

Conversing with the Psychiatrist: Patient Narratives within Glasgow's Royal Asylum 1921-1929

Hazel Morrison

C. Charlotte Murray

ADMITTED: 1929

FORM: *Schizophrenia Episode*

CAUSE: *Personality unhappy domestic life*

H.P. Neg ...

General Behaviour.

This is very variable. She slept for an hour and a half following admission. When she began to act at times in a very extraordinary manner; she was noted to speak to herself a great deal. At times she got very impulsive ... When seen during the forenoon ... she lay in bed, her eyes were flashing and she immediately made strange signs. She blew from her mouth and made movements of her arms which seemed to indicate that she was pushing or brushing away the medical officer ...

Stream of Activity

On going to make the official physical examination I found her in her "high" state. She spoke in a loud declamatory voice ... got very antagonistic and said if I remained where I was she would spit on me. I sat. She spat on me, three times; and then she said something like, "Thank God, Thank God, he does not flinch" and her antagonism seemed to go away very largely; and she allowed the sister to begin to arrange her dress for the physical examination... I then proceeded with the examination; but again she showed momentary flashes of antagonism ... and proceeded to sing aloud "Danny Boy, Danny Boy ... This was while I was attempting to auscultate the thorax. Gradually this phase seemed to subside; and finally I proceeded to talk to the patient...

"Is your head clear?"

"Fairly."

Do you feel confused?

"No" (definite)

She then made reference to the coming of Heaven, said this was a preparation for Heaven, ... and then said how when she was a child she had a fancy. She looked into a looking glass and saw another room; and that she had wished to get into that other room, the other side of the glass. (She smiled and agreed when I mentioned Alice through the Looking Glass.) But she seemed to suggest that we were now "through the glass" – we were through the veil of Death into Heaven.

(*Patient Case Notes*).¹

"I was always conscious," wrote the British-American neurologist Oliver Sacks in 1990, that "there were always *two* books, potentially, demanded by every clinical experience." One which was purely nomothetic, 'medical' or 'classical' which offered an objective description of "disorders, mechanisms and syndromes" and the other which was idiographic, an "existential," "personal empathic entering into patient's experiences and worlds" (*Awakenings* xxxvi-vii). Patient case note records, recalled Sacks, which encase lay narratives of illness and experience within the linguistic devices and thought-style of clinical psychiatry, once enjoined both nomothetic and idiographic representations of the clinical encounter through "richly, beautifully [. . .] detailed, empathic descriptions" of the "total *picture* of disease" ("Narrative Medicine"). But as the rise of biomedicine came to dominate psychiatric practise in the post-1945 era, the latter half of the twentieth-century marked for many within the cognitive sciences the demise of the clinical narrative, which had hitherto enjoined a

physiological understanding of mental illness to the more humanistic impulses of psychiatric practise (Berkenkotter 3).

On closer inspection, the history of Anglo-American case notes during the nineteenth and twentieth century fluctuates between these two interpretative paradigms, as vying 'biomedical' and 'psychological' models of mental illness shaped the construction and contents of patient records and medical publications (Wallace 696; Andrews 260). Within North American psychiatry, the early twentieth-century brought about an array of medical models from which to explore the biological and psychological roots of mental illness. Case note records were shaped by a range of (often competing) medical models, the most prominent of which are encapsulated by the biological principles of Emil Kraepelin, the psychoanalytic theories of Sigmund Freud and the psychobiological teachings of Adolf Meyer. Across the Atlantic, British psychiatrists were predominantly defining lunacy in organic, neuropathological terms, which placed little value in the relation between patients' inner phenomenological worlds and the aetiology of mental disorder (Stone 251). Within Scotland, the case note records of Gartnavel Royal Asylum had, from the 1870s onwards become "impersonal, aloof from the patient" as the "highly organic interpretations of mental illness dominating late nineteenth-century alienism encouraged a propensity to ignore, or downgrade, patients' impressions and experiences" (Andrews, "Documents and Sources" 279). Yet, by the early 1920s, a unique blend of psychoanalytic and biological psychiatry was overhauling, indeed forcefully breaking decades of silence, as patient narratives began to populate the pages of Gartnavel's case note records. Such a rapid surge of interest in patient narratives was due to the appointment of Dr David Kennedy Henderson to the position of Physician Superintendent of Gartnavel in 1921. Trained under some of the most eminent psychiatrists within this period, including Thomas Clouston in Edinburgh, Adolf Meyer in the United States and Emil Kraepelin in Germany, Henderson advocated a "dynamic" approach to psychiatry which charted the interaction of "biological, social and psychological factors in the aetiology of mental illness" (Andrews and Smith 328; Tomes, "The Development of Clinical Psychology" 658). Moreover, as the dynamic approach appropriated to differing degrees the psychoanalytic methods of Freud and other European analysts (Gifford 631-633), the life history and prior experiences of the patient became a most valuable component of the medical record (Grob 540-41).

We therefore see within the case note records of Miss Charlotte Murray, a patient admitted to Gartnavel in 1929 whose narrative opens this article, that whilst the clinical encounter is recorded from the perspective of the psychiatrist, the narrative of the patient, and indeed, her non-verbal forms of communication were accorded a high degree of significance by Henderson. In accordance with the principles of Adolf Meyer, Henderson defined mental illness as the unhealthy reaction of the patient's mind to their physical and social environment (*A Text-Book of Psychiatry* i), so whilst the organic origins of disease were regarded as being of great etiological importance (as evidenced by the psychiatrist's attempt to "auscultate the thorax"), Henderson taught that it was equally as vital to let the patient tell their own story so that they were understood as a "human being" rather than a mere organic entity (*Text-Book of Psychiatry* viii). From within pivotal moments in a patient's confinement, such as the physical and mental examination, the actions, emotions and volitions of patients such as Miss Murray were therefore bound to the narrative structures and routine techniques of psychiatric case note taking. As the psychiatrist used common cultural discourses, as evidenced by the reference made to Lewis Carroll's *Through the Looking Glass* (1872), to give expression to experiences that may otherwise have proven incomprehensible or unspeakable, the illness narrative became the conduit through which Henderson and other practitioners explored how the inner workings of a patient's mind responded to exterior environmental pressures. (*Text-Book of Psychiatry* viii, 68-81). Alongside such records, patient letters, stories, artworks and

poetry were also collated within case note records, and such archival materials have preserved a fascinating resource for medical historians and literary theorists.

