 'so full that much time would be lost in going over individually the various statements which he has made at different dates.'[6]

In a stunningly comprehensive list, the man (we are not told his name) experienced hallucinations of the following sensory fields: dolorific, kinetic or muscular, thermal, hygric,

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[2] Ibid.

[3] Ibid.

[4] Ibid.

[5] Ibid.

[6] Ibid.

tactile, genital, visceral, respiratory, olfactory, gustatory, visual, auditory, and psycho-motor. These experiences roamed across mind and body. For the patient, these attacks were acutely immediate and intensely real. Through Norman, he described that

> '"The practice does not come without the torturing voices nor the voice without the torture." This fact confirms him in his intense belief in the reality and external nature of all his troubles. "It would be," he has said, "a queer mind and body that would torture anyone in this manner of its own accord."'[7]

For his doctor, such a case revealed 'clearly' that

> 'whatever may be the remoter origin of hallucinations the sensory centres in which in health we receive impressions from without must be engaged in disease. No force of imagination would enable our patient to conceive so complete a series of sensations involving almost every variety of every sense and distinguishing from one another with physiological accuracy various sensory fields of the existence of which he must have been intellectually perfectly ignorant.'[8]

Through Norman's clinical and discursive dissection, the incredibly rich and descriptive language the patient used to narrate his painful and distressing hallucinations and delusions does the opposite of its apparent intention. Rather than helping the doctor to understand the immediate painful and affective implications of his experiences, his testimony facilitated his reconstruction and reframing as a medical curiosity for whom his ignorance of his own body's processes and systems renders him an intriguing piece of evidence to furnish a theory of the mechanism of hallucination in insanity. These two competing voices and the deep ambivalence regarding the significance of hallucinatory experiences, especially in relation to

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[7] Ibid., 5.

[8] Ibid.

self and reality, prompted further consideration of the 'picturesque and remarkable' hallucinations Norman claimed were insignificant compared with the 'fact that the judgement is so far impaired that it accepts the hallucinations.'[9]

I started this project with this case, this story, and this doctor. Whilst superficially about hallucination, this article and case spoke to a deep curiosity and tension surrounding the body, mind, and self in the world. It touched on pain, belief, the imagination, and emotions (like fear and, perhaps for the doctor, excitement). Whilst I began by looking at hallucination and delusion (as guided by the article's title), I began asking myself the central question which underpins the research which follows here: how did different people in different positions of the clinical encounter understand and imagine the body, its processes and its possibilities, in the asylum?

Through cases and interactions such as these, this thesis considers competing notions of evidence, proof and reality which surrounded the body and experience in the nineteenth- and early-twentieth century. This was a period in which asylum populations were growing rapidly and changes in legislation led to an extensive network of newly established institutions for the insane across the British Isles. Those housed therein could seemingly be studied and observed to furnish the mercurial theories and diagnoses of an emergent sub-discipline of medicine. Statistical methods were gaining traction and popularity alongside the continued practice of observation and genre of the case study. In such a context, how were

[9] Ibid.

the experiences of insanity and the body interpreted, narrated, understood, recorded, communicated, and *lived* in the clinical space?

Alongside this, it examines 'boundaries of belief'; how do these proofs determine what is and is not possible and, consequently, who is and is not insane? If electricity, for instance, was a relatively new technology with ambiguous (and anxiety-inducing) applications to the world, body and medical practice itself, what separated a delusion of being tortured by electricity which might confine the sufferer to an institution for the insane, from the entirely plausible sane suspicion of a member of the public or even a highly respected medical professional? Once within the asylum, how could it be determined whether that 'electricity' was hallucinatory (and therefore not rooted in an external physiological stimulus), delusive (false conviction with or without a physiological basis), or illusory (perhaps as a misinterpretation of a lesion-based explanation)? Why did it matter, and who had the authority to *be believed* or tell 'truths' about the body?

This thesis seeks to explore these questions by taking a flexible, phenomenologically-engaged and reflexive approach, considering how the experience of 'insanity' was lived through the body, as well as how this body was made or negotiated through the practices of both subjective and clinical meaning-making. The following chapters trace the ways in which supposedly abnormal expression, perception, movement, or feeling were assessed, defined, experienced and given meaning by people occupying different positions in the medical encounter. It will consider patients, medical professionals in the emerging discipline of mental science, and the historian accessing records over a century later.

Whilst this study is about the body of insanity more broadly; its movements, sensations, reactions, and reflexes, hallucinations and delusions are returned to and woven throughout as a central thread. How did hallucinations and delusions challenge supposedly established notions of proof and reality about the body? These 'sensory perversions' or 'disturbances' are considered here as key but contested interpretations (of personal and clinical significance) and communications about the body's experience which frequently sit ambiguously or uneasily between 'mind' and 'body'. Hallucinations and delusions complicate this much-contested binary distinction, which itself has a long history. Within that, they urgently require a reconsideration of concepts such as 'real' or 'imaginary', or self and other. They represent moments of tension in clinical archives and narratives between patient and doctor which rely on a distinction between subjectivity and objectivity running through much of contemporary asylum (and broader) medicine. This research looks at perception, sensation, movement, and *feeling* to understand how people attempted to understand and situate the insane body and its experience in the world in this period.

This thesis therefore considers and draws on a constellation of practices, actions, sights, feelings, sensations and perceptions to write a collaged history of the body. It begins with accounts and discussions of hallucinations and delusion as 'symptom experience', but deliberately pushes out from and beyond these terms to consider embodied experience and how it was discussed and communicated. What did hallucination and delusion have to do with movement, facial expressions, or excretion? Contemporary attempts to understand and organise the experience of apparent mental and perceptual disorder repeatedly crossed boundaries we have since drawn around mental health, diagnosis and even symptoms. This thesis will demonstrate that efforts to *understand, explain* and *communicate* were not neat, nor do they readily fit into our current models.

Conolly Norman's lectures: sources for experience

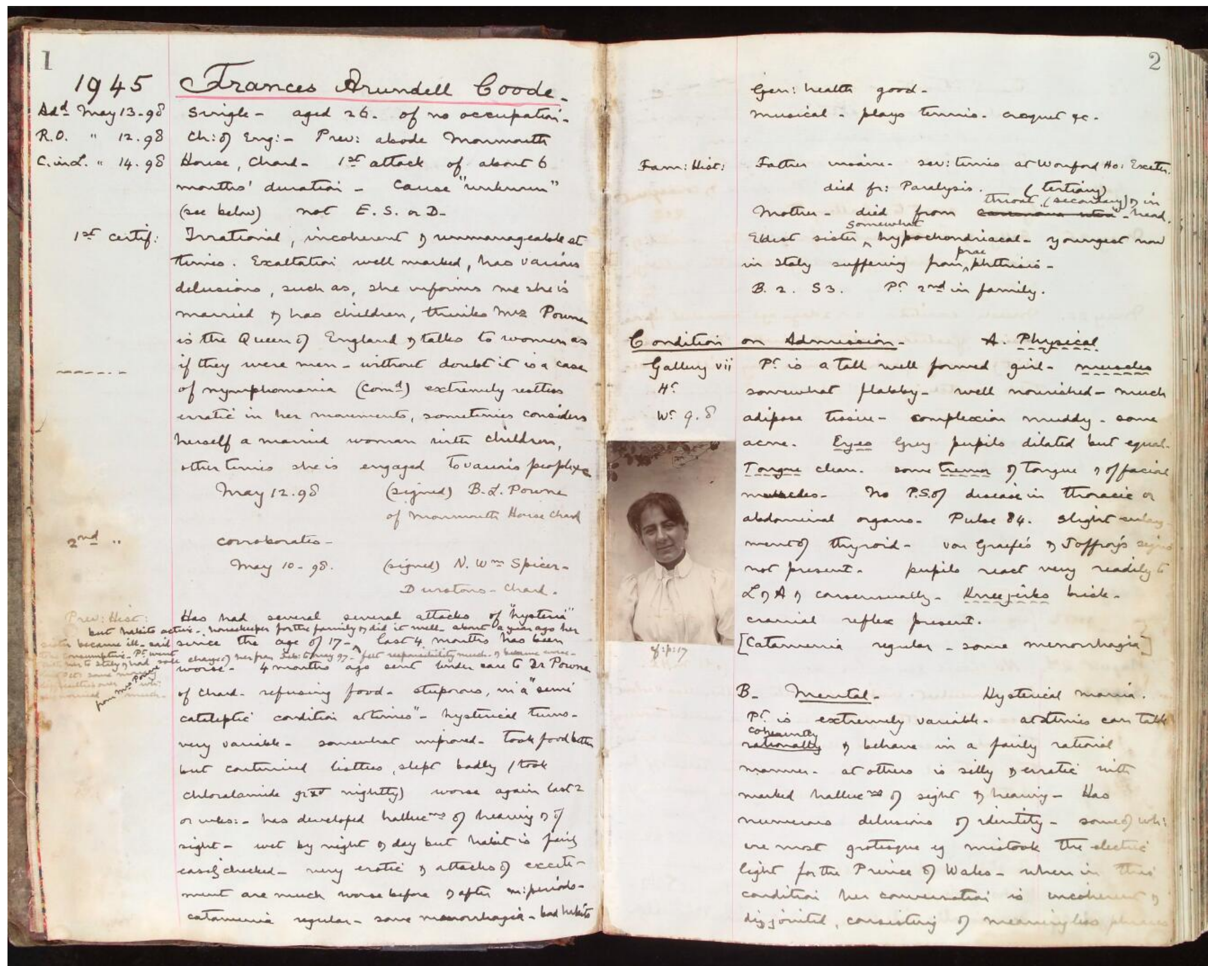
Whilst this research is about experience, what do I mean by this term and how might one 'find' or 'uncover' it? Is this even possible? Attempts to answer such questions have hitherto largely coalesced around two types of source: the asylum casebook and forms of life-writing or self-narration. There is a growing literature on patients' own writing and testimony in letters, published autobiographies, magazine or journal articles, or pamphlets.[10] Often produced following 'recovery',[11] many of these sources discuss asylum life, the imposition of medical authority and cases of wrongful confinement, or question the categories of 'illness' themselves. Whilst writing accounts of patients' lives from these sources can be empowering and validating in seemingly letting them speak for themselves, this is not the 'experience' considered by this thesis. I am interested in the *conversations* between medical professional and patient during the time of confinement; in the texture of interactions at times fraught by cleavages of meaning, understanding, and categorisation. As such, I am looking not only at 'experience', but its interpretation, communication, and contestation.

Turning to within the institution itself, writing this history through the casebook can be tempting, but fraught. The policy changes of the nineteenth century, such as the Lunacy Act of 1845, led to a proliferation, not only of asylums themselves and the patients therein, but also to the introduction of administrative and bureaucratic changes that have left

[10] Allan Beveridge, "Voices of the Mad: Patients' Letters from the Royal Edinburgh Asylum, 1873–1908," article, *Psychological Medicine* 27, no. 4 (1997): 899–908; Allan Beveridge, "Life in the Asylum: Patients' Letters from Morningside, 1873-1908," article, *History of Psychiatry* 9, no. 36 (1998): 431–69; Carol Berkencotter, "A Patient's Tale of Incarceration in a Victorian Lunatic Asylum," article, *International Journal of English Studies* 11, no. 1 (2011): 1; Cristina Hanganu-Bresch and Carol Berkenkotter, "Narrative Survival: Personal and Institutional Accounts of Asylum Confinement," *Literature and Medicine* 30, no. 1 (2012): 12–41.

[11] Recovery can, of course, mean multiple things at different times and for different people and is immensely historically contingent. A medical model of 'recovery' or convalescence which might inform the notes in casebooks stating that a patient was 'discharged recovered' will not necessarily correlate with a patient's.

historians a considerable and rich textual footprint of the lives of these people and places. We are held captive and captivated by the many hundreds of thousands of pages of asylum case notes produced by the nineteenth century institution. Patients' details, such as that of Frances A.G. in Figure 1 from Holloway Sanatorium,[12] filled into admissions forms with proof of insanity, and subsequent 'progress notes', taken at semi-regular intervals.


1

1945 Frances Arundell Coode

Ad. May 13-98 Single - aged 26. of no occupation.
R.O. " 12.98 Ch: of Eng: - Prev: abode Monmouth
C. ind. " 14.98 House, Chard - 1st attack of about 6
months' duration - Cause "unknown"
(see below) not E. S. or D.

1st certif: Irrational, incoherent & unmanageable at
times. Excitation well marked, has various
delusions, such as, she informs me she is
married & has children, thinks Mrs Powne
is the Queen of England & talks to women as
if they were men - without doubt it is a case
of nymphomania (Contd) extremely restless
erratic in her movements, sometimes considers
herself a married woman with children,
other times she is engaged to various people
May 12.98 (signed) B. L. Powne
of Monmouth House Chard

2nd " corroboration -
May 10 - 98. (signed) N. Wm Spicer -
Durstons - Chard.

Prev: Hist: Has had several several attacks of "hysteria"
since the age of 17 - last 4 months has been
worse - 4 months ago sent under care to Dr Powne
of Chard - refusing food - stuporous, in a "semi
cataleptic condition at times" - hysterical turns -
very variable - somewhat improved - took food better
but continued listless, slept badly (took
chloralamide gr xx nightly) worse again last 2
or wks: - has developed hallucns of hearing & of
sight - wet by night & day but habit is fairly
easily checked - very erotic & attacks of excite-
ment are much worse before & after m: periods -
catamenia regular - some menorrhagia - bad habits

2

Gen: health good -
musical - plays tennis - croquet &c.

Fam: Hist: Father insane - sev: times at Wonford Ho: Exeter.
died fr: Paralysis.
Mother - died from throat (tertiary) (secondary) & in head.
Eldest sister somewhat hypochondriacal - youngest now
in Italy suffering from prae phthisis -
B. 2. S 3. Pt 2nd in family.

Condition on Admission - A. Physical
Gallery vii Pt is a tall well formed girl - muscles
Ht somewhat flabby - well nourished - much
Wt 9.8 adipose tissue - complexion muddy - some
acne. Eyes grey pupils dilated but equal.
Tongue clean. some tremor of tongue & of facial
muscles - No P.S. of disease in thoracic or
abdominal organs - Pulse 84. slight enlarge-
ment of thyroid - von Graefe's & Joffroy's signs
not present. pupils react very readily to
L & A & consensually - Knee jerks brisk -
cranial reflex present.
[Catamenia regular - some menorrhagia]

B - Mental - Hysterical mania.
Pt is extremely variable - at times can talk
coherently & behave in a fairly rational
manner - at others is silly & erratic with
marked hallucns of sight & hearing - Has
numerous delusions of identity - some of which
are most grotesque e.g. mistook the electric
light for the Prince of Wales - when in this
condition her conversation is incoherent &
disjointed, consisting of meaningless phrases

Figure 1: Casebook of Frances A.G., c.1898, photograph of HS CB 11.

Whilst these documents ostensibly provide extensive information about a patient's time in the asylum, appearance, and how they described themselves, repeated theorists have

[12] Frances A.G, c.1898, CB 11 Females, 1898-1907, MS.5159, HS, WL, https://wellcomecollection.org/works/m5qcwkpa, 1.

pointed out that they are problematic and indirect accounts of 'experience' or patients' 'voice', and the first section of this thesis will consider such tensions further. Questions of power and control have coalesced around the nineteenth-century psychiatric institution and medical profession more broadly. These concerns were put under close critical scrutiny in the ground-breaking and formative work produced in the 1960s by R. D. Laing, Erving Goffman, Michel Foucault, Thomas Szasz, and others, but have been continued to this day, especially following Roy Porter's influential article on patient voices and history 'from below'.[13] However, my project contends that such work has created a circumscribed critical momentum that can obscure the whole picture.

Rather than framing studies necessarily as a relational (and often combative or confrontational) consideration of power and the clinical encounter, this thesis considers the multi-dimensionality and texture of the clinical encounter. It asks how meaning was negotiated and co-produced *as well as* imposed or resisted. Often at the root of both approaches lies a dangerous assumption of or aim towards 'representativeness'.[14] This can make it easy to forget that behind the icons of the doctor and establishment or the 'sufferer' and patient, there are real people and nuanced relationships, not heroes (however reluctant or otherwise) and villains. Most of the surviving textual evidence is a partial fragment of conversations between these different people, each possessing their own agendas, backgrounds, beliefs, assumptions, bodies, and emotions.

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[13] Roy Porter, "The Patient's View: Doing Medical History From Below," *Theory and Society* 14 (1985): 175.

[14] It is of note that many of the published autobiographies discussed above are written by a particular type of patient who was generally male and, if not middle-class, certainly educated and literate.

Our understanding of the 'voice' (and its absence) should be considered and problematised in light of this. Although silence has hitherto been seen as the preserve of the patient, the silences of the asylum and archive are actually not always where we expect them. The filtered case note narrative gives us (some version of) the patient's answer, but rarely the question. Equally, when we use the term 'the patient's voice' we are generally implicitly talking about something *articulated,* often consciously. We think less about the grunts, murmurs, exclamations, sniffs, and *laughter* which are arguably just as integral to our interactions with others. When we talk about sources for *experience* in mental health, we so often forget bodies, silences, and the incomplete or unarticulated. This is partly because they are *hard to find* in the textual, clinically-coded casebooks of the asylum. These institutional records are partial and two-dimensional representations of a three- or four-dimensional complex embodied process and encounter. In looking at experience, I am looking at bodies *and* voices.

Sensitive to this (and as a response), this thesis is shaped by a set of sources which represent and offer an entirely new perspective from the top-down, bottom-up approach to the history of psychiatry and experience; the transcribed lectures of Conolly Norman. A forceful presence in the emerging psy- professions in Britain, Norman was employed at major institutions such as Bethlem Royal Hospital (London) and as Medical Superintendent of multiple asylums, including Castlebar (1882-5) and Monaghan District Asylum (1885-6), before holding this position in of the largest asylums in Ireland, Richmond District Lunatic Asylum (Dublin) from 1886 until his death in 1908.[15] Prior to this post, Norman had received the licenses of the King and Queen's College of Physicians in Ireland and Royal College of

[15] Brendan Kelly, *Hearing Voices: The History of Psychiatry in Ireland* (Newbridge: Irish Academic Press, 2016), 111–12.

Surgeons in Ireland in 1874, becoming a fellow at the Royal College of Surgeons and Royal College of Physicians by 1890.[16] Norman published extensively in contemporary medical journals, including the *Journal of Mental Science (JMS), The Lancet,* and *The British Medical Journal,* becoming joint editor of the former.

Norman's published writings and approach to asylum policy and governance establish him as 'an inveterate innovator and a freethinker.'[17] Irish historian of psychiatry Brendan Kelly notes that, whilst at Richmond, 'the energetic, enthusiastic doctor had a profound effect on the vast institution: restraints were relaxed, buildings renovated, staff numbers increased and a laboratory built.'[18] Upon his death, the *Irish Times* published an extensive discussion of his impact on the profession and situation of patients in Irish institutions, claiming that,

> 'Dr Norman's name will be associated with almost all asylum reforms in this country, and it is impossible to estimate his efforts in this respect. His services have brought about a wonderful change in the treatment of lunatics, and many lives have been brightened by his zealous devotion to their welfare.'[19]

A particularly key component of Norman's writing and thinking was his advocacy for alternative systems of care for the insane, which de-emphasised the institution. Concerned about the impact of the asylum space itself on the experience and mental state of his patients, the physician believed that changes of surroundings was highly beneficial in most cases, whether simply a walk in the garden for "violent" patients, or moving an individual outside

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[16] Davis Coakley, "Norman, Conolly (1853–1908), Psychiatrist," in *Oxford Dictionary of National Biography* (Oxford University Press, 2004).

[17] Kelly, *Hearing Voices: The History of Psychiatry in Ireland*, 112.

[18] Ibid.

[19] Irish Times, 29 February 1908, in Ibid.

of the asylum and into the community once the 'acute stage' of their condition was believed over. Norman argued that confining people within asylum walls was often more harmful than curative and there was 'a great danger, lest, in the dull atmosphere of an asylum, [a patient] may grow more and more indolent and timid', falling 'into a monotonous groove, from which he becomes too apathetic to strive to emerge.'[20] Compounded by criticisms that the growing asylum population was a financial drain on the state, Norman advocated a system similar to that observed in Gheel, whereby 'the patients live in the houses of the hosts, mixing freely with them in domestic life, and in the case of the public patients following as far as they are able the trade or calling of the hosts or assisting them in the ordinary labour of the household.'[21] These components of his writing and thinking situate Norman's interactions with his patients in context. As a clinician and thinker, he was at once embedded in the dominant 'tradition' of the emerging psy- disciplines in Britain and represents something different.

Notably, I first became aware of Norman as he was one of the few British doctors to publish journal articles specifically on hallucinations. Prior to his 'Clinical Lecture on Hallucination' with which this thesis opens, he published a three-part series of 'Notes on Hallucinations' between January 1902 and July 1903.[22] These articles were not restricted to a

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[20] Conolly Norman, "The Domestic Treatment of the Insane," *The Dublin Journal of Medical Science* 101 (1896): 112.

[21] Ibid., 116.

[22] Conolly Norman, "Notes on Hallucinations. I.," *Journal of Mental Science* 48, no. 200 (1902): 45–53; Conolly Norman, "Notes on Hallucinations. II," *Journal of Mental Science* 49, no. 205 (1903): 272–91; Conolly Norman, "Notes on Hallucinations. III," *Journal of Mental Science* 49, no. 206 (1903): 454–73.

particular supposed diagnosis,[23] theory, or sensory modality.[24] Rather, they were case-based explorations of experiences of the hallucinated. Norman's flexibility and emphasis on clinical realities allowed a fuller exploration of the narratives, tensions, interpretations, and explanations which coalesced around particular patients such as the butler at the opening of this thesis. Whilst this is far from an account centred on one physician, institution, or *type* of source, material which features or is produced by Norman constitutes a key focal point throughout. His evident interest in patient experience, the body, and hallucination and delusions as symptoms which defied easy understanding and classification, makes his writings and interactions with patients a remarkable and detailed source for this research.

Norman gave three series of lectures to medical students[25] between 1905 and 1907, inviting not only patients from Richmond Asylum into the theatre, but also employing a transcriber to record the conversations in typed copy. It appears likely that Norman had intended to turn these lectures into a publication, perhaps clinical or pedagogical manual, as the transcript includes sparse corrections and additions of patient names and case numbers made by hand. However, Norman's death following the third series led to these records being overlooked until their 'discovery' in the basement of the RCPI in 2017. Peculiarly performative and utterly remarkable, these lectures have thus far been unexplored by historians of the field and represent a transformative and novel source. My encounter with them urged a forceful confrontation with the ways in which 'the archive' was a romantic,

[23] W. Julius Mickle, "Note on Hallucinations in General Paralysis in Reference to Cerebral Localization," *Journal of Mental Science* 27, no. 118 (July 19, 1881): 217–217.

[24] George Fielding Blandford, "Auditory Hallucinations," *Journal of Mental Science* 19, no. 88 (January 19, 1874): 507–19.

[25] I have deliberately not said male here as there is reference to at least one female present, although Norman generally refers to 'gentlemen'.

mysterious, and arguably fetishised place of 'discovery' and intimacy. The typescripts I poured over (and the stories they contained) had remained untouched and unread for over a century. Reading them *felt* like entering a rarefied world in which I could *see* and *listen in* without being seen or heard.[26] This box of loose papers felt different to the casebook records I had become familiar with. Somehow, they felt more human.

The lectures are loosely structured and read as organic and responsive textured interactions with insanity, clinical practice, and patients themselves. Principally pedagogical in purpose, Norman explained in his very first lecture in March 1905 that 'this course shall be a strictly clinical one' so as not to 'dwell on the theoretical advantages of some little knowledge of diseases of the brain'.[27] In each lecture he brought a variety of patients into the room to talk to him in order to 'exhibit some cases showing the most ordinary forms in which the disease will come under your notice'.[28] Norman gave his students the instruction that,

> 'when you see the case first you ought to put to yourselves the following questions:
>
> In what was does this man or woman differ from ordinary human beings? What sign of insanity do they show?
>
> It may often happen that intoxicated with the exuberance of my own verbosity having put the question I may omit to answer it, and it is your business to put the question and answer it from the case before you.'[29]

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[26] A feeling and impression which will reappear and be unpicked throughout this thesis.

[27] Series 1, Lecture 1, 3 March 1905, ACC/2017/2, CN/1/1, CNL, RCPI.

[28] Ibid.

[29] Ibid.

This instruction highlights the adaptability and often ambiguity of both the lectures and clinical practice. Meaning was not always presented to the students (or me, through the sources), but rather could be negotiated, inferred, or multiple. Similarly, whilst he claims to have chosen 'ordinary forms' of insanity, this does not necessarily mean Norman adhered to clinical manuals and emerging diagnoses or psychiatric nosologies. Rather, he chose cases which he felt he commonly encountered in clinical practice and, crucially, which *interested* him. Norman is a forceful presence in these sources. The lectures are specifically a product of his conversations and relationships with patients and rooted in his clinical experience. The lectures were loosely structured and, as he had warned, Norman frequently failed to make any particular concrete argument or claim. Instead, he spoke to his patients before an audience and 'explored' the case. Even more than in his published work, Norman ranged across topics and ideas, rather than sticking to rigid categories. Although his selection process was intended to show the 'representative', instead it frequently highlighted the enormous diversity and range of experience, embodiment, emotion, and behaviour in a space the historian usually only has limited access to through institutional archives.

Some patients were dragged into the room, others invited and the ways in which these lectures are performed and embodied will be discussed more fully in section two on 'encountering the body (in the world)'. The transcripts record physician, patient and audience laughing and joking, crying, criticising, begging, accusing, watching, listening, resisting, bargaining, and reasoning. The answers of patients do not just 'appear', recorded following an inaccessible clinical encounter. The historian is allowed inside the process and practice of clinical medicine in key and novel ways. At times, Norman even identified his own emotions and identifies what is usually silent and can only be inferred from clinically dispassionate notes. Interviewing a patient in his first lecture series he explained to students that,

> 'at first she was extremely reticent and very slow, and in fact, exasperating, and one had to go squeezing her and carrying on as if one had the whole day to examine this patient. This is common with the general paranoic. They are suspicious, they fence with you. There is no case that wastes more time. They answer slowly, indifferently, and so forth.'[30]

In both the conversations themselves and the commentary or explanations such as this, these lectures provide unparalleled insights into the humanity and subjectivity of patient-physician interactions and experiences.

This thesis is structured principally around themes and questions raised by these lecture-conversations. It explores their specificity and limitations alongside the unusually intimate and novel angle on how experience was discussed and communicated in spaces generally associated with the formal and impersonal structures of clinical medicine. These sources are partial and contextual, offering insight into medical education as well as the clinical encounter and how experience was understood and communicated, verbally and frequently non-verbally. The different perspective on the history of psychiatry and the asylum they offer has never been more important. A *messy* source, Norman's lectures inevitably shape patients' stories and experiences, but are also tangibly shaped *by* them and responsive *to* them.

Norman's interests and approach in many ways mirrors my own; starting with stories of hallucination and delusion (amongst other 'symptoms' and experiences) he *struggles to*

[30] Series 1, Lecture 16, 10 April 1905, ACC/2017/2, CN/1/16, CNL, RCPI.

understand or access, he asks questions and writes more widely on ‘the body’ in the mind sciences to unlock its nuance, messiness and subjectivity. Moving from these sources across other writings and casebooks, it became apparent that countless contemporary doctors, like Norman, admit uncertainty; they admit failures and boundaries of knowledge and experience. This was especially evident when speaking and writing on hallucination and delusion, as will be returned to and explored as a thread running throughout this thesis. Moving across other casebooks and published literature, my research pulls at these moments of uncertainty, slippage and negotiation to illuminate submerged practices, processes and beliefs which enmesh and constitute the body and its experience (both now as then). This means foregrounding the ‘experience’ found in conversations, discussions, and negotiations rather than just the ‘patient’s voice’ as an elusive ‘pure’ historical myth. This thesis asks what were people disagreeing or agreeing over and where were people pushing back? What assumptions are being made about the body and what questions are being asked?

Crucially, it also highlights where Norman and others resisted the idea of an emerging consensus in mental science as a profession, drawing attention instead to the failure of theory, diagnosis, and clinical textbooks or statistics in capturing and describing both patient experience in all its complexity and the reality of practicing asylum medicine. This thesis acknowledges and considers this intellectual and cultural context, drawing in the writings of alienists such as Henry Maudsley, George Savage, and Daniel Hack Tuke as extensive monographs which attempted to develop a medical framework to ‘pin down’ the human mind and for symptom-experience. Articles published in *The Lancet,* the *Journal of Mental Science,* and the *British Medical Journal* further inform this study and often show the ways in which theories became muddier when debated amongst a professional community or readership, or when applied to individual selected case studies such as that of Conolly

Norman's patient at the start of this introduction. As Norman himself urges, it is crucial to recognise that the 'ideal' presented in monographs, textbooks, and journal articles did not always directly translate into daily asylum practice, not least given the pressures and practical considerations of a burgeoning asylum population with complex needs.

In formulating this thesis, a conscious choice has therefore been made to draw largely from Norman's lectures and, from there, to move between published medical literature and select casebooks. This is principally to reject the 'representative' and the dominance of the 'institution' and highlight other messier narratives which wove through the asylum. Rather than a systematic trawl through the stacks of records produced by one asylum, with its associated medical superintendent, nurses, attendants, doctors, and specified socio-economic class of patient, this thesis has sampled a myriad of stories. This mirrors and reflects Norman's approach. It contends that each story found in the asylum archive and elsewhere is of value and raises important questions. This approach leaves space for meaning-making which might or might not include diagnosis or labelling. Whilst this research focuses on unsettling or expanding our existing asylum-based histories and foregrounds the experience of the body in the clinical encounter, it also acknowledges that there were many practices and sites beyond this in which the 'insane body' was seen and the 'insane voice' heard: in the home, in lecture theatres and teaching rooms, in ballrooms. Insanity and the asylum were written into newspapers and novels, imagined, drawn, joked about, and performed on stage.

Change over time

Beginning around 1840 and finishing in 1914, this thesis is framed by complex questions of change and stasis, which frequently pull apart from one another. It has been

extensively discussed by historians that the period under consideration here (the nineteenth- and early-twentieth centuries) was a time of immense upheaval and *change.* This is often written of, or perceived as, an exciting image of ‘progress’*:* medically, technologically, and socially. Throughout this thesis, I will touch on some focal points of these changes; new legislation which reformed the provision for and treatment of lunatics, the construction of asylums, the non-restraint movement, new languages and theories of clinical psychopathology or explanations of aetiology, the emergence of statistical methods and forms of record-keeping, and technological ‘innovations’ such as the telephone, phonograph, camera, and railway.

The association of change with ‘progress’ is not uniquely Victorian. A strong historical myth has emerged in both historiography and popular culture of the nineteenth-century asylums as a terrifying and inescapably coercive place. This generally rests on the idea that understanding of and provision for mental health disorder has improved over time, particularly since the advent of a specialised and evidence-based profession with quantifiable results and scientific methods. The history of science, technology, and medicine is often underwritten by a directional language which emphasises ‘discovery’, ‘innovation’, and people (largely men) who *changed things.* The notion of change as radical disjuncture is appealing and compelling to historians as much as contemporaries. Historical studies frequently coalesce around the abrupt or revolutionary; they draw the eye. In the history of psychiatry, it might be the doctor who came up with a new theory, a ground-breaking study, the use of a new technology like photography in the asylum.

This thesis, however, urges a reconsideration of (or disruption of) such ways of telling the history of psychiatry and attention to what they make visible or obscure. The social, cultural, political, and economic impacts of these 'grand' changes, and others underwritten by gender and class, during the period of study touch or inflect the lives of patients and doctors at different times in different ways. Some will be more directly looked at by this thesis than others. However, a significant thread of the story which will be told in this thesis is one of surprising continuity and persistence. Norman's lectures are not returned to throughout this research because of the radical ways in which he sought to change psychiatric practice. Rather, they illustrate the ways in which the immediacies of the asylum environment, patient care, and the humanity of clinical interactions, were as crucial to the daily lives of patients and doctors in the institution as *change* in theories, diagnoses, or policies. These lectures are inconsistent, uncertain, and fragmented as frequently as they purport to provide answers, theory, and information.

In a period of immense uncertainty, change, and the recasting of social, political, technological and medical frames, in many ways the asylum was a place where time 'stood still'. In being attentive to archival silences, disruptions, and tensions, it becomes possible to see the ways in which stories were consciously or implicitly being constructed and told. People were repeatedly attempting to draw boundaries around concepts, experiences, categories, diagnoses and *things* which escaped these constraints and divisions. This thesis considers the ways in which doctors were trying to access, understand and define other people's experiences, internal worlds, how they related to others. In doing so, they were also looking at themselves. Asking questions about 'insane' experiences and bodies (without necessarily settling on 'answers' rather than further questions) also meant asking about the ways in which the sane thought, felt, moved, and emoted.

The starting point of this thesis in the 1840s emphasises the changing landscape of both clinical practice and public perception prompted by new lunacy legislation and regulation introduced in this decade. Starting here also reflects the increase in writing on hallucination and delusion as medicalised concepts and the significance attached to this event by contemporary psychiatric writers. Whilst in this period a clinical language was being (or had been) established, meaning was still unstable and these terms or categories had porous boundaries, especially in the clinical space itself and in how they mapped onto the body.

Closing this study in 1914 recognises the impact war had both on people's understandings of their bodies and the anxieties which shaped the ways in which people saw, felt, or perceived their world. This also serves to emphasise the period in British alienism before the theories of Freud and Kraepelin gained enough momentum to move therapeutic regimes in different directions and imposed a greater diagnostic fixity on dementia praecox as central to the hallucinatory experience. Crucially, both contemporary and present-day debates around the body and psychiatry during the war crystallised around the diagnosis of 'shell shock'.[31] However, Psychiatry's relationship to the body has a long and intricate history not restricted to the gendered diagnoses of hysteria or shell shock. Consideration of the decades immediately preceding the emergence of the shell-shocked body from the trenches allows us to deconstruct many of the myths of modern psychiatry, periodisation, and psychiatric history. These bodies must be seen as part of a shifting spectrum of psychiatric disorders and

[31] Tracey Loughran, "Hysteria and Neurasthenia in Pre-1914 British Medical Discourse and in Histories of Shell-Shock," *History of Psychiatry* 19, no. 1 (2008): 25; Tracey Loughran, *Shell-Shock and Medical Culture in First World War Britain*, Studies in the Social and Cultural History of Modern Warfare ; 48 (Cambridge: Cambridge University Press, 2017).

ongoing debate regarding the interrelationship of diagnosis, emotion, movement, pain and perception.

Hallucination and delusion: entangling 'symptom' and 'diagnosis' with 'experience'

Whilst I weave hallucination and delusion in particular through this research, the narratives and experiences I discuss under these terms are not always easily recognisable to a present-day reader (or, indeed, contemporary doctors).[32] The process and practice of historical research itself is implicitly shaped by its own notion of *change*. I am writing *now* about *then.* One consequence of this is that I am drawn to moments or notions of difference and this change. As has been discussed, I was first drawn to this research when reading Norman's 'Clinical Lecture on Hallucination' in which clinical languages of hallucination and delusion and the systems of the body or senses came into tense contact with a patient's experience of 'torture'. I was struck by a sense of *difference* which prompted reflection on the conceptual baggage and assumptions I was bringing to clinical records, thinking and writing from my own particular historical moment. How might looking at a period in which these questions were being asked and boundaries redefined emphasise the need to unsettle and historicise our own meanings, languages, and categories for experience or diagnosis?

This thesis considers a period prior to the development of both a "fixed" diagnostic manual or psychopathological framework and the established profession of "psychiatry". As

[32] The ways in which I occasionally use the term as a convenient shorthand in itself simplifies these experiences in an often-unavoidable way.

such, it considers the ambiguity, flexibility and *slippage* that constituted the practice of the science of mind in this period. This is, in part, an effort to highlight the critical importance (and long history) of debates currently surrounding clinical practice in the psy- disciplines, the question of lived experience, and diagnostic systems such as the *Diagnostic and Statistical Manual of Mental Disorders* (currently in its fifth controversial edition).[33] The conversations and stories which emerge through this thesis challenge existing assumptions about how experience, symptom, and diagnosis map onto each other. This is not a passive process and is explicitly historical; embedded within broader social, cultural, economic and political systems. This broader and longer sense of *change* frames this analysis in complex ways.

My approach echoes that of Janet Weston in her text on medicine, the penal system and sexual crimes.[34] Weston considers the period from 1919 to the 1960s, emphasising this as a period of 'ontological anarchy' in psychiatric approaches and thinking on sexual offences. This 'allowed a new and potentially fragmented profession to remain united' and enabled doctors' explanations for the wide variety in outcomes which resulted from their chosen treatments.[35] This research similarly looks at a period of malleability and multiplicity in medical approaches, which can reveal underlying assumptions (from both practitioner and patient) which guided belief, practice and outcomes. The spike in interest evident in this period and the proliferation of medical frames or models used to explain and understand

[33] American Psychiatric Association, *Desk Reference to the Diagnostic Criteria from DSM-5 (R)* (Arlington, TX: American Psychiatric Association Publishing, 2013).

[34] Janet Weston, *Medicine, the Penal System, and Sexual Crimes in England, 1919-1960s: Diagnosing Deviance*, Bloomsbury Collections (London ; New York: Bloomsbury Academic, an imprint of Bloomsbury Publishing Plc, 2018).

[35] Ibid., 3.

these experiences fragmented attitudes and approaches in a way similar to that Weston identifies in sexual deviance and crime in her work. It also, however, allowed for a flexibility in interpretation and diagnosis, which this thesis explores. When clinical boundaries and frames were porous and contested, could this also create space for patient's own meaning or co-production?

Once more, hallucination and delusion offer a useful way to illustrate or *think through* these questions and tensions. Referred to in current psychological and psychiatric medicine as 'psychotic' experiences, they are generally associated with the diagnosis of schizophrenia and have become largely synonymous with this label and its cultural baggage or stigma.[36] That was not the case in the period under consideration here. Boundaries and diagnostic categories were porous. The presence of delusions and hallucinations could signify delusional insanity, monomania, delirium tremens, dementia praecox, melancholia, general paralysis of the insane, or other provisional and much-debated terms. It was precisely this slippage which made contemporary doctors fascinated by them as concepts and experiences – as things which could not be fit neatly into a box, although ill-fitting boxes were tentatively constructed.

Norman's 'Clinical Lecture on Hallucination' with which this thesis opens gestured to this historical psychopathology and the significance of *attempts* to define, understand, and explain narratives such as his distressed patient's. This lecture clearly stated the importance of such experiences, boldly claiming that 'one of the most striking symptoms of alienation is

[36] This has been challenged or problematised in recent years by interdisciplinary research such as by Durham University's *Hearing the Voice.* This project seeks to transform the ways in which voice-hearing is managed, treated, and understood by people with lived experience, clinical practitioners and broader culture and society.

the existence of hallucination.'[37] Norman stated that his interest in 'sensory phenomena' resulted from the frequency with which they occurred, the seeming ease of their study, and the observation that 'sensory disturbances which seem identical with, or more closely akin to, hallucination occasionally occur, perhaps physiologically and certainly in conditions which are not commonly classed as mental diseases.'[38] Entangling the body and mind, his hope was that given that hallucination '*appears* to be a relatively simple if not an elementary mental disturbance… its study may furnish a key with which to open the more intimate chambers of the mind, for the progress of knowledge in other departments has usually been from the more simple to the more complex.'[39] Norman's claim regarding the simplicity of the phenomenon belies a long and contentious history within both the medical and alienist communities over the previous century regarding the understanding and classification of embodied experiences of insanity, such as 'hallucination' and related 'sensory disturbances'. Whilst seemingly at the heart of both practitioners' conceptualisation of insanity and many patients' affective and physical experiences of it, hallucination remained a slippery concept when Norman gave his lecture, and still does today.

Attempts to understand this physiological and psychological phenomenon drew attention to the ambiguities around the emerging language and institutions of mental science in the nineteenth- and early-twentieth centuries. According to clinical historian German Berrios, Jean-Étienne Dominique Esquirol established the terms for the debate on this subject with his 1838 publication of *Des Maladies Mentales.* This compilation of his writings and papers on insanity was subsequently translated into English by Ebenezer Hunt in 1845 as the

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[37] Conolly Norman, "A Clinical Lecture on Hallucination," *The Lancet* 163, no. 4192 (1904): 3.

[38] Ibid.

[39] Ibid.

first psychological textbook.[40] Esquirol argued for a separation of the terms of hallucination, illusion, and delusion. The former being a perception without an external sensory stimulus; illusion constituting the *mis*perception and misattribution of an external stimulus; and delusion the aberrant reasoning process whereby meaning is attached to a perception, object, or sensation. Esquirol also argued for a specific term to denote the pathology of 'hallucination' across sense modalities as distinct from the 'visionary' of previous centuries. He contended that

> 'Hallucinations of sight, reproducing objects which occasion the most general interest, and make the strongest impression upon the multitude, have been denominated *visions.* This name is suited to a single form of hallucination. Who would dare to say, visions of hearing, visions of taste, visions of smell?... A generic term is wanting. I have proposed the word *hallucination.*'[41]

Esquirol's creation of this 'generic term' for hallucination sought to demystify the 'visionary' of previous centuries to define misperception across sensory modalities (partly decentering sight alone) as pathological. He thus urged theorists to elucidate the means by which this deviation could occur.

Esquirol was also principally responsible for espousing what Norman himself later termed the 'psychical theory' of hallucination.[42] Further developed by Lélut and Moreau de

[40] German E Berrios, *The History of Mental Symptoms: Descriptive Psychopathology since the Nineteenth Century* (Cambridge: Cambridge University Press, 1996).

[41] Etienne Esquirol, *Mental Maladies*, trans. Ebenezer K Hunt (Philadelphia: Lea and Blanchard, 1845), 110.

[42] Conolly Norman, "Notes on Hallucinations. III," *JMS* 49, no. 206 (1903): 454.

Tours, this theory argued for the central role played by the brain rather than the peripheral sensory organs in the production of hallucinations. He contended that

> 'The pretended sensations of the hallucinated, are the images and ideas reproduced by the memory, associated by the imagination, - and personified by habit. Man then gives a form to the offspring of his mind. He dreams, while fully awake.'[43]

The translation of Esquirol's work immediately followed the 1844 annual dissertation prize of the French School of Psychological Medicine, which had sparked a fierce international debate when it turned to the topic of hallucination. Eleven candidates, 'amongst them… some of the most distinguished psychologists of the day', responded to the call for further elucidation of the hitherto seemingly mysterious phenomenon.[44] The psychical theory was thus joined and challenged by these and subsequent alienists over the following decades, keen to mark out a distinct language and ontology of psychiatry as an authoritative discipline with its associated pathologies and institutions. Situated somewhere between body and mind, brain and sensory organs, hallucination fascinated and confounded numerous theorists and prompted particular consideration on the porous line between sanity and insanity.

As Norman stated, practitioners were acutely aware of the possibility of hallucination in the sane under particular conditions. Intoxication and the half-state between sleep and wakefulness were particularly known for their tendency to cause altered sensory perception. However, given the centrality of hallucination to the classification of insanity and the medicalisation of the 'visionary' and often religious experiences of previous centuries, the

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[43] Esquirol, *Mental Maladies,* 107.

[44] George Sigmond, "On Hallucinations," *Journal of Psychological Medicine and Mental Pathology* I (1848): 585–608.

occurrence of such experiences in the wider 'sane' population caused a problem for psychiatric authority. This was especially the case in Britain in the final decades of the century when the British Society for Psychical Research (SPR), headed by Edmund Gurney, Frederic Myers and Henry Sidgwick, published the findings of their 'Census for Waking Hallucinations', conducted between 1889 and 1892 on the non-institutionalised population. Gurney was himself a psychologist and the study prompted major responses from numerous members of the international psychological and alienist community, including a comprehensive analysis and discussion by German psychologist Edmund Parish in 1897.[45]

If thousands of people responded that they had hallucinated when fully awake and not under the influence of intoxicating substances, did this mean that the spiritualists and psychical researchers were right? Or did it instead mean that hallucination could be non-pathological? And what implications would this latter idea have for the innumerable figures of the past, especially within the Judeo-Christian religious tradition, who claimed to have had visionary experiences? Did hallucination always mean insanity? For many, the answer was that it sat on the borderline of creativity, genius, superstition, technology, and modern medicine; pathological only when delusion gave it the coloration of another abnormal or unrecognisable reality.

Delusion, or false and often systematised belief resistant to contrary evidence, proved considerably more difficult to theorise and define. Was this too necessarily always pathological and incompatible with sanity? What of persistent superstitions and the popular

[45] Edmund Parish, *Hallucinations and Illusions : A Study of the Fallacies of Perception*, Contemporary Science Series (London: Walter Scott, 1897).

belief in witchcraft of previous centuries? Did this fundamentally differ from those in British asylums telling their doctors that they had been bewitched or were visited by the devil who rotted their insides? The idea of the mass psychology of crowds and ages of delusion began to be discussed by both medical practitioners and the public press,[46] who were interested in this seemingly multifaceted and mysterious phenomenon. Whilst generally the line was drawn between sensation (or perception) and belief, this was not an unproblematic distinction, as this thesis will explore. The tangled nature of hallucination and delusion as concepts and experiences provides key insights into the ways in which experience was codified and understood both within and without institutional walls. Crucially, it was a central way in which hallucinations were mapped on to a 'self' and identity; delusion could be a language which expressed the meaning people attributed to sensation, whether of an external stimulus or hallucinatory, be that witchcraft, electricity, or paranoia and persecution.

Existing literature and approach

This thesis uses stories which coalesce around the terms of 'hallucination and delusion' as starting points to speak about the body as it was and is communicated or discussed, seen, and felt. My exploration of existing work and historiography has therefore taken a similar approach; starting from hallucination and pushing out across the body, pulling at assumptions. Why do most studies of madness map the growth of current systems of clinical psychopathology? Why do histories of medicine which consider clinical languages and institutions not look at the gaps and negotiations in meaning which gathered around these terms and experiences? How can we talk about the body without imposing our own systems,

[46] Particularly following the publication of Gustave Le Bon, *The Crowd: A Study of the Popular Mind* (New York (State): Macmillan, 1896).

terms and meanings on it? The historiography itself reflects the ways in which we have constrained and intellectualised hallucination and delusion, rather than exploring the ways in which the meanings, sensations, and experiences these terms attempt to describe roamed across culture, politics, society, and the body. It asks, through hallucination and delusion, why insanity was so entangled with the body in ways 'mental health' is not.

Keyword searches for 'hallucination and delusion' will produce limited results, which is indicative in itself. How does one approach something which doesn't 'show up' in sustained, direct or straightforward ways? Annamarie Jagose's work on the orgasm, with its emphasis queer theory, instability and on leaving narratives open ended is immensely conceptually helpful. She observes that

> 'with very few exceptions, orgasm has seldom been the object of sustained scholarly attention… Far from there being nothing written on the subject, it is rather that the many scholarly references are dispersed and unsustained, seldom substantial enough to have a presence in anything as orienting as a title, a table of contents, or an index. Under these circumstances, reading becomes more like tracking, some untrained sense of vigilance sharpening in the vicinity of certain words, drifts of thought, and mental association, in anticipation of their revelation of a concealed figure… orgasm has been for me a volatile and unstable basis for a research project.'[47]

The following literature review reflects this 'tracking' and 'drifting'. The history of the body in the asylum, and hallucination and delusion in particular, is mercurial, half-concealed, and

[47] Annamarie Jagose, *Orgasmology* (Durham, NC: Duke University Press, 2013), xii.

volatile. I am interested in this disorientation and how, where, and why these embodied experiences (and questions about them) appear across fragments and in diverse places.

Studies of hallucination and delusion experience are surprisingly difficult to come by in the existing historiography of psychiatry. A cornerstone of many psychiatric diagnoses, particularly the hotly-debated schizophrenia, and with experientially profound consequences for individual sufferers, hallucination and delusion lie at the heart of what for many people it means to 'be *mad*.' Its centrality to the way insanity is imagined and discussed is, however, a significant barrier to its consideration. These are easy experiences to marginalise and characterise as the epitome of mental abnormality; in perceiving things that are not there and believing in a reality that seemingly exists only in one's own mind, sufferers often find themselves separated and isolated in meaningful ways from the world, people around them, and sometimes themselves.[48] This distance has often situated such individuals as fetishised and exceptional figures of 'truth'; holding a mirror up to and offering a commentary on the world and society from its shadows, uninhibited by restrictive social codes. The 'schizophrenic' too often stands as the lonely, and often unwilling, champion of the anti-psychiatry movement.

Although featuring prominently as symptoms in studies on madness following the surge of interest in social control and psychiatric history from the 1970s, such research has generally overlooked the everyday, immediate and embodied aspects of these experiences. Emphasis has instead favoured either considering abstract social control exerted in the reassertion of normativity and deviance, or tracing the development of psychiatry as a

[48] Often referred to as ipseity disturbance.

profession with associated nosology. Clinical historian German Berrios has contributed significantly to our understanding of this traditional history of descriptive psychopathlogy. He argues that the ways in which psychiatric disorder is classified and diagnosed has remained remarkably stable since a rupture he identifies in the first half of the nineteenth-century. According to this framework, hallucination and delusion shifted from a 'culturally integrated and semantically pregnant' experience prior to eighteenth century medicalisation, believed to carry messages for the individual or world, to independent diseases, settling as a fragment or symptom of various diagnoses in the nineteenth century.[49] Importantly for this study, Berrios has published on tactile hallucination and the particular problems these experiences presented for the medical profession.[50]

However, whilst providing a helpful overview of the ways in which the medicalisation of hallucination increasingly differentiated and marginalised these experiences, the teleological view underpinning such articles provides a neat, sharp picture of this transition which does not hold up to closer scrutiny of both everyday asylum practice and the 'borderlands' of sensory experiences outside of these pathologies. It also inevitably situates itself in an intractably presentist perspective; tracing the development of a disease concept towards current understanding rather than necessarily interrogating the ways in which this concept was socially constructed as well as historically and culturally contingent. This is reflective more broadly of tensions between clinical history and social and cultural history. The emergence, in the 1980s, of the first wave of interest in the medical humanities prompted a number of clinicians working in psychiatry, psychology and medicine, to

[49] Berrios, *The History of Mental Symptoms: Descriptive Psychopathology since the Nineteenth Century*, 37.

[50] German E Berrios, "Tactile Hallucinations: Conceptual and Historical Aspects.," *Journal of Neurology, Neurosurgery & Psychiatry* 45, no. 4 (1982): 285–93.

critically examine both their current practice and its historical roots through the lens of the humanities. In a key example, psychiatrists Jerome Kroll and Bernard Bachrach's 1982 article on 'medieval visions and contemporary hallucinations', compared twenty three patients experiencing hallucinations with religious themes and accounts of visions with similar but culturally sanctioned content from the Middle Ages.[51] This cross-fertilisation between historical research and clinical practice raises fraught questions of cultural relativism in mental health and psychiatric imperialism in the assumption that the experiences of psychosis in the industrialised countries of the global north are universal and stable manifestations of mental disorder.

A key challenge faced by historians of psychiatry and medicine is the use of language. Seemingly innocuous, keyword searches rely on our contemporary understanding of and often deeply entrenched medical and psychiatric nosology which can provide a critical epistemological obstacle to research. It has proven surprisingly difficult to separate the phenomenological experience of hallucination and delusion from a diagnostic label of schizophrenia or psychosis. Such interdisciplinary research in the medical humanities as that of Kroll and Bachrach offers both the potential for further entrenchment of this assumption and association, as well as a welcome complication to this classification. Such studies, when done poorly, risk uncritically engaging in the retrospective diagnosis of historical sources. This is a dangerous and problematic exercise rooted in presentist assumptions of teleological and progressive development, the universality and ahistoricity of 'disease concepts' and stability of medical or scientific knowledge as 'knowable' or objective goals.

[51] Jerome Kroll and Bernard Bachrach, "Medieval Visions and Contemporary Hallucinations," *Psychological Medicine* 12, no. 4 (1982): 709–21.

Whilst delusions have long been grouped together according to thematic genres established by this psychiatric nosology and the increasingly controversial DSM, including persecution, influence, grandiosity, and control, study of the actual content and phenomenological variation of these sub-groups remains rare and offers considerable potential for exploration. Recent work by Slovenian psychiatrists Škodlar, Dernovšek and Kocmur on the historical psychopathology of schizophrenia in Ljubljana has drawn attention to this oversight, emphasizing the importance of the humanities in engaging in research to explore questions of the pathogenesis vs pathoplasticity of schizophrenia.[52] Whilst their quantitative analysis of variation in delusional content mapped against changes in Slovenian political regimes and the spread of radio technology is a novel contribution to the field, the brevity of their study and statistical approach to cultural and historical mutability in hallucination and delusional content reinforces a conception of the passivity of delusion formation.

According to this narrative, change in delusional content simply reflects changes in technology and social preoccupations whilst indicating the stability of the core concept and biomedical model of 'schizophrenia' or psychosis. Delusions of influence, for instance, reflect the same processes and have the same phenomenological implications whether they are of witchcraft and demonic possession, or the telegraph and electric machines. Whilst to an extent there is some truth to this, and parallels between the emotional and social meanings

[52] Borut Škodlar, Mojca Zvezdana Dernovšek, and Marga Kocmur, "Psychopathology of Schizophrenia in Ljubljana (Slovenia) From 1881 To 2000: Changes in the Content of Delusions in Schizophrenia Patients Related To Various Sociopolitical, Technical and Scientific Changes," *International Journal of Social Psychiatry* 54, no. 2 (2008): 101–11.

for these metaphors can be drawn, this connection is not as neat as is often believed. Louise Hide, in an article on delusions of electricity and syphilitic pain at the turn of the century, has shown this particularly well.[53] She highlights the particular nuances of the descriptions of sensation and emotion which using the language of electricity allowed delusional patients. Rather than just a convenient and culturally relevant metaphor, electricity had specific implications, and associations which made it useful for the understanding and negotiation of meaning in individual pain narratives. The complexity of the interplay of the languages of hallucination and delusion and cultural scripts or conceptions of the possible is thus a critical area of study. To consider this, we must problematise and move beyond the tyranny of the concept of 'schizophrenia' and rigid psychiatric diagnosis to view 'experience' and meaning in more open and engaged ways.

Clinical historians might take account of culture in the ways in which experience was understood, but they must be conscious of the risk of reinforcing a core disease concept which underplays the role of the present-day psychiatrist or clinician as inextricably bound up in the same contextual flux and subjective, discursive, and interpretative practice, as those of previous centuries. Rhodri Hayward and Janet Weston have drawn critical attention to the extent to which historians have struggled in broadly similar ways to doctors, past and present, in establishing 'definitions and boundaries surrounding health and mental illness', with both groups often implicitly leaving natural and cultural categories of experience unchallenged. [54]

[53] Louise Hide, "Making Sense of Pain: Delusions, Syphilis, and Somatic Pain in London County Council Asylums, c. 1900," *19: Interdisciplinary Studies in the Long Nineteenth Century*, no. 15 (2012).

[54] Weston, *Medicine, the Penal System, and Sexual Crimes in England, 1919-1960s: Diagnosing Deviance*, 9; Rhodri Hayward, "'Much Exaggerated': The End of the History of Medicine," *Journal of Contemporary History* 40, no. 1 (2005): 167–78.

Rather than necessarily framing and containing illness, they may in fact be remarkably unstable, with concepts moving in, out of, and between these frames.

As such, this study has consciously eschewed both over-reliance on contemporary psychiatric labels (reflecting and drawing attention to their patchy and unstable usage in the cases chosen) and has particularly avoided attempting to draw neat lines between past experiences and current diagnostic terms. Instead, it contends that a dramatic change has taken place over time, between the period under examination and the present day. I explore the viscerality and inextricability of hallucination and delusion from the body and the debates and conversations about it, in direct contrast to the intellectualised and disembodied nature of hallucination and delusion in current psychopathological systems. This study considers a period in which the lack of diagnostic fixity implied a greater emphasis on the qualitative and phenomenological experience of hallucinations and delusions, and their entanglement with language, social dynamics, change, and the body.

Whilst they have received little historical attention as ways of being-in-the-world or as emotional, affective, and embodied experiences in themselves, hallucination and delusion have featured in a handful of studies as part of a wider picture of insanity, ghost-seeing and spiritualism, or visionary religious experience. Of these, Shane McCorristine's book, *Spectres of the Self: Thinking about Ghosts and Ghost-Seeing in England, 1750-1920,* has been especially influential in the preparation of this study.[55] This book can be read, not only as a study of the figure of the ghost and the associated intellectual and cultural movements of

[55] Shane McCorristine, *Spectres of the Self: Thinking about Ghosts and Ghost-Seeing in England, 1750-1920* (Cambridge: Cambridge University Press, 2010).

spiritualism and the Society for Psychical Research (SPR), but as a consideration of the 'haunted mind' more broadly. McCorristine expertly incorporates medical history into a social and cultural historical perspective to explore ghost-seeing as a manifestation of society's haunted consciousness and personal, internalised psychological concern. He argues that the 'modern', ambiguously bodied ghost was distinct from its medieval and early modern counterparts in crucial ways. Rather than the recognisable souls of the departed, imminently involved with the ongoing personal and religious concerned of the living, these ghosts were gradually internalised and psychologised. Evicted from objective reality, McCorristine contends, 'the spectral sphere was now held to originate chiefly within the mind of the ghost-seer: one became a *victim* of the hallucination as well as its originator.'[56] As such, ghosts (and, for the purposes of this thesis, hallucination and delusions more broadly) were mapped onto the self in competing and shifting ways as this transformation took place. However, it is crucial to recognise that this was neither a uniform nor complete shift in understanding or the conceptualisation of hallucination experiences. In this study, the nineteenth-century ghost emerges at the crossroads of an increasingly formalised and professionalised psychiatry, the rationalist-empiricist philosophies of the Enlightenment, and the emergent technologies of communication, vision, and movement.

This approach crucially recognises hallucinatory experience, particularly in the nineteenth century, as situated on a broad spectrum of understanding and classification; encompassing medical discourses on pathology and disorder as well as socially and culturally accepted 'sane' explanations of dreaming, intoxication, and the imagination. Importantly, McCorristine largely avoids discussion of insanity and asylums in his consideration of the

[56] Ibid., 32.

topic. This is presumably because the confinement of patients describing ghosts is the ultimate end-point and extreme of this psychologisation and pathologisation process. He also focuses on a social and cultural view of the changing discourse around supernatural phenomena with little consideration of the messiness of the experiences themselves both within and without the asylum. This is an intractably top-down approach to understanding the meaning people made of their perceptual experiences; establishing a persuasive and useful, if overly cerebralized and intellectualized story of the road to the modern ghost as the shadowy counter-image of the modern self.

Like McCorristine's ghosts, this work does not claim to provide any concrete answers about hallucination and delusion or the body. Rather, it aims to 'think about' what the shifting conceptualisations and interpretations of these experiences meant for those who experienced them as well as those who similarly, but over a hundred years ago, tried to grasp the seemingly ungraspable. Hallucination did not mean one thing and was not unproblematically within the professional remit of the emergent psychiatry. The example of the ghost points to a discursive and imagined battleground to establish the meaning of experiences at once on the margins of and at the heart of 'modern' consciousness. Where the boundaries are drawn between the possible and the impossible; the superstitious, the supernatural, and the rational, tells the historian a lot about what society wants to think of itself and the world around it.

A consistently intriguing thread throughout these works is that of the imagination and its role in both the constitution and understanding of the body or senses. This imagination, or creativity and the conception of the possible, has repeatedly shown itself to be both

historically and culturally contingent. Descriptions of hallucinations and delusions allow us insight into the ways in which people made meaning of their experiences and bodies in the world, documenting how they grasped for available languages to communicate what they felt, saw, and believed. It is these languages themselves which necessitate an integrative approach across psychiatric history and social or cultural history. French historian Laure Murat drew attention to this in *The Man Who Thought He Was Napoleon.*[57] Tracing the historical relations between madness and politics, Murat contends that the sources of madness reflect the shifting political conditions in a particularly turbulent period of French history. Her central question: "what does madness make of history?" is a thought-provoking and fruitful reversal of the general approach of psychiatric history.

Whilst Murat's argument that an emergent French psychiatric nosology was developed substantially in response to political subversion and revolutionary behaviour is persuasive, it is her close consideration of patterns in delusional themes which is particularly novel. Her assessment of the importance of the guillotine and contemporary debates and controversies around the survival of consciousness after death is a compelling account drawing together histories of the body, emotion, and psychiatric pathology or delusion. She argues that the public spectacle of the guillotine and experiments in feeling and sentience created a concept of the 'divided self' as the origin of the medical approach to madness; the counterpoint to the frequently emphasised debates and discourse of the individual in the revolutionary political scene. [58] Moving her perspective downwards, this found expression in asylums in people quite literally 'losing their heads'. She wrote on people entering asylums

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[57] Laure Murat, *The Man Who Thought He Was Napoleon: Toward a Political History of Madness*, trans. Deke Dusinberre (Chicago: The University of Chicago Press, 2014).

[58] Ibid., 31.

with the firmly held belief that they were a walking, talking, headless victim of the guillotine, with an apparent mismatch between their 'objective' bodily reality and 'subjective' feeling or conviction. Considering the ways in which contemporary anxieties, hopes, and beliefs were translated into delusion and experienced through and with the body (whether imagined or actual) allows her to write a history that moves between a political, intellectual, and emotional historical account.

Studies such as Alison Winter's *Mesmerized* and Iwan Rhys Morus' *Shocking Bodies* have drawn attention to the profound ways in which such technological change and popular reception of scientific knowledge and theories could influence the ways people imagined their bodies and the possibilities of their interactions with the world.[59] Rhys Morus has published extensively on the ways in which electricity had an immediate and visceral impact on the Victorian body both literally and the ways in which it was imagined. He has drawn critical attention to the Victorian fascination with the telegraph as a technology which inspired fascination and promised to alter the barriers of space and time. At once inspiring fascination and fear, such technology disrupted the ways in which people imagined and interacted with their environment and destabilised the boundaries of the self.[60]

The recent publication of cultural historian of film and media Jeffrey Sconce's *The Technical Delusion: Electronics, Power, Insanity* (2019), has connected the impact of these

[59] Alison Winter, *Mesmerized: Powers of Mind in Victorian Britain* (Chicago: University of Chicago Press, 1998); Iwan Rhys Morus, *Shocking Bodies: Life, Death & Electricity in Victorian England* (Stroud: History Press, 2011).

[60] Iwan Rhys Morus, "The Nervous System of Britain: Space, Time and the Electric Telegraph in the Victorian Age," *The British Journal for the History of Science* 33, no. 4 (2000): 455–75.

disruptive technologies most explicitly to experiences of insanity and highlighted the ambiguities and tensions which surround our understanding of 'delusion'. Sconce is primarily concerned with delusion as a way in which to consider how the 'politics of the electronic' coincide with the 'another historical trajectory within modernity: *the politics of psychosis.*'[61] Building on Michel Foucault and Thomas Szasz's critiques of psychiatry as possessing a 'recursive authority to rewrite moral questions of social abnormality as settled matter of scientific pathology',[62] Sconce explores the fine line between 'technically deluded' and 'deluded technically'; asking whether those confined to institutions by this psychiatric classifying authority are actually simply more finely attuned to the same destabilising forces of modern electronics which plague all of us. His critique builds on the claims made by writers such as clinical psychologist Louis S. Sass in *Madness and Modernism*, philosopher David Michael Kleinberg-Levin, and most recently medical humanities scholar Angela Woods, that there is a causal or determinative connection between 'modern' identity and the profound psychological alienation from self and reality generally termed 'schizophrenia'.[63]

Like Murat, Sconce writes a history of contemporary anxieties and concerns through delusional themes.[64] Drawing on the work of literary historian Raymond Williams, he interrogates how identity and selfhood in conversation with the world and technology can be

[61] Jeffrey Sconce, *The Technical Delusion: Electronics, Power, Insanity* (Durham: Duke University Press, 2019), 7.

[62] Ibid.

[63] Louis A Sass, *Madness and Modernism: Insanity in the Light of Modern Art, Literature, and Thought* (Cambridge, Mass: Harvard University Press, 1994); David Michael Kleinberg-Levin, *Pathologies of the Modern Self: Postmodern Studies on Narcissism, Schizophrenia, and Depression* (New York: New York University Press, 1987); Angela Woods, *The Sublime Object of Psychiatry: Schizophrenia in Clinical and Cultural Theory*, International Perspectives in Philosophy and Psychiatry (Oxford: Oxford University Press, 2011).

[64] Sconce, *The Technical Delusion: Electronics, Power, Insanity*, 37.

read in narratives of delusion. Williams' concept of 'mediation' posits that, rather than simply reflecting the world around them in a similar way to paintings or film, delusions are actively political and crafted by material social processes.[65] Sconce argues that delusions in themselves are not simply a cultural artefact binding the two autonomous realms of the self and the social, but are instead 'a meaningful transaction produced by the self and social in a situated dialogue of interdependent construction.'[66] This raises the crucial question of agency, which similarly nestles at the heart of this thesis. Sconce's way of seeing delusions moves beyond Murat's central question of what madness makes of history to foreground, not a disembodied and abstract 'madness', but the patient as an active author of his or her delusion in, through, and of the body. He emphasises the importance of listening to the negotiation and reasoning in the ways in which patients explain the voices, sensation, and other phenomenological alterations of their psychosis.

Whilst such studies of delusion explore this interplay with the self and social, hallucination is rarely discussed in the same frame. Although frequently central to the ways in which these experiences and beliefs were embodied, the connection of hallucination to delusion has been little considered. Sconce's research discusses the body but he treats hallucination and delusion as remarkably separate, ardently rejecting a biomedical perspective. In researching delusion, it is too easy to discuss experiences as abstract concepts, whether they relate to Murat's political history or Sconce's technological anxiety. Integrating hallucination, more easily reconciled with a biomedical model of sensory abnormality, allows this research to integrate explicitly embodied concepts such as pain and pleasure with such

[65] Ibid.

[66] Ibid., 38.

histories of belief, culture, and emotion. In connecting the physical sensations of *tabes dorsalis*, the language of electricity, and feelings of shame, Hide's work begins this challenge to the remarkably persistent dualist framework which underwrites this separation and which has blinkered the history of psychiatry.[67] It is often assumed that delusion was rooted in the mind and did not have a physiological component; that the history of psychiatry is therefore only peripherally a history of the body or the senses.

This thesis therefore urges a move away from madness or 'schizophrenia' as an idea or endless series of signs, symbols and representation, towards using experiences which gather around the terms and narratives of hallucination and delusion to write an engaged history of the body, sensation, emotion, and experience. Whilst the discursive construction of insanity is a crucial part of the picture, it can be too easy to forget that the asylum was filled with broken, painful, urgent, and feeling *bodies* as well as minds. Indeed, the commonly drawn distinction between body, mind, and world, is often untenable, especially in these narratives. This reminder is particularly important when considering pathologies of sensation and perception. According to the dominant biomedical model, hallucination and delusion are generally conceived of as a disconnect between the physiological and neurological processes of perception and the psychological interpretation or meaning-making whereby this information is sorted. As such, this topic presents an intriguing opportunity with which to explore the history of the senses.

[67] Hide, "Making Sense of Pain"

Constance Classen's work is at the centre of an explosion of interest in exploring the myriad "ways of sensing" the past. In the introduction to her *The Deepest Sense: A Cultural History of Touch,* Classen strongly advocates the value of this sensory approach in "fleshing out" the bodies of history, contending that "exploring the history of touch makes the past come alive … It clothes the dry bones of historical fact with the flesh of physical sensation."[68] Connecting this literature with recent work in the history of medicine, corporeality, and psychiatry, raises crucial questions about the ways in which the past was experienced, felt, and embodied. These questions are critical in destabilising notions about "the body", what it means to "have" a body, and how forms and practices of perception structure and shape our engagement with or response to our world. Sensory history broadly conceived represents an increasingly rich interdisciplinary methodological approach, drawing concepts particularly from phenomenological theory, anthropology, and psychology. *Ways of Sensing: Understanding the Senses in Society,* for example, is a collaboration between Classen as a sensory historian and the anthropologist David Howes, emphasising that 'ideas are communicated through sensory impressions all the time' and that these impressions are formed through culturally modulated ways of sensing, informed by one's immediate spatial and socio-cultural environment.[69] Not only are the senses culturally specific, but they are also historically contingent. This contextual determination of sensory practices applies not only to the period of study, but our own practice as historians.

[68] Constance Classen, *The Deepest Sense: A Cultural History of Touch* (Urbana: University of Illinois Press, 2012), p.xii.

[69] David Howes and Constance Classen, *Ways of Sensing: Understanding the Senses in Society* (New York: Routledge, 2014), 3.

Whilst histories of sight have existed for some time, work on the 'lower' senses is notable in its paucity. Although there are roots of these histories in the Annales school with its history of *mentalités*, and Norbert Elias' *Civilising Process,* it was not until work such as Alain Corbin's 1986 work on smell in modern France, *The Foul and the Fragrant: Odour and the French Social Imagination,* that concerted efforts were made to methodologically engage with perception beyond the ways in which people in the past saw their world.[70] The primacy of the eye, according to oft-cited narrative advanced by McLuhan and Ong, has been hard to shake since Enlightenment thinking and the print revolution associated sight with reason and civilisation in Western culture, and touch in particular with brutality and the animalism identified in the cultural worlds of non-western peoples.[71] It is this same history of sensual hierarchy, however, that makes the 'lower senses'; particularly touch, a vital access point to the history of insanity; those historically associated as beyond reason. This vision-centric account of history nonetheless has a strong foothold in cultural and social histories of madness. Work by Sander L. Gilman on *Seeing the Insane,* Jane Kromm on the madness in visual culture, and recent work on photographic sources in asylum history by Rory Du Plessis, Susan Sidlauskas, and Caroline Bressey, have urged scholars to look away from a purely text-based approach to encourage multi-dimensionality in accessing patient experience.[72] These accounts offer crucial illumination of patient combined with important

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[70] Norbert Elias, *The Civilizing Process*, trans. Edmund Jephcott (Oxford: Blackwell, 1994); Alain Corbin, *The Foul and the Fragrant: Odour and the French Social Imagination*, ed. Christopher Prendergast, Miriam L Kochan, and Roy Porter (London: Picador, 1994).

[71] Walter J Ong, *Orality and Literacy: The Technologizing of the Word* (London: Methuen, 1982); Marshall McLuhan, *The Gutenberg Galaxy : The Making of Typographic Man* (London: Routledge & Kegan Paul, 1962).

[72] Sander L Gilman, *Seeing the Insane*, ed. Eric T Carlson (New York: John Wiley & Sons, 1982); Jane Kromm, *The Art of Frenzy: Public Madness in the Visual Culture of Europe, 1500-1850* (London: Continuum, 2002); Rory Du Plessis, "Photographs from the Grahamstown Lunatic Asylum, South Africa, 1890–1907," *A Journal of African Studies* 40, no. 1 (2014): 12–42; Susan Sidlauskas, "Inventing the Medical Portrait: Photography at the 'Benevolent Asylum' of Holloway, c. 1885–1889," *Medical Humanities* 39, no. 1 (2013): 29; Caroline Bressey, "The City of Others: Photographs from the City of London Asylum Archive," *19 : Interdisciplinary Studies in the Long Nineteenth Century*, no. 13 (2011).

critical engagement with the materiality of asylum history also invaluable for other sensory approaches. The senses do not operate in isolation and work on visual theory has increasingly emphasised the importance of intersensoriality inherent in perception through such concepts as the haptic, whereby touch is posited as a central way of *knowing* which leaks into other sensory modalities such as vision in film.[73]

Work considering 'the senses' more broadly as a medical, social, and cultural concept offers significant potential to enrich work on the history of insanity and lived experience. Approaches combining the distance and 'lower' senses holds significant potential to phenomenologically "flesh out" the historical subject.[74] Integrating the history of touch into studies reminds us that asylum patients were living, breathing, pained bodies before they were case records. The Cartesian mind-body distinction survives implicitly in the absence of these figures from such histories. Studies such as that of Classen on touch: *The Deepest Sense* and *Book of Touch*, skirt around the space of the asylum, with only a cursory chapter in the latter on electrotherapy as an expression of a broader cultural fascination with electric power.[75]

This seemingly numbed or disconnected body and pained mind of the psychiatric patient is largely a product of the groundwork laid by Foucault in *Madness and Civilisation*

[73] Rizvana Bradley, "Introduction: Other Sensualities," *Women & Performance* 24, no. 2–3 (2014): 129–33; Laura U Marks, *The Skin of the Film: Intercultural Cinema, Embodiment, and the Senses* (Durham: Duke University Press, 2000).

[74] Mark Smith, *Sensory History* (Oxford: Berg, 2007); Robert Jütte, *A History of the Senses: From Antiquity to Cyberspace*, trans. James Lynn (Cambridge, UK: Polity, 2005).

[75] Classen, *The Deepest Sense: A Cultural History of Touch*; Constance Classen, *The Book of Touch*, ed. Constance Classen, Sensory Formations Series (Oxford: Berg, 2005).

and *Discipline and Punish* and subsequently elaborated upon by Andrew Scull.[76] Although it has come under significant attack, the Foucaultian thesis remains remarkably persistent. It has been difficult for historians not to see in the asylum a vertical hierarchy in which power-knowledge was imposed on the docile body of the patient as deviant 'other' through social codes of behaviour and manifest in confining institutions. Roy Porter's ground-breaking article 'The Patient's View: Doing Medical History from Below', published in the mid-1980s, mounts some challenge to the invisibility of the patient in Foucault's conceptualisation of insanity and instead calls for a history 'from below'.[77] As discussed earlier in this introduction, Porter foregrounds the patient and urges emphasis on patient experience in historian's methodologies in order to reclaim the voice of the voiceless. However, the idea of insanity as a social construct has proved durable and has resurfaced regularly, particularly in studies on gender and madness. At the base of this discussion is the assumption that, whether from the top or bottom, 'insanity' is a cultural construction, "created" or "imposed" on a static and stable biological body. This body is confined, rendered docile, observed, and recorded, but the instability and dynamism of bodily experience and perception is conspicuously absent from these accounts.