Nonetheless a critical appraisal of illness narratives that were co-narrated by patient and practitioner within institutional confines raises important enduring methodological questions. "A silent tug-of-war" remarks Katherine Montgomery Hunter, "over the possession of the story of illness is frequently at the heart of the tension between doctors and patients" and therefore the degree to which authorial agency is shared between patient and practitioner is a highly debatable variable (13). Letters, stories and artworks may reflect a higher degree of patients' authorial agency, but as such works became embedded within case note records their meaning is nonetheless refracted through the diagnostic lenses of clinical psychiatry (Beveridge "Life in the Asylum" 436). Illness narratives that were preserved within case note records therefore read as fractured, incomplete accounts of illness and experience. Behind the smooth ordering of patient case note records the absence of other, more unruly or seemingly unexceptional illness narratives attest to the hidden histories of asylum patients (Shapiro 70). Finally, whilst such records were formed, not only through the interpersonal relations between patient and practitioner but by wider forces of influence, we must be sure to question how the institutional, social, cultural and medical contexts in which illness narratives were first given expression, shaped their meaning.

To explore case note records, which are constructed through this complex interplay between patients and practitioners within institutional confines, therefore demands a highly interdisciplinary approach (Davis 13). The sheer depth, breadth and complexity of case note records, remarks medical historian Gayle Davis, necessitate analysis be methodologically grounded and theoretically informed not only by the natural and social sciences, but also by the humanities (30). Yet, as sociologist Andrew Scull argued in 2006, the "invasion" of the social historian upon a field of research, which was traditionally the preserve of sociologists and psychiatrists-turned-historians, historically engendered "tense, if not openly hostile" relations, which threatened such interdisciplinary collaboration (132). A "lacuna," argues Davis, has, until recently, largely separated those who explore a clinical from a social history of psychiatry (17-18), but within interdisciplinary spheres such as that of the medical humanities, a discourse form that enjoins such seemingly oppositional paradigms offers scholars a discursive space in which to explore the intersection of personal and professional illness narratives.

Tracing the historiographic foundations of the medical humanities reveals that whilst the reductive stance of biomedicine in the 1960s increasingly narrowed the practitioner's perspective to the inner world of biochemical processes and neural units (Gach 400; Kleinman 5-6), the radical historicism of Foucault, the psychoanalytic criticism of Lacan and the process of Derridean deconstruction, inspired cultural and literary studies to re-appropriate a critical hermeneutics of illness and to begin to address disease not only as a biological entity but as a discursive construct (Shuttleton 11). By the 1980s, texts such as *The Illness Narratives*, written by psychiatrist Arthur F. Kleinman, marked for many within the medical humanities a turning point for interdisciplinary collaboration that bridged the paradigmatic gap between the sciences and humanities. A generation of clinicians, disenchanted by the limitations of biomedical training, endeavoured to study illness not only as the physiological determinant of disease but to engage with illness sufferers upon an empathic, indeed a phenomenological, level (Kleinman xiv). Illness narratives, articulated by chronically ill patients, were seen to create a "symbolic network linking body, self and society," and therefore the role of the clinician, argued Kleinman, was to uncover the lost art of clinical case history taking. By learning to interpret patient stories, Kleinman underscored that we are better equipped to understand how "physiological processes, meanings, and relationships" recursively link the social world to patients' inner experiences (6; xiii).

Within the decades that followed, scholars such as Anne Husanker Hawkins (1986), Arthur W. Frank (1995), Kathryn Montgomery Hunter (1991), David E. Shuttleton (2007) and Kerry Davies (2001; 2007) strove, within the interdisciplinary sphere of the medical humanities, to promote the "recognition that storytelling plays an essential and therapeutically significant part in shaping medical understanding" (Shuttleton 40). Such a movement, which blurred the genres of literary criticism, history, human geography and anthropology with those of sociology and psychiatry, placed at the centre of their research the illness narratives; those dialogues and the discourses that passed between patients and practitioners. By questioning the degree to which narrative tropes, cultural referents and interpersonal relations shaped the ways in which patients narrated experiences of illness and identity, this provoked a deeply self-reflective response by clinicians and scholars in regards to the collation, dissemination and analysis of illness narratives. As Johanna Shapio makes clear, this process will always remain to some extent ambiguous and dynamic, offering contradictions and contestations, and yet, no matter how "incomplete, flawed, transgressive or unexceptional" illness narratives may be, they have been secured as a subject of study that "merit respect and empathy" (70).

Amongst such interdisciplinary works, it is most notably to the research of human geographers upon the historical, spatial and dialectical significance of illness narratives within institutional confines that this article is methodological grounded. In alignment with the approach advocated by Henderson throughout his professional career, human geographers have emphasised the significance of space and place in shaping the narratives of asylum patients (McGeachan 76; Philo 111). Working in the sphere of disability studies, human geographers have increasingly adopted and adapted the literatures of cognate studies, such as sociology, cultural studies and anthropology, and therefore illness narratives have become embedded within a rich history of social, intellectual, material and phenomenological contexts (Parr and Butler 6).

Through the exploration of patient case notes dating back to the 1920s that were produced within Glasgow's Gartnavel Royal Asylum (a Scottish institution then populated by a predominantly middle class, private, fee paying clientele (Andrews, "The Patient Population" 105-6)), this article tackles the methodological problems facing the analysis of such rich, yet fragmented illness narratives. As an array of power structures, narrative conventions and spatial parameters shaped the discourses and dialogues which passed between patient and practitioner within institutional confines, this article examines how the meaning invested within illness narratives is integrally embedded within the "particular place in time, history, culture and society" in which they were once contextualised (Shapio 68).

Taking inspiration from the late Roy Porter who argued that "the history of mad people's writing is a crescendo of reaction to [. . .] the dominating presence of the asylum" (Porter, *Mind Forg'd Manacles* 273) the overarching contextual framework of bricks and mortar is ever present within this article. For as the disciplinary regimes, the physical confines and the penetrating gaze of the medical profession suffused the asylum environment, such conditions integrally shaped the narratives of asylum patients (Goffman). In alignment with recent scholarly interest in the 'turn to affect,' this article contends that as histories of emotion, imagination, experience and identity are encased within illness narratives, that an interior history, one that blends notions of self and bodily experience to the distinct perceptual environments of the institution may be revealed (Bondi, Davidson and Smith 1). Indeed in many ways the thrust of this article is to demonstrate how illness narratives often transgress the boundaries imposed by distinct diagnostic categories and institutional environments. In alignment with the research of Kerry Davis upon the subject of patient testimony, this article explores the ways in which illness narratives may pull their readers in many different directions ("Silent and Censured Travellers'?" 274). Lurching backwards and

forwards in time, space, memory and imagination, patient case notes may be explored to reveal how a vast patchwork of cultural histories, subjective stories and psychiatric practises shaped the narratives of asylum patients (Hurwitz 414).

Guided by the writings of two female patients that were preserved within Gartnavel's case note records, the first in-depth analysis of a patient narrative begins by exploring a story written in 1929. The analysis of this patient's story focuses in particular on the social, gendered and spatial histories of asylum patients. But whilst this article is attentive, not only to the narratives of patients, but also to the dialogues which passed between patients and practitioners, patient narratives will also be used to demonstrate that it is only when such histories collide with the knowledges, developments and discourses of the psychiatric profession, that patient case note records reveal the active role played by patients in shaping the clinical encounter. Such narratives do not represent an average sampling, or overall estimation of patient experiences. Rather they were chosen for the depth of insight they reveal into patients' subjective experiences within institutional confines, whilst they demonstrate the role played by the clinical encounter and the asylum interior in shaping the illness narrative.

A Tale of "An Exciting Night"

Creativity and the expression of individuality was greatly encouraged by Dr Henderson, for under his superintendency Miss Dorothea Robertson was the first Occupational Therapist to be appointed within Gartnavel in 1922 (Snedded 37). The production of crafts, art and literary works was undertaken by many of the asylum patients as evidenced in the *Annual Report* (1925) and by the publication of patient articles, letters and stories within the asylum's own *Gartnavel Gazette*, a magazine that was almost entirely produced and written by patients (Andrews, "The Patient Population" 109). Alongside such publically available records of patients' creative works, a number of patient letters, stories, artworks and poems dating from the mid 1920s to the early 1930s were preserved within an unpublished correspondence folder (*Patient Letters*). Filed away amongst this collection was a story entitled "An Exciting Night" written by a young female patient around 1929. Through descriptions of a single day and night spent within one of the hospital dormitories, her narrative demonstrates a highly creative response to experiences of illness, identity and asylum care. An early twentieth-century photograph of Gartnavel's infirmary ward (Fig. 1) therefore provides a tangible backdrop against which "An Exciting Night" may unfold.



Fig. 1.

Image showing the East House Infirmary circa the early 1900s.

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An Exciting Night

I did not leave my home to come to this benighted spot without leaving behind me also wandering hearts and widely opened eyes among the natives of the village at my sudden and apparently unwarranted transportation. However, always a promoter of peace, except where peace proves ineffectual I decided to spend a few nights in this cold, grey, and if all be known, historic pile. How many unfortunate individuals with pronounced political views or weary claimants to a disputed inheritance must have in past ages been interned here by ambitious rivals or obliging relatives to waste their days in fruitless hopes, with one eye forever on the clock, the other on the door that only brings good tidings to another. –So from early manhood into age time slips away for many Resignation may come at last, but the eyes still retain their keen expectant glare waiting though years have passed for an order of release [. . .] I had not passed many nights here without being reminded that a portion at least of the outer world had not forgotten me. It happened thus. The day had been sultry, with now and then an outbreak of hail showers. Small stones peppering sharply against the window glass. The storm that was brewing had evidently passed. The night was silent though the atmosphere was oppressive. Starting up in the night I heard a distant shout, a wild haloo in chorus. As the shouting increased in volume the galloping of horses could be distinctly heard [. . .] this stirring sound was again broken by a louder yell.