A central negotiation in many of these works is that between a perceived physiological and a social body. The 'dry bones' and 'flesh' of Classen's earlier quotation draws the reader's attention to are inherently loaded terms implying a metaphorical physiology around which such histories have been constructed. Phenomenological literature

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[76] Michel Foucault, *Madness and Civilization : A History of Insanity in the Age of Reason*, ed. David Cooper, trans. Richard Howard (London: Tavistock Publications, 1967); Michel Foucault and Alan Sheridan, *Discipline and Punish : The Birth of the Prison* (Harmondsworth: Penguin Books, 1991); Andrew T Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (London: Allen Lane, 1979).

[77] Porter, "The Patient's View: Doing Medical History From Below."

has long discussed the body as being-in-the-world: constituting and interacting with the world through perception and engagement. Sensory studies such as that of Classen, Howes, and Jütte thus shed crucial historical light on the ways in which this *being* is historically contingent. However, such multisensory studies run the risk of constituting themselves as implicitly teleological narratives telling the story of the emergence of the 'modern' body or the currently prevalent division in the West between five senses. Indeed, Jütte's broad-brush study titles itself with explicit reference to a directional development of 'the senses': 'from antiquity to cyberspace', whilst his introductory chapter traces the emergence of these five senses over time.[78] This affirms not only physiological 'norms' which underpin sensory perception and experience, but also centres the work around the historian's modern body. In his discussion of 'the senses and their ailments', Jütte frames sensory perception through a binary understanding of function/dysfunction which limits his critical engagement. In the 'normal' body, one can either see or not see, smell or be unable to smell, feel or be numb/paralysed, and so on. His chapter is thus organised accordingly: 'defective vision', 'hearing problems', 'loss of the sense of smell', and 'numbness and paralysis'. This conceptualisation and language flattens out the dynamism and subjectivity of the senses and the lived body, which my final section on 'sensing the lived body' particularly interrogates and reconsiders.

Throughout this thesis, the senses and perception will also be considered alongside movement, time, narrative, and other components of a phenomenological *being-in-the-world* little accounted for in these histories of the 'five' senses. This is a deliberate choice to draw attention to the lived reality and communication of the body, perception and sensation as

[78] Jütte, *A History of the Senses: From Antiquity to Cyberspace*.

integrated processes and practices of immense phenomenological complexity. Such embodied experiences cannot be easily reduced to the presence or absence of a clinical pathology (such as hallucination or delusion). Insanity in the nineteenth- and early-twentieth-century asylum and this thesis is mapped onto and experienced through the body in dynamic and tangled ways.

Illness is generally understood along these conceptual lines: dysfunction of something that ordinarily functions 'normally', or presence of a lesion that is not ordinarily there. This applies more readily to physical health in the persistent pseudo-Cartesian distinction between mind and body: 'illness is thus seen as the visible, externalised horror of this transformed body.'[79] Philosopher Drew Leder has explored this language of absence from a phenomenological perspective as it pertains to the 'anonymous visceral dimension' of the body; a facet of experience hitherto little considered.[80] Whilst critical to our phenomenological engagement with the world, attempts at understanding the body at the seat of experience must also grapple with what is beyond perception rather than just lost from it. Leder convincingly argues for the amendment of Merleau-Ponty's identification of the body primarily with its perceptual faculty; arguing that 'my sensorimotor being-in-the-world rests upon a set of vegetative functions hidden from myself no less than others.'[81] The beating of the heart, the movement of the gut, and other vital processes form the lifeblood of

[79] Bryan Turner, "Review Article: Missing Bodies – Towards a Sociology of Embodiment," *Sociology of Health & Illness* 13, no. 2 (2008): 268.

[80] Drew Leder, *The Absent Body* (Chicago ; London: University of Chicago Press, 1990).

[81] Drew Leder, "Flesh and Blood: A Proposed Supplement to Merleau-Ponty," *Human Studies* 13, no. 3 (1990): 209.

interoceptive perception – they quite literally sustain us - and yet in health they are supposedly beyond our physical and perceptual reach. However, this is not always true.

In her work on the records of eighteenth-century physician Johannes Storch and his female patients in Eisenach, Barbara Duden directly challenges the assumption of universal bodily reality/stability, which she believes is rooted in our own 'modern' body of the last two hundred years.[82] In confronting her sources, she 'had to understand that [her] body – through which [she is] rooted in a non-historical nature – is a unique historical creation that [she] must set aside.'[83] According to Duden, our understanding of this modern body is intractably shaped by what Foucault discussed as the medical gaze and the birth of the clinic which rendered the patient's body a passive object of clinical examination, exposed to and crystallised as a 'thing' under the dissecting vision (and dispassionate hand) of the physician, for whom the patient and corpse of the dissection room became increasingly conflated.[84] Duden considers the ways in which context constitutes the body itself, not just the codes and meanings imposed on it. The subject is not just embedded in his or her context, as sensory history argues, but is constituted by it in even more fundamental ways. It is not for the historian to question the reality of patient narratives, but rather to consider the implications of these, what they can tell us about the ways in which the patient imagined and believed his/her body to *be* or *feel*, and how others responded. Accounts of what doctors of the 'modern body' categorise as hallucinations frequently refer to the viscera with vivid languages of spatial, temporal and metaphorical specificity that Leder as well as sensory historians generally

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[82] Barbara. Duden, *The Woman Beneath the Skin: A Doctor's Patients in Eighteenth-Century Germany* (Cambridge, MA ; London: Harvard University Press, 1991).

[83] Ibid., 3.

[84] Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. Alan Sheridan (London: Routledge, 1989).

ascribe to exteroceptive or sensory perception. When approaching historical bodies, it is crucial to decentre the assumptions we make based on the experiences of our own.

Jennifer Wallis's study of late nineteenth-century General Paralysis of the Insane (GPI) offers perhaps the most dynamic study of the body within the asylum yet published.[85] She identifies restrictions inherent in purely visual accounts often due to the ghost of a Foucaultian narrative of the one-directional pathological/clinical gaze which has proven hard to shake, and echoes Roger Cooter's identification of the ways in which the assumption that in the broader social history of medicine bodies have always been 'imposed upon' has similarly injured prior scholarship. Wallis suggests instead that for contemporary practitioners, bodies were 'things to think with'.[86] In light of this, she structures her book through the anatomy itself; aiming 'to mirror contemporary processes of investigation, from admission to the asylum to examination of the body after death' in a chapter by chapter 'dissection'.[87] Using Janelle S. Taylor's theoretical lens of 'surfacing', she discusses the importance of the body within late nineteenth-century asylum practice and records, beginning with the skin as the most superficially visible area of the patient's body for both historian and doctor, then breaching its surface and delving deeper.[88] Her chapters are chosen according to the ways in which doctors thought about the body, where they identified conceptual problems, and where they looked (during the patient's life and death) for the 'seat' or aetiology of madness. Wallis' approach and emphasis on physiology within the asylum

[85] Jennifer Wallis, *Investigating the Body in the Victorian Asylum: Doctors, Patients and Practices*, Mental Health in Historical Perspective (London: Palgrave Macmillan, 2017).

[86] Ibid., 4.

[87] Ibid., 14.

[88] Taylor, "Surfacing the Body Interior."

moves focus away from the docile and confined body of the Foucaultian narrative in psychiatric history and instead sees the body as enmeshed in psychiatric practice and experience rather than imposed upon by it.

Bodies were not simply written upon in asylums, they were engaged in constituting the relationship between doctor (or attendant) and patient. In this way, Wallis' study again connects well with Duden's consideration of the negotiation occurring between doctor and patient which takes understandings of bodily function as its centre-point. Both are interested in the overlap and points of resistance between doctor and patient when communicating feeling and 'dis-order'. These conversations are hugely shaped by the medium through which they are conducted. For Duden, this is primarily letters and thus sensory experience mediated by text and at a spatial remove from the patient herself. For Wallis, this also engages a tactile, olfactory, and visual immediacy within the asylum environment which the historian must reinvigorate through the textual and photographic trace of the archive. Whilst there is some discussion of physical examination and thus tactility in Wallis' study, her work primarily focuses on vision, albeit in a nuanced form. This is principally because Wallis is concerned with scientific practice, the asylum as a scientific space, and the formation of the physician's sense of self in his encounter with the patient. Emphasising surfaces positions her spatially as an observer of the patient and acting on their bodies rather than penetrating perceptive experience. She begins to identify the ways in which doctors engaged with the bodies of both living and dead patients across a range of sensory interactions (including visual observation and recording, physical examination, tactile therapies, and debates around physical restraint of patients), but patient experience is largely restricted to the first section of the book with limited multidimensional engagement and close-reading of patient case-notes. The latter

chapters are dominated by an intellectual history of contemporary physiological theories for the aetiology and development of mental 'disease'.

This thesis considers how body and mind were tangled together in clinical theory, practice, and experience in the asylum. Perception and sensory experience are not purely physical. In approaching historical narratives about these experiences, I have sought to engage with bodies in their phenomenological complexity. Philosopher Drew Leder's amendment to Merleau-Ponty's embodied theoretical concept of 'flesh' to include the 'flesh and blood' of interoception, exteroception, and proprioception offers a valuable starting point through which we might begin to understand the way people of the past saw their bodies from a range of chiasmatic encounters; their interactions with their own bodies, those of others, and the world around them for instance.[89] Phenomenology as a practice and school of thought was, in itself, born alongside psychology and the science of mind in the period under consideration here.[90] As a practice or branch of philosophy it asks similar questions about how to approach or *think about* the body, mind, and experience, at a time of shifting boundaries of belief in the late-nineteenth and early-twentieth centuries. It has, however, shifted through time and is being used flexibly here in ways rooted in my own historical time and concerns.

This work particularly considers Ahmed's conception of queer phenomenology, which considers how particular bodies are situated and orientated towards or away from

[89] Leder, "Flesh and Blood: A Proposed Supplement to Merleau-Ponty."

[90] Guillaume Fréchette, "The Origins of Phenomenology in Austro-German Philosophy," in *A Companion to Nineteenth-Century Philosophy*, ed. John Shand (John Wiley & Sons, 2019), 418–53.

objects, others, and the perceived world.[91] Ahmed's theory thought about the lived body as spatially and temporally lived, examining how disruptive or transformative *re*orientations or *dis*orientations reorder accepted paths through this world. This concept of queering lived experience, hinted at in the title of this thesis, will be revisited and unfolded throughout this this research. Queering, or a queered approach principally involves looking for and finding places where norms and structures of experience might be challenged or questioned. Originally and primarily concerned with sexuality and gender, queering is a fluid concept which might also be fruitfully applied to other fields of identity and oppression. Historically used to signify something apparently odd or strange (as in the titular quote), this term suggests the importance of perspective in considering, analysing, and understanding a phenomenon, norm, or experience.

Viewed in the context of the perceived physiological stability and ahistoricity of the 'modern body', case-notes within the asylum present bodies and perceptions which confound both the hand documenting the experience as well as the historian reading it. Embodied asylum histories thus demand a nuanced engagement with experience which, rather than 'othering' patient sensory perception, takes an approach more like Duden's when confronting the seemingly impossible bodies of Storch's eighteenth-century female patients. Patients' experiences in these narratives and sources do not necessarily follow linear paths and their bodies are often experienced as somehow alien, different, disrupted, transformed, or unsettled. Similarly, this research looks at moments and phenomena like laughter, digestion, or time, which do not readily fit into our current conceptualisation of 'mental health', the diagnosis of schizophrenia, or indeed our understanding of hallucination and delusion.

[91] Sara Ahmed, *Queer Phenomenology : Orientations, Objects, Others* (Durham: Duke University Press, 2006).

It draws attention to the many ways in which embodiment appeared in the asylum and tangled with the experience of 'mental health', but which prompt surprise now in light of an intellectualised and largely disembodied psychiatric nosology, which began to emerge towards the end of the period under consideration here. Essentially, it considers how patients were surprised at their own bodies and experiences and how doctors were surprised, confused, and curious about what they described or saw. Finally, it is shaped by my own surprise and disorientation at the viscerality of these experiences and extent to which the body or discussion about the body inflected and saturated the experience of insanity, writing in a very different intellectual, cultural and social world following the introduction of the Diagnostic and Statistical Manual of Mental Disorders.

Whilst this introduction has outlined the broad trends in scholarly literature which have informed and shaped my research, each section has its own story to tell from a different position or perspective. Accordingly, other theoretical perspectives and voices will appear and be woven through the narrative as it progresses or shifts. This is inspired in part by medical ethnographer Annemarie Mol, who, in frames and explains her study on *Eating in Theory* with the contention, that

> 'the theory relevant to this project is not a grand scheme that holds smaller elements together in the way a large wooden box may hold smaller wooden boxes. It is rather like a cloth that may be wrapped around or, alternatively, is folded within what is

> being said and done. It is a repository of metaphors to write in, models to think with, ways of speaking and forms of responding. It is a style.[92]

The rigid imposition of a particular theoretical perspective risks ignoring the messiness and chaos which in itself is much of the story being told. This research is written in multiple registers, across multiple layers, around multiple timelines, and from multiple perspectives. This will be explored more fully in the first section, which sketches a methodology informed by fragmentation and these multitudes. Here, I have outlined where I began - from hallucination and delusion and towards a nuanced and queer history of the body/mind which resists easy categorisation, conceptualisation and understanding.

Framing and positioning

The principle contention of this thesis is that, depending on position and perspective, 'truth', image, and experience can appear, feel, and often *be* radically different, for both those we are writing about and those doing the writing; the researcher is not exempt. Like the voices of physicians, the authorial voice and position of the academic researcher can disappear in a myriad of ways. It brings its own contextual field, disciplinary and authorial conventions; even the sites in which knowledge is shared, produced and developed contribute to the shaping of the material and narrative. At the risk of untethering the comforting threads of safety which attach me as a researcher and my own practice to a discipline, department, or professional identity, this thesis sees unsettling as a creative and reflexive practice in itself. Rather than adhering to a singular critical or analytical perspective, it weaves together queer theory, disability studies, anthropological approaches, and a flexible phenomenology to

[92] Annemarie Mol, *Eating in Theory* (Durham: Duke University Press, 2021), 25.

approach these past bodies and practices. We cannot divorce ourselves from these positions any more than we can ignore that we have a body ourselves through which we experience the world, but we can own it and make it as visible and self-aware as possible. The complexities of this position will be unpicked more extensively in the first section of this thesis.

A researcher makes a number of choices when approaching and formulating a project, which inform how she positions herself in relation to both the research itself and the historical subject. One of the central ways in which this is done is through addressing the ethics involved in the research process; how one's own values impact how (and often why) the research is done.[93] Until very recently, the ethics of historical study has been a woefully underdeveloped area of thought. Work conducted in areas such as anthropology and psychology, reliant on the trust and co-operation of participants with whom they frequently have extensive face-to-face interactions, has long been hyper-cautious of ethical concerns. Research interviews are surrounded by extensive paperwork disclosing much of the purpose of the research participated in, outlining interviewees' rights to privacy or confidentiality, and the researcher's duties to these ends. Whilst there undoubtedly remains an asymmetry in the power dynamic between interviewer and interviewee, steps are taken to make this as visible as possible and thus reduce its impact. This reflexive process and bureaucratic endeavour is in no small part due to the fact that the researcher is both morally and legally liable should their work misrepresent or deal insensitively with people who are still living, feeling, and thinking.

[93] At the outset and in the formulation of this project I was not required to submit to my institution for ethical approval. I nonetheless believe that the nature of my project necessitates such consideration and have therefore elaborated upon the brief discussion which follows here in the attached appendix on historical ethics, anonymisation, and representation.

Historians, unlike their colleagues in these departments, generally write about people who are dead. Codes discussing standards and principles of academic practice from professional bodies such as the Royal Historical Society and the American Historical Association consequently remain conspicuously silent on questions of the ethical duties and obligations of the historian to the subject of their study. For some, the people subjected to their academic scrutiny have been dead for hundreds of years, receding into the obscurity (and sometimes, problematically, abstraction) of the long-distant past. When the ethics of historical research to the historical subject have been discussed in such forums it has largely been within the methodological remits of oral history or in reference to democratisation of history consequent to the growth in family history facilitated by digitisation of records. These concerns are intractably presentist. When the subject of study is still alive, or when the lives of those discussed overlap in some way with the present (perhaps through their living descendants) historians ought to be careful in how they conduct and write up their research.

However, increased historiographical and methodological emphasis on the operations of power in history and the archive has started to raise further ethical questions, some of which are remarkably difficult to answer. Especially when dealing with extremely personal and sensitive material such as medical records which, for patients still alive, are considered highly confidential and are carefully restricted, it is crucial for historians to reflect on the ways in which they are using such materials and to what end. In doing so they are engaging in structures of power and knowledge themselves. Whether or not the historical subject *can* speak (or indeed be seen), albeit filtered through multiple other voices and powerful mediators, is a question which will be addressed later. This has been the subject of extensive

historical study in recent years and has reanimated the study of marginal and ‘de-voiced’ or silenced groups, including the psychiatric patient.[94] Less frequently considered, but equally as crucial, is whether they *want* to? And, if they do, how can the historian facilitate this in some measure without engaging in an equally paternalistic act of power or re-voicing? Ultimately, does the historian have the consent of the dead to tell their story and what rights do the dead have to this story?

In asking these questions, I found myself returning to an image from the Holloway Sanatorium Casebook A. The photograph (Figure 2) is of patient Elizabeth D, taken in August 1903 to illustrate the manner in which she spent much of her day in the asylum.[95] Her notes state that Elizabeth ‘sits all day in a chair with her hands over her face, rarely speaking voluntarily’.[96] She sits like this ‘even for meals’ so ‘that no one may see’.[97] Elizabeth did not want to be seen, she rarely wanted to be heard, and she certainly did not want to be photographed. There is a consequently deep irony in the choice to record her image in these case notes; she has been captured and displayed for those she will likely never even interact with face-to-face, thanks to the new technology of photography. What does

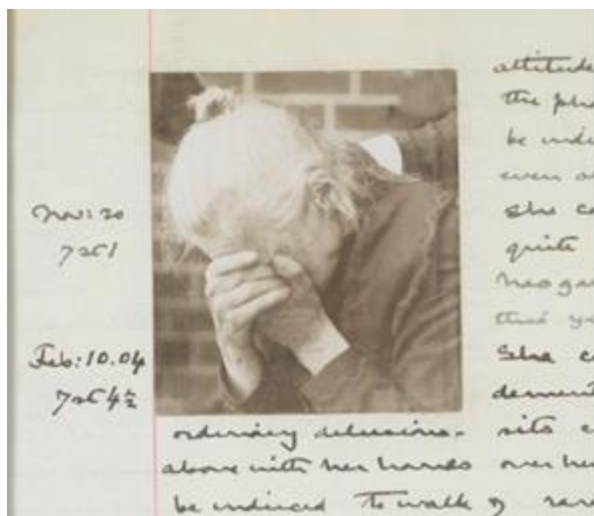

Figure 2 Photograph of Elizabeth D., 1903, HS Female CB A.

[94]Gayatri Chakravorty Spivak, “Can the Subaltern Speak?,” in *Marxism and the Interpretation of Culture*, ed. Cary Nelson and Lawrence Grossberg (Urbana: University of Illinois Press, 1988); Bressey, “The City of Others: Photographs from the City of London Asylum Archive.”

[95] Elizabeth D., 1903, photograph, HS Female CB A, 1885-1907, MS.8159, HS, WL, https://wellcomecollection.org/works/dh9vubaj, 192.

[96] CB A Females, 1885-1907, MS.8159, HS, WL, https://wellcomecollection.org/works/dh9vubaj, 191.

[97] Ibid., 193.

this mean for the historian writing? If she did not wish to be seen by the asylum authorities, do I have a right to make her seen here now?

In making these kinds of decisions, researchers should be cautious of an over-reliance on archival 'rules' obscuring a responsibility to engage in reflexive practice. Elizabeth D's image was captured over one hundred years ago, in 1903, and is thus freely available to use (provided, of course, the holding archive is credited.) However, by including the image am I not using her in a similar way to the doctors of Holloway and overriding her wishes in the pursuit of some objective concept of 'truth' or illumination of academic knowledge? There is also an assumption implicit in these regulations that people are not entitled to confidentiality following their death. Both time and death offer an insulating barrier for the historian who is protected by the knowledge that the person they are observing cannot return their gaze or talk back whilst laying the historical object bare. This idea reoccurs and is explored throughout this thesis.

What separates the act of power engaged in by the historian in using this image from the coercive practices with which it was originally rendered? Central to a sensitive approach to these historical sources and lives is thus a reflexive and considered methodological approach which seeks to understand and recognise past personhood. In *Responsible History,* historian and co-ordinator of the Network of Concerned Historians, Antoon de Baets argues whilst the dead may not possess human rights, the living nonetheless have a core set of duties and responsibilities towards them.[98] For de Baets, these include posthumous dignity, privacy,

[98] Antoon De Baets, *Responsible History* (New York : Berghahn Books, 2009), 3.

and reputation. Fundamentally, beyond rigid or legal restrictions, historians ought to conduct themselves within the archive and in the subsequent research process in a respectful manner that is mindful of the historical subject as another person; a member of a collective humanity transcending death or an arbitrary one-hundred-year rule. Particular kinds of evidence can forcibly remind the researcher of the centrality of this principle of respect and empathy to their enterprise. In regarding this image and subjecting it to historical scrutiny, the researcher is given a sharp reminder of the humanity woven into the textual practice of both case-note recording and its subsequent interpretation. Elizabeth resists our gaze and our regard of her challenges us to confront our own comfortable and empowered position; we have a front row seat to her distress, whether she wanted it or not.

This photograph offers hints at Elizabeth D's time in Holloway which allow us to better understand both her lived experience and the broader environment of psychiatric care and treatment. An uncomfortable reminder of the removal of self-determination within this institutional and archival context can be found when one looks beyond Elizabeth as the photographic subject to the arm behind her which appears to be holding her in place for the image. Of course, not all patients are photographed against their will, but this uncomfortable instance of the practice reminds the historian that, whilst psychiatric historians are increasingly keen to write patient agency back into their accounts, this must be done with a realism that acknowledges the highly unequal operation of power within such controlling institutions. I have sought to read Norman's lectures with this awareness. Where I find conviviality, informality or familiarity, that is not to say that I believe the clinical encounter was a conversation between equals.

Whilst many asylums admitted voluntary patients, and, many patients once admitted (although perhaps involuntarily confined to begin with) sought or found refuge in the environment, using it for their own purposes, huge numbers of people in the British asylum populations were forced to live in an institution they found alienating, scary, controlling and restrictive. Therapeutic practices were conducted frequently with little consideration of patient consent and, although mechanical restraint was ostensibly abolished, coercive and controlling practices continued within the asylum walls. The historian approaching these sources must therefore balance a duty to bring these practices to light and attempt to restore voices which have been written or spoken over, with an ethics of care and recognition of the humanity of those who originally experienced what they are discussing. Historical objectivity is not always the paramount ethical concern and professional duty faced in the course of research. Whilst de Baets' concepts of the duties of the historian to the dead are useful to bear in mind, in the context of marginalised and historically-silenced people they require further interrogation, particularly in the context of naming and questions of anonymisation (see Appendix 1).

With these questions and considerations in mind, how then might we approach the task of reanimating and reinvigorating the body and its contexts through the ways in which we research and write its histories? A crucial tool is putting ourselves as researchers, thinkers, and bodies, into the frame and acknowledge our role or part. These are complicated and difficult stories about infinitely complex experiences, conversations, and bodies. How we write and speak about them is immensely significant and ought to reflect this intricacy and positionality or *view*. I have a view of this body and position of my own (with associated responsibilities, assumptions, and limitations), as much as a contemporary physician had. The dynamics of these positions, however, differ.

This thesis approaches the body by considering how it moved, breathed, spoke, and *lived*. It considers practices and processes as central to the ways in which the body is materialised, made and unmade. It also seeks to regard and explore these as multi-dimensional, subjective and dialogic. The verbs that constitute and enmesh the body and its sites have many subjects, objects and positions. By moving around and within the 'insane body', this thesis attempts to replace a static image with a constantly shifting and protean process by which insanity is negotiated, constructed, experienced, lived, and *situated* in the world, both physically and literally as well as figuratively and metaphorically.

'Situated' and 'negotiated' are crucial concepts here. It emphasises the dialogic character of such processes and interactions. The viewer and being seen is implicit in *appearing* insane; in sounding insane, the listener and being heard. An 'other' is defined against a norm, but this does not necessarily mean that this norm is stable, nor does it mean that the norm is not inflected, shaped, and informed by the Other. Gender, for instance, was developed as a conceptual apparatus principally to destabilise implicit assumptions regarding a binary whereby it was generally believed one dominant group ('man') imposed itself upon the subjugated other ('woman'). Existence, experience and representation are relational, reflexive, and active. That is not to say necessarily that 'insanity' is wholly socially constructed, but neither is it exclusively organic and biological. Far from existing in a vacuum, insanity is constituted through interactions with others; through subjective experiences of people with their own bodies and beliefs. It is refracted through language and through perception, and read or performed through movement, interpretation, and observation. Rather than writing such a history from a 'top down' or 'bottom up' approach,

this thesis therefore steps back to emphasise the importance of *positionality and movement.* This positioning is spatial, geographic, temporal, embodied, and subjective. It operates on both the literal or physical level and the figurative or imagined one and is a central way in which identity and being is negotiated and contextualised.

Taking shape

This thesis is divided into three main sections, each of which contains two chapters. Each section takes as its starting point a verb as a way of approaching or imagining 'insanity' as experience, or concept. These chapters thereby assume and explore different 'positions' and constellations of varied corresponding practices surrounding the insane body and experience. Within each section, the two chapters aim to move between different scales and views, with the latter looking 'up close' at a phenomenon or idea through which the theories, concepts and questions of the first chapter might be explored. As this introduction has emphasised, two threads are woven through these sections: binding and pulling them together. The first is that of hallucination and delusion and the second, the lectures of Conolly Norman. Both of these threads appear and disappear as the reader moves through the work but will be particularly integral towards the end and to the final chapters. I begin each section with an excerpt from Norman's lectures in which he discusses a case which features hallucination and delusion in some form. These excerpts are designed to draw attention to particular moments of surprise or tension around these two threads which will be unpicked, explored and contextualised throughout the section.

The section on *'framing and telling stories about insanity'* considers the ways in which testimony, voice, and narrative situate insanity and the body. This frames and

foregrounds what is meant by 'experience' in this research; the ways in which 'insanity' and the body were communicated and interpreted as well as felt and lived. Rather than looking at autobiographies or explicitly patient-produced accounts, this section will instead explore the focus on experience in the clinical encounter as fragmentary and collaged; formed through interactions and negotiations between the body and language, as well as doctor and patient (or indeed other bodies implicitly or explicitly present). The first chapter on *narrative* looks to how worlds, and indeed bodies, are often structured through stories and how considering or thinking about these stories can reveal layers of voice and agency which underpin their construction. This chapter particularly moves between layers of these narratives and the positions they are told from, to consider the historian, institution, doctor, patient, and finally the voices or characters of delusions and hallucinations themselves. The second chapter looks at structure and how these stories from the asylum are organised and told. It particularly shifts the scale, to look at one particular case study, asking how time and the body are *lived* in these clinical stories. Through this, it exposes the tension between the clinical structuring of narratives and temporalities as linear and that of 'progress', and a subjective or lived time which can fold or disrupt this linearity and direction.

The second section looks at '*encountering the body (in the world)*'. As such, it takes a more spatial and visual approach to the material and phenomenal body. The first chapter on *movement* asks how movement, as the external manifestation of nervous action and mentation, was seen and understood. It looks at the ways in which types of movement were separated and conceptualised, for instance as automatic or reflex action, and the different ways in which these might be *seen*, imagined, and figured. How, for instance, was the absence of movement and sensitivity to the external world in stupor or the cataleptic separated from seemingly uncontrollable twitching? Its companion chapter considers the

phenomenon of laughter. How was laughter conceptualised and paired with feeling as a seemingly expressive constellation of movements enacted or performed on and through the body? Why did the 'laughing lunatic' cause discomfort and what are the ethics of laughter in complex narratives and experiences such as hallucination and delusion?

The third and final section looks at the densely woven threads which tangled around the concepts of perception and sensation, or '*sensing the lived body*.' The first chapter on *feeling* examines how the function and perception of the body was understood; how languages for experience were developed, interpreted, and translated, and what role metaphor might have in connecting the self and lives experience to the world and the Other? The key focus for this chapter will be the different forms of evidence for and about the body which were used to establish the concept of 'truth'. How were accusations of abuse and concepts of risk or harm considered in this context and what might they reveal about assumptions made about the body and feeling in insanity. The concluding chapter on *digestion and the visceral* considers the bodily interior and the seemingly invisible processes occurring therein. It looks at how delusion and hallucination impacted and recast binaries and structures which supported both one's being-in-the-world and clinical frameworks, particularly those of the real and imaginary, and appearance and disappearance.

Through these sections, this thesis considers experience and its communication as messily entangled in the body and mind. Indeed, it is generally attempts to prise the two apart, which cause distress, frustration, and miscommunication in the asylum clinical encounter. It also considers how the ways in which the body of the nineteenth-century asylum was described, accounted for, and 'factored in' to the practice of clinical medicine were

tangibly different to our current approaches to psychiatric disorder and the experience of 'mental health issues'. Each section grew from something with *surprised* me in Norman's sources and the difference at the heart of this surprise is unpicked over each chapter pair. From the different ways in which the body forcefully *appears* in medical notes and clinical interactions, across the significance attributed to movement (whether large or confined to the laughing face or fidgeting fingers), to contested notions of fundamental embodied difference between the sane and insane populations, these are not the bodies we are *used to* in the DSM and the current socio-cultural imagination. This is a dynamic account of experience and how the body appears and disappears in clinical practice and through time.

This project has therefore somewhat organically developed; starting from Norman's lectures and weaving in and out of different institutions, stories, and sites of knowledge production or meaning, in and around the body. It highlights the messiness and kaleidoscope of meanings that constitute what we refer to as insanity or madness, rather than attempting to stabilise and distil into a neatly organised narrative of history's 'change over time'. The following pages engage with a multiplicity of disciplinary approaches, frameworks, and positions to create a dynamic account of insanity; described, felt, perceived, imagined, and experienced. In essence, this thesis is my own exploration. I began, as I did in this document, with narratives of hallucination and delusion, but use these pages and the following analysis to expose and understand the tensions which surrounded the complex narratives and experiences of the body these conjured and discussed. We have constrained and intellectualised hallucination and delusion. This research attempts to do the opposite of this – to unbox it and see it roam across the body.

Framing and telling stories about insanity

'*I have been in the South Union for the last four years and came in here ill and helpless.*

But you didn't come in ill and helpless, and you were able to give a particularly interesting account of yourself.

(The patient remonstrates with this statement).

It is in my notes, and my notes, - like those of the late Mr Justice Stirling, - are always correct. You told me voices repeated long sentences to you, and you told me some of the sentences you heard. Do you remember any of them now?

(No reply).'[99]

[99] Series 1, Lecture 16, 10 April 1905, ACC/2017/2, CN/1/16, CNL, RCPI.

Chapter 1: Narrative

This section considers the practices and processes of telling stories in institutional spaces. It asks how meaning reaches us from the asylum, and through whom. This is not to say that it treats every story as explicitly institutional or bureaucratic, or even necessarily shaped or tarnished by the asylum. Rather, it looks to how stories were produced in this space, shaped, recorded, and how they wove in-between, through and around one another. Ranging across Norman's lectures, I was immediately struck by the ways in which the patients' story was negotiated, undermined and, in places, co-produced. Our ability to read or 'hear' the questions as well as the answers had a monumental impact on my understanding of the ways in which stories were constructed, organised and preserved in clinical spaces. Patients contested narrative as well as meaning; pushing back, clarifying, withholding, or insisting on telling their stories or accounts of themselves. It was not just *what* was said, but also *how* it was told and *when* which mattered.

I not only began to realise how partial the story was that I was *used to* in asylum casebooks and published medical literature, but also how *many* stories or ways of telling can be found in asylum archives. Some narratives present themselves as complete or 'objective', others are interrupted, fragmented, or considered 'imaginary'; such stories are woven together in these sources, pushing and pulling at each other. This chapter asks questions inspired by this realisation. Are hallucinations and delusions stories? What does reading or thinking of them as such do? How were clinical ways of telling stories and producing or establishing meaning different in this period of diagnostic instability and porous boundaries of belief? How can the way in which a story is told change the story itself? Were Norman's notes always 'correct'?

Considering narrative here allows us to pull apart assumptions and structures of time, scale, and voice encountered when approaching clinical archives and experiences. Firstly, what is narrative and why is it important? Then, how can it be applied to or found in the space and time of nineteenth-century mental science and life in both the asylum and the worlds of hallucination and delusion? This chapter begins by teasing apart the different narratives which constitute the clinical archive, after which chapter two illustrates, primarily around one case study, how these narrative strands and voices come together and are arranged or structured, sometimes uneasily, sometimes in harmony. In Norman's lectures, the historian can 'see' or 'hear' the questions as well as the answers, and the movements and silences which are generally skipped over in institutional clinical records used by most historians of psychiatry interested in patient experience. Here, I consider the different ways in which experience is presented and *reaches us* through narrative and time, discussing the lectures alongside the casebook.

What is narrative?

More commonly spoken of in relation to literature, narrative is integral to the ways in which we remember, reconstruct, organise, and communicate experience. Roland Barthes urged us to remember that,

> 'The narratives of the world are numberless … Able to be carried by articulated language, spoken or written, fixed or moving images, gestures, and the ordered mixture of all these substances'.[100]

[100] Roland Barthes, *Image, Music, Text*, trans. Stephen Heath (London: Fontana, 1977), 79.

Barthes encourages thinking about narrative to broaden beyond the spoken or written word. Whilst it is principally seen in the global west as textual, narrative reaches us through, not just literature, but art, photography, medicine, the voice, and, finally, the body. The body itself can tell stories, and the narratives we tell *about* that body feed back into the ways in which it interacts with and *feels* the world. Telling stories is fundamentally an act of co-ordination and *making sense* of time, experience, the environment, a community, and the self within it. In Aristotelian terms, telling these stories gives us a shareable world.[101]

An important clarification and expansion of Barthes' point, however, is the recognition that not only can narrative be transmitted through and translated into many forms, it can also be framed, fragmented, partial, repurposed, and retold. In whichever space, telling a story involves the translation of experience into a shareable form, whether language, gesture, or other form of sign. It necessitates a sequencing and situation of this information in time and space. It also implies an audience. As such, considering narrative or stories also involves engaging with ideas of voice, agency, ownership, and distance; who is telling the story, whose story is it, how is it being told, and why? Whilst narrative often implies a coherence and fixity, this thesis engages with it as a more protean and malleable construction. Instead of whole stories, this section thinks through narrative fragmentation and multiple, layered stories which pass through many hands. Engaging with the broad concept of narrative, as the process whereby things are brought together and formed, takes us back to the fundamentals of experience and its communication. Telling stories about the asylum allows us to destabilise the scaffolding of objectivity and solidity which individuals and the history of medicine and psychiatry itself constructs.

[101] Richard Kearney, *On Stories*, Thinking in Action (London: Routledge, 2002), 3.

Medicine is reliant on practices of telling stories, although this sits uneasily in clinical practice. Patients observe and report symptoms to their physicians, while doctors correlate these stories about the body with knowledge gained from their personal and professional histories in medical school, clinical training, and previous experience. Comparisons are made, information and evidence gathered, and conclusions extrapolated, in order for a treatment plan to be decided upon. The testimony of the body and of the patient are subsumed into a medical metanarrative which purports to provide an explanatory framework and continue the story within the medical space and language.

The growth of narrative medicine from the 1980s responded to an enduring dissatisfaction with the structural and emotional separation between doctor and patient which leads to this narrative occlusion and colonisation. Physician and literary scholar Rita Charon is a key proponent of the school, which borrows from the humanities, to propose that holding the patient's story as central to clinical practice shifts the emphasis from the role of doctor as reactive and problem-solving (with the patient as problem) to medicine as an interaction based on understanding and empathetic engagement. Charon contends that such an approach both strengthens the relationship between doctor and patient and encourages co-operation towards better health outcomes. She argued that,

> 'with narrative competence, physicians can reach and join their patients in illness, recognize their own personal journeys through medicine… multiple sources of local – and possibly contradicting – authority replace master authorities; instead of being

> monolithic and hierarchically given, meaning is apprehended collaboratively, by the reader and the writer, the observer and observed, the physician and the patient.'[102]

Narrative of this sort is disruptive and holds within it a radical potential to cross boundaries of space, power, meaning, and entrenched assumptions which underpin the knowledge and experience of medicine as an embedded practice, discourse, and system.

However, whilst the medical humanities have made significant inroads into medical training and practice, narrative medicine has been met with apprehension and anxiety by many practitioners. Critics ground their arguments in both the reality and urgency of the clinical space and an awareness of the time pressures physicians are subjected to, as well as a more profound reluctance to alter the conceptual and epistemological foundations of their practice. In an article on this resistance, David Morris observed that 'science-oriented physicians… tell stories that resist identification as stories.'[103] Practices that have developed within the western biomedical tradition are themselves stories but approaching them as such threatens to destabilise the certainty and rigor with which they are generally seen by their proponents.

Science and medicine have a long and uneasy relationship with narrative and storytelling. In *The Primacy of Perception,* phenomenologist Maurice Merleau-Ponty contended that

[102] Rita Charon, "The Patient-Physician Relationship. Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust," *Journal of the American Medical Association* 286, no. 15 (2001): 1897–98.

[103] David B Morris, "Narrative Medicines: Challenge and Resistance," *The Permanente Journal* 12, no. 1 (2008): 88.

> ‘science manipulates things and gives up living in them. It makes its own limited models of things; operating upon these indices or variables to effect whatever transformations are permitted by their definition, it comes face to face with the real world only at rare intervals.’[104]

Science actively seeks to create a separate space; a managed site in which an objective knowledge or reality might be strived towards and ultimately achieved. Merleau-Ponty saw science therefore as actively seeking to insulate itself from the phenomenological complexity of lived experience which threatens to undermine this comforting certitude. It constructs frameworks and worlds in which order and structure provide a stable objecthood through which the world and the body might be viewed. In confronting multiple narratives, we find the messiness of life and experience that science and medicine struggle to fit into these structures. The accommodation necessary to assimilate this *life* is challenging and unsettling. By weaving together the stories of institutions, medicine, and the individuals who embody it on both sides of the clinical encounter, this section seeks to challenge and disrupt the binary so often established between scientific knowledge and lived experience. Stories do not always mean fictions and they are not always whole; they are created in the processes and practices of understanding, mediating and communicating.

Philosopher Richard Kearney explored how the creation, rather than simply uncovering, of narratives is at the core of life and identity, when he contended that ‘every life is in search of narrative... In our own postmodern era of fragmentation and fracture… narrative provides us with one of our most viable forms of *identity* – individual and

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[104] Maurice Merleau-Ponty, *The Primacy of Perception and Other Essays on Phenomenological Psychology, the Philosophy of Art, History, and Politics*, ed. James M Edie, Northwestern University Studies in Phenomenology & Existential Philosophy (Evanston, Illinois: Northwestern University Press, 1964), 159.

communal.'[105] This interpretation of narrative is as a process whereby lived experience is scaffolded, structured, ordered, managed, and made meaningful to the individual or group. It also allows for the possibility of these multiple narratives, orders and meanings which might overlap, complement each other, or pull apart. Institutions, doctors and patients all tell stories which medicine and science accommodate or resist. Thinking of narrative as multiple, subjective, and protean, casts new light on the ways in which they are made and function. The synthesis of these overlapping voices and narratives; the ways in which they are brought together in this research, is similarly the product of a storytelling impulse. Research is itself an attempt at creating unity from dispersal. As such, this chapter begins with a critical look at the role of the historian as mediator and teller in the process.

As the third section of this thesis will elaborate upon, metaphor is a way of expressing and articulating how one sees and conceptually orders the world and the self. To this end, one might imagine this research (and the sources of clinical medicine it uses) across two metaphors. Perhaps it might be imagined as a drawing brought together over transparent layers of acetate. Together they give the appearance of a complete and multi-dimensional image. Once a layer is removed, however, the picture changes; some things once obscured are visible and others which appeared to make sense no longer do, instead presenting as a gap or hole. Alternatively, given the language of 'voice' which repeatedly surfaces in the historiography, we might regard it as a chorus. At points discordant, others in harmony, the song is sung by many parts and has multiple layers of sound, often making it difficult to isolate and listen to just one. This chapter begins to listen to the parts to expose what's underneath, hidden, and how things are sequenced and brought together. Whilst the

[105] Kearney, *On Stories*, 4.

subsequent chapter will foreground the chaotic detail of the stories found in the archive themselves, this one will emphasise the historical researcher's role in their uncovering and creation. In this way, this section itself collapses or manipulates structure and the linearity of time in approaching or telling stories; I am beginning at the end.

Historian

History and the historian cannot escape their roles in the telling and retelling of stories. Writing an account of the past necessitates a fundamentally creative and reconstructive act of ownership, whereby these disparate sources and voices are pulled together into a coherent account of 'what really happened' or changed over time. The clinical archive is suffused with multiple voices and stories, all telling the listener about themselves and their perspectives on something. However, this role of 'listener' is not a passive one. Surrounded by these different voices, the researcher ultimately decides whose story or voice to listen to and when. The historian hears, responds to, and indeed attempts to conduct, the chorus. There is an inherent responsibility in this role of listener, not least because the researcher's mode of listening is to select and ultimately retell and repurpose herself. She attributes agency and decides on its relevance, meaning, and significance. More fundamentally than this, the historian does this through her own experience of agency and of the world. She occupies and *has* a body through which she experiences herself and her surroundings and appreciates or attempts to understand that of the other. We generally take these bodies for granted. The narratives found in these sources can confront, challenge, and uproot the stability of this body, way of seeing the world, reality, and time.

Whether medical or historical, research as practice is undeniably embedded in its surrounding institutional, cultural, and social structures. There is an armoury of concepts and both intellectual and emotional apparatus with which the historian approaches her subject and subjects. These, however, often operate below the threshold of the written work. Using the example of Munchausen Syndrome and Ian Hacking's concept of 'making up people', historian of psychiatry and medicine Chris Millard effectively demonstrates that not all theory and concepts find a home in historical research if one is to do justice to the material and people of the past. Hacking's interpretive approach to history in Millard's article, was 'a vision of difference that is founded upon a plastic sameness, an historically specific vision of human nature and of the past.'[106] In pulling the past towards himself, Hacking (and historians who refuse to accept the boundedness or limits of our conceptual tools) encourages a progressive sense of 'universal plasticity'; an empowered but restrictive backwards look.

Millard instead urges a consciousness of historical specificity (our own and that of past actors or thought) and strongly encourages reflexivity in writing history. According to Millard, this reflexivity is intimately connected to the historian's role as curator and storyteller. He maintains that

> 'the key to history is awareness that one is telling a story, building a narrative and using a specific conceptual armoury to do so. These narratives and tools have limits. They assume and accentuate, diminish and dismiss various parts of the past as they identify and interrogate source material.'[107]

[106] Chris Millard, "Concepts, Diagnosis and the History of Medicine: Historicising Ian Hacking and Munchausen Syndrome," *Social History of Medicine* 30, no. 3 (2017): 20.

[107] Ibid., 22.

Our historical concepts do not stand outside of history any more than the medical ones scrutinised by this thesis. Histories are created and written based on the teller and writer's own experience, body, time, resources, and interest.

In this thesis, I aim to be explicit about my position and the ways in which I am telling these stories. I unpick the central concepts used and which frame the telling but are fraught and complex, particularly in the history of psychiatry. In this section this is principally those of narrative, voice, and agency. These will reoccur and other concepts will surface as the text progresses and penetrates the practices and experience of insanity. This is the principal reason for the thesis' paired chapter structure. I introduce each section with an extract from one of Norman's lectures which unsettled particular categories, assumptions, and narratives surrounding either the clinical encounter or the experience of the body in hallucination and delusion. The initial chapter will introduce and discuss key concepts and processes embedded in this extract; narrative, movement, and feeling. The subsequent chapter will look at a detail, whether a, a particular case, movement, or phenomenon which challenged my own assumptions about what I would find when looking for and at hallucination and delusion. This approach is in part inspired by medical ethnographer Annemarie Mol's *The Body Multiple,* in which a subtext of approaches and personal perspective was explicitly articulated and accompanied the main text, both spatially (on the page) and conceptually paired and woven around the main academic work.[108]

[108] Annemarie Mol, *The Body Multiple : Ontology in Medical Practice*, Science and Cultural Theory (Durham: Duke University Press, 2002).

This thesis is unavoidably shaped by fragmentation and embraces it as an honest approach and method. The first of these fragmentations was outside of my control. Halfway through its creation, the global COVID-19 pandemic closed archives, libraries and workspaces. The spaces of research and availability to sources were suddenly limited or unavailable, leaving shards of stories. The records of The Heath Asylum (Bexley), were extensively studied at the outset of the project. Numerous patients' records had been sorted into a spreadsheet grouping them together into my own categories of hallucinations and delusions, their diagnoses, and other key identifying information. The case study in the next chapter is a product of this preliminary research. However, these notes were often 'incomplete'. In the interests of understanding what the records had to offer across the years, I had roamed across casebooks and patients in a way that favoured exploration rather than a systematic approach. I also moved between different ways of understanding, grouping, and fundamentally *making sense* of these stories in a way that could be translated into a research study. The number of categories in my spreadsheet of asylum cases steadily grew; changed in their specificity until I frequently had just one patient in each. As soon as I paid close attention to the detail and complexity of individuals' narrations and experiences, creating an umbrella to put them under felt unethical as well as missing half the story. My spreadsheet had been replaced by case studies and summaries from randomly selected patients with delusions or hallucinations recorded.[109]

The abruptness with which the pandemic removed access to these archives and stories splintered this research. I was left with multiple approaches taken over the course of more than a year and multiple archives and asylums. I no longer had access to the administrative

[109] This in itself interestingly mirrors contemporary tensions between statistical methods and case-based approaches which will be discussed in the next chapter.

records of the asylums from which I had collected extensive detail of patients' records. Left with what appeared to be fragments, I was forced to reflect on what I thought an 'incomplete' set of records was and confront the ways in which I was in my research and using these stories myself. Writing a story that presented itself as perfect, coherent, or *whole* was always going to be a fiction, whether this was of one institution, one doctor, one case, or one geographical region. I would always choose the ways in which I selected and curated material. Whether I had been able to read more records or not, the stories of the past always arrive with us as unstable and layered pieces which I could move around and pull at. I am undeniably implicated in this work.

We write ourselves into our texts and our research, often as much as those we purport to be writing *about.* Whilst this is not always explicitly stated throughout academic work, this chapter creates a space to foreground the matter and asks; is the historian author or narrator? This difference is central. Establishing oneself as author presumes an omniscience and omnipotence over what is being written and how. It also renders oneself largely invisible in the end product. The author is involved in and drives the process, but their voice merges and blends into those of all their characters. A narrator sits both above and within the story; they are implicated in it. They take responsibility for the narrative and its telling, conveying it to the reader. At times, they appear directly in the story; personal pronouns appear, and opinions are stated. Unreliable narrators admit to their flaws, whether directly or in the manner in which they tell their story. Narrators have a perspective we can imagine or sometimes spatialise; authors rarely do.

Admitting in this work that the historian is herself both selective and emotional, and putting herself in these stories, is therefore a deliberate methodological and conceptual choice. This is often avoided in the interests of the ever-fading idea of objectivity and professionalism strictly framed. Just as in the case of ethics previously discussed (and continued in the Appendix), historians have much to learn from and with colleagues in other disciplines and particularly the social sciences. In particular, the emphasis in anthropology on fieldwork has made the emotional and personal involvement of the researcher in her research subject an important consideration in the framing, formulation, and writing of the research. By physically going to the field and meeting the inhabitants of another world, the researcher is implicated and entangled in the research through her own experience and perceptual apparatus. The focus of much of historical work on the document, text, or archive, has obscured the ways in which we do precisely the same.

Texts and documents are not stable objects or sources of truth; they are worlds in and of themselves as much as a physical space. Historians travel and immerse themselves as much as anthropologists do. We go to the archive, move within its world and try to access its reality; its conceptual, intellectual, emotional, and lived fabric. Inevitably, the things we find there distress, provoke, anger us, or make us feel joy. Writing about pain, isolation, and distress in a global pandemic caused its own sort of fragmentation and strain on the story. *We* are implicated and involved in this work and this world. What is principally lacking, however, is the admission or indeed awareness of this.[110] Part of the conclusion drawn over the course of this project is that we should not necessarily be attempting to close the gaps and draw together the corners. These experiences will never be neat. They are subjective and for

[110] Chris Millard, "Using Personal Experience in the Academic Medical Humanities: A Genealogy," *Social Theory & Health* 18, no. 2 (2020): 184–98.

every adjective one could use to describe them, its counter is equally true: bizarre, painful, pleasurable, incomprehensible, incommunicable, insistent. Ultimately, these stories are tangled, messy, and incoherent.

Whilst this research at times picks out threads and ties them together, isolating particular voices and meanings and drawing conclusions, the stories will remain confusing, discordant, and fraught. Even in places where my historical voice tells 'the story' more clearly, I have sought to emphasise silences and tensions, particularly in the ways in which experience is gathered and cohered into the archive and structures of medicine. I was inspired in large part by Marisa Fuentes' work on enslaved women, violence, and the archive, in which she is 'driven by questions of historical production in the context of archives that are partial, incomplete, and structured by privileges'.[111] Fuentes asks 'what [it would] mean to be critical of how our historical methodologies dependent on such sources often reproduce these silences?'[112] Her work 'uses some of the same records but draws different conclusions by productively mining archival silences and pausing at the corruptive nature of this material.'[113] Moving between Norman's lectures and the asylum case book or published medical literature, I have sought to do something similar; to use this challenging thought to write a history of the body in the asylum shaped by questions and fragments. In sections where I 'pull things together', this can be to illustrate what is missing or what is assumed. In discussions such as that on abuse, it is the effort of contemporaries to synthesise and reconcile different accounts or meanings which *is* the historical story. In chapters such as that

[111] Marisa J. Fuentes, *Dispossessed Lives : Enslaved Women, Violence, and the Archive*, Early American Studies (Philadelphia, 2016), 4.

[112] Ibid., 5.

[113] Ibid.

on movement, the approach must necessarily be entirely different. Textual sources, for instance, are fragmentary and partial in entirely different ways to the visual or material. I have endeavoured to write a story with an approach which remains adaptive to the material itself which shifts through each chapter or section.

Institution

In their telling of stories, historians are reliant on the ways in which information is recorded and preserved. This thesis grows from precisely this contention, asking; how does moving across and between sources change our perspective on, position in relation to, and knowledge about the body? Lived experience can only be accessed through its remaining textual and material fragments. Whether these objects and pieces of the past have a life, memory, and politics of their own has been the source of considerable debate, particularly following the publication in 1995 of French philosopher Jacques Derrida's *Archive Fever: A Freudian Impression.* This work connects collective or institutional remembering and that of the individual, comparing the archive to the brain as a repository for traces of the lived past.[114] Derrida explores the archive as 'a point of intersection between the actual and the imagined, lived experience and its remembered (or forgotten) image.'[115] As such, the archive is 'inscribed' with things supressed as well as remembered, and the process whereby things are uncovered in this space are 'as much about the complexities of contemporary understanding as about the creation of historical narratives.'[116]

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[114]Jacques Derrida, "Archive Fever: A Freudian Impression," *Diacritics* 25, no. 2 (1995): 9–63.

[115] Francis X Blouin and William G Rosenberg, eds., *Archives, Documentation, and Institutions of Social Memory: Essays from the Sawyer Seminar* (Ann Arbor: University of Michigan Press, 2010), 1.

[116] Ibid.

Historians, therefore, ask themselves whether the archive can ever actually contain experience. Cultural historian Carolyn Steedman contends that what is uncovered is instead a raw transcription of visceral impression into 'reproducible linguistic form'.[117] Quite different to human memory, which,

> 'actively processes, suppresses, distorts, selectively remembers, and applies in sometimes quite different ways the memory traces of past experience, material either carefully selected for or randomly placed in an archive just sits there until it is read and used and narrativized… the archive is thus quite benign. The historian, the user, the social rememberer give the archive's "stuff" its meaning.'[118]

The archive may not work in quite the same way as human memory, but that does not mean it is necessarily benign. It may not have its own agenda or priorities, but its gatekeepers, institutions, and users certainly do.

This study moves between Norman's lectures and different archives and sources of clinical medicine to build a self-conscious and collaged narrative. It also wanders across different geographical localities and regions. The majority of the institutional records used or consulted are of the Heath Asylum (Bexley) and Holloway Sanatorium. Casebooks discussed were therefore created under the Lunacy Act of 1845, which reformulated asylum policy and regulation in England and Wales. It is worth noting, however, that whilst asylum and lunacy legislation across Britain shared a general model, the legislative framework had some internal

[117] Steedman "'Something She Called a Fever': Michelet, Derrida, and Dust", 4-20 in Ibid.

[118] Ibid.

variation according to region and was implemented at different times throughout the period. Much of this legislative difference covered areas such as provision for 'dangerous lunatics' and criminal or legal responsibility, which falls largely outside of the remit of this study.[119] There were also slightly different provisions for the establishment of pauper and county asylums under the different acts as well as changes in the regulation and monitoring.

Richmond Asylum, Dublin, where Conolly Norman was Medical Superintendent and staged his lectures, was one of the first and biggest institutions for the mentally ill established in Ireland. By the time of the Irish Lunacy Act (1821), it remained only one of two such asylums. This legislation appointed the Commission of General Control and Correspondence to oversee their operation, as well as charging the Lord Lieutenant of Ireland with founding and running a network of district asylums. In Scotland, the Madhouses Act of 1815 formed the basis of lunacy legislation until 1857, when the Lunacy Act similarly created a General Board of Commissioners in Lunacy for Scotland. This body was charged with both taking over the oversight of institutions for the insane from the Scottish Sheriffs and created publicly funded district asylums for those who couldn't afford the fees of private or charitable 'Royal' asylums, such as Crichton Royal Hospital.

These changes were part of an effort to improve and standardise provision across Britain, responding to increased awareness of the pervasiveness of insanity to 'modern' life (and the changing nature of those lives), shifting responsibility for the care of the insane further towards the state. This was, of course, not as universal and coherent a paradigm shift

[119] For a discussion of this legislative change and difference in Ireland see Kelly, *Hearing Voices: The History of Psychiatry in Ireland*.

as has been proposed by earlier historiography, most notably those following French historian Michel Foucault and his idea of a 'great confinement.'[120] Care for the insane frequently remained in the hands and at the discretion of more informal familial or community networks.[121] It is, however, once they enter the asylum or institution that they become more visible.

In England and Wales, this pattern of bureaucratic formalisation remained consistently a focus of policymakers and alienists. Prior to the 1845 act, local magistrates were responsible for regulating asylums, however, they were laymen and were invested with very little power to control institutional practice, able only to intervene when the medical superintendent was overspending.[122] Asylums were thus under-regulated, disorganised, kept poor or patchy records, and patients were extraordinarily vulnerable to abuse of power. The Act reformulated the number of commissioners for the permanent inspectorate as well as changing the composition of this body to ensure informed oversight. Three medical commissioners and three legal officials joined five laymen on the board and their purview was extended to cover all institutions caring for the insane in England and Wales: that is, asylums, hospitals, and licensed houses. These visits could be conducted at any time and at considerably more regular intervals, with every asylum being visited at least once a year. During their visits, commissioners were authorised to review all asylum records, including patient admissions, case-notes, registers of restraint, and medical visitations books. This

[120] Foucault, *Madness and Civilization : A History of Insanity in the Age of Reason*.

[121] David Wright, "Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century," *Social History of Medicine : The Journal of the Society for the Social History of Medicine* 10, no. 1 (1997): 137–55; Joseph Melling, "Family Matters? Psychiatry, Kinship and Domestic Responses to Insanity in Nineteenth-Century England," *History of Psychiatry* 18, no. 2 (2007): 247–54.

[122] Carol Berkenkotter, *Patient Tales: Case Histories and the Uses of Narrative in Psychiatry* (Columbia: The University of South Carolina Press, 2008), 77.

comprehensive evaluation was time-consuming, especially given the proliferation of patients and institutions over the course of the century. Consequently, asylums were required to standardise their record-keeping and provide these materials within a set number of days following the arrival of the commissioners. As well as providing a formal structure to the records, brief notes in red ink can be found in margins throughout the case-notes at the Heath Asylum, testifying to the implicit presence and observation of these overseeing figures, marking where notes have been checked.

Whilst Norman's lectures are primarily the product of observed conversations between doctor and patient (although informed by case notes), case books are first and foremost institutional records. They are written by, or in the words of, physicians and other asylum staff, follow a standard procedure and format, and are monitored by regulating parties. As such, they represent the first overlay the historian encounters when peeling back the tinted layers of the clinical archive. Casebooks gather patients within their pages, fit them into categories, and monitor their progress and outcomes. They pass through many hands, many of which are anonymous or disappeared by the time they reach the historian. When asking whether the institution itself can really be said to have a 'voice' in our conventional understanding of the term, it can be too easy to imagine it as a sort of hive-minded creature, speaking in monstrous unison. The coercive and shadowy influence of the asylum as a Foucaultian dream speaks over and silences, but actually identifying a voice involves work and a more specific understanding of the ways in which the institution is created and endures through our understanding of it and archival practices.

The formality of these institutional bureaucratic footprints obscures and consciously makes disappear the ways in which stories are more organically created in the archive. It prioritises, selects, and sequences parts of memories, experiences, and voices in order to create a narrative which has a *purpose.* This purpose is inseparable from its scale and form. Casebooks as institutional records cultivate the illusion of totality and stability; a window into truly *understanding* an individual case in order to make sense of their experiences. In isolating individuals within a larger collection, the casebook as a document is explicitly designed to tune out the excess noise and messiness of the asylum environment. Whilst Norman physically removes patients from the asylum environment to 'present' their cases, case books create an apparently self-contained n-of-1 case-based narrative through particular forms of clinical coding, documentation, and categorisation.[123] It provides the physician with a snapshot of a patient's life and symptoms. It is a collection of observations, gathered together to illustrate and evidence an individual's insanity or, indeed, progress and recovery. It also allows the institution to manage its own anxiety, monitor its history and control its spaces and practices. The next chapter will return to the case to explore these tensions and pressures further as well as investigate how, as a narrative and a genre, it moves beyond this institutional frame and assumes a life of its own.

Whilst my approach to this project began with, and was intractably shaped by, these institutional documents, it was also the product of the randomness and discovery Steedman alludes to. I came across the catalogue entry for Norman's lecture notes shortly before the first national lockdown blocked me from 'finishing' my story about the Heath Asylum. Over the pandemic, the photographs I took of Norman's material in the RCPI completely upturned

[123] Elizabeth O Lillie et al., "The N-of-1 Clinical Trial: The Ultimate Strategy for Individualizing Medicine?," *Personalized Medicine* 8, no. 2 (2011): 161–73.

my thesis. They not only offered a huge amount of fresh material, but an entirely different perspective. If casebooks isolate patients and are riven with silences, these lectures did the opposite. The emotion, movement and noise of clinical spaces and conversations was tangible; close to the surface and barely concealed. Details of the records' production was woven through the material itself, as in the interaction recorded in lecture eight of the first series, in which the transcriber documented a patient addressing him as part of the interaction with Norman. The document recorded that,

> 'noticing the shorthand-writer in attendance [the patient] remarked that there was a phonographer present and that he wrote at the rate of a mile a minute. He then made some disjointed remarks about St Gregory, great Pope, Papi Pio Quatuore, and Hell.
>
> *Is that down? (To the shorthand writer). Loud cheers and laughter. Put that down in a bracket. Anyone can read that. Ho! ho*!'[124]

Like breaking the fourth wall in film and television, in which a character looks to the camera and audience or addresses them directly,[125] such passages break the conventions of the form or genre to bring the reader abruptly into the room and amongst the people of such interactions. They dissolve the illusion established by the physical and conceptual barrier of the page or screen. Rather than a concept, the shorthand writer becomes a character; situated and positioned, impacting the interactions they are recording, if just by their physical presence in the room. The medical students too are brought into the frame, observing and reacting to what they were witnessing. The historian as reader, listener, and observer, equally becomes aware of their existence and role, having previously been in many respects situated

[124] Series 1, Lecture 8, 21 March 1905, ACC/2017/2, CN/1/8, Conolly Norman Lectures, Royal College of Physicians Ireland (RCPI), Dublin.

[125] Tom Brown, *Breaking the Fourth Wall: Direct Address in the Cinema* (Edinburgh: Edinburgh University Press, 2012).

in parallel to the shorthand writer as an apparently dispassionate and invisible observer. Similar moments of appearance reoccur throughout this thesis.

These lectures, therefore, add depth to, and frequently test, assumptions which can go unchallenged in an overreliance on case notes. These case notes, created in and preserved by institutions, form the most substantial body of surviving evidence available for the historian of medicine and psychiatry in this period. They can be tempting as a source; offering an illusory coherence and wholeness. As clinical stories, they have a clear beginning, middle, and end. Their structure appears rigid, with pre-prepared forms detailing patient information and their interactions with the institution. Whilst the specifics of their production and politics will be explored in the next chapter, it is worth here outlining how this thesis engages with casebooks as well as encouraging decentring them in the historiography of insanity to allow other messier and fainter voices and stories to break through. Expanding the remit and view of this historical story beyond the case and casebook, incorporating sources on a different scale or with other positions, means challenging and undermining the primacy of the institution in the historiography of insanity. It does not have to mean denying that institutional frames shaped many of the stories housed and subsequently encountered therein.

Doctor

Medical records therefore generally follow specific conventions, are created for a particular purpose, and are highly curated documents which by no means faithfully record and convey patients’ own voices, meanings and intentions. They do, however, offer insight into medical practice. They are traced from the perceptions, assumptions, categories, and languages of medicine and its institutions and professionals. They cannot provide direct

access to patient lived experience, but they can demonstrate how experience and communication in the asylum was understood, categorised, and re-packaged or retold. Information and speech reach casebooks at a remove. Not only are records created or updated after a conversation with a patient rather than necessarily during, but they are also not consistently the product of the doctor himself.

Medical care throughout history has been far from the exclusive preserve of the institution or, indeed, the doctor. Encounters with nurses, care in the home from families, or forms of vernacular medicine have often replaced or supplemented formal or institutional practice.[126] As historian of tuberculosis Flurin Condrau has emphasised, 'if one wants to write medical history from below, the doctor-patient polarity is detrimental to the cause, obscuring rather than enhancing the analysis.'[127] Archives are surviving fragments, not only of institutions which housed and necessitated their collection, but also of the people who were involved in their production. Institutions were not faceless, but run by individual Medical Superintendents, as well as a significant but often overlooked number of attendants or nurses. This thesis largely focuses on the clinical relationship and dialogue between doctor and patient given its root in Norman's lectures, in which patients were temporarily isolated from the wider asylum environment for the purpose of the lecture. The testimony and memories of nurses, attendants and assistants were, however, frequently relied upon to collect information about patients and monitor the development or changes in delusions and

[126] Peter Bartlett and David Wright, eds., *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000* (London: Athlone Press, 1999).

[127] Flurin Condrau, "The Patient's View Meets the Clinical Gaze," *Social History of Medicine: The Journal of the Society for the Social History of Medicine* 20, no. 3 (2007): 533.

hallucinations within the asylum.[128] They also appear fleetingly and indirectly in Norman's lectures and this thesis when bringing a patient into the room, in anecdotes used to contextualise a case, or in recommendations and guidelines for clinical practice. They implicitly shape and record much of the material available on patients as witnesses and presences in the asylum space, whilst generally escaping explicit appearance in archives themselves.[129]

Medical Superintendents like Norman, in turn, had responsibilities for shaping asylum policy and training within the institutional environment, leading to some variation in the material collected. The archive of Crichton Royal Hospital, for instance, includes a number of articles written by Medical Superintendent William Browne, which add crucial contextualising information for the interpretation of the case-note material, allowing for analysis across multiple genres and therefore dimensions. These archives also include 'scrapbooks' of seemingly randomly selected and preserved materials relating to both the life of and inside the asylum; both patient- and staff-produced. Browne was particularly interested in the use and relation of artistic or creative output in madness and its treatment, making the Crichton records particularly helpful as a source for patients' use of these outlets. Through Norman's lectures we hear his voice forcefully and see the ways in which he, his politics, and his interests shaped patient interactions. This is true for the interactions from which case notes are built, albeit often in less tangible and obvious ways.

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[128] For a rare example of an article which explicitly references attendants' role in gathering this information, see A. Campbell Clark, "Digest of Essays on Hallucinations by Asylum Attendants," *Journal of Mental Science* 30, no. 129 (April 19, 1884): 78–83.

[129] The class and social dynamics between doctors these nurses and attendants will be touched on in Chapter Five. For fuller studies on these figures see Mark Neuendorf, "Psychiatry's 'Others'? Rethinking the Professional Self-Fashioning of British Mental Nurses c. 1900–20," *Medical History* 63, no. 3 (2019): 291–313; Neil Brimblecombe, "Asylum Nursing as a Career in the United Kingdom, 1890-1910," *Journal of Advanced Nursing* 55, no. 6 (2006): 770–77.

In his article on case notes and recording at Glasgow's Gartnavel Royal Asylum, Jonathan Andrews demonstrated the significant alterations in focus, style, and fidelity to patient testimony, within the archives of one institution. He found that these changes were dependent, not only on legislative change, but also on 'fashions' within the profession and the more capricious priorities and approach of the medical superintendent in charge.[130] Prior to 1840, Andrews found that 'extensive patient testimony is conspicuous by its absence from the case notes', whereas in the following decades (until the 1870s), notes 'became a much more literal and reliable source for patients' own views of their histories.'[131] He contended that 'despite all their limitations, the apparent faithfulness of much of the reportage and the amount of patient testimony that is reproduced verbatim is striking.'[132] This change in policy and emphasis was attributed to the merging of roles within the institution of Physician and Superintendent, with the associated medicalisation of the case record. These documents now concerned themselves more with patients' 'various peculiarities, pathologies, and symptomatologies', than infringements of the rules.[133]

From the 1870s, Gartnavel's records were supervised and shaped by David Yellowlees, under whom 'direct patient testimony virtually disappeared from case-taking, which became a much more clinical, detached discipline'.[134] This change was associated with

[130] Jonathan Andrews, "Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century," *Social History of Medicine: The Journal of the Society for the Social History of Medicine* 11, no. 2 (1998): 255.

[131] Ibid., 278.

[132] Ibid.

[133] Ibid.

[134] Ibid., 279.

more organic and less personal approaches to asylum science and mental medicine in which the somatic and objectivised was prioritised over the patients' impressions and subjective experiences. Whilst these shifts in case-note taking and asylum records are reasonably consistent across institutions, changes in record style did not uniformly or unproblematically reflect changes in patient care and staff priorities. Andrews also stresses the importance of understanding these records as products of their environment, production, and function. They are 'innately jaundiced… in the type of information they record' and 'were not designed to be complete records of a patients' interactions within the asylum, but rather to be clinical and managerial aids to those treating and attending the patient.'[135]

Although case notes are frequently discussed as the product of the doctor's voice, it can be unclear what exactly is meant by this. Ultimately, the physician occupies and embodies multiple roles. His position as a member of the medical professional might overlap or operate at odds with his own humanity, corporeality, and other aspects of his personal identity. This co-existence is often uneasy and fragments the narrative; a tension most obviously seen in physician-produced records created or discursively situated partially outside of institutional bureaucracy, such as Norman's lectures. The reader is situated as witness to a conversation between two *people* trying to understand one another and share a language, as well as that between a doctor and his patient. To ignore the latter dynamic and dominant discourse would be a gross oversight, but the often half-submerged former is evident and tangible, and will be considered throughout this research.

[135] Ibid., 266.

The friction between the messiness of personal interaction and clinical 'relevance' is demonstrable in a tense interaction in the second series between Norman and a patient about 'the influences that come through the stone wall' to control his speech and movements.[136] When Norman asked his patient whether he could 'remember hearing any commands not to speak', the man retorted,

> *'Oh, indeed! Why do you ask me.* [sic] *Look here! you needn't speak to me at all. Anything I have gone through you have mentioned. Not since Christmas Day have I spoken to you. "Do I hear this: do I hear that: does it run through me"*
>
> (Here follows a passage-at-arms of personal badinage and repartee, difficult to follow, and apparently of small clinical importance).'[137]

This patient expressed frustration at Norman's approach to his experiences and the ways in which he told his story. In repeating features of his case, presumably for the assembled students' benefit, the physician irritated his patient and derailed the very clinical discussion he was attempting to focus or steer. The note-taker chose to interpret and label what he witnessed as an incidental moment in clinical practice, or a light-hearted exchange; two people teasing each other, rather than necessarily a doctor with an uncooperative patient.

On other occasions, physicians were acutely aware that they were patients' primary contact with the knowledge and authority of clinical medicine. Norman's lectures were about the dynamics of the interactions between physician and patient as much as they were about the theory of insanity. Indeed, he frequently dismissed the work of contemporary theorists, preferring instead to highlight his personal experience of the sensitivities, challenges and

[136] Series 2, Lecture 13, 2 April 1906, ACC/2017/2, CN/2/13, CNL, RCPI.

[137] Ibid.

curiosities of patient care as well as the immediacies of the asylum environment. Towards the end of his first lecture series, he delivered a 'caution' to his pupils to 'never forget you are a physician.'[138] He explained, that

> 'some patients have an objection to being examined by doctors, but that objection is rarely insuperable. In the first place your position as a physician enables you to talk about subjects which would be gross impertinence of anyone else.'[139]

There may be space within interactions for humanity, but the distance and authority offered by the edifice of medicine was enshrined and emphasised in medical training. Interactions between Norman and his patients were adaptive and often convivial but traversed uneven ground. He advised that 'once you have in your mind that the patient is of unsound mind always regard him as a sick man. That gives you an advantage.'[140] This comment is enormously illuminating. The information extracted from someone about his or her experiences, sometimes freely given, sometimes coercively or forcefully gained, bolsters the physician's claim to authority over his patient.

Delusion and hallucination colour these narratives and, consequently, situate and orientate the teller's identity and world as a 'sick man' within an institution for the unsound mind. This 'sick man' experiences and participates in the world and the environment or interaction of care from the asylum or bed. He (or she) is politically, socially, culturally, and medically orientated towards the spaces, people, and systems he interacts with from this position. Johanna Hedva's 'Sick Woman Theory' emphasises the forms of existence and

[138] Series 1, Lecture 31, 29 May 1905, ACC/2017/2, CN/1/31, CNL, RCPI.

[139] Ibid.

[140] Ibid.

resistance afforded to such people; those whose embodied reality is situated outside of, or at a slant to, the systems of oppression and normativity which require them to survive. They contend that

> 'Sick Woman Theory is an insistence that most modes of political protest are internalized, lived, embodied, suffering, and no doubt invisible. Sick Woman Theory redefines existence in a body as something that is primarily and always vulnerable'.[141]

The stories of these people in these bodies are visible and audible because of their status as disordered. They occupy a vulnerable role in these records and the asylum itself, but their very existence can in this way be read as resistance. Paternalistic and strategic approaches to establishing 'truth' (as well as its contestation) in these bodies, such as Norman's here, are explored more fully in the final section.

Physicians often relied on practices of narrative and storytelling to gain insights into their patients' worlds and align them with their own. Questioning patients granted the doctor partial and fragmentary access to patients' experiences and how they framed them. This, in turn, allowed the doctor to fill in or overlay the narrative with their own knowledge and expertise, resituating the patient's narrative into one of clinical relevance. The shards of patients' stories that reach casebooks, for instance, created a collaged narrative across multiple story-tellers (whether nurse, attendant, family members and friends, or the patient themselves) rather than a complete one. However, narrative and questioning was not always limited to this transactional process. Some physicians even went so far as to suggest

[141] Johanna Hedva, "Sick Woman Theory," 2016, 9, https://johannahedva.com/SickWomanTheory_Hedva_2020.pdf.

encouraging patients to tell their own stories in their own ways; to structure, order, and narrate their delusions, could have curative properties. Norman stated,

> 'I don't think it causes any particular pain in these unfortunate people to question them in a general way. A recent German author has told us that the best means of dealing with delusions is to purge them, that is, make the patients tell all about them, - tell them out.'[142]

This idea reoccurs in the lectures. In his first series Norman drew specific attention to the importance of questioning in 'extracting' delusions from patients (in this case, specifically when the patient was melancholic). Norman commented to his students that they 'will notice I put indirect questions to him first, but having the clue I put the plain question at last. It is always advisable to let the patient tell his own story as much as possible.'[143]

Particular delusions and experiences of the body often make this process of questioning and establishing symptoms or stories more evidently problematic. Norman urged his students to 'bear in mind that there is a great probability that one of [this patient's] delusions is that his soul is lost. This is a very painful idea. It is not necessary to have any delusion at all in melancholia, - at least, one that can be discovered.'[144] Patients could often be unwilling or unable to speak with their doctors. In The Heath Asylum, William B. 'never speaks acting under the delusion that he has no lungs.'[145] Instead, his case notes record that 'he stretches, salutes, and fidgets generally & frequently sighs'.[146] William's lack of verbal

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[142] Series 3, Lecture 3, 5 March 1907, ACC/2017/2, CN/3/2, CNL, RCPI.