Coming from the throats of over a score of men as they hastened on their excited steeds, the old grey building echoed with the sound [. . .] Then there was silence. Inside the old grey building no one stirred. Whether they slept, or lay awake under the bedclothes stiffened with horror to inaction it is difficult to say. Presently there came hurrying footsteps past the window, then the disorderly tramp of men. A loud knocking at the front door, re-newed shouts, loudly repeated demands for admittance made it evident a decisive step must be taken. The building still remained coldly silent [. . .] Roused men are impatient, gradually the cold truth illuminated my mind. It was I who would have to open that door [. . .] Wild thoughts surged through my brain – I pictured myself being dragged from the building in scanty attire, flung across one of the horses, and galloped through the city streets with no more respect to ceremony than if the only road lay across a prairie, the riders yelling all the way. And what after? A voice called out suddenly "D. Better than that!" I did not stop to think. Liberty was sweet [. . .] Getting quietly out of bed I carefully opened the room door, preparatory to rush down the passage to the unknown. But a cold hand drew me back. It was the hand of the guardian Angel who watched my bed. She locked the door, withdrew the key & put it in her pocket. Ad libetem. (*Patient Letters*)

As fragments of reality and fiction intermingle, stories such as this bring movement, atmosphere and emotion into the frozen image of the asylum interior. The photograph of the infirmary ward was staged to display a pleasantly fitted room, ornamented with pictures, clocks and flowers, where the viewer's eye is drawn to the foreground, to the physician superintendent and his nursing staff. Within this tableau the patient is a passive, almost peripheral component to the picture: the object of medical care within the clinical encounter. By contrast, in the narrative of "An Exciting Night", objects such as the clock that hung above the door are immediately endowed with alternative symbolic values. A somewhat inauspicious item, half hidden by the light fixture, the clock becomes one of the focal points of the story, as the narrative describes political prisoners and inheritance claimants who, in ages gone by, spent their days "one eye forever on the clock, the other on the door." For Davies, such "spatial metaphors, physical descriptions of buildings and wards, and a sense of movement from place to place dominate accounts of being a psychiatric patient" ("A Small Corner that's for Myself" 305). Indeed whilst such focal points are highlighted, the passing of time becomes a slow, tedious, even painful component of the interior landscape of the asylum. The "keen expectant glare" imagined of past asylum patients highlights the interminable passage of time, whilst the author's portrayal of the buildings historical legacy in "An Exciting Night" elongates her tale of suffering, so that it becomes embedded in a rich network of meta-narratives that stretch back to the heyday of the asylum in the nineteenth century. Such an opening passage, which spoke of illicit incarceration, is highly reminiscent of the literary devices and plot structures used in Victorian sensation novels such as Wilkie Collins's *The Woman in White* (1860). Collins's unfortunate heroines and heiresses were committed to asylums by beguiling fortune hunters and mysterious foreign Counts demonstrating the influence fictional narratives can have upon the aesthetics and emplotments of patient narratives (Shapiro 68).

As the author of "An Exciting Night" describes how the hailstones that had peppered so sharply upon the asylum windows passed over to be replaced by darkness and the oppressive atmosphere of a silent night, the orientation of her story passes from a sensational perspective of the asylum's past to one which is more immediate, as she invites her reader to peer at the ward from beneath her bed sheets and to listen to the silence of the building and

the hurrying of the footsteps that passed under the window. Through this complex interplay between place, time and the individual imagination a sense emerges of how patients' affectual and emotional responses to such a vast and imposing stone structure were shaped, indeed became embedded within the building's long and tendentious history. "The subjective sense of time passing," states Brian Hurwitz, "is often a major feature of an illness narrative" as the compression and elongation of time often accompanies the disruption of "bodily functions and feelings [. . .] relationships and assumptions of futurity" (423). The temporal sequencing of patient tales may therefore be explored to reveal not only patients' expressions of their most immediate, felt engagements with the institution and its inhabitants, but also how they were shaped by literary discourses that originated far beyond the asylum walls.

Indeed, as well as this story providing such an interior account of the asylum building, the plot line of "An Exciting Night" goes beyond such physical boundaries, for as her story spoke of a "loud knocking at the front door," the external world comes into focus. As "the building remained coldly silent," impervious to the hammerings of angry men, the hospital was forcefully juxtaposed against the aggression and action of the outside world. Such tensions within "An Exciting Night" illustrate Davies's observation that patient narratives are often invested with "movement and rhythm"; that the sharp contrasts between outside life and institutional care produce a wealth of metaphors within patient narratives that explore the stark division of their identities and experiences inside and outside of the hospital (308).

Against such a backdrop, it is the identity of the author herself that comes across most vibrantly within the story. By redefining and reinforcing a sense of self that lay outside of the hospital, she negotiates the boundaries imposed by a patient identity and transforms into one markedly different. Taking on the role of a heroine in distress to be swept up in the arms of her unknown liberators, the author of "An Exciting Night" immersed herself within a somewhat eroticised tale of fantasy and escapism. Picturing herself being "dragged from the building in flimsy attire," flung across a horse and paraded through the streets, this overt portrayal of 1920s cinematic femininity made way for a more subtle expression of confinement, dependency, identity and control. Like the on screen heroines who starred alongside 1920s heart throbs such as Rudolph Valentino and Douglas Fairbanks, freedom within her story was largely dependent upon the unknown, upon the power and aggression of the masked rider or the desert sheik. Imagining herself to be treated with "no more respect to ceremony" than if she were racing across the vast emptiness of a prairie, liberty was expressed not only in terms of excitement and anticipation, but with fear and apprehension. Her narrative, as feminist scholars such as Nancy Tomes have long argued, may be explored to reveal the ambiguous, often conflicting experiences of patients, for whom the asylum could be regarded as a place not only of confinement but of refuge ("Feminist Histories of Psychiatry" 359).

Finally, as "An Exciting Night" came to an abrupt end as the cold hand of the guardian angel drew the author back, withdrew the key and locked the door; there is a sense of the ways by which systems of observation, dichotomously expressed in terms of care and cold disempowerment, pervaded the asylum building. Through the imagination of such patients, the asylum may be viewed through a multiplicity of human relations, power structures and through a vast network of perspectives (Foucault, *Psychiatric Power* 15). Such tales demonstrate that as "stories can act as sites of oppression, self-delusion and dissimulation [. . .]they can also serve as acts of self-empowerment" (Shapiro70).

By locating her entry in the admission register, her diagnosis, which was one of "dementia praecox," may also enable scholars to appreciate its contemporary medical significance and therefore understand why this story was preserved. Dementia praecox, a diagnosis which was redefined by Eugen Bleuler as schizophrenia (Gilman 467), was defined

by Henderson as that which characterises "a person who tends to get out of touch with reality, and to suffer from what [Hoch] aptly termed the 'shut-in' personality." Such individuals, wrote Henderson, are often "dreamy, asocial, lacking in aggressiveness, shy, ultra-conscientious, and far too sensitive to criticism." ("War Psychoses – Dementia Praecox in War Time" 5) and it is therefore against this wider diagnostic history that her story may gain other decisive layers of meaning. Within the asylum's *Register of Deaths* it is also revealed that this patient spent the next thirty years within Gartnavel until her death in the 1960s (*Register of Deaths*), and therefore this longitudinal perspective underlines the temporal significance of her tale and the poignancy of the passage which described the patients whose "eyes still retain their keen expectant glare waiting though years have passed for an order of release."

With an array of fluctuating perspectives emerging from her story, "An Exciting Night" demonstrates that "patients' tellings are not objects to be comprehended or mastered, but rather dynamic entities that we approach and engage with." For whilst an array of interpretative frameworks may give meaning to illness narratives we must "simultaneously remain [. . .] open to their ambiguity" (Shapiro 70-71). As this patient's desires, fears, creativity and individuality were given expression within her story; the underlying ambiguity of her tale recreates the building and its staff as dynamic, ever changing, yet powerfully permanent features of the illness narrative.

A Dialogue of Emotion, from Moral deficiency to the Psychopathic States

A Text-book of Psychiatry for Students and Practitioners (1927)

By D. K. Henderson and R. D. Gillespie

Chapter XIII

MENTAL DEFECT

[. . .] Individuals who display moral deficiency have suffered from some antecedent abnormality, intellectual or emotional. This antecedent abnormality may be inborn, or may be acquired from the environment through infection [. . .] or through faulty training [. . .] Under this heading we include persons who have been from childhood or early youth habitually abnormal in their emotional reaction and in their general behaviour, but who do not reach, except perhaps episodically, a degree of abnormality amounting to certifiable insanity, and who show no demonstrable intellectual defect [. . .] There are certainly a few cases in whom the emotions are stable, but perverted in their application [. . .]

The following is an example [. . .];

CASE 58. – M.B., 24 years old, single, admitted on May 4 1921. For a long number of years this patient had been creating a great deal of difficulty at home, so that her brothers and sisters felt that their mother's life was not safe. It was stated "Her vindictiveness is so extreme that she is capable of anything, while, at the same time, she is so plausible and cunning that she is able to impress all strangers that she is a persecuted saint condemned to live in a family of criminals and savages" A few instances of her conduct are sufficient to describe the case. One of her brothers arrived home on leave from France to visit his father who was dying. She refused to sit by her father when he was ill, to prepare food for him, or to relieve those who had been constantly with him night and day. On the contrary, she jeered at the constant "morbid atmosphere" of the sickroom. The family tried to induce their mother

to have a nurse in the house, but she refused to do this lest a stranger should talk outside about her daughter's conduct. [. . .] She terrorised the home for years, and drove more than one of her sisters away from home by her threats and her violence [. . .] It was also stated that one of her brothers, who was an apprentice engineer, had to stand over the water which he had heated to have his wash, because if he relaxed his vigilance the patient would take the warm water and pour it down the sink. One day in mid-winter she threw a bucket of cold water and deluged his hens, which were his hobby, "just to see what he would do". Frequently she told her mother that she "would make her suffer" [. . .] Indian ornaments, sent home by a sister, disappeared, and some Greek metal-ware which was also in the house disappeared and was discovered hidden in the commode in the patient's bedroom, awaiting a chance to be smuggled out of the house [. . .] On account of the difficulties of management, she was certified as being of unsound mind, and was admitted to hospital. During her stay in hospital she has been unreliable in every way. There have been times when she has been better controlled and better behaved, but sooner or later she gets into difficulty again. When found fault with, or criticised, or restrained in any way, she has outbursts of great passion, during which it is almost impossible to control her. She is sulky, spiteful and destructive, making life difficult for the other patients, and even striking those who are most helpless. (Henderson and Gillespie 371-377)

The second patient narrative to be explored is most notable for its diagnostic, as well as its social significance to histories of psychiatry/madness. Miss Frances Beaton, who was certified insane and admitted to Gartnavel in 1921, was diagnosed as a moral defect/constitutional psychopathic inferior and in 1927 her case history appeared within Henderson and Gillespie's *Text-Book of Psychiatry* under the pseudo name of Miss M.B. Published case histories were widely used by the psychiatric profession within this period for a variety of educational and promotional purposes, (Andrews, "Documents and Sources" 274) and within the *Text-book* large numbers of case histories were employed to demonstrate how the symptomatology of mental illness played out within the distinct biological, personal, environmental and historical "settings[s] in which they occur" (Henderson and Gillespie viii). So, as the case history of Miss M.B. was situated in the "back yard" where the chickens were drenched, the bedroom where stolen ornaments were hidden, and the asylum wards where she struck the most helpless of patients, the case history of Miss M.B. bound her antisocial misconduct to distinct settings and social encounters. Described by Henderson as a class of patient who, despite the possession of a "normal" intellect, had periodically displayed antisocial patterns of conduct from an early age; Miss M.B.'s case history tells us much about the delineation of contemporary diagnostic frameworks, whilst descriptions of her petulant, destructive and passionate behaviour demonstrate the particular incidents in a life history considered most pertinent to the diagnostic process (Henderson and Gillespie 371-377).