[143] Series 1, Lecture 4, 10 March 1905, ACC/2017/2, CN/1/4, CNL, RCPI.

[144] Ibid.

[145] CB 2 Male, 1899-1915, H65/B/10/001, BH, LMA, 27.

[146] Ibid.

communication put greater emphasis on practices of observation and physical, embodied languages. This will be explored further in Chapter Three. Whether intended or not, the questions of physicians often allowed patients to form and communicate their own narratives in a frequently hostile or alien space, but the perception of the body and delusion and hallucination could shape these practices of telling and narrative formation in complex ways.

Patient

The key question which preoccupies much of this thesis is whether patienthood precludes the experience of selfhood. Does the clinical repurposing and retelling of patients' stories move them into the realm of scientific knowledge and practice rather than lived experience? Whose voice actually reaches us from the archive and why? Åsa Jansson contends that searching for the patient as a human being with agency and life history does not and cannot exist in medical records; that 'she or he is a fiction, a necessary linguistic object.'[147] Building on the work of Gayatri Spivak,[148] Jansson therefore claims that the patient exists only in the discourse that objectifies and constructs them. Whilst to refer to the patient as a fiction undermines the push and pull found in these clinical archives, it is important to ask about the ways in which these stories were told and by whom.

Whilst some patients were encouraged to tell their stories and allowed to drive the interactions, others' volubility was dismissed or framed as a barrier. Jonathan Andrews urges

[147] Åsa Jansson, "Chapter VI: Melancholia between the Casebook and the Textbook: Knowledge Production in the Victorian Asylum," n.d., 7, accessed March 15, 2022, at https://www.academia.edu/8453072/Chapter_VI_Melancholia_between_the_Casebook_and_the_Textbook_Knowledge_Production_in_the_Victorian_Asylum.

[148] Spivak, "Can the Subaltern Speak?"

historians to keep in mind that ‘any account of patients’ experiences through the case note medium is also prejudiced in favour of the wealthy, educated, articulate or extrovert patient.’[149] The stories of the asylum’s older women stand out. Whilst I am wary throughout this research of grouping and dividing patients into categories or classes to firmly, cases and lectures involving this demographic group of older women feature heavily in this thesis and speak to the ways in which clinical interactions were embedded into broader social hierarchies and scripts of gender, class, and age. Louise Hide has explored this in her thorough study on gender and class in British asylums. Her study drew heavily from the sources of the asylum in Bexley from which the case study of Julia R in the subsequent chapter is taken. These women could be described as either garrulous and troublesome, or charming and eccentric. For example, the account of an elderly female patient, in Norman’s second series of lectures, was peppered with ellipses, with the sporadic incursions of the doctor often ignored or glossed over. For instance, Norman asked,

> ‘Who called you a prostitute?
>
> *The person I have mentioned. . .. I have had to roll my head in blankets at night.*
>
> And she used to threaten you?
>
> *.. .. and she got my deposit at the Bank of Ireland. Mr Major said he would put it in the safe and keep is safe for me.’*[150]

Such interactions evidently caused some frustration for the physician. This patient believed herself persecuted and explained that ‘my whole body is so acted upon that I could not exist.

[149] Andrews, “Case Notes, Case Histories, and the Patient’s Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century,” 266.

[150] Series 2, Lecture 14, 3 April 1906, ACC/2017/2, CN/2/14, CNL, RCPI.

I have read of secret inquisitions such things as used to work the brain to torture you.'[151] Appealing to doctors was her recourse from these attacks. She explained that 'sure, it was that made me go the morning to Dr McCutcheon. I went to Store St and reported her.'[152] Telling her story to those in positions of perceived power was intended to subvert what, or *who* was 'working' on her. The information relayed to her audience in this instance was described as 'only a slight sketch of what I have suffered.'[153] She is not coerced into telling this story, but rather deliberately and insistently tells and performs it.

This persistence in being heard was commented upon. Norman told warned his students of the 'excessive volubility and discoursiveness [sic] which are the characteristics of old women' such as this. He stated that

> 'there are a great many people who tell one stories with that minute and irrelevant detail which is so exasperating in these old ladies. I allowed her to go on because I could not help it; also that you might be able to judge of the extreme accuracy of her memory. These classes of cases are often characterised by extraordinary minute memories.'[154]

Norman claimed not to have interrupted or cut short the old woman's narrative of her sufferings and persecutions, not only because this volubility was demonstrative for his students of her mental state, faculties, and condition, but also because he was unable to do anything else.

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[151] Ibid.

[152] Ibid.

[153] Ibid.

[154] Ibid.

Norman frequently noted when older female patients were brief or co-operative. In the following series, an interviewed patient was described as a 'reasonable old lady' who 'does not launch into details as so many patients of this class and of her sex and years are inclined to do.'[155] He presented his students with an eighty-five-year-old woman who laboured under auditory and visual hallucinations, with delusions that 'these were the effect of mesmeric influences worked on her.'[156] He referred to this patient as a 'charming old lady' with whom he conversed extensively before his students, asking, 'tell me, what was the story about your being mesmerised'.[157] Rather than seeking to stall the telling of a story, Norman here instead pushed for it. This amiable partnership between doctor and patient was portrayed as remarkable and exceptional; its opposite was exasperatingly common. Stories between doctor and patient could be interwoven and mutually constitutive as well as resistive and discordant and interactions were frequently shaped by the dynamics of class, age, and gender. Details offered by some patients was marvelled at and discussed by their physicians at length, whilst for others this insistence on narrative and their experiences was evidence in itself of their insanity, particularly amongst particular social groups.

Delusions and Hallucinations

As well as the narratives and narrators already identified, there exist stories and speakers even less visible or audible. The stories of the asylum are populated by thousands of figures and voices rarely ever accounted for by the historian, but of immense significance to

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[155] Series 3, Lecture 9, 22 March 1907, ACC/2017/2, CN/3/8, CNL, RCPI.

[156] Series 3, Lecture 5, 11 March 1907, ACC/2017/2, CN/3/4, CNL, RCPI.

[157] Ibid.

patients' lives nonetheless. One patient, identified only as Fanny in Norman's lectures, told the audience and doctor, 'I have been troubled with hearing something strange, - story-telling, I think.'[158] In a subsequent lecture, a patient, who remains unidentified but appears to be Fanny, again described what she experienced in the language of storytelling. She told the doctor, students and auditor of what she called 'treated spells' in which 'somebody makes something sad happen or thinks of something sad.'[159] When Norman asked her whether she knew 'anything about the means by which you are made to understand the sad thoughts of other people', she attributed it to the 'influence' and 'science of hypnotism'.[160] For twenty-six or seven years, the patient explained that she had been hearing things. Norman asked,

> 'Hearing what?
>
> *Some stories. Some stories are pleasant and some sad.. .. it is said there were a lot of children killed last night and two maids*.'[161]

The language people used to narrate and explain their experiences matters. It can reveal a considerable amount about the nature of experience and its consequences. Fanny is being told a story by someone or something else. These stories, when told in turn to a physician or relative, mark her as belonging to the space of insanity and the asylum. In telling *her* story of these stories, she becomes visible through the institution, whose own narrative preserves hers.

Considering the voices and delusional figures patients identify as inhabiting their worlds necessitates a queered approach to these histories and concepts we use when

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[158] Series 1, Lecture 15, 7 April 1905, ACC/2017/2, CN/1/15, CNL, RCPI.

[159] Series 3, Lecture 4, 8 March 1907, ACC/2017/2, CN/3/3, CNL, RCPI.

[160] Ibid.

[161] Ibid.

approaching narrative. Thinking about ways in which people's lived worlds and bodies are orientated in ways other than that which is seen as 'straight' and coherent allows for a general reorientation and destabilisation of assumptions and knowledge about how the world and identity is structured. Ideas such as voice and agency become complicated when we consider stories such as Fanny's. The subject of this research therefore presents its very particular difficulties when approaching insanity. By putting hallucination and delusion specifically in the frame and immersing oneself in these stories and experiences, it becomes necessary to adapt conventional or established understanding of narrative and associated questions such as agency, voice, and time.

Why, in the reams of research on the history of psychiatry, are voices and delusional characters never directly discussed? The binary between doctor and patient repeatedly resurfaces, but these figures, invisible and imaginary to some but embodied and real for others, haunt and shape these interactions, often underpinning the stories of both parties. Is this omission because hallucinatory voices and delusional characters are seen as occupying the imaginary and are realised or actualised only by the articulations of another: the patient? As I have explored, to varying degrees this is true of every narrative in the asylum.

Agency is generally seen as something which the historian is looking for and can 'find'. It considers the actions of an individual or collective, the intent behind that action, and the relationship of this to a sense of selfhood and identity. Agency entails an ability to have an impact on those around you and effect change, on whatever scale. It is, however, a highly contested term in historical perspective. When agency is viewed within the frame of narrative, we start to think in characters. Who is speaking and interacting at any one time, and

with whom? In their search for agency, historians have therefore most commonly asked about the patient's 'voice'. This is predominantly because in texts, bodies can be hard to imagine and reconstruct. Voices are both of the body and apart from it; they are the product of ourselves which we put out into the world and simultaneously identify with and feel alienated from.[162]

The voice is phenomenologically complex, particularly when translated into textual form. In the world of the asylum and the context of hallucination and delusion, a general understanding of the voice must be qualified and expanded. Durham University's *Hearing the Voice* project is a rare example of a research group that has considered the complexities of the lived experience of insanity, looking at the phenomenological ramifications of these experiences of voice-hearing for the self.[163] Voices can happen without associated bodies. Patients who hear voices are confronted by an experiential complexity and defamiliarisation which is often described as distressing, threatening, and alienating. Voices can be intimately connected to the self, but seemingly not under its control. They can shape an individual's identity yet sit apart from it.

When considering phenomena such as laughter and storytelling throughout this thesis, the other figures that occupy the asylum and patients' inner worlds are therefore accorded some historical agency. Voices, which are not heard by the doctor, laugh at, speak to, mock,

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[162] For further thinking and elaboration on the voice, see Steven Connor, *Dumbstruck: A Cultural History of Ventriloquism* (Oxford: Oxford University Press, 2000).

[163] See, for instance, Simon McCarthy-Jones et al., "Stop, Look, Listen: The Need for Philosophical Phenomenological Perspectives on Auditory Verbal Hallucinations," *Frontiers in Human Neuroscience* 7 (2013): 127; Ben Alderson-Day and Charles Fernyhough, "More than One Voice: Investigating the Phenomenological Properties of Inner Speech Requires a Variety of Methods," *Consciousness and Cognition* 24 (2014): 113–14.

or persecute patients hearing them. Injuries sustained in the asylum are attributed not to attendants, other patients, or accidents (which implied no human agency and will be explored later), but sometimes the mysterious but sinister 'they' identified by others as delusional but immediate for the narrator/patient. 'They' are experienced, by some of the historical subjects considered, as phenomenologically entangled with themselves and the space of the asylum. Voices or persecutors are also frequently identified, named, and positioned. Julia R.'s delusions and hallucinations, for instance, discussed more fully in the next chapter, take the shape of a man named Mr. Mathieson who lived inside of her, and a mouse and a weasel which crawled over her skin. To treat these characters as inhabiting the imaginary changes the nature of experience. They are viewed by different narrators in this account in different ways. Throughout this research, they appear as concepts, evidence of pathology or disorder, ghosts, fragments of the self, persecutors, supernatural agents, and very real people. Patients frequently invested these figures, shadowy or otherwise, with power, agency, and subjectivity, so this thesis speaks of them as containing or being invested with these things when this is the case. It will also look to how this attribution or understanding of agency and reality was contested and fraught across the clinical encounter in which different narratives, frameworks, languages, and beliefs were either legitimised or de-legitimised. This process was often dependent on the teller.

Where, how, and why agency was identified was important, but patients did not all identify these voices or characters in the same way, as external to themselves or their bodies. This research involves listening closely with and to the patient at time in which they hear these voices or believe themselves acted upon by these agents. Patients vary in their attribution of agency to the 'others' they experience and identify in hallucination and delusion. Stanley G., an old soldier whose insanity was described in Norman's lecture as

prompted by a gun carriage falling on him and injuring his knee, exhibited what his physician described as ‘a very curious notion… of some subtle sympathy between himself and external agencies and forces.’[164] More specifically, he ‘thinks that blind people and deaf people are in singular rapport with him, and if the blind get in communication with him they use his eyes to see, and deaf people use his ears. He became a sort of automaton to benefit the deaf and blind.’[165] Whilst Stanley identified specific agents under whose influence he was suffering, they were connected with his sense of self in the ways in which he was embodied. Stanley *felt* their influence through what he described as sympathy.

When approaching experiences such as these, the historian must separate herself from her own conventional, culturally and personally specific understandings of what it means to have control of one’s own embodiment and corporeality. These narratives are highly nuanced. Stanley also maintained that

> “when I shut my eyes the blind move my hand when I am holding my pen and make me write their thoughts.’ They don’t actually make him write with the pen. He was very plain on that point. He feels movements of his fingers and hands wherever they may be, but his eyes must be shut. This seems to point plainly to the psychomotor nature of his troubles.’[166]

Norman read his audience a quotation, from what were presumably Stanley’s previous case-notes,[167] stating that ‘at one period of his career he said a most interesting and remarkable

[164] Series 1, Lecture 19, 1 May 1905, ACC/2017/2, CN/1/19, CNL, RCPI.

[165] Ibid.

[166] Ibid.

[167] In other lectures he made explicit that he refers to casebooks and appeared to have them in the room during presentations.

thing, “When the voices speak loud or are far away they seem to come to both ears. When they are low or speak close to me they always come through the right.”’[168] The ways in which his patient spatialised and understood the voices he was experiencing in relation to himself was of immense interest for the physician. Here, as in the extract which introduced this section, written notes were used to create a consistent narrative that referred back to itself, bridging the patient on paper and the patient in the lecture hall. Even if what Stanley said in that present moment differed, this repurposing and retelling by Norman centred his ‘insane’ experiences as an identifying feature and persistent feature of his story; looping the narrative around.

Delusions often had main characters, places, instruments or technologies. They were very easily constructed into narratives, which, in turn, made them easy to be retold and repurposed. This revealed different levels and cross-purposes of meaning making depending on the teller. Confined to the Heath Asylum between July 1899 and her death in 1908, Eliza S. was described as ‘an old, grey-haired, busy, talkative, interfering, grossly deluded patient’ who believed her medical attendant was hypnotising her and expressed extensive hallucinations and delusions described as ‘of a fixed nature’.[169] She was persecuted, hypnotised and suffocated by gases, but also expressed delusions of grandeur which persisted throughout her case.[170] Eliza declared herself ‘the sister of the late Queen, kidnapped at the age of 2’ and her notes read that ‘she seems to know the private life of all members of the aristocracy, and gives long discourses upon them.’[171] Both these perceptual experiences and

[168] Series 1, Lecture 19, 1 May 1905, ACC/2017/2, CN/1/19, CNL, RCPI.

[169] CB 3 Female, 1899-1912, H65/B/10/028, BH, LMA, 11.

[170] Ibid.

[171] Ibid.

her general manner appear to have made her difficult to deal with and her notes described her as 'not a very pleasant patient to deal with, is always complaining of something'.[172] She spoke in an 'irrational manner' and 'seldom lets MO [Medical Officer] pass without a long tired of grievances, uttered in an irate melodramatic tone'.[173] Despite this, however, her medical notes in 1903 also featured the entry, that 'this old lady has missed her vocation, she has a wonderful imagination & ought to be the writer of sensational society novels.'[174] Eliza's delusions are explicitly described here as stories and fictions. Rare for case notes (but explored through Norman's lectures in chapter four), this note of humour is ambiguously situated between mockery and intrigue, with a suggestion of respect for her imaginative capabilities or faculties. Also noted was the observation that she 'can be easily managed if treated with the proper respect.'[175] For a woman whose story was that she was of noble birth and currently submitted to cruel injustices, those around her listening to her story and recognising her position was vital. Delusions such as these could significantly shape both how staff perceived and interacted with patients, and how patients believed they should be seen or treated.

Locating and understanding the voice, figure of delusion, or 'they' referred to, was a clinical priority as well as important and relevant for the patient. Norman stated that 'it is said that this voice which takes the patient's part is a bad sign, – a sign that the patient's present condition will last a long time and will not be followed by recovery'.[176] However, Norman

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[172] Ibid.

[173] Ibid.

[174] Ibid.

[175] Ibid.

[176] Series 1, Lecture 16, 10 April 1905, ACC/2017/2, CN/1/16, CNL, RCPI.

frequently diverges from understandings and frameworks for clinical significance. In his lectures we see which ideas and terms he takes up and which he dismisses in his own practice and when confronted by the nuances of particular experiences of patients. He contended, 'that a voice answers and takes the part of the persecuted does not seem to be singular when you have the same thing in a dream, Our [sic] own replies sometimes surprise us so much that we wake with a start.'[177] Situating voice-hearing on a continuum of experience, which included the dreaming of sanity, allowed Norman to interrogate the specificities of patients' descriptions. He does, however, frequently establish himself as omniscient narrator and interpreter of these experiences. He immediately followed this discussion with the statement that 'patients always take it as absolute fact that the voice is external, but we know to the contrary.'[178]

Whilst Stanley identified a particular group to whom he attributed his present troubles and actions, other patients refer to agents in the abstract. A vague and anonymous 'they' reoccurs in case-notes, and physicians frequently link cases through the presence of this mysterious agential force. In discussing whether paranoid patients presented a safety risk, Norman advised attention to the ways in which patients narrated their experiences, the language they used and the agency they attributed to their delusions. He stated that

> 'the persecuted attributes, - is liable to attribute, - his or her persecutions to different entities who vary on a more or less definite scheme. The bulk of our patients fortunately say that 'they', - the French 'on', - annoy them. Sometimes they don't know who it is. German patients say 'man'; the French say, 'on'; our patients say,

[177] Ibid.

[178] Ibid.

> 'they'. 'They' annoy me; 'they' speak about me. These patients are generally pretty safe.'[179]

Norman separated two other 'classes' of patients. He identified those who believed 'some organisation' was 'against them' and 'plotting injury or annoyance', whether identified as 'the Freemasons… Jesuits… or the Salvationists'.[180] He suggested that in these cases 'they are generally tolerably safe, little likely to react to their delusions and hallucinations' because such agents are 'large bodies, pretty broad-shouldered and pretty safe.'[181] The final group of patients 'believe some definite individual is the chief organiser. In asylums it is the Medical Superintendent. It occasionally happens that someone outside occupies that bad eminence.'[182]

Medical staff could therefore be integrated into patients' narratives and explanations of experiences in ways that could either facilitate or present a barrier to the clinical encounter. This will be explored more fully in the final section, covering accusations of abuse in the asylum environment. Patients might distrust the physician (or other members of staff), blame him for their pain or suffering, or see him as a source of protection and salvation. For some, a physician's interest in their account of themselves and their story could be validating, and they narrated their experiences with rich detail. For others, it confirmed their suspicions and amplified a feeling of threat or fear. Norman advised a delicate manipulation of these delusions and emotions in interviewing patients when he said that,

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[179] Series 3, Lecture 9, 22 March 1907, ACC/2017/2, CN/3/8, CNL, RCPI.

[180] Ibid.

[181] Ibid.

[182] Ibid.

> 'It is important that you should gain the confidence of your patients. You will then be able to question them as you should. You should be able to anticipate them by judicious questions. You seem to know what is wrong with them, and you thus gain their confidence. In suspicious paranoics if you do not have their confidence the longer you question them the more difficult it will be to get anything out of them.'[183]

Whilst doctors did not necessarily believe in the objective existence of these figures, they nonetheless haunted conversations and interactions between physician and patient. Voices or the agents of delusion were discussed with extensively and frequently, often as though they were in the room. As will be discussed in the following chapter, time works in complex ways in the asylum, and for many patients, 'recovery' or convalescence could mean returning these figures to the realm of the unreal, or the time in which they were insane, emptying them of both power and agency in their personal narratives. For others, "feeling better" meant simply not being plagued by them any longer; this being in their past. As with all these experiences, they were acutely personal and variable.[184]

Once these narrative strands are picked apart it is apparent that when each of these storytellers speaks *of* something, they may share a verbal language (although this is not always the case), but their meaning might be incommunicable in its entirety. These sources are records of negotiation and communication in order to establish meaning and make experience accessible in some way by another who occupies a different body, different mind, and a different world. The researcher must, then, expand her understanding of the world and

[183] Series 1, Lecture 19, 1 May 1905, ACC/2017/2, CN/1/19, CNL, RCPI.

[184] For work on 'recovery', psychosis, and social identity, see Tania Gergel and Eduardo Iacoponi, "Psychosis and Identity: Alteration or Loss?," *Journal of Evaluation in Clinical Practice* 23, no. 5 (2017): 1029–37; Sonja Bar-Am, "First Episode Psychosis: A Magical Realist Guide Through Liminal Terrain," *Australian and New Zealand Journal of Family Therapy* 37, no. 3 (2016): 381–96.

its reality and her highly contextual and historical body. She must engage with the idea that the concepts she uses to write or retell her own story are not stable and impermeable. She listens, but she also interprets, prioritises, orders, and retells.

The next chapter moves from character, voice, and agency in these layered narratives to explore these complex questions of time and structure. What is a ‘case’ exactly, and how might thinking of it as a travelling genre or moving story affect how we think and write with it? The historian’s narrative is undeniably and unavoidably shaped by the same processes of interpretation, translation, and manipulation as contemporary writers and theorists who wrote and assembled these cases. We too structure our stories by scale and time. Pulling together the threads and splintered meanings discussed in this chapter involves an often fragmentary and arguably creative act of mediation and completion. Our privileged access to these voices and ability to move across sources and genres allows us to compare, contrast, and pull together these fragments. Creating a historical account therefore involves synthesising and moving between narratives and layers, to pull together a coherent story about something, someone, and someplace. In many ways, this process attempts to bridge a gap and close a distance between ourselves and the historical past. Sitting at a desk, over one hundred years after these notes were originally recorded and these cases discussed, I must emphasise that time is undeniably an integral part of the historical process.

Chapter 2: Structure

This chapter considers these questions of interpretation, translation, and manipulation through the case as a fragmented genre, framework, and site of knowledge and identity. It asks how stories were structured and organised through scale, genre, and time. Unlike casebooks, Norman's sources are 'stuck' in the present moment (albeit our historical past). Stories *unfold* or progress to us as readers in a simulacrum of real-time. Reading these script-like conversations, I realised I had become so familiar with the format and structure of the asylum casebook, that I had begun to read these stories *out of time.* I read in minutes a case which unfolded over months or years. I had become used to the ways in which they structured and shaped my apprehension and understanding of the stories they contained and the people I imagined. This process of defamiliarisation in itself changes the story and how it is written. Norman lifted patients from the asylum space and from the casebook (where they have another form in the archives of Richmond) and re-presented them. In order to understand how these interactions are *different*, I needed to consider the case and casebook I was used to encountering and how this was in itself reflective of a historical moment or story. Norman was speaking at a time in which emerging statistical methods and organic theories of disease shifted the interrelationship between time, scale, and stories. The case, however, persisted.

Case-notes represent the most significant surviving corpus of material on patients' condition and care. Their utility as a source is manifold, but not without complication to the psychiatric historian. A recent special edition of the *History of the Human Sciences* took John Forrester's article 'If *p,* Then What?' as a starting point to explore the case as both an object and a *thing to think with.* This chapter similarly looks to historicise and approach the case

study, not as a stable genre or form, but as an adaptable convention and frame used in clinical practice to contain and manipulate time and scale. It considers the case and casebook (with its conventions, languages and forms) in order to frame and situate Norman's lectures and the concept of recording and organising experience. The case mediates between clinical practice or knowledge and patients' experiences, or communication thereof. The genre has a long history. Cases shape and are made by particular disciplines, and epistemological fields. The psychoanalytic case might be of the same genus as the nineteenth-century asylum casebook, but the two are nonetheless distinct and frame their subjects in different ways to different ends. Likewise, whilst ostensibly both are of the same species, the case as contained within the institutional bureaucracy of the asylum and cases published in a clinical journal or medical periodical to illustrate or furnish an article with evidence, are distinct types of narratives and objects.

Cases, in their various forms, are used throughout this research. Here, they are considered explicitly as a way of framing both knowledge and experience throughout various stages, times, and multiple layers of the clinical encounter. The case was made or created as a container and frame for mediating between both patient experiences and clinically relevant information, symptoms, and observations. It then frequently travelled across sites of knowledge, including to medical periodicals and textbooks or clinical manuals. Understanding the positioning and construction of the frame is important to then understand the ways in which it broke or its containment was transgressed. Thinking in cases allows us to illuminate the ways in which clinical knowledge and lived experience were mutually constitutive but also fraught with tension. Whilst cases cannot unproblematically be used as sources of knowledge and experience, thinking *through* and *with* them opens up a myriad of fruitful avenues of enquiry.

This chapter will consider how case notes and histories collapse or curate time and narratives in order to fragment and fit lived experience into a frame. It considers how confronting case notes as structured, framed, and re-situated narratives can illuminate the tension contained within them about how stories are produced in these spaces. It will do this in two key ways. The first, looking at how scale is handled in these histories as a means of distancing and managing the messiness of the asylum world. Then, it sees the case history as a temporal phenomenon; a way of ordering and containing experience through an assertion of straight, linear, and apparently objective time.

The case sits at a crucial fault line in both medical practice and the history of mental science in this period. In their edited volume on the history of observation, Lorraine Daston and Elizabeth Lunbeck urge a blending of the histories of experience and knowledge, to historicise and consider how scientific practices which insulate from disruption, subjectivity, and destabilisation were 'refined, framed by context and circumstance.'[185] They contend that the twin practices of observation and experiment which anchor modern medicine evolved 'in contradistinction' to one another in the nineteenth and twentieth centuries. Moving from being closely intertwined and working together in the eighteenth and early-nineteenth centuries; forming 'an endless cycle of curiosity', the two were pulled apart in the 1820s as scientific writers began to promote experiment as the more 'objective' approach. The following period entrenched a belief in and fear in the contamination of observation and its findings with preferred theory and personal prejudice or selection.

[185] Lorraine Daston and Elizabeth Lunbeck, *Histories of Scientific Observation* (Chicago: University of Chicago Press, 2011), 3.

These debates were played out in the pages of medical journals and, indeed, the spaces of the lecture hall, asylum, and casebook. Practices of observation and experiment resurface repeatedly throughout this thesis as different parties contend with how best to determine the truth and reality of the body and mind in illness. Textbooks of mental science purported to be collections of generalisations and guides to clinical practice, whilst medical journals simultaneously revealed a great deal about the inconsistencies and curiosities debated in medical communities and sought to gather together like cases for consolidation in professional networks. As the principal source from which such extrapolations could be drawn, asylum casebooks represent messy and protean documents which shifted the scale and revealed the daily negotiations and conflicts inherent in the asylum space. As such, the details therein frequently undermined or resisted moves towards standardisation and the construction of the 'representative' in clinical discourse.

Whereas both experiment and observation constructed conventions and practices to disappear the observer and the experimenter, narrative re-centres the narrator in accounting for what the story is and how it is told. Whilst the archives of the asylum and mental science clearly indicate a growing interest in the idea of the standard and representative, other messier and more fraught practices of telling stories in clinical and institutional spaces endured, persisted, and adapted. In allowing for and subsuming multiple narratives, temporalities, scales, and types of knowledge, the case remained a persistent feature of mental science throughout this period and beyond.

Scale

A crucial factor in the consideration of cases is their relation to an individual selfhood and the concept of reproducibility in and outside of the discursive realm of mental science. Callard and Millard, in the special issue on cases, mentioned earlier, posited that 'the illusion – and the utility – of the case is that it isolates and analyses an individual.'[186] The patient's story brought into focus in this chapter is one of thousands to be found in the enormous leather-bound casebooks of the Heath Asylum (Bexley). Patients' lives within institutional walls and pages, laid out, annotated, signed, dated, and filed away. In this context, and in ways very different to Norman's lectures, it can be incredibly easy to forget how embedded these stories are, not only in the physical space of the asylum, but also the social environment; the interactions people had with other patients and their doctors. There is an internal tension in case-note recording. Whilst the 'clinical gaze' and narrative structure of the case-note is isolating, a closer look at the concerns and questions of those writing it draws attention to an underlying social and medical anxiety around the seemingly swelling numbers in public and private asylums supposedly resulting from the pressures of the modern age.

Writers such as Henry Maudsley were keen to establish that it was the changing bureaucracy and systems of care for the insane that conveyed this illusory impression of growth, rather than this being a response to an actual increase in insanity. In an article of 1877, he argued that 'those who would explain the increase [in the insane population] by a

[186] Chris Millard and Felicity Callard, "Thinking In, With, Across, and Beyond Cases with John Forrester," ed. Chris Millard and Felicity Callard, *History of the Human Sciences* 33, no. 3–4 (2020): 6.

greater liability of the population to go mad run no small risk of proving a great deal too much.'[187] Rather,

> 'when we look more carefully into the matter… we find cogent reasons to conclude that much, at any rate, of the very great increase in the number of insane persons is owing to the successive Governmental regulations which have been made and enforced for the better supervision and care of the insane. Each new Act of Parliament concerning them has been an instant and effective means of swelling their numbers.'[188]

The statistics that were increasingly produced, facilitated in large part by governmental regulation and the attempts of the new asylums at standardisation, did not necessarily help to understand the cause and significance of insanity in the population. In dealing with large numbers and detecting patterns, Maudsley claimed there was a significant danger in coming to erroneous conclusions and catastrophising, or making assumptions about the future, which did not hold up when the detail behind the numbers was considered.

In this broader context, the casebook is discussed as a pseudo-experimental approach. It offered a method and structure through which to contend with, classify, and attempt to understand this change on a manageable and contained scale. Speaking in 1869 to the members of the Medico-Psychological Association (a talk later published in *JMS*), Thomas Clouston urged his fellow asylum physicians to take advantage of the unique environment offered by the asylum to 'arrive at a much greater degree of scientific accuracy in [their]

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[187] Henry Maudsley, "The Alleged Increase of Insanity," *JMS* 23, no. 101 (1877): 46.

[188] Henry Maudsley, *Body and Mind : An Inquiry Into Their Connection and Mutual Influence, Specially in Reference to Mental Disorders* (London: Macmillan, 1873), 46.

treatment of certain forms of insanity'.[189] He contended that given 'patients breathe the same air, eat the same food, wear similar clothing, get up and go to bed at the same time, and are entirely under our control', 'the numerical method of research' could be uniquely applied in asylums to approach 'more nearly to the accuracy of the physical sciences'.[190] By controlling the lived environment and regulating the conditions under which patients lived and interacted with staff, Clouston believed something of the laboratory environment might be produced and broader generalisations about mental life and science made, with the assistance of statistics.

However, whilst asylums ostensibly offered a key environment for the collection and collation of data on insanity, especially using the casebook as a regulatory system, they were intractably reliant on practices of observation, interpretation, and communication. Thirty years later, A. H. Newth lamented that Clouston's advice to the profession had not been heeded. He remarked that 'there is a decided lack of uniformity as regards clinical and therapeutical observations in different asylums.'[191] In order to facilitate effective and scientific generalisations, Newth argued that

> 'there must be a collaboration of the observations of a large number, and this can only be achieved by an uniform, systematic method of case-taking. The vexed question of a proper scientific nosology, a correct classification of disease, and the most

[189] Thomas S Clouston, "The Medical Treatment of Insanity," *JMS* 16, no. 73 (1870): 24.

[190] Ibid., 25.

[191] Alfred H Newth, "Systematic Case-Taking," *JMS* 46, no. 193 (1900): 256.

satisfactory treatment, might in some measure be arrived at by a combined system of medical book-keeping.'[192]

Asylum physicians were acutely aware of the variation and lack of consistency which dogged and undermined their practice and profession. Casebooks were formulated according to a standardised layout and system, with many asylums introducing pre-printed pages for admissions documents. However, gaps and inconsistencies remained a persistent feature of the records across institutions. Diagnoses changed over time or were never entered, terminology was used with disparate and divergent meanings, and whether because of the immediacies of the asylum environment or uncertainty, spaces were left, or details omitted.

Whilst theories of mental science were increasingly erring towards the organic and physiological, with a growing emphasis on pathological work in asylums, Newth observed that 'though pathology is most important, it has no significance without clinical histories of the cases.'[193] Patients' descriptions and communications may have been increasingly subsumed into a broader narrative and discourse of theory, but they remained of vital importance. This approach shows a particular awareness of the importance of time as a frame in case notes; the presentation of the body and brain at the moment of death seemingly meant little unless this could be connected with the behaviour and communication which marked them as 'insane' in life.

[192] Ibid.

[193] Ibid.

Statistics, similarly, abound in contemporary medical journals. However, Newth rather cynically and cuttingly concluded his article with the observation that

> 'it is a question whether these tables are of much value; at any rate no one seems to use them for any real practical purpose. They are printed in the asylum reports at considerable expense and trouble, and these reports are distributed to other asylums, where they are glanced at, thrown into the waste-paper basket, or shut up in some obscure cupboard, eventually to be taken out at some future time to serve the only useful purpose of which they are worthy, namely, to light the fire.'[194]

Such remarks draw attention to the space that is easily ignored or forgotten between what was read and published, and what was subsumed into practice and reached patient care. The production and existence of a source or idea does not necessarily mean it was *used.* The immediate realities of individual patients and the practicalities of asylum management were considerably more forceful agents for shaping the experience of insanity than statistics and changes in theories which made their way into textbooks, journals and clinical manuals. This is not to say that they had no impact, but rather that historians ought to be cautious in using medical publishing, or even casebooks, as indicators of change and experience. They more readily reflect a promise or principle, than what came to pass. Whilst the history of medicine and psychiatry in this period is often written as one of radical and transformative change and disjuncture, a shift in perspective challenges and undermines parts of this story or the ways in which it is written.

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[194] Ibid., 258–59.

Instead of metanarratives and grand conclusions, considering one 'story', either through a close reading of a casebook or through Norman's conversations, allows the historian to interact with the historical record in such a way that highlights the silences as well as the speech, the presences and the omissions, the inconsistencies and the confusions that riddle people's lives as well as institutional records. It recognises someone as a person, not just a patient, making meaning of her experiences and attempting to communicate these. As John Brewer and Filippo de Vivo have discussed through the lens of Jay Appleton's landscape theory, rather than assessing the 'prospect' of the historical past as a detached and generalising observer, microhistorical methods consider history from 'close up', allowing for a critical change in perspective that recognises the individuality and complexities of individual lives, conversations, events, and places within the asylum. [195] Crucially, it also necessitates reflexive consideration on the part of the historian who finds themselves suddenly nose to nose with their subject/object.

This proximity can be challenging and affronting, deconstructing comforting boundaries of distance. In an article problematising the concept of this historical distance, Mark Salber Phillips contended that its ubiquity 'has tended to render it invisible, and over time… it has become difficult to distinguish between the concept of historical distance and the idea of history itself.'[196] Phillips urges the historian to consider what is actually meant by 'distance' and how it comes to shape her work and writing. What is gained by this arm's-length approach, and what is lost? Does consciously collapsing or playing with this

[195] John Brewer, "Microhistory and the Histories of Everyday Life," *Cultural and Social History* 7, no. 1 (2010): 87–109; Filippo de Vivo, "Prospect or Refuge? Microhistory, History on the Large Scale: A Response," *Cultural and Social History* 7, no. 3 (2010): 387–97.

[196] Phillips Mark Salber, "Distance and Historical Representation," *Historical Workshop Journal* 57, no. 57 (2014): 125.

convention of distance allow the illumination of particular details or a change in perspective? The discomfort and sensitivity such an approach presents are phenomena not altogether different from that of counter-transference, as discussed in psychoanalytic theory on the case.[197] Whilst Freud not only urged an awareness of the dangers of this emotional entanglement with the patient, but mastery over it, here I rather encourage an awareness and sensitivity to it and where it might come from.

For the analyst, counter-transference comes with the intimacy of personal conversations and face-to-face encounters with the Other. For the historian, although she is separated by the physicality and distance of the written medium, there is a sense of intimacy involved in accessing and pouring over previously confidential medical records or 'listening in' to conversations. In a ground-breaking article, Jill Lepore reflected on the conventions of microhistory and biography which bring us 'up close' and foster a sense of intimacy and connection with the person or people we are writing about. The method changes the narrative. She reminded that,

> 'finding out and writing about people, living or dead, is tricky work. It is necessary to balance intimacy with distance while at the same time being inquisitive to the point of invasiveness. Getting too close to your subject is a major danger, but not getting to know her well enough is just as likely.'[198]

[197] Michael J Redinger and Tyler S Gibb, "Counter-Transference and the Clinical Ethics Encounter: What, Why, and How We Feel During Consultations," *Cambridge Quarterly of Healthcare Ethics* 29, no. 2 (2020): 317–26; Del Loewenthal, "Countertransference, Phenomenology and Research: Was Freud Right?," *European Journal of Psychotherapy & Counselling* 20, no. 4 (2018): 365–72.

[198] Jill Lepore, "Historians Who Love Too Much: Reflections on Microhistory and Biography.," *Journal of American History* 88, no. 1 (2001): 129.

In many respects, the temporal distance at which the historian works offers her privileged access to material not available to many at the time. Our received conventions of distance, separation and objectivity, can stem from the very questions this chapter addresses. Case-*histories* are stories, framed by the spaces and praxis of the medical profession, designed and written to illustrate change over time and speak to or illustrate a broader phenomenon.

The case as genre

Whilst case-notes have been most discussed as a genre following their use by psychoanalysis and Freud, the medium has a much longer history and endure as a central supporting structure of medical and psychiatric practice today. John Haslam's *Illustrations of Madness* is a particularly crucial and early demonstration of the ways in which case studies travelled outside of the asylum and carefully negotiated 'voice' within narrative to contest and establish authority.[199] Following a legal dispute in 1809 over the alleged insanity of Bethlem patient James Tilly Matthews, Haslam published the first book-length case history in his role as institutional medical officer. He detailed Matthews' persecutory delusions about an 'Air Loom' which Matthews believed was operated by a gang of villains, in a basement not far from Bethlem in London, who used the machine to torture him. Matthews included an extensive and detailed description of the machine, which wove airs and gases together into a 'warp of magnetic fluid' to be directed at its victim. He even created a detailed technical illustration or engineer's blueprint of this Air Loom torture device, seen in Figure 3,[200] depicting Matthews himself being worked on by the machine, operated by a 'middle man'. In

[199] John Haslam, *Illustrations of Madness: Exhibiting a Singular Case of Insanity, and a No Less Remarkable Difference in Medical Opinion* (London: G. Hayden for Rivingtons, 1810).

[200] James Tilly Matthews, *Diagram or Plan of the Cellar, or Place where the Assassins Rendezvous and Work: Shewing their own and their Apparatus's Relative Positions, as it has at all times appeared to Me by the Sympathetic Perception*, early nineteenth century, engraving, reproduced in Ibid., courtesy of WL.

its formulation, Haslam relied heavily on both his case notes, the drawing, and his patient's own writings, to prove both that Matthews was insane and to justify his own actions in labelling him as such, following a challenge from both the physicians George Birkbeck and Henry Clutterbuck (who had been called in for a consultation), and Matthews' own family. Haslam was appealing to a trial by public and sensationalising Matthews' delusions in order to shore up the polarity between sane and insane, situating the case history at the intersection of medical report and novel.

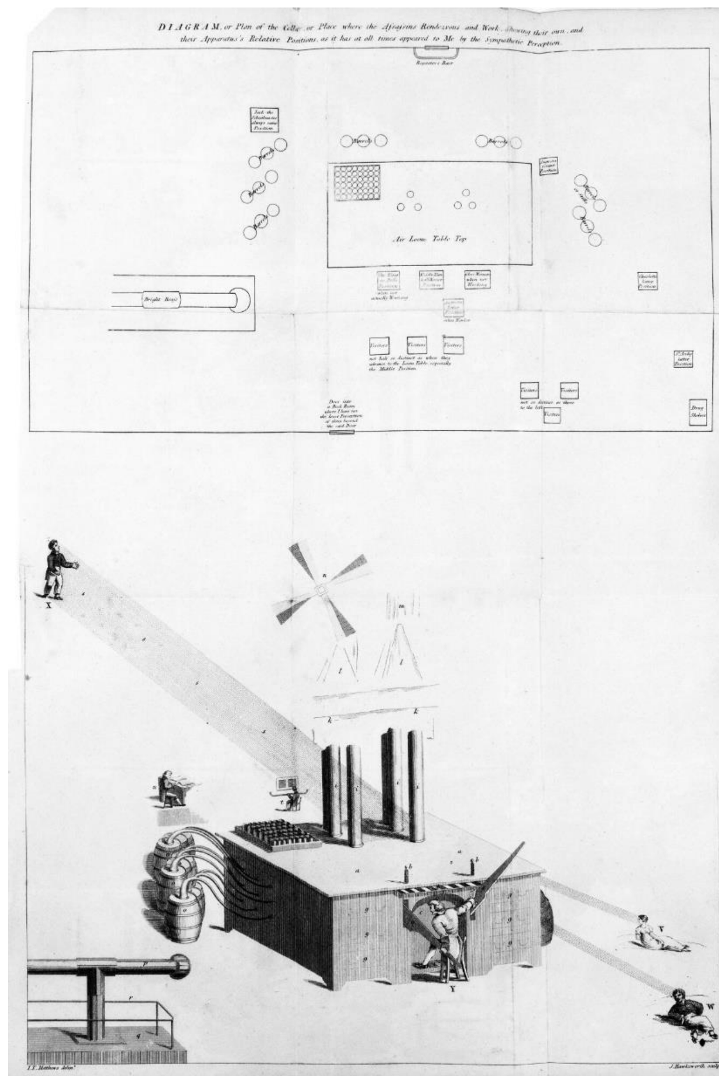

Figure 3: James Tilly Matthews, Diagram or Plan of the Cellar, or Place where the Assassins Rendezvous and Work: Shewing their own and their Apparatus's Relative Positions, as it has at all times appeared to Me by the Sympathetic Perception, early nineteenth century, engraving, reproduced in Illustrations of Madness by John Haslam (1810).

Cases were used across a range of platforms in nuanced ways to conceptualise or polarise this distinction between reason and unreason, or to explore and imagine the body and mind of the insane patient once they were situated on this spectrum. Whilst they were not as thorough or public as the example of Haslam's publication, cases presented in medical periodicals used patient stories and experiences to create connections across geographical regions and institutions, and to consolidate professional networks. The *Journal of Mental Science*[201] was divided into sections, according to type of article and contribution to knowledge and the profession. One of these sections was labelled 'Clinical Notes and Cases', in which authors furnished the journal with collections of patient case notes, generally drawn from the asylums at which they worked or episodes through their career. These case contributions were framed with the physician's own commentary and observations. Through the case, questions about the limits of psychological and biological understanding, or the methods with which this was attained, were raised and debated. Articles published were frequently written versions of papers presented to more local or closed spaces and groups, as a way of disseminating and reproducing them more widely.

An article published in *JMS* in 1891, entitled 'A Case of Delusional Insanity', provides an excellent example of the ways in which cases were reframed and used in medical journals. The article was the written version of a 'paper read before the Scotch Meeting of the Med. Psych. Assoc., Nov., 1890' by Dr Keay, Medical Superintendent of the Mavisbank Asylum, Edinburgh.[202] Dr Keay opened his paper by stating that 'the following notes of a

[201] This title is used here and throughout this thesis in order to avoid confusion. The publication underwent two title changes over the course of the period covered by this research, but the *Journal of Mental Science* was the longest-lasting (1858-1963.) It was also called the *Asylum Journal* (1853-1855) and the *Asylum Journal of Mental Science* (1855-1858).

[202] Keay, "A Case of Delusional Insanity," *JMS* 37, no. 157 (1891): 245.

case of delusional insanity, in which recovery took place after nine years, may be of interest to the members of the Medico-Psychological Association'.[203] This preface, which framed and situated the case by its dominant note or special mark of interest, is a common feature of articles in this section of the journal. The author's commentary, generally at the start and close of the article, is in a slightly larger typeset, thereby differentiating it from the case-notes presented. This allows for a switch in voice and register; marking the patient notes as a different *type* of document. These notes inside the paper could be lifted apparently directly from the asylum archive, with time stamps signifying the date at which the progress report was recorded. In this case, they appear to be the physician's own paraphrasing or retrospectively consolidated notes on the patient. He explains his decision-making process, and opinions on the patient's behaviour and condition. In many ways a comparable case to the one discussed later in this chapter, considering how Keay's case was structured and presented to a broader professional audience allows us to think about how the case as a genre and frame might be manipulated and used in different discursive and physical environments.

Keay described his patient as 'W.J., an unmarried lady, fifty years of age' who was 'admitted into Mavisbank Asylum on 17th March, 1881'.[204] He noted a 'well-marked hereditary tendency to mental disease' on both sides of her family, that 'her temperament was somewhat reserved and suspicious' but she 'was a woman of considerable intellectual ability, and well educated, being a good linguist and musician.'[205] As for her bodily health, 'she was of small stature and feeble muscularity, very anaemic, and a constant sufferer from chronic

[203] Ibid.

[204] Ibid.

[205] Ibid.

rheumatism.'[206] Through this description, Keay draws out the key features of the patient's notes, which he later refers back to and connects together in order to approach or begin to posit an explanatory framework for the development of her case. He stated that

> 'for years she had been a sufferer from chronic rheumatism, the twinges of which in her joints and bones when misinterpreted easily became blows and twists inflicted by imaginary enemies.'[207]

Her 'naturally reserved and suspicious temperament',[208] combined with physical ailments, developed into and became grafted onto hallucinations and delusions of a painful and persecutory nature.

The ways in which W.J.'s delusions and accusations were temporally marked and situated by the author of the case, both inside and outside of the asylum, is of particular importance. Keay established a clear timeline of the patient's experiences. He narrated that

> 'The attack of insanity commenced about a year before her admission into the asylum. At first her natural suspicious disposition seemed to become exaggerated, so as to amount to eccentricity, and later on definite delusions were evolved.'[209]

He then clearly demarcated, within this broader narrative, a beginning, middle and end to her case. He recorded, that

> 'at the time of her admission she had the ordinary delusions of suspicion, believing that her father and other relatives were plotting against her, and that her food was

[206] Ibid., 246.

[207] Ibid., 247.

[208] Ibid.

[209] Ibid., 246.

> poisoned. She had also delusions of unseen agency, complaining that people directed jets of noxious gases at her, and "worked on her" at night by some mysterious means.'[210]

This description 'sets the scene', allows the physician to expand upon how her perceptual experiences, or hallucinations and delusions, mapped onto the chronology of the case. He continued, explaining that

> 'for several months she remained free from excitement, firmly believing in the treachery of her relatives, but on moderately good terms with those around her. She then began to suspect individuals in the asylum, particularly members of the staff, of trying to injure her, and became most irritable, excitable, and violent. She accused people of whipping her, and stated that on awakening from sleep she frequently felt that she had been beaten all over. Auditory hallucinations then began to trouble her, and when lying awake she had altercations with her imaginary enemies, and abused them to her heart's content. She continued in this state – irritable, suspicious, abusive, and delusive – for about five and a half years, that is, till four years ago, when she came under my care.'[211]

During Keay's personal involvement with the case, he 'found her the most troublesome and trying patient in the asylum'.[212] Compacting the narrative and timeline to summarise rather than detail, he stated that, whilst under his care,

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[210] Ibid.

[211] Ibid.

[212] Ibid.

> 'her mental state [then] remained apparently unchanged for about two years, when the delusions seemed to gradually lose power. She complained less about them and the nightly persecutions, and in another six months they had entirely left her.'[213]

Once rid of her delusions, Keay states that 'she complained more of rheumatism. The rheumatic pains were not at this time really more severe, but she began to interpret them more correctly.'[214] Keay used his patient's testimony and correlated her experience (both physical and mental) with his perceived timeline or evolution of her mental disease or symptoms, in order to establish fact from fiction within the body. He used a sense of time and narrative to establish a distinction or bifurcation between objective and subjective truth.

Condensing and reframing the timeline of this case allowed Keay to draw out or emphasise features of interest, trace patterns, and cause and effect. It meant being able to state which elements of a case were typical, unusual, curious, relevant, interesting, and of general potential interest to colleagues with similar cases under their care. Keay here drew attention to two key features in his timeline of W.J.'s illness. Firstly, the difficulty in pinpointing when insanity begins in cases of delusion and hallucination. He stated that

> 'It would be impossible to fix the time when such a person became insane. Her suspicious disposition becomes more intensely so – is exaggerated. Delusions are evolved which she keeps to herself as long as she possibly can, being naturally reticent. It is only when they become so strong as to overcome her self-control that she expresses them, and is looked upon as insane. Cases of delusional insanity such as

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[213] Ibid., 247.

[214] Ibid.

that here recorded, in which, without a preliminary maniacal attack, there is a slow and steady evolution of the disease, are looked upon as the most unfavourable of all.'

The temporality of disease was a key feature in its diagnosis, treatment, and duration. According to this narrative, unless the delusions and hallucinations are detected early, which is frequently very difficult, recovery is considerably less likely. The situation of disease on a timeline from an early stage thereby establishes its progression and potentially end. The rate at which it progresses; here, an 'evolution', further shapes and determines the nature or outcome of the case.

Secondly, Keay stated that 'the attack of mania complicating the case is interesting.'[215] He posited that 'perhaps [this] was a fortunate complication and let to the ultimate recovery of the patient from the chronic insanity.'[216] The condition of the blood vessels in the cerebral cortex and cell nutrition, to which Keay attributes W.J.'s insanity, were apparently altered by the acute and sudden maniacal attack, so that 'when the acute symptoms subside the centres are left in a condition more nearly approaching the normal.'[217] The anomalies and disruption in the timeline and progress of W.J,'s case changed its prognosis. Keay concluded that 'the diseased habit has been, in short, changed by the stimulation of the cells affected.'[218] Published cases such as this were used to develop a concept of the typical or representative in the timeline, progression, and key features of a case. They aimed to help physicians predict outcomes, establish causality (especially in

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[215] Ibid., 248.

[216] Ibid.

[217] Ibid.

[218] Ibid.

connecting the progress or features of a case and the results of a post-mortem or observed and measurable physical symptoms), and to refine treatment options.

These sources, much like a birds' eye view of the asylum and the case, allow for the mapping of disease and the consolidation of knowledge about its nature and progress amongst other colleagues afforded a similar vantage point. A high-profile case such as Matthews' was unusual in its detail and public dissemination, and even the cases published in medical journals like W.J.'s are not necessarily 'representative', although they may aim and even purport to be. For most patients, whose pleas for release remain within the asylum, their stories can appear smaller and less fraught to the historian. It becomes too easy to see such patients' lives as entirely restricted to this institutional snapshot. Whilst case notes are often the only contact people had with the historical record, there is a very real danger of inflating such sources to encompass an entire personal history. In describing these sources as records of patients' lives, as 'histories', it is crucial to ask if this truly is *their* history. It is not just patients' words which are reframed and re-contextualised. Case notes present the reader with a fragmented and curated episode of people's lives.

The remainder of this chapter explores the institutional case notes of one woman confined to the Heath Asylum (Bexley) over the duration of her confinement. Whilst Norman's patients 'appear' in his lectures in a suspended 'present', considering other forms of case-taking, such as the casebook, illuminates the ways in which scale, intimacy, and this temporal disjuncture frame the nature of experience and its preservation in records. Norman 'lifted' patients out of the asylum environment. The case book is in many ways inseparable from it, showing how, through particular processes and practices, people became patients and

how experience was clinically resituated and coded. Here, I will consider Julia's case as a different window into the body in the wider asylum and the ways in which time and 'the case' structured how both doctors and historians interact with patient experiences.

Julia R and her 'annoyances'

"Mine is an injury case by the police, putting that telephone on me & drawing my secrets out"[219]

May 28th 1909, Bexley Female CB 10, LMA.

In early June 1902, sixty-three year old Julia Rendell was admitted to the Heath Asylum, Bexley from St Pancras Workhouse, adamant that 'she has been persecuted for the last 4 years.'[220] These persecutions, which she termed 'annoyances', plagued her night and day prior to and throughout her stay at the asylum. Primarily visual and auditory on admission, organised through the delusion of persecution by the Police, these hallucinatory 'torments' changed throughout her thirteen-year stay at the Heath Asylum, coming to incorporate her physical health problems as she developed a large ovarian cyst and ventral hernia. Despite her impaired hearing (she has been largely deaf since twenty years old), Julia was alert and attentive: 'she understands all said (with shouting) and answers smartly' with 'good cognition of self and surroundings'.[221] Her memory was described as accurate and this alertness to time, place and self appears to have facilitated the construction of a fairly satisfactory personal history. Described as 'decidedly simple' she nonetheless tells the doctor

[219] CB 10 Female, 1902-1911, H65/B/10/034, BH, LMA, 15.

[220] Ibid., 11.

[221] Ibid.

that 'she came to this ward from the "sanitary" meaning the Hospital Villa',[222] frequently co-operating and communicating with her physicians in their interviews.

Over the standard two pages allocated to patients at the Heath Asylum and sandwiched in between other cases in spare space dotted throughout Female Casebook 10, the chronic and supposed incurability of Julia's case did not stop the medical staff from recording in considerable detail her various 'annoyances'. In a far from comprehensive list, she felt like she was being electrocuted, smothered, had "telephony" put on her, a mouse and a weasel crawled over her skin, she felt a man called Mr Mathieson inside of her, and she was plagued by noises, flashing blue lights and people making faces at her, which prevented her from sleeping. For her medical officers, Julia was a deluded, verbose and indignant old woman who nonetheless presented little problem and was seemingly deserving of their patience and sympathy as her physical and mental state both deteriorated over her stay as a chronic patient at the asylum.

Whilst it is not the key focus of this chapter, it is important to acknowledge that certain social pressures and context could shape who entered the asylum at all as well as the language used, dynamics of the clinical encounter, and how cases are recorded. Norman discussed with his patients the social and financial (as well as clinical) reasons why asylum confinement was often necessary, stating that,

> 'Insanity is a disease unlike others. It has numerous social relations. You cannot allow a patient to go about at large distraining his property and making a fool of himself.

[222] Ibid.

> You cannot allow any female patient to go about exhibiting even a mild form of erotic excitement; so that sending a patient to an asylum often becomes a measure of defending themselves against themselves'.[223]

Such ideas and discussions surface regularly in the historiography, particularly in the Irish context, where Brendan Kelly and Alice Mauger have particularly considered care for the insane in the context of a socio-economic emphasis on land and its interconnectedness with notions of class identity and respectability.[224] Mauger has questioned 'the popular notion that relatives were routinely locked away to be deprived of land or inheritance'.[225] This theme of 'inconvenient people' and families using (or abusing) the asylum system for their own social or economic purposes or prejudices has been much-discussed in the context of English asylums, especially interrogating the idea that it was married women who were the most usual victims of these unjust incarcerations.[226]

Studies in the wake of second-wave feminism, particularly Elaine Showalter's work on hysteria and Mary Poovey on the ideological work on gender in mid-Victorian England, have urged a reconsideration of the ways in which gender has been written about in the history of the asylum.[227] Madness was far from a particularly female affliction, but gender

[223] Series 1, Lecture 30, 26 May 1905, ACC/2017/2, CN/1/30, CNL, RCPI.

[224] Alice Mauger, *The Cost of Insanity in Nineteenth-Century Ireland: Public, Voluntary and Private Asylum Care*, Mental Health in Historical Perspective (Cham: Springer International Publishing, 2018); Kelly, *Hearing Voices.*

[225] Mauger, *The Cost of Insanity in Nineteenth-Century Ireland: Public, Voluntary and Private Asylum Care,* 1-2.

[226] Sarah Wise, *Inconvenient People : Lunacy, Liberty and the Mad-Doctors in Victorian England* (London: Vintage Books, 2013).

[227] Lesley A Hall, "Does Madness Have a Gender?," *History of Psychiatry* 20, no. 80 Pt 4 (2009): 497–501; Cecily Margaret Devereux, "Hysteria, Feminism, and Gender Revisited: The Case of the Second Wave," *English Studies in Canada* 40, no. 1 (2014): 19–45; Jonathan Andrews and Anne Digby, eds., *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam: Rodopi, 2004).

and other forms of identity did shape key ways of talking to and about patients. These socially-inflected assumptions and languages will appear through this thesis, whether in the ideas of 'decorum' and femininity in the discussion of the stuperose Mary Jane in Chapter Three, the ways in which violence and risk were thought about in relation to male asylum patients in my section on abuse and William S. in Chapter Five, or other moments of 'resistance' or silencing. The dynamics of class, gender, religion, age and profession were highly nuanced and shifting both within and in the society surrounding the rarefied world of the asylum. Looking *up close* can illuminate these shifts, languages, tensions, and structures.

How do different people live, experience and appear in the asylum in different ways? How does form make experience readable? How does language and narrative structuring make the body communicable? Clinical casebooks might be specifically coded and institutional, but closely considering cases such as Julia's allows an exploration of how personal and lived experience was intertwined (in either harmonious or uneasy ways) with clinical ways of measuring, understanding, and recording in these documents. This chapter particularly looks at how time and temporality is negotiated and situated between these narratives. It will consider how clinical time constructs and insists upon a fixed axis, upon which the patient is situated and often zigzags across. This frame makes the patient's experience readable, as well as making clear the tension which exists between the discordant and disjointed temporalities. Lived time is competing with and operating at a slant against the axis of clinical time. Whilst in the published sources already discussed, clinical time is the dominant note, case notes from asylums themselves speak to the process through which this was effected. The patient's own lived temporality slips through and resists the frame and clinical voices or structures in these institutional documents in ways slightly different to those in Norman's lectures.

Thinking about time

Time is both central to historical practice, and indeed the basis of the discipline, yet only rarely directly examined. Marxist historian E.P. Thompson's article of 1967 is a notable and formative exception. In this work, Thompson considered changing conceptions of time in their broad social and economic contexts; connecting a shifting personal and community perception of time's passage and timekeeping with the growth of industrial capitalism.[228] Whilst the specifics of Thompson's theory have been subsequently challenged,[229] this notion of historicising apparently universal and fundamental facets of lived experience, such as time, was an important conceptual move in the discipline. In cultural anthropology, the study of lived time is far from new. As Nancy D. Munn stated, 'the problem of time in anthropology, as in other disciplines, is subject to the Augustinian lament: how difficult to find a meta-language to conceptualize something so ordinary and apparently transparent in everyday life.'[230] The concept of time is, essentially, taken for granted. It fades into the background; not necessarily phenomenologically distinct or brought to the front of consciousness until it is running out, moving too slowly, valuable, or a waste.[231] Munn concluded her article with her own notion of "temporalization", viewing

> 'time as a symbolic process continually being produced in everyday practices. People are "in" a sociocultural time of multiple dimensions… In any given instance, particular temporal dimensions may be foci of attention or only tacitly known. Either

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[228] Edward P Thompson, "Time, Work-Discipline, and Industrial Capitalism," *Past & Present* 38, no. 1 (1967): 56–97.

[229] Paul Glennie and Nigel Thrift, "Reworking E. P. Thompson's `Time, Work-Discipline and Industrial Capitalism'," *Time & Society* 5, no. 3 (1996): 275–99.

[230] Nancy D Munn, "The Cultural Anthropology of Time: A Critical Essay," *Annual Review of Anthropology* 21, no. 1 (1992): 116.

[231] Drew Leder, "Healing Time: The Experience of Body and Temporality When Coping with Illness and Incapacity," *Medicine, Health Care, and Philosophy* 24, no. 1 (2021): 99–111.

way, these connectivities among persons, objects, and space are continually being made in and through the everyday world.'[232]

In this way, time emerges as a complex embodied and lived phenomenon. It can be made and challenged by everyday practices and manipulated through the ways in which it is structured. Time rests on a host of assumptions we make which are, ultimately, highly political, and historically and situationally specific. Case histories present an ideal form through which to explore the ways in which medical time and the asylum space encountered, accommodated, and resisted challenging bodies and ways of living in time.

Case notes construct a linear, seemingly 'straight' temporality. This temporality is designed to contain within itself and assert power over other ways of *being in time.* Case notes record what the patient says, which tells the reader (whether doctor or historian) how they see and live time. These inclusions in case notes are recorded *in* time; given an objective marker of time passing. When a doctor speaks to or interviews a patient, a date is recorded in the margin, creating a timeline which progresses at regular interviews. This creates a clinical narrative of progress, telling the reader, over time, whether the patient is improving, deteriorating, or remains unchanged. It is not only the numerical or calendar time which establishes this linearity and solidity or objectivity. Julia's case notes record phrases such as 'still very worried by telephony', 'unimproved mentally', 'last note again applies', 'no variation to record', and 'remains as hallucinated & deluded as before.'[233] In this way, the case notes refer back to themselves and self-consciously construct a narrative or temporal structure. It makes visible the *purpose* of this sense of clinical time. Case notes and case

[232] Munn, "The Cultural Anthropology of Time: A Critical Essay," 116.

[233] CB 10 Female, 1902-1911, H65/B/10/034, BH, LMA, 11,15.

histories are designed for standardisation and accessibility. It would not always be the same doctor or member of asylum staff who encountered a patient; being able to refer back in case notes to assess whether behaviour was typical or a deviation, was a useful clinical tool. This time-specific narrative indicated whether a delusion had changed; developed, become localised, or perhaps was oriented around a new physical complication and change in their overall case. A doctor or the Commissioner could use this structure to establish whether a patient's delusions were 'fixed' or systematised. Such markers had clear and important clinical implications.

They could indicate whether there was any hope of recovery and possibility of a departure from the asylum space. Resident in the asylum for almost thirteen years before a drawn-out physical illness ultimately led to her death in May 1915, Julia's notes are overshadowed by a sense of persisting and exaggerated time. Her case is one of what the Asylum's Medical Superintendent Dr Thomas Stansfield referred to as 'the hopeless chronic cases who make up the remaining 90%' of people in asylums once those with 'a prospect of recovery' have been discounted.[234] These 'poor unfortunate creatures' were frequently elderly and infirm cases who also made up significant proportions of the workhouse wards and whose cases were reduced to periodic recording of symptoms and management with diet, bed rest and occasional sedation.[235] As in Keay's case, a sense of time was unavoidably linked to clinical treatment and outcomes. For such patients, they were enduring time in the asylum space, which was not necessarily designed as a therapeutic one, geared towards patient recovery, but rather efforts were made to create 'a home where they may enjoy ordinary comforts and have their lives made as happy as their condition will admit of, at the

[234] Thomas E K Stansfield, "The Villa or Colony System for the Care and Treatment of Cases of Mental Disease," *JMS* 60, no. 248 (1914): 30.

[235] Ibid., 31.

least possible cost to the ratepayers.'[236] As such, Julia's case can reveal a great deal about how delusions and hallucinations had an impact on patients' experience of daily operations within the asylum, interactions with its staff, and the institutional space itself.

Psychosocial theorist Lisa Baraitser's *Enduring Time* is of help here.[237] Her work urges a reconsideration and defamiliarization of our relationship to time, particularly asking us to consider that change may occur 'in and through chronic time rather than merely through time passing.'[238] Baraitser draws out particular elongated temporalities, such as waiting, staying, and persisting, to recalibrate the ways in which we have come to associate time with something fundamentally linear, fleeting, and progressive. As a chronic patient, Julia's experiences in clinical time moved differently to other patients who passed in and out of the asylum space and whose notes tracked 'progress.' Case notes look at how time has passed, then situate the patient as they are now in that timeline, creating a superstructure. This timeline may not, however, be relevant to the patient themselves. If a patient is dealing with hallucinations and delusions at that moment in time, it is frequently irrelevant to them whether this was untrue a week previously. Embodied and lived time can be more urgent or, indeed, slow, for some than others.

Numerous theorists have explored this disconnected and uneasy lived temporality when considering trauma. Artist Clementine Morrigan wrote a compelling personal account of the ways in which she experiences time through her experiences of both queerness and trauma. She stated that

[236] Ibid.

[237] Lisa Baraitser, *Enduring Time*, Bloomsbury Collections (New York: Bloomsbury Academic, 2017).

[238] Kate Eichhorn, "Enduring Time by Lisa Baraitser," ed. Doris Allhutter et al., *Feminist Theory* 21, no. 4 (2020): 517.

> 'There is something very queer about the way I experience time. As a person living with complex trauma, I do not experience time as a straightforward, orderly procession from the past, through the present, to the future. The past rushes up on me with the urgency of the present. The future creeps out of crevices, leaking into the now. The future and past are intimately entwined, the present produced in their merging.'[239]

For Morrigan, this experience of temporality is unsettling and it is her embodied experience of trauma (in her case, child abuse) which queers time. She contends that 'trauma is what allows me to understand time as queer, as something which does not follow a straight trajectory.'[240] This deviation or queering of the 'straight' and linear normative progression of time happens when 'amnesia sucks up whole stories, leaving embodied feelings but no facts. Sections of time are uprooted and relocated into different chapters of my life.'[241] For her, this means that 'the present is disconnected, disoriented, unmapped.'[242]

Exploring patient stories in asylum casebooks involves a similar process of disorientation and queering. Morrigan's work self-consciously connects it to a disability theory or crip critique of queer theory and queer temporality, which argues that work on queer temporality has rarely directly considered people with disabilities. One such critique, from Ellen Samuels, contends that 'ill and suffering, marginalized and abjected, dependent

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[239] Clementine Morrigan, "Trauma Time: The Queer Temporalities of the Traumatized Mind," *Somatechnics* 7, no. 1 (2017): 50.

[240] Ibid., 53.

[241] Ibid., 50.

[242] Ibid.

and interdependent bodies [and who] often provide the most compelling examples of queer temporality are at once essential and unnamed, foregrounded and made invisible.'[243]
The patient's conception of time is slotted into that of the institution but operates at a disconnect from it. The casebook is how the patient's time or lived temporality is rendered readable, but it does not provide full access to it. It rather produces and shows the points of tension between these two lived experiences and uneasy structures in the clinical space. The extract with which this section began alluded to these frictions and moments of divergence.

Julia's insistence on her sense of time, as with her insistence on her own meaning for the sensations she experienced, marked her as insane. The tension between temporalities in the clinical space othered those who insisted on their own lived time. Just as with categories of experience such as consciousness, reason, mental action, or embodiment, clinicians and mental scientists engaged in conceptual manoeuvring designed to explore the boundaries of normativity and sane experience in a 'modern' Victorian, civilised and rational society. Time is one of these normative structures. In a paper published in *JMS*, psychological consultant to Crichton Institution and late Commissioner in Lunacy for Scotland, William Browne, discussed how 'our notion of Time' is connected to embodiment, mental action, and historical and cultural specificity. His article drew together a number of cases and broader social or medical 'phenomena' across what he perceived as the spectrum of human behaviour. He was principally interested in

> 'the power or process by means of which Time is mentally recognised and estimated independently of, or before, its external and artificial measurement'.[244]

[243] Ellen Samuels, "Cripping Anti-Futurity, or, If You Love Queer Theory so Much, Why Don't You Marry It?," *Annual Meeting of Society for Disability Studies, San Jose, California*, 2011, 15–18.

[244] William A F Browne, "The Perception, &c., of Time as a Feature in Mental Disease," *JMS* 19, no. 88 (1874): 519.

Studying 'the perception of Time in mental disease' was placed alongside its perception and measurement in physical disease or fever, history (as in 'our Celtic forefathers'), and the 'uncivilised races'. In this way, the writer consciously explored the limits or boundaries of Victorian society through a process of metaphysical and phenomenological othering. As modern society and 'civilisation' progressed, apparently so too did its understanding of time-keeping and a shareable lived time. This was true, both for the development of a literal watch on one's wrist and for an internal 'sense' of the passage of time connecting the self to the world and others. Other ways of *living* this time, put them outside of this civilised society which created a community based on how one thought as well as how one lived and acted.

For Browne, the perception of Time was not connected to any 'act of consciousness in noting the succession of mental states', nor was it the result of the 'regular succession of external impressions'.[245] Rather, it stems from the

> 'existence of a time-perceiving and time-regulating power, either created and conducted by some physico-psychical operation, or by intuitions similar to those which recognise the relations of number, &c.'[246]

These 'depend upon the integrity and activity of the whole, or of a part, of the nervous centres.'[247] His theorising therefore entangled the 'muscular sense' of the body and the mind's conceptual scaffolding or structuring. The answer to the complexities of phenomena observed in asylums lay somewhere between mind and body; the nervous system regulated and operated both the physical movement of the body which conveyed a sense of rhythm, and the mental operations upon which consciousness and self-awareness rested. In pathological

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[245] Ibid., 532.

[246] Ibid.

[247] Ibid.

states, then, the 'enfeeblement, or exaggeration, of this power [of time perception]; its morbid influence, either in compliance with, or in opposition to, volition, and as demonstrated in acts, habits, and muscular movements.'[248] The pathological disorientation and temporal disjuncture encountered in mental disease and the asylum were not conceptually distinct from the ways in which the insane body was discussed or seen. In both these records and contemporary theories of mental disease, the body was implicated in the experience, awareness of and construction of time.

The following sections will consider how the materiality of the casebook itself as well as its content demonstrates the ways in which this axis is constructed and how it produces itself. Like any narrative, clinical records have a beginning, a middle, and an end. Admissions documents are the beginning of the narrative; setting the scene for the story and introducing its characters. The reader sees what Julia looks like, both through a minute description of her physical appearance and a photograph of her (Figure 5). However, this photograph is situated immediately next to a notice of her death. In this way, the reader is told the end of the story before hearing the middle, or how it unfolds. The narrative is both linear and circular; consciously looped or folded back on itself. The historian encounters her in this moment as both alive and looking directly at them, and as deceased. To an extent, this is always true in the history of the distant past, as was discussed in the section on ethics. The emotional resonance of these histories and historical practice is undeniably altered by the fact that the historian's only relationship to their subject is through their textual remains. In this case, this is the clinical archive which reduces them to their patienthood. The time in which the historian is working shapes the access they are allowed and the ways in which they read the narrative.

[248] Ibid., 522.

Figure 4: Page showing medical certificate and admissions material for Julia R, 1902, photograph of BH CB, LMA.

Figure 5: Page showing photograph of patient and progress notes for Julia R, c.1902, Heath Asylum CB, LMA.

Beginning: admission

The first page encountered on opening Casebook 10 is an outline of the regulations governing the records kept therein as set by the Lunacy Act of 1845 (Figure 4). This regulation speaks to the ways in which knowledge about the patient was collected during interviews and the primary concerns which shaped both initial consultations as well as subsequent physician-patient interactions. Case notes are first and foremost institutional records. They are written by, or in the words of, physicians, follow a standard procedure and format, and are monitored by regulating parties. If we consider Julia's case within this institutional narrative frame, her admissions notes and medical certificate mark its beginning. From the form, we know that she weighs eight stone, has grey hair, marked furrows and lines of expression on her face, an 'alert' physiognomy, and old and small white scars on her forearm. Even before we see her admissions photo, a vivid image of Julia is established. In the context of nineteenth century physiognomy, phrenology, heredity, and an increasing interest in organic aetiology of mental disease, these incredibly detailed records reveal interest in explaining, quantifying, and controlling the perceived spread of insanity. Minute details are recorded from the physical examination and it is difficult to shake the consequent impression of an alarmingly intrusive exercise of power by the institution in order to render the patient's body as observable and recordable. Indeed, like many other patients following the widespread uptake in photographic practices of recording in asylums in the latter decades of the nineteenth century, Julia's notes include a photograph which appears uncomfortably similar to prison snapshots and had a crucial purpose in patient identification and recovery in the case of patient escapes.[249]

[249] Katherine Rawling, "Visualising Mental Illness: Gender, Medicine and Visual Media, c. 1850-1910" (PhD dissertation, Royal Holloway, University of London, 2011).

If these records are primarily written for and by the institution, can they really be used to reliably reconstruct patient experiences and narratives? Not as immediately obviously 'performed' as Norman's lectures, case notes are nonetheless the product of staging. Both the photograph and the admissions documents momentarily suspend Julia and her case in time and space. As Sally Swartz points out:

> 'Like photographs, patient histories purport to be a representation of factual reality. But like photographs, they select, foreground some events, render others invisible, and seek to enter the world of representation without authorial signature. Their fictional status lies partly in the sleight of hand which offers fragments as wholes, and partly in the disappearance of the hand which holds the pen.'[250]

Once more, case notes are fragmentary; first, in isolating an individual and making claims at generalisability, now offering fragments or snapshots of people's lives. They provide the illusion of totality and purport to be the patient's own story. Events are recorded if they are considered to constitute evidence of insanity or liability and patients' words are rarely directly recorded. Berkenkotter describes this as the 'double narrative' of case notes and points to a process whereby the patient's own account of personal experience is re-contextualised into 'a more encompassing narrative framework that has been highly codified within the psychiatric profession'.[251] However, rather than simply acknowledging the coercive power of the institution, recent work has looked to case-notes to illuminate the co-

[250] Sally Swartz, "Shrinking: A Postmodern Perspective on Psychiatric Case Histories," *South African Journal of Psychology* 26, no. 3 (1996): 150.