Miss M.B.'s published case history can also be explored to demonstrate underlying tensions and diagnostic uncertainty that surrounded this patient's certification. Her behaviour, wrote Henderson within his *Text-book* analysis, did not constitute a "mental disorder in the usual sense." Rather, the justification for her confinement lay with matters of social and familial control, for as she periodically transgressed the moral and legal codes of society, it was "on account of the difficulties of management" that she was certified as being of unsound mind (Henderson and Gillespie 371-377). Henderson found such a diagnosis problematic, as he wrote in 1927 that the diagnosis of "moral deficiency" was a stigmatising and medically limited diagnostic term that clung to theories of hereditary degeneracy that

stemmed back to the Victorian era (Henderson and Gillespie 371-374). But with little other provision having been made for the treatment of such "morally oblique" individuals ("Moral Imbecility and the Mental Deficiency Act" 1316), this young, female patient was to spend over ten years confined within Gartnavel.

To encounter Miss M.B. within the *Text-Book* is to encounter the representation of an individual placed within a highly unstable diagnostic category. Bound to society through moral, legal and familial codes of conduct, Miss M.B.'s identity emerges from the conflation of ideas surrounding illness and antisocial behaviour. Defined by her lack of those essential emotional complexes which are commonly held to make up the social being, the readership of the *Text-Book* engages with a symptomatic description of an abnormal personality set against social and clinical backdrops, but such an analysis does little to unveil the subjective meaning of this patient's actions and words. Since Miss M.B. was reported to have "jeered" at the morbid atmosphere of the sick room, her actions seem alien and her story evokes neither empathy nor understanding. Described by her family as a plausible and cunning liar, Miss M.B.'s words were bereft of authenticity, while her behaviour was a family secret, a social disgrace. Moreover, Henderson's *Text-Book* description of her unreliable and petulant behaviour did little to evince the psychobiological approach which relied so heavily upon the analysis of the patient's subjective story. Nonetheless a collection of letters written by this patient, hereafter referred to as Miss Beaton, were stored within her corresponding case note and correspondence folders. Written from within Gartnavel these letters give an account of illness and identity from within the clinical encounter. Analysed alongside the published works of Henderson they add significantly to an understanding of the clinical narrative.

Faces of Lunacy, Theatres of Madness

After Miss Beaton had spent over four years within the hospital her corresponding case notes records reveal that she had grown largely uncontrollable. During a particularly violent outburst she was judged to threaten the safety of patients and nursing staff and was therefore transferred from an open plan dormitory on the first floor to a ward several floors higher within the building where she was locked in a single room. This ward was reserved for the more disturbed, unmanageable class of patient, and after she spent a year within the confines of this enclosed, segregated ward, she wrote a number of letters to Dr Henderson (*New Case Book Series: Females*). After thanking him for letting her see a woman doctor, her first letter began by describing her experiences within the segregated ward, a place she described as the "refractory." An abridged version of the letter reads as follows:

4th February 1927

Dr Henderson

[. . .] Some years ago when my sister was a medical student [. . .] and we were staying in Edinburgh [. . .] she was [. . .] anxious to see over the medical museum there [. . .] and took me for company. It was all so abhorrent to me that I kept my eyes shut most of the time – but there was one thing that particularly impressed and nauseated me. It was a group of wax heads of a family of mentally afflicted persons of different types. While my sister positively gloated (from a technical point of view) [. . .] I was haunted by these faces. The shapes and expressions of them (although they were dumb) and tried hard to think of [. . .] anything beautiful to drive out the horrible thoughts that had arisen from what I had seen but it was no good – they predominated over everything. [. . .] Perhaps that gives you a little idea of what this is to me. I have to live beside the embodiment of insanity of the worst kind and listen to them all day and at night too [. . .] Fortunately I do not see them, being in this room, but I hear them all the

time and know I can't get away from them and am said to be one of them myself. [. . .] The spirits of all the insane people that I have seen in this room, and who have been in this room that I have not seen, permeate it – the walls, the ceiling, the floor and the bed and every cubic inch of the atmosphere I breathe [. . .] This illness is not due to either hereditary or disease, so it must be due to present environment [. . .] Please will you let me go back to ward [I] again.

Frances Beaton. (*Patient Letters*)

Within this letter to Dr Henderson, Miss Beaton defined insanity as not only an illness afflicting minds and bodies, but as an independent entity, a pollutant and a source of corruption which permeated the walls, the ceiling and “every cubic inch of the atmosphere” in which she breathed. Within the confines of her single room in the upper wards of the hospital, the presence of insanity she argued was inescapable. Categorically placed among a class of patient whom she regarded as the “embodiment of insanity,” Miss Beaton insisted that it was the environment of the ward, not heredity, nor disease which was the cause of her illness. That if only she were to be removed from such a corrupting space, and placed downstairs within ward I, then, she impressed upon Dr Henderson, could she recover.

With distinct points in time and space conflating within her letter, it becomes clear that Miss Beaton's experiences within the “refractory” ward were innately connected to an array of memories, objects, sensations and identities that originated beyond the asylum walls. While the sounds of the patients who populated the ward encroached upon her mind, it was the image of the waxen faces that had so horrified and nauseated her within the medical museum that predominated over her imagination. As Miss Beaton described the permeation of the sounds, spirits and memories of “the insane” pressing upon her, dragging her down to the depths of illness, the sheer weight of emotional distress held within her narrative may be further comprehended by recovering these past memories and affectual encounters. By becoming engrossed in the field of analysis and following Miss Beaton's tale into the anatomical museum, such faces of insanity may allow contemporary viewers to begin to comprehend how these “felt moments,” expressed so powerfully within illness narratives, became ingrained upon patient's minds and bodies (Jones 208).

Edinburgh University's Anatomical Museum provides a material and cultural backdrop against which the contents of Miss Beaton's letter may be explored. Within the early decades of the twentieth century the museum was composed from an eclectic assortment of physical specimens as skeletal remains, organs, plaster casts and wax moulages were displayed to academic and educated visitors (Kaufman 506-7). Grotesque to the untrained eye, many of these objects still remain in a state of preservation within the museum today, and therefore contemporary viewers may emulate the journey expressed within Miss Beaton's narrative as she recalled following her sister, eyes shut, through one of Edinburgh's medical museums.