[251] Berkenkotter, *Patient Tales,* 2.

narration of patient histories and recognise them as highly variable and constructed documents through which doctor-patient interactions are refracted.[252]

Whilst these admissions documents certainly provide a documentary footprint of the ways in which people were transformed into patients and slotted into the categories of nineteenth-century medical science, closer consideration shows a revealing inconsistency in their application. Caution should also be exercised in reading admissions details in too Foucaultian a light. Whilst physical examination was frequently unwelcome, and records often show patients resisting this intrusion, many undoubtedly co-operated with the process in its entirety or with varying degrees of interest, compliance, or eagerness. Julia's admissions photograph, for instance, shows a seemingly willing engagement with the process. She looks directly at the camera with what appears to be curiosity, whilst many patients resist, cannot sit still long enough for the exposure time necessitated by the technology, or refuse altogether. Inclusion of seemingly standard elements of the file, such as the photo, is often determined by the patient's condition or agency. Ann Naomi Harris, another patient at the Heath Asylum and in the book just a few pages later, does not have a photo included in her notes. Detail from her medical certificate appears to provide a likely explanation: 'she states that "voices" speak to her through the wall calling her a whore and other foul names. She states it is done by Edisons Electrical Company who take photographs of her in bed &c.'[253] In a patient whose delusions and hallucinations feature photography as a danger or violation, the medical officers appear to have either deemed the process unnecessary or were unable to successfully capture her image. Case notes and their

[252] Hazel Morrison, "Conversing with the Psychiatrist: Patient Narratives within Glasgow's Royal Asylum, 1921-1929," *The Journal of Literature and Science* 6, no. 1 (2013): 18–37.

[253] CB 10 Female, 1902-1911, H65/B/10/034, BH, LMA, 35.

admissions documents record conversations and interactions between doctor and patient, are firmly situated in both a physical and social environment and can reveal a considerable amount about the intricacies and practicalities of asylum life. Being attentive to what is missing or invisible can be just as illuminating as what is materially or evidentially present. The ways in which experience is recorded, where, and by whom *matter*.

Whilst a diagnosis is generally recorded on admission, this is often amended at a later date, or shifts as time passes through the progress notes. Despite being recorded as suffering from Senile Delusional Melancholy, the instability of this general classification for patients such as Julia is highlighted in the immediate qualification that 'she is only slightly depressed however, the main feature in her case is the existence of numerous very fixed delusions associated with hallucinations of several senses.'[254] Indeed, just two years after this label is applied on admission her case notes refer to the more general 'Delusional Insanity' as her classification and there is little discussion of melancholia in the affective sense in her notes. This inconsistency within cases is far from an uncommon occurrence and testifies to the plasticity of diagnostic labelling in these case notes. Indeed, emotion is highly contested within asylum notes and represent diverse and malleable categories of experience or behaviour, especially when correlated uneasily with the broad categories of 'mania' and 'melancholia'. Unlike published case histories, the temporal range of the handwritten notes uncover changes in both patients' affective worlds and medical officers' interpretation of this, especially in relation to an unstable diagnosis. Later descriptions of Julia as 'fat, happy, fatuous and demented' jars uncomfortably with the entry less than a month previously relating that:

[254] CB 10 Female, 1902-1911, H65/B/10/034, BH, LMA, 11.

> 'she has well marked hallucinations of hearing & vision. "Telephony" is constantly upon her injuring her internally and enabling others to know all her thoughts, her mouth & throat are parched by "secrets". She is in impaired health from arterio sclerosis but is fairly nourished.'[255]

This does not sound like a 'happy' woman as we are familiar with the term.

It is somewhat difficult to piece together Julia's history prior to her admission. We know that, like many other patients at the Heath Asylum and other county asylums, she came to the institution from a workhouse. Not previously treated 'at any time or place', she came via the Female Insane Ward or Infirmary at St Pancras Workhouse before her arrival at the Heath Asylum and this is listed as both the chargeable Union and her previous known address. Little can be gleaned of her family history and living arrangements beyond this, as limited amounts of this section of the standardised form required by the Lunacy Act have been filled in. All we know of her family is that her notice of death was to be sent to her sister, Mrs Kezia Jane Humphrey at the Stanhope St Institute on Euston Road. However, how much contact Julia had with her prior to her admission is unclear, especially given that her sister's voice is conspicuously absent from the medical certificate, which is often based on the testimony of family members who have cared for the patient at home until this became impractical or their behaviour unmanageable. Instead, the 'facts communicated by others' to justify her admission for insanity are provided by the Superintendent of the Female Insane Ward at St Pancras, Sophy Bryant, who tells the admitting medical officer that Julia 'has delusions of detectives watching her and voices speaking to her through a telephone both in her room and more faintly in the world and that people were burning sulphur in her room to

[255] Ibid.

drive her out.'[256] Whilst this paucity of detail in recording history may be due to practical considerations of time or simple oversight, the record does indicate that Julia has 'no near relative insane' and family history was deemed irrelevant once heredity and intemperance had been adequately disqualified. Instead, Julia's state at that time represented a physical and mental degeneration precipitated by the death of her husband some time between four and five years ago. Rather than a case of hereditary insanity, this old woman's story was apparently categorised as belonging to the many thousands of cases in British asylums and workhouses in which an emotionally troubling event had precipitated and expedited their 'second childhood' and made it one fraught with the delusions and hallucinations of insanity.

Julia's account frequently highlights the divergent understandings of patients and practitioners regarding causality and (dis)ability. On her admission, she is recorded as having been deaf since the age of twenty. This state she attributes to police interference and the asylum itself, saying 'this is a place of torment, Things are on her face, ears &c. & make her deaf'.[257] This state evidently hampers her doctors' ability to communicate with her, and the case notes record the necessity of shouting in order to interact with her in interviews. However, despite this impaired hearing, Julia's hallucinations are predominantly auditory: 'She is suffering from Delusional Insanity. Auditory hallucinations are a prominent feature and she believes she is persecuted by things constantly said to her through the telephone.'[258] This seeming-conundrum of her case calls attention to crucial contemporary debates regarding the nature and cause of hallucinations involving the 'distance' senses of hearing and sight. Numerous cases were published and discussed in monographs and journals in

[256] Ibid.

[257] Ibid.

[258] Ibid.

which, like Julia's, the 'peripheral' sensory organs were impaired and hallucinations of this sense were marked.[259]

Whilst the recording officer initially stated that this was her first attack and has lasted three weeks prior to her admission, a later interview noting 'mental state' associated her insanity with Julia having 'been a widow of 4 years', prior to which she had enjoyed good health. Julia herself freely associates her current situation with this life event, albeit through a different filter to her doctor. She stated that whilst she 'cannot fix when her annoyances began either before or after her husbands [sic] death' they 'have existed over three years "and probably some time before she felt them".'[260] This phraseology reveals the dichotomous approaches to the experiences described between doctor and patient. Although clearly medically categorised and dismissed as prominent hallucinations, delusions and illusions (filling every category of anomalous perception in the textbook), Julia clearly situated her persecution, which she termed 'annoyances', in an objective external reality. They had been acting on her for some time as an insidious and invisible force and, for her, her perception of them in the previous few years was only part of the story.

Middle: 'progress of case'

Following the admissions material, casebooks included a more free-form section for asylum staff to record clinically relevant information on the case over the patient's stay in the asylum. At the Heath Asylum, this section constituted a number of blank pages, with a

[259] For instance, see Conolly Norman, "Notes on Hallucinations. I.," *JMS* 48, no. 200 (1902): 45–53; William H B Stoddart, "The Psychology of Hallucination," *JMS* 50, no. 211 (1904): 633–51.

[260] CB 10 Female, 1902-1911, H65/B/10/034, BH, LMA, 11.

margin running along the left, entitled ‘progress of case’. This label alone speaks to the construction of a linear narrative in these documents. Patients ‘progress’ over time through these notes; deteriorating, improving, or persisting, marked at intervals. Julia’s notes, for practical reasons, spilled across her standard allotted number of pages, with ‘continued’ sections sandwiched in between other patients’ records. Given she was a chronically insane patient, resident in the asylum for a protracted period, this was far from unusual. Similarly, patients who were discharged ‘recovered’ from the asylum, and subsequently returned, reappear across multiple pages and casebooks. In Julia’s case, her progress notes were frequently squeezed into spare paper through Casebook 10, making ‘finding’ her and sequencing the story a material practice as well as a conceptual one.

Casebooks are not just texts or documents. Carol Berkenkotter argues that ‘asylum casebooks with their patient histories and progress notes are in many ways like pottery shards and other artefacts of earlier cultures’.[261] This is an illuminating comparison to make. In the discussion of ‘the archive’ as a concept and foundation stone of historical enquiry it can be too easy to forget that it is also a place; its contents physical ‘things’. They have a physical history as well as historical content. In being leather-bound and presented as a book, they achieve an illusory differentiation from the image of archival primary sources; bestowed with an authority and seeming-fixity little associated with loose sheets and documents collected in boxes to be re-made by the investigative historian. Our understanding of a book or text endows them with a stability which their closer consideration undermines.

[261] Berkenkotter, *Patient Tales*, 71.

From a material and archival perspective, what was included in the book varies hugely between patients. Whilst many patients wrote letters to family members, friends, the asylum superintendent, or even public figures featuring in their delusions, these are only occasionally affixed to the casebook itself and thus preserved. Studies considering these documents, such as Allan Beveridge's paper on the letters written at Morningside asylum, demonstrate their richness as a less mediated source of the patient's voice in the first person.[262] However, this is not an unproblematic form of direct access. Case-note entries might carefully select what will be recorded and reframe or re-word, but letters are similarly carefully curated insights into patient narrative. Julia is recorded as having written a letter in a progress note: 'remains actively hallucinated. Wrote a letter yesterday stating she was "tortured day & night".'[263] This is, however, conspicuously absent from the book despite being referred to, having either been omitted as an administrative or medical choice or lost in its physical archival history. In the context of her physicians' identification of 'delusions of persecution' and the next note states that Julia 'is here "as an injured woman and must be paid for"',[264] so while we are not told who the letter was intended for or further detail on content, it is reasonable to assume it was an appeal for her release, the cessation of her tortures, and a way to bargain with her captors or persecutors.

When letters are included, they are not always the original documents. Another patient, Ann Naomi Harris, wrote a letter to the asylum's Superintendent Stansfield in September 1902 which was clearly considered important enough to the illumination of her

[262] Allan Beveridge, "Life in the Asylum: Patients' Letters from Morningside, 1873-1908," *History of Psychiatry* 9, no. 36 (1998): 431–69.

[263] CB 10 Female, 1902-1911, H65/B/10/034, BH, LMA, 16.

[264] Ibid.

case as to be preserved. However, consideration of the handwriting reveals that it was likely transcribed by the same author as wrote the case notes themselves. Many patient letters are near-illegible reminders of the physical challenges and emotional distress experienced by patients and were included because patient handwriting was often seen as diagnostically important. A lengthy entry with examples was included on the subject in Daniel Hack Tuke's *Dictionary of Psychological Medicine* in 1892.[265] However, this transcription points to the importance of their contents as well as form. Ann Naomi Harris appealed directly to Stansfield, recognising his authority and power over her case, attempting to draw his attention to her situation, she was unwilling to be lost in the crowd of patients or the casebook: 'I feel it my duty to ask you if you are aware of the treatment I am receiving in A2 ward'.[266] Superintendents had administrative as well as medical functions and patients mostly came into contact with more junior medical officers; Stansfield's signature is rarely found authorising the regular progress notes. She told him; 'I have been here three months and have been tortured day and night by the cemergraph all day in the day room continual and most filthy accusations and charges made against me this state of things'.[267]

Letters therefore often point to attempts at bargaining and an awareness of asylum or broader social structures through which patients might regain some control over their situation. An article in *JMS*, written by Medical Superintendent at Garlands Asylum, J. Campbell, referenced a patient who apparently made complaints 'as part of [his] disease'.[268]

[265] George H Savage, "Handwriting of the Insane," in *A Dictionary of Psychological Medicine: Giving the Definition, Etymology and Synonyms of the Terms Used in Medical Psychology, with the Symptoms, Treatment and Pathology of Insanity and the Law of Lunacy in Great Britain and Ireland*, ed. Daniel Hack Tuke (London: Churchill, 1892), 568–74.

[266] CB 10 Female, 1902-1911, H65/B/10/034, BH, LMA, 35.

[267] Ibid.

[268] John A Campbell, "Complaints by Insane Patients," *JMS* 27, no. 119 (1881): 348.

Formerly a railway guard, the patient was described by Campbell as 'fairly educated, plausible, and well mannered when he chose'.[269] Campbell described, that he nonetheless

> 'took an active interest in all that went on, kept what he called "Tallies" of every one, and everything, wrote voluminous letters to the Visiting Committee, reported the attendants to the head attendant, the Justices at their visits to the wards. Wrote fairly sensible letters to the Commissioners in Lunacy, and occasionally wrote about the two latter bodies to the Lord Chancellor and the Home Secretary.'[270]

This patient indicated, through these complaints, a remarkably comprehensive awareness of the formal organisational or legal, as well as social, structures which governed and monitored such institutions and systems. Such forms of resistance and appeal were, however, monitored and classified by asylum staff and reframed in light of disorder, accumulating diagnostic importance. An appeal to the King or a government official would point to the persistence of delusional beliefs of grandeur or monomania in a patient; working alongside note entries which record patients' lack of progress or recovery who continue to demonstrate and defend firmly held delusions. Surviving letters can also uncover how relationships were negotiated between patients and doctors as well as maintained with family and friends outside the asylum, as Louise Wannell has discussed.[271]

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[269] Ibid.

[270] Ibid.

[271] Louise Wannell, "Patients' Relatives and Psychiatric Doctors: Letter Writing in the York Retreat 1875-1910," *Social History of Medicine* 20, no. 2 (2007): 297–313.

Whilst increasing interest in digitising historical sources makes them easier to access, their materiality remains a crucial part of the story.[272] The sheer physicality and *thingness* of the books in which Julia's notes are encased is vital. Tangibly different to the individually typed sheets of Norman's lectures, Female Casebook 10 is large, heavy and leather-bound. It is an official document designed for durability and comprehensive, formal data or record-keeping. The considerable effort and strength it takes to carry, move and leaf through the book is a heavily embodied reminder of the process by which case notes were recorded. Whilst Norman's transcriber would have been sat in the room, recording the conversation between physician and patient 'as it happened', casebooks operate at a temporal disjuncture. Whilst it is likely that some form of note-taking practice was engaged in by the physician conducting patient interviews during or immediately following the conversation, the leather-bound final copies were far too large and impractical to be used in the room during these interactions. Whilst each entry was signed by a medical officer and that a host of different members of staff came into contact with patients such as Julia, the handwriting is consistent throughout the casebook, pointing to a transcription process following the interview. This would have been an intensely laborious process given the sheer number of patients residing in the asylum at any one time.

Focusing on Julia herself, how did she live in this environment? How did the asylum and her own illness shape the fabric of her daily life? We are told that prior to her husband's death and subsequent troubles she was a needlewoman, and her admission to the workhouse may have partially resulted from her inability to continue in this occupation when she began

[272] For a critically engaged and theoretical look at broader digitisation trends in archives and historical collections, see Jenny Newell, "Old Objects, New Media: Historical Collections, Digitization and Affect," *Journal of Material Culture* 17, no. 3 (2012): 287–306.

to believe she was being followed to and from her work.[273] Within the asylum, this background proved useful and may have provided some sense of familiarity when her initial refusal to engage in the moral therapy of the asylum through work was replaced with compliance. Her notes explain that initially the "telephony" of her hallucinations and delusions prevents her from working and she 'cannot be induced to employ herself',[274] thereby providing a significant obstacle to effective integration into asylum life and co-operation with the corrective regime. This refusal, however, came without the violent and physically recalcitrant behaviour often expected by asylum staff: 'she is unemployed but gives no trouble.'[275] However, from September 1902 she was 'employing herself industriously in the ward' and by November she was at work in the Needleroom.[276] Whilst Julia's particular feelings on this change were not included, many patients found resuming such domestic or work activities to foster a sense of connection with a time and identity outside of the institution, although there were considerable debates and protests around the lack of pay for this labour.[277] It also allowed the asylum to move towards a narrative of 'return' or the reassertion of productivity and use or purpose; using the past in the present, to serve the future.

As total institutions and microcosms of a wider society or domestic space, daily management in the asylum frequently included negotiating the physical health concerns of patients (this will be more fully explored in the final section). Julia, unlike many other

[273] CB 10 Female, 1902-1911, H65/B/10/034, BH, LMA, 11.

[274] Ibid.

[275] Ibid.

[276] Ibid.

[277] Charles Mercier, "The Payment of Asylum Patients for Their Work," *JMS* 39, no. 164 (1893): 45–50; "Payment for Work Done in Asylums," *JMS* 23, no. 104 (1878): 572–73.

hallucinated and deluded patients, did not present the attendants with trouble eating (she does appear to have believed her food to be poisoned, but this was rarely commented on), there is no record of her being fed by nasal tube, and no evidence of any attempt to deliberately harm herself. However, she had considerable difficulty sleeping and often required transfer to wards for constant night-time observation. She was 'very restless' at nights, attempting, on at least one occasion, 'to get into other beds saying there was death in her own.'[278] Her delusions of persecution and hallucinations prevented her from sleeping and she was described on admission as an insomniac. She believed the police 'come close to her at night, and make faces at her', she 'hears telephones going all night', and 'sees blue lights flashing before her eyes at night & is kept from sleeping day & night.'[279] This condition only worsened throughout her stay at the asylum and was framed by the patient herself as some form of torture, which she communicated to her doctors as if in a plea for assistance and benevolent intervention in an environment in which constant supervision was expected. The medical officer reported that 'she is hallucinated, deluded, tormented & persecuted. They make her get up at night'.[280]

It is at times impossible to fully disentangle Julia's experiences of somatic ill-health from her mental pathology. Indeed, to do so would grossly underestimate both the importance these corporeal experiences had on Julia's being-in-the-world and the difficulties they presented for her management and the understanding of her mental condition. Whilst details are included in the case notes about Julia's physical health, these are not necessarily explained in connection to her mental state or 'symptoms' as they are in Norman's lectures,

[278] CB 10 Female, 1902-1911, H65/B/10/034, BH, LMA, 11.

[279] Ibid.

[280] Ibid., 15.

thereby shifting a more significant burden of 'interpretation' onto me as a historian. Many of her delusions and hallucinations centred on perceived anomalous sensations of her own body. Even the onset of her decline intertwined physical and mental health: 'history says that her reason began to go 5 years ago thro' death of her husband then informant relates cough and night sweats, has spat blood and lost weight'.[281] It is unclear from the history whether the 'informant' here was Julia herself, but her physical decline was liberally narrated by both her and the asylum staff throughout her case, albeit through very different lenses and dichotomous understandings of body, causality and implication. Repeated physical examinations are hinted at throughout, and vivid narrative description of her hallucinations and delusions are interlarded with highly medicalised language detailing her gradually worsening condition.

For the asylum staff, it is undoubtable that Julia is contending with significant physical illness. However, medical officers consistently struggled to distinguish supposedly fabricated, attention-seeking or delusory physical sensations from this very verbose and insistent patient from accurate self-reporting. Julia was very vocal and keen to detail her many complaints to her doctors, but this appears to have contribute to a somewhat resistive rather than co-operative relationship reflected in the co-narrated record. The language Julia used represents an entirely different imagining of her bodily symptoms and are highly emotional and combative in their framing. This appears to have presented an obstacle to the medical officers' empathetic and cognitive engagement with her reports. Relatively early in her stay at the asylum in November 1903, medical officer F.G. Gibson recorded that 'she is full of hypochondriacal complaints, pains in her head, shortness of breath, lumps in her

[281] Ibid., 11.

throat' and yet determined by examination that she has 'a few bronchitic signs in chest'.[282] These bursting lumps had been reported by Julia since August of the same year, but were not at all commented on in the frame of somatic health until they develop into an attack of bronchitis in February 1904 and she was transferred to the Infirmary. Throughout her case Julia reported sensations of breathlessness and 'bursting', integrating them into her wider narratives of persecution by the police and other external malignant forces. These were rarely pursued.

As her physical health declined, her protestations and narration of her symptoms became more urgent and detailed; included with some regularity and depth in her notes. In November 1906 she tells her doctors that they have now 'put something in her face to cause it to swell', in March 1907 'she is short of breath, has something over her mouth she says'.[283] In July the following year 'they have taken her bearing away & injured her eyesight' and a few months later 'they make her get up out of bed & force her water from her they also make her mouth bleed in the morning, she is also blown up & thinks she is to be burst'.[284] In 1909, 'she attributes her deafness to her ovarian tumour, flaccid breasts etc to malignant agencies, she is in impaired health on account of the ovarian cyst which however has not changed much in the last few months', 'her breath has been shrivelled up & her abdomen blown out by "them"', a telephone and a telescope 'turn her inside out' and 'she is tormented, blown up, powders are constantly put in her mouth, electricity is applied to her etc, she is very garrulous on the subject of her persecutions.'[285] When her face became paralysed, 'she will not believe

[282] Ibid.

[283] CB 10 Female, 1902-1911, H65/B/10/034, BH, LMA, 15.

[284] Ibid.

[285] Ibid., 16.

that the “police” were not the cause of it & says it feels as if a “knot” is there & wants cutting out.’[286] It is difficult to tell whether these details were included in the case-notes because they provided the doctors with encoded clues as to the progress of her illness as her tumor grew and her ovarian cyst caused more and more problems, or whether Julia was simply discussing these sensations more frequently and insistently. Regardless, they provide us with significant insight into how Julia’s affective and physical world was filtered through her delusions and hallucination, as well as the problems and potential insights these presented for the asylum staff.

Clinical staff were not the only people involved in practices of record-keeping, interpreting, and insisting on meaning. The medical officers recorded that Julia ‘has a list of the things she sees & hears’.[287] The relationship between doctor and patient was evidently not entirely resistive and confrontational: whilst Julia was unhappy at her confinement, she repeatedly stated that she wished the telephony to be removed in order to precipitate her release. Like the patient letters discussed earlier, this goal-oriented approach suggests something of a co-operative relationship with the asylum staff further evidenced by her regular communication of her ‘story’ during interviews and this list might constitute a strategy employed to affect this end. However, the inability for the physicians to either hear her or stop these persecutions and annoyances appears to have established a confrontational relationship at times between patient and medical staff, as her frustration comes through the case notes and the language of the medical officer speaks to her forceful insistence on being heard. She was described as having ‘no insight into her condition’ and ‘vehemently declares

[286] Ibid., 15.

[287] Ibid.

her intention to take further proceedings.'[288] She 'declares she ought to be home & the injury done to her paid for', later insisting that 'the king ought to be told about it.'[289] Whilst Foucault pointed to case notes as demonstrating a medical 'power of writing' with the power to transform patients into 'describable, analysable object[s]', responsible in large part for the cementing of the clinical gaze, he also suggested that this process can reveal a considerable amount about the construction of patient identities and subjectivity through the exercise of power within broader social structures.[290] To an extent, this holds true, as patients' identities, like their case notes were frequently defined within or in opposition to their patient-hood and status within the clinical space and encounter. However, when we consider cases such as Julia's a more nuanced and less dogmatic approach ought to be taken. Far from a 'docile' body, moments intrude into and disrupt the case notes in which she instead co-opts the power of the asylum for her own ends and attempts to negotiate with her doctors for both her treatment and release.

End: deterioration and death

Towards the end of her case, Julia's voice is almost entirely occluded from her case notes. Instead, the language used becomes increasingly medicalised and less rich in narrative detail. We are regularly told her temperature, measurements of her physical lesions, and a range of observable physical markers of disease, but these began to overshadow her own interpretations of these sensations. Her ability to communicate seems to have been severely compromised by her worsening physical health, although it is difficult to tell whether she was

[288] Ibid.

[289] Ibid.

[290] Michel Foucault, trans. Alan Sheridan, *Discipline and Punish* (London: Sheridan Books, 1977), 189-94.

unable to do so or whether this narrative strand was simply not deemed crucial in light of this declining condition. The Medical Officer recorded that her abdomen required regular tapping and draining (twenty six pints are drained from her in November 1914 alone), 'her bowels never act', she was plagued by 'vomiting attacks' and was unable to retain adequate nourishment.[291] Wasting away under constant observation and medical care, Julia became both more manageable and her protestations easier to ignore. The writer of her notes documented, that

> 'while she is quieter now her physical condition overshadowing her mental condition. She remains hallucinated & deluded & enquires "why these people are allowed to pull her inside about". She attributes all her physical troubles to persecutory delusions.'[292]

Julia continued to insist on her own interpretation of physical sensations, her words even being quoted, but this inclusion appears a courtesy to an ill old woman who her doctors knew would be unlikely to last much longer (they deemed her too unwell for an operation.) Her physical condition rendered her a pathetic object of sympathy and rather than 'garrulous' or 'indignant', her medical officers referred to her with a tone of pity: 'this poor old woman is continually asking for more meat. She is getting much thinner and her chronic bronchitis is giving her a lot of trouble.'[293] A voice which had been so forceful a presence, even filtered through layers of medical and bureaucratic curation, gets smaller and harder to hear.

Throughout her notes, Julia's interactions with the medical staff at the Heath Asylum point to a case of an indignant and incredulous elderly woman who felt like she had to

[291] CB 10 Female, 1902-1911, H65/B/10/034, BH, LMA, 47.

[292] Ibid.

[293] Ibid.

repeatedly narrate her tale of injustice and persecution by a half-seen malignant police force, yet received little understanding and no help from the persons and institution supposedly established to provide refuge. One of the most curious claims she makes is that these interferences have taken away her voice and she was unable to speak; a claim that her doctor views with some evident amusement and describes her as 'a very deaf indignant and verbose woman'.[294] Julia is quoted directly in an entry highlighting the tension between doctor and patient in case-note reporting, which reads,

> '"Mine is an injury case by the police, putting that telephone on me & drawing my secrets out" she tells her systematised story of persecution, the police followed her about, experimented on her &c &c her tale is long & rambling & ever on the tip of her tongue.'[295]

Whilst patients are often quoted in case-notes, this example in Julia's case is rare. Her comment on having her insides pulled about is considerably more typical of the reframing process in which the medical officer or transcriber took the patient's words, grammatically framed them within the punctuation of a direct quotation, and yet transformed the statement from the first person to third person: instead of '"pull my inside about"', the note records 'her inside.' However, when discussing her 'injury case', Julia's words were personalised and conspicuously absent of this process. This is also the most direct reference to Julia's delusions and speech as a 'story' she insisted on telling. Her doctors were aware of the centrality of this 'story' to her identity and situation in the asylum. To her doctors, Julia's account was a 'story' in the way one might tell a fairy tale. It was fictional and based on a malfunction or degradation of 'reason'; her admissions notes specifically identify that her

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[294] Ibid., 15.

[295] Ibid.

'reasoning power is perverted.'[296] Her case provides a rich source testifying to the intense importance both Julia and the medical staff placed on these hallucinatory and delusory experiences in furnishing her physical, mental, and affective world, as well as providing repeated barriers to effective communication and empathy.

This chapter has centred on the case, and the asylum casebook specifically, in order to anchor and orientate 'experience' to both clinical and lived or subjective time. Julia's life and death in the asylum reaches us through multiple layers. I have emphasised, through this case, the importance of sensitivity to and awareness of the ways in which experience was communicated, interpreted, organised, and recorded, rather than asking how we might 'find' Julia's voice and experience without the interference and filtering of the institution or physician. Considering the particular silences, omissions, and layers of different ways of preserving the clinical encounter can illuminate, not just how patients told their own stories, but how they were negotiated, co-produced and translated intersubjectively and across diverse forms and physical or conceptual spaces.

Whilst differently situated, structured and recorded, Norman's lectures nonetheless present patients in cases. Interactions are generally contextualised according to perceived pertinent features of their case or background. Pencil annotations periodically refer to Richmond's records and names are occasionally added to ensure the physician could refer to the patient's complete history. Similarly, some patients who appeared in Norman's lectures appear in his published writings. The conventions, form, and adaptability of the case facilitated the movement of people and experiences moved across genres and spaces. In the

[296] Ibid., 11.

lectures themselves, case notes as documentary ‘memory’ informed the questions Norman asked and the ways in which he interacted with patients. They inflected the language used in the lecture and the warnings he gave to students.

Who the historian ‘meets’ through these lectures is specifically curated. Norman acknowledged this framing practice and the ways in which it impacted on the clinical exchanges they witnessed, saying,

> ‘you may sometimes be misled in endeavouring to closely imitate my methods of dealing with patients. When I bring a patient in here it is generally, - not always, - a case I know well: whose notes I am familiar with: and I can go straight to the point in a manner you will not be able to do when you are examining a patient in private practice’.[297]

These lectures in some ways present the ordinary in the movements, conversations and experiences they make visible. In another sense, they are exceptional and unusual. Norman discussed features of cases which had changed over time, and when patients reappear in lectures, he emphasised what may have changed or persisted, either in the case as a ‘whole’ or between that day and the prior lecture. However, as can be seen in the tense interaction with which this section started, Norman’s use of case notes in these conversations could undermine patients’ own narratives, especially as they shifted over time.

[297] Series 2, Lecture 10, 26 March 1906, ACC/2017/2, CN/2/10, CNL, RCPI.

How information and experience was recorded and used mattered. Its materiality was significant. Following Norman's interview of his patient, Letitia G., who will be discussed in Chapter 5, he drew attention to a significant and telling mistake:

> 'In examining this woman you will notice that I very often referred to a printed paper. That is a note of the case I have made. I thought I remembered her case better than I did. I wanted to lead her in the direction that her mind was tampered with, but she would not be led. I now find that it is not in my notes as all.'[298]

Clinical notes were a form of insulating clinical knowledge against time and structuring memory. This does not mean that they were not permeable, layered, partial, and *fallible* stories. This chapter has explored what the assumption that case notes were 'never wrong' *did* and whether this was actually the case in clinical practice itself. It has thought about how case notes as documents, forms and multi-layered narratives sought to stabilise the stories and bodies of the asylum in particular ways, making them monitorable, recordable, and measurable. This chapter has considered the institutional stories and records which lay behind Norman's lectures rather than viewing them as entirely separate. Given their function as pedagogical instruction, Norman also spent significant time in his lectures on the key features of case notes through which this was achieved, such as the certificates of lunacy, and discussing with students how to *translate* experience into these devices and forms; how to turn people into patients.

When we write medical or psychiatric histories, even when writing them 'from below' with a socially engaged perspective, history can quickly lose sight of patients as

[298] Series 1, Lecture 14, 4 April 1905, ACC/2017/2, CN/1/14, CNL, RCPI.

people. The very act of calling someone a ‘patient’, although largely unavoidable, marks them out as belonging to her medical care and institution. Their identity is defined within these limits and through this lens. Patients’ lives before their admission to the asylum profoundly shaped not only their experience of asylum life and physician interactions, but also the meaning they made of their delusions and hallucinations. Symptoms such as hallucination and delusion are not stable markers of an asocial, disembodied disorder. Viewing them as such renders the patient simply a carrier for a universal and ahistorical pathology: at best a ‘typical’ or ‘atypical’ presentation of the disease (which takes the places of both subject and object over the person herself, at worst simply an irrelevance. Taking a closer look and shifting the scale to consider the ways in which cases as narratives were framed and structured illuminates the ways in which meaning and significance was established and negotiated across people and within the discursive and physical space of mental science. Whose story is it and how is it told?

Considering ‘the case’ in this way crucially allows one to think about the different *ways of knowing* and *ways of telling* running through contemporary medicine and mental science. The central binary already introduced in this section; that of scientific knowledge and lived experience, is in itself fraught at its core. The degree to which conclusions and knowledge could be based on ultimately subjective and fallible human experience is a question which informed much of the discussion within the scientific community itself as well as in conversation with patients. Did grouping together cases and sharing observations across asylums, countries, and professional networks lend authenticity to claims and theories, or could only a move to statistics and organic, testable theories for the aetiology of insanity be relied upon? If they could not be proven beyond personal and professional experience, could both physicians’ or patients’ theories about the body and mind inform understanding or

indeed be named as truth? What separated the physician's truth claim from his patient's if, ultimately, both were based on the senses and systems of knowledge about the body?

Encountering the body (in the world)

‘Now, to return to our rigmarole, what indications of insanity did she exhibit?... She sat in the most uncomfortable way she could. She was too wicked to be comfortable. She could not meet the conditions of her environment, and so she sat like a poker on the edge of the chair. She may have been embarrassed at the sight of so many intelligent young men looking at her, - but I don’t think she was. Having once sat down her attitude remained singularly fixed, yet some of you may have noticed that although she looked very wooden there was a slight rocking movement backwards and forwards. It was very slight but curiously rhythmical. She kept up a slight rhythmical movement all the time she was with us. Her hands remained something in this posture, - (Illustration) – with little or no movement.’[299]

[299] Series 3, Lecture 2, 4 March 1907, ACC/2017/2, CN/3/1, CNL, RCPI.

Chapter 3: Movement

Norman's lectures *show us bodies.* Translated into text, these lectures read as a script and my experience of reading them began to slip into seeing or imagining, with discomforting effects. Familiar with both the textual case note format discussed in the previous section and having spent time with the photographic records of asylum patients like Julia, the way of seeing bodies these sources presented me with was unfamiliar and felt particularly voyeuristic. The lectures are peculiarly intimate sources, but it was not only Norman who displayed bodies and staged the performance of insanity. On reading Norman's 'rigmarole' about the patient who rocked back and forth on her chair and apparently thought herself 'too wicked to be comfortable', I recalled both an image of Charcot demonstrating hysteria in a hypnotised patient at the Salpêtrière (Figure 6), and an article on 'Insane Movements and Obsession.' Published just two years after Norman gave his lecture, Lougheed Baskin, Medical Superintendent to Fisherton House asked his students, 'now, gentlemen, what are these [insane] movements? What do they mean?'[300]

Figure 6: A. Lurat after P.A.A. Brouillet, Jean-Martin Charcot demonstrating hysteria in a hypnotised patient at the Salpêtrière. 1888, etching.

[300] Joseph Lougheed Baskin, "Insane Movements and Obsession," *JMS* 55, no. 230 (1909): 501.

In all three of these sources, a woman deemed insane and in distress was displayed before an audience of (predominantly) male medical students for the purposes of demonstration and clinical education. If insanity was of the mind, and hallucination and delusion detectable primarily by *talking to* the patient, what purpose did such displays of bodies serve? In the *Journal of Mental Science,* Baskin lamented that 'the progress of research has had more difficulties to contend with in the subject of mind than in almost any other. It is a subject which is intangible, yet its reactions can be timed. It is unseen, yet its force can manifest itself in various ways through various channels'[301] In attempting to differentiate itself from the broader practice of medicine, mental science met with numerous conceptual and practical obstacles. In so many ways ephemeral, invisible, and intangible, the mind could not be directly looked at, but with so many patients in the closed and controlled space of the asylum, the body could. As such, the study of the mind involved understanding its relationship to the self and body. Translating this body into a 'readable', shareable and preservable form was, however, a complicated process which took place in different ways across multiple technologies and mediums. This section will explore how movement and the surface of the body was thought about, seen, and measured, mapped, or recorded, in order to gain access to and insight into the mind, or, interaction of mental and physical self. Prior to and during the advent of 'organic psychology' and 'evidence-based therapies', in what ways did 'insanity' put the body in the frame in ways present day 'mental health' does not?

This chapter therefore asks a series of questions inspired by these moments and places where insane bodies *appear*. These questions begin with; why do bodies matter, or, why is

[301] Ibid.

embodiment important? Then, what made a body and movement insane? How can we *see* movement and the body; how does technology inflect and shape the meaning made of the body or the ways in which it is seen? Finally, through the case of a man who described himself to Norman as an 'automatic lunatic', how did delusion and hallucination challenge the boundaries and medical explanations of the body? Are the medical and personal systems and explanations for what governed and controlled these movements, or mediated between the physical and mental or emotional self entirely separate?

These questions are asked by those for whom access to the bodies and minds studied can never be lived and subjective; for those whose understanding of the bodies of the asylum is always that of the Other. They are questions I ask myself as a historian, but they are also questions being asked by mental scientists and asylum superintendents who witnessed and observed insanity in insane spaces. These two perspectives are woven together, with the common thread; what does it mean to look at and try to understand the body of another from the outside?

Why do bodies matter?

> 'We are well acquainted with such terms as insane acts, insane expression, insane language, insane conduct, and insane movements. There will be no doubt from what may be learned from these movements that they are insane… Now, gentlemen, what are these movements? What do they mean? How can we explain them? Are they very common? Are they prejudicial to the patient's life? How can such cases be treated? These are questions which naturally occur to the physician when they are brought

> under his notice. Let us examine the mental condition of the patient, and then we shall be in a better position to understand the movements.'[302]

In his article, Baskin saw and treated 'insane movement' as a conceptually distinct category or phenomenon. He clearly demarcated and justified its use and importance in the study of insanity. Such focus on the body and its movements sits awkwardly with current clinical understandings and diagnostic systems, emphasising the ways in which the entanglement of body and mind in medical or diagnostic systems has shifted. When discussing insanity and what we currently term *mental* health, why are we also discussing the body? What does limb movement have to do with paranoid delusions? Baskin, however, spoke with assurance that the two went hand in hand, although their particular consideration and study frequently prompted more questions than answers. We can never truly gain access to the body and mind of another in the subjective and lived sense. The body can be seen, talked about, and imagined, but it cannot be fully and phenomenologically shared in all its complexity. This does not, however, mean that the body does not matter. Movements could be looked at to investigate the mind, and, as here, the mental condition of a patient might situate and give meaning to or explain their movements.

The remaining two sections deconstruct, destabilise and blur the distinction between mind and body, whilst also asking what work mental science and broader social contemporary cultures were doing to stabilise the material and discursive boundaries of the body or to tie together body and mind. Whilst the previous section looked primarily at accessing experience through verbal communication and its documentary footprint, this section considers how to access the moving, breathing, living, and feeling body of the

[302] Baskin, "Insane Movements and Obsession," 501.

asylum. However, this process of re-embodying involves a fundamental reconfiguration and queering of our understanding of what it means to have a body and the possibilities this entails with regard to movement, sensation, and *being in the world,* whether social or physical.

The relationship between madness and disability is complex and contested, especially in light of recent Mad Activism, as Mohammed Rashed has particularly explored.[303] Many people with lived experience reject labels of 'illness' or 'disorder' which have generally aligned discussions on madness and insanity with disability theory by arguing that madness is inherently disabling and therefore cannot form the basis of culture and identity for the subject. Instead, activists contend that 'mad' can instead be an empowering identity and urge mad-positive approaches or Mad Pride. For the purposes of this research, however, a flexible approach is taken to queer and disability theory which does not necessarily label and engage more broadly with social identity, but rather is sensitive to the phenomenological complexities of othered bodies and the immediacies of particular bodily experiences which have an impact on how one engages with oneself and the world. I work with disability as a concept in these cases principally because patients themselves identified a sense of bodily alienation, disruption, transformation, and difficulty.

In her essay on queer and crip embodiment in activism, Eli Clare urged that there is a very real and imminent danger of forgetting, ignoring, or reframing bodies in the process of uncovering and challenging systems and discourses of oppression. Like Hedva, she urges a

[303] Mohammed A Rashed, "In Defense of Madness: The Problem of Disability," *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine* 44, no. 2 (2019): 150–74.

radical re-embodiment of theory and understanding of disability and queerness. She argues that,

> 'I want to write about the body, not as a metaphor, symbol, or representation, but simply as the body. To write about my body, our bodies, in all their messy, complicated realities. I want words shaped by my slurring tongue, shaky hands, almost steady breath… Words shaped by how my body—and I certainly mean to include the mind as part of the body—moves through the world.'[304]

This chapter (and the thesis as a whole) looks at shaking hands, fidgeting fingers, whirring arms, frozen necks, and dribbling mouths. It doesn't look to these experiences and phenomena in order to render them an imagined spectacle (although this is indeed a danger which will be discussed in the contemporary context), but rather to expose the ways in which these experiences were central to, rather than a by-product of, what insanity meant and how it felt to be insane in an asylum. It also looks at bodies which, to the observer or Other, worked as they apparently should, but to the person with that body, felt *wrong*. The movement, action, and lived reality of the body (in the period considered by this thesis and beyond) was integrated into discourses and practices of marginalisation, pathologisation and stigmatisation, but this is not to say that in order to understand or move against these currents the body must be ignored. Instead, this chapter looks to the processes and practices of understanding and meaning-making which occur with, through, and around bodies which fail or refuse to function or tell stories 'as they should'.

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[304] Eli Clare, "Stolen Bodies, Reclaimed Bodies: Disability and Queerness," *Public Culture* 13, no. 3 (2001): 359.

Cultural and literary historian of medicine Sander L Gilman asked the apparently straightforward question in a 1983 article on the use of the term 'bizarre' in twentieth-century approaches to schizophrenia: 'how do psychiatrists talk about their patients' illnesses?'[305] Writing and thinking at the height of the 'linguistic turn' in historical practice, Gilman observed that whilst there had been obvious scholarly interest in the 'signifiers of psychiatric nosology', Michel Foucault was alone in considering the vocabulary itself in which terms and categories were rooted. Foucault's work exposed and interrogated the structures of such nosological systems which were shaped by the vocabulary of and behind psychiatry, asking what considering such vocabulary could reveal about the presuppositions behind clinical practice. Gilman asserted that

> 'in studying how psychiatrists talk about patients, especially within the published literature on mental illness, the often contradictory presuppositions concerning mental illness as well as the nature of the patient can be documented. The system of signifiers reveals the underlying presuppositions of the mental health practitioners, often in contrast to their own expressed intent.'[306]

This section looks at bodies and movements described as 'grotesque', 'queer', and 'curious'. Such language was, however, used by patients about their own bodies as well as physicians about the body of the Other. There was certainly a space which emerged between the theory and ontological basis of clinical practice. This space was created in conversation with and in response to patients' own vocabulary and meaning.

[305] Sander L Gilman, "Why Is Schizophrenia 'Bizarre': An Historical Essay in the Vocabulary of Psychiatry," *Journal of the History of the Behavioral Sciences* 19, no. 2 (1983): 127.

[306] Ibid., 27.

This thesis considers not only how doctors talked about patients, but how patients talked about themselves and to doctors. Decades of work following Gilman's article have undermined a Foucaultian over-emphasis of the structures and discourses of knowledge and power, in favour of a re-embodied hybrid model of the clinical encounter which does not see patients and patient bodies as docile and inherently disempowered. However, a history of the body need not mean an ignorance of linguistics and how that informs the structures of the world, meaning, and corporeality. Language and body do not exist in different realms; they are tangled together. This is a thread which runs throughout this thesis, reflecting what I found in the contemporary literature and accounts. Gilman's question ought to be revisited and expanded. How do psychiatrists and patients talk about and encounter the body?

What made a body and movement insane?

Put very simply, the body matters here because it mattered then and there. As consideration of Tuke's *Dictionary* alone makes abundantly evident, considering the scientific interest in insane movement could easily fill a whole thesis by itself, let alone a chapter. Countless entries featured movement and the body in some sense. Passages on chorea, somnambulism, mesmerism, posture, movement, mania, melancholia, to name but a few, emphasised the movement, situation, and appearance of the body as central to their conceptualisation, aetiology, and identification. As Baskin opened his article,

> 'one cannot visit the wards of an asylum without realising that there are many types of mental disease, each with its own symptoms and physical signs and overlapping affections of the mind are especially common'.[307]

[307] Baskin, "Insane Movements and Obsession," 500.

Physical signs, symptoms, and referents were being discussed and refined as markers of particular disorders, but these were not stable. Differentiating between the movements of the body in order to fit these nosologies involved emphasising minute, and often indistinguishable, details or nuances.

Whilst any observable behaviour and action of the body within the asylum *could* be interesting, it was the exceptional, bizarre, curious, ridiculous, and grotesque which physicians principally isolated, focused on, and used to refine their theories of mental action and the psychomotor. As will be explored in the next chapter, movements (and those who moved) were situated on a spectrum or hierarchy of cerebral, emotional, nervous and physical organization or sophistication. Baskin stated that 'there are many insane persons whose movements are highly skilled and well co-ordinated',[308] making them able to play billiards, the organ or piano, do needlework, paint, and otherwise occupy themselves. How, therefore, could one establish whether a variety of movement was insane and therefore a marker of disorder? For Norman's patient, perched on the edge of her chair, the way in which she moved and situated her body evidenced that 'she could not meet the conditions of her environment.'[309] Baskin argued that 'there is a simple test'. He contended that

> 'if the movement is incorrectly applied for the realization of the end or purpose in view, whether in excess, showing lack of inhibition, or by inefficiency, thereby revealing feeble energizing power, in either case we have a movement which is not sane or healthy.'[310]

[308] Ibid., 503.

[309] Series 3, Lecture 2, 4 March 1907, ACC/2017/2, CN/3/1, CNL, RCPI.

[310] Baskin, "Insane Movements and Obsession," 503.

These were apparently bodies *out of sync*. It was not only what the body did, but why it did it, where it did it, and the way in which it was done, which mattered.

Contemporaries were fascinated with how insanity might be detected, observed, and read on the surface of the body as well as how this connected with the processes of the brain, physiology, and biology. Published in *Brain,* across two volumes between 1880 and 1881, physician Francis Warner argued for the immense importance, across all branches of medicine, of attention to the movement and expression of the body. He contended that

> 'all expression of feeling is effected by muscular action, whether it be by words, by facial movement, or gesture, movements effected by voluntary muscles; or expression may be produced by dilation of the pupil, erection of the hair, or disturbed action of the heart, these being due to the condition of inorganic muscular fibres.'[311]

Whilst primarily an expert on the development and understanding of motor and muscular activity in children, Warner's work was subsequently used in the understanding of insanity and mental science. Passages such as this discuss the reflex or automatic movements of the body; entangling body and mind in a loop of cause and effect, even once the concept of volition and conscious mental action was removed. The body reacted to the action of the mind and nerves. The movement and reactions of the body, and these ways of seeing it, were important because they rendered the mind accessible and readable. Understanding these movements and how they connected to the mind or nervous system involved developing and elaborating upon nosological categories that made meaning of the apparently meaningless.

[311] Francis Warner, "Visible Muscular Conditions as Expressive of States of the Brain and Nerve Centres," *Brain* 3, no. 4 (1881): 478–79.

In his immensely popular and well-read *Dictionary of Psychological Medicine*, Daniel Hack Tuke included an extensive seven-page-long section written by Warner and devoted to ‘movements as signs of mental action’, beginning the entry: ‘all mental action is known to us only by its expression in movements.’[312] Warner dissected the processes whereby brain activity was prompted by a stimulus, in the form of a sensation or impression received through the sensory apparatus, and conveyed through nerve force to the proximal and distal regions of the body, creating physical movement. He emphasised that ‘certain characters of brain are ‘essential to the manifestation of mental action’ and might be ‘inferred from the attributes of visible movements’.[313] These characters were; spontaneity, retentiveness, delayed expression of impressions, double action in nerve-centres, and controllability of movements by physical forces. The movement of the body would therefore correspond to a particular character or property of brain, indicating degeneracy or sophistication of cerebral function and process.

Spontaneity referred to the movement of parts of the body without any apparent circumstances stimulating them. Warner specified that this was most commonly observed in infants or children, but is also a foundational explanation of the spontaneous laughter of insanity and idiots discussed later. Retentiveness was largely analogous to reflex action; ‘retentiveness in nerve-centres tends to repetition of similar action under similar

[312] Francis Warner, “Movements as Signs of Mental Action,” in *A Dictionary of Psychological Medicine: Giving the Definition, Etymology and Synonyms of the Terms Used in Medical Psychology, with the Symptoms, Treatment and Pathology of Insanity and the Law of Lunacy in Great Britain and Ireland*, ed. Daniel Hack Tuke (London: Churchill, 1892), 820.

[313] Ibid., 821.

stimulation'.[314] Automatic movements, according to Warner, are observed in idiots and parrots, indicating their 'unimpressionable brains', reliant on pre-existing patterns. Delayed expression of impressions was indicated by a disjuncture between the impression produced in or on the nerve-centre and its manifestation in physical movement. Double-action in nerve-centres was supposedly observed in more sophisticated cerebral organisation, whereby a local molecular change in the centre is made (indicating a lasting impression and retention) and simultaneously an efferent current is sent to the muscles of the body, producing visible movement. Finally, Warner emphasised that the movements produced by physical forces or impressions received through the peripheral sensory apparatus could be organised in different combinations or series of movements in the parts of the body; in a uniform, augmenting, or diminishing series, or action adapted by circumstances.

Tuke's *Dictionary* was used to illustrate both pathological and 'normal' states of psychological and physical function associated with mental science. However, the augmenting and diminishing movements cited were particularly central to the understanding of the two broad groups of melancholic and manic patients. Such theories were elaborated upon by writers of insanity to explain the seemingly bizarre and incomprehensible movements observed in asylums which seemed disconnected from their external environment and so supposedly must have more to do with internal process. In 1904, assistant medical officer at Bethlem Royal Hospital W.H.B. Stoddart connected such series of movements and nerve-action explicitly to asylum pathologies in an illustrated *Lancet* article on 'motor symptoms of mania and melancholia; with a theory of their origin and of the origin of

[314] Ibid., 821–22.

delusions arising in these conditions.'[315] According to this work, studying the more severe cases of 'mental dissolution' allows for the most illuminating and thorough investigation of such motor phenomena, as the 'characteristic symptoms' are 'most marked';[316] the findings might then be applied to milder cases or, taking the argument one step further, to the cerebral and motor function of the sane body. Stoddart claimed that 'characteristic movements of melancholia occur at the small peripheral joints and that characteristic movements of mania occur at the large proximal joints', with the occasional exceptional cases.[317] Writers such as these were engaged in the classification, codification, and representation of movement as an externally observable guide to the inner workings of the mind. The insane body provided a form of corporeal diagnostic; a roadmap for a glitch in the nerve processes of mentation and cerebral localisation.

Insane movements were, however, not always wild and theatrical. Whilst the observation of extreme cases was considered especially helpful and illustrative of underlying mental pathology, finer movements, postures, and expressions were equally important. Both Warner and Stoddart highlighted the importance of the 'movements of small parts of the body, parts of small mass and weight, such as the eyes, the mobile features of the face, the hands and fingers.'[318] These actions were framed as expression and indicative of the more nuanced (and more involuntary) internal states. According to this model, 'when the movements seen have apparently no circumstances immediately stimulating them they are

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[315] William H B Stoddart, "Motor Symptoms of Mania and Melancholia; with a Theory of Their Origin and of the Origin of Delusions Arising in These Conditions," *The Lancet* 163, no. 4201 (1904): 639.

[316] Ibid.

[317] Ibid., 640.

[318] Warner, "Movements as Signs of Mental Action," 821.

sometimes said to be "spontaneous," and the occurrence of many such acts is said to indicate spontaneity in the subject.'[319] Behaviours of this kind, such as 'wandering eyes and fidgeting fingers',[320] Warner stated were indicative of certain emotional states.

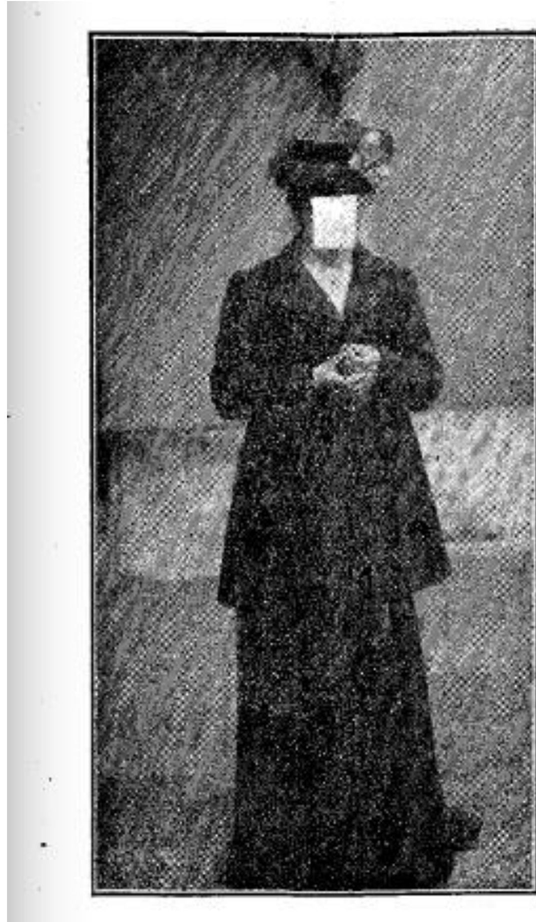

Figure 7: Patient with fingers in constant movement, c.1904, photograph, from Stoddart, 'Motor Symptoms'.

The images that accompanied such texts were therefore included as embodiments of the 'characteristic symptoms' and 'severest cases'; representative bodies rather than individual patients. In Stoddart's case, this is especially marked, as his concern was primarily with the movements of the joints and limbs, rather than the finer functions of the face and

[319] Ibid.

[320] Ibid.

expression. When the article was published in *The Lancet,* the accompanying images (such as Figure 7)[321] featured patients with faces hauntingly occluded by small white boxes, as in the photograph used to demonstrate a melancholic patient whose ‘fingers are in constant movement’; ‘constantly picking the skin of the fingers or fumbling with the clothes’[322]. Such images of the insane body in motion were intended to both train and direct clinical attention on the body. These static forms of documentation were, however, inevitably limited by the form to being suggestive and representative of such movement.

The importance of the body to the ways in which insanity was imagined and represented both through and beyond the medical gaze is most famously evident in the statues which adorned Bethlem Royal Hospital until 1815 (Figure 8).[323] Created by Danish sculptor Caius Gabriel Cibber in 1680, these figures were intended to embody the archetypes of raving Mania and Melancholia. Quite literally casting a shadow over those entering the space of insanity, these bodies were warped and twisted, muscular yet pained; allegories of madness, hinting at the power and danger inherent in the ways the mad body was seen, imagined, and represented. These figures were removed from the portico to the building in the early nineteenth century, but the projection of the image of embodied lunacy as spectacle, using the body and its implied or actual movement, persisted.

[321] Stoddart, “Motor Symptoms of Mania and Melancholia; with a Theory of Their Origin and of the Origin of Delusions Arising in These Conditions,” 639.

[322] Ibid.

[323] C. Warren (after C. Cibber, 1680), Statues of "raving" and "melancholy" madness, each reclining on one half of a broken segmental pediment, formerly crowning the gates at Bethlem Hospital, 1808, engraving, courtesty of WL.

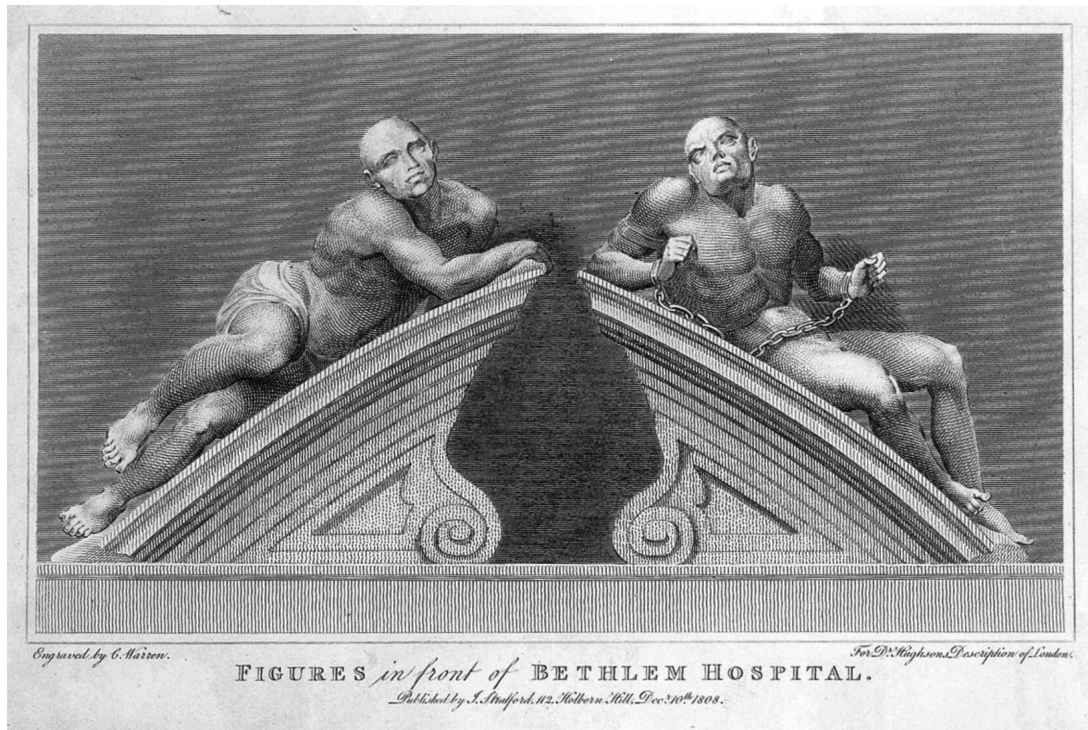

Figure 8: C. Warren after C. Cibber, Statues of "raving" and "melancholy" madness, 1808, engraving.

Whilst institutions were largely enclosed spaces, they nonetheless staged and performed insanity in their own ways to the public. Although a comprehensive study has yet to be produced on cultures of visiting and spectacle in the nineteenth century British asylum, Janet Miron's study of asylums and prisons in the nineteenth-century USA and Canada is immensely revealing of the ways in which the body and movement in insane spaces was subject to the 'tourist gaze'.[324] Miron writes with an awareness of the interrelationship of seeing and being seen, arguing that these practices ought to be considered within the wider contexts of looking and defining the self against the other; alongside world fairs and scientific or industrial exhibitions. Certainly, these visitors were engaging in voyeuristic and empowered practices of looking, whereas those they looked *at* had limited recourse or resistance to this gaze, but this act and practice of looking inherently contained within it an

[324] Janet Miron, *Prisons, Asylums, and the Public : Institutional Visiting in the Nineteenth Century* (Toronto: University of Toronto Press, 2018).

awareness of being seen. Those looking were thinking about their own movements and embodiment through that of the insane Other.

A particularly interesting example of the spectacle of insane bodies in insane spaces can be found in the newspaper report of a fancy-dress ball held at the Surrey County Lunatic Asylum at Brookwood, in 1881 for four hundred patients, two hundred visitors, and several staff (including Medical Superintendent Dr Brushfield). Published in the *Illustrated London News*, the report on the event and its attendees (insane and otherwise) detailed that 'the music was supplied, till nine o'clock, by the Asylum Band', that 'every person admitted had to wear some fancy dress' and 'the spacious Recreation Hall was beautifully decorated with exotic plants, flags, wreaths, statuettes, mirrors, and Chinese lanterns.'[325] This article was accompanied by both an illustration of a selected number of the costumes worn (Figure 9)[326] and description of what the costumes were. The detail included in this description and the caricaturised illustration, which lent bodies to the scene, urged and encouraged readers to imagine and conjure the scene in their minds' eye. The description of the costumes and events themselves are lent an almost delusive quality; that of a fever dream or bizarre imagining.

[325] "Fancy-Dress Ball at a Lunatic Asylum," *Illustrated London News*, January 22, 1881, 86.

[326] Illustration of Ball Costumes, 1881, print, accompanying Fancy Dress Ball, Illustrated London News, accessed March 15, 2022, https://www.britishnewspaperarchive.co.uk/viewer/BL/0001578/18810122/034/0012?browse=true.

Figure 9: Ball Costumes, 1881, printed in Illustrated London News.

The writer explained that the artist had deliberately made no distinction between lunatic, asylum staff, and visitor; that 'most of the persons whose fancy dresses are shown in our Artist's Sketches, are patients of the Asylum, but two or three are attendants or visitors.'[327] The ball and its costumes had seemingly blurred the boundaries between groups, through the visual trickery of illusion. The article's author discussed a few of the costumes in detail, guiding them around the image and scene, writing that,

> 'The reader will observe such amusing devices as "The Queen of Hearts," an old lady covered with playing cards; and the two newsvenders, plastered with announcements of the topics of their "special editions;" while "Captain Cuff," in Hanoverian officer's costume of the last century, with exaggerated wristbands and ruffles, the Duke of York, Flora MacDonald, Queen Elizabeth, Mother Goose, an Indian Chief called "Fine Feathers," a Clown, a Nigger Minstrel, and a personification of the Temple Bar Griffin will at once be recognised.'[328]

This fancy dress ball explicitly played with the concepts of reality and the imagination through the body in the asylum space, ambiguously situating the institution and its inhabitants between mad patients and figments of the imagination or a cultural unreality. The illustrative examples were predominantly taken from allegories and fairy tales; their bodies and performances were here briefly an actualization of caricature. The final figure in this list, is particularly drawn out of the crowd of disguises. The author identified 'The Medical Superintendent, in his costume of "The Hunchback," at the bottom of the page, as "The

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[327] "Fancy-Dress Ball at a Lunatic Asylum," 86.

[328] Ibid.

Ruling Spirit" of this lively and diverting company.'[329] The asylum Superintendent himself assumed a costume of physical disability or embodied otherness; that of The Hunchback.

Such episodes and their representation lend weight to Christine Ferguson's claim that 'by the end of the century, public attraction to the split self, to the individual who is at once freak and non-freak, insurgent Other and tame citizen, had reached its zenith.'[330] Insanity was entangled with the body, movement and identity and the asylum was not just a space of mental science, it was a space which staged bodies and in which the concepts of reality, whether personal or collective, and the imagination, bounced against one another. Bodies and their visible movements offered ways to understand and locate both otherness and recognizability or sympathy and recognition. Like their delusions, these movements situated patients in an often ambiguous space between recognizability and the grotesque, bizarre, curious, and incomprehensible. Movements and bodies were seen as theatrical and pantomimic as well as disordered and as objects of medicine. Perhaps by clothing everyone, including the staff, in the costume of delusion, fiction, or the imagination, this ball and its illustration blurred the lines between imagination and reality, questioning the basis on which practices of looking and othering centred around the body.

These bodies could therefore be read as both signs and as performative spectacles. Once emptied of apparent and recognisable or understandable meaning and purpose, the visibility and immediacy of the frozen, chaotic, unruly and disordered body was hard to avoid

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[329] Ibid.

[330] Christine Ferguson, "'Gooble-Gabble, One of Us': Grotesque Rhetoric and the Victorian Freak Show," *Victorian Review* 23, no. 2 (1997): 246.

in the asylum. Baskin justified his choice of 'insane movement and obsession' as the topic of his paper to his audience of the Salisbury Division of the British Medical Association by stating that,

> 'for some years it has been my lot to witness, on my daily rounds of the wards, grotesque movements, antics and pantomimic display by patients, which, were they not interesting as symptoms and physical signs of nervous disease, might otherwise be depressing because of their meaninglessness.'[331]

Insanity and disease marked and differentiated the body in these spaces. Insane bodies and the ways in which they were seen; performed and displayed, were *interesting*. Asylums were not just places where conversations happened, and stories were told or experience communicated verbally; they were also spaces in which the body moved and insanity was staged or performed. The body was made to speak when the patient could or would not.

Confining someone to an asylum not only separated their belief and thought as different and socially othered, but also marked and resituated their bodies. This space itself gave meaning to these movements; whatever the particular diagnosis or pathology, they were insane. These spaces were, however, permeable; the lines between sane and insane porous and transgressable. If the built environment of the asylum was a domesticised space which staged sanity in hopes of creating or effecting it,[332] perhaps the insistence of insane bodies and their movements in this space might be read as a form of embodied resistance. How the

[331] Baskin, "Insane Movements and Obsession," 501.

[332] Louise Hide, *Gender and Class in English Asylums, 1890-1914* (Basingstoke: Palgrave Macmillan, 2014), 93–99; Mary Guyatt, "A Semblance of Home: Mental Asylum Interiors, 1880-1914," in *Interior Design and Identity*, ed. Susie McKellar and Penny Sparke, Studies in Design (Manchester: Manchester University Press, 2004), 48–71.

body is seen depends, in large part, on where it is seen and by whom. Baskin's comment highlights a particular scientific *way of seeing* which reframed looking and watching as a medical practice; witnessing and observing the body as an objective and dispassionate process, rather than a voyeuristic one. There were, however, a myriad of ways of seeing which surrounded and enmeshed the insane body and its movement; connecting it, the way it looked and performed, to the world and the Other.

How can we *see* the body?

Two key cases will be considered in the following discussion: one from Norman's lectures (identified as Mary Jane) in which the body was othered and insane because of its absence of movement, the other found in Baskin's article (anonymous) where it was the movement of the body which marked and signified insanity. Through these cases, multiple ways of seeing the body are highlighted and discussed which move beyond the conventional understanding of exteroceptive sight and visual sources such as photography and film. These ways of seeing and understanding embodiment are dependent on the position of the person seeing, what is available to them, and how available it is. As with narrative, the historian is in most part reliant on what has survived in order to see this body; what the physician thought was important or relevant, how they saw, and what and how this was recorded or preserved in archives.

History has been slow to consider its own ways of seeing. As with the ways of telling discussed in the previous section, these ways of seeing are central to historical practice, yet are often only implicitly discussed. Bodies matter because they have often been overlooked in the writing and formulation of history. However, increasing moves towards

interdisciplinarity and away from the purely textual has offered illuminating pathways for their consideration. Whilst this section engages with visual technologies and cultures, considering performance and the visibility of the body does not exclusively mean studying photographs taken within the asylum or illustrations and images produced to represent the insane body. As historians such as Tiffany Watt-Smith and Rae Beth Gordon have demonstrated, the concept of the moving, performing, and dynamic body percolated across the cultural, social, scientific and medical world of the nineteenth century.[333] It is in this context that the performances and conversations in Norman's lecture theatre should be considered.

Dance, theatre, and the performing arts more broadly, and medical or evolutionary science, staged, displayed, and negotiated the body in modernity, drawing on a common emerging and shifting visual discourse and embodied or gestural languages. Alienism or psychology and mental science were barely differentiated from other branches of medicine in this period. Similarly, it could not and did not stand apart from other platforms and spaces in which and on which the body was staged. As such, the katatonic or stuperose body of the asylum ought to be considered alongside the tableaux vivants; the manic, hysteric, or choreatic movement along with dance and music hall entertainment; delusions of control, hallucination of mental action and psychomotor hallucination next to electric science, mesmeric shows, and their use in medical practice. The latter will be the particular focus of the rest of this chapter.

[333] Rae Beth Gordon, "From Charcot to Charlot: Unconscious Imitation and Spectatorship in French Cabaret and Early Cinema," *Critical Inquiry* 27, no. 3 (2001): 515–49; Tiffany Watt-Smith, "Darwin's Flinch: Sensation Theatre and Scientific Looking in 1872," *Journal of Victorian Culture* 15, no. 1 (2010): 101–18.

The conceptual foundation for this section can be traced to much of the work being done in performance studies and the history of emotions and the body. In their recently published edited volume, *Emotional Bodies: The Historical Performativity of Emotion*, Beatriz Pichel and Dolores Martín-Moruno gathered together essays arguing for a model for emotions as embodied cultural phenomena.[334] Such studies are contributing in many ways to the very same debate which they study in historical context; namely, are emotions and their social or physical expression and experience the ahistorical and universal product of biology and inheritance, or evidence for how the body is culturally and socially enmeshed and produced? This work effectively and coherently fuses together a material and embodied historical approach which considers a range of different visual sources as well as documentary evidence for the ways in which emotion is actualised, imagined, and experienced. Pichel, Martín-Moruno, and their authors focus on the surface-level of the body; that which is visible, observable, and readable to others. They offer and expand upon a radical way of reimagining and seeing the body in historical practice.

They, like this thesis, are working in the tradition of the "practice turn" in history, which elides such conventionally received dichotomies as that between experience and expression, or mind and body. This sees emotion as emotional practices and scripts, received and enacted by both collective and personal bodies, and the stories we tell. It also considers bodies in light of feminist theorist Karen Barad's work, which explains that 'bodies are not objects with inherent and fixed boundaries and properties; they are material and discursive

[334] Dolores Martín-Moruno and Beatriz Pichel, "Introduction," in *Emotional Bodies: The Historical Performativity of Emotions*, ed. Dolores Martín-Moruno and Beatriz Pichel, History of Emotions (Urbana: University of Illinois Press, 2020).

phenomena.'[335] Crucially, such work engages with the concepts of performance and the performativity of emotion 'beyond the representational theory and the linguistic turn.'[336] Processes and practices of seeing, talking about, and imagining are central to the ways in which bodies are made, remade, and shift in meaning. They do not simply refer to a stable and objective material. Bodies matter because they shape, inflect and inform the ways in which we understand the world, our relationship to it, and situation within it. They are also shaped, inflected, and informed *by* this being-in-the-world.

Our embodiment opens up a range of phenomenological possibilities and complexities which also allow us to begin to access the experiences of others. Seeing someone deeply cut their hand is very often felt in one's own body. Based on past experience, it assumed that this must hurt, we anticipate bleeding, an expression of pain. In moments such as this, it can be hard to phenomenologically disentangle our experience and perception of our own bodies from that which we are seeing.[337] The processes which constitute this entangling and disentangling across bodies; at once a recognition and differentiation of self from Other, is what this section considers.[338] Physicians framed a discussion of insanity in terms of often fundamental embodied difference whilst also exploring the sane processes and movements in the population beyond the asylum. The ways

[335] Karen Michelle Barad, *Meeting the Universe Halfway: Quantum Physics and the Entanglement of Matter and Meaning*, E-Duke Books Scholarly Collection (Durham: Duke University Press, 2007), 153.

[336] Martín-Moruno and Pichel, "Introduction," 7.

[337] Fredrik Svenaeus, "Edith Stein's Phenomenology of Sensual and Emotional Empathy," *Phenomenology and the Cognitive Sciences* 17, no. 4 (2017): 741–60; Bassam Sidiki, "Doctored Images: Enacting 'Pain-Work' in John Berger and Jean Mohr's A Fortunate Man (1967)," *The Journal of Medical Humanities* 42, no. 4 (2020): 777–93.

[338] For feminist theoretical reflections on 'embodied engagement' and 'embodied reflectivity' which have informed this approach, see Carla Rice, "Imagining the Other? Ethical Challenges of Researching and Writing Women's Embodied Lives," *Feminism & Psychology* 19, no. 2 (2009): 245–66.

in which this was achieved and effected are crucial to understanding the layers of meaning-making which distilled and coalesced around the body, sane and insane, in this period.

This section is the most explicitly positioned and spatial of this thesis. To imagine it in embodied terms; I am watching and talking about physicians such as Baskin who are observing and talking about their patients. I am explicitly and self-consciously weaving together seeing with being seen over multiple layers. Seeing and being seen do not rely upon *being there*. Whilst the embodiment of patients and doctors are extensively considered, I continue to put myself in the frame, making myself seen and thereby vulnerable. I can only see patients' bodies by way of my own and through whichever means their watchers chose to record, preserve, or describe them. The internal workings of the mind had to be imagined and visualised and contemporaries such as Baskin and Norman (and to some extent I am doing the same) clearly intended to use what they could see to help access and understand what they could not. Bodies mattered not least because they *could* be seen, but these ways of seeing are not as simple as the sense of sight and visual sources like photography.

Norman's lectures make this way of seeing the body of insanity as embodied intersubjective performance particularly explicit. He began a lecture in April of 1907 with the wry statement to the assembled medical students: 'gentlemen, you will perceive that among the numerous accomplishments of your lecturer he is not much of a stage manager because everything ought to be arranged before the arrival of the audience.'[339] Lectures such as these staged and displayed insanity primarily to teach and demonstrate clinical practice; to

[339] Series 3, Lecture 10, 8 April 1907, ACC/2017/2, CN/3/9, CNL, RCPI.

introduce the reality of asylum medicine which could not readily be found in textbooks and clinical manuals. Norman frequently spoke dismissively of current theories of disease aetiology. He stated, for instance, when discussing patients' 'dirty habits' that

> 'it is untrue, as laid down in a little text book which is very likely in the hands of some of you, - a very able book in its way, written by a very able man, a great friend of mine, - that when a patient becomes wet and dirty that patient is incurable. That is not true.'[340]

Norman was clear that he agreed with 'the grounds on which that opinion is formed'; that 'personal cleanliness, avoiding the secretions in such a manner that the body is not defiled is so primitive an instinct that as far as we are aware it is shared by the lower animals'.[341] However, he contended that 'the mind is not built up on that beautiful basis' and that 'almost all young maniacs are extremely dirty… and yet they get perfectly well.'[342] Discussing the body in insanity and building it into emerging or shifting theories meant balancing and meditating upon what could be seen immediately before the doctor with the knowledge and ways of seeing developed over time, exposure to multiple bodies in the asylum, and informed by literature written through the eyes of colleagues. Straightforward rules connecting the body to the mind rarely held true. This only re-emphasises the importance of not restricting the historical view to the written word and instead engaging with our own ways of seeing, accessing or *getting close to* the body under discussion.

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[340] Ibid.

[341] Ibid.

[342] Ibid.

By physically bringing insanity and the bodies being discussed into the room, Norman demonstrated and *brought to life* what textbooks and manuals could only echo. In this April lecture, which focused on 'the condition that is known as stupor', whereby the body froze or became insensitive to stimuli, he stated that it was 'rather a difficult condition to describe [and]… demonstrate unless it is very pronounced, so that I am in the habit of bringing together several cases so that the distinctive features may be seen en bloc.'[343] In grouping together patients and displaying or staging their bodies to an audience, Norman allowed students to practice a particular way of seeing and anatomising the body. Whilst I was drawn to these sources precisely because of how they allowed me to see patients in new (and less clinical) ways, Norman often encouraged students to *see* the body as representative or a collective body rather than necessarily individual.

Norman often used patients and their bodies or reactions as teaching objects. Patients were pinched in order to demonstrate reflex action (or its absence), as in the case of a male patient, who, 'if you pinch his arm he will say 'Damn''.[344] In a later lecture, the notes recorded that '(the lecturer examines the tongue and the teeth)' in order to assess whether the patient had been 'gnashing his teeth'.[345] Such instances of manhandling and physical examination practiced without the patient's consent are distinctly uncomfortable and unsettling mental images, not least because the act of checking teeth brings to mind the assessment of a horse or slave's age and health at market. Before his audience, Norman's

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[343] Ibid.

[344] Ibid.

[345] Series 3, Lecture 15, 23 April 1907, ACC/2017/2, CN/3/14, CNL, RCPI.

patients' bodies were expressive of illness and implicitly othered, whether just by their presence there or as a result of his manipulation of them.

The physician was, however, not only reliant on staging bodies so that they could be seen live and in that moment. During the lecture, Norman moved between photographs, references or read-aloud sections of patients' asylum case notes, reference to the physical body in the room, theories of medicine, and his own descriptions and interpretations of the patient or notable features of the case. This method allowed him to combine different *ways of seeing* the body and cross the sensory modalities or ways of understanding available to the students and connect the mind with body through conversations (or, in the cases of stupor here, lack thereof) staged before them.

Particularly illustrative and interesting is his discussion of a stuperose patient he referred to as Mary Jane. In order to help them understand her case and what they saw before them, Norman read his students 'a very keen note made by one of my excellent assistants who seems to see everything that comes before her.'[346] The note read, 'she smiles and will not reply; when I talk to her she puts her arm round the nurse's waist standing by in a languishing way'. Norman explained that he thought this was 'a most excellent note which brings the scene before one's eyes.'[347] Norman valued and emphasised seeing as a clinical practice, and the use of case notes written through the eyes of others, whether physicians, nurses, or attendants. Such notes layered both sight and meaning. Once more, this scene emphasises the importance of time in the context of asylum medicine. Whilst Mary Jane's

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[346] Series 3, Lecture 10, 8 April 1907, ACC/2017/2, CN/3/9, CNL, RCPI.

[347] Ibid.

stuperose body and its live reactions or condition could be seen before them in the lecture theatre, reading a note before his class demonstrated the immense importance of the collection of moments which coalesced around the body. Clinical notes collapsed time and facilitated the imagination as a way of seeing and understanding the body. As such, they were far from dispassionate. Words were carefully chosen as expressive and revealing of particular emotional and embodied signifiers. In this instance, Norman asked his students to imagine, or bring before their eyes, how it might look to put one's arm around another in a 'languishing way'. Is this embrace for support? Is this support emotional or physical? Is it seeking protection or a way to hide from perceived threat? Such extracts speak to the layers of meaning which structured how the body was seen, imagined and talked about.

In order to situate Mary Jane's body on a timeline and provide a visual and semantic context for her condition as seen before them, Norman used these notes and photographs taken within the asylum as a way of seeing a degeneration in bodily condition or autonomy (and therefore mental condition) and a consequent alteration of emotional state. As Norman described her, as her body shut down, there was little of Mary Jane left. She disappeared, from a 'young girl' to 'poor woman'.[348] The note-taker wrote that 'the lecturer here left open for the inspection of the class a photograph of the young girl before her admission to the asylum.'[349] The photograph, taken 'some time ago' was described in text as showing 'a bright face, a smiling, animated young person... full of merriment.'[350] She is almost spoken of as a ghost, phantom, or illusion. The woman in front of them had long since 'passed into an

[348] Ibid.

[349] Ibid.

[350] Ibid.

apparently chronic delusional condition' followed by 'a state of more or less stupor.'[351] The transcript read that she stood before the audience, having been

> 'decorated specially for your benefit. I suppose the nurses, without any regard for the mise en scene thought it necessary to put on the blue apron, but she wears a bib in order to counteract the messing of her garments by secretions from her nostrils.'[352]

Once more, Norman explicitly refers to insanity and its embodiment as a performance; something that is, consciously or otherwise, set and staged. He does not simply present patients to his students, but attempts to show a representative example, both of the condition discussed in the patient selected, and in their behaviour, movement, or attitude. Whilst presenting patients physically before the audience was intended to add an authenticity, spontaneity and richness to the clinical experience and observation – to bring it to life – this intention itself shaped the ways in which the body was seen.

As she was presented, Mary Jane was described less like a twenty-five-year-old woman and instead as if she were a child, a puppet, or a doll. She had to be daily 'dressed and undressed' and for the purposes of the lecture was 'decorated' by the nurses, perhaps to make her presentable for an audience of men she did not know; to materially shape or influence the ways in which she was seen. However, this staging and costuming was apparently counter to or undermined the ways in which Norman sought to present her himself. His reference to the *mise-en-scène*, like his description of his own role as 'stage manager' deliberately and self-consciously elides theatre and asylum; insanity and performance in a manner similar to the fancy dress ball already discussed. Such practices of presentation and costuming were not

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[351] Ibid.

[352] Ibid.

uncommon in the asylum. Figure 10 is a particularly haunting photograph from Holloway Sanatorium, in which Constance B., whilst similarly in a stuperose condition, was captured properly and decorously dressed in a manner which would have been impossible for her to achieve by herself.[353] The hat atop her head, tied neatly under her chin in a bow appears particularly ridiculous and jarring when her posture has the appearance of being held or propped up; her arms hanging at her sides with seemingly little or no muscle tone. The caption of the image reads, ‘usual attitude – head bent, arms falling to side.’[354]

Figure 10: Two photographs of Constance B., c.1898, HS CB 11.

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[353] Two photographs of Constance B., c.1898, CB 11 Females, 1898-1907, MS.5159, HS, WL, https://wellcomecollection.org/works/m5qcwkpa, 7.

[354] CB 11 Females, 1898-1907, MS.5159, HS, WL, https://wellcomecollection.org/works/m5qcwkpa, 7.

Such conscious acts of staging and framing implicitly spoke to and revealed the values of the institution and the ways in which it saw itself and its role in shaping bodies. However, patients' own bodily realities frequently undermined such efforts and intent, drawing attention to the space which emerges between what is meant to be seen and *can* be seen. Mary Jane was unable, by either reflex or volition, to stop herself from dribbling and soiling her costume. Norman drew attention to this as a crucial element of her case and condition when he stated, 'now you see she dribbles saliva a classic indication of insanity since the days when David let his spittle fall on his beard'.[355] Visible to others on the surface of her body, this dribbling created a commonality across centuries with the bodies of others marked as insane. Embodied difference with the sane implied embodied parity with the marginalised other, whether also insane, uncivilised, animal or a child.[356]

Mary Jane's body spoke to a perceived degeneration and increasing inability to control her own body. Norman explained that

> 'this woman was not dirty in her habits in the early course of her illness in which case one is inclined to think it is of bad prognostic significance, the filthy slobbering, the tasselous nose the utter apathy in every attitude, in every line of this poor woman's form.'[357]

The failure of her bodily autonomy implicitly meant a consequent failure of empathy by the physician. Her body had moved her beyond recognition. What can be discerned of the tone

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[355] Series 3, Lecture 10, 8 April 1907, ACC/2017/2, CN/3/9, CNL, RCPI.

[356] The hierarchy of bodies and feeling is discussed further in the following chapter on Laughter.

[357] Series 3, Lecture 10, 8 April 1907, ACC/2017/2, CN/3/9, CNL, RCPI.

through the language used, suggests a disgust, revulsion and abjection. It also, however, implies a sympathy and unequal sense of charity or pity. Whether she did not care to control her body and its secretions, or she was unable to. Either way, she was essentially *different.*

How is the historian to access experience and how this difference or embodied otherness was felt, constructed, and negotiated if she is not in the room? We too do not only see with our eyes. Understanding and accessing embodiment is a multisensory practice in historical research as much as medical practice. We think with and through our bodies. Author Toni Morrison wrote that 'imagining is not merely looking or looking at; nor is it taking one's self intact into the other. It is, for the purposes of the work, becoming.'[358] When we imagine the bodies of the past, we are explicitly positioning ourselves. Through the sources of clinical medicine, this can involve moving between the body of the patient and that of the physician, confronting our own in the process. Although presented in textual form, without a visual representation of the body moving and *being seen*, the ways in which Baskin's article constructs and manipulates an embodied otherness or spectacle prompts an awareness of how we might see and attempt to understand with *our* bodies.

Baskin explained that 'about three years ago… [he] had [his] attention drawn to a woman who seemed engaged in making movements, the precise character of which [he] had not read of or seen before in any asylum.'[359] By what she says, or her 'mental condition', he classed the patient as suffering from 'the well-known disease dementia praecox' of the

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[358] Toni Morrison, *Playing in the Dark: Whiteness and the Literary Imagination* (Cambridge, Mass: Harvard University Press, 1992), 4.

[359] Baskin, "Insane Movements and Obsession," 501.

‘paranoidal form’, exhibiting verbigeration, negativism, and impaired affections.[360] She ‘spoke constantly about the Röntgen ray, wireless telegraphy and electricity’, believed herself to be ‘the Empress of China’, and ‘developed also hallucinations of hearing, carried on conversations with imaginary people, the King of Sweden being one.’[361] Baskin urged that his description of the patient’s movements ought to be considered in light of this mental condition, drawing particular attention to the fact that ‘hallucinatory troubles, errors of the affections, likes and dislikes, at one time fear or repulsion, at another time an unhealthy sensitiveness, were apparent in our patient’s history.’[362] In the absence of explicit explanation of the movements by the patient, the physician relied on his understanding of her history to conclude that these factors constituted ‘the necessary conditions for the development of the obsession’, which ‘the most recent works and authorities all describe… as being able to provoke a motor reaction.’[363] Her hallucinations and delusions were entangled with the movements of her body.

In its published rather than spoken form, the article verbally described the movements extensively. Too much would be lost from this description in the process of paraphrasing and the depth and detail of the narration is telling and important, so it is included here at length.

> ‘You will observe the frequent elevation of the arms: the movement begins from below upwards; the hands are raised to the level of the head and passed down to a few inches below the knees, with the arms fully extended and adducted so as to touch the knees in their upward passage. The patient performs always in the sitting posture; the

[360] Ibid., 501–2.

[361] Ibid., 505.

[362] Ibid., 508.

[363] Ibid.

> fingers are extended and adducted. There is no tremor of the limb, the upward movement is perceptibly quicker than the downward, the eyes are fixed looking straight in front; at the beginning of the action the lips twitch slightly, the expression is one of pain; as the operation is repeated the expression becomes less unhappy, and finally even a semi-contented appearance takes place on the countenance. These movements are performed daily all the year round; they begin when she rises in the morning, the continuity being only broken for the purpose of dressing and having her meals. They continue all day, and when the other patients have been put in bed she still insists on sitting in her bedroom and performing for an hour after everyone else has gone to sleep. The movements are noiseless; they are rhythmic and varying in frequency from 30 to 45 per minute, which is about the rate of stroking in the boat race.'[364]

Notably, and perhaps unsurprisingly, reading this passage prompts me to enact and perform these narrated movements myself. Sitting in my desk chair, I anticipate the bemused and curious look from the person seated next to me. Moving in this way myself is a, perhaps hollow, attempt to put myself into the body of another. I am aiming to understand what it would *feel like* to perform these movements. This exposes and prompts thought on what exactly it means to *see* something with and of the body.

Certainly, Baskin's vivid description helps me to establish what he was talking about. It conjures a mental image; an imaginary or phantom visualisation or mental picture of the patient herself. To create this image, I rely on my prior knowledge and understanding of what he described; a basic anatomy, in both medical terms and culturally general ones; my

[364] Ibid., 502.

vocabulary and linguistic referents which tell me what verbs such as adduction or twitching signify; and a spatialised understanding of the body. I imagine and conjure for myself an image of her body and the way she moved.

This mental picture gives me an understanding of how *I* might make my body move in this way. Internalising and actualising it from the Other, whether imagined or observed in front of me, I transfer this action to my body and stir my own limbs and fingers into movement. I create a sort of mimetic echo. I see with my body; repositioning the action and observing my own limbs or what I can see of them. Surprisingly, too, I rely on specific forms of cultural embodiment and scripts. Given I used to be a rower, I am all too familiar with what a stroke rate signifies and what these numbers entail for the rhythm and pace of how I am moving. This gives me a particularly uncomfortable sense of parity with the physicians observing and describing this woman's body, filtering her through their lens with a particular coloration. Such a casual reference to this learned embodied practice tells us a great deal about what assumptions can be safely made by Baskin of the gender and class makeup of his audience. Using these cues, I concentrate on what I am doing and whether or not this is accurate. Increasingly, I become aware that this self-consciousness itself changes the meaning of the action and its embodiment.

My movement is a self-conscious performance. I am following a script. In the case of Baskin's patient, this is less clear. Whilst he explicitly used a language of performance, the explanation the physician offered failed to explain or account for conscious mentation, instead suggesting that the movement is a 'motor obsession'. This was described as 'an obsolete, anomalous function – a parasitic function – engendered by some abnormal mental

phenomenon, but obeying the immutable law of action and reaction.'[365] The observed actions were therefore the result of an inadequate or compromised 'psychic metabolism' whereby a poorly organised mind is unable to eliminate 'a psychic component, destined to move transiently over the field of consciousness and to fall into the unconscious'.[366] As will be explored more fully in chapter six, the functions of the body and mind which generally operate below active awareness and volitional control were of immense interest to mental scientists in this period. The concept and process of digestion is not limited to food and the stomach. Here, the 'metabolism' is used to signify the ways in which the patient processes the sensorimotor input, subsequently expressed through the body in movement and emotion. Baskin does not, however, explain what diagnostic significance he attributed to this change in facial expression or output; how the movements of motor obsession connect to the embodiment of these apparent emotions. I realise, however, that I have filled in the gaps. The transition from a lip-twitching expression of pain and unhappiness to a semi-contented countenance makes me think this action, which is bringing me mild embarrassment and discomfort, brought its original performer a sense of happiness and relaxation. Perhaps it made her smile.

As I continue the movement, I realise that rather than bringing me a sense of satisfaction, my limbs are growing heavy. The longer I continue, the more conscious mentation it takes to maintain the rhythm and movement required. I marvel at the fact that Baskin's patient continued in this manner near unceasingly. This, in itself, prompts thought about embodied difference. Is this why Baskin is so curious about his patient's movement;

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[365] Ibid., 508.

[366] Ibid., 507.

why he is attempting to understand the process; to medicalise the reason *why*? In connecting my body with the body I am reading, am I establishing commonality and some form of retrospective and embodied historical empathy, or am I instead reifying difference? I also remind myself that my ability to do this sort of movement at all relies on the fact that I am not physically disabled. I *can* move my arms smoothly for an extended period. My process in understanding, formulating my ideas, and writing them are unavoidably shaped by my own corporeality and the availability of certain objects or movements to me.

Finally, whilst I am reliant on the textual translation of the body; the way in which the patient's body was rendered verbally readable and thereby shareable, Baskin's original medical audience were not. Included in the article is his statement,

> 'I shall show you this patient making these movements by means of the cinematograph. We would have brought her here only she obstinately refuses to operate when watched, and it was necessary to have the cinematograph pictures focused through a partly open window when she least suspected observation.'[367]

This is not only a discussion of seeing, but of seeing and *being seen.*[368] Baskin's patient, I wonder, may have been more self-conscious of her movements and the presence of others than I thought. I find her refusal and resistance to 'operate when watched' endears me to her even further and provides me with insight into what this movement *meant* to her, although it is not commented on by her physician. Perhaps it was personal and exposing. Whilst Baskin claims these actions happened without her will or volition, and she stopped only to get dressed and to eat; activities which involve competing and interfering physical actions, she

[367] Ibid., 501.

[368] The idea of self-consciousness and control will be discussed later.

nonetheless ceased to move in this way when conscious that someone else was looking. In particular, when asylum staff are observing her, given from the rest of the description it seems highly unlikely she was stilled by the presence of other patients in the asylum space.

I find myself irritated on her behalf at reading that she was captured against her wishes and knowledge; tricked by the staff. Baskin and many of his colleagues may have differentiated their practices of looking, observing, and recording the body from voyeurism and situated it as dispassionate, objective, and scientific, but his patient appears to have disagreed.[369] As with most of Norman's patients, but particularly the stuperose Mary Jane, I am acutely aware of my ability to see, in my own way, people who did not wish to or consent to being seen and who had little recourse or ability to block their or my view. Baskin's patient was not aware she was being watched and recorded, whilst Mary Jane either was too stuperose and apparently insensitive to know or was unable to remove herself from the room to avoid being looked at.

Changes in visual technologies could make the body simultaneously more available and more vulnerable. The development of these technologies designed to amplify, disrupt, or alter the exteroceptive connection of humans to their world and others, such as Baskin's cinematograph, significantly impacted the ways in which embodiment and corporeality was experienced in the asylum. Whilst case notes and journals froze bodies and flattened experience into clinically readable and preservable forms, they also attempted to harness visual technologies in order to communicate a three-dimensional and dynamic corporeality in

[369] I return to the ethics of looking and the disconnection of emotional expression and emotional states in mental disorder in the following chapter, referring to laughter.

two-dimensional form. *Ways of seeing* were situated on a spectrum or hierarchy; a more perfect image seen as implying a more perfect knowledge and understanding of the world, the mind, and the body.

The development and use of the photograph was lauded in medical and scientific circles as a more scientific and reliable instrument for the observation and recording of the world and its phenomena. The language used in contemporary journals and other texts to describe the manifold uses of the camera was that which aligned it to the sensory organs of the body itself. Hugh W. Diamond, an early doctor-photographer known especially for portraits of patients confined to Surrey County Lunatic Asylum, stated in a paper of 1856 that

> 'the Photographer secures with unerring accuracy the external phenomena of each passion, as the really certain indication of internal derangement, and exhibits to the eye the well known sympathy which exists between the diseased brain and the organs and features of the body.'[370]

The lens of the camera was a technological extension and enhancement of the exteroceptive (but ultimately human and fallible, as illustrated by hallucination and illusion themselves) sense of sight and the intellectual or cognitive function of memory in preserving this mental image. Jennifer Tucker has written on the role of the camera and photography as eyewitness in Victorian science. She argues that the mechanical objectivity attributed to the photograph as process and material object offered the potential for the elimination of human agency, judgement, and interpretation in the reporting of scientific results.[371] The camera was both the

[370] Hugh W. Diamond, "On the Application of Photography to the Physiognomic and Mental Phenomena of Insanity," (1856) in *The Face of Madness: Hugh W. Diamond and the Origin of Psychiatric Photography*, ed. Sander L Gilman (New York: Brunner/Mazel, 1976), 20.

[371] Jennifer Tucker, "The Historian, the Picture, and the Archive," *Isis* 97, no. 1 (2006): 111–20.

ultimate observer and tool for experimentally acquired knowledge and information. As such, she claims, it sparked debates about scientific practices and the dissemination of scientific knowledge, as well as the ambiguity of photography as a medium which straddled the artistic and scientific worlds.[372] Fundamentally, the same questions are being asked throughout this thesis: what are the ways of *knowing* being relied upon, and how can they be trusted or proven?

Whilst the use and practice of photography in asylums and psychiatric discourse has been most extensively studied in the French context through the *Nouvelle Iconographie de la Salpêtrière* and medical periodical press,[373] Katherine Rawling's excellent study of asylum photography at Holloway Sanatorium has exposed the ways in which this technology was drawn into, and became a vehicle for, the gendered and class-based ideologies and structures of Victorian mental science. She encourages historians 'to see photography as part of a continuum, a tradition, in fact, of trying to envisage madness through visual media that began long before photographic technologies were available.'[374] Photographic depictions of madness were a representational, as much as a technological, development. They could make claims to truth and objectivity which the paintings, sculptures, and illustrations of insanity could only echo. As such, for many who studied insanity and mental science, the camera was as much a scientific instrument of classification, measurement, and understanding, as it was

[372] Seth Koven has explored similar tensions in his article on the photographs, or 'artistic fictions', taken for the philanthropic promotion of Dr Barnardo's East End Juvenile Mission. See Seth Koven, "Dr. Barnardo's 'Artistic Fictions': Photography, Sexuality, and the Ragged Child in Victorian London," *Radical History Review* 1997, no.69 (1997): 6-45.

[373] Beatriz Pichel, "From Facial Expressions to Bodily Gestures," *History of the Human Sciences* 29, no. 1 (2016): 27–48; Beatriz Pichel, "Reading Photography in French Nineteenth Century Journals," *Media History* 25, no. 1 (2019): 51–69.

[374] Katherine Rawling, "'She Sits All Day in the Attitude Depicted in the Photo': Photography and the Psychiatric Patient in the Late Nineteenth Century," *Medical Humanities* 43, no. 2 (2017): 99.

an artistic one. As Rawling outlines; 'the camera and the photograph became tools to communicate information about the individual patient, and mental disturbance more generally'.[375] Photographs such as that of Julia R might be used within an asylum context for the purposes of identification in cases of escape, to monitor any physically visible change in a patient's condition, to demonstrate what disorder looked like or how to identify it with the body, and occasionally as a therapeutic tool.[376]

Practices of seeing are necessarily very often exploitative, especially in a discursive and physical space predicated and formed around the idea of removing or limiting autonomy and coercive practices. Insanity was not only pathologising and marginalising particular thoughts and beliefs, but also suggesting that the way patients looked, behaved and moved marked them as insane or a problem. Crucially, however, these practices and ways of seeing are historically and culturally specific. The ways in which physicians saw Mary Jane or Baskin's patient's body, and those on their daily rounds of the asylum, were shaped by their profession and training; inflected by class and by gender. They are seeing from a fundamentally empowered position, less exposed to the reciprocal vulnerability of being seen.

I, in turn, am also seeing from a more protected and less exposed view. With the ways of seeing available to me, I am trying to understand the practices of seeing and how those impact experience; how meaning emerges and is shaped from different positions in an asylum or in and out of body. How does experience and meaning change if you are in that body,

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[375] Ibid., 100.

[376] Ibid.

compared to if you are looking at this body? By looking, we are engaging in a process of establishing the boundaries of the body; our own and that of the other. We differentiate the other from ourselves by looking and, in being seen, we become away of the presence of that other. Seeing and being seen are not simple or one-directional processes. They are uneven, layered, and complicated. As these cases have illustrated, both seeing and being seen can and do frequently cause intense discomfort. The ethics of this interaction and phenomenon will be explored in the next chapter on laughter and seeing the body through the lens of emotion and expression (or its absence).

What was the connection between delusion and movement, or, what is an 'automatic lunatic'?

The relationship of these uncontrollable, chaotic, nervous, frozen, and dis/ordered bodies and movements to hallucination and delusion exposes a rift in the understanding and conceptualisation of insanity in this period. Moving from the discursive and theoretical space of mental science to the lived asylum, understanding mental action and the psychomotor, or how the mind was manifested in the body, remained a nebulous and slippery concept. Whilst movements could be seen, understanding and categorising where and why they originated was a complex and thorny exercise. If mental action was the idea that the mind, whether above or below the threshold of consciousness, controlled the body and its many varieties of movement, patients had countless other explanations for why their bodies moved with or without their conscious control. The remainder of this chapter will consider the boundaries of belief which surrounded and informed both insane and sane experiences and conceptualisations of the body, or the ways in which it was imagined.

How did patients in the asylum seek to find languages to understand how their bodies worked and moved? How did metaphors and languages coalesce around this idea of loss of control and a disruption between self, identity, environment, and will or volition? How does technology filter into conceptual systems to inflect and shape the meaning made of the body or the ways in which it is seen? It was not only the role of the camera that disrupted the sensory or exteroceptive and proprioceptive ways of being in the world. The role of technologies and practices such as the phonograph, mental telepathy, mesmerism, and electricity had the potential and ability to capture the imagination and shape the ways in which one interacts with and understands the boundaries of the body and mind in the world. It is also important to draw attention to the fact that these discussions and experiences occurred in a space or institution which did, ultimately, intervene in patients' self-determination and control over their own bodies, actions, and thought in both explicit and implicit ways. Physicians and their patients often spoke about the processes of the body, mental action, and the self in similar ways, but through different languages, concepts and systems.

On July 26th, 1902, a Post Office employee was admitted to Richmond Asylum, Dublin. Approximately a year after admission, the patient told his doctors the frightening tale of events immediately preceding his confinement:

> 'I felt strange, as if some person had made me subservient to his will-power and urged me to do things I did not want to do; this, I believe, is known as mental telepathy. I was tormented by means of a voice, the owner of which can remain at a distance and hold up his victim to contempt. One day I was much tormented, and an impulse which

> I could not resist came upon me, when I was in my brother's workshop, to lift up his shoemaker's knife and draw it across my throat. The cut was slight, but I and my mother and brothers and sisters were all terribly frightened.'[377]

He felt compelled, not only to harm himself, but those around him and he 'more than once' had the impulse to 'knock out [his] brother's brains.'[378] He concluded, in November 1902: 'I am an automatic lunatic; I can sing, dance, or do anything through the wires that are acting on me.'[379] Crucially, underpinning all of this was his central belief that he was no longer the author of this story and controlling his own body; a belief and *feeling* so acute that he described emotions of terror and alienation, having almost ended his own life and that of his brother's.

This story of loss of control, unfamiliar impulses, disembodied voices, and terror was published in *JMS* in April 1903; one of three talks given before the Medical Section of the Academy of Medicine in Ireland by Conolly Norman. Patients of Norman's in these papers have their thoughts read by "The Female Hypnotic School", are 'made the medium through which a conversation is carried on between two persons', are made the instrument of 'the blind' through which they might write and communicate, are played upon by 'an American gang of "sporers," "spookers," or "worsters"' 'by means of an "ether connection", or are made to lose 'control over [their] talk' by 'theology and medicine.'[380] Descriptions of such persecutions by new disruptive technologies such as the camera, phonograph, telegraph and electricity, or by invisible forces of spirits or through mesmeric means challenged what was

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[377] Conolly Norman, "Notes on Hallucinations. II," *JMS* 49, no. 205 (1903): 282.

[378] Ibid.

[379] Ibid.

[380] Ibid., 281, 287.

thought to be possible and explored the boundaries of both belief and the body. If the development of these technologies was disrupting and challenging the supposedly reliable rules of time and space, what made the mental telepathy of Norman's patient, or indeed the Air Loom of John Tilly Matthews' famous account of a singular delusion any less plausible than the camera?[381] Indeed, discussions of hallucination and delusion frequently centred on the connection of the individual to the environment.

Although published in a medical journal, Norman's post office employee can also be found in his transcribed lecture notes. Here, both physician and patient elaborated with considerable detail upon his situation and the entanglement of his delusions with his body and movement. Norman introduced his patient by explaining that

> 'The chief thing that one is anxious to talk about this morning is that he complains that his mind is subject to certain external influences which take possession of it, distort it, influence it, contrary to his will, in a very distressing manner.'[382]

In particular, the patient stated that

> 'My claim is that I am of sound mind and understanding. They can confuse the mind and disturb it at will. It is not hallucination. I have been only an automaton. It has been brought out in America. It is ether communication with the brain, - something like wireless telegraphy, taken in the state of New Jersey for worrying things out of

[381] Mike Jay, *The Air Loom Gang : The Strange and True Story of James Tilly Matthews and His Visionary Madness* (London: Bantam, 2003).

[382] Series 1, Lecture 8, 21 March 1905, ACC/2017/2, CN/1/8, CNL, RCPI.

you. As people say in the city of Dublin, a thing for making you mad. It confuses the mind.'[383]

The patient constructed a clear narrative, identifying characters, instruments, and locations. He clearly attributed his confinement to the asylum, his movement and actions to external agencies influencing and controlling him. He contested the imposition on him of the status or identity of patient and insanity on the basis that he was subject to the whims of another through invisible but very real forces. The patient drew a firm boundary around the self which situated his current situation and experiences outside of and separate from his identity. 'They' and 'I' were distinct agencies, with his body and mind sitting at their intersection. *He* was under the will and control of the sinister Other who interfered with his brain through an unseen ether or telegraphic communication, 'producing chaos instead of concentration';[384] disarray where there should be order and clarity. These agents had their own narrative which he alluded to. They come from somewhere, at some time, and have intent and agency.

These unseen forces are identified as the root of his dis-orientation, or the queering of his experiences. He established that before their influence, he *felt* himself; he could work, think, and live as he wished and as 'the Almighty' intended. Now, the world and his interaction with and within it, are at a slant; viewed through this unseen influence. Norman's line of questioning focused accordingly on 'the effect it has on the mind rather than the machinery by which it is produced.'[385] The interaction between the two which followed offers incredibly rich insight into the tension between medical and patient-produced meaning

[383] Ibid.

[384] Ibid.

[385] Ibid.

which enmeshed the body. In light of the discussion in the first chapter of this thesis, I have chosen not to deconstruct this narrative and have presented it instead as a lengthy excerpt. This allows a demonstration of the dialogic nature of the interaction and how both doctor and patient revealed (in slightly different ways) fragments of the narrative and meaning about the body and experience over the course of the exchange. Norman asked his patient,

> 'What effect has it on your mind?
>
> *Practically speaking, I have no control over myself.*
>
> (The patient in similar language condemns the power which is being exercised over his mind) *The Almighty gave me the power to make my own living. They can disturb the mouth and the features.*
>
> But the mouth is not the mind.
>
> *Well, it is influenced from the mind. The distortions of the features comes from the brain.*
>
> Some where I have got a note of a conversation I had with you in which you told me, for example, that one of the effects produced on your mind was that you were made to sing songs, - popular melodies of the period: 'What ho! she bumps' They made you sing 'What ho! she bumps', even though you have no more voice than I have myself.
>
> *Well, they made me bump anyway. They could make an octogenarian dance. No mind is too strong a mind but they can't control his will and acts. What brought him* (the imaginary tormenter) *to this city I don't know. He made a boast in this city that he would make me put out my hand to beg before he had done with me. Of course, it is a wonderful invention. For instance, if a man was writing on foolscap, or painting, or*

> *anything else, and could see he could do the work in a thorough manner they could botch the work. At the same time the man who is doing the work is responsible for it.*
>
> Well, you seem to paint remarkably well. And you have written me a long letter, - at my request, - which was extremely well-written and extremely clear.
>
> *You asked me for a description.'*[386]

This exchange illustrates the points of tension, accommodation, and negotiation which often formed the basis of clinical practice around delusional beliefs and systems. Norman himself pointed out that he interviewed this patient suffering from paranoid delusion in this manner before the class as he 'exhibits this condition in an exquisite form.'[387] Such conversations are remarkable, highly revealing, and far from exceptional.

Physician and patient both frequently used remarkably similar language and ontological structures. In this case, Norman was particularly interested in demonstrating to his students that the patient 'divides his mind in true metaphysical fashion into impulse, will, and so on. Every one of them is influenced. Everything is in the hands of others. He acts like a marionette. When you pull the strings he sings, dances.'[388] The presence of singing and dancing offered an especially interesting example of the patient's apparent loss of control. Like Baskin's explanation that movement is insane when it is inadequately or inefficiently suited to its environment and purpose, Norman and his patient both express dismay at a mind so clearly tormented and distressed, who nonetheless sang and danced. Dance, as a

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[386] Ibid.

[387] Ibid.

[388] Ibid.

meaning*ful* sequence of movement has a long and complicated history in association with insanity, as numerous physicians pointed out.

The Tarantism (or Tarantulism) and St Vitus' dance were cited as particular examples of 'dancing manias', in which a sort of apparently mass hysteria prompted groups of people to dance themselves to death or total exhaustion. These phenomena appeared in both clinical publications, as Tuke's *Dictionary,* as well as in the more popularly read *Epidemics of the Middle Ages*, published in six editions between 1832 and 1855.[389] Tuke's *Dictionary* referred to Tarantulism as 'an epidemic dancing mania occurring in Italy in the sixteenth and seventeenth centuries… adopted as a remedy for the bite of the tarantula.'[390] The entry contended that fear of the spider bite, thought to cause intense depression and ultimately death, was prompted by the 'number of epidemics prevalent at the time' and that 'music and dancing were found to relieve the depression and it was stated that by these means the poison was dispersed and expelled'.[391] However, the treatment apparently became the disease, and 'the remedy induced great nervous excitement which spread by infection, and very many people became affected by this dancing mania. People danced till they dropped from exhaustion, every emotion seemed excited and suicides occurred.'[392] Molly Engelhardt has pointed to the Victorian fascination with these historic instances which entangled ideas of contagion and bodily movement or dancing across both public and medical audiences and

[389] Excerpts from *Epidemics* also appeared in popular magazines such as *The Penny Magazine*.

[390] Daniel Hack Tuke, *A Dictionary of Psychological Medicine : Giving the Definition, Etymology and Synonyms of the Terms Used in Medical Psychology, with the Symptoms, Treatment and Pathology of Insanity and the Law of Lunacy in Great Britain and Ireland* (London: Churchill, 1892), 1273.

[391] Ibid.

[392] Ibid.

platforms, as expressive of a 'slippage of metaphor into the materially real.'[393] The 'social craze of dancing' and 'rhetoric of movement present in the debates about disease' grew together and fed off one another.[394] Dance moved across social, cultural and medical discourses and spaces to engage anxieties and interests in how the body expressed or was engaged and implicated in expressing ideas or states such as health, vitality, volition (or indeed their opposites.)

In Norman's case, both parties agree that the patient had little to no control over his actions; that his will was being surpassed by impulse and that these movements and behaviours make him incapable of participating in wider society (such as his work at the Post Office.) At issue is the explanation for what governs these systems and how connected they are to the self. The patient attributes his troubles to 'the wirepuller'; the doctor to paranoid delusion. Particularly notable is the connection made by the patient between mind, brain, and mouth or features. Whilst Norman reminded the patient that 'the mouth is not the mind', the patient in turn explained that what he believed was no longer under his control was the process which connected the two: that the 'distortions of the features comes from the brain.' Ultimately, this causal explanation, in its own way, fit the medical model whereby the brain either receives and processes signals from the sensory organs and communicates these to the rest of the body, prompting muscular action, or creates these entirely of its own accord. Ultimately, both doctor and patient believe this movement is automatic, in different senses of the term. For Norman's patient, the processes which governed his body, movement, and perception, were unchanged, but they were no longer his own.

[393] Molly Engelhardt, "Seeds of Discontent: Dancing Manias and Medical Inquiry in Nineteenth-Century British Literature and Culture," *Victorian Literature and Culture* 35, no. 1 (2007): 137.

[394] Ibid.

Throughout this thesis it has been a deliberate methodological choice to focus on 'hallucination' and 'delusion' as languages for experiences marking a disruption or alteration between a person's self and world rather than on diagnoses. Looking solely through the lens of a defined set of diagnostic categories can not only flatten out individuals' experience in what is necessarily a highly personal and variable situation, but also risks both falsely stabilising a diagnostic system which was very open to adjustment and exception. Norman's patient quoted above himself drew attention to the irrelevance of a simple classification or diagnosis to his experience. He told his doctor that 'from creeping melancholy to the distorted maniac they can reproduce every form of lunacy.'[395] He does not feel in control of his own body and feels himself 'a complete automaton.'[396] This patient, and many others uncovered in the asylum archives, was in some sense aware of the systems and languages used by physicians to describe their experiences; this could allow them to actively resist their imposition and build narratives around them.

Norman's patient was keen to insist that the forces which controlled him could mimic the appearance of insanity through and using his body, but was nonetheless adamant that 'it is not a hallucination.' He was apparently aware of the metaphysics of insanity and the processes his physicians were using to read insanity on his body and from what he was saying. Terms such as hallucination were becoming culturally dominant and recognisable ways of organising and understanding experience. However, the systems of thought and belief they were seen as organising and explaining and how these connected the mind and

[395] Norman, "Notes on Hallucinations. II," 282.

[396] Ibid.

body, action and mentation, were not necessarily stable in either the medical community or the wider population.

What did the terms hallucination and delusion really mean, how can we see the experience beyond the theory, and how can we find slippages between them? Esquirol's framework had specified that hallucination was a perception without an external sensory stimulus; illusion the *mis*perception and misattribution of an external stimulus; and delusion the aberrant reasoning process whereby meaning is attached to a perception, object, or sensation.[397] However, the boundaries between these categories of hallucinations, delusions and illusions, how the body or mind produced them, and their cultural currency, remained the topic of considerable debate throughout the century and into the next as the final section will explore. Crucially, if a hallucination was, of sorts, a dream, then surely once this had passed one would be conscious of its unreality. Delusion, on the other hand, was surely insanity: the inability to wake up, living forever in the dream. Looking to Norman's concept of the 'hallucination of mental action' therefore draws attention to the debates surrounding these categorisations and understandings. The term and concept hinged on a point of tension in which patient narrative was foregrounded in novel ways to blur this conventional distinction.

Whilst he stated that 'no one will deny the importance of the sense of vision in respect of our relation to our environment', the 'sense of mental action… is one which has escaped the notice of the physiologist because it is of no great importance in the normal state, when it rarely appears above the threshold of consciousness.'[398] Norman here used language

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[397] Esquirol, *Mental Maladies*.

[398] Norman, "Notes on Hallucinations. I.," 45.

remarkably similar to that used by Warner in his *Dictionary* entry describing mental action as the conveyance, through nerve force, of a sensory impression received outside of the body, to the muscular and motor systems, resulting in action. Hallucination was not just a fault in the distance senses; it could impact the body in a more direct way. Constituting altered perception in both physical and mental terms, the sudden awareness of this ‘mental action’, according to Norman, serves:

> ‘to reinforce delusions of malign and occult influence. Nothing is more common among patients of this class than the complaint that their thoughts are influenced, that they are compelled to think in certain ways or are rendered incapable of thought or the like.’ [399]

Norman emphasised the processes which shape feelings of control and influence in both normal and abnormal function. Further to the three ‘Notes on Hallucinations’ published between 1902 and January 1903, he subsequently published on ‘Modern Witchcraft: a Study of a Phase of Paranoia’.[400] Exploring what he called ‘the sense of mystery from which we can never wholly rid ourselves’, Norman identified the resulting suspicion and feeling of ill-ease as ‘one of the primitive phases of human thought… perhaps connected with that great human desire to look beyond the surface of things.’[401] For Norman, the ‘mystery and suspicion’ in the mind of his patients suffering from what he calls the ‘special emotion of paranoia’, whilst morbid in its expression, was intimately tied to a spectrum of belief amongst the wider population. [402] Its study, according to his writings, might illuminate both secrets of the

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[399] Ibid., 46.

[400] Conolly Norman, “Modern Witchcraft: A Study of a Phase of Paranoia,” *JMS* 51, no. 212 (1905): 116–25.

[401] Ibid., 116.

[402] Ibid.

species as well as the mysteries which the alienist and physiologist had yet to fully investigate and explain in the sane.

Norman frequently marvelled at the creativity and novelty of patients' explanations for their bodies and the systems which came to control them in these cases. He was particularly fascinated by the use of 'neologisms' or invented words used often to describe the technology or mysterious force the patient believed acted upon them. In a lecture on paranoia, he introduced Lizzie O, who was 'tormented with a hypnophone'; 'an instrument for reading one's thought and translating them into logarithms.'[403] Norman remarked that

> 'it is rather curious that an elderly unlettered person should invent such a beautiful Greek compound. After some years of suffering under the hypnophone she developed another beautiful word and talked about the sympaphone, which you might imagine from its composition is an instrument for connecting mind with mind without any intermediary. The artiphone, - which is not so good a word because it combines Greek with Latin, - is another instrument by which she is tormented. As you might gather from its name it is a mechanical device for transferring words from one person's tongue to another person's ear. You will see the peculiar mysterious thread that runs through the whole of these ideas.'[404]

Lizzie's belief underwent subtle shifts, as did the language she used to describe them and thus the way in which she imagined her body in relation to the forces controlling it. The different technologies she created and described were each used in apparently slightly

[403] Series 2, Lecture 8, 20 March 1906, ACC/2017/2, CN/2/8, CNL, RCPI.

[404] Ibid.

different ways to disrupt and interrupt the connection between her volition or mental action and purpose with her environment and other people, seen or unseen.

Lizzie's particular complaint regarded her hands. The conversation she had with Norman was immensely revealing of how multiple meanings could collect around one part of the body and its movement. Norman prompted,

> 'Tell me, what about the troubles of your hands? – besides the rheumatic gout to which you are subject. Does your husband still continue to communicate with you?
>
> *I don't know if it's him.*
>
> Someone else?
>
> *Not at the present moment.*
>
> When did it last happen?
>
> *I can't exactly say. Sometime after I came to the house first. Someone is making my lips tremble now. There is something going on. I can't understand it*.
>
> It isn't merely trembling that occurs in your fingers.
>
> *They make me speak on my fingers against my will.*
>
> Your husband is a deaf mute. Isn't that so?
>
> *Yes*.'[405]

This interaction speaks to the immense importance of the layers of meaning which coalesced around the body and entangled it with language and conceptual systems. Lizzie's experiences

[405] Ibid.

are telling of the ways in which disability shaped the body's interaction with the world and practices of meaning-making. Moving one's hands, for her, was intimately connected to language and communication rather than implicitly so. Norman explained that this personal history of making 'her fingers move and formulate signs in the deaf and dumb alphabet' changed his understanding of the case and how he categorised the experience she described; 'it is muscular. It is not merely the sensation of movement, but the sensation of movement expressing language, - a highly interesting and complicated hallucination.'[406] Physicians were not the only parties interested in the body and its movements as a language or as meaningful signs.

Gestural languages as ways of connecting with others are of immense significance in the asylum, especially given the removal of choice and control over communication and bodily autonomy in this space. These could be integrated into and grafted onto delusions in highly complex ways. Norman detailed a case of 1903 in his article on 'modern witchcraft', in which a patient believed he was the one 'influencing' her.[407] 'He made her stupid and impeded her speech when he passed by. She "did not know" but "thought" this was by mesmeric means.'[408] Such control could cause the feeling of immeasurable pain and cause her to faint, for instance when he pointed at her heart and asked 'how was the pain?' The means by which such control came to be established over her were very clear to the patient.

> 'Question: "How did [Dr N---] get such influence over you?" Answer: "*He asked somebody to get my handwriting. I wrote a letter to a girl who is a friend of mine.*

[406] Ibid.

[407] Norman, "Modern Witchcraft: A Study of a Phase of Paranoia," 119.

[408] Ibid.

> *They got it and gave it to him and once he had my writing and my signature he could influence me by that as he wished*… I was then in his power. He could do what he liked when he had my signature to work on."'[409]

Patients frequently wrote letters to friends and family outside of the asylum; appealing for their release or simply as a means of maintaining contact, in an unfamiliar and controlled environment, with touchstones of their previous life.[410] These communications were, however, generally intercepted and either read or blocked by asylum staff.[411] Whilst the detail of the patient's assertion may not have had a substantial basis in 'reality', her feelings of being controlled and her willpower being subverted by the surveillance and practices of the asylum was not as far from the truth as Norman asserted. Such narratives often create a shadow-view of the daily practices and interactions of the asylum as well as the world around it. This thread will be picked back up in the final section on abuse narratives and the 'value of evidence' in untangling the apparently real from imaginary.

Delusions and hallucinations could challenge a straightforward model of the 'five senses'. Rather than attributing paranoid belief to delusion and thereby dismissing it as irrational, Norman foregrounded listening to patient narratives to establish the ways in which patients experienced and explained their bodies and mental processes. He contended, that

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[409] Ibid., 120.

[410] Beveridge, "Life in the Asylum"; Allan Beveridge, "Voices of the Mad: Patients' Letters from the Royal Edinburgh Asylum, 1873–1908," *Psychological Medicine* 27, no. 4 (1997): 899–908.

[411] Beveridge, "Life in the Asylum," 434.

> 'it is obvious that we are not dealing with a mere inference in these cases, but that the feeling (sense) of mental action (taking place in an abnormal way) is as distinct as the hallucination of any other sense.'[412]

Such experiences therefore represented a disconnect between corporeal self, a feeling of mental control or possession, and the wider social and physical environment. Delusions frequently blended patients' understanding of their own bodies with what was happening around them in the asylum space. During his conversation with this patient, Norman was handed a telegram by an attendant. The transcript recorded how this was integrated into and reinforced the patient's belief and explanatory framework. She stated, 'you could do a good many things by telegrams, - and gramophones.'[413] Norman, rather than dismissing this statement instead responded, musing that 'it is indeed a very occult matter.'[414] These narratives and bodies highlighted a fault line in the contemporary understanding of the porous boundary separating the possible, the unknown, and the insane.

Referencing Esquirol, Norman's stated that 'hallucinations are so common and universally recognised as an indication of insanity', occurring in 80 per cent of cases of 'mental alienation', and that 'we all know that even with the general public there is no proof of aberration more convincing.'[415] However, despite its centrality to insanity, the credulous Victorian public were apparently more prone to hallucination than this statement would suggest. Superstition and the paranormal became the focal points of discussion. The publication by Edmund Gurney, F.W.H. Myers and Frank Podmore of the two volume

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[412] Norman, "Notes on Hallucinations. I.," 46.

[413] Series 3, Lecture 10, 8 April 1907, ACC/2017/2, CN/3/9, CNL, RCPI.

[414] Ibid.

[415] Norman, "Notes on Hallucinations. I.," 45.

Phantasms of the Living in 1886,[416] and the subsequent enquiry into waking hallucination in the sane by the Society for Psychical Research pointed to an increasing overlap with this pseudo-science of spiritualism and the realm of professional psychiatric authority. The SPR's census had canvassed a remarkable seventeen thousand people in 1894, with an alarming 1,684 claiming to have seen apparitions, and represented one of the most substantial studies of abnormal sensory experience and the conditions under which it might occur.

It wasn't just the sight of an apparition in so many that alarmed medical professionals, but the belief in their reality. It was one thing for hallucinations to occur in the sane; in transitionary state preceding sleep, if the sensory organs were compromised (by applying pressure to the eyeball for instance), or under the influence of toxins such as cocaine, opioids, alcohol, or belladonna, it was quite another thing to believe in the reality of the ghosts. Such a belief was directly counter to understandings of both the evolution of mental organisation and civilised society. British psychiatrist Henry Maudsley's publication of *Natural Causes and Supernatural Seemings* came in the same year as *Phantasms of the Living,* offering an explanatory counterpoint to the belief in the reality of ghostly apparitions.[417] According to Maudsley, the ability to correctly control one's baser belief or impulse; to reason and distinguish science from superstition, was the mark of a civilised society and well organised cerebral structure.

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[416] Edmund Gurney, Frederic William Henry Myers, and Frank Podmore, "Phantasms of the Living," (London: Rooms of the Society for Psychical Research, 1886).

[417] Henry Maudsley, *Natural Causes and Supernatural Seemings* (London: Kegan Paul, Trench, 1886).

Historian Roger Smith, in his influential *Inhibition: History and Meaning in the Sciences of Mind and Brain,* pointed to not only the importance of the concept of control to nineteenth-century understandings of insanity's aetiology, but expanded such discussions out into a consideration of the connection between science, society and the emergence of the 'self-regulated' modern individual.[418] Shane McCorristine has pushed this idea of self-control in the context of spiritualism to argue that the belief in ghosts reflected a point of critical tension between the emergence of industrial 'modern' society and this self-regulated individual in which 'the sensorium emerges as a 'haunted perceptual engine at the mercy of all types of sensation with little distinction between perceptions that are 'real' or 'fictive''.[419] He points to the porous boundary between ghost-belief and insanity as reflecting a rapidly disintegrating epistemological field; whilst credulity and superstition were being dismissed as vulgar attributes and thus counter to modernity, spiritualism challenged and 'radically interrogated mid-Victorian notions of evidence and evidential proofs.'[420]

It was not just ghost-seeing that challenged notions of the stable or coherent self, the possible, and scientific certainty. Mesmerism had been lingering on the peripheries of popular culture and the medical establishment for decades by the time Norman wrote his articles. Photographs and other staged promotional material for mesmeric shows reflected the contemporary fascination with the idea of surrendering control of one's body to another by way of an intangible and imperceptible mesmeric fluid or animal magnetism which a select few had the power to manipulate. It was, however, not entirely a fringe science, on-stage

[418] Roger Smith, *Inhibition: History and Meaning in the Sciences of Mind and Brain* (London: Free Association Books, 1992).

[419]McCorristine, *Spectres of the Self*, 78–79.

[420] Ibid., 77.

spectacle, or parlour trick. Through the century, recognised medical and psychiatric practitioners and theorists began to experiment with and write about its potential benefits in psychological therapies. Figures 11 and 12 are taken from an instructional text on mesmerism, published by D. Younger in 1887.[421] This book included a series of these illustrations 'showing various phases of mesmeric treatment', designed to assist in influencing and manipulating the body in these extraordinary ways.[422] Such visualisations as that of catalepsy interrogated the notion of the possible in human physiology. Whilst practitioners often risked accusations of quackery, such ideas were also integrated into broader works and thought on emerging psychological or neurological theories and speak to a deep-rooted entanglement of the mind and body through concepts such as 'the imagination' or sympathy'.

THE CATALEPTIC STATE.

Figure 11 The cataleptic state, 1887, illustration, from D. Younger, The Magnetic and Botanic Family Physician (1887).

THE CURATIVE MAGNETIC PASS FOR SPINAL COMPLAINTS, NERVOUS DISORDERS, OR TO PRODUCE THE CATALEPTIC STATE.

Figure 12 The curative magnetic pass, 1887, illustration, from D. Younger, The Magnetic and Botanic Family Physician (1887).

[421]Illustrations from D Younger, The Magnetic and Botanic Family Physician (London: E.W. Allen, 1887).

[422] Ibid.

In 1872, Daniel Hack Tuke, co-editor of *JMS* and author of the widely-read *Dictionary of Psychological Medicine*, wrote a chapter in *Illustrations of the Influence of the Mind upon the Body in Health and Disease* exploring the relevance and use of 'the Imagination' in psychiatry.[423] He contended that this faculty was a potent psychological force over the body which might be controlled or influenced by the suggestions of hypnotism or mesmerism to alleviate symptoms and illness. Medical historian Sarah Chaney has pointed to the importance of this strand of Tuke's thinking in the wider context of Victorian asylums and psychological therapies.[424] Medical publishing was consistently engaged in exploring the mutual influence between expanding concepts of neurophysiology and the lived experience of mental disease. The experiences of the mind and body in these spaces were not as separate as is often believed and contextual consideration such as this inevitably reorientates and prompts a reading of delusional narratives such as Norman's Post Office employee differently.

When these debates came to be applied to the institutionalised population, the lines between hallucination and delusion were therefore frequently hazier than anticipated by medical professionals. If mesmerism, seances, or indeed electricity, were believed to produce altered sensations in the body and sever or disrupt the connection between the cognisant individual and his or her volition or control, how could one tell if such sensations were self-produced by insanity and damaged neurophysiology, or imposed by an external force? For patients, the ability to separate a sense of self and disentangle identity from their current

[423] Daniel Hack Tuke, *Illustrations of the Influence of the Mind upon the Body in Health and Disease, Designed to Elucidate the Action of the Imagination* (England: J. & A. Churchill, 1872).

[424] Sarah Chaney, "The Action of the Imagination: Daniel Hack Tuke and Late Victorian Psycho-Therapeutics," ed. Sarah Marks, *History of the Human Sciences* 30, no. 2 (2017): 17–33.

sensations or experience was critical. This frequently meant insisting on a language closer to hallucination than the deeper-rooted delusion. This tension and ambiguity will be explored in the next section on perception, which looks to the difficulties of understanding and disentangling experience once delusions and hallucinations moved *inside* the body and were no longer directly accessible and *provable* without penetrating the bodily surface.

There is not one stable way of seeing or understanding embodied experience and how the Other sees the world. These are inherently personally and subjectively, as well as historically and culturally, specific. They depend on what technology is available and how it is thought about; they depend on what position is occupied in relation to that body (whether conceptually and discursively, or physically and spatially); what means is used for recording, translating and describing the body. Ways of seeing and making meaning of and from bodies are processes and practices rather than stable things which just *exist.* Contemporary medical practice and theory was frequently occupied with and interested in stabilising systems of knowledge and experience which were actually remarkably unstable and often opaque.

Insane movement was far from meaningless. Rather, different meanings and explanations for movement coalesced around the body in the asylum. Medical frameworks for how and why the body moved and patients' own subjective meanings or metaphors for their experience, tangled around one another. Such structures grew from and fed off the same questions. Why is the body moving in this way? Why does it seem to do so without the volition of the mind, awareness, or control? The ways in which the body was seen and thought about as an expressive object involved a negotiation of concepts often constructed as boundaries; mind and body, emotion and action, thought and feeling. Looking to the

development and discussion of these concepts across medical, popular, and personal or subjective discourses during a period where they were so unstable and subject to scrutiny highlights the work that was done to entrench these as binaries. Or, frequently, to undermine and elide them.

Norman's lectures indicate that movement was far from irrelevant to the experience of hallucination and delusion. Both the inclusion of brackets describing actions or comportment, and the detailed dialogue between physician and patient, offer the historian insight into how the body was entangled with the experience of the self, reality and emotion, as well as medical care. Patients whirred their arms, believing themselves to be steam trains, their wills and 'mental action' were co-opted by unseen agents, and they referred to themselves as marionettes, felt weight in their limbs, and experienced 'psychomotor hallucination'. Crucially, the lectures demonstrate the significance of how doctor and patient interacted and physically occupied space. The very first patient we 'meet' through the lectures forcibly demonstrates this point and framed the ways in which I 'saw' the body in these documents. The transcriber recorded that,

> '(the first patient, a woman, necessitates the attendance of two nurses, as she fiercely struggles, throwing herself on the ground loudly screaming, and swearing at and reviling some person or persons unknown. She looked towards the lecturer, but whether at him or not it is difficult to say.)'[425]

Norman's first telling question to his audience was 'what sign of insanity does she display?' Gestural, behavioural, and embodied languages were as much a part of both reality and

[425] Series 1, Lecture 1, 3 March 1905, ACC/2017/2, CN/1/1, CNL, RCPI.

communication as the verbal languages and narrative structures discussed in the previous section. Through these sources, we can ‘see’ these bodies, their significance and complexity, in new and exposing ways.

Chapter 4: Laughter

This chapter delves deeper into the idea of the expressive body; of movement and action as meaningful in that it apparently rendered emotion or feeling readable on the bodily surface. To do this, it considers one apparently distinct expression I was not familiar with finding or thinking about in this context; that of laughter. Norman, his patients, and his students, *laughed.* Importantly, so did I. The phantom of intimacy conjured in these archives prompted pleasure, amusement, and humour as well as the discomfort and voyeurism discussed in the previous chapter. Some of the movements, expressions, stories, and hallucinations or delusions which I encountered in Norman's lectures made me laugh. Sometimes I just couldn't stop myself. In this chapter, I ask how we should think about laughter in these sources and this space.

On the 6th March, 1905, Conolly Norman introduced a male patient to the assembled audience of his students. The record of this lecture described that this patient was a 'well-built man in the prime of life, who immediately commenced speaking with such rapidity that only an occasional series of consecutive words could possibly be grasped by the listener.'[426] What followed was over a page of disconnected phrases, half-thoughts, names, and images listed by the patient, periodically interrupted by the doctor. 'I was dreaming about the first Mary .. .. .. machine for cutting your hair .. .. .. White's of Kilkee .. .. dog. Who poisoned it? .. .. .. Mary Mooney, Blind Point. .. .. ..'[427] Concluding the lecture, Norman told his students:

[426] Series 1, Lecture 2, 6 March 1905, ACC/2017/2, CN/1/2, CNL, RCPI.

[427] Ibid.

> 'Well, the essence of wit is turning up with something unexpected. The rapidity of thought of this man produced something like wit and gives us such a surprise that we cannot help laughing, and I don't think it is unkind to laugh in this case.'[428]

Norman acknowledged the dangers of laughter whilst effectively giving his students permission to do so. He warned that in some cases laughter could indeed be unkind, and that it was not always possible to control one's physical response to a stimulus, regardless of the 'objective' and dispassionate aims of clinical medicine. He also, crucially, determined that the laughter was prompted by the surprise at finding a simulacrum of wit in an insane man, where it was unexpected. Laughter *did* happen, even in places where it shouldn't or where it sat uneasily and uncomfortably. This is a chapter, not just about laughter in the asylum and Victorian mental science, but about my own surprise in finding it there (or indeed finding it at all). Laughter slipped off the page in asylum casebooks. In Norman's lectures I found patients smiling, laughing, and *being laughed at*. Once I did find it, how ought I think, write or *feel* about it?

This chapter looks to Norman's lectures to explore the curiosity and ambivalence with which particular types of embodied experiences and movements were recorded and discussed by both doctors and patients. It considers how the laughter of both doctors and patients was viewed and experienced in the physical and conceptual spaces of mental science. Was laughter expressive, disruptive, empty, social, grotesque, or uncomfortable? Can the experiences of patients in the asylum ever be funny? Why can laughter happen seemingly without our will or volition? It can be difficult to untangle at times whether Norman was laughing *at* or *with* his patients, prompting us to ask what laughter *means* and how

[428] Ibid.

interpersonal dynamics or power inform this meaning. Whilst laughter and humour sit uneasily amongst the often painful and distressing stories of insanity, it is far more central than the paucity of historical literature on the subject would suggest. The image or idea of the 'laughing lunatic' is not unfamiliar in popular culture and language and the term 'in hysterics' or 'hysterical laughter' remains in common parlance. This chapter explores why laughter is so central to what it means to us to be human, but why the relationship between laughter and emotion is not always a simple one. What role does the familiarity and recognisability of embodied expression have to play in how we relate to other human beings, and why is laughter more uncomfortable or unexpected in some places than others?

The malleability and contextuality which makes laughter such a rich source of information about the past and embodiment has often been at the heart of historians' reticence to engage with it. It may be widely recognised as a peculiarly human experience, but this is not to say that it is ahistorical or universal. This has been explored in work such as Robert Darnton's *Great Cat Massacre* on peculiarity and eighteenth-century French humour and Mikhail Bakhtin's discussion of the subversive and grotesque laughter of the carnivalesque illuminated.[429] What causes us to laugh is inherently subjective and unstable. We define ourselves by what we find funny; that there are national senses of humour (or perceived lack thereof). There is apparently an appropriate and inappropriate time to laugh, or indeed make a joke. In deciding whether to laugh, we first ask whether the laughter of others is *at* us or *with* us. Laughter and humour are relational and intersubjective experiences through which we interact with the world.

[429] Mikhail M Bakhtin, *Rabelais and His World*, trans. Hélène Iswolsky (Bloomington, Ind.: Indiana University Press, 1984); Robert Darnton, *The Great Cat Massacre: And Other Episodes in French Cultural History*, (New York: Basic Books, 2009)..

Generalising across centuries, how can the historian hope to find and pick apart humour when it may not be funny to her? Further than this, when we do find something funny, is it always ok to laugh, and how does what we find funny inform our identity (or indeed *vice versa*)? Laughter often coalesces around the tragic, traumatic, violent, or threatening, both on the macro level and that of personal experience. This tendency has resulted in the proliferation of adjectives through which we situate and understand humour and laughter as interrelated phenomena. We refer to dark humour, and nervous or anxious laughter, for instance. This politics of humour have been widely recognised by both contemporaries and current theorists, especially in the context of identity and oppressed groups, against whom humour can be turned as a form of discursive violence.[430]

Nineteenth-century commentators pointed to the 'morality of laughter' in such texts as Vasey's *Philosophy of Laughter and Smiling*.[431] Our image of the Victorians as lacking a sense of humour, compared to the scatological and satirical irreverence of the eighteenth-century,[432] is undoubtedly partly the legacy of such assertions as Vasey's that the subject of laughter is 'no laughing matter' and these 'absurd and stupid excitements' had dire pecuniary, social, and developmental consequences.[433] The Victorian corseted middle-class

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[430] Martina Kessel and Patrick Merziger, *The Politics of Humour: Laughter, Inclusion, and Exclusion in the Twentieth Century*, German and European Studies (Toronto: University of Toronto Press, 2012); Pol Dominic McCann, David Plummer, and Victor Minichiello, "Being the Butt of the Joke: Homophobic Humour, Male Identity, and Its Connection to Emotional and Physical Violence for Men," *Health Sociology Review* 19, no. 4 (2010): 505–21.

[431] George Vasey, *The Philosophy of Laughter and Smiling* (London: J. Burns, 1877).

[432] Vic Gatrell, *City of Laughter : Sex and Satire in Eighteenth-Century London* (London: Atlantic, 2006); Simon Dickie, "Hilarity and Pitilessness in the Mid-Eighteenth Century: English Jestbook Humor," *Eighteenth-Century Studies* 37, no. 1 (2003): 1–22.

[433] Vasey, *The Philosophy of Laughter and Smiling*, vii, 33–34.

identity of the popular historical imagination seems inextricably entwined with such ideas of morality and decorum which resisted frivolity and the excess of the body or emotion indicative of moral and social degeneracy.[434] Laughter and humour had a moral, intellectual, and therefore social, dimension which ought not be overlooked.

One can laugh at or with. As such, it is an immensely important social exchange through which scholars might see a range of social or interpersonal nuances. Biologist and sociologist Herbert Spencer, in his article on the subject, pointed out that 'some have alleged that laughter is due to the pleasure of a relative self-elevation which we feel on seeing the humiliation of others.'[435] The 'fatal objection' to this theory, however, was that 'there are various humiliations to others which produce in us anything but laughter'.[436] Instead, pity, condescension, sympathy, sadness, or a myriad of other emotions might stand in amusement's stead. Laughter is not the only response to perceived superiority or inferiority, but it certainly plays a role. This connection between physiology, behaviour, emotion, and social relationships, is critical when considering humour and laughter both inside and outside the asylum. Far from mirthless, the Victorians were instead fascinated by *why* they laughed. What did laughter mean and why did it happen? Crucially, laughter is a social as well as physical action and reaction: laughter *does* something.

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[434] Gesa Stedman, *Stemming the Torrent : Expression and Control in the Victorian Discourses on Emotion, 1830-1872* (Aldershot: Ashgate, 2002).

[435] Herbert Spencer, "The Physiology of Laughter," *Macmillan's Magazine* (Cambridge: Macmillan, 1860), 395.

[436] Ibid.

This chapter sees and uses laughter in these sources and encounters as both a disruptive and creative tool, entailing multiple phenomenological possibilities. This chapter considers laughter and humour in the context of three adjectival descriptors; empty, grotesque, and (in)appropriate. In doing so, it explores the ways in which it was lived, seen, and judged. Most importantly, it considers laughter as an experience which momentarily or continually altered the subject's relationship with their body, environment, and other people.[437] The entanglement of laughter as an embodied experience or action, with humour as an interpersonal social phenomenon can tell the observer (whether historian or contemporary, physician or peer) a great deal about how an individual navigates their world and experiences their lived body. Laughter could represent both a failure of this process of mental action discussed, or its realisation and manifestation.

Empty laughter?

The insane frequently laughed, giggled or smiled seemingly without cause, either external or by way of an internal emotion. Whilst positioned at the far end of a spectrum, these laughing lunatics raised crucial questions about impulse, nervous response, and the body's connection to interior states in the sane as well as the insane. One of the central reasons the history of the asylum and insanity has hitherto been largely humourless is because laughter is fairly difficult to document, particularly in the physical sense. However, in many ways closer to a theatrical script than asylum casebooks, Norman's lecture transcripts feature 'stage directions' in which the patient's behaviour, movement, expression,

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[437] For a fuller discussion of laughter and weeping as moments of chaos and disjuncture between the mind and body, which simultaneously remind the laugher of their interconnectedness, see Helmuth Plessner, *Laughing and Crying: A Study of the Limits of Human Behavior*, ed. James Spencer Churchill and Marjorie Grene, Northwestern University Studies in Phenomenology & Existential Philosophy (Evanston: Northwestern University Press, 1970); Bernard G Prusak, "The Science of Laughter: Helmuth Plessner's Laughing and Crying Revisited," *Continental Philosophy Review* 38, no. 1 (2006): 41–69..

or interaction with other people in the room was noted as it was observed. They document patients' laughter, weeping, screaming, bargaining, explaining, and resisting. This allows unprecedented insight into what a conversation between doctor and patient *looked* like, as well as sounded like, thereby allowing us to think about the disconnect that often occurred between the two. One such example in Norman's eighth lecture of his third series is as follows:

> 'You feel you can't control your thoughts. Is that so?
>
> *Yes, sir.*
>
> You can't control your temper sometimes?
>
> *Yes, sir.*
>
> Were you not a little unnecessarily violent just now?
>
> *Yes, sir, I was.* (Begins to laugh)
>
> What are you laughing at?
>
> *Indeed, sir. I couldn't tell you. If I was to put on my Gospel oath I couldn't. Do you want any more? I'm Mary O' Connor.'*[438]

Mary O'Connor laughed but didn't know why.[439] Just as she seems to have been little able to control violent outbursts, her laughter appears to occur without a stimulus or her own knowledge and control.

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[438] Series 3, Lecture 8, 19 March 1907, ACC/2017/2, CN/3/7, CNL, RCPI.

[439] Her full name has been used here as this was how she chose to present and identify herself.

Norman referred this behaviour to Mary's being 'a tolerably good type of the maniacal state', whereby 'she was unable to keep her attention fixed on any subject of conversation, and every moment without any particular reason her temper got the better of her and she gesticulated in a wild fashion.'[440] This seemingly uncontrollable and unprovoked laughter is most commonly associated with patients, like Mary, deemed maniacal. Whilst in a previous lecture Norman stated that he disagreed with the categorisation of mania as a distinct disease type, he used the term as a collection of behaviours and symptoms or markers, discussing it in the context of apparent incoherence. He contended that patients often 'babbled' in this state, and that

> 'the words are probably more connected and more associated with ideas actually in the mind of the patient than appears on the surface, but we cannot see the connection. I don't [sic] think the thoughts are entirely disconnected as they appear to be. The apparent incoherency is probably more due to the rapidity with which the ideas are produced and associated.'[441]

This incoherence was a valuable sign of insanity, representing a breaking down of the boundaries of the self. Norman argued that 'whether produced by absolute disintegration of the mind, produced by exaltation of ideas in mania, or produced by confusion in other types of insanity, – incoherence is a thing that cannot be imitated.'[442]

Immediately following his discussion of patients' babble, he explained that this verbal incoherence would be referred to in a certification for insanity for this particular patient,

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440 Series 3, Lecture 8, 19 March 1907, ACC/2017/2, CN/3/7, CNL, RCPI.

441 Series 2, Lecture 1, 2 March 1906, ACC/2017/2, CN/2/1, CNL, RCPI.

442 Series 3, Lecture 8, 19 March 1907, ACC/2017/2, CN/3/7, CNL, RCPI.

alongside the statement that 'she perpetually indulges in unmeaning and fantastic gestures.'[443] Gestural and expressional language made visible an inner world, which mania could cast into turmoil, disintegrating the connections which sustained an embodied and cognisant selfhood. Laughter was an embodiment of this disintegration, either of the mind itself or the connections between states, ideas, and their verbal or physical expression. In laughing, the patient 'exhibited a form of exaltation which commonly takes the place of hilarity in cases of acute mania.'[444] The language used by Norman clearly indicates that whilst it was remarkable for its absence of emotion, Mary's laughter was still regarded as an exteriorisation of an internal state. Rather than happiness or amusement, it demonstrated or 'exhibited' her inner turmoil and lack of self-control or regulation. Laughter in such cases might be seen as a form of physical incoherence; a discordant physiological response indicating a body out of sync with its mind and environment.

Cases such as Mary's raised crucial questions for physicians and biologists working on the nerves and emotional process in the sane as well as insane. Did the appearance of happiness necessarily indicate the genuine emotional condition? The manic state provided a particularly interesting and tricky ground on which these enquiries were built. In such patients, ought one to observe the behaviour and actions of the body as evidence for feeling, or listen to what the patient said? And, if the latter, at what time? Asylum narratives are far from static. They are at once synchronic and diachronic; the evidence we possess disrupting and recasting time in complex ways. These are not new questions, and when confronted by patients such as Mary who laughed without knowing why, doctors frequently drew attention

[443] Series 2, Lecture 1, 2 March 1906, ACC/2017/2, CN/2/1, CNL, RCPI.

[444] Series 3, Lecture 8, 19 March 1907, ACC/2017/2, CN/3/7, CNL, RCPI.

to the particular problems posed by expressions of happiness not necessarily presented by its opposite. Norman warned his students,

> 'Whereas in melancholia the patient is emotionally depressed[,] in mania the patient is emotionally exalted and is unduly cheerful, happy, and hilarious. Hilarious they often are; cheerful they sometimes are; happy they may be. Patients of this kind who have shown high spirits have afterwards described to me that during the whole time they were suffering with the perpetual state of mental fuss. Although it showed in much laughter it really was accompanied by a feeling of pain and exhaustion.'[445]

Norman did not treat all emotional states as equal in his patients. It was evidently easier to understand the presence of sadness in insanity and the asylum than positive emotions. This distrust is, however, not purely physician-generated and Norman indicated that patients themselves pointed to a disconnect between their performed emotion and 'authentic' affective state. He also maintained that, 'I don't think it [emotional exaltation] is accompanied by happiness[:] I think it is a cheerless state.'[446] In an earlier lecture he went further, stating that '(I doubt if these maniacal creatures are happy) I think their state more resembles a sort of nightmare than true gaity [sic].'[447] There is an intensely uneasy relationship in these sources between embodiment, humour, emotion, laughter, and insanity; one which necessitates a broader view of contemporary understandings of emotion, the body, and its processes.

How could one laugh without feeling happy? Whilst generally seen as a simple exercise in cause and effect; one feels happy, so one laughs, nineteenth-century writers

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[445] Ibid.

[446] Ibid.

[447] Series 1, Lecture 2, 6 March 1905, ACC/2017/2, CN/1/2, CNL, RCPI.

engaged extensively in a discussion of the physiology of emotion and expression, which challenged this formula. Divisions drawn in the nineteenth-century bear striking resemblance to that which continue to be discussed by neurologists and philosophers. Such an argument often rests on ideas of a trajectory of development from the expressional to the cognitive. A child or primate responds with physical cries when stimulated (as with tickling), but an adult is better able to control this elementary or rudimentary response and laughter might be prompted by a range of cognitive, emotional and physical stimuli instead. In a 1907 article on hysterical laughter, reviewed in the *JMS*, Argentine physician José Ingegnieros divided the 'complex' 'phenomenon' of laughter into three main groups of elements which might be 'combined in various ways': the expressional, emotional, and intellectual.[448] The psychopathologies of these elements might be distilled as: laughing without feeling, laughing with the wrong feeling, or laughing at the wrong thing. Ingegnieros foregrounded the physical movement of the body we call laughter, separating it from and discussing it before the emotional element. He claimed that the laughter of the 'child, the idiot, and the dement' might be limited to this expressional element 'as a phenomenon of cerebral automatism determined by imitation, or as a simple reflex.'[449] Similar to the jerk of a knee when struck, laughter might be a response to the tension of the body in certain pathological, degenerate, or undeveloped states.

Although most of the involuntary actions of the body had obvious life-sustaining or useful purposes (such as a beating heart, expansion and contraction of the lungs, or dilation of

[448] José Ingegnieros, "Hysterical Laughter [Le Rire Hystérique]," *Journal of Mental Science* 53, no. 221 (1907): 411.

[449] Ibid.

the pupils) Spencer maintained that 'the movements of chest and limbs which we make when laughing have no object.'[450] He did, however, go on to state that,

> 'those external actions, through which we read the feelings of others, show that under any considerable tension, the nervous system in general discharges itself on the muscular system in general, either with or without the guidance of the will.'[451]

The physical expression of emotion served a social purpose. Strength of feeling led to the impulse and action of the body: through the nerves, to the face, then body in a semi-automatic cascade. In a fully developed and refined nervous system, one did not laugh for no reason, even if one laughed without wanting or meaning to; it was a *meaningful* expression of emotion through which social bonds might be fostered and a commonality of feeling established. This is where the laughter of the insane presented a problem. One might laugh without wanting to, but why did Mary laugh without knowing why?

Grotesque laughter

This laughter suggested abnormal or inferior connection between nervous or affective impulse and mentation. As such, a particular kind of laughter was frequently aligned with the grotesque or brash and uncivilised: the insane, the child, the savage, and the historical past. In referring to these 'maniacal *creatures'*, Norman put the lunatic closer to the animal than civilised man. In his *The Expression of the Emotions in Man and Animals,* Darwin built on and referenced Spencer's work. In 'idiots and imbecile persons' and 'children at play, who are almost incessantly laughing', laughter might be read as the 'expression of mere joy or

[450] Spencer, "The Physiology of Laughter," 398.

[451] Ibid., 395.

happiness', but this was very different to the laughter of adults.[452] This physical way of expressing emotion was described as raw and innate rather than taught or imitated. Darwin demonstrated this assertion by referring to the case of the blind and deaf Laura Bridgman who, despite having never witnessed what joy and happiness *looked like* in another, "laughed and clapped her hands, and the colour mounted to her cheeks" when met with a letter from a beloved friend.[453]

Figure 13: Photographs from Charles Darwin, Expression of the Emotions (1872).

Darwin was immensely interested in the question of whether the physical expression of emotion was involuntary; preceding and prompting the emotion and cerebral alteration itself, or whether this process was reversed. In her work on 'scientific looking' and spectatorship practices in Victorian Britain, Tiffany Watt-Smith argues that Darwin viewed emotion and its gestural or expressional languages as part passive and part active, but unavoidably social.[454] His theory of emotions was shaped and informed by broader contemporary practices of looking, including theatre, sensational performances, photography, and illustration. A selection of photographic images and engravings of neurology patients, actors, and children were included in *Expression,* as

[452] Charles Darwin, *The Expression of the Emotions in Man and Animals* (London: John Murray, 1872), 198–99.

[453] Ibid., 198.