Amongst such specimens a phrenological collection of life and death masks had, from the 1880s onwards, been held by the Anatomical Museum. Amongst this collection that displayed the heads of criminals, nobles, geniuses and the ‘insane,’ a collection of life masks displayed cases of insanity due to cranial deformities. As part of this collection a microcephalic family of six casts, comprised of a mother, her sister and her four children were catalogued as the “Hillings family of idiots” (Kaufman 506-7). Cast by the sculptor A. L. Vago in the second half of the nineteenth century (evidenced by the base inscription on the casts) the Hillings craniums were characterised by their “sugar-loaf” shaped skulls, rapidly receding foreheads, beak-shaped noses and receding chins. Demonstrated in the photographs below, this set of casts may be used to explore how the heads described by Miss Beaton

became a central component to her illness narrative (Scotland's Cultural Heritage Unit).



Fig. 2.

Photographs of the Hillings plaster casts, objects held by the National Galleries of Scotland, Ref, PGL 2199, PGL 2200, PGL 2201.

Printed with the kind permission of the Collection of the University of Edinburgh.²

Scholarly text books published as late as the 1920s described the Hillings casts as a set of specimens which demonstrate the physical features of a degenerative, animalistic, characterless set of creatures for whom “coarseness, crudeness and abomination [were] written in every line [. . .] form and [. . .] feature.” Used to teach their viewers to read upon the surface of the body contemporary signifiers of “mental deficiency” and hereditary degeneration, the intersection of medical science with artistic technologies produced objects that functioned not only to replicate the outer protrusions of a biology entity, but which upheld an array of moral judgements (McCormick 637). As Miss Beaton described the patients who surrounded her in such derogatory terms, parallels between her description of the “embodiments of insanity” and text book accounts of the degenerate “insane” may clearly be drawn, but unlike such contemporary medical texts, fear is also a strong component of her illness narrative. To explore her narrative account of affect and emotion, analysis therefore needs to look past the cultural framing of insanity, towards the interpersonal relations that exist between object and onlooker on a more immediate, precognitive level of experience.

Taking inspiration from recently scholarly interest in the “turn to affect,” such material artefacts may induce a reaction which, like that of Miss Beaton, is difficult to verbalise, which in many ways evades replication but which nonetheless leaves a lasting impression on those who encounter them (Schnalke 204). In response to calls within the medical humanities for scholarship to look beyond the limits of narrative, and towards mediums of communication other than the written word (Woods 76), consideration of these waxen faces enable scholars to bypass such linguistic limitations and to explore the affective experiences that are bound within illness narratives. As Allan Ingram has argued, illness sufferers may attempt to retrieve their experiences through narratives and storytelling, but “the experience of pain and mental suffering must always exist in a region remote from language.” “It is at the point of expression that the critic or historian is entitled to take an interest,” conceded Ingram (8) and yet, if patient narratives are embedded within the material and cultural worlds from which they emerged, this may enable scholars to explore affect as it

existed prior to language, prior to its conscious articulation (Leys 442).

In a second letter written to Dr Henderson upon the subject of the wax heads, Miss Beaton enlarges upon the tale, as she expresses fear and anger that her identity will be forcefully displaced by the medical profession and by those around her. "*Dr Henderson*" she wrote on the 8th of February 1927:

[. . .] To think [. . .] that I am in a place like this - [my sister] Though mental was her pet subject – [. . .] need not have put me, in her imagination – with your encouragement it seems – on a pedestal along with the other wax heads I told you about + placed me in the same category + left me there. The nurses hit the patients + say it does not matter because they haven't the same feelings mental or physical as other people – but perhaps, in some cases their feelings are intensified, where a person with a blunter, coarser mind would not mind such treatment [. . .] Please do not keep me up here any longer. (Patient Letters)

As Miss Beaton argued that her head was unjustly showcased, that she did not fit the physical mould, such a passage evidences her need to demarcate the world of the insane from her own enclosed space. Resisting, yet increasingly finding that the refractory ward enforced a debilitating patient identity upon her mind and body, her narrative fought to retain a sense of self and health within such institutional confines. As Sander Gilman suggests, medical representations of disease taught viewers to identify the physical, outer characteristics of mental illness upon the human body, but these images could simultaneously produce an "anxiety about identifying oneself with the image of the mad" (50). As plaster casts and wax mouldages blurred the boundaries between real and artistic representations of mental illness, they too may have blurred the boundaries between object and onlooker. As Miss Beaton came to be housed amongst a class of patient who she regarded as the embodiment of insanity, the symbolic significance of the waxen faces allowed such an expression of the loss of her own ontological security.

In telling her story to Henderson, Miss Beaton's narrative enables an external readership to explore how cultural discourses and medical representations of disease actively shaped patients' phenomenological experience of illness. But on a wider scale of analysis, when such a narrative is evaluated within the history of the psychiatric profession, such acts of storytelling highlight the importance of patient narratives to the evolution of psychiatric thought.