[454] Watt-Smith, "Darwin's Flinch: Sensation Theatre and Scientific Looking in 1872."

illustrated in Figure 13.[455] Darwin was in regular correspondence with neurologists Duchenne du Boulogne and Crichton-Browne between 1869 and 1872, when he published *Expression*.[456] The latter, who was medical superintendent of the West Riding Pauper Lunatic Asylum, frequently attached photographs to his letters indicating the physiognomy, physiology and behaviour of asylum patients. Phillip Prodger, curator and editor of the 1999 edition of *Expression,* has drawn attention to the presence of such photographs of lunatics in Darwin's archives and collections as indicative of his belief that the inability of the insane to control their emotions meant that, unlike most adults, their expressions were 'raw', 'uninhibited and unconstrained'.[457] However, Darwin's interest in images of lunatics and their expressions went further than this. The insane did not just show exaggerated physical manifestations of raw emotion, they also supposedly mimicked emotion without feeling it.

Considering the visual practices and observation of emotion reveals how contemporaries attempted to establish this relationship (or lack thereof) between interiority and exteriority or physical appearance. It demonstrates how people attempted to navigate their world, both through and with their bodies and intersubjectively. However, as a physical expression, laughter loses something as words on a page. How do we reconstruct how it was *seen* and lived through the body, when we are often reliant on text in historical practice? Representing, imagining, and capturing the exteriorisation of interior states was the subject of extensive study in the nineteenth and early-twentieth centuries. Laughter was a way in which feeling could be *seen* and emotion rendered observable. As such, its study requires now, as

[455] Wallich, Rejlander, and Duchenne, Plate III, Figures 1-6, photographs, from Charles Darwin et al., *The Expression of the Emotions in Man and Animals* (London: John Murray, 1872), opp 202.

[456] Phillip Prodger, "Darwin's Camera : Art and Photography in the Theory of Evolution" (Oxford: Oxford University Press, 2009), 95.

[457] Ibid., 93.

then, an incorporation of visual and textual methodologies. Although generally seen as interchangeable, the difference between humour and laughter is significant. Principally, humour implies emotional and affective responses to a stimulus, which then *can* have a physiological manifestation in laughter or smiling. Humour is generally seen as the cause and laughter is the effect of affect. As a phenomenon, the latter is embodied in complex ways. We have a myriad of words for laughter, which are generally contextually determined. In English, we might laugh, giggle, roar, chuckle, snigger, chortle, guffaw, and a host of others. These descriptors are often have particular social connotations of class, race, and gender and a sensitivity to the particular adjectives and verbs with surround or describe movements such as laughter can be immensely telling.

The 'giggle', for instance, was an explicitly feminised form of laughter which aligned the giggler with childhood and girlhood. As such, it could have entirely different meanings where it appeared in notes or interactions between patients. A male patient giggling signified something different to a female patient, and different again to an elderly woman. Whilst laughter is rarely explicitly included in asylum casebooks, the 'giggle' occasionally appears, as in the case of twenty-three-year-old Annie Elizabeth G. Annie Elizabeth was confined to Bexley in 1903 for 'chronic mania… apparently the result of dementia praecox' when she started hearing a saint's voice, seeing 'visions of heavenly faces' and believed herself to be 'in a community of saints.'[458] Annie Elizabeth's giggling was described alongside statements in her casebook recording she 'cannot be controlled' and was 'very incoherent, irrational in her behaviour.'[459] One entry read that she 'often mistakes the nurses for men, and puts her

[458] CB 3 Female, 1899-1912, H65/B/10/028, BH, LMA, 4.

[459] Ibid.

arms round their necks and kisses them, manner foolish and flighty.'[460] Her tendency to giggle was aligned with this 'foolish' manner, apparent impulsivity, and implicitly sexualised behaviour. The 'giggle' marked the body and mind in different ways.

Ways of describing the laugh could therefore signify particular qualities or imply meaning on the body and its movement. Ways of describing the laugh can also be reflections of the extent of the body's reaction to the stimulus or the appropriateness of the context in which it occurs. Writing in 1860, Spencer maintained that 'emotions and sensations tend to generate bodily movements, but also that the movements are vehement in proportion as the emotions or sensations are intense.'[461] An excessive physiological response implied an excess of nervous tension which discharged itself on the body, rendering the subject effectively helpless. Vasey's text included illustrations designed to demonstrate the warped and contorted physical effects the surrender to laughter had on the human body and face, or 'the human face divine.' Humour might be dangerous and reflect the degeneration or moral incontinence of the laugher, but these 'distortions' were equally grotesque and alarming. The illustration in Figure 14 showed his readers the 'superlative

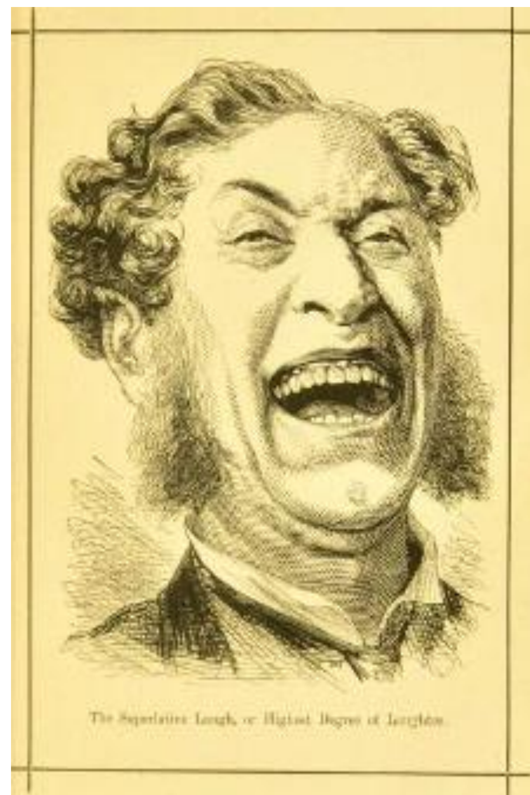

Figure 14: "Superlative laugh", engraving, from George Vasey, Philosophy of Laughter (1877).

[460] Ibid.

[461] Spencer, "The Physiology of Laughter," 396.

laugh', which twisted and apparently spoiled the features of the face in its exaggerated expression.[462] Transforming the dynamically embodied experience of laughter into a static engraved image in this manner prompted its dispassionate and decontextualised regard. Assuming an appraising gaze, the viewer is confronted by the absurdity and grotesqueness of a face captured at a moment in which control was surrendered to spontaneity and raw impulsive physiology.

Vasey included this visualisation of such grotesque exaggeration in his text to demonstrate that 'a laugh distorts every feature, and renders even a handsome face unpleasing and ridiculous, so that a refined and intelligent spectator is apt to turn away from it.'[463] This face was intended to cause discomfort and revulsion, illustrating the disruptive and corrupting power of laughter which destabilised and upturned the order of the serene or smiling face. Vasey contended that 'the various species of the genuine or amiable smile are all beautiful, whether of benevolence or kindness – sympathy or gratitude – admiration, veneration, or affection – they are all sweetness and beauty.'[464] In stark opposition, the 'various species of laugher are all ridiculous, absurd, or impudent – vulgar or idiotic – presenting ugliness to the sight, and harsh grating sounds to the ear.'[465] The author's dismissal of laughter was not only on the grounds of morality and what laughter indicated about the laugher, but how others regarded and experienced the laughing body and face. There was a taxonomy or hierarchy of the physical expression of emotion, discussed and

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[462] "Superlative laugh", engraving, from Vasey, *The Philosophy of Laughter and Smiling*, courtesy of Wellcome Library.

[463] Ibid., 105.

[464] Ibid., 109.

[465] Ibid.

established in such moral tracts as well as physiological explorations as Darwin's work. Laughter is portrayed as intersubjective on a sensory level as well as a social and political one.

If the laughter of the sane represented a moment of abandon, deformation, and disintegration, the laughing lunatic was alarming precisely because it was situated on the same spectrum. The insistent corporeality of insane bodies urged a confrontation with how the cognisant self was connected to embodiment. The apparent physical as well as emotional or intellectual incoherence of patients was the subject of extensive discussion and exploration. Apparently meaningless yet absurd movements appeared to parody emotional expression when reduced to their immediate physicality. Whilst the excessive expression of emotion in the sane was supposedly uncomfortable or repulsive to observe in another, the ability to arrange one's features into this characteristic physical language was inescapably human. Expression reflected a responsiveness to one's surrounding environment as well as internal state. In the insane, it was not simply the appearance of excess that was grotesque, but the contortion without the recognition of meaning. Norman commented on one patient, who 'tends to remain in a grotesque attitude with a fixed smile which is not human'.[466] Like the example of Mary Jane in the previous chapter, patients such as this were treated as inferior in both their appearances and responses to physical as well as social stimuli.

[466] Series 3, Lecture 10, 8 April 1907, ACC/2017/2, CN/3/9, CNL, RCPI.

Emotion in the asylum was often depicted as shallow, hollow, basic, and, in many cases, fleeting. It was also cast as exaggerated, uncouth, grotesque, and uncomfortable to look at. Norman contended that,

> 'the patient who is laughing, hilarious, and exalted, is apt to burst into tears and become self-pitying, and so on… This is rather to be regarded as an example of instability than of any real alteration in the emotional condition.'[467]

The display and performance of emotion could apparently exist independently of affect. Indeed, Darwin contends that 'it is probably due to the close similarity of the spasmodic movements caused by the widely different emotions that hysteric patients alternately cry and laugh with violence'; a pattern of interchangeability supposedly shared with children and 'the Chinese.'[468] In conditions such as general paralysis and experiences of stupor and catatonia in particular, descriptions of patients' bodies and expressions are frequently minutely anatomised and analogised. Such descriptions differentiated them from laughter and emotional expression in the wider population.

Just as the sight of emotion without its depth effected an alienation and condescension, so could its conspicuous absence. A patient introduced by Norman in his third lecture series was presented to students as he exhibited a 'flabbiness produced by obliteration of the lines of expression'.[469] Norman remarked that he would 'often compare the expression of the ordinary general paralytic, - I hope not unkindly, - to the common intelligent dog, - one of these dogs, a great Dane, whose eyes look full of fire, and the rest of the face hanging in

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[467] Series 1, Lecture 3, 7 March 1905, ACC/2017/2, CN/1/3, CNL, RCPI.

[468] Darwin, *The Expression of the Emotions in Man and Animals*, 208.

[469] Series 3, Lecture 14, 22 April 1907, ACC/2017/2, CN/3/13, CNL, RCPI.

flabby dewlaps.'[470] The lecturer vividly described an image curiously situated between human and animal, at once cognisant, intelligent, and apparently feeling behind its eyes, but somehow unable to express this through the body. He commented that,

> 'the expression of emotion is largely the function of the facial muscles; also of the laryngial muscles, The different tones of the voice express emotion. It is interesting that one of the earliest groups of muscles to be engaged in general paralysis is this general group of muscles subserving emotion.'[471]

The face was of vital importance in recognising the self in the other and establishing a commonality of meaning lived and enacted through the body. The ways in which the insane body was seen and represented offer considerable insight into how it was lived, both intersubjectively and phenomenologically. Historians have long been concerned with accessing the voice of insanity, but Norman clearly stated the importance of the face and ways in which the insane were *seen* as well as *heard*. These faces and bodies can assist the historian in understanding the ways private experiences were framed, expressed, and shared in clinical contexts.

Images of lunatics, male or female, did not just represent madness, they were used for multiple purposes and in many contexts. They could be illustrative, representational, fragmenting, institutional and bureaucratic, intimate, dispassionate and anatomical, or grotesque. Entwining and incorporating the visual, material, and textual sources in their historical analysis allows the researcher to better appreciate the corporeal, gestural, and

[470] Ibid.

[471] Ibid.

expressional in historical experience. In their edited volume exploring transcultural perspectives on laughter, Elisabeth Cheauré and Regine Nohejl argued that ‘images are often able to express humorous elements better and more concisely than words’, whilst ‘on the other hand, the connections are usually too complex to manage without any verbal remarks at all.’[472]

In the context of asylum archives, the verbal and textual layer meaning and offer a dynamism and multi-dimensionality to the photographic images and illustrations which historians have begun to explore. An image might capture laughter, but the contortions of the face often remain ambiguous. What *kind* of a laugh was it? Was it perceived as empty, genuine, anxious, or foolish? Did the patient *feel* amused, or rather distressed that they could not control themselves? For patients who described delusions in which they were being controlled by a mysterious and sinister ‘they’, laughter and expression could mean something entirely disconnected and alienated from the self. When Norman’s ‘automatic lunatic’ explained that ‘they can disturb the mouth and the features’,[473] and that these ‘distortions of the features come from the brain’,[474] he was attributing significance to his expressions, but for him the meaning was entirely different to that of his physician. A grotesque leakage in an entirely different sense, in which his body betrayed him. Those controlling him bypassed his will and worked through the body, making him sing popular comic songs and rendering him an object of ridicule. Rather than exposing his emotion to the world and others, it was being manipulated and made the vessel for something or someone separate from the self. Laughter

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[472] Elisabeth Cheauré and Regine Nohejl (eds.), *Humour and Laughter in History: Transcultural Perspectives*, Historische Lebenswelten in Populären Wissenskulturen; 15 (Bielefeld, 2014), 7.

[473] Series 1, Lecture 8, 21 March 1905, ACC/2017/2, CN/1/8, CNL, RCPI.

[474] Ibid.

and physical expression were ways in which the body and one's appearance to others exposed an interiority which generally remained hidden. Its sight exposed the apparent presence or absence of control, emotion, and reason in ways often represented and perceived as disconcerting, uncomfortable, and haunting.

The bodies and expressions of the insane were at once seen as malleable and uncontrollable or unpredictable; visible manifestations of otherness rather than necessarily exteriorisations of true 'feeling.' The meaning attributed to expression ranged widely and could cause surprise or amusement in those regarding it. Bodies demonstrated emotion where there apparently was none or were unable to express it when it was felt. These absences or leakages of the body and of emotion diminished the perception of coherence of both form and self in these sources, recalling art critic Kirstin Hoving's description of the grotesque. Hoving argues that 'the grotesque exists in opposition to things that have clear identities and undoes form.'[475] Bodies in Norman's sources were often described as chaotic or signposted by the 'parasitic prefixes' Hoving describes; '*mis*shapen, *de*formed, *un*focused, *in*distinct, *dis*integrated, and *anti*thetical'.[476] The exposition or display of these bodies was a way for physicians to explore when the connection between body and mind went wrong: the laughter of the insane disrupted the coherence of the embodied self and the perceived link between physiological expression and emotion in adults.

[475] Kirsten A. Hoving, "Conclusive Bodies: The Grotesque Anatomies of Surrealist Photography," in *Modern Art and the Grotesque*, ed. Frances S. Connelly (Cambridge: Cambridge University Press, 2003), 220.

[476] Ibid.

(In)appropriate laughter

Ingegnieros' second category was described as the 'intellectual element' of laughter, or the 'perception of the ridiculous, or laughable in the exciting, idea'.[477] He identified this as 'the highest stage in the evolution of the laugh' which 'may be accompanied by neither of the preceding elements.'[478] This casts new light on Lougheed Baskin's comment, discussed earlier, that it was the physician's daily lot to witness patients' apparently meaningless and uncomfortable, yet clinically relevant, movements. These bodies were recast and reframed. They were given new meaning in the discursive and physical clinical space. However, this did not mean they were not problematic or had intersubjective emotional meaning and significance. Given that physicians and attendants were daily confronted by these uncomfortable bodies and the unexpected and apparently ridiculous in the speech, movements, and responses of patients, was it deemed acceptable to allow oneself to laugh? Or did the epistemic and physical contexts of professionalism and the asylum restrain the laughter and replace it with some other emotional response to the distress or meaninglessness of what they witnessed there? Could both feelings exist simultaneously and give meaning to the old adage that if one didn't laugh, one might cry? Did one's body determine when, at what, and how to laugh, or did the mind? Clinical practice was informed by such theories as we have discussed, but ultimately the emotions and reactions of the physicians as *humans* as well as alienists must be accounted for.

[477] Ingegnieros, "Hysterical Laughter [Le Rire Hystérique]," 411.

[478] Ibid.

From Norman's transcriptions, we know that doctors and students certainly did laugh, whether or not they were meant to or it was appropriate. When a patient mistook Norman for Mr Torrence, the tailor's son, the note-taker recorded that,

> 'referring to the laughter of the auditors the lecturer said: They're not laughing at you. They are laughing at me.
>
> *Well, I don't want to be a laughing-stock with you. I am not afraid or ashamed of anybody*.'[479]

Evidently acutely aware of their audience, both doctor and patient responded to and anticipated the emotion and judgement of the onlookers. Whilst these are immensely valuable and surprisingly direct records of conversations conducted with patients, such exchanges signal that it is a far from intimate environment. As such, it once more raises the question of how experience is mediated, not only by seeing or feeling, but by *being seen.* In this context, although patients might laugh (purposelessly, to themselves, or at the doctor and audience like the lady in his third series who 'laughed at the group standing round her'),[480] Norman stressed that clinicians' laughter could not only be unprofessional, but insensitive and unethical.

Whilst patients who 'desire to joke or chop logic are sometimes rather amusing, and it is hard to keep from laughing,' he warned that more acute cases, whether melancholic or maniacal were a 'different thing.'[481] These patients 'are conscious of their condition and very

[479] Series 3, Lecture 14, 8 March 1907, ACC/2017/2, CN/3/3, CNL, RCPI.

[480] Series 3, Lecture 11, 9 April 1907, ACC/2017/2, CN/3/10, CNL, RCPI.

[481] Series 3, Lecture 8, 19 March 1907, ACC/2017/2, CN/3/7, CNL, RCPI.

sensitive about it, and it is a cruel thing to laugh at them.'[482] Before Mary O. was introduced to the room, Norman warned that,

> 'she may, - probably will, - make grimaces and indulge in grotesque gestures, … but I particularly ask you not to laugh or seem to be amused by her condition because she is conscious of disturbance and is sensitive about it.'[483]

Neither her words nor her actions were to be laughed at by the students, this being, he continues, 'a rule that one has to adopt in dealing with most of the insane.'[484] Whilst clearly establishing a guide of professional decorum, Norman nonetheless left space for adaptive interactions with select patients. The circumstances under which this rule most strongly came into effect were frequently based on the nature of the delusions and hallucinations the patient described. Whereas some patients could be affectionately conversed or joked with, Norman asked his pupils 'to be careful'[485] in cases such as Mary's where she 'complained with considerable feeling that her mind was not under her control, so that her consciousness must be very painful'.[486] It was not just doctors or the public who laughed at lunatics: Mary described the voices she had been hearing which kept her up and 'restless' at night and lamented that 'they're always jeering me.'[487] For patients described as paranoid with delusions of persecution, the laughter of others could become incorporated into their life-world to reinforce these systems of thought, adding to their distress.

[482] Ibid.

[483] Ibid.

[484] Ibid.

[485] Ibid.

[486] Ibid.

[487] Ibid.

Laughter could upset the delicate dynamic between the clinician and patient, with unpredictable consequences. Patients frequently protested at the disagreeable, insensitive, and trivialising reactions of those listening to them. One woman, convinced that Norman was tormenting her, protested to the students, 'If you only knew what I have gone through with this man you wouldn't laugh. I have been awake night after night. A week without closing my eyes.'[488] She was acutely aware of the evident and tangible power differential at play in this situation and environment, and declared to Norman that

> 'I am a very small person compared to you, but still I could do a good deal but I wouldn't soil my hand or boot. You are a contaminated mesmerist. There you are. If you are Dr Conolly Norman you are a disgrace to the medical profession.'[489]

This woman insisted on being heard and paid the respect owed to her, no matter what the status of the man persecuting her. She turned the assumption of superiority implied by laughter around as an attack, citing this power differential as the very basis for her contempt of Norman: a real doctor would not treat his patient so unkindly.

In a relatively controlled environment, students were exposed to every variety of testimony, behaviour, and situation, under supervision. This was evidently designed to prepare them for the surprises, incongruities, and peculiarities of the asylum environment and its inhabitants. Humour was inseparable from this space, yet sat uneasily within it. It is likely that a significant explanation of why humour is little discussed directly in journals and manuals is because a basic degree of sympathy and kindness was seen as natural when regarding the insane. Norman stated, 'I have seldom, I am glad to say, to mention this matter

[488] Series 2, Lecture 13, 2 April 1906, ACC/2017/2, CN/2/13, CNL, RCPI.

[489] Ibid.

because I have always found natural good feeling was sufficient.'[490] In many ways, these lectures were designed to supress the natural instincts and reactions of the students. In others, they aimed to encourage them. Clinical practice often meant exposure to bodies as well as minds considered alien and othered. The impact of this on the emotions of care were profound; sympathy, pity, compassion, and a myriad of others had an embodied and phenomenological dimension or root as well as a cognitive one and offer a fruitful route for further analysis.

It is not just contemporaries who found the laughter of the asylum uncomfortable at times. Historians are in many ways engaged in the same questions as the physicians whose notes they are studying and using: principally, how do we read and interpret the emotions of others? What part does empathy play in our historical practice and how close is too close for comfort? Hallucinations and delusions frequently contain images or experiences we would identify as distressing, shocking, and painful. They can, however, also be bizarre, humorous, and pleasurable. Patients laugh, joke, perform, and mock their doctors. These experiences are as much a part of the history of the asylum as pain, power, and coercion. However, when both contemporary clinicians and historians find humour in sensitive places, it ironically prompts an even greater sense of discomfort, the uncanny, and the grotesque. As Norman pointed out, 'the essence of wit is turning up with something unexpected.' Surprise makes us laugh. Denying that some of the experiences encountered in the material on the asylum can strike us on a basic level as amusing would be mistaken. Confronting our own unease at finding these fragments of tension can also challenge our historical prejudices regarding subjectivity and experience in these spaces. Is our discomfort or laughter any more or less

[490] Series 3, Lecture 8, 19 March 1907, ACC/2017/2, CN/3/7, CNL, RCPI.

unkind than that of Norman and his contemporaries simply because we are not physically in the room and the patient cannot see our laughter? How do the ethics of laughing change when we are not in the room and the patient is not aware of being seen? Do we find laughter in this space difficult because we don't recognise such experiences as multi-dimensional with a capacity for pleasure as well as pain? Does recognising the former undermine patient's claims to the latter? Norman's transcriptions bring insanity to life and give it a body in an often uncomfortable way, but these sources also urge the historian and clinician to remember that patients are human with human reactions. Is it ethical, unkind, or indeed human, to laugh?

Having considered how the body *moved* and *reacted*, the next section shifts to how it *felt,* to consider what set insanity as an experience apart from the systems of thought and feeling or the 'sane' or 'ordinary person'. The same questions underpin both sections. Did the body look different? Did it work differently? Did it feel different? Or did people just believe that it did? As writers and physicians attempted unpick what set the insane delusion apart from the systems of thought, feeling, and action of the rest of the population, fault lines emerged and were negotiated in belief, experience, and how the body was implicated in both. The ontological ground was shifting and attempts to restabilise systems of knowledge, certainty, and liveable reality resulted in numerous permutations of belief and existence. A crucial role of mental science was to classify and separate the apparently ridiculous from the plausible; the impossible from the probable, and establish how this might be known and proven.

Sensing the lived body

‘She said she suffered from imagination that no-one could see, and she gave up dressing herself. She complained of minor hypochondriacal feelings. Her bowels did not act; she could not sleep… She developed ideas, - at least, she gave expression to ideas, - that there was something wrong with her internally. ‘Internally’ meant, - as it commonly does with people of this class, - that she had something uterine the matter. It is rather important to know that the ideas of something being wrong with the generative organs often give rise to depression. There is no other part of the body about which people are so liable to become depressed. She complained at this time that she emitted a bad odour.. She said that she smelt this odour. (Nobody else did, by the way). She therefore had olfactory hallucinations.’[491]

[491] Series 2, Lecture 5, 12 March 1906, ACC/2017/2, CN/2/5, CNL, RCPI.

Chapter 5: Feeling

This chapter delves *into* as well as roaming *across* the body Norman's lectures offer intimate access to. It asks how one could one suffer 'from imagination that no-one could see'? How did notions of validity and proof impact narratives of and experience of the body? This chapter particularly explores the languages for experience which coalesced around the binaries of the real and the imaginary, and the visible and invisible, or tangible and intangible. How did delusions and hallucinations confuse and undermine attempts to separate these, and are they helpful distinctions in any case? Discussing their lives and bodies with patients, Norman frequently asks about pain, pleasure, and *feeling* in ways I did not anticipate finding. Hallucinations and delusions were far from constrained, intellectualised and easily folded into clinical categories (or one particular diagnosis; they emerge in these sources as visceral, emotional, complex, and slippery, escaping easy conceptualisation and often identification.

In their 'practical and clinical manual', *Insanity and Allied Neuroses,* former medical superintendent of Bethlem Royal Hospital, George Savage, and medical superintendent at Cardiff City Mental Hospital, Edwin Goodall, attempted to demystify delusional insanity and unpick what set the insane delusion apart from the thought and feeling of the sane. They contended that,

> '[the insane] differ from those whom we call sane in having sense impressions, which differ entirely from the sense impressions of the ordinary person, or in having some fixed idea, which owes its origin to some sensation and feeling which we do not understand; and this delusion, like the hypochondriac's sensation, is not to be

removed by argument. Such persons have a faculty of faith; "they cannot reason, they can only feel."'[492]

Whilst insanity is generally situated as belonging to the realm of the mind, both this extract and the excerpt from Norman's lecture betray the deep entanglement between mind and body in nineteenth and early-twentieth century approaches to delusion and hallucination in clinical practice. The root of delusion is often identified by Norman, like Savage and Goodall, as sensation and feeling, twisted and warped in ways largely inaccessible and mysterious to the Other. His conversations with patients frequently centred on contestations and negotiations of meaning and belief about the body. Some things were ostensibly objective; whether or not his patient smelled, for instance. Others were more difficult to evaluate and situate in 'reality' or the 'imaginary', whether hallucinatory or delusive. How the body, sensation and perception were understood were central to contemporary languages for difference, yet the experiences of the body in insanity apparently escaped easy categorisation. The body could not be ignored, but it was hard to access and evaluate.

As explored in the first chapter, the asylum was responsible not only for patients' mental health, but had also to consider and monitor their somatic health. The ties which bound the two together were considerably more intricate and inescapable than the historiography on insanity would suggest. A vital component of re-embodying the asylum; putting flesh and sensation on to the discursive bodies which have dominated this historiography, is exploring these bodies as complex and infinitely diverse in their movements, forms, functions, perceptions, and sensations. As this thesis has considered,

[492] George H Savage and Edwin Goodall, *Insanity and Allied Neuroses : A Practical and Clinical Manual*, New and En (London: Cassel, 1907), 237.

bodies hurt, moved when they weren't supposed to, froze, unravelled, and broke. Bedsores, stomach ulcers, and mysterious scrapes were in many ways as immediate a concern of asylum attendants as delusions of electricity or voices at night. Such physical health concerns were vital to experience within this space and frame, not only because they shaped patients' experiences of wellbeing and care on a practical level, but also because of their conceptual and lived entanglement with delusion. Given the phenomenological importance of delusional experiences or languages as well as patients' sensory perceptions and interpretations, physical ailments such as stomach pains, paralysis, or bowel issues, could have very real consequences for their experience of themselves and the world on a subjective level, as well as for clinician's understanding of their case. This was introduced in the first section, through Julia's case, but will be examined more fully here.

This section particularly introduces and engages with the concept of liminality. Borrowed from anthropology, this idea of the *in-between* and indistinct describes a space whereby something has become not one thing, but is not yet another.[493] Liminal experiences and spaces, whether physical and material or imagined, therefore challenge and upset binaries which underpin the experience of being-in-the-world. This work draws particularly on philosopher Drew Leder's discussion of chronic pain as having this liminal quality. As such, it is characterised by 'ambiguity, paradox, a confusion of all the customary categories'.[494] For him,

> 'pain manifests as both sensation and interpretation, certain and yet uncertain to the sufferer and others. It unfolds in both a present and a projective time, exhibiting a

[493] Victor W Turner, *The Forest of Symbols : Aspects of Ndembu Ritual* (Ithaca: Cornell University Press, 1967); Arnold van Gennep et al., *The Rites of Passage*, Second edition. (Chicago, 2019).

[494] Turner, *The Forest of Symbols : Aspects of Ndembu Ritual*, 97.

> never-changing and yet ever-changing pattern. It is seemingly located simultaneously in body and mind, self and other, the here and everywhere. Presenting as both in-control and out-of control, pain unleashes productive and destructive forces in the realm of meaning.'[495]

This is the frame in which I read narratives of the body in the asylum. Delusion folds and unsettles these distinctions between mind and body, structures of time and self, and collapses the material and discursive boundaries of the world.

Whilst I have used the term pain and continue to do so throughout this section, this too is an uneasy category of experience in these accounts. The stories discussed and which float around delusion and hallucination are considered here as liminal precisely because they destabilise such structures of experience and the body as pain itself. The experiences found within the asylum certainly *sound* painful, yet frequently assume an indistinctness and intermediacy in their expression, configuration, and conceptualisation. The very definition of concepts situates delusion at this intersection. How can a false and systematised *belief* be painful? In Savage's terms, can a 'faculty of faith' truly make one *feel* in an embodied manner? He sought to navigate this confusion, or liminal space, by contending that delusion was itself a structure of existence which frequently sprang from and twisted around a sensation or particular feeling. Delusion was a system of association and interpretation. Like the sense of mystery Norman suggested was proper and inherent to all human beings, this sensation, which was both of the body and somehow apart from it, escaped the grasp of the alienist or mental scientist. Whilst slippery and intangible, it was nonetheless manifest in

[495] Drew Leder, "The Experiential Paradoxes of Pain," *The Journal of Medicine and Philosophy* 41, no. 5 (2016): 16.

countless delusional patients and stories from the asylum space. The root of delusion lay somehow in the body. It separated the insane body from the sane. They can only feel, yet their feeling is disorientated by belief and some intangible force.

To explore these ideas, this section looks at processes and practices as moments of liminality and unsettling or transforming. It will therefore begin by considering how people find languages for and configure the body and world through perceiving and hurting as interpretive *doing* and *knowing.* In order to anchor this first chapter, one case in particular reoccurs to be explored from different angles. Norman's patient Letitia G. was described to the lecture's auditors as 'very instructive, as she is a compendium of hallucinations.'[496] She was brought before the students across multiple years and lecture series in order to demonstrate and dissect the functions of mind, consciousness, sensation and perception. Norman's belief that 'it is always advisable to let the patient tell his own story as much as possible' is especially evident in this case, not least because Letitia is very keen to tell it.[497] As such, her case offers a densely woven seam which runs through the lectures and allow us to see how particular ideas, meanings, and layers of experience or narrative were brought together into clinical archives and the practice of medicine.

This section explores how the practices and processes of materialising, understanding, and making meaning from and of bodies such as Letitia's changed yet again once the body was penetrated, figuratively and materially. Rather than the visible and observable body, it looks to how inaccessibility, invisibility, and intangibility, affected experience and meaning.

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[496] Series 2, Lecture 7, 19 March 1906, ACC/2017/2, CN/2/7, CNL, RCPI.

[497] Series 1, Lecture 4, 10 March 1905, ACC/2017/2, CN/1/4, CNL, RCPI.

To what extent is the basis of 'insanity', the perception of it, or its experience, a product of that 'which we do not understand'? By extension, how do our attempts to understand, name, and make the unknown known, shape its lived reality? What is the difference, if any, between reason and feeling, how are these subject to multiple layers of interpretation and translation which coalesce around liminal bodies?

Interpreting and translating

> 'It may be convenient, but it is not philosophical to treat of the body apart from the mind, and the physical symptoms separately from the mental… a man who believes himself forsaken by God, may, after all, have got that idea in consequence of some gastro-intestinal trouble, and that damnation has been his method of interpreting dyspepsia.'[498]

How were different parties in the clinical encounter engaged in understanding, interpreting, and translating the experience of the body? How were languages formulated and arranged to *make sense* of these experiences and stabilise or settle them? Savage and Goodall's text alluded to two languages for experience which tangled together around delusional bodies; here, expressed as the examples of dyspepsia and damnation. One was primarily rooted in the body, the other ostensibly and apparently in the mind. Whilst apparently worlds apart, both are embedded in the same location and are both the result of a strategy of ordering and making meaning of *something* happening there. Although the physicians only refer to one of these explanations explicitly as interpretive, both are. Establishing a diagnosis of somatic disorder involved determining a lesion or symptom, correlating this against existing

[498] Savage and Goodall, *Insanity and Allied Neuroses : A Practical and Clinical Manual*, 130.

knowledge and systems (in this case of clinical medicine), and establishing a hypothesis or truth claim about the body.[499] The patient was ultimately engaged in a similar process, but with different (although frequently overlapping, as will be explored) frames of reference, evidence, and convictions or beliefs.

In turn, the systems which physicians developed to explain these apparently 'bizarre', 'ridiculous', 'grotesque', 'fantastic' and 'hideous' ways in which patients understood and explained their bodies were no less revealing of their beliefs, ideas, and interpretations. Determining that something was a delusion involved a deliberately evaluative and interpretive practice, resituating the body in a medical and 'provable' reality rather than a lived one. Physicians were aware that mind and body were intimately entangled, but that delusion, hallucination, illusion, and other symptoms observed within asylum walls and case studies were windows into how this connection had *gone wrong* and where. They turned *experience* into *symptom-experience.*

This chapter is prefaced with the statement that the dominant note here will be one of complexity. Experiences, their explanations and ideas here are often contradictory, speaking to the unknown or unknowable. More questions will be asked than answered, both by contemporaries and myself. Unlike the moving body discussed in the previous section, the internal body and sensation could not be readily *seen* or imaged from the outside. As such (and without surgical intervention) it was intangible and only available through practices of interpretation which connected and entangled mind, body and world. Patients interpreted

[499] For a thorough analysis of this process and the development of legion-based medicine, see Andrew Hodgkiss, *From Lesion to Metaphor: Chronic Pain in British, French and German Medical Writings, 1800-1914* (Amsterdam: Rodopi, 2000).

what they felt of and in their bodies, turning this into the shareable form of language. Physicians probed patients' descriptions of their experiences and bodies to access and understand perception and translate or fit this into their frames of references and diagnostic or explanatory categories. In simpler linguistic terms, bodies were interpreted and read by patients, explained and communicated to doctors, who in turn translated these experiences into a clinical and discursive frame. This frame did not, however, always fit easily or comfortably and it was not rigid or impermeable. As the metaphor hints, this process involved multiple parties speaking and figuring multiple languages. At each level of this process, something gets transformed and changed. Writing about confusion and liminality inevitably leads to more questions and ambiguities than answers, not least in this historical translation. I do not claim that this is the most perfect, conscious, or accurate translation or language. Patients and doctors both insisted on their own versions of truth and reality; I make no claim to have one of my own. Rather, I look to the process and how experience moved across these spaces and voices.

For physicians, translating these experiences involved working out a dictionary or set of definitions, whether diagnostic or more broadly conceptual. Whilst Esquirol and subsequent theorists had attempted this, it is clear from Norman's lectures, asylum records, and journals that the mechanics of perception and how to read it remained slippery and intangible, the subject of frequent discussion. The lines which separated delusion, hallucination, and illusion were themselves generally indistinct, especially when these concepts travelled between theoretical and clinical spaces. In an especially comprehensive article of 1904, William Stoddart, assistant medical officer at Bethlem who later published the textbook *Mind and its Disorders* in 1908, made a case for more clarity in the points of similarity and difference between hallucinations, illusions, percepts and ideas. When

originally presented orally at the Annual Meeting of the Medico-Psychological Association, Stoddart was congratulated by its President, as the 'psychology of hallucinations… is a very difficult subject, and any work on it is most useful to the Association.'[500] Stoddart's paper intended to help the physician navigate and untangle these ubiquitous terms, appreciate their relevance and assist in their correct use. Whilst there was a proliferation of theories in continental Europe, he stated that 'the psychology of hallucinations does not enter largely into the literature of this country' but that most English psychologists recognised, in these categories, 'a family resemblance.'[501] This resemblance could lead to more confusion and conflation in clinical practice.

He explained that 'while their resemblance is mainly psychological, their difference is mainly physiological.'[502] Taking the example of a cigar as an 'object before you', he explained that,

> 'you have a percept of it; when you think of a particular cigar, you have an idea of it; when there is a pencil on the table, and it appears to you as a cigar, you have an illusion; and if you see a cigar on the table when there is nothing there, you have an hallucination.'[503]

He contended that, however it appears to you, the idea of a cigar is constituted by how it is experienced and that these sensations of and with the body are the root of perception in all its forms; that,

[500] Stoddart, "The Psychology of Hallucination," 650.

[501] Ibid., 633.

[502] Ibid., 634.

[503] Ibid.

> 'you experience sensations of pressure, warmth, brownness and, if you roll it between your finger and thumb, muscular sensations and perhaps a crackling sound. If you smoke the cigar, you may have sensations of bitterness or saltness as well as a characteristic flavour appreciated by the sense of smell. These various sensations go to make up the percept "cigar."'[504]

According to Stoddart, this to some extent holds true whether it is that you 'have a cigar in your hand', or you are '[thinking] or a particular cigar, have an idea of it'.[505] In the latter case, whilst it is not directly available to the body as a sensation,

> 'the sensations are in slight degree experienced. There are faint visual, olfactory, and tactile images of the cigar. Further, there may be faint visual and auditory images of the word "cigar," as well as muscular sensation about the mouth, similar to that experienced in saying the word, a so-called psychomotor image.'[506]

From this discussion, Stoddart emphasised three key points; that 'various sensations are not separately apprehended'; 'not all combinations of sensation will form a percept or idea'; finally, that 'perception and ideation localise an object and give it a shape occupying a certain amount of space. It follows that our percepts and ideas are in reality but abstractions.'[507] Such explanations were attempts to explain and understand the mechanics of perception in both the sane and insane populations. How were the organs of sensation connected to the mind, and was perception fundamentally a neurological, physiological, or ideational process?

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[504] Ibid.

[505] Ibid.

[506] Ibid.

[507] Ibid., 634–35.

If the mind could create, in some sense or slight degree, an experiential echo of the body and the sensory organs, how could the process and pathology of delusion and hallucination be untangled? How would it be possible to tell if a patient was describing the phantom of a sensation, or a sensation incorporated into a phantom? Physician's attempts to categorise and thereby understand these phenomena as they occurred in the insane therefore relied on mapping the body and mind. Within a medical model, this meant determining the real from the fictive. Stoddart drew particular attention to the fact that the 'tendency to combine several sensations in one idea is constantly seen in institutions for the insane.'[508] Patients' minds and nervous systems were creating and telling stories about their bodies and reality. Delusions could be an organising system or way of telling this story; both of the body and yet only spectrally associated with its processes and functions. The body became a haunted space of sorts; subject to this muddling *dis*organisation which unsettled and rendered world and embodied self unfamiliar and unrecognisable.

Topics such as hallucination and delusions wandered across and implicated countless disciplines and systems of knowledge-formation. As this thesis has thus far explored, they escaped the permeable bounds of both mind and body, physiology and psychology, and threatened to destabilise the concept of an objective, material and shareable reality itself. In the discussion which followed this paper, Dr Robert Jones stated that

> 'if it has taken Dr. Stoddart eighteen months to understand one part of his own paper, it will occupy me far more to take the whole paper in… it is a very valuable paper, for up till now the pure pathologist has done nothing to elucidate hallucinations.'[509]

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[508] Ibid., 635.

[509] Ibid., 650.

Whilst the manner of writing in these texts can offer an illusion in itself of fixity and answers, such discussion highlights the confusion and negotiation which coalesced around the processes of truth-seeking and interpretation in scientific circles, particularly across disciplines. Working with patients both alive and dead, sensible and insensible, mental scientists claimed a privileged position and ability to co-ordinate theories and information across body and mind.

Without being able to see neural processes and the associative centres themselves, physicians were reliant on the specificities of patients' language and the way they told these stories, as well as an understanding of their conceptual, sensory, and physiological or neurological systems to differentiate between hallucination, delusions, and illusion. The true 'reality' of the body and mind and its organising system was apparently situated somewhere between these poles. The patients' methods and systems of meaning-making were not neatly aligned with their own, but the physician might find clues to help navigate the body and perception. Rather than simply relying on the 'objective' knowledge the material body offered, there was a space for patients' language and explanations, although this was far from an equal interaction and often more of an extractive process. If physicians were able to establish and understand the systems which governed perception themselves, in disease and health, this could supposedly have significant clinical implications. Whilst these remained illusory themselves, physicians' truth claims were tenuous.

How could one hope to offer clarity to an apparently confused and distressed patient, if there was no clear framework to be had or agreed upon? Jones continued, musing that,

> ‘it struck me that if we were able to educate several of our patients as to the exact physiology of their various hallucinations, we might be able to convince them of their error. I do not suggest we could do so with a large majority. We know, among our own patients, those whom it is absolutely impossible to convince as to the unreality of their hallucinations. Innumerable instances of this might be recorded, but I have been able to convince some patients of the hallucinatory character of their delusions’.[510]

As it was, clinical encounters were negotiations, albeit on unequal ground. Patients had access to, and some degree of control over, their subjective experience, sensations, and interpretation of the signals of both body and mind. Doctors had a different view, apparently situated in an objective reality, but dependent on the information patients chose to give or what they could take.

The physician’s role was to untangle the narratives of patients and establish what was *really going on*, based on their, often tentative and shifting, understanding of the processes and systems of the body. Edmund Parish, in his 1897 response to the SPR’s census, *Hallucinations and Illusions: a study of the fallacies of perception,* spoke specifically of the difficulty inherent in this process. He noted that,

> ‘the observer is liable to be misled by the expressions of the patient, whose loose use of words may lend his *délire,* or mental delusion, the guise of a sensory impression. But a somewhat closer analysis will serve to make the distinction clear.’[511]

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[510] Ibid.

[511] Parish, *Hallucinations and Illusions : A Study of the Fallacies of Perception*, 2.

However, just as patients' specificity and careful choice of language could reveal a great deal about their experiences to the physician, so too could staff be frustrated by resistant or chaotic patients who either refused to enter dialogue with them or indeed would only do so on their own terms and in their own languages. Staff at the Heath Asylum, for instance, expressed frustration at Emma G, as 'the degree of confusion of ideation and association of ideas, renders it difficult to arrive at any accurate delusion or hallucination'.[512] Such failure in communication and understanding could be either the result of an act of resistance or symptomatic and revealing of the perverted reasoning and ideation.

Those taking case notes were themselves often unsure or imprecise about the nature of the perceptual experiences they were categorising, leading to regular confusion and conflation of terms in patient records. William S., confined to the Heath Asylum, 'has no hallucinations, illusions nor delusions', yet his case notes also detail that 'patient says he has pains in his inside and that he has no inside, and that it moves up and down and that his stomach moves up and down.'[513] There are layers of *non*sense in this case alone which are immensely revealing of the inconsistencies and ambiguities which undermined coherent clinical practice.

Whilst hallucination and delusion were theoretically separated, writing on delusion in these sources undermines such a straightforward separation of experience. Lilly O.J. was described as having 'systematized delusions of Rank and Power' when she was confined to

[512] CB 3 Female, 1899-1912, H65/B/10/028, BH, LMA, 15.

[513] CB 2 Male, 1899-1915, H65/B/10/001, BH, LMA, 29.

the Heath Asylum in 1899.[514] Whilst this delusional system is not on first impression an embodied experience, her asylum notes also extensively detail the ways in which this reality was lived physically as well as emotionally. She stated that 'she is of Royal Descent from the bourbons [sic], strangers in the streets pass her and say so', she 'constantly hears a voice say [sic] "courage child"', and was 'prone to illusions, reads messages to her in the daily papers'.[515] This constellation of sensory perceptions and misperceptions constituted a systematised delusional framework which doctors acknowledged as a way in which Lilly's experience and life was organised. Despite these references to the conventional definition of hallucination, however, her notes specified that Lilly had 'no hallucinations except perhaps one of common sensation' as she was 'inclined to have electrical ideas, says that her body attracts electricity'.[516] Delusional systems permeated much of the subject's world and necessitated a perceptual and sensational element, although it was not always categorised as a hallucinatory experience.

At times, clinical notes explicitly blur the use of the terms 'hallucination' and 'delusion' as well as conflating or merging their meaning and experiential or symptomatic significance. Sixty-nine-year-old Eliza S., also residing in the Heath Asylum, was described as a problematic patient in her attitude, behaviour, and experience. The asylum's notes detailed her 'fluent' ideation, which 'can be directed into ordinary channels, otherwise it dwells chiefly on her hallucinatory beliefs.'[517] It was recorded that her 'reasoning power' was 'largely perverted' and she

[514] CB 3 Female, 1899-1912, H65/B/10/028, BH, LMA, 16.

[515] Ibid.

[516] Ibid.

[517] CB 3 Female, 1899-1912, H65/B/10/028, BH, LMA, 11.

> 'evidently has numerous hallucinations, declares suddenly she began at night to feel and know a man, or man's voice, was in her room, this man she believes has hypnotised her, on another occasion God appeared by her side, and her late husband on the other'.[518]

This description on her admission in 1899 emphasised her hallucinations and suggested that this 'fluent' but flawed 'ideation' and 'reasoning power' which shaped her sensory perversions into belief. After two years in the asylum her physicians specified that she was

> 'suffering from Paranoia, she has systematised delusions of being acted upon by means of hypnotism, and of being operated upon thro [sic] the walls of her room, she thinks she has a machine in her chest, which she can hear conversing at times.'[519]

This system labelled her as 'the subject of Delusional Insanity', with

> 'numerous delusions associated with various sensory perversions whereby she believes herself tortured and acted upon by electricity and other means, she also has a feeling of being generally persecuted by all those about her, and makes the most extravagant complains of ill-usage, coupling such with much exaltation of manner'.[520]

These notes draw a distinct line from hallucination and 'sensory perversions' to the development of delusion. Whilst the tone of persecution and paranoia remains consistent across these years, both the content of her experiences and the language (both clinical and metaphorical) used to narrate them underwent subtle changes.

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518 Ibid.

519 Ibid.

520 Ibid.

Unlike clinical journals, which presented patients as illustrative examples of particular problems or conditions, case notes and Norman's lectures recorded these, often subtle, shifts in physicians' or attendants' perspectives on a case and the terminology used. They also illustrate changes in the ways in which patients organised or communicated their experiences themselves, depending on mood, levels of trust in the person taking notes, or indeed longer-term changes in the meaning they ascribed to them. It can often be difficult to determine which of these two explanations is responsible for shifts in detail. Whilst a great number of patients experienced delusions, such as of grandeur or persecution with little explicit reference to their embodiment, delusional systems or beliefs did not have to mean a conviction in abstract concepts of identity and self, with hallucinations their more explicitly physical counterpart. Notes and commentaries on individual cases emphasized these slippages and ambiguities arising out of the ways in which language revealed how subjects structured their worlds and expressed their bodies.

The mechanics of these processes and perceptions became particularly central when it undermined or threatened a patient's sense of self; the coherence of these bodies and how this body and exteroceptive perception was connected to the world. 'It is rather important to know that the ideas of something being wrong with the generative organs often give rise to depression. There is no other part of the body about which people are so liable to become depressed.' The 'subject of mysterious attacks and persecutions', Norman's patient E.F. heard voices at night, feels '"darts" of pain more or less everywhere, but particularly about the genitalia. Sensations of tightening, of dilation of the vagina, and specific sexual sensations.'[521] For E.F., these sexual sensations were imposed by another against her will and

[521] Norman, "Notes on Hallucinations. II," 285.

constitute a form of sexual violation and assault by an unknown party. She also saw '"visions," sometimes of the machine over the ceiling that works all the mischief, sometimes of abominable and impure objects.'[522] When quizzed further, she told her doctor: '"I do not see these things; I am made to have a vision of them."'[523] In this case, E.F.'s clarification indicated that this distinction was far from arbitrary; the ways in which her experience was articulated linguistically mattered to her. She distinguished between a self-produced phenomenon; an image or feeling created through her sensory apparatus, and a vision as something imposed upon her by some unknown and external force. This separation of self and perception is a common theme in such narratives. For her, this reframing established the experience as imposed and situated outside of the self; it happened *to* her. Hearing the same statement, the doctor could, in turn, establish that the patient was delusional rather than hallucinated.

Illustrating the ways in which delusion could come to infiltrate multiple areas of a patient's life and perception, Norman presented Letitia G.'s case to his students in his first lecture series to illustrate 'paranoia'. He preferred this term to Esquirol's 'Monomania', finding the latter too restrictive in that it 'commits you to the idea that the person is insane on one particular subject – which is quite incorrect.'[524] Norman explained that,

> 'the characteristic of paranoia is the existence of fixed and systematised delusions. They are sometimes said to be limited. I don't think the idea of limitation is a very just one as applied to this condition. Involvement of the intelligence is relatively

[522] Ibid.

[523] Ibid.

[524] Series 1, Lecture 14, 4 April 1905, ACC/2017/2, CN/1/14, CNL, RCPI.

> limited, but the delusions are not limited, - rather unlimited. It is rather characteristic that they grow from a small seed and develop into a very large tree which overshadows the whole world.'[525]

The interviews Norman conducted in such lectures allow insight into the ways in which physicians often attempted to treat patients' delusions as co-ordinating and explanatory frameworks in themselves; a second key or dictionary with which to navigate the body and patients' apparently askew reality.

The rest of Letitia's case was used by Norman to illustrate the ways in which such perceptions could come to organise both physical and mental experience. When she was first introduced, Norman stated both that 'my friend here has a long story to tell' and was a 'compendium of hallucinations.'[526] Letitia clearly outlined her belief that for seven and a half years she has been submitted to outrages and violations by unseen medical persons through mesmerism and machinery. These systems cause her significant pain and discomfort. She described both internal and external pain, particularly in her head, skin (which was 'quite sore to the touch'), and a sensation 'as if something was pulled in the throat', which was accompanied by loss of breath.[527]

Letitia's descriptions of these sensations were meticulously recounted by Norman, and he brought her before the class on multiple occasions over years. He relayed that,

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[525] Ibid.

[526] Ibid.

[527] Ibid.

> ‘She has apparently engagement of all the functions of common sensibility. She elegantly describes her pains as like hot sparks from an anvil. She has engagement apparently of the muscular sense. Her arms feel like lead. She has engagement of the temperature sense. She described herself as ice-cold. She has also the sensation of heat. I forgot to question her about the tactile sensibility. She described her finger-tips feeling like silk. While rubbing her finger and thumb together she felt as if rubbing a piece of shining silk. She has true gustory [sic] sensations which are not very common. She was weak on the olfactory sensations to-day, but she has had olfactory sensations like the smell of lemons. The olfactory hallucinations are usually of a disgusting nature.’[528]

Norman included considerable detail in such descriptions, in which he blended medicalised verbiage and his understanding of the physiology and operation of the senses, with the patient’s own language. One key alteration is, however, maintained in such summaries. In reporting patients’ sensations and descriptions, metaphor is transformed into simile: finger-tips felt *like* silk; arms feel *like* lead.

This seemingly minor distinction is indicative of a process of clinical distancing whereby the meaning of such descriptions was changed. Rather than describing a profound alteration of identity or corporeality, simile distances the perception or sensation from the self; a technique for highlighting the similarity between the description and sensation rather than its reality. Such linguistic re-working highlights the importance of positionality and selfhood in the perception and interpretation of significance in such accounts. Doctors could maintain this boundary of distance whilst acknowledging the patient’s perception of and

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[528] Ibid.

conviction in its reality, with the concomitant implications for selfhood. Doctors attempted to enter into patients' worlds through access points, such as of language, but they were only ever visitors there. These accounts of near-total sensory 'perversion' or alteration reveal the ways in which sensory perception, or 'hallucination' was incorporated into and inseparable from both patient experiences of their bodies and selves, as well as physician's understandings of disorder and psychiatric nosology.

Letitia too engaged in her own process of distancing. For some patients, the relationship they had to their sensations and perceptions underwent shifts or changes over time, which might be reflected in or gleaned by the doctor from particularities of their language and expression. On one occasion, Letitia described seeing an angel carrying a brand, or sword, pass before her in a church. Before the medical students, she explained that,

> *'There were people in the gallery.*
>
> The organ loft? You think they threw it from there?
>
> *They were showing it.'*[529]

Norman described this as a visual hallucination, but remarked on the importance and particularity of the way in which it was expressed and how this had evolved or mutated over a period of time. He explained that,

> 'although at first she spoke of that as being a vision without any qualification whatever, latterly she has taken to say it was done by limelight. To-day she spoke about a photographic business. She talked about a camera that threw the image in the air as it were and she saw it that way. This is a very curious and interesting. A great

[529] Series 2, Lecture 7, 19 March 1906, ACC/2017/2, CN/2/7CNL, RCPI.

number of people talk of their visual hallucinations with that peculiar air of unreality.'[530]

Chapter three explored the increasing interest in visual technologies as a means to capture movement, offering new ways of seeing the world. However, with these augmentations or alterations of sight and vision came a deep skepticism and curiosity around the failings of the human eye and the ways in which it might be deceived. Iwan Rhys Morus has exposed how Victorian physics 'played with vision' through such spectacles as 'pepper's ghost' and increasingly popular scientific shows and exhibitions. His work on Victorian illusion argues for 'a specific discourse of spectacle that linked different practices, instruments and performances together. We can think of this in terms of an assembled tradition of illusory practice.'[531] The ways in which the senses, perception, and the body were discussed and framed in broader social and cultural discourses mattered in such narratives. In particular, how the self was configured in relation to the experience was impacted by culturally predominant conceptions of the 'real' or 'possible'. The ways in which the distance senses of vision and hearing were discussed were often less entangled with the self than those of touch and the bodily interior, which will be discussed in the final chapter.

The specificities of the ways in which patients' described and articulated their experiences and the ways in which their body felt *mattered*. Such descriptions are immensely revealing of the ways in which individuals structured and understood their worlds and how their relationships with their bodies and experiences shifted, mutated, and transformed.

[530] Ibid.

[531] Iwan Rhys Morus, "Illuminating Illusions, or, the Victorian Art of Seeing Things," *Early Popular Visual Culture* 10, no. 1 (2012): 38.

Hurting

'She elegantly describes her pains as like hot sparks from an anvil.'[532]

How did pain shape both the ways in which people experienced their bodies in hallucination and delusion, and how they communicated or interacted with others? Whilst it is rarely discussed in the published texts of mental science, pain surfaces repeatedly in asylum stories and Norman's lectures, as in statements such as Letitia's here, yet sits uneasily in this space. Situated somewhere between stimulus and interpretation, pain is a complex phenomenon which itself tangles the structures of perceptual and lived experience, or the material and phenomenal body of the person in pain. In a sense similar to delusion, pain is a way of organising and attaching a particular emotion, feeling, or meaning onto a sensation (or a constellation of sensations) apparently rooted in the body. Pain is evaluative. If delusions were not *quite* of the body, but were entangled with it and implicated and shaped by it, could they be painful? Could pain occur in experiences interpreted and translated as imaginary or apparently without a basis in the material body?

Whilst medical professionals have developed and elaborated upon numerous systems whereby disorder within the human body might be identified, classified, and understood according to a wider and ostensibly objective system or metric of meaning, they are ultimately still reliant on some level on these instances of patient reporting and translation of bodily experience into a communicable and shareable form. Historian Joanna Bourke has written extensively on the cultural and social mediation involved in the process of finding a

[532] Series 1, Lecture 14, 4 April 1905, ACC/2017/2, CN/1/14, CNL, RCPI.

language for pain.[533] Finding this language has a number of uses; it can help an individual to understand their experience of pain in relation to an understanding of a self and can foster bonds of sympathy and commonality in the face of suffering or the apparently unshareable and personal. It can also provide those in a position to offer practical assistance to the person in pain an opportunity to understand the cause and nature of the pain experienced. Given these different purposes and audiences, pain languages are necessarily adaptable and contextual.

The relationship between metaphor and physical sensation; feeling and language, is intricate and inescapable. For centuries, philosophers have regarded pain in particular as the ultimate subjective experience, yet marvelled at humanity's insistence on and attempts to share and express it. Wittgenstein explored and critiqued the possibility of a 'private language' in his *Philosophical Investigations*; one meaningful and comprehensible only to the individual. He specified that 'the individual words of this language are to refer to what can only be known to the person speaking; to his immediate private sensations.'[534] This private system for sensation, however, was determined to be impossible given such a private definition of vocabulary lacks the essential component for meaning; the stage-setting which reaches beyond the 'mere act of naming' in order to 'make sense'. Language is enmeshed, connected, and meaningful both because of its subjective significance, and its situation in a wider society or network of rules. As a referent or a sign, language is constituted by consciousness and, in turn, that subjective consciousness or self is shaped by it.

[533] Joanna Bourke, *The Story of Pain: From Prayer to Painkillers* (Oxford: Oxford University Press, 2014); Joanna Bourke, "Pain, Sympathy and the Medical Encounter Between the Mid Eighteenth and the Mid Twentieth Centuries," *Historical Research* 85, no. 229 (2012): 430–52; Joanna Bourke, "Languages of Pain," *The Lancet* 379, no. 9835 (2012): 2420–21.

[534] Marie McGinn, *The Routledge Guidebook to Wittgenstein's Philosophical Investigations* (Abingdon: Routledge, 2013), 138.

Language may be inextricably bound up with sensation, but numerous theorists have pointed to its inadequacy and failure in particular contexts. Elaine Scarry's work on *The Body in Pain* has drawn particular attention to the tendency of pain to actively destroy linguistic expression.[535] Writing in 1985, in the heat of the 'linguistic turn' in history and a growing climate of theoretically-engaged interdisciplinary research, Scarry's work challenged the primacy of language in considering the subjective experiences of the self and the past. However, whilst Scarry's work carves out and urges focus on an ethics of and with the body, her account implicitly upholds both a body-mind dualism, and a conception of both the body and pain (or indeed sensation more broadly) as universal and ahistorical. Scarry's 'body in pain' is an urgent and violent figure which anticipated the re-embodiment of more recent historical theory, but ultimately it is a starting point for the intricacy and complexity of pain's perception, framing, experience, and communication. Pain, like any other experience, is shareable, complex, and *lived* with and through both language, the body, and the world. In describing it, subjects often find and repurpose available languages, images and concepts; drawing in and embedding experience in a conceptual as well as physical world.

Pain surfaced frequently in Letitia's case. Norman attended to the specificities of her languages and was evidently greatly interested in her self-monitoring of her body. In one exchange, included here at length to demonstrate the detail with which the two discussed her physical sensation, he asked her to elaborate on the nature, location, and quality of her pain, both past and present. The notes of this conversation read as follows:

[535] Elaine Scarry, *The Body in Pain: The Making and Unmaking of the World* (New York: Oxford University Press, 1985).

'Have you pains in your limbs?

Yes, in my knees. In my hands and arms and face.

Are the pains in the joints?

Not so much in the joints as in the knees and down the back. Are they in the flesh?

Yes, in the flesh.

What kind of pains are they?

Sore to the touch as if there was something 'bealing' in them.

You used to tell me of pains of another kind? Are they gone?

Here in the back of my neck and the arms. I think I have enumerated them all.

But you used to tell me of sharp pains.

Yes, like a knife running through me.

Do you remember telling me of pains like sparks?

That's down the back, just as if something was shaken on me. She used a remarkable expression on one occasion… a number of her descriptive expressions were like other patients' descriptions. She described them as stitches, stabs, darts, and so forth, but the expression 'hot sparks from an anvil' is peculiar to herself.'[536]

In a later lecture, she described that 'there is something dragging from the heart to the lungs. When I draw breath I draw my heart. Whether it's a pull like a drag I don't know.'[537] Far from arbitrary, the verbs used to articulate the experience of the body were often carefully

[536] Series 1, Lecture 14, 4 April 1905, ACC/2017/2, CN/1/14, CNL, RCPI.

[537] Series 3, Lecture 6, 12 March 1907, ACC/2017/2, CN/3/5, CNL, RCPI.

chosen and gave shape, movement, and quality to the sensation. They were interpretive devices which were of personal and conceptual significance to the narrator.

Bourke has written on the difficulties in clinical practice, from the nineteenth century onwards, of rightly interpreting physical distress and identifying the presence or seat of pain in patients. Drawing on Mary Fissell's research, she demonstrates that clinical narratives and languages of pain became less elaborate and dialectically specific over time and the 'social chasm between patients and physicians widened', before the introduction of such systems as the McGill pain questionnaire in the twentieth century.[538] Whilst this was true for much of the population, a huge variety of creative languages slip into asylum pain narratives. Neologisms, or the use by patients of invented words for their experience, abounded in asylums. We have already encountered Lizzie O.'s hypnophone, sympaphone and artiphone, and Tilly Matthews' Air Loom, but neologisms were often verbs as well as nouns. As well as describing something apart from and acting upon oneself, these new words could therefore also express sensation and feeling rooted in the body. In Norman's interview of Letitia, the transcriber chose to include quotation marks around her term 'bealing', to indicate the particularity of this expression to the patient. Whilst some of her descriptions and vocabulary for pain were recognisable and drawn from a common language, which might connect her to both other patients and the doctor, nurse or attendant, she also reached for new ways to express the many different types of pain she experienced. Her pain was different in different parts of the body and assumed different forms.

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[538] Bourke, *The Story of Pain,* 136–37.

Another patient, who remained unnamed in the lecture transcript, described how 'voices roll up from my stomach and nearly choke me'.[539] The patient was referred to as 'very incoherent' and 'full of neologisms. He is tormented by a system of 'suckage', - whatever that means; also something or other called 'cheatening'.[540] This patient similarly found the standardised verbs of the English language inadequate, or perhaps inaccurate, for describing and explaining his distress and sensation. Such accounts urge an expansion and revision of what ought to be considered as *painful.* For this patient, words and voices were *felt* in the body. Such languages proliferated and attracted clinical attention rather than necessarily being dismissed. Published in *JMS,* a patient under Norman's care and referred to as B.C., was used to illustrate how patients' expressions connected to their sensations. Norman explained that she

> 'speaks of "brine," which is a sort of tingling pain that runs down to her feet and toes. Suffers also from what seems to be an abdominal sensation, which she calls "crickets" – (possibly delusional interpretation of the feelings produced by a dilated heart palpitating in the epigastrium).'[541]

Whilst these are not invented words, the patient's repurposing of language to explain and figure her sensations was considered of clinical significance. Again, differentiated from the rest of the text with punctuation, this appears to here be used as a device to indicate that whilst a 'real' concept (and in this case insect), the patient was repurposing it and using it beyond or outside of its received meaning.

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[539] Series 1, Lecture 19, 1 May 1905, ACC/2017/2, CN/1/19, CNL, RCPI.

[540] Ibid.

[541] Norman, "Notes on Hallucinations. II," 278.

The article was formatted like a casebook, with dates framing each entry. This allowed readers to observe when such sensations and ideas or percepts shifted, developed, or indeed disappeared. Whilst the first entry which spoke of "brine" was from December 15th of 1902, by December 22nd, 'the tingling pain is better; it was electricity. She says she called it "brine," because it gave her the sensation of being pickled.'[542] By February 8th, 1903, B.C. 'talks of the voices as "delusions," and says she is "cured." But says they *were* real… the "electricity" which she *used* to feel on her skin was a feeling of "softness" – a "creamy" feeling.'[543] Such testimonies speak to the experiential complexities of bodies and pain narratives in the asylum which muddied the clinical categories we have discussed. Their use of language can reveal how patients processed and categorised their bodies and experience. However, whilst they saw these languages and experiences as fascinating, curious or remarkable, doctors struggled to interpret and translate them into specific information about the body or involvement of the faculties and systems of that body in mental disorder. Neologisms were a clinically relevant symptom of mental disorder, but given they could also represent a pain language, this was harder to grasp. What is also apparent, however, is that they were attempting to do so and engaging with patients' own languages.

Assertions such as B.C.'s of both the reality and unreality of her sensation and belief sat awkwardly with definitions such as Stoddart's. Patients frequently framed and defined their experience against and between these clinical binaries of self and other, then and now, mind and body, or real and imaginary. One patient, who remained unnamed, discussed the ways in which she had been hurt with Norman as her doctor, saying that it was

[542] Ibid.

[543] Ibid.

> *'Just a slight cutting.*
>
> A slight cutting on your hands?
>
> *It went away afterwards.*
>
> How was it done?
>
> *Like a knife.*
>
> It was not a knife because you could not see the knife
>
> *Yes. It was bleeding.*
>
> Are you sure it was a knife?
>
> *It seemed like a knife.*
>
> Wouldn't it have some other name?
>
> *The mind-knife. I questioned them. I noticed the appearance. They told me that it was.'*[544]

This expression sits somewhere between the 'mental pain' Norman discussed frequently (as an emotional experience, generally in the context of melancholia), and physical pain with its root in sensation. His patient identifies a location, quality, explanation, and even object which cut her so. She nonetheless leaves the description of this experience and the object itself without definite boundaries and with a liminality which was pressed by the doctor. How could something be real if it could not be seen? Similarly, how could something be unreal if it caused her to bleed? These descriptions are compelling not least because what they do make visible is the negotiation and discussion which mediated and shaped how experiences

[544] Series 2, Lecture 9, 23 March 1906, ACC/2017/2, CN/2/9, CNL, RCPI.

were received and conceptualised across subjective positions or bodies and systems. How could a mind-knife be easily placed in the mind or body? How might Stoddart's frame account for the man who informed his doctor that 'they were delusions then, but they have come true now'?[545]

Patients' sensations and convictions in such accounts resisted the concepts of 'reason', 'logic', and evidence by observation which physicians held close and formed the basis of recognition. When Letitia told Norman that her deafness in one ear had been caused by 'electricity', he seemed to sympathise, saying that

> 'That's a cruel thing.
>
> *Yes, it's a fearful pain. After a few minutes it passes away. This side* (left) *is quite numb…. And now I have some dreadful pains across here.* (The left breast)…
>
> That side is numb?
>
> *Yes, all this side.*
>
> From the top of your head to the sole of your feet all your left side is numb. Is that so?
>
> *Yes, and tingling a lot…*
>
> These pains and numbness are you think due to your nerves being electrified?
>
> *Yes; I think they are using phosphorous on my head. Something eating right across there. (Her forehead).*
>
> Is it a gnawing pain or is it a darting pain?

[545] Series 3, Lecture 19, 3 May 1907, ACC/2017/2, CN/3/18, CNL, RCPI.

No; a gnawing pain. I never see anyone. I hear voices talking on the electric wire.'[546]

Letitia is both numb and pained. Her ear, breast and forehead were described as tingling and electrified. She differentiated between the types of pain named by the doctor. The pain she felt was dreadful, fearful, and gnawing at her. It affected and limited the way she moved as well as the way she felt. It also changed over time; it wandered across her body and shifted in shape. As such, exchanges such as this are the basis of complex stories about the body which resisted easy explanation or categorization in both physiological and psychological terms.

Doctors and patients were both therefore engaged in these complex processes of identification, interpretation, evaluation, and communication of their bodies and experiences. These attempts to establish the real from the fictive across different parties and positionalities in patient narratives raise crucial questions which the remainder of this section will unpick. Who had the authority and ability to determine when something was real or not, or whether it hurt or not? Why was it important that physicians establish the 'truth' of the patients' bodies? Why was disentangling physical sensation with a stimulus from delusion important? For the historian, it can be remarkably difficult not to find oneself 'choosing' a narrative and determining herself what was real, forgetting that this in itself is an evaluative judgement based on notions of ingrained validity and value of evidence. The remainder of this chapter looks at cases of abuse, in which narratives and types of evidence were explicitly situated next to each other and compared or tested. Notions of embodied difference and the mystery or curiosity of patients' bodies, given shape and new meaning through delusion, could enable and legitimise abusive practices by situating voices and bodies on a vertical hierarchy. If

[546] Series 2, Lecture 7, 19 March 1906, ACC/2017/2, CN/2/7, CNL, RCPI.

patients were apparently unable to correctly identify and evaluate their own sensations, could their material bodies be trusted? Were patients the unreliable narrators of their own bodies?

Abuse

Instances of bodily injury and physical harm assumed a liminality between the real and the fictive when delusion apparently tangled the processes of interpreting and evaluating the body. How were physicians to tell whether accusations made in clinical interviews were the product of something conjured by the patient's mind and body or facilitated by the blind spots of the asylum? If a patient appeared lucid or reasonable and embedded their delusions in a shared or common language and space, this became particularly complex. The following conversation between Norman and Letitia, in which she explains the system by which she is tormented and pained, is included extensively as it challenges the assumption that delusions were easily identifiable and necessarily fictive. The transcript recorded,

> 'These people who annoy you in this way with electricity are very malignant persons?
>
> *Do you teach this?*
>
> I am sorry to say I know nothing about it.
>
> *Some doctors tell me the medical superintendents work the machine.*
>
> You think they are very wicked people?
>
> *They shouldn't keep people very long under it. I hear by the rule of the instrument they're not to be kept under it longer than three weeks or a month.*
>
> It has been carried on with you for some years?

> *I am eight years and six months under it. I am four years and five months here and I was four years in the other place.*
>
> I know. You haven't told us everything.
>
> *Well, doctor,* - (with dignity), - *I think I have answered all the questions you asked me.*
>
> The patient on leaving the room complained that all the medical gentlemen before her ought to know that anyone suffering for some time from great pain required a stimulant. She herself knew that as she had knowledge of pain nursing herself.
>
> Well, tell me before you go: you don't know who uses this instrument?
>
> *I think you do it yourself, doctor.'*[547]

This exchange reads more like a witness statement or enquiry than a clinical exchange. Letitia accused her doctor of ill-using her, expressed knowledge of the practices, instruments, and treatments of clinical medicine, and refused to be led by questions she did not wish to answer. She also made a claim to authority, in both her own experience and of pain nursing, indicating some knowledge of the medical systems she believed acted on her. The transcriber themselves read this interaction as dignified and decided this interpretation warranted inclusion in the transcript itself. Letitia appears to have been scolding her physicians and observers. I find myself wondering whether these men believed she was in pain and whether she was in fact subject to abusive and coercive practices, not least given she certainly was detained against her will.

[547] Ibid.

Patients were not always the passive recipients of doctors' definitions and understandings of their experience. As has been demonstrated, they created and insisted on their own languages, evaluations, and meanings. Such instances might be read as moments and episodes of resistance to the imposition of clinical frameworks and structures, whether material or discursive. If the lived asylum space we are exploring might be imagined as constructed, temporarily, as two-dimensional lines, these run alongside each other in parallel. There exist multiple timelines, narratives, meanings, bodies and worlds. They are, however, far from straight lines. Just as clinicians came into contact with patients' descriptions in order to understand and interpret their bodies and realities, so too could patients use their awareness of clinical medicine and the asylum space to ground or centre their explanations or beliefs. Patients made frequent accusations of ill-use, exploitation, sexual assault, violation, or degradation in the asylum space. In cases such as these, determining fact from fiction and the real from the imaginary was an urgent and high-stakes negotiation.

With so many conflicting, sensational, and partial accounts, how do we establish trust in our sources and unpick the tangled narratives which surround these spaces and events? Accusations of abuse, and investigations conducted to establish their legitimacy, reveal a host of assumptions about trust, validity, and reliability, as well as profound questions of embodied difference. A rift and tension emerged through these accusations and investigations between the ideal and the reality in asylum practice and patient care. Questions of risk were crucial in such negotiations. As referenced in chapter one, when patients first entered the asylum, they were categorised as violent, epileptic or suicidal in order to determine whether they could pose a *problem* from the perspective of asylum management. Such categorisations shaped patients' behaviour, sensation, and how their bodies or testimonies were seen and understood. These categories initially separated types of patients into constellations of

behaviours, providing a warning for staff who came into contact with them at a later date, and shaping interactions. However, the significance and relevance of such terms stretch beyond this initial label and can reveal a great deal about the ways in which the relationship between self and body was viewed and constructed both from a subjective perspective, as well as for those observing and interacting with the bodies and behaviours of others. It was not just feeling which situated patients in liminal spaces. The meaning and significance of behaviour could reinscribe the body with social and medical meaning which did not necessarily reflect the patient's own meaning or intention.

The violent, suicidal, or self-mutilating patient presented a particular problem to an asylum system ostensibly committed to non-restraint and moral treatment, especially when physicians were confronted with determined and non-communicative patients. Whilst institutions were exceedingly careful to differentiate themselves from the methods and attitudes of the previous generation of alienists and physicians in treating the insane, they were frequently forced to concede that some form of restraint was often a necessity. As late as 1902, George Robertson (the Medical Superintendent of Stirling District Asylum) argued that 'there are not only many things to be done in our asylums but much to be undone, for asylum treatment of the insane, to its great misfortune, has a "past."'[548] Robertson referred to the 'repulsive horrors' of 'chains, cruel violence, and systematic neglect' which had gone from accepted practice, but 'much of the past is not dead; traditional ideas of dealing with the insane still exist, handed down from one generation to another.'[549] Acceptance of the

[548] George M Robertson, "Hospital Ideals in the Care of the Insane: A Statement of Certain Methods in Use at the Stirling District Asylum, Larbert," *JMS* 48, no. 201 (1902): 261.

[549] Ibid.

principles of non-restraint proselytised by Pinel, Conolly, and countless others,[550] had ostensibly reformed much of the daily practice in asylums, but Robertson warned that 'we have assumed too readily that the mass [of asylum officials] was leavened with these ideas.'[551]

Accessing lived experience frequently involves unpicking and challenging assumptions constructed on and around the idea of a historical myth. The question of restraint is of particular importance, not least given its centrality to our understanding or picture of the asylum as discursively coercive but self-consciously not physical. Chains were ostensibly replaced with moral therapy. The morality of adapted physical as well as chemical restraints was extensively debated throughout the period; the practice was condemned in humanitarian circles and its abandonment allegorised in paintings, but the daily practicalities of asylum care did not always live up to these ideals. Balancing the apparent dangers of the manic, violent, self-mutilating or suicidal patient to themselves or others, with understandings of sensibility, perception, pain, sympathy, and ethics in the insane was an immensely fraught issue.