By the end of the 1930s, Henderson had rejected the term moral deficiency and redefined such individuals as belonging to the diagnostic category of the psychopathic states. Henderson was fast becoming one of the most widely respected and renowned experts on the psychopathic states; influencing the diagnosis and the treatment of such problematic patients on both sides of the Atlantic (Tyrer 81) and by 1940, the case history of Miss M.B. was removed from the *Text-book* chapter on "Mental Defect" and reinstated as the prime example from which to demonstrate the "complexity" of the "Psychopathic States." Rather than define such individuals as a degenerate class, whose antisocial behaviour stemmed from birth, psychiatrists such as Henderson were increasingly demonstrating how environmental factors of causation shaped the development and diagnosis of such individuals. Defined as a class of person who, quite simply, "fails to grow up" their responses to fear, wrote Henderson, were exaggerated under conditions of "solitude and loneliness" (*Psychopathic States* 128-131). The seeming irrationality of the *aggressive* psychopath, postulated Henderson, could be understood as the response of a personality dominated by fear. As they were seen to feel more intensely pain and anguish, their responses to emotional stimuli, which often resulted in

spiteful, destructive and violent actions, were seen as a means of self-preservation (*Psychopathic States* 130-134).

As Henderson lamented that the stories of such patients were "often not listened to" or, that if they were, they were "not given a great deal of credence," the retrospective value of patient narratives to the diagnostic process and to the development of psychiatric knowledge is most clearly acknowledged (*Psychopathic States* 46). Locked within her single room in the upper wards of Gartnavel, Miss Beaton's letters expressed, sometimes in the most vitriolic, and sometimes in the most plaintive of terms, such pain, despair and fear. As she spoke of a sense of self that was bound to distinct affective spaces; of a building which was so intimately and sickeningly experienced, her narrative began to unveil this most complex of relations between emotion, identity and environment.

Her letters, which were filed away, were written in an institutional and social environment that enforced such isolation and solitude, yet, it is apparent that as a dialogue passed between patient and practitioner within the asylum, Henderson's comprehension of his patient's experiences began to converge with that of his patient. Years later, as Henderson gained the power to influence public opinion and social reform, the experiences, sentiments and stories of patients such as Miss Beaton can distinctly be heard, weaving back and forth within his publications. Only through the in-depth analysis of the psychopath's life history, wrote Henderson in 1939, only by listening to their stories and analysing their "social, racial, economic and personal problems," could psychiatrists begin to understand how environmental factors shaped a mind which was "already unduly sensitive and susceptible" (*Psychopathic States* 35-36).

Conclusion

This article has argued for the interdisciplinary stance which must be taken to the analysis of case note records if the wealth of meaning embedded within the illness narratives is to be retrieved. With the exception of scholars such as Jonathan Andrews (1998), Gayle Davis (2008), and Allan Beveridge (2011), the analysis of British case note records from the twentieth-century is notably absent within histories of mental illness/psychiatry. But as these three patient cases demonstrate a rich seam of archival materials, which unite illness narratives to the spatial, cultural and clinical contexts in which they were set, awaits further exploration.

As Davis contended in 2008, case note records remain "a rich but neglected source amongst historians of medicine," as the "confidential nature of patient records, the sheer volume of some collections, and the technical complexity of the information they contain, have acted as disincentives to their use for historical research" (23). Andrews likewise remarked that scholarly negligence of case note records stem from the "inconvenient" nature of materials that are hand written, that pose problems of access and which do not easily lend themselves to quantitative analysis ("Documents and Sources" 256). For medical historians, such as Andrews and Berkenkotter, the array of opinion which surrounds case note records arguably derives from the irregular and inconsistent nature of case note keeping within the nineteenth and early twentieth century. For although case books were used by all of the Scottish Royal Asylums before the 1845 Lunacy Act made the keeping of case books statutory within England, "substantial variations in both the form of the case books and the assiduity with which they were completed," means that such sources do not easily lend themselves to uniform historical enquiry (Berkenkotter 9, 19). However, it is precisely in the subjective factors that shape these primary sources that their historical value lies. Illness narratives were a prized part of the clinical record for Henderson and other dynamic psychiatrists of his period, and there lies their distinct value to historians, literary theorists and contemporary clinicians. The records from Gartnavel are truly remarkable, with this

article barely scratching the surface of their contents, as the memories, imaginations, dialogues and discursive constructs of asylum patients populate case note records. But within historical periods in which the illness narrative is notably absent from case note records, such silence may offer an equally pertinent degree of insight into the lives that were once contained within these institutions. For as Foucault wrote, whilst the "power of writing" enabled medical professionals to capture, fix and construct patients as "describable, analysable object[s]," he nonetheless argued that such disciplinary activities reveal the ways in which patients were constituted as individuals within their distinct social, spatial and historical contexts (*Discipline and Punish* 189-94). In periods in which authorial agency lay most strongly with psychiatrists rather than with patients, each case record evidences the application of power which led to the production of individual patient identities.

Reflecting upon the methodological problems raised in the introduction to this article, it is clear that the possession of the illness narrative shall always be torn between patient and practitioner. The ability to give expression to experiences of illness and identity is in many ways curtailed by the dominant cultural and medical discourses made available to patients and practitioners, and therefore the illness narrative is never an authoritative representation of illness itself. But rather than be guided by the search for some authentic narrative of illness and experience, case note records enable researchers to explore how illness is given meaning within memory, imagination, space and place. Case note records enable scholars to explore the "assertions, negations, experiments" and "theories" that operated within the clinical encounter, which, as Foucault argued, gave way to a "game of truth" as patients and practitioners fought to define the illness narratives (Foucault, *Psychiatric Power* 13).

Notes

1. This is an excerpt of the handwritten physicians' report of the physical and mental examination of a female patient, who for reasons of anonymity, I have represented by the pseudo name C. Charlotte Murray. The examination was conducted within Gartnavel Mental Hospital in 1929 and the document may be found within Patient case note records. All three patients mentioned have had their names removed or replaced by a pseudo name to retain their, and their family's anonymity.

2. Edinburgh's Anatomical Museum's collection of life and death masks closely matches the objects described by Miss Beaton. Although this collection of heads was produced in plaster rather than wax, the base of these objects reveal that before these heads were repainted in the 1990s, they were originally coloured in a flesh like tone, and therefore could have been mistaken for being made from wax.

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