Although Norman claimed such practices had 'almost entirely disappeared from modern asylums' and he maintained that he did not use it them at Richmond, he contended that, 'I am not going to lay down any inflexible law. There is more necessity to look after

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[550] John Conolly, *The Treatment of the Insane without Mechanical Restraints*, Cambridge Library Collection. History of Medicine (London, England: Smith, Elder & co., 1856); Robert Gardiner Hill, *Total Abolition of Personal Restraint in the Treatment of the Insane: A Lecture on the Management of Lunatic Asylums, and the Treatment of the Insane* (London: Simpkin, Marshall, and S. Highley, 1839); Robert Gardiner Hill, "On the Non-Restraint System," *The Asylum Journal* 1, no. 10 (1855): 153–55.

[551] Robertson, "Hospital Ideals in the Care of the Insane: A Statement of Certain Methods in Use at the Stirling District Asylum, Larbert," 261.

one's patient than to be consistent.'[552] He claimed to have resorted to mechanical restraint on only two occasions out of the 'many thousands of patients' who had 'passed through [his] hands' in over twenty years.[553] Norman didn't detail one case, stating only that it was 'of a technical nature', but the other was 'a woman who had been operated on for goitre.'[554] He explained that,

> 'she became maniacal and pulled out the trachial tube. I had a straight waistcoast made of her and kept her in that for some days until I had a new trachial tube made. I then removed the straight waistcoat.'[555]

He had witnessed other instances of mechanical restraint at other asylums when working as an assistant medical officer. In one case, a straight waistcoat was used when a patient attempted to gouge out her eyes. The decision to restrain this patient was insisted upon by 'the superintendent of that asylum, against any advice [Norman] was able to give'.[556] Despite this physical management, the patient was left alone for two hours during which time she managed to remove her central incisors. Norman observed that 'there was no injury to the gums suggesting that they had been knocked out by the nurse. So this shows you what can be done while a person is in a straight waistcoat.'[557] Not only was mechanical restraint to be ideologically objected to, but it was also evidently not an effective a method for the prevention of harm.

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[552] Ibid.

[553] Ibid.

[554] Ibid.

[555] Ibid.

[556] Ibid.

[557] Ibid.

Ideology was doubtless important in shaping such clinical encounters, but principle was necessarily often modified or refined by the anxieties and urgencies of confrontations with unruly or resistive bodies. It is significant that when confronted by the seemingly impossible feat of removing one's incisors whilst in a straight waistcoat, Norman's first consideration was whether the teeth might have been knocked out by a nurse. Given that medical superintendents were often involved in patient care in the abstract rather than this immediate sense outside of such lecture theatres, nurses and attendants played a vital role in the process of translation between ideology and practice. They were also subject to the immense pressure of institutional scrutiny, which the remainder of this chapter will explore. Few articles explicitly discussed the realities of patient care from this perspective or position.

What power did the asylum, and its workers or authorities, have to impose on the bodies of patients? What level of harm was considered acceptable in interactions with patients? What did resistance mean and what could it look like? Norman's clinical lectures raise particularly crucial questions about the autonomy and subjectivity of patients in the discursive and physical space of insanity. Patient David K. was brought before lecturer Conolly Norman and his students 'resisting desperately' and 'shouting loudly'.[558] The transcriber present indicated that that the difficulty getting him into the room was due to his distress as well as a practical issue given his difficulty walking. Whilst it was generally accepted that patients in a maniacal state would present a physical difficulty given the 'mental excitement' they experienced and the concomitant wildness of their limbs or

[558] Series 3, Lecture 20, 6 May 1907, ACC/2017/2, CN/3/19, CNL, RCPI.

gesturing, the ‘tendency in the melancholic class to resist’ was specifically noted by Norman.[559]

The physician remarked on patients’ unwillingness to move or behave as they were directed and required. He commented that ‘any number of patients show this condition which is technically called ‘resistance’. It occurs in all kinds of insanity from time to time. Sometimes they are violent and sometimes stronger than one would suppose.’[560] The inclusion of quotation marks, for the present-day reader, conveys a sense of irony. For Norman, it appears to have signified novelty and perhaps incredulity. Resistance did not have to mean violence. It could mean a shutting-down of the body; an either voluntary or involuntary insensibility to both manipulation and external stimuli. Another patient, referred to only as Pat and recorded in the first series of lectures, was presented as a particular example of such a case. As Norman explained to his audience,

> ‘You will see that when one endeavours to move him about in a certain way he resists and puts a certain tension in his muscles which is remarkable. If you try to get his head back[,] he fights against you. If you try to move it forward[,] he does the same.’[561]

This patient presented Norman with considerable difficulty given both his refusal to speak and engage in a dialogue about his condition for the students’ educational benefit. In an apparent attempt at jocularity, Norman introduced him by stating that ‘our friend belongs to

[559] Series 1, Lecture 5, 13 March 1905, ACC/2017/2, CN/1/5, CNL, RCPI.

[560] Series 3, Lecture 20, 6 May 1907, ACC/2017/2, CN/3/19, CNL, RCPI.

[561] Series 1, Lecture 5, 13 March 1905, ACC/2017/2, CN/1/5, CNL, RCPI.

the order of uncommunicative people.'[562] A further interaction with a David K. demonstrates the implications of 'overcoming' patient resistance and displaying bodies without patient consent of co-operation. The notes document that Norman 'turned back the patient's great toe to the posterior, a thing which he did not believe anyone could do except a trained contortionist. The heel was also quite easily placed in the groin.'[563] After this manipulation and display of the body of a patient who had already been noted as resisting and in pain, the physician explained to those observing, that

> 'it is highly probable that where I held that man above the knee there will be marks of my fingers on his skin. These are the difficulties we sometimes have to encounter in asylums. We sometimes see patients covered with bruises which give us some anxiety.'[564]

Bruises, broken bones, and even death, were as real a bodily reality or potential in this environment as bedsores.

Staff had the ability, opportunity and, to some extent, the remit to wield immense physical power over the supposedly malleable, insensible dangerous, or chaotic body of the lunatic unable to control themselves. The coercive practices often inherent in being seen have been discussed in a previous chapter, but some images also help visualise the explicit violence this could entail. An image of Lilly O.J. (Figure 15) was included in the Heath Asylum casebook, showing her resisting having her image captured.[565] The physical

[562] Ibid.

[563] Series 3, Lecture 20, 6 May 1907, ACC/2017/2, CN/3/19, CNL, RCPI.

[564] Ibid.

[565] Lilly O.J., c.1899, photograph, CB 3 Female, 1899-1912, H65/B/10/028, BH, LMA, 16.

manipulation Norman described himself engaging in – moving the patient's head or body about against his will – was clearly deemed a necessary assessment of mental action, sensibility, and flexibility, and Lilly O.J.'s photograph was not an exception in illustrating violence in the physical examination and recording of patients. However, attendants, nurses, and doctors were repeatedly reminded to exercise caution in such direct contact with resistive patients. Pat was evidently distrustful of the physician, prompting Norman to ask, 'what are you looking round for. Is it you are afraid something will happen to you? (No reply).'[566] Presumably in case the finer details of the scene were missed by the students or transcriber, Norman narrated that 'he looks about with an air of apprehension as though some of you had some designs on him.'[567] It is unclear whether the patient was believed to be experiencing delusions of persecution or paranoia, but Norman did explain that 'he presented the other day when being bathed a bruise, and also a fracture between the Gonoid and the   ligaments' [sic].[568] Whilst Norman stated that 'it is not easy to see how a strong bone bound down with so many ligaments would break without direct

Figure 15: Photograph of Lilly O.J., c.1899, photograph of the Heath Asylum CB, LMA.

[566] Series 1, Lecture 5, 13 March 1905, ACC/2017/2, CN/1/5, CNL, RCPI.

[567] Ibid.

[568] The transcriber included the space and omitted the second ligament name here.

violence',[569] he did not speculate as to whether this could be the result of abuse by asylum staff. Norman simply mused that 'probably someone struck him with a sweeping brush or similar weapon of warfare'.[570]

Yet more disturbing was the lamentation that 'when you have a melancholic absolutely silent all things may happen to him and he will not break his mute condition.'[571] This explanation is an alarming reminder of the abuse and violence by both staff and other patients that the asylum environment (or patients themselves) could facilitate and obscure. Silence was not only imposed in clinical archives. It could also be chosen or unavoidable. If insane bodies were seen as unreliable and somehow malfunctioning, just as their testimonies and beliefs could be dismissed as delusional or their sensations as hallucinated, did this provide the perfect conditions in which they could be controlled, manipulated and hurt? When patients expressed what were described as delusions of persecution, or viewed those around them with suspicion were these always unfounded or misapprehensions? What did labelling them as such do to patients' ownership of their own bodies, voices, sensations, perceptions, and meaning?

Both the public and asylum authorities were aware and anxious of these dangers. Norman describes one case of a general paralytic man who died under his care. The patient

[569] Series 1, Lecture 5, 13 March 1905, ACC/2017/2, CN/1/5, CNL, RCPI.

[570] Ibid.

[571] Ibid.

> ‘had five ribs on one side and six on another fractured. He never complained or gave any sort of clue as to how he had been injured. He told general stories about having been engaged in the Peninsular War, and the battle of Waterloo.’[572]

In this case, the patient appears to have incorporated his bodily condition and injuries into a delusional system centred on wartime service. Separating such lived worlds from the realities of the institutional environment, when they could become enmeshed and entwined in complex ways, was problematic for asylum oversight. This situation could be exploited, and it often meant that incidents of abuse went unchecked; an issue that medical superintendents were often all too familiar with. Norman added to the document in pencil that he did not ‘discover that [the patient] had been leapt upon by a brutal attendant’ until ‘some months later.’[573] Whilst medical superintendents claimed to (and often did) strive to establish their institutions as centres of care and refuge for patients who were seen as physically as well as mentally and emotionally vulnerable, such violence was far from unheard of.

Cases of abuse or mishandling reoccur in Norman’s, often remarkably candid, lectures. He evidently thought it necessary to educate his pupils on the risks and dangers involved in managing the lunatics and asylum staff he encountered as superintendent of a large institution. These lectures highlighted the difficulties, ambiguities, and anxieties of the supervision of care for the insane. Accusations of abuse had to be delicately handled, especially when they involved violent patients. Norman referred to one man who similarly told stories of war which he believed was the cause of his injuries; the patient ‘showed bruises and injuries and scars on his legs and so on, and gives an account of various bloody

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[572] Series 2, Lecture 24, 11 May 1906, ACC/2017/2, CN/2/23, CNL, RCPI.

[573] Ibid.

battles.'[574] This was also 'the man who wanted to perform several murders.'[575] When considering 'his story about being assaulted and battered and so on', the physician reminded his audience that 'he came here with scarred wrists. He was very violent here. He broke glass and put his head through a window'.[576] These features of the case evidently served to undermine the patient's claims and Norman concluded that 'I do not think there is any truth in the statement.'[577] He felt more inclined to disbelieve his accusations because of both his propensity to aggression and these delusions of battles, which could ostensibly manipulate reality, fitting it into a warped account of events. Given that on admission, one of the first things noted was whether the patient was violent or dangerous, suicidal, or epileptic, such categories undoubtedly shaped the ways in which such individuals were handled and their experiences of care.

In attempting to restrain or calm a distressed, violent, or manic body, some physical injury was seen as largely unavoidable, the responsibility for which would generally be the patient's themselves. Especially with violent patients, Norman stated that 'a great deal of force is often necessary in dealing with them, when they bruise themselves.'[578] Determining injury which was directly attributable to the malice or ill-handling of the staff could therefore be a problematic and fraught exercise. Norman showed his audience another man, explaining that he had

[574] Series 3, Lecture 16, 26 April 1907, ACC/2017/2, CN/3/15, CNL, RCPI.

[575] Ibid.

[576] Ibid.

[577] Ibid.

[578] Series 3, Lecture 16, 26 April 1907, ACC/2017/2, CN/3/15, CNL, RCPI.

> ‘casually complained about being beaten with a belt around the head and the arms and legs. That story, I regret to say, turned out true. I enquired into it immediately after. I spent a good deal of the day enquiring into the story, and satisfied myself it was true. You will be glad to hear that justice was executed on the offender. I am glad to say that of late years this is rare at this institution.’[579]

Institutions prided themselves on the rarity with which such accusations were verified, whilst simultaneously stating that patient’s delusions and hallucinations generally made their testimony unreliable and their behaviour often necessitated treatment which could leave them with significant personal injury. It is difficult for both historians and superintendents to assess how regularly such abuses of power occurred. Norman is certainly correct in stating that the frequency of accusations could be overwhelming.

The basis on which accusations were dismissed could therefore be immensely revealing of implicit biases, assumptions, and inequalities in patient care. A paper of 1881 by J. Campbell, Medical Superintendent at Garlands Asylum near Carlisle, compared two cases which he determined were false. He stated, that

> ‘many complaints are distinctly the result of delusions, which very slight examination can demonstrate. I have at present a patient under my charge who persistently tells all visitors in vague and general terms that I illuse [sic] him. When closely questioned, however, and asked to particularise the ill-usage, and pressed on this point, he says that I get into his head at night. A female patient complains to me each morning that

[579] Ibid.

the female attendants are men in women's clothes, and that they "raped her during the night. She is over 60 years of age.'[580]

The presence of delusion directly relating to the claim was foregrounded in each example. However, they are not as equal as he claimed. Campbell chose to add the extra information in the second example that the woman who made the accusation was sixty years of age. This seems an unnecessary addition and appears to speak to the physician's determination that this detail made the claim even less likely, speaking to an implicit 'perfect victim' model.[581] Both are physically invasive experiences individuals said happened when they apparently could not have, but the cases are not comparable. Campbell presents it as just as farcical that he was physically in someone's head at night, which he can objectively prove and pertains to his own experience, as for an attendant to rape someone under their control. According to Campbell, neither case warranted full consideration because they were both evidently untrue.

Medical superintendents and officers often had sporadic or limited contact with patients. They were reliant, therefore, on these bureaucratic records, categories of risk, and crucially the presence and reports of attendants. These intermediaries were active agents in the experience of care themselves and dealt with most of the daily operations of the asylum and patient care, yet are easily forgotten in discussions of the power of doctors over the silenced patient. Throughout the century there was much discussion of the difficulties in recruiting the right people for this critical role. There was a recognition that these positions entailed risk to the attendants or nurses themselves and that hiring people who would remain

[580] Campbell, "Complaints by Insane Patients," 348.

[581] Olivia Smith and Tina Skinner, "How Rape Myths Are Used and Challenged in Rape and Sexual Assault Trials," *Social & Legal Studies* 26, no. 4 (2017): 441–66; Janice Du Mont, Karen-Lee Miller, and Terri L Myhr, "The Role of 'Real Rape' and 'Real Victim' Stereotypes in the Police Reporting Practices of Sexually Assaulted Women," *Violence Against Women* 9, no. 4 (2003): 466–86.

in this role was difficult,[582] but also that patients were vulnerable to abuse by poorly chosen or trained staff. This caused a dilemma. This was especially the case from the 1860s and 1870s, as newspapers and their public were increasingly concerned with such issues following a number of high-profile abuse cases in large asylums. Jennifer Wallis has discussed the impact of these asylum 'accidents' in which patients were found to have numerous broken ribs at their post-mortem examinations.[583] These cases caused a *problem.* It inspired the detached humanitarian concern of the public for the dangers of the apparently helpless behind asylum walls, vulnerable to abuse by cruel attendants.

Campbell's article included a number of tests and measures he used at Garlands to assess the validity of accusations. When it came to 'complaints of personal violence', in which patients accused attendants of beating them in some way, he explained that

> 'the invariable rule at Garlands is at once to have the patient stripped and examined; if a man he is seen naked, his ribs felt, and his chest examined; if a female her body is looked over by the head attendant, and her chest only examined by the medical officer if no marks are noticed. I had a patient, M. S., who for some time complained of having been beaten everv day, and so far as I could make out, without cause, as she never had a mark on her; but she gave it up owing to the trouble it involved to herself in dressing and undressing.'[584]

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[582] Norman's lectures and the Heath Asylum casebooks include numerous instances of patients harming staff by stabbing, pushing them down stairs, or punched and kicking them. The case of William S., discussed later, was precipitated in a sense by one such incident.

[583] Jennifer Wallis, "The Bones of the Insane," *History of Psychiatry* 24, no. 2 (2013): 196–211.

[584] Campbell, "Complaints by Insane Patients," 350.

Perhaps unsurprisingly, when accusations such as these involved submitting to an unwanted and exposing physical examination of the patient's naked body, further claims were less likely to be made to asylum authorities. Such examinations crucially relied on the presence of a physical and visible mark on the surface of the body to assess veracity; the body's truth claim more dependable and reliable than that of the patient. Campbell claimed that this practice 'ensures the safety of the patient, and necessitates care and accuracy in reporting of injuries by attendants as they soon know that such matters cannot be hidden.'[585] Physicians saw themselves as arbiters of good practice. Attendants were to be kept in line by the knowledge that covering up injuries sustained, even in the apparently necessary force their daily duties often entailed, would be discovered.

Whilst cases of patient injury could be due to deliberate abuse, it was much discussed that they could also be a result of inattention, lack of sufficient training, the incorrect selection of staff with the proper personal attributes for patient care, or indeed the unmanageability of patients' bodies themselves. The annual reports of the Commissioners in Lunacy repeatedly raised the training and conduct of asylum attendants as central to the quality of care provided in institutions for the insane. In the fifteenth report, covering the year 1860, the Commissioners stated in no uncertain terms that

> 'nothing in connexion with the treatment of the insane has a more direct and immediate effect, for good or ill, upon their condition and comfort, than the fact of their being under the charge of good or bad attendants.'[586]

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[585] Ibid.

[586] *Report of the Commissioners in Lunacy to the Lord Chancellor: 15th, 1860*, Reports from Commissioners (Ordered to be printed, 1861), 55.

The report claimed, that the Commission had devoted steady attention to this subject for many years already, resulting in 'some improvement generally in the class of persons selected, and in the wages paid to them.'[587] However, whilst emphasising the importance of the topic, the Commission lamented that in larger asylums there was still much to be done and maintaining adequate levels of supervision was 'found to be hardly possible',[588] meaning that 'too many instances still occur of the employment of persons entirely unfit for the charge.'[589] The resultant complaints, whilst of grave importance and concern, were 'received with caution, proceeding almost always from the Patient himself'.[590] Interestingly, the report stated that nonetheless, once made, 'their correctness generally is rather the rule than the exception, and we have seldom found them, even when not altogether borne out, to be without some foundation'.[591]

Later in the same decade, William Browne, Superintendent of Crichton Royal Asylum and Commissioner in Lunacy for Scotland wrote an article for *JMS*, subsequently reprinted in book form, entitled *Sisterhood in Asylums.* Whilst taking great pains to state that its purpose was not to 'frame an indictment against the attendants upon the insane',[592] this text claimed that the 'chief impediment to the successful management' of asylums and the 'grand and ceaseless anxiety and alarm' of its government was 'the inefficiency of their instruments, the want of self-control, common-sense, and co-operation in their subordinates.'[593] Harm to

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[587] Ibid.

[588] Ibid.

[589] Ibid.

[590] Ibid.

[591] Ibid.

[592] William A F Browne, "Sisterhoods in Asylums," *JMS* 12, no. 57 (1866): 44.

[593] Ibid.

patients could result, not just from their own inability to control themselves or submit to asylum authority, but the same inabilities or failures in their supervising attendants.

Although there were undoubtedly some described as 'noble exceptions' and 'individuals who loved their charges as children', the author claimed that 'the mass' were rather

> 'course, harsh, passionate, indifferent, untrustworthy, intemperate; as having no higher conception of their office than as that of gaoler, no clearer estimate of their duty than what obtained in the days of Esquirol – "at all hazards and by all means to keep the lunatic quiet" – and as having no better or kinder or more humane bond with them than that of watching and warding and ruling them.'[594]

Such tracts clearly engaged in a process of distancing and establishing a hierarchy within the asylum environment itself in which attendants and nurses were not only subordinate in station, but in feeling and vocation. They also carefully constructed a narrative of progress and development in the profession, its ideas, nature, and conventions. Whilst Esquirol's ideas, especially regarding experiences such as hallucination, were still frequently discussed and informed practice at the start of the period of this thesis, only twenty years later they were presented as implicitly barbaric and unrefined.

As an intended corrective to these issues in patient care, attempts were made to emphasise the treatment of the insane as a calling that required a sympathetic and emotional

[594] Ibid.

engagement with one's wards. Especially for women, Browne emphasised the opportunities offered by asylum work and the potential refuge or calling it could offer. He observed that

> 'for such as have no home, or no suitable home, here is a retreat; for such as crave a wider field for exercising sympathy than what their natural vocation affords, are offered a life of cares and anxieties, duties and rewards… - an asylum provides real, substantial Christian exertion, so varied and yet so constantly appealing to the better part of human nature, and exacting so much of thoughtfulness, reticence, and self-possession.'[595]

When properly engaged, the attendants' regard for the distress of others and devotion to their service was ostensibly a humane, Christian, and tender profession. Such a description of the work, which asylum notes show was frequently actually messy, disgusting, distressing, menial, and dangerous, was undoubtedly aimed at the recruitment of a 'better class' or standard of attendant and the training of feeling. Whether this was translated into practice is, of course, questionable and highly variable across both institutions and geographical areas, but it is critical to recognise that this was foregrounded as a primary concern and that institutions were not as cavalier or dismissive of their patients' testimonies, concerns and welfare as much of the Foucaultian-inspired historiography would suggest. It was, however, framed less as a systemic and institutional concern, and more as an individual or human problem. Abuse was attributed to cruelty in individual attendants. This also meant that responsibility for both the recruitment of the correct staff and the conditions and treatment they imparted received was the concern of the asylum management or superintendent.

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[595] Ibid., 62.

Patients with delusions of persecution, apparently hypochondriacal notions, or hallucinations centred on their own corporeality, struggled to establish fact from fiction within their own bodies and were believed to incorporate their immediate environment into such perversions of sensation and belief. Norman contended that

> 'such patients have nearly always stories of violent assaults to tell. It requires a good deal of care to know whether they are ill-used or whether they are not. Most of them[,] when their period of excitement is over or temporarily over[,] have an idea they have been engaged in a fight.'[596]

Especially with cases of mania and delusion, many physicians believed altered sensation, delusion, and self-perception could be transient, with patients changing their 'stories' depending on the extent of nervous force or agitation. Such states created a form of disruption between self and environment, or even a rupture in spatio-temporal permanence or a coherent identity built on memory and feeling. If stories could change, who could the physician trust, and when?

These accusations and investigations were not confined within asylum walls. Relatives, friends, the Commission for Lunacy, the legal system, newspapers, and charitable organisations were mediating presences in such operations. For relatives who confined the insane, accusations were distressing and difficult to assess. Although communications were highly restricted, letters leaving asylums frequently pleaded with family members or friends to release the writer from their wrongful confinement, often listing distressing experiences they were undergoing. Relatives appear to have seldom believed such accusations enough to

[596] Series 3, Lecture 16, 26 April 1907, ACC/2017/2, CN/3/15, CNL, RCPI.

withdraw the patient from the asylum, but they were not always ignored. Norman discussed the case of one woman whose friends and family believed her claims of mesmerism and 'that she is knocked about, – as she expresses it, with a fine eloquence, she is tattooed all over with bruises from the nurses.'[597] Norman's response clearly attempted to undermine both the patient's credibility and that of the general and uninformed public. He stated that 'when she has made complaints even in that frivolous and untrustworthy manner she has been carefully examined and no sign of injuries have been discovered.'[598]

He defended the conscientiousness of asylum oversight in investigating even such apparently ridiculous accusations and rationalised that, 'of course, some of our patients do sometimes get injured by the nurses' but 'one of the duties of the medical staff is to prevent that' and, as such, he reassured his audience that all claims were investigated.[599] However, he also defended the integrity of such processes which be believed belonged within asylum walls, rather than subject to outside interference. He remarked with some tangible contempt that

> 'it is curious and interesting to note that her friends seemed to believe everything she said about being injured. It is difficult to think they believe she is mesmerised. The depth of ignorance is difficult to plumb in the general public.'[600]

Perceiving attack and censure from both the public and authorities regulating practice, medical staff often sought to defend the expertise and control they exercised over the asylum

[597] Series 2, Lecture 15, 6 April 1906, ACC/2017/2, CN/2/15, CNL, RCPI.

[598] Ibid.

[599] Ibid.

[600] Ibid.

and its patients. Distinguishing reality from delusion may have been a difficult task, but it was proclaimed to be one for which alienists were uniquely qualified.

For those making such accusations, the responses of loved ones and asylum authorities was undoubtedly distressing and isolating, whether or not they were beaten. Even when the incident did not occur precisely as they claimed, they may well have ardently believed or *felt* that it did. Ultimately, however, the physical evidence of the body and notions of credibility were of paramount importance. In the case of the woman 'tattooed all over with bruises', the absence of marks on her body undermined her account; an objective physical or material reality was more tangible and medically legitimised over a subjective one. However, close consideration of cases that went to inquiry or trial reveals that such medical expertise and physical evidence was not always as objective as claimed. Establishing what happened from a patchwork of, often competing, evidence was a complex negotiation. It was also a process fraught with power struggles between different groups tasked with the management of both of the insane and the institutions which housed them. The involvement of parties outside of the asylum left a trail of such debates and exposes tensions. These illuminate the relationship between patient and apparent caregiver at the critical juncture where it went wrong. When a patient claimed abuse or died, their body became even more of a problem within the asylum, one which a post-mortem report could not always resolve.

The 'value' of evidence

Cases of abuse are near impossible to trace using statistics and quantitative methodologies, especially amongst the delusional of asylums. Although there was a proliferation of both statistics and reports on such incidents in institutions and parliamentary

inquiries, it is unclear whether this is a spike in their occurrence, significance, or documentation. This is where the methodological choice which engages with individual cases or microhistorical approaches can illuminate what would otherwise be overlooked. It is not just that cases of abuse were uncovered in the Victorian institution that is pertinent to this study, but the detail of such cases: what evidence allegations were grounded on, whose testimony was considered credible, and why these questions have a broader significance.

Considering one case here allows me to unpick the assumptions and beliefs surrounding the bodies of the insane as well as what it meant to be both physically and discursively vulnerable or empowered in this environment. Documented at length in the 1860 *Report of the Commissioners in Lunacy to the Lord Chancellor*, Patient William S. was alleged to have died as a result of the actions of two attendants who were subsequently prosecuted for manslaughter. The description of these events is recounted here in some detail as it provides crucial insight into the dynamics of testimony and voice as it pertains to delusion within the asylum. Once more, the ways in which stories were structured or experience organised in these sources *mattered*. William's refusal or inability to conform to the routine and expected comportment of the asylum supposedly endangered the others, staff and patients, he encountered in that environment. Ultimately though, it was William who was the most vulnerable.

On his sudden death in Colney Hatch Asylum, William S.' post-mortem report recorded the cause of death as a ruptured liver, of unknown origin. When the Commission requested a report from the Asylum Superintendent, an altercation with an attendant named Gann was reported and they were notified that, as well as the liver damage, 'on the post-

mortem examination of the body many ribs and the sternum had been found to be fractured'.[601] Whilst initially dismissed, the case was reopened some months later by a letter from the Home Office, 'enclosing statements of the alleged circumstances of William's death, communicated by the Secretary to the Alleged Lunatics Friends' Society, together with a copy of the depositions at the coroner's inquest'.[602] On being pressed, the Commission launched a 'full inquiry' in July into the conduct of two other attendants, Vivian and Slater. The description in the report, of the 'facts disclosed on the investigation, assuming them to be trustworthy',[603] was clearly intended to testify to the thoroughness of the investigation and considered process of such allegations (even in the case of violent or 'refractory' patients, as was emphasised). It also, however, revealed substantial omissions, oversights, and manipulations.

Whilst William S. had an apparent history of violent behaviour preceding his admission to the asylum, once there he 'appears to have committed no act of violence'.[604] This was the case until May, when the Commissioners reported that he assaulted the attendant Gann, who struck him in self-defence. Following the incident with Gann on May 9th, William S. was removed to 'a ward occupied by a more refractory class of Patients'.[605] This was common practice in cases of violence against other patients or asylum staff, and such wards were designed to provide greater supervision of their occupants, especially in large asylums where the sheer force of numbers rendered this impossible across the

[601] *Report of the Commissioners in Lunacy to the Lord Chancellor: 15th, 1860*, 56.

[602] Ibid.

[603] Ibid., 57.

[604] Ibid., 56.

[605] Ibid., 57.

institution. When in this new environment, William was nonetheless described as 'cheerful and loquacious, as his ordinary custom was; making no complaint, eating his meals heartily, and showing no symptom of bodily injuries'.[606] The day before his death, he apparently became 'more than usually noisy and troublesome',[607] prompting him being ordered from the ward. At this point,

> 'Slater, one of the accused, seized the Patient, tripped him up, and, with the help of the other attendant, Vivian, dragged him to the padded room. Here they remained alone with him; but a noise from within as of scuffling, throwing down, and kicking, and cries from the deceased, were heard on the outside.'[608]

The events of the next day were recorded at length. The written account included extensively here to illustrate how such narratives were told in a manner which unfolded events almost as if they were happening in real time.

The reader follows the story in pieces, already aware and informed of the main character's death. This allowed for the exposition and emphasising of particular curious details, such as the reports of the patient's physical experiences apparently inconsistent with other evidence. Though William

> 'ate his breakfast as usual, and one of the Assistant Medical officers of the asylum stated that he had felt his pulse in the morning, and it was in its ordinary state, he appeared much hurt in sitting down and getting up; called the attendants Vivian and Slater "brutes;" said it was too bad to kick him so and in the afternoon of that day,

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[606] Ibid.

[607] Ibid.

[608] Ibid.

while in the Airing Court of the ward he had been placed in, complained of their conduct to him. Immediately after this, the alleged more fatal injuries were inflicted. The men, Vivian and Slater, were seen, a little before five that afternoon, in a scuffle with the deceased. They were observed by other Patients throwing him down, kicking and kneeling upon him; and finally they took him again to the padded room, from which he was heard to call out "murder," and in which he was seen, twenty minutes later, lying silently on his back, with Slater's hand upon his head. At twenty minutes to eight the medical attendant was sent for, who came in three minutes after and found him lying on his back, evidently recently dead.'[609]

The detail of reports such as this is immediately striking and warrants inclusion. Timelines are established, key players identified, and testimony from multiple parties considered. Such processes referenced other attendants, patients, and medical officers alike. However, when the case was pursued further, credibility and voice became a fraught issue.

The Commission reported that sixteen patients were examined for evidence, using only those 'the nature of whose mental disorder, carrying with it no incapacity to distinguish between truth and falsehood, involved no necessary doubt of question of their veracity.'[610] The legitimacy of such claims often hinged on whether the patient exhibited either a delusion or alteration in comportment and general behaviour. Two witnesses in the case were

[609] Ibid.

[610] Ibid., 58.

described as ‘undoubted lunatics’, who were ‘subject to delusions’.[611] This necessitated ‘great caution’ in considering their testimony.[612] They were nonetheless described as

> ‘legally and morally competent. Take the first witness, the one who says he has been the subject of poisonings. He may be mad upon that subject, but upon all other subjects, he may be just as sane as I am, or as you are.’[613]

A delusion could seemingly be restricted to a particular area without wholly affecting a person’s ability to comprehend reality or testify to events. However, in the asylum rather than legal environment, this distinction was not always made, especially in such cases of abuse accusations. Whilst William repeatedly claimed he had been beaten and abused by attendants, this was clearly overlooked in between the first beating by Vivian and Slater and the subsequent lethal one.

Cases and inquiries such as this created a space in which issues such as the value of the evidence of the insane were explicitly discussed. An article published in 1891 in *JMS,* outlined and commented on the inquiry into a death, seemingly at the hands of an attendant named Hayes, whilst under Conolly Norman’s care at Richmond Asylum.[614] In many ways comparable to William’s case, the patient concerned (O’Connor) was classed as a violent and refractory patient, who ‘had to be manacled by the attendants’ while being moved between asylums.[615] At the inquiry held by the Board of Governors into the death, during which two

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[611] Ibid., 61.

[612] Ibid.

[613] Ibid.

[614] “The Value of the Evidence of the Insane,” *JMS* 37, no. 156 (1891): 106–12.

[615] Ibid., 107.

other patients testified to the abuse and attack.[616] One patient, corroborated by the other, stated that he witnessed the deceased being 'knocked down and kicked in a brutal manner' by the attendant (Hayes) but had not been able to 'report the matter earlier… because he did not want to make it bad for himself.'[617] However, the Recorder summed up by dismissing and undermining this evidence, stating that

> 'he did not see why Hayes was to be ruined for life on the evidence of three lunatics unless they were coerced to believe them… there was no evidence whatever to show that Hayes had been guilty of violence, not any evidence to show that the injuries to O'Connor were caused on the 12th June.'[618]

For the paper's author, 'such a state of the law as laid down by the learned Recorder is intolerable and contrary to English precedent.'[619] The judgement was despite the same Recorder also stating that 'the patients had given their evidence in an admirable manner, and that he had never heard better witnesses, but they were insane!'[620] Corroborating concerns similarly expressed by Lord Shaftesbury in a Select Committee in 1859, the article stated that such dismissal would leave patients at the mercy of their attendants as well as disempowering medical superintendents of the power to protect their wards from cruelty. Instead, the author contended that 'although a witness may be insane he may be labouring under a form of insanity which will not invalidate his evidence if it is outside the range of any delusions he may have.'[621] As both Peter Bartlett and Janet Weston have explored in greater depth,

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[616] There were three witness testimonies before the inquiry but one patient relapsed and was unable to give evidence.

[617] "The Value of the Evidence of the Insane," 108.

[618] Ibid.

[619] Ibid., 109.

[620] Ibid.

[621] Ibid.

understanding and elaborating upon the mechanism and function of delusion within the rest of the patient's perceptual system and the ways in which they structured their world had significant implications for their interactions with the legal system as well as in broader social and cultural structures.[622]

If the reliability of insane witnesses was contested, the physical evidence became particularly important. Patients could claim abuse which did not happen, or might fail to report injury which did, but their bodies and the observations of others was preferred over their reports. The evidence of the William S.' body was carefully documented and recounted at the inquiry. However, the conclusion of this trial points to the ambiguities surrounding even this physical evidence. The testimony given by the Medical Officer appears to have changed in between the initial inquiry and when the trial went to court. The doctor, during the trial,

> 'found himself able to swear, in contradiction to what he had stated on oath to the Examining Commissioners, that, in his opinion, Swift's death had resulted from injuries received in the struggle with the attendant Gann on the 9th May, and that, it was quite possible that the deceased might, for three days, have gone about, have dressed himself, and have taken his meals as usual, with a broken sternum, eleven broken ribs, and a ruptured liver.'[623]

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[622] Peter Bartlett, "Sense and Nonsense: Sensation, Delusion and the Limitation of Sanity in Nineteenth-Century Law," in *Law and the Senses: Sensational Jurisprudence*, ed. Lionel Bentley and Leo Flynn, Law and Social Theory (London: Pluto Press, 1996), 21–41; Janet Weston, "Citizenship, Vulnerability and Mental Incapacity in England, 1900–1960s," *Medical History* 63, no. 3 (2019): 270–90.

[623] *Report of the Commissioners in Lunacy to the Lord Chancellor: 15th, 1860*, 59.

The evidence that the fatal injury happened on Friday or Saturday was extensive. It was corroborated by two 'insane witnesses', no seeming abnormalities in the patient's pulse were detected by the assistant medical officer, and the opinion of 'four medical men' testified that the injuries that killed him 'were inflicted a few hours before his death.'[624] Nonetheless, the testimony of the two patients with very similar corroborating accounts of the incident was deemed inadequate, their claim that they 'dared not' speak out against the attendants was dismissed, and it was decided that it may have been possible for the patient's body to be so insensible to internal sensation that he was able to continue about his routine, eating and dressing himself, with internal injuries sustained days before.

Ultimately the behaviour of the attendants, though clearly marked as immoral and cruel, did not result in conviction. Although dismissed following the commencement of the trial from their positions at the asylum for 'ill-usage of another Patient', the attendants were acquitted of the charges in William's case. The report stated that the inquiry and 'the publicity it has given to the details of this melancholy case will operate to the better protection in these large asylums of a most helpless and afflicted class of the insane.'[625] The Commissioners may have believed this case to be a sad one, and the events distressing, but ultimately the words of the judge in urging that 'the prisoners were dealing with a dangerous lunatic' and 'are to be protected unless you think that they have transgressed their duty' summarise the events best of all.[626] Whilst pity and sympathy were lauded as important characteristics in the treatment and regard of the 'unfortunate inhabitants of all the Asylums

[624] Ibid., 64.

[625] Ibid., 59.

[626] Ibid., 64.

in England',[627] their delusions, medical understandings of the 'otherness' of their bodies, and their erratic, 'dangerous' or uncontrollable behaviour separated them from the rest of the sane population in crucial and insurmountable ways.

This case draws attention to three crucial factors: the importance of physical examination and corporeal health in the context and environment of mental science, the tension which enveloped the twin concepts of responsibility and vulnerability in this space, and finally how the othering of patients' physical capabilities, sensations, and experiences had an impact upon their care and engagement with others. Such cases bolster Wallis' argument that asylum patients' behaviour and incapacity or inability to account and care for themselves was repeatedly emphasised by medical professionals as well as the press.[628] Patients were cast as objects of pity and condescension; emotions connecting readers to the subjects of articles were grounded in assumptions of difference. Wallis connects this to Thomas Laqueur's thesis identifying 'an extraordinary number of hitherto untold stories of human suffering' which were disseminated in the press and official publications in the nineteenth century.[629] Such stories were 'explicitly tied to sympathy for the plight of strangers' based on the commonalities in physical experiences of the body. Whilst this is certainly a vital component of these accounts and their reception, and her consideration of bone fragility in cases of GPI is especially illuminating, the details of cases such as William's reveal further troubling and curious ambiguities surrounding the body in this context.

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[627] Ibid.

[628] Wallis, "Bones of the Insane".

[629] Thomas Laqueur, "Bodies, Details, and the Humanitarian Narrative," in *The New Cultural History*, ed. Lynn Hunt, Studies on the History of Society and Culture (Berkeley, California: University of California Press, 1989), 190.

Accounts of deaths and injury in asylums across a variety of circumstances use term such as 'mysterious' and 'curious' with remarkable regularity. Whilst attempts to measure, assess and quantify such physical markers of insanity as the breaking strain of bones Wallis discusses were proliferating and became increasingly vital to determining events and culpability and such inquiries, space remained for the unknown and apparently inconceivable. Medical professionals were evidently uncertain as to the precise extent to which the troubled mind could register physical incapacity and pain. The medical officer's altered testimony appears to speak to a retrospective erasure of incompetence, error, or even malice, but it could also signify a genuine lack of coherence and understanding in such cases. Similarly, the acceptance of those passing verdict on the case that William could have continued 'cheerful' and perform daily activities with invisible yet fatal internal injuries speaks to the uncertainty with which the visceral space or internal body were regarded.

The ways in which feeling was evaluated, described, monitored, and *used* in the asylum and clinical practice were complex and diverse. Conversations about pain, pleasure, and the nature of reality happened in the asylum. This chapter has considered how language and metrics were formulated and adjusted to *make sense* of the body and its sensations. Crucially, it has foregrounded the complexities of pain and ideas of harm in the context of bodies which apparently 'could not be trusted.' Some stories told about the body were prioritised over others. Where I expected to find a dismissal of patients' accounts of their bodies and the meaning they made of sensations, I instead found a range of diverse negotiations and dialogues. Moving from these across legal sources and journal articles

highlights the ways in which policies and practice surrounding ideas like the value of evidence and ‘responsibility’ were informed by such discussions and tensions.

Chapter 6: Digestion and the visceral

What did it mean for patients to have 'something wrong with [them] internally' and why did Norman associate particular forms of insanity or symptoms with distinct organs or parts of the body? How do the processes discussed in the previous chapter, of making the unknown known and somehow tangible, rely on the ways in which the mind and body mediate between the internal and external? How do they reify or undermine a conception of the self as a coherent entity or materially bounded object? This chapter considers the visceral bodily interior and the process of digestion, through which, perhaps appropriately, the ideas and practices discussed in the previous chapter are filtered and absorbed. Digestion is examined as a process, rarely discussed in present day psychological care, through which the entanglements, disruptions, interpretations, and transformations of this material and phenomenal body might be unfolded and considered. The choice of digestion to focus the remainder of this chapter is largely inspired by my own surprise at finding how regularly eating, digesting, excreting, and feeling in the abdomen surfaced in Norman's interactions with patients and more broadly across mental science. These are intimate sources and experiences at once occupying the realm of the private and intensely public.

Reading Norman's lectures and returning to the excerpt framing this section, patients repeatedly discuss their bowels and internal organs before a room full of curious and interested people. Their bowels 'did not act',[630] they are 'twisted about',[631] and one man explained that his 'chief trouble at present' was 'in the rectum and private parts' where he

[630] Series 2, Lecture 5, 12 March 1906, ACC/2017/2, CN/2/5, CNL, RCPI.

[631] Series 1, Lecture 14, 4 April 1905, ACC/2017/2, CN/1/14, CNL, RCPI.

experienced ‘considerable pain’ at the ‘invasions of [his] body’.[632] This chapter explores and challenges a hierarchical understanding of the body’s senses, functions, and processes in light of such accounts.[633] These experiences were both central to the body itself and many of the narratives I found. They were frequently discussed as painful, distressing, confusing, or disorientating for an individual’s sense of self, reality, and connection to the wider environment or world. Reading journal articles and asylum records with this in mind, it became clear that for a discipline ostensibly exploring and dissecting the functions of mind in health and disease, formative psychiatry more broadly was fascinated with these supposedly ‘lower’ functions of the body.

Many authors even went so far as to identify the seat of consciousness in the gut, stomach, and epigastrium. An extract from Tuke’s D*ictionary* unequivocally situated the root of the self, and the central point of the body, in the stomach, contending that,

> ‘self means stomach. That is to say, the function of assimilating food is the most fundamental of all the functions. It is the first to appear in the most rudimentary of all organisms. Its existence is antecedent even to locomotion and propagation… If we remove to a sufficiently distant standpoint to get a true perspective on the functions of the individual animal organism, it will be seen to be primarily a stomach, and, secondarily, to have attached to the stomach, limbs, members, and organs by which the stomach may be filled.’[634]

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[632] Series 1, Lecture 18, 14 April 1905, ACC/2017/2, CN/1/18, CNL, RCPI.

[633] Annemarie Mol, *Eating in Theory*, book (Durham: Duke University Press, 2021), 3.

[634] Charles Mercier, “Consciousness,” in *A Dictionary of Psychological Medicine: Giving the Definition, Etymology and Synonyms of the Terms Used in Medical Psychology, with the Symptoms, Treatment and Pathology of Insanity and the Law of Lunacy in Great Britain and Ireland*, ed. Daniel Hack Tuke (London: Churchill, 1892), 260.

More fundamental even than movement in sustaining life, the stomach in such accounts was an urgent and central force which, ironically, could not necessarily be recognised from a subjective position. To appreciate and understand its significance, one must ‘remove to a sufficiently distant standpoint’. How is it so central a part of one’s body and being, yet so intangible and invisible to the self and subjective experience? Once more, we return to the question of positionality; does proximity compromise claims about the body and ‘truth’, and does distance allow one to *see* or *know* better?

Physicians used the digestive processes of the body to elucidate and demystify how the self and body, sensation and perception, real and delusive, were entangled. If self was stomach, perhaps understanding the stomach could help one to understand the Other. Asylum casebooks made frequent mention of, and often meticulous notes about, how much and regularly patients ate, whether they were fed by stomach or nasal tube when they did not, indigestion, bowel movements, and other processes, sensations, and perceptions associated with digestion. Patients, in turn, spoke of these in their own ways. As this chapter will explore, delusions were commonly rooted in the abdomen, stomach, or epigastrium. Contained within the body and intimately connected to its essential functions, the viscera and digestive process somehow sat outside of the self and felt alien to it.

As Ian Miller has explored in his work on the gut and digestive health, ‘the gut-brain axis’ which currently occupies an important position in understanding human behaviour and emotion, is in many ways a return to and elaboration upon ideas developed in nineteenth-century medical and public cultures. Whilst researchers working on the developments in understandings of the microbiome have presented this research as radical and offering

significant yet little-explored potential for the better understanding of one's body and 'what it means to be human', nineteenth-century physicians and patients were both aware of the 'complex interactions between their guts and emotions' through theories of the nerves and psychology.[635]

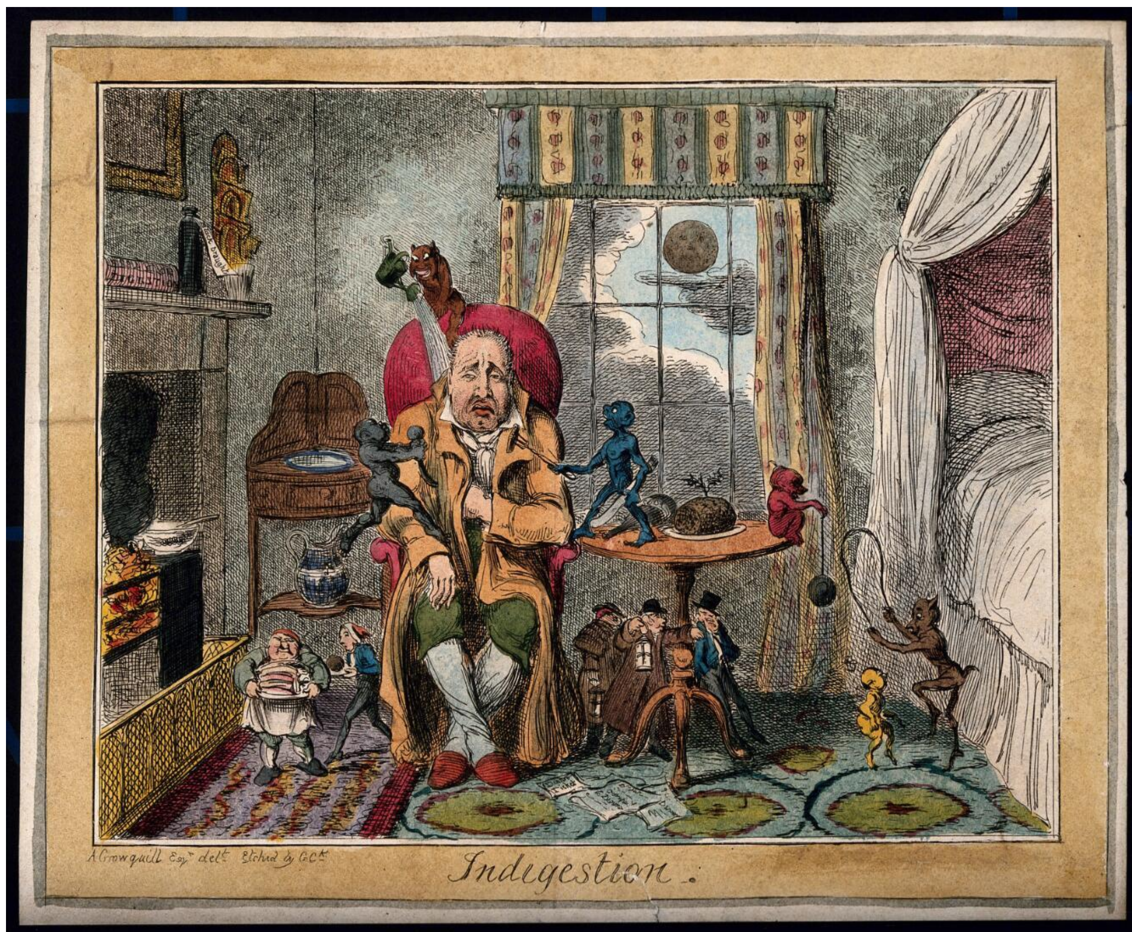

Figure 16: G. Cruikshank after A. Crowquill, A man suffering from indigestion; suggested by little characters and demons tormenting him, 1835, coloured etching.

The viscera and digestion appeared to be a focal point for the imagination and the body in pain. In such portrayals as Cruikshank's 1835 illustration (Figure 16),[636] indigestion

[635] Ian Miller, "The Gut-Brain Axis: Historical Reflections," *Microbial Ecology in Health and Disease* 29, no. 2 (2018): 1542921–1542921.

[636] G. Cruikshank after A. Crowquill, A man suffering from indigestion; suggested by little characters and demons tormenting him, 1835, coloured etching, image courtesy of Wellcome Library.

was visualised as torments by demons and miniature figures external to the self. Whilst the man seems to clutch at his heart, unlike a companion illustration for the headache, the torturing characters wielded a range of weapons and wandered across the room as well as the body. This image is notably comparable to the narratives of delusions and hallucinations, in which serpents appeared in stomachs, Napoleon marched in a patient's insides, and tiny ladies dressed in lavender and pink escaped from a patient's mouth and ran down her leg. Such visualisations speak to the intangibility and fascination of such experiences of pain and discomfort, which had the potential to both splinter the self and challenge its very basis.

Digestion is both rooted in a region of the body and escapes these bounds. Whilst we imagine and think of digestion as principally concentrated in the abdomen, it begins at the mouth and extends through the body, by way of the stomach and intestinal tract, finishing at and through the anus. This journey itself involves countless transformations. On a basic level, a substance enters the body as food, changes in texture and is masticated to move through the body, broken down by the acids of the stomach, transformed into energy for use, and exiting the body as excrement. Throughout this process, our bodies are both implicated in and changed by these movements and conversions. Our limbs and hands convey food to our mouths, our mouths and jaws chew, and our guts contract. Issues with the viscera or stomach, and the organs or process of digestion, occur, however, within the body and are generally invisible to the eye. We are governed in this realm principally by feeling; a visceral awareness of what 'normal' sensation (or indeed its absence) is and means for our selves and bodies. This has even manifested in metaphorical expressions in the English language, such as 'gut feeling', which speak to the belief that the visceral operates below reason and conscious thought.

So integral a part of human life and our bodies, ingestion, digestion and excretion are often deemed indelicate or baser functions; either irrelevant to cognisant and interpersonal exchange or too uncomfortable to discuss and bring into particular contexts. In this way, they speak to an implicit hierarchy of the body which similarly emphasises the distance senses of vision and hearing over touch. These distance senses appear to offer a means of *knowing* about the Other without compromising or exposing ourselves in the process. Touch and feeling, however, are messier phenomena, which also provide information about ourselves. One cannot touch without also being touched. However, as the rest of this thesis explores, this distinction is far from true (seeing, for instance, frequently involves being seen, and the voice is a phenomenologically intricate concept and experience). Touch and feeling are forms of carnal knowledge about the world.[637] As such, they also provide a foundational basis for our engagement with this world across all sensory modalities, or, how we make sense of what we perceive in it.

The visceral space will therefore be explored here to conceptualise and understand how ideas about feeling and subjective experience or perception were mapped onto the material body. Stoddart's framework for understanding the function and psychology of hallucination and delusion grew from his particular consideration of the epigastric region. Published five years prior to his 1904 article, he also wrote on 'anaesthesia in the insane', in which he first introduced the centrality of this area of the body and the complexities of its appearance (or disappearance) in the narratives of the asylum. In this paper, he drew attention

[637] Kevin Paterson and Bill Hughes, "Disability Studies and Phenomenology: The Carnal Politics of Everyday Life," *Disability & Society* 14, no. 5 (1999): 597–610; Vivian Sobchack, *Carnal Thoughts: Embodiment and Moving Image Culture* (Berkeley: University of California Press, 2004).

to the work of neurologist Dr Hughlings Jackson, to contend that it was the 'parts most represented in sensation in the physical basis of mind… which are frequently most anaesthetic' in cases of insanity.[638] As the 'last sensory areas to be completely evolved', with their sensation 'the least organised and most unstable', Stoddart identified the backs of the fingers, forearms, hands and legs as generally the most affected by anaesthesia.[639] Conversely, 'the parts which are most rarely involved in this form of anaesthesia are just those parts which are apt to dominate consciousness in mental disturbances in general.'[640]

Stoddart discussed the dominance, in both medical and subjective frameworks or explanations for experience, of the visceral interior of the body. He remarked,

> 'how frequently do we meet with cases of insanity in which the patient refers all his trouble to his abdomen! His bowels are blocked up and the abdomen is distended with food; he has a snake in his abdomen, or a voice talks to him from there, which he refers variously to his own conscience or to some animal or spirit there. Again, when we receive some dreadful news we have an indescribable sensation in the abdomen. The very names "hypochondriasis" and "melancholia" recognise this symptom. In common parlance, a man *vents his spleen* against another, and sympathises with him *from the bottom of his heart.*'[641]

Such passages draw attention to the multiple meanings, stories, and languages which mapped onto the body. The visceral space here was an unseen and liminal, yet life-sustaining and

[638] William H B Stoddart, "Anæsthesia in the Insane," *JMS* 45, no. 191 (1899): 711.

[639] Ibid.

[640] Stoddart, "Anæsthesia in the Insane," 711.

[641] Ibid.

culturally prescient, region. This is the starting point for the remainder of this section. Why do doctors and patients talk so much about their guts?

Appearing and disappearing

One crucial binary frame which reoccurs in discussions of insane embodied experience is that between these appearance and disappearance, or presence and absence. The importance and relevance of such loss of sensation or sense of anesthesia and numbness was discussed by Stoddart in his later explanatory framework. His 1904 article was underpinned by the contention that there was little psychological difference between the processes of hallucination, illusion, and ideation, but rather that the differences were to be sought amongst their physical bases. Most obviously, that in perception and illusion, there 'is a stimulus to the peripheral end-organ' (as the retina in vision), whereas in ideation and hallucination there was no such stimulus.[642] Instead, 'the stimulus reaches it by way of other association-fibres'.[643] As such, hallucination was more common and likely in the absence of sensation. A deaf man is more likely to be aurally hallucinated, for instance.[644] 'Hallucination, then, depends upon two factors, diminution of sensation and disturbance of association.'[645] Something is more likely to be present or appear, if something else (in this case sensory and exteroceptive information) is absent. Doctors believed delusional and hallucinated patients were frequently unhealthily or pathologically preoccupied or obsessed with their bodies,

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[642] Stoddart, "The Psychology of Hallucination," 640.

[643] Ibid.

[644] This is observable in Julia R's case of Chapter 2.

[645] Stoddart, "The Psychology of Hallucination," 641.

sensations, and the interpretation of these. This led to the appearance of ‘hideous and grotesque hypochondriacal delusion’.[646]

Stoddart was therefore fascinated by areas of sensitivity and insensitivity in the insane body and how this connected to delusions and hallucinations in that region or indeed elsewhere. He presented that

> ‘consciousness is entirely derived from sensation, for in the absence of sensation consciousness does not exist. When, therefore, any part of the body becomes anaesthetic, consciousness is dependent on the sensitive remainder.’[647]

Understanding the process of hallucination and delusion therefore involved mapping the body. Stoddart contended that ‘anaesthesia peculiar to the insane, has… a characteristic distribution’ which might be ‘obtained by mapping out on patients the areas insensitive to a pin-prick.’[648] Whilst he believed ‘insensibility to touch invariably accompanies insensibility to pain’, he stated the difficulty, in severe cases of mental disease, of securing ‘active attention’ and the fact that ‘many patients are unable to give verbal information about their sensations, in which case information must be obtained by noting the patient’s gesture: tactile stimuli does not provoke gesture.’[649]

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[646] Series 3, Lecture 19, 3 May 1907, ACC/2017/2, CN/3/18, CNL, RCPI.

[647] Stoddart, “The Psychology of Hallucination,” 647.

[648] Ibid., 642.

[649] This concept of gesture is explored further in the chapter on Movement; Ibid., 642–43.

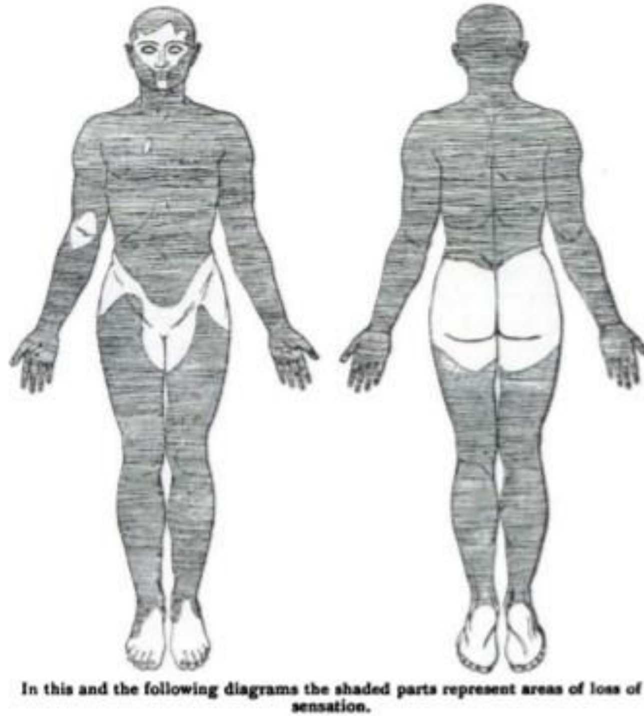

Figure 17: Diagram showing areas of anaesthesia, 1904, illustration accompanying Stoddart, "Psychology of Hallucination".

The illustrations accompanying the article matched cases of hallucination and delusion (although no specifics of these features of the cases were discussed) with areas of loss of sensation on the body. Figure 17 is an illustration of a case from Prestwich; a fifty-year-old woman who had been suffering with melancholia for five months.[650] Stoddart explained, she 'came to me one morning, saying, "Doctor, something has gone very wrong with me in the night." She complained of a sinking sensation in the lower part of the abdomen, and I found that she had the anaesthesia figured in the diagram.'[651] The physician used these cases as illustrative of the centrality of the abdomen and epigastric region in narratives of hallucination and diseased ideation or perception. Insensitivity in other parts of patients' bodies, meant 'the abdomen and neighbouring parts thus [demanded] a relatively

[650] Diagram showing areas of anaesthesia, 1904, illustration accompanying Ibid., 643.

[651] Ibid.

large amount of the patient's attention and thus become the seat of abnormal sensations. They "have greatness thrust upon them."'[652] Just as delusional belief could be rooted in, and an interpretation of, the failure of the body to operate or *feel* as it once used to or ought, so too could it spring from the relative perception of sensation in the body, or the appearance of certain processes, regions of the body, or feelings which had previously been absent.

How do these processes; their disruptions and transformations, surface in narratives of the asylum? How did people explain and find a language for what was happening to their bodies? The invisibility of this bodily interior apparently made it particularly vulnerable and liable to delusive interpretation. Norman interviewed one patient to ask,

> 'What has happened? Who has been interfering with you?
>
> *It must have been in the middle of the night someone interfered with my bowels.*
>
> How do they do it? …
>
> I laughed at the remark she made which I don't think you heard. She said her bowels were regularly 'cartered', a phrase I have never heard before, but I think it must be from the pills of that name. I questioned her before she went away in order that we might have satisfaction: in order that we might have a definite delusion.'[653]

[652] Ibid., 647.

[653] Series 2, Lecture 3, 6 March 1906, ACC/2017/2, CN/2/3, CNL, RCPI.

This patient's description of interference rather than explicitly a language of pain, particularly situated it within Norman's delusional frame. Rather than a description of a sensation, this was an interpretive move. Whilst she remains unclear what or who was behind this interference, she does invent a language to identify and describe the feeling. The physician's supposition that his patient was drawing on a cultural reference to inform her language of sensation is of particular interest. Carter's Little Liver Pills were widely and internationally advertised (as in Figure 18) as ingestible medication to treat headaches, biliousness, a torpid liver, constipation, and indigestion. In essence, they promised 'perfect health.'[654] Through the digestion, one might achieve a 'keen eye, clean tongue and clear complexion'. It is faintly ironic that here the term 'cartered' implied the opposite; an interference and discomfort (or perhaps sense of pain) in this woman's insides.

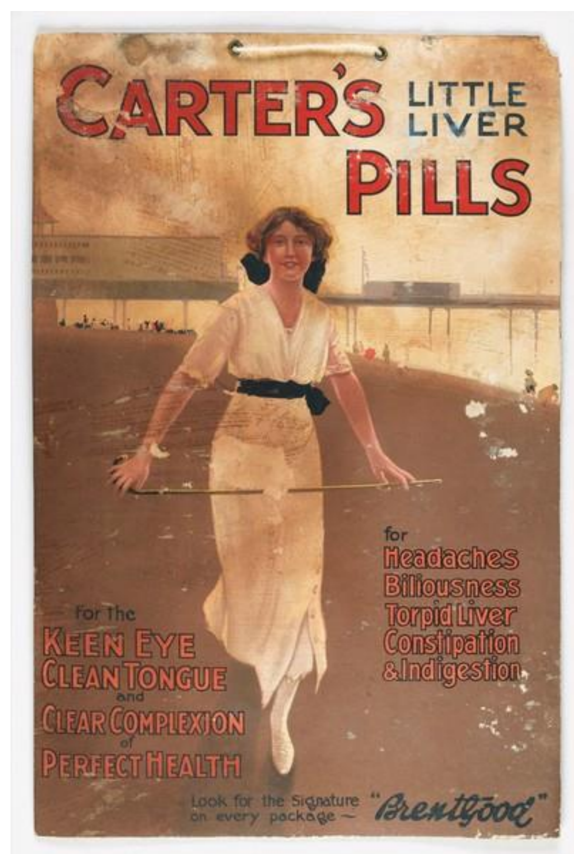

Figure 18: Advert for Carter's Little Liver Pills, est. between 1910 and 1919.

Letitia's descriptions of her torments were more specific than this sense of 'interference'. Norman asked her, 'what about this sensation you feel as if your bowels were being twisted about?'[655] She confirmed for his students that 'they put a force in as if they were working up and down.' When questioned further regarding the significance of these

[654] Advert for Carter's Little Liver Pills, est. between 1910 and 1919, image courtesy of WL.

[655] Series 1, Lecture 14, 4 April 1905, ACC/2017/2, CN/1/14, CNL, RCPI; Series 2, Lecture 7, 19 March 1906, ACC/2017/2, CN/2/7, CNL, RCPI.

sensations: 'who were these people, and why should they be doing that to you more than to me or anyone else?'[656] She explained that,

> 'I think it is all the machinery. I hear there were three or four people connected with it. They were ignorant and could not use it properly… I am under this mesmeric influence, and under electrical influence.'[657]

She believed that her persecutors influenced her body and made her feel such things 'for medical purposes. It seems as if it was a medical instrument.'[658] As explored in narratives of abuse, many patients associated the appearance and intrusive nature of these experiences and sensations with external agency and often their confinement in medical care. Given *before* they had felt nothing, the presence *now* of sensation in their abdomen must be explained in the context of their situation or delusion.

It was equally possible that patients might appeal to doctors for help in understanding or treating their bodies, offering their self-assessment to asylum staff as evidence. One patient documented his experiences meticulously. In one of his lectures, Norman 'produces a bundle of communications apparently sent to him by the patient, each of which describes different phases of his troubles.'[659] Like Letitia, this patient's delusions and hallucinations expanded across his whole body and a huge range of the sensory sub-divisions. Such detailed and comprehensive description and documentation supplemented the physician's own material and allowed Norman to work systematically through the body and senses. Some sensations

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[656] Series 1, Lecture 14, 4 April 1905, ACC/2017/2, CN/1/14, CNL, RCPI.

[657] Ibid.

[658] Ibid.

[659] Series 1, Lecture 18, 14 April 1905, ACC/2017/2, CN/1/18, CNL, RCPI.

and perceptions were drawn out as of more interest than others, reflecting both its centrality to the patients' own emphasis and the clinical relevance or importance. When discussing the descriptions of the patient's abdomen, Norman told his auditors that,

> 'I think there are sensations of the peristaltic action of the intestines which are usually below the level of consciousness, but which in disease arise above the level of consciousness. It is difficult otherwise to explain. He has often complained to me of sensations of rumbling and movements inside. In him the sensation is usually connected with the lower bowel, and he has a sensation of painful twisting.'[660]

In this patient's case, Norman was keen to emphasise the function of sensation and the interest of the case in how sensory sub-divisions might be obtained from his narrative, as he contended that 'disease dissects functions often more carefully than our physiology can'.[661]

Drew Leder's text, *The Absent Body* offers a particularly helpful theoretical frame for these experiences of painful disruption and appearance. He argues that whilst we exist in a constant state of transformation, this is not necessarily consciously felt and experienced in our immediate and daily engagement with and in the world. One's body and its form and structure offer a certain stability which recedes into the background of this being-in-the-world. Leder termed this a 'primary absence', or 'self-effacement that first allows the body to open out onto a world.'[662] We trust that our heart will beat, our lungs will draw in air, our kidneys will filter our blood, and our stomach will break down our food. In fact, our ability to be in the world relies on these functions and feelings not being present in conscious thought.

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[660] Ibid.

[661] Series 1, Lecture 14, 4 April 1905, ACC/2017/2, CN/1/14, CNL, RCPI.

[662] Leder, *The Absent Body*, 90.

In what Leder terms as ‘dys-appearance’, whilst the body is reflexively directed away from attention and observation, it can appear urgently in consciousness in particular moments or situations. These are generally of radical disruption or transformation, such as an amputated limb, heart attack, pregnancy, or food poisoning. Leder explains, that ‘this presence is not a simple positivity. It is born from the reversal, from the absence/of an absence’.[663] Something which used to support and structure our existence without our conscious attention or volition, now presents a problem or represents a transformation or disjuncture.

Philospher Vivian Sobchak engages with this theory of dys-appearance when examining her own experience of a ‘phantom limb’ following her right leg’s amputation. Her article offers a rich theoretical contemplation of embodied subjectivity through this phenomenon or concept, tethering it to the ways in which it is experienced by a lived body (her own) in order to rescue it from abstraction. The ways in which this is reflexively approached and written warrants extensive inclusion here as it breaks down the ways in which one might approach or think about the body in these moments of both material disappearance and phenomenological dys-appearance. She writes that,

> ‘I began to focus, with as much phenomenological specificity as possible, on my transparently ‘absent’ (rather than ‘dys-appeared’) right leg – that is, on its general transparency and lack of self-presence in contrast to my left leg. Indeed, I had to explicitly force myself to sense my right leg even as I could clearly see its objective location and shape. (And, here, I would ask you, the reader, to consider how you feel the presence and absence of your own leg and how precisely – or not – it registers as a solid ‘thing’ with objective boundaries.) As it happens, I have never had knee or ankle

[663] Ibid., 90–91.

problems and so realized, as I bent these joints, that I hardly experienced their movement as a particularized physical sensation at all; rather, such action was accomplished and marked by a general sense of corporeal realignment.'[664]

What makes an amputated limb (or absence of one in terms of the material body) less 'real' than the present and remaining leg? Sobchak's self-reflection contends that the *absent* leg was rather phenomenologically experienced as more *present* than the other. She could feel it, experienced as a ''something' here – 'the 'something' sort of like my leg, but not exactly coincident with my memory of its subjective weight and length.'[665] It was "here' somewhere in the vicinity my leg had previously occupied, but not exactly coincident with what had been its objective form and boundaries.'[666] What supports the binary distinction between 'real' and 'imaginary'? Especially when we are speaking of pain and the interior of the body, these experiences are subjectively sealed. They can be figured in language, imagined, interpreted, translated, and shared, but delusions are not the only embodied experiences which occupy a liminal space between the mind and body, real and imaginary, there and not-there of sensation.

In such philosophical work on pain and embodied disruption and transformation, the *I* of the researcher intrudes more regularly and forcefully into the academic field of view. This is likely because of its particularly and perhaps peculiarly isolating experience, or the limitations of subjectivity. Following this example, I must admit my own entanglement with these ideas and questions; what I brought to the subject and material and had to find ways to

[664] Vivian Sobchack, "Living a 'Phantom Limb': On the Phenomenology of Bodily Integrity," *Body & Society* 16, no. 3 (2010): 58–59.

[665] Ibid., 57.

[666] Ibid.

both acknowledge and bracket.[667] I wrote much of this thesis in pain. A medically evasive, chronic, ever-changing abdominal pain, which has shaped, over time, my relationship with myself, my body, and with this work. This has unavoidably and implicitly impacted how I have read, understood, and written the experiences of the bodies I found in the nineteenth-century asylum. It expanded and informed my vocabulary for the pain I experienced and opened me to the creative and metaphorical languages or structures others used. It also connected me, in some intangible and largely ungraspable way, to those I encountered in this space. As I read about people describing their pain and how they asked for help or resisted doctor's attempts to conceptualise and explain it in ways they did not identify with, my own body also felt more urgent and insistent. My interactions with doctors and how I felt being poked, prodded, and questioned, at times began to experientially blur with those I was reading and thinking about in my work. I told others and thought to myself repeatedly that my body let me down, felt alien to me, and somehow Other. Patients' own narratives of the sensations, percepts, and experiences they situated both physically and conceptually, both in some way outside of themselves and within, took on new light. They were both recognisable to me and entirely unique.

The not-knowing of what I experienced meant this ever-changing pain intruded into my consciousness, emotions, and life with force. In being unable to grasp, conceptualise and 'put it in a box', particularly a medically-defined and obviously treatable one, it wore down my resilience. In particular, the failure of my doctors to provide this explanation changed the nature of the pain. More than this, the sense that my experience of the pain was invalid or somehow either fabricated or exaggerated because it was both seated in my abdomen and

[667] See also Millard, "Using Personal Experience in the Academic Medical Humanities".

related in some way to both menstruation and digestion, unable to be 'found' in any physical, chemical, or imaging test, meant a wavering of my sense of self, reality, and the stability of structures which supported this existence. Whilst a doctor never explicitly asked me, I asked myself repeatedly, 'am I making it up? What does that say about me?' All this left me with the questions with which I wrote this chapter. Why does abdominal pain seem so threatening to our sense of self? Why does the feeling of *something there* or dys-appearance in this region attract so many metaphors and shifting adjectives? Why is it so liable to interpretation, translation, and social and cultural mutability by physicians as well as the sufferer themselves?

Eating

> 'In February of this year he complained of a pain in his stomach. He accounted for it by saying that his wife, - he is not married, by the way, - was in his inside, and she was hungry and looking for food, and that it caused him pain.'[668]

If the stomach is the self, how can the extraordinary bodies of hallucination and delusion in asylum archives be thought about as narratives of self and feeling? How are we to understand what it is like to have a woman living in your stomach and causing you pain; at once part of the self and alien to it? How does this challenge our embedded conceptions of the human? Annemarie Mol, in her work on *Eating in Theory,* draws attention to persistent hierarchies and a stratified understanding of 'the human', which continues to shape many of the theoretical terms, frames, and concepts used in academia. She identifies that 'thinking and talking are elevated above eating and nurturing', but asks, 'what if, I wonder, we were to

[668] Series 2, Lecture 22, 7 May 1906, ACC/2017/2, CN/2/21, CNL, RCPI.

interfere with that hierarchy? What if we were to take bodily sustenance to be something worthy, something that does not just serve practical purposes, but has theoretical salience as well?'[669]

Through exploring situations of eating and the 'lower' or basic labour and functions of the body, Mol reimagines *being* 'as a transformative engagement of semipermeable bodies with a topologically intricate world.'[670] Through ingestion, digestion, and excretion, our bodies come into contact with themselves, others, and this world. These are complex ways of knowing, doing, and relating, which involve and implicate our cerebral selves, but also our corporeal being. As a process, digestion therefore constitutes an important foundation for this self-in-the-world as a conceptually and materially bounded entity. This is also, however, why it both attracts metaphors and languages for delusion and unsettling of being or knowing, and why such languages, beliefs or sensations are particularly intrusive and loaded with meaning for the sufferer. The patient's wife was 'hungry and looking for food'. If she was fed, would this satiate the patient, or his stomach wife?

For medicine, the digestive process could be considered both curative and causative or indicative. In the general population, medications such as Carter's Little Liver Pills abounded which claimed to treat a variety of regions of the body, imbalances or pains through the digestion and stomach. As scholars such as Ian Miller and an edited volume by Manon Mathias and Alison Moore have explored, nineteenth and early-twentieth century consumers were well aware of the connections between the 'nerves' or nervous disorder and

[669] Mol, *Eating in Theory*, 2021, 1.

[670] Ibid., 30.

the stomach or indigestion.[671] Within the asylum, poor digestion and nutrition might be seen as key markers of certain disorders or states. Conditions such as ‘circular insanity’, whereby patients alternated between a state of mania and that of melancholia or stupor, involved a transitionary or liminal state in which the digestion was considered a crucial indicator and process. Citing Marcé, from *Traitédes Maladies Mentales,* Tuke’s *Dictionary* claimed that ‘gastric symptoms, as bad digestion or diarrhœa, sometimes signalise the transition from one period into another’.[672] Reviewed by A.W. Wilcox in *JMS,* an American journal article on the ‘clinical investigations of the digestion in the insane’ discussed the application of experimental methods to ‘the work of the digestive glands in the insane’.[673] The authors and reviewer especially drew out the finding that ‘hyperacidity is the rule in melancholia’ and was associated with ‘increased peptic power and rapid evacuation’.[674] Monitoring the digestion, and how what was ingested was changed by its journey through the body, could tell an interested party a great deal about the patient and their condition.

Particularly emphasised was the regularity with which ‘various forms of gastro-intestinal disease’ went ‘overlooked’ in asylums despite their regular occurrence in cases. The authors contended that this was largely ‘because complaints of and delusions concerning the digestive tract are so common in these patients.’[675] To avoid this risk, and in many ways

[671] Miller, “The Gut-Brain Axis: Historical Reflections”; Manon Mathias and Alison Moore, *Gut Feeling and Digestive Health in Nineteenth-Century Literature, History and Culture*, Palgrave Studies in Literature, Science, and Medicine (Cham, Switzerland, 2018).

[672] Ant. Ritti, “Circular Insanity,” in *A Dictionary of Psychological Medicine: Giving the Definition, Etymology and Synonyms of the Terms Used in Medical Psychology, with the Symptoms, Treatment and Pathology of Insanity and the Law of Lunacy in Great Britain and Ireland*, ed. Daniel Hack Tuke (London: Churchill, 1892), 224.

[673] A. W. Wilcox, “Clinical Investigations of the Digestion in the Insane,” *JMS* 52, no. 219 (1906): 796–796.

[674] Ibid.

[675] Ibid.

bypass the need for close attention to the patients' claims about their body, whether coloured by delusion or not, both authors and reviewer urged

> 'the absolute necessity for systematic routine examination of all the secretions and functions of the body, including that which is often a very difficult task, the examination of the stomach contents. As the signs of disease in the insane are almost wholly objective, it is therefore even more essential than in normal mental states that every modern method of value should be exhausted in order to arrive at a complete diagnosis of the case.'[676]

In order to understand the mind, one had to go through the bowel and stomach. Although in many ways disappeared and inaccessible within the body and viscera, digestion did surface or appear at the material limits of the body, in excrement and as changes in weight, skin, hair, or nails.

Nutrition was a vital component of clinical practice. Norman commented on a patient whose scalp was dry and whose hair was 'growing thin',[677] explaining that although they appeared at the surface of the body, these were common and useful markers in cases of mental disturbance. Norman commented that,

> 'The skin in a great many cases tends to be dry and rough. Her hair tends towards a particular wiry roughness. Sometimes the skin of the face gets a peculiar tough leathery look. The skin perhaps gets dry and scaly, and the general nutritional changes

[676] Ibid.

[677] Series 2, Lecture 3, 6 March 1906, ACC/2017/2, CN/2/3, CNL, RCPI.

> that take place all over the body show themselves in other organs besides the brain.'[678]

Eating and digesting transform the body from the inside out. Such ostensibly superficial and irrelevant physical symptoms were extensively discussed within medical circles, but could be ridiculed outside of them. How could thinning hair possibly relate to an individual's mental state, or scalp dryness to delusion? Norman told his students an anecdote to warn them that,

> 'some years ago an unfortunate member of our profession mentioned this as an indication that the patient was insane. Of course, he had many others. Well, the judge proceeded to make one of these elephantine jokes which coming from the Bench causes an enraptured court ripples of laughter, that a man's mental capacity should be judged by the dryness of his hair.'[679]

Such accounts speak to this perceived hierarchy of the body in medical, social, and cultural discourse. The ways in which the emerging profession of psychology drew lines of causality between mental disorder and its manifestation on and through the body left it susceptible to criticism. Mental scientists were in many ways similarly vulnerable to the stigma surrounding insanity and a move to organic understanding and theories on the cerebral aetiology of mental disease was an effort to move away from tenuous evidential proofs largely reliant on observation and the patient as unreliable narrator of their own bodies.

Whilst they could be prompted by the mental or cerebral changes themselves, such bodily transformations were also caused by patients' refusal of food. This was frequently the

[678] Ibid.

[679] Ibid.

result of delusions and hallucinations that their food to be poisoned, because they experienced pain and discomfort, or felt that someone lived inside them. Mary H. told asylum staff that she was 'poisoned at night by mercury & morphia which in her opinion are the same things, which causes [sic] her to have a feeling of being mangled.'[680] Whilst it is unclear from the Heath Asylum's case notes if the belief that she was being poisoned was based on a sensory impression, whether hallucinatory or illusive, for her, the delusion did manifest in a physically rooted sensation.

These processes and their effective functioning would, in turn, support the healthy action of the mind or reduce the diseased and delusive associations of patients. If dyspepsia could be read as damnation, the best course of action would seem to be to prevent or cure dyspepsia, thereby removing the delusive conviction's foundation and seat in the body. One of the most common treatments recorded in such cases was the administration of 'beef tea', which 'contains the extractive and stimulant elements rather than the nutritive constituents of the meat'.[681] This was particularly so in cases where patients refused to take food by themselves. An 1895 article on 'the forcible feeding of insane patients' advised on the appropriate foods to maintain a patient's diet and nutrition. Its author, A. Turnbull, recommended that

> 'when the feeding is occasional, or required only for a limited time, milk, custard, or beef-tea is generally used. If it needs to be kept up for a long period, the diet should be varied from time to time, and for this purpose eggs, pounded meat (chicken, beef,

[680] CB 3 Female, 1899-1912, H65/B/10/028, BH, LMA, 68.

[681] Adam R Turnbull, "Some Remarks on the Forcible Feeding of Insane Patients," *JMS* 41, no. 175 (1895): 651.

or mutton), pounded biscuit, gruel, sugar, vegetables, etc., may be used in various combinations, with wine or other stimulants.'[682]

Whilst uninspiring, this diet is a cornerstone of the daily life of the asylum and could have significant effects on how the body was experienced or felt. In particular, he warned that when alternating between one meal of beef-tea and the rest of milk or custard, 'the fatty constituents should not be removed from the beef-tea by skimming, as they help to counteract the constipating effect of the milk diet.'[683] Given that patients claimed with frequency that their bowels were 'stopped', or, like Patrick M. in Norman's lecture, 'my bowels have not acted since I came here',[684] it can be difficult untangling sensation from delusion. It is often blurred in such accounts what could be traced to the physical environment or actions of the asylum itself and what was the product of the patients' subjective world.

Paying attention to patients' own explanations for their bodies and actions is rather particularly revealing of the ways in which they structured and understood themselves, what was happening to them, and their environment. They also expose, in turn, how these encountered and came up against medical frameworks to either manage or conceptualise bodies. Norman asked his patient Sam,

'Why don't you take your food?

I couldn't take it.

Because what?

[682] Ibid.

[683] Ibid.

[684] Series 3, Lecture 18, 30 April 1907, ACC/2017/2, CN/3/17, CNL, RCPI.

It would not pass through me.'

This 'idea that his bowels would not act' was described by Norman as both a 'perversion of instinct' and a 'hypochondriacal order of ideas', although it was left ambiguous whether it was explicitly framed as delusive. The root of this belief appeared to shift and 'at one time the reason given was that his bowels would not act, at another it was poison.'[685] For this patient, the interior of the body was a mysterious or liminal space in which something external to the self might enter, but not re-emerge. The body was not working as it ought and the patient therefore felt unable to eat, if he could not excrete and expel this food from the self. Eating could therefore threaten a patient's sense of bodily integrity and boundedness. What is inside me, is *me;* what is outside, is *other.*

The notes of Mary H. documented an incident in December of 1906 which, as well as her description of poisoning, offered a further explanation as to why she refused to take food. The note-taker detailed that she

> 'declares she was given human flesh to eat for lunch today, as she was eating she felt something run down her leg on to her food, she looked & saw a little lady about a foot long dressed in lavender & pink running away down the room, this indicated to her that she was eating human flesh.'[686]

The notes subsequently recorded that 'she has been suffering from semi-starvation for over a year, the food she eats is taken from between her shoulders.'[687] B.C., whose case was discussed earlier, similarly explained that 'when she eats, her food goes up her back. People

[685] Series 1, Lecture 4, 10 March 1905, ACC/2017/2, CN/1/4, CNL, RCPI.

[686] CB 3 Female, 1899-1912, H65/B/10/028, BH, LMA, 68.

[687] Ibid.

draw it up out of her stomach. There is a "split in her head."'[688] Turnbull's article referenced a man who, when 'questioned about the reason of his conduct… asserts that he is God and needs nothing to support him, or, patting his mouth with his hand and making the movement of swallowing, says that he has already got the food he wants in his own special way.'[689] Food could both be drawn from and enter the body or digestion in extraordinary ways which challenged a medical model of objective and material corporeal coherence or the self as a bounded physical entity tied to consciousness.

Bodies contained within asylum archives mutate, shape-shift and transform in function, feeling, form, and meaning. Delusional narratives frequently expose particular fault lines between the human and non-human. This was not only manifest in medical or social discourses which aligned the insane body with the animal kingdom in its embodied otherness and poor or degenerate cerebral and physical organization, explored in this section and the prior one on movement and expression. Patients too discussed their bodies as inhabiting a liminal and often uncomfortable space between animal, human, and machine. Such stories could range from relatively minor disruptions and alterations to experience or corporeal form, to the 'remarkable', or 'grotesque'. These accounts were often explicitly compared and situated on a spectrum, prompting evaluative statements from doctors such as, 'no one can say that it is a delusion that runs on all-fours with the fantastic delusions that many patients have.'[690] This language exposes a revealing animalistic quality. Doctors were particularly drawn to exceptional and curious cases in which the structures of human experience were somehow disintegrated or challenged; the apparent laws which governed and harmonized

[688] Norman, "Notes on Hallucinations. II," 278.

[689] Turnbull, "Some Remarks on the Forcible Feeding of Insane Patients," 652.

[690] Series 1, Lecture 5, 13 March 1905, ACC/2017/2, CN/1/5, CNL, RCPI.

body and mind, self and other, human and non-human, were temporarily suspended or altered.

Recent scholarship, largely inspired by Donna Haraway's work on the cyborg, has explored the idea of lived experience as informed by human interactions with the non-human world, whether plant, animal, or machine.[691] Drew Leder has considered 'diverse performances' across different times and cultures, in which 'the human body incorporates elements of the natural world… through imitation, implication, and imagination'.[692] In this way, he posits shape-shifting as a carnal gesture and transformation as 'the human body longs to open beyond itself—to explore, play with, learn from, and internalize the myriad non-human bodies it encounters.'[693] Discourses, not least those of western biomedicine and psychology, conceptually and materially separate what makes a human, *human,* from the non-human Other. However, delusional narratives suggest an exploration, and often disintegration, of these boundaries, evidencing Leder's argument that 'our human body, lived fully, is ever protean, open to inspiration from the more-than-human world.'[694]

This restructuring of the body and its anatomy, form, or function could have a direct impact on how patients experienced space, both within and outside of their material bodies. Norman recalled a patient who 'got an attack of dysentery and suffered a good deal of

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[691] Donna Haraway, *Simians, Cyborgs, and Women: The Reinvention of Nature* (New York: Routledge, 1991); Donna Haraway and Cary Wolfe, *Manifestly Haraway*, Posthumanities (Minneapolis: University of Minnesota Press, 2016); Glen A. Mazis, *Humans, Animals, Machines : Blurring Boundaries* (Albany: SUNY Press, 2008); Helen Wadham, "Relations of Power and Nonhuman Agency: Critical Theory, Clever Hans, and Other Stories of Horses and Humans," *Sociological Perspectives* 64, no. 1 (July 14, 2020): 109–26.

[692] Drew Leder, "Embodying Otherness," *Environmental Philosophy* 9, no. 2 (2012): 123.

[693] Ibid.

[694] Ibid., 124.

abdominal pain.'[695] Norman drew a line of causality to her delusions, connecting the stomach with a diseased process of reasoning. He stated that 'she accounted for it by saying that Napoleon and all his marshals were in her inside and this produced the pain. One has known several patients who complained that their insides were full of serpents.'[696] Patients reached for meaning to root, conceptualise, and explain their sensation. In such accounts, it was doctor, not patient, who drew a line and made a distinction between reality and imagination or a material and experiential body. For patients, these were entwined together and could become indistinguishable. They either contained or *were* machine or animal. Another patient told his physician that 'his heart was working like a clock, and his other viscera were only a machine. The real man was dead by mortal sin.'[697] Whilst Norman drew from this an example of 'the melancholic idea interwoven with what looked like hypochondriacal notions', the patient is convinced in the complete transformation of parts of his body and the ways in which he now operated. Both metaphor and similie are devices which reveal the ways in which people structured, lived, and linguistically expressed their worlds. Whilst metaphor speaks to a transformation and disruption of an individual's self-conception or structures of being, using the distancing strategy of '*like'* instead suggests a subtle differentiation between self and the animal, machine, or person in the comparison. Such linguistic reworkings and nuances reveal how patients experienced and saw themselves and their bodies in a complex material and discursive world.

What one consumed could transform one's being, whether through nutrition, the mechanics of digestion, or more fundamentally in the interpretation of delusion. When and

[695] Series 2, Lecture 22, 7 May 1906, ACC/2017/2, CN/2/21, CNL, RCPI.

[696] Ibid.

[697] Series 1, Lecture 10, 27 March 1905, ACC/2017/2, CN/1/10, CNL, RCPI.

what patients ate could also transform the way in which they were regarded by clinicians. Psychological consultant to the Crichton Institution and former Medical Commissioner in Lunacy for Scotland, W.A.F. Browne, published a lengthy meditation on the 'morbid appetites of the insane' in 1875. He drew particular attention to one patient who 'assumed the quadrupedal position which might have betrayed to certain theorists a relic of his origin from animals of a lower grade.'[698] However, it was not just the patient's stance which tied him to the 'lower' animals. Browne explained that

> 'his lips were repeatedly noticed to be green and particles of grass suggested the suspicion that he chewed and perhaps swallowed the herbage in the airing ground. He was watched and detected in devouring considerable quantities of the grass and in making what might have served as a meal for one of the herbivora.'[699]

Browne commented on the regularity with which the physician encountered such 'morbid appetites' in patients under there care and that 'in many classes of the insane the eating garbage, excrement, even grass, is a symptom both of general debasement and of a perverted craving for unsuitable and innutritious diet.'[700]

Browne situated this patient's case in the context of 'the earliest and most celebrated illustration of morbid vegetable-eating', from the Book of Daniel. He discussed the case of Nebuchadenezzar's seven-year madness (illustrated in Figure 19)[701] in which, as a punishment, he 'was driven from men, and did eat grass as oxen, and his body was wet with

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698 William A F Browne, "Morbid Appetites of the Insane," *Journal of Psychological Medicine and Mental Pathology* 1, no. 2 (1875): 236.

699 Ibid.

700 Ibid., 238.

701 J. Casanovas, "The Madness of Nebuchadnezzar", 1881, drawing, from *La Civilizacion*, Volume I.

the dew of heaven, till his hairs were grown like eagles' feathers and his nails like birds' claws.'[702] The retelling and recasting of spiritual and religious stories such as this in light of emerging materialist psychological, neurological, or biological discourses and theories was central as strategies in professionalizing these disciplines. Digestion and the act of eating emerges through such stories as part of the 'mythology of madness' which accompanied the birth of western medicalized psychiatric approaches. They were also, however, open processes, subject and vulnerable to multiple meanings.

Figure 19: J. Casanovas, "The Madness of Nebuchadnezzar", 1881, chromolithograph, from La Civilizacion, Volume I.

Rhodri Hayward has also drawn attention to the movement of ideas which continued to occur across and between the supernatural and materialist realms. He argues that,

> 'scientific models did not simply drive out religious beliefs; rather, a much more textured process took place in which spiritual practitioners actively incorporated

[702] Book of Daniel quoted in Browne, "Morbid Appetites of the Insane," 237.

> contemporary psychiatric, neurological, and epidemiologic knowledge as part of a general attempt to make sense of their supernatural experiences.'[703]

Hayward contends that 'scientific innovation… was an open-ended process.'[704] An increasingly formalised medical model for particular behaviours, perceptions, and experiences, did not necessarily mean that other explanations were rendered irrelevant and unimportant. Instead, multiple meanings, languages, and beliefs coalesced around particular experiences of the mind/body in the world. How did particular physiological and psychological experiences provide a foundation for what it meant to be human and how might their disruption, transformation, and alteration illuminate the fault lines in this knowledge about the self and Other?

Swallowing

In a similar sense to the distinction made between humour and laughter, here one is offered between eating and swallowing. Whilst both are involved in the process of digestion and the means by which the external world, or food, enters the body, they have different implications. Eating implies the satisfaction of the impulse for food. Generally (but not exclusively), eating is prompted by the sensation of hunger and need to fuel the body. Eating is a life-sustaining action involving a combination of bodily movements. It is also usually a choice; the force-feeding practices discussed earlier could hardly be termed 'eating', as Ian Miller has explored in his work on hunger strikes.[705] Swallowing, however, is a basic

[703] Rhodri Hayward, "Demonology, Neurology, and Medicine in Edwardian Britain," *Bulletin of the History of Medicine* 78, no. 1 (2004): 39.

[704] Ibid.

[705] Ian Miller, *A History of Force Feeding: Hunger Strikes, Prisons and Medical Ethics, 1909-1974* (Basingstoke: Palgrave Macmillan, 2016).

physiological process; a bodily means of conveying something foreign to the body to the interior of the body and the internal organs of digestion. Crucially, however, the term 'swallowing' does not necessarily imply agency. Rather, swallowing is a reflex action. One might stroke an animal's throat to prompt them to swallow medication. Whilst the distinction appears slight, it is significant when discussing cases in which, as considered in the previous section on movement, insanity might disrupt patients' volitional connection to their bodies. Whether or not patients had control over their actions, and what meaning was intended and made from these acts, extended also to the process of consuming and digesting.

Whilst occurrences of such 'perverted' ingestion were discussed as bizarre and remarkable, rendering the patient the dehumanised and often ridiculed object of medical curiosity, other instances of patients swallowing non-digestible objects during their time in the asylum could present a more immediate and troubling danger. Browne recalled 'a lady, whose gown was secured at the back by small padlocks', who 'succeeded in tearing off one of these and passing it down her throat.'[706] In this case, the physician remarked with seeming amazement what whilst it was unclear 'in what manner these objects entered the stomach' and that 'what became of them was never ascertained', it was 'certain… that no injury or disturbance followed their entrance into the system.'[707] In this case, the measures and restraint of the asylum, used to stop such self-injurious behaviour, were ineffective. Those of the body, however, appear to have prevented the act from causing actual harm. Browne marvelled, that

[706] Browne, "Morbid Appetites of the Insane," 639.

[707] Ibid., 239.

> 'the tolerance of the organs of digestion has been demonstrated in various other ways and in a more striking manner. The handles of spoons have been cut out from the walls of the abdomen, which had been furtively thrust down the oesophagus by lunatics, and cases have occurred here, after death, spoons, knives, buckles, buttons, coins, and a miscellaneous collection of small articles have been disclosed by dissection.'[708]

Such ingestions were difficult to explain and characterize. In the absence of suicidal ideation, the rash impulse of 'maniacal paroxysms', or delusions 'of invulnerability or mortality' were often used as causal explanations.

The stakes in such cases were high. Patients' 'morbid appetites' could have major consequences which were not always thwarted and forestalled by the defences of their material bodies.[709] Norman discussed the case of a male patient confined under his care at Richmond, who

> 'announced on one occasion that there were diamonds in his inside. That statement did not receive the attention that it should have. It turned out to be a very important statement. It was noticed some weeks afterwards he experienced a difficulty in swallowing his dinner, and he resisted in an energetic manner any attempt to examine his throat. From the signs and the rise of his temperature one would have imagined

[708] Ibid.

[709] Sarah Chaney, "Curious Appetites: Surgery and the Foreign Body," *The Lancet* 380, no. 9847 (2012): 1050–51.

> that he had an attack of quinsy. After this had been going on for some days he coughed up a piece of glass, and said that was one of the diamonds.'[710]

Incidents such as this highlighted the immense importance of physical examination, supervision and observation in the asylum space as a means of establishing truth from fiction; sensation from perception or the delusive imaginary. As in cases of abuse, if delusions often gave fantastic shape to the interior of the body, it was framed as the role of the asylum and medicine to disentangle the real from unreal, or what actually happened, where possible. Reading the patient's body and interpreting their metaphors and stories as signifying systems formed a constellation of truth-seeking and demystifying practices. In life, rather than at autopsy, the interior body and viscera were discussed as a mystifying space, but one which obeyed systematic laws and rules. As the previous chapter demonstrated, the machinations of mind and metaphysics of self or the consciousness entangled with this material body were harder to grasp. If medicine could not definitively establish motive, it could access the process and chemistry of an embodied phenomenon like digestion which was implicated in the act.

Ingestion and digestion were intimately connected to the self. The act of swallowing involved taking something inside the body. In instances in which the motivation and intention of nutrition and nourishment were removed, doctors were often unclear whether such acts should be read as intending harm and attempts to destroy the self. What prompted a patient to apparently turn on their own body? Why would someone willingly inflict pain on themselves? Was it pain at all? In many ways similar to the physical evidence in William S.' case, in which it was deemed possible for a 'lunatic' to continue cheerfully with life-ending

[710] Series 1, Lecture 8, 21 March 1905, ACC/2017/2, CN/1/8, CNL, RCPI.

internal injuries, instances of self-mutilation (or its visible bodily consequences) could suggest an absence or perversion of sensation. Some patients continued apparently as normal after having gravely harmed themselves, apparently expressing no pain through which asylum authorities might have been alerted to the situation. Norman referenced a patient who decided to 'amputate both her nipples, which was not discovered until attention was drawn by the smell.'[711] The body offered clues and assisted the physician which the patient apparently did not.

Particularly baffling were cases in which patients professed to having inflicted harm on themselves, but none was found. A case cited by medical superintendent James Adam, in his entry on self-mutilation in Tuke's 1892 *Dictionary*, drew attention to the 'circumstantial statements' made by patients, especially when of the 'more educated classes', which describe 'supposed injuries said to be self-inflicted, of which there is no evidence.'[712] He described 'an eminent scientific man', 'educated as a surgeon', who 'laboured under occasional maniacal attacks, alternating with extreme depression.'[713] This man claimed that 'in the course of the preceding night, he had dislocated his ankle- and hip-joint on one side, and broken both bones of the leg of the other', also mentioning a 'wound in the temporal artery.'[714] Whilst the man 'gave evidence of his own firm belief in the existence of those injuries by having bandaged all the parts named for them respectively' and 'resisted, with evident anxiety, the removal of those bandages', the doctor could find 'not the smallest sign

[711] Series 2, Lecture 32, 29 May 1906, ACC/2017/2, CN/2/31, CNL, RCPI.

[712] James Adam, "'Self-Mutilation,'" in *A Dictionary of Psychological Medicine: Giving the Definition, Etymology and Synonyms of the Terms Used in Medical Psychology, with the Symptoms, Treatment and Pathology of Insanity and the Law of Lunacy in Great Britain and Ireland*, ed. Daniel Hack Tuke (London: Churchill, 1892), 1149.

[713] Ibid.

[714] Ibid.

of injury' on his body.[715] Such accounts had obvious medico-legal consequences in the asylum environment. If patients were adamant of the reality of their sensations and convictions, which appeared to be phantasmic, was the physician purely reliant on this unreliable testimony to determine not only what was happening with or in the patient's body, but what was happening to it?

Establishing motive helped to understand how and why this relationship between self and body was apparently disrupted; to position the behaviour in the borderland between sanity and insanity. Adam stated that, consequently, 'an investigation into the various causes leading to the act is attended with so much the greater interest on that account.'[716] Physicians were both obliged and encouraged to converse with their patients where possible to establish why the mind and will might turn on the body in this way. In cases described as melancholic, the body and its condition were discussed extensively in part because of an apparent inability to communicate with the patient themselves. Adam claimed that by the time the patient came to the attention of an asylum or newspaper, their 'condition of mind' meant that the physician would experience

> 'difficulty of obtaining reliable evidence as to the mental condition of the patient before, at the time of, and immediately subsequent to the infliction; and we are often baffled by obstinate and persistent taciturnity or by stupor, the associate of the melancholic condition.'[717]

[715] Ibid.

[716] Ibid., 1148.

[717] Ibid., 1149.

Such cases associated with melancholia were generally (but not universally) believed to indicate suicidality; in a condition of mental pain which manifested on or through the body. Patients experiencing hallucinations and delusions, however, were described by Adam as 'sometimes talkative and communicative', and would therefore

> 'readily admit that the act had been committed owing to hearing a voice from heaven commanding them to do it, or by terror at seeing a vision, and in the frenzy produced thereby, being impelled to self-mutilation or injury. The act may be induced by a fear of loathsome disease, produced by a perverted sense of smell, or of poison by diseased sense of taste.'[718]

In such circumstances, physicians recognised self-mutilation as a direct consequence of their lived experience with direct physical or sensational elements rather than purely affective.

A number of excellent studies on nineteenth-century self-mutilation have been produced in recent years, particularly by historians of medicine and emotion Chris Millard and Sarah Chaney. Millard's work emphasises the inextricability of 'self-harm', as both, category and behaviour, from the social and political context it is situated in.[719] He explores the ways in which it was defined, explained, and interpreted, particularly around the introduction of the welfare state. In Millard's text he particularly centres the changing practices, concepts, and ideas of psychiatry, politics and medicine, rather than the patient experience. However, this approach illuminates 'new connections' between these systems and self-harm, drawing attention to assumptions and values which underpin the former.[720]

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[718] Ibid.

[719] Chris Millard, *A History of Self-Harm in Britain: A Genealogy of Cutting and Overdosing* (Basingstoke: Palgrave Macmillan, 2015).

[720] Ibid., 199.

Beginning earlier, Chaney's monograph on the subject, *Psyche on the Skin*, emphasises the multiplicity and complexity of meanings which surround the concept and experience of self-mutilation or self-injury. She traces the history of such behaviour beyond what historians have identified as the nineteenth-century pathologising project, to discuss the historical and cultural specificity of harming one's own body. Despite this long and varied history, the assumption largely prevails that 'self-mutilation can be thought of as a constant, universal human behaviour with a particular set of meanings.'[721] Of these, the medical meaning is just one of many; Chaney foregrounds the ways in which 'medical definitions have often been assumed to be neutral and objective in a way that personal experience is not'.[722] Her consideration of a wide variety of sources and contexts, ranging across literature, religion, and politics, as well as medicine re-centres the personal and subjective meaning-making which occurs on and with the body, in conversation with broader cultures (whether medical or otherwise) but is not indelibly shaped or determined by them.

She particularly identifies the nineteenth century as the period in which the understanding of self-mutilation being under the remit of medical expertise ostensibly began, but emphasises the space that emerged for this multiplicity of meanings even within the profession itself. Authors 'used the behaviour as justification for a psychological rather than a biologically determined model of mental illness, and even an argument for the value of diversity in evolution'.[723] Self-mutilative behaviours were positioned at both ends of a spectrum; was this behaviour a demonstration of the savagery and lack of civilisation of the insane, or indeed the degeneration of body and mind which was the apparently inevitable

[721] Sarah Chaney, *Psyche on the Skin: A History of Self-Harm* (London: Reaktion Books, 2017), 12.

[722] Ibid., 10.

[723] Ibid., 11.

outcome of society's rapid progress in the modern world? Crucially, these cases once more highlight the importance of insanity's 'borderlands' to alienists.

Self-mutilation was not treated unproblematically within the remit of mental science. The particularly mysterious nature of cases led many physicians and authors to take a more historical view; integrating modern medical belief with the mystery of a more embodied and impulsive, less refined or controlled past. Adam's *Dictionary* entry began by highlighting the obscurity, mystery, and strangeness of the cases themselves as well as the fascination which surrounds them the professional and public forums alike. He mused that,

> 'The interest which naturally attaches to those strangely mysterious cases of self-mutilation, self-torture, and self-dismemberment of various parts of the body which are sometimes met with in medical practice, and not unfrequently by the alienist physician, both within and without asylums, will probably be intensified, and possibly some additional light may be thrown upon the obscurity which surrounds the whole subject, by an endeavour to trace some of the motives which have prompted to the commission of the acts at various periods of history and under religious conditions.'[724]

Adam wondered at the extremity and violence of these acts against one's own body as well as the seeming similarity of these cases in a civilised society and mind to the apparently archaic and superstitious behaviours of the past and cultural Other.

[724] Adam, "'Self-Mutilation,'" 1147.

The insane body and its behaviours were not just situated in comparison to the sane. Adam contended that to understand the apparently mysterious in modern medicine, one must explore the wider context of 'unduly exaggerated religious fervour, enthusiasm, or fanaticism' which he believed characterised much of the history of 'self-inflicted tortures'.[725] This history spanned across multiple cultures 'from the earliest ages', but Adam credits the 'birth' of the 'custom' to 'the peculiar religious beliefs of Orientals in the remoter East.'[726] He was careful to establish that 'all the states of mind leading to self-mutilation, self-torture &c.' discussed in this frame were 'compatible with reputed sanity, although they are to insanity near akin, and generally indicate more or less mental derangement.'[727] The physician self-consciously connected self-mutilative behaviour to superstition and the darkness of past ages or alien cultures whose societies were supposedly more corporeal than cerebral. Such discourse did not explicitly render the self-mutilating body incomprehensible or entirely othered, but instead established it as unfamiliar or displaced; parallel to the past, superstition, the 'oriental', or religious fanatic. As such, self-mutilation was not entirely medicalised, but situated on a spectrum of behaviour. In a modern world, however, harming oneself ran against the established current of belief, behaviour, or norm, and was therefore insane rather than uncivilised. It represented a *disrupted* relationship with the body of the self.

Published in 1886, *JMS* made a remarkable and deeply telling connection between a case which occurred in an Australian asylum involving a 'native of Ireland', and the seemingly inexplicable behaviour of a lioness in a Dublin Zoo.[728] Initially admitted suffering

[725] Ibid.

[726] Ibid.

[727] Ibid., 1148.

[728] Eric Sinclair, "Case of Persistent Self-Mutilation," *JMS* 32, no. 137 (1886): 44–50.

from mania supposedly caused by intemperance, P.McT. had oscillating 'attacks of acute insanity, with intervals of comparative quiet' but remained consistently delusional for the first year of confinement. These delusions were said to have had a direct effect on his behaviour and he, 'in acting on their promptings was an aggressive and dangerous patient, who required much watching.'[729] However, it was not until his seeming decline into dementia that he 'developed a tendency to mutilate himself in various ways.'[730] P. McT. first dissected out his left testicle with a sharpened fragment of a wire nail. Five months later, he 'removed the remaining testicle, this time using the tongue of a trouser-buckle.'[731] On this second occasion the article detailed that he 'said he had swallowed the testicle to prevent any one else getting it', confirming that 'this was probably true, as there was no blood about his mouth, and the organ could nowhere be found.'[732]

The author of this exposition situated this act somewhat uneasily. Whilst describing P. McT. as 'demented', he also described in some precise medical detail the 'injury' the patient had inflicted on himself and the rationale with which such an act was conducted. In the first excision, P.McT 'cut through the scrotum, and dissected out the testicle, partly cutting and partly tearing through the spermatic cord and vessels as high as the external abdominal ring.'[733] When questioned, he gave the 'explanation', that 'the testicle did not belong to him, but to another patient, a black man, in the same ward.'[734] He was also evidently asked

[729] Ibid., 44.

[730] Ibid., 45.

[731] Ibid.

[732] Ibid.

[733] Ibid.

[734] Ibid.

whether the operation had caused him pain, but he replied, 'No, but it did the other b—r."[735] The decision was made to remove the patient to a different asylum as 'the black man seemed obnoxious to P. McT'.[736] Rather than a senseless and inconceivable act of self-mutilation, asylum staff monitored both the patient's reasoning for the act and took steps to subvert its continuation. The apparent absence of pain in such a violent act was also evidently of interest. The patient did not believe his body to be entirely his own; this manifested not only in physical acts against it, but in its lived reality as a feeling and responsive being. It is also of note that he removed the testicle from his own body, as he contended that it did not belong to him, yet then swallowed it. Whilst this act reintroduced the offending organ into his body, it speaks to the liminality with which the patient viewed this interior space. Passing through the digestion, the testicle both was and was not part of the self.

In the second instance, 'the operation was much better performed; a clean incision two inches long leading into the tunica vaginalis, which remained to line the cavity, the cord being separated close to the testicle.'[737] The language of a medical procedure and, especially on this second occasion, considered removal of the offending body part, came from both physician and patient. The tone of the article is one of incredulity at the means and motive by which it was effected, as well as the act itself. P.McT. follows the second removal by refusing to provide an explanation, but 'expressed the opinion that there was now no reason for his detention in the Hospital.'[738] Just as any other surgical operation, this recourse was taken by the patient seemingly in order to right a wrong or anomaly in his own body.

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[735] Ibid.

[736] Ibid.

[737] Ibid.

[738] Ibid.

Curiously, this too was a possibility considered by the doctor, who appears to have left a possibility for the operation to offer a corrective to some imbalance in the patient's body. Immediately following this explanation, Sinclair stated that 'no mental improvement followed the castration, and indeed no great change could be detected in the mental symptoms, though care was taken to watch for this.'[739] Whilst it was not necessarily anticipated or expected that P. Mc.T's auto-castration would alleviate his symptoms or make him more manageable, it was thought to be a possibility and he was carefully monitored following the event. His mental state (particularly the violence of his behaviour) was implicitly linked to his sexual organs.[740] Such cases were apparently delicate interplays between medical assessment; working with the physical body and what was known or could be seen, and the apparent incomprehensibility of the behaviour and motive, as well as the patient's failure to communicate to aid comprehension.

Following the description of P. McT.'s case, Sinclair's article was accompanied by details of the 'self-mutilation in a lioness', originally presented to the Pathological Section of the Irish Academy of Medicine by P.S. Graham. Explicit parallels were drawn between the two, with the explanation that 'in connection with the foregoing case it may be of interest to add the following example among the lower animals.'[741] This article reported that the 'fine lioness… was discovered to have devoured, during the night, some six inches of her tail – the hair, skin, bones, and everything.'[742] Like P. McT., this behaviour was repeated some time

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[739] Ibid.

[740] See also Chaney's discussion of the case of Isaac Brooks in Sarah Chaney, "Self-Control, Selfishness and Mutilation: How 'Medical' Is Self-Injury Anyway?," *Medical History* 55, no. 3 (2011): 375–82.

[741] Sinclair, "J. Ment. Sci," 46–50.

[742] Ibid., 46.

later and 'on the 27th of the month she recommenced her extraordinary conduct, and demolished, during the night, a great part of the remainder of the organ.'[743] This self-mutilation was repeated at intervals until 'at the end of a month there was nothing left of her caudal appendage but the "butt,"'[744] which was brought along and exhibited to the Academy. When the stump became impossible to reach, the hope was that 'she would resume her usual tastes and be satisfied with the flesh of other animals'.[745] Instead, she began to 'lick and gnaw off the skin' of her paw.[746] Unlike the previous case, however, the author remarks that

> 'it was quite certain that while all this was going on the animal suffered extreme pain; the stump of her tail was seen to be in a constant state of quiver, and when a part of the foot was gone, the leg was drawn up, and the creature limped about the cage on the other three legs.'[747]

Given that, unlike P.McT., the animal was unable to verbally communicate the felt sensation (or absence thereof) that accompanied the physical act, the body was used as an indicator; providing its own language and signs which might be read or interpreted. The body of the animal appeared to demonstrate the presence of pain. It was entirely ambiguous whether this was also the case with P. McT.

Both patient and animal seem to have been working against their own interests or 'natural' instincts. However, this is where a language of impulse becomes important. Whilst generally seen as interchangeable, impulse and instinct as terms reflect a nuanced difference.

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[743] Ibid., 47.

[744] Ibid.

[745] Ibid.

[746] Ibid.

[747] Ibid.

An article of 1866 described insanity as involving 'morbid impulses and perverted instincts.'[748] The occurrence of both, according to the author McIntosh, was 'found to be regulated by the degree of civilisation, mode of life - whether in town or country - and the prevailing tendencies of the age, which indelibly stamps them with its characteristic features.'[749] Awareness was central to the distinction between these ideas. Instinct was described as 'the blind impulse of nature';[750] as a product of the evolution of man, reducing the individual to their animal needs. It was the duty of civilised man to resist his baser impulses, whereas to ignore or be disconnected from one's instincts (such as hunger and thirst) could have grave consequences for basic life-sustaining functions.

[748] William C McIntosh, "On Some of the Varieties of Morbid Impulse and Perverted Instinct," *JMS* 11, no. 56 (1866): 512–33.

[749] Ibid., 512.

[750] Ibid.

Conclusion

> 'You are getting better. So, cheer up. I hope I haven't teased you talking to you.
>
> *You have.*
>
> I am sorry.
>
> *I forgive you.*'[751]

Once we have entered someone's world, how do we leave again? How ought we to reflect upon the way in which we have done this work or what impact it has had, or might have? I came to this research with a host of questions as well as assumptions about what I might see and how I might go about finding it. I had a set of broad parameters for what I meant when I spoke of 'lived experience' in the asylum. However, such interactions confused and muddied these ideas. This excerpt is just one instance of many in which Norman and his patients truly astonished me. The interactions I found between doctor and patient in these transcribed lectures were mercurial. They were at once funny, bizarre, surprising, unsettling, distressing, and uncomfortable. They therefore urged me to reflect on the assumptions, 'rules' or conventions, and boundaries both implicit and explicit in encounters with those living with 'insanity'.

Each section and chapter of this thesis has therefore sought to trace and pull at this surprise and ambiguity encountered on reading Norman's lectures and the stories of hallucination, delusion, and the body. It has sought to settle around moments of tension, cleavages of meaning, and fragments of experience. The first section considered how

[751] Series 1, Lecture 9, 24 March 1905, ACC/2017/2, CN/1/9, CNL, RCPI.

experience was recorded, preserved, ordered and accessed; framing Norman's lectures in the context of the sources for experience we are used to encountering and using in clinical archives. 'The case' as a container and frame for experience was explored in the second chapter of this section, considered the ways in which Julia R.'s body and experience were interpreted and translated into clinically readable forms and structures. The second section considered how the moving and expressing body was relevant to both clinical practice and patient experience in ways largely unfamiliar to current diagnostic and cultural frameworks for mental health disorder. Again, it wove through cases which involved hallucination and delusion to unpick these questions. This section also centred largely on the novel ways of seeing offered by Norman's lectures and the intimacy and discomfort these can prompt. It looked at how Norman staged bodies, whilst also acknowledging that this happened outside of these particular sources and across the asylum in a range of ways. This section was framed by the recognition that when we refer to patient experience, we must pay attention to what was 'left out' of clinical cases or verbally unarticulated; the laughter, grunts, silences, and twitches of the asylum which I found in Norman's lectures. The final section was the most explicitly centred on hallucination and delusion, considering the ways in which sensation was established and mapped onto the body. This looked at contestations of meaning around pain and harm in the first chapter, moving to the ambiguities and (dis)appearance of the visceral interior in the second. The ways in which hallucination and delusion are discussed and thought about frequently grow from half-submerged concepts of the imaginary, evidence and truth in which the body is implicated and processes and practices through which it is made and unmade.

One of the crucial questions with which I approached this research, and which I must now answer, is why does this history need to be written? Histories of psychiatry and insanity

are hardly scarce. As this thesis has explored, hundreds of perspectives on the topic exist across multiple disciplines, coalescing around different institutions, diagnoses, people, or political perspectives. Excellent studies have been written on gender, class, 'the patient', and other categories of identity and experience. This thesis has particularly looked, however, at exploring tensions, assumptions, boundaries, binaries, and conventions as they appear in the archives of asylums and the work produced about and with them, including around these categories. The manner in which I have approached and constructed this work therefore leaves it in many ways with more questions than answers. In this thesis, I have argued for a *dis*orientation and *un*settling of categories and binaries, particularly the real and imaginary, scientific knowledge and lived experience, body and mind, and self and Other. This thesis has advocated for a dynamic approach to the clinical encounter and the space of the asylum. Rather than restricting the view or position to top-down or bottom-up approaches, research should rather consider exchange, negotiation, bargaining, accommodation, and resistance as multi-dimensional concepts and practices.

Conceptually and theoretically, this has meant exploring what a queered approach might mean in a context not explicitly tied to gender and sexuality. This would, however, be a fruitful route for further analysis, particularly considering sexual hallucinations and delusions featuring gender, which appear with regularity in both Norman's notes and casebooks. Here, queering has been used as a tool to think about the body and identity; tracing and exploring its possibilities, transformations, and lived realities in new ways which also draw from disability theory and phenomenological philosophy. Theory has been used in this work as a flexible and illuminating tool with which to view and consider experience without imposing my own rigid boundaries or interpretations onto those of the past. Phenomenological theory in particular has been little explored in a historical context, not

least because we cannot interview past actors. However, a phenomenologically-engaged approach as used here can illuminate the ways patients occupied space (in their bodies and as beings in-the-world) and made their own meanings within, around, and separate from clinical, institutional, and broader social frames.

This thesis has further argued that part of doing this unsettling work is shifting focus away from existing models for writing histories of psychiatry, particularly studies built on the systematic analysis of carefully selected asylum case-studies with their reams of case notes. This does not mean wholly abandoning such material or this approach. Asylum records are rich sources and establishing patterns and trends is important, revealing work. However, my research contends that it is vital to see these as part of a process rather than an end-product. Case-notes, which have dominated much of the historiography on insanity (this itself has become broadly interchangeable with the history of the asylum in this period), are two-dimensional representations of a three- or four-dimensional process and encounters. A more dynamic approach, moving in and out of asylum walls, and incorporating the textual, visual, material, and conceptual, as I have done here, allows us to reanimate and reinvigorate the way we think and write about 'insanity'.

One of the key contributions to the field made by this research is therefore its consideration of Conolly Norman's lecture notes. Although they were discovered in 2017, this is the first study using and discussing them. As this thesis has explored, these transcribed notes are remarkable and invaluable sources for the history of insanity, psychiatry, and patient experience in this period. I have included a tiny fraction of the material uncovered in this box and the potential for future research is enormous. Every time I returned to these

notes, I found a new fragment of a conversation, moment, or exchange. These lectures highlight the moments of clinical practice which were generally unseen and less formalised than the symptom-experience that was preserved in casebooks as clinically relevant. As such, they represent a significant, resource for the experiences of insanity as well as for professional practice and medical pedagogy. I intend to explore these notes more fully in future postdoctoral research.

It is, of course, evident that there is a firm basis in much of the conception of asylum medicine as exploitative, hierarchical, and deeply uncomfortable for a twenty-first-century reader. There were certainly exchanges, such as that opening this conclusion, in which Norman sympathised with a patient or showed a deep and considered concern. However, equally in evidence are conversations such as that in a lecture just three days later, in which the physician mocked a patient who was instead begging him for forgiveness. The record of this lecture shows that

> ‘The patient suddenly gets down on his knees:-
>
> *Dr Norman, I ask your pardon I am very sorry for having offended you the last time I was here in company with you. I ask your pardon humbly.*
>
> I don’t remember you having offended me last time, but I do remember you were making use of silly gestures, and you are doing so still. I wish you to look straight like any other Christian, and not like a sick duck.
>
> (The patient here begins to cry).

> There is absolutely nothing to cry about. Can't you stand up straight and hold your head straight.'[752]

Moments such as this broadly align with the model of power and exploitation we have come to expect in the nineteenth- and early-twentieth-century asylum system; the image of coercive practice which dominates the cultural imagination. It also causes an intense feeling of discomfort. A central contention of this thesis is a reflexive one; that historical practice *should* look at these moments of discomfort and unease, both in the historical record and our own contact with it. These interactions are not simply scholarly. Just as I have sought to illuminate the clinical encounter as a multi-dimensional interaction between two people as well as a 'patient' and a 'doctor',[753] my own professional context and concepts shape my practice, but this is not the only lens I use to interpret, understand, and write about what I came across. Over the course of this study, I have explored how frequently I found myself asking remarkably similar questions to contemporary physicians, albeit in different ways. Unlike Norman, I could not speak to these people directly about what they experienced in this space. My questions could not distress or tease them, but they can still expose them and reveal moments of profound vulnerability and distress. When writing about these experiences and people, I am unable to ask if I have gone too far, or to hear from them what story they want to be told and how.

This reflexive approach, drawing both from phenomenological theory and anthropological literature, has been woven through this thesis, binding chapters together. I have sought to ask myself *how* I am approaching these experiences and bodies, as well as

[752] Series 1, Lecture 10, 27 March 1905, ACC/2017/2, CN/1/10, CNL, RCPI.

[753] I have elaborated upon and complicated this binary, drawing attention to the importance of nurses and attendants, for instance, in chapter five.

why and with what assumptions or concepts. I have sought to own my interpretive practice and make myself appear through the narrative, not because I am imposing myself on these stories, but rather because in choosing to tell them and construct this research, I am there anyway. In considering narrative and voice, I have thought about how I am 'giving voice' or prioritizing some voices over others. In the chapter on Structure, I have considered how I have organised this research and how my temporal distance might inflect or alter the material I am using to build these arguments. Time gives me an insulating barrier; some distance from the people, spaces, and emotions I am writing about. When discussing movement and expression, I have articulated how seeing and *being seen* are multi-dimensional processes. My physical separation from these events and experiences alters my relationship to them. In this section, I explored the ways in which the body is socially and spatially situated and reflected on practices of 'reading' this body, which we engage in to learn about others we encounter. Finally, in looking at how feeling was articulated and imagined, I have emphasised the ways in which we draw lines around binary concepts such as the real and the imaginary, which shape how we perceive both the body of the Other and ourselves. Throughout this work, I have therefore explored how understanding the Other is hugely dependent on one's own position, both spatially, temporally, and discursively or conceptually.

With this position and awareness in mind, the thesis has moved between different scales and across different concepts and phenomena, to emphasise multiplicity, complexity, and fragmentation. Both in structure and content, it has sought to destabilise, or draw attention to the instability of, *ways* of knowing, doing, being, and seeing. What I am looking to do is make space. Or, perhaps more realistically, to find the space that existed and think about why it is there and what it might do. The history of medicine and psychiatry, or science

and technology, are the main areas in which a conceptualisation of history as a teleological narrative endures, persists, and does *work* now. Over years, theorists and clinicians have elaborated upon, developed, and refined understandings of what 'mental illness' or 'mental health' *mean*. 'Discoveries' and 'breakthroughs' have brought us closer to the 'truth' of the *way things work*. In the realm of psychiatry, that has generally meant an increasingly extensive diagnostic framework and system for the understanding, categorisation, and treatment of disorder and, by extension, people. Diagnostic manuals, peer-review, and statistical methods would suggest that we *know better now* than we did *back then.* This may not necessarily be untrue, and it is not for me to decide. However, what this thesis seeks to do is ask questions and open avenues for inquiry which unsettle such assumptions and metrics.

By looking at a period in which doctors commented on the curiosity of the question more than they did the certainty of the answer, and when professional networks and codes of practice were not necessarily rigid or formalised, this research emphasises the spaces this could create for patients' own explanations, meaning, and languages, as well as adaptive interactions. Psychopathological categories for disorder, brain imaging, and theories of organic aetiology or brain chemistry certainly provide a wealth of information, but they implicitly situate this data on a hierarchical spectrum which devalues patients' own narratives. Shifting the scale and looking between these categories can reveal a great deal about how people construct relationships with particular experiences, themselves, and others.

Accordingly, this is not a 'neat' thesis, but that in itself is a reflection of the topic under consideration. These experiences and spaces are not simple or tidy, and this research has chosen to reflect that, rather than attempting to rigidly and precisely structure and

compartmentalise. Some shaping is, of course, necessary and inevitable, but I have sought to allow the fractures and fragmentations of this thesis to lie where I found them; let the ends fray, rather than always tying them together.

Perhaps the most effective way to explain how and why this structure was chosen is by explaining what was considered and discarded. It became very clear from the early stages of this project that the nature of the material studied resisted a conventional structure or classification. Settling on definite 'objects' of study implied precise categorisations of experience. Given the strong engagement with sensory history and experience, moving through the five senses seemed like a viable option. However, the hallucinations, delusions, and other embodied phenomena described on page after page defied such easy separation. The experiences were enmeshed and entangled. Similarly, prising apart delusion, hallucination, and illusion across all the sensory modalities proved impossible, as the boundaries between these categories of experience were hazy and porous for doctors and the public arguably just as much as they were for those describing them, as was discussed in the final section in particular. Again, the archival and conceptual research for the project would have been considerably easier had it coalesced around a specific 'diagnosis' or institution. Crucially, however, such an approach would have reflected our current preoccupation with diagnosis and labelling more than it would the nineteenth and early twentieth-century practice and world. Whilst I weave the terms and narratives of hallucination and delusion themselves through the research, even this is rejected as a rigid analytical frame or way of selecting and bringing together material. This thesis does not treat hallucinations and delusions as bounded *things*, but rather *things to think with* and places to begin asking questions.

Moving through different areas or processes of the body, in a broadly similar way to how I framed the final chapter on the visceral space, was in some ways a viable option, but I was particularly interested in a broader and less bounded exploration of the ways in which processes and practices enmeshed and entangled the body, wrapping around each other. Future research which takes such an approach would, however, offer a rich seam of analysis. Given the emphasis in this thesis on exploring boundaries and emphasising their porosity, I repeatedly found myself having to simply *stop.* Each of the chapters of this thesis could easily have become an entire doctoral project, and in future work I hope to expand upon the other processes of the body. To digestion, I would add respiration, vocalisation, and visualisation, considering the phenomenological complexities of these embodied but also cultural, social and political processes and practices.

This thesis has explored, in historical context, how publics and individuals engaged in to understanding, accessing, and defining the experience of the Other and themselves. As such, the current increase in awareness around the concept of 'mental health' must be carefully considered and its implications thought about. Whilst consciousness of the stigmatisation of diagnoses such as schizophrenia has been increasing, this climate of interest in mental health and a broader socio-cultural awareness of and language for its experience, comes with its own creeping dangers. 'Mental health' as a broad concept is gaining in social and cultural capital. However, activists and the 'mad pride' movement have urged how this is unevenly distributed and has not necessarily significantly deconstructed systems of marginalisation and discrimination people living with diagnoses such as schizophrenia are confronted with. Increased familiarity with the concepts or vocabulary of psychiatric systems

can lead to trivialisation of particular experiences. Obsessive Compulsive Disorder (OCD) has been found to be particularly liable to trivialisation, especially on social media platforms.[754] This is not to say that growing awareness is damaging, but rather that there is an increasingly timely need to think about the half-submerged and embedded concepts and languages being used to articulate and steer these debates and discussions.

Take, for instance, the idea of 'recovery'; this has endless implications and meanings, depending on the individual as well as the social, cultural, political, and economic context they live in. For some living with the present-day constellation of experiences often termed 'psychosis', recovery might mean integrating this term into their identity, living *with* voices and other apparently 'abnormal' or pathologised perceptual and sensory experiences. For others, it might have a temporal dimension; moving *beyond* or past the psychotic 'episode'. All these terms are, or can be, loaded and significant. The terms 'episode' and 'break' in the context of psychotic experiences, hallucinations, and delusions, are in broad cultural use, but rely on a particular concept of the self, time, and a host of other categories for experience. The work of mad activists and service user networks is crucial in offering personal perspectives on these questions, as well as reframing and challenging the basis for many of the debates, a number of which were set in the period this thesis has studied.

Moving forward, engaged and interdisciplinary research is required to explore the concept of lived experience. This term has attracted particular discussion in recent years, in

[754] Patrick Robinson et al., "Measuring Attitudes Towards Mental Health Using Social Media: Investigating Stigma and Trivialisation," *Social Psychiatry and Psychiatric Epidemiology* 54, no. 1 (2018): 51–58; "Why the Language We Use to Describe Mental Health Matters," accessed March 15, 2022, https://www.mentalhealth.org.uk/blog/why-language-we-use-describe-mental-health-matters.

the context of identity and voice, across both academic circles and social media platforms. Throughout this thesis, I have used this term in a variety of different ways and for a range of purposes. The twin ideas of 'disclosure' and 'experts by experience' repeatedly surface in these discussions. Whilst I have strongly advocated for reflexive practice, this is not to say that I believe it necessary for academics working in these areas to reveal their own experiences of mental health or services, but rather that a consciousness of one's own position, assumptions, and involvement in the work or topic is important and too often overlooked. Whether or not one chooses to disclose this involvement remains a personal choice, but I would encourage more work reflecting on and thinking about these ideas.

To conclude with a provocative statement from Conolly Norman to his students: 'it is a mistake to suppose that the insane are very different from the sane.'[755] According to Norman, 'we all act according to our nature and not according to the dictates of reason. Hence, when a patient assigns some delusional reason for his acts, that is his notion about it, but it is not correct.'[756] Above all, this thesis has exposed numerous boundaries which were drawn around insanity and the body; to contain it, define it, understand it, and explain it. However, this has not been done to emphasise the presence of these boundaries, but rather to draw attention to their mutable, indefinite, and often porous nature. There was no *one* way to look, feel, act, or be insane. The boundaries of belief and the limits of sanity were in many ways similarly indefinite. Instead, insanity sit somewhere at the fringes of the knowable. Insanity was part of a broader spectrum of experience, rather than always a necessarily separate and Othered identity. This is not to say that it was not marginalised and stigmatised,

[755] Series 1, Lecture 7, 20 March 1905, ACC/2017/2, CN/1/7, CNL, RCPI.

[756] Ibid.

but there was also a deep curiosity and ambivalence in the ways that the insane were spoken about, seen, and fit into discourses on feeling. One of the central arguments through this research is that bodies themselves do not have fixed boundaries. However, as with the others discussed here, the perception of this boundary is important. In approaching the bodies of the Other and the past, it is important to be aware of our own and the particular assumptions we may make based on its presence, experience, and limits.

As Chris Millard has pointed out, when using a theoretical or conceptual frame in our work, it becomes too easy to overlook that 'the concepts used by historians are as historical as the diagnoses or categories that are studied.'[757] Diagnoses, practices, beliefs, and identities overlapped; they were messy and contested and negotiated in multiple sites and contexts. There is no universality or ahistoricity to be found, and we should not be looking for it. Like broader arguments over agency, voice, power, and resistance, I argue that such debates in psychiatry and its history have narrowed our focus and shaped the material to suit our own beliefs and ends. This study is far from an intellectual history of hallucination and delusion as nosological or psychopathological categories. It is not an examination of the psychoses or 'schizophrenia' of those in the past. Instead, it sees the meaning people gave their own experiences, both alongside and in resistance to broader cultural or medical definitions, as central to an understanding of both the social and personal significance of hallucination and delusion and the body more generally. For those experiencing such 'sensory disturbances', what they experienced was acutely and intensely real. This is a history, not of a symptom, but

[757] Chris Millard, "Concepts, Diagnosis and the History of Medicine: Historicising Ian Hacking and Munchausen Syndrome," *Social History of Medicine* 30, no. 3 (2017): 1.

of, as Esquirol stated, 'pleasure and pain, love and hatred.'[758] It is also a history of electricity, mesmerism, poison, witches, kings and queens, and werewolves.

[758] Esquirol, *Mental Maladies*, 107.

Appendix 1

Ethics, anonymisation, and representation

Whilst my university or professional body may not necessarily mandate or ask for it, I maintain that the considerations and choices I have made about the ethics of how and why I write about the material contained in this thesis in the way that I have warrants fuller consideration here. It is crucial to recognise the importance of a sensitive and engaged approach to the experiences we find narrated in such asylum casebooks, especially given their frequently distressing nature. Questions of vulnerability, marginality, and anonymity have particularly reoccurred over the course of this project. In making decisions about their practice, recourse is generally made by historians either to these university guidelines or to the restrictions put in place by archives as the keepers of these sensitive materials. In the British case, medical records are restricted by a one hundred year closure period following the Public Records Act of 1958. This has left many historians of the twentieth century dealing with stringent legal requirements to anonymise material which might compromise patient identities. One of the few texts published specifically on the methodological and ethical issues inherent in confidentiality and the study of sensitive institutional case note records is *On the Case: Explorations in Social History.* Here, historians Wendy Mitchinson and Franca Iacovetta lamented the ethical quandary these restrictions leave the historian in when it comes to their duties to historical subjects. They argue that

> 'in uncovering their agency we face a paradox: our legal obligations as researchers to protect the privacy of individuals in the past can lead us to write the marginal into history by writing their names and faces out of it.'[759]

These records offer the social and cultural historian a rich seam of qualitative material with which to attempt to access patient experience, but does this come with a price for both the researcher and the patient? Unquestioningly accepting the justifications or conditions of confidentiality would be a major methodological and theoretical error. Once they are over a century old, patient materials from public institutions are therefore opened for free access. This decision is predicated on the assumption that anyone discussed will, after this time has lapsed, be deceased and their right to confidentiality thus safeguarded. This policy essentially allows the historian to sidestep some complex ethical considerations. Naming and anonymisation are far from value-free practices.

Firstly, returning to de Baet's concept of the duties of the historian to the dead, the concept of protecting posthumous reputation is a particularly complex idea in this context. By anonymising records, whose reputation we are protecting and why? Anonymisation in research is most frequently discussed in relation to criminal behaviour and shielding vulnerable people. Historians writing histories of sexual assault have discussed the importance of removing names and thus shrouding identities. This seeks to prevent victims from both having to revisit their trauma (if they are still alive) or to conceal them from public scrutiny and the risk that their entire identity and memory might be subsumed by the event. However, this is not entirely unproblematic. Rape and assault is principally an act of power

[759] Franca Iacovetta and Wendy Mitchinson, *On the Case: Explorations in Social History* (Toronto: University of Toronto Press, 1998), 6.

which removes the survivor's choice and often fragments or compromises their identity.[760] Silence in the historical record often allows such acts of violence to continue unchallenged or submerged. Recent social movements such as #MeToo have highlighted the importance of humanising survivors rather than entirely obscuring their identities. This need not mean a lack of anonymity, those long since deceased cannot give consent to such a choice, and to make it for them unilaterally risks an act of gross paternalism. However, records can be partially anonymised whilst retaining a sense of personhood, dignity, and recognition that these were not abstractions but people experiencing or committing something of profound significance to their personal histories.

To remove identities entirely also imposes and perpetuates an ultimately presentist moral judgement under the guise of standard historical practice. Anonymising is not a value-free act; it is crucial to recognise and understand why we are anonymising and make case-by-case decisions rather than generalising highly individual experiences. Especially in cases in the far past, once the parties involved are dead, removing names and identities entirely implicitly reifies the idea that past victims of assault have been through something inherently shameful, whilst simultaneously protecting the memory and reputation of the rapist. In cases of mental health, an aim to protect patients and their descendants from the stigma associated with mental health ironically risks imputing greater stigma on them. Indeed, in many cases patients were confined to asylums with the very purpose of anonymising them and removing them from the domestic environment as inconvenient, embarrassing or shameful people, rendering them secrets of the archive. In such a historical context, echoing this anonymisation in its entirety effectively renders the researcher complicit. Whilst we might aim to protect, we

[760] Feminist literature on this subject principally follows from Susan Brownmiller, *Against Our Will : Men, Women, and Rape* (London: Secker & Warburg, 1975).

simply add another layer of silence to their narrative and reinforce the idea that these experiences are extraordinary, shameful, and somehow replace personhood with patienthood or victimhood.

Whilst the historian has this duty of care to the past and ought to acknowledge the personhood of the historical subject they are seeking to listen to or find, it is also critical to acknowledge how naming is linked to identity and power as well as social codes and 'morals'. The importance of a name is clearly illustrated by Norman's discussion of a patient he presented to students in his third series of lectures. When she first entered the room, the exchange was as follows:[761]

> 'Good morning, Katherine.
>
> *Don't address me as Katherine.*
>
> Well, what will I address you as?
>
> *My married name, Mrs McGowan, - Mrs Daniel McGowan.'*[762]

On her exit, the physician explained, that

> 'when you are dealing with the insane you sometimes find them not as insane as you would wish, and they sometimes turn out to be troublesome. I didn't bring this lady before you to hear her recriminations. I treated her badly for when she came in I did not immediately greet her as one is bound to in common civility, and that want of tact was the cause of her being so exciteable. I addressed her as 'Katherine' not desiring to

[761] Punctuation and spelling in all quotations are as in the original document.

[762] Series 3, Lecture 4, 8 March 1907, ACC/2017/2, CN/3/3, CNL, RCPI.

mention her name. Usually my people prefer me to address them that way. That little attempt to recover lost ground was a failure.'[763]

The choice of naming had a direct effect in shaping the clinical encounter. The physician's public and incorrect use of a name was perceived by his patient as an insult and failure of common civility or recognition. In using her forename, the physician had assumed a familiarity and seemingly paternalistic relationship or power dynamic with his patient, which she chose to push back against. These interactions are built on levels of trust, and personal relationships as well as political or professional dynamics. This is part of the reason I have referred throughout to the 'clinical *encounter'* and particularly emphasised what Norman's lectures can reveal about how these relationships were built and operated beyond medical theory.

Whilst naming has less direct impact on my practice, the issues and implications are similar, requiring consideration and sensitivity. Removing a patient's name and replacing it with initials, or even altering it entirely by way of a pseudonym, risks forcibly depersonalising them altogether. Naming is a critical marker of identity and history, with a consequent affective history, as current discussions around the practice of 'deadnaming' as a violation of transgender rights and dignity highlights.[764] Particularly within an institutional context designed to re-inscribe the individual with the codes of broader society, names provide a touchstone to an intimate history and external world; one of family ties, cultural identity, marital status, and personal memories. Historians have been particularly interested

[763] Ibid.

[764] Jane Fae, "Changing Your Name Should Be a Joyous Moment, but for Many It's a Nightmare," *The Guardian*, May 19, 2015; Adi Robertson, "Twitter Has Banned Misgendering or 'Deadnaming' Transgender People," *The Verge*, November 27, 2018.

in considering identity within the institutional context, and yet little has been said on naming and historical practice. Especially when this institution removed the person from their familiar environment, changed their clothes, and allowed limited contact with family and friends, a name could be all a patient had left to tie them to their pre-institutional identity. Removing this when writing patient histories of these experiences seems a final act of symbolic violence.

Historians must therefore be self-consciously aware of how they engage with power and silence in the archive. It is thus not just the perpetrators of historical traumas who are left unaccountable by select anonymisation practices, but the accountability of the scholar and rigour of the research is also compromised. Isolating patients and removing their identities entirely, erasing the historian's footprint from the archive, effectively reduces them to a floating story; a representative example or historical fable mined from the archive to prove a point. This is especially true in cases where the researcher has opted to remove all identifiable markers of the patient's identity from the historical record. In seeking to protect her subjects, historians such as Jacqueline Leckie in her study of colonial asylum patients in Fiji opted to provide no specific references to the records of patients she cited.[765] This effectively erases the historian's footsteps and blocks the accepted mechanism for professional accountability.

For the purposes of this thesis, although surnames have been removed and replaced with the first letter in the interests of preserving some privacy, the use of patients' first names

[765] Jacqueline Leckie, "Unsettled Minds: Gender and Settling Madness in Fiji," in *Psychiatry and Empire*, ed. Sloan Mahone and Megan Vaughan, Cambridge Imperial and Post-Colonial Studies Series (Basingstoke: Palgrave Macmillan, 2007), 120–31.

is a deliberate choice, taken in order to highlight historical persons' identity and embed them in their own cultural and social context. Principally, it recognises and humanises them; a dignity not always afforded them in their own contemporary context. Taking my cue, however, from Mrs McGowan, where patients insist on their full names or some other form of naming practice, this is how I refer to them. Equally, a number of sources either publicise patients' full names or remove them entirely or alter them (into only initials such as B.C., for instance). In these instances, I have little to no choice but to refer to them in this way or as 'the patient.' This general method encourages an empathetic, connected, and intimate approach to the highly personal material about the lives exposed in these sources. In *History, Ethics and the Recognition of the Other,* historical philosopher Anton Froeyman engages with the thinking of Emmanuel Levinas to similarly argue for history as an ethical, emotional, and existential engagement with past 'others'.[766] In approaching historical persons, we are confronted by this 'other'. The endeavour of history ought not to be to force parallels with this other or to use them for our own purposes, but to seek to engage with them, starting from the basic recognition of them as a human being (past or present) in all their multifaceted alterity. Such a historical approach can, at times, be uncomfortable for the historian. However, the writing of history should not be an easy or protected task. The researcher is exposing other lives in all their complexity and vulnerability; perhaps something of themselves should be exposed in return. In seeking to find the 'voice' of historical actors, especially marginalised groups, are we not attempting dialogue with the past rather than aiming to speak for it?

[766] Anton Froeyman, *History, Ethics, and the Recognition of the Other: A Levinasian View on the Writing of History*, Routledge Approaches to History 17 (New York: Routledge, 2016).

As for their doctors, an extensive literature has discussed their increasing visibility and professional consolidation or accountability, but little has been written on the ways in which they disappeared from view.[767] It is worth highlighting here that it is not necessarily just the historian or archivist who chooses where and when anonymity is practiced in these case notes. Whilst asylum records are generally discussed as interviews revealing interactions and conversations between physician and patient, there are countless faceless and nameless other actors inhabiting the asylum environment. Generally, attendants and a host of medical officers remain just out of the reach of the historian, until they are accidentally captured on film as behind Elizabeth D. (Figure 1) or in an incident report when a patient's bones are broken. We also learn surprisingly little, through the case notes, about the physicians directly. Other than a hastily scrawled initial below a case-note entry, outside of the published journal article or monograph most doctors leave little of their interactions with patients which we can directly attribute to them. Ironically, despite historians' repeated insistence on writing the patient *back in* to histories of psychiatry, it is the doctor we rarely hear from directly. He frames the responses we get from the patient, but we are left ignorant of how forcibly or gently; even of the questions which were actually asked. We can only hear half of the conversation, if that. The rest is conspicuously silent. If we are listening, we therefore ought to be sure what we are listening to and not hear what we think we ought to and from whom we think is talking. The transcribed lecture notes and clinical interviews of Conolly Norman at Richmond Asylum, Dublin, represent a remarkable and rare exception to this powerful and asymmetrical archival silence.[768] Through these records, we might begin to challenge assumptions which continue to plague the historiography of the nineteenth and twentieth-

[767] Guenter Risse and John Warner, "Reconstructing Clinical Activities: Patient Records in Medical History," *Social History of Medicine* 5, no. 2 (1992): 183–205.

[768] Series 1-3, 1905-1907, ACC/2017/2, CN/3/3, CNL, RCPI.

century psychiatric encounter. The complexities of how voices were layered in the asylum and its archives are explored fully in the first chapter.

It is generally assumed that the perceived ‘victim’ of history ought to be anonymised and protected in their vulnerability. However, in this thesis naming practices have been chosen in order to make visible the structures of power as well as recognising the humanity of all actors involved. Patients are not nameless and faceless victims, but neither are doctors simply anonymous representative figures of an institutional hand of power. Both parties deserve names, if just to undermine the tendency within some strands of historiography to present the patient-doctor dyad as a simplistically confrontational or one-directional operation of power and agency; the oppressed and the oppressor. I have chosen to address doctors, where they are known, by their title and full name (or title and surname) in the first instance. In including the title of ‘Dr’ or ‘Mr’, especially when juxtaposed with the forename and initial of people like Elizabeth D, I am elucidating the structural inequality on which their interactions were predicated.

When it comes to hallucination and delusion, as the specific concern of this research, the ethical implications and obligations inherent in historical ‘story-telling’ become even muddier. In foregrounding the intricacies and complexities of human experience and emotion in psychiatric and cultural sources for hallucinations, this thesis will inevitably provoke emotional and perhaps physical reactions in the reader. Indeed, this is surely a core tenet of an empathetic approach. However, this relationship between present and past feeling is not always straightforward and this complexity is what this thesis seeks to expose. Hallucinations and delusions frequently contain images or experiences we would identify as distressing,

shocking, and painful, but they can also be bizarre, humorous, and pleasurable. This applies both to our current re-reading and re-experiencing of their descriptions, as well as what we can glean of the historical subject's described affective response. Just as assuming marginality or vulnerability is a key historical methodological trap, so is reading distress or trauma without question or further analysis.

We have come to see such accounts as so inextricable from symptom-narration and the associated pathology of deviance (especially in such an institutional context) that aligning these accounts with the mode of story-telling or positive emotion *feels* discordant. As I have mentioned, for many the asylum was a refuge or home: the patient who believed herself to be Queen Victoria, the man who proudly asserted himself asylum Superintendent, or the woman who saw and spoke to her sisters at night, 'says she has been [at Hanwell] three years and that she likes living with the "mad people" very much' all have stories just as valid a part of the historiography of experience and psychiatry as those detailing distress, fear, or coercive control.[769] We cannot assume either trauma or negative emotion in the past when reading the past; to do so would be an undue imposition based on current social and psychiatric assumptions which are increasingly coming to be challenged.

Crucially, when we (often unexpectedly) encounter humour in the archive, there is an inherent danger. Is it acceptable to laugh at these people's experiences? Does that risk reducing complex historical and personal narratives into glib anecdotes? And what does it say that we do not expect to experience complex emotions ourselves in such an archive? How

[769] Female CB 19, patients admitted Nov 1870-Apr 1871, H11/HLL/B/19/019, Hanwell Pauper Lunatic Asylum, LMA, 15.

then do we sensitively approach stories such as that of Elizabeth B., who the physicians at Holloway Sanatorium recorded as being

> 'full of delusions, that she is a steam engine her conduct partly bearing out this delusion – eg she continues to make whirring noises with her mouth when her joints, which she speaks of as "cranks", are moved – gulps down water, in large quantities, & shovels in her food which she speaks of as "stoking".'[770]

Her attribution of bodily sensation, not to her rheumatism, but to the wet 'rusting her piston & parts of the engine',[771] and attempts at 'keeping down the steam' by both piling books and papers on her head and 'working her arms round & round while making a peculiar whirring sound',[772] might understandably provoke an amused reaction in a current reader. For contemporary observers too; whether physicians, potentially other patients, family members or the wider observing public, such behaviours, beliefs, and the people experiencing them were frequently objects of humour and ridicule. This response is a central strand of the story. Extracting these responses from within the formalised framework of case-notes and psychiatric journals, and through the more sensationalist accounts and overt incredulity of newspapers is a central methodological strand. Does the nosological and diagnostic framework in which hallucination plays a key defining role in medical texts both historically and presently essentially neutralise and dehumanise this experience, rendering it comedic more than distressing, especially when decontextualised? Is the mental image conjured of Elizabeth's whirring arms and piles of books just too close to the slapstick physical comedy of the subsequent century?

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[770] CB A Females, 1885-1907, MS.8159, HS, WL, https://wellcomecollection.org/works/dh9vubaj, 68.

[771] Ibid., 63.

[772] Ibid., 65-7.

In the case of Alice M., does our perception of her experience change between when we read that she believed she had 'eaten God' and when we subsequently learn that this belief and sensation prompts her to refuse food, necessitating her force-feeding by tube three times a day, or that she also believed the food she is compelled to consume contains 'the souls & bodies of children'?[773] What makes the first claim bizarre and slightly humorous and the latter distressing and disturbing? We are subsequently told that she became so distressed that she made herself 'a ghastly sight' when she made a 'deliberate attempt to poke her eyes out with her fingers' and 'forced herself through a very small window in her attempts to escape'. This action 'tore her scalp to the length of 7 or 8 inches'; a wound she repeatedly tried to 'forcibly reopen' 'in order to destroy herself.'[774] The literal "fleshing out" of the narrative these details provide gives Alice a pained and broken body beyond an idea or belief. In this way, this thesis seeks to bring together histories of emotion with histories of the body and sensation. Hallucination and delusion narratives in these accounts are far from the ideational and interpretative moves of both contemporary and present psychiatric theorists; they are immediately lived and felt, both by those experiencing them in the nineteenth century and by those reading these accounts now.

Whilst there are no easy answers to any of the questions raised here, this thesis contends that a sensitive and reflexive methodological engagement with asylum records and an empathetic approach which foregrounds the humanity or personhood of those we study (alive or dead) is of central importance to navigating these issues. As historians, we work

[773] Ibid., 41.

[774] Ibid., 42.

with a different trace of personhood to those responsible for dissecting and anatomising the bodies of the deceased. However, whilst it is generally acknowledged that the physical remains of the dead ought to be treated with dignity and respect by the living, and a complex ethical and bureaucratic framework protects their treatment and use, the historian dealing with the textual remains of past lives has limited restriction on her practice and must ask herself if these same principles apply and how. Does the tactile act of interfering with the bodily integrity of the corpse hold any more profound a potential for violence than mining the archive for historical evidence without adequately and sensitively considering the humanity of those about whom we are writing? Perhaps the historian ought to consider their enterprise more as an exploratory post-mortem; a final service to the dead to offer an end to their story, rather than a Frankenstein-like experiment in resurrection in which we have patched together enough fragments to mimic personhood and made it walk.

Ultimately, I am inclined to agree with French phenomenological philosopher Paul Ricoeur in his evaluation that:

> 'as soon as the idea of a debt to the dead, to people of flesh and blood to whom something really happened in the past, stops giving documentary research its highest end, history loses its meaning.'[775]

We cannot lose these patients to abstraction; to the cold and distancing games which frame them not as people but as discursive constructs and endless signs. We can seek to hear their voices and write their stories, but we cannot 'rescue' them from coercion and control, or the abuses, distressing emotions of painful experiences they underwent whilst they were alive.

[775] Paul Ricoeur, *Time and Narrative*, trans. Kathleen Blamey and David Pellauer, vol. 3 (Chicago: University of Chicago Press, 1984), 118.

This would itself constitute an act of paternalistic power against which the subject has no recourse. Indeed, part of 'listening' is understanding that sometimes people do not want to be saved and for many in the asylum this is true. Simply because it suits our narrative as researchers, we have an ethical duty to uncover, to the best of our ability, what was actually felt, said and experienced, rather than listening to what we want to hear. What we can do is aim to illuminate the operations of this power and uncover these experiences, as long as we confess to our own role and position of control over the sounds and silences of the archive and the patients captured therein.

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