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About the JLS

The *Journal of Literature and Science (JLS)* is a peer-reviewed academic journal published twice annually in Summer and Winter. The JLS was founded in 2007, and produced its first issue at the beginning of 2008. It was originally hosted by the University of Glamorgan's Research Centre for Literature, Arts and Science (2007-12), before moving to its own independent online site in March 2013, with the support of the University of Westminster and the Centre for the Study of Science and Imagination. The journal's first, and present, editor is Professor Martin Willis, Professor of Science, Literature and Communication at the University of Westminster. The Advisory Board includes leading scholars of literature and science from around the world. The JLS is published in digital format, is entirely open access, and requires no subscription fee.

The journal is dedicated to the publication of academic essays on the subject of literature and science, broadly defined. Essays on the major forms of literary and artistic endeavour are welcome (the novel, short fiction, poetry, drama, periodical literature, visual art, sculpture, radio, film and television). The journal encourages submissions from all periods of literary and artistic history since the Scientific Revolution; from the Renaissance to the present day. The journal also encourages a broad definition of 'science': encapsulating both the history and philosophy of science and those sciences regarded as either mainstream or marginal within their own, or our, historical moment. However, the journal does not generally publish work on the social sciences. Within these confines, essays submitted to the journal may focus on the literary and scientific productions of any nation or group.

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Introduction: Rethinking Approaches to Illness Narratives

Keir Waddington and Martin Willis

All of the articles in this issue attempt, whilst doing many different things, to do one thing in common: consider how illness narratives can be approached in new ways. Whilst scholarship in the Medical Humanities frequently presents its approach to illness narrative as essentially interdisciplinary in nature, there are a significant number of perspectives yet to be properly used to elucidate narratives of health. Largely, this is a result of a very limited set of influential critics (and works of critical insight) whose own specialisms are not those of the humanities but instead come from the sociological and health disciplines. Notwithstanding the upsurge in interest in the literary possibilities of illness over the last two decades, their conception of narrative understandably reflects their subject expertise. If this scholarship acknowledges that illness narrative is a social and cultural phenomenon, narratives are either 'data' to be mined for information-giving patterns or 'life stories' which require some form of generic categorisation or typologies as a way of humanising medicine or thinking about 'narrative medicine,' while they tend to frame the rise of biomedical approaches in particular ways that both accept a narrative of medicalization as inevitable and positive and lament the loss of the patient's voice in this process. There are, of course, critical works that deal with illness narratives from decidedly humanities perspectives: any study of the range of articles in the journal *Literature and Medicine* or an examination of recent scholarship in the history of psychiatry for example, will testify to that. There are, too, critics who have not only led the way with their own humanities' focussed research but who have also used their position to call for further work in a similar vein. Catherine Belling exemplifies this critical stance, as does one of the contributors here, Angela Woods, who has written previously about the limitations and opportunities of illness narrative research. However, and as both Belling and Woods would agree, the limited range of methods presently employed unnecessarily restricts what illness narratives might be allowed to mean, and even what they might look like.

For example, narratives of illness, in the present critical consensus, are restricted to narratives of a certain type: the linear, progressive, story framed with the context of biomedicine and the doctor-patient encounter. Surely it is possible to acknowledge, as literary critics have, that narratives need not be linear, they need not be structured as traditional story-telling forms (as dramas, poetries, and prose), nor need they offer logic, coherence, or temporal movement. Yet literary postmodernity – as an intellectual position or set of theories most capable of posing questions of the meaning and nature of narrative – has had little involvement in illness narrative research and therefore has made no impression upon the potential research opportunities on the structures and philosophical insights of different forms of narrative. Even this is an excessive case. More traditional literary methods – of close reading and textual analysis – are, with exceptions, rarely put to work on illness narratives in any methodological way. On a larger scale, the historical dimension and situatedness of these narratives has also been left in the cold, especially as scholarship in the Medical Humanities tends to concentrate on those narratives produced after 1950. Despite medical historians' increasing sensitivity to the patient's voice and

work on early modern medicine and in the history of psychiatry that seeks to examine medical history 'from below,' in the Medical Humanities illness narratives are largely read in presentist contexts as narratives of the now rather than as narratives with a past. Such adherence to contemporaneity leaves history as an absence in illness narrative research. This is to the detriment of illness narrative research on two fronts. First, it disallows contemporary narratives the opportunity to be placed within a properly understood historical context of writing about illness. Second, it delimits illness narratives as narratives written only in the present period when in fact they have been written for as long as illness has been felt and then mediated through some form of lasting communicative act.

The contributors to this issue – Alysa Levine and Kevin Siena, Hazel Morrison, Angela Woods, and Martin Willis, Keir Waddington and Richard Marsden – all attend to one or more of the absences in illness narrative research. Their collective aim is to highlight possibilities whilst placing a check on current practice. Their work emerges from different disciplines: Levine and Siena are social historians of early modern medicine, while Morrison's research focuses on the history of twentieth-century asylums. Woods is a Medical Humanities scholar working in interdisciplinary ways at the boundaries between literary theory, medicine, and philosophy. Willis is a scholar in the field of literature and science, emerging from a background as a literary and cultural critic, while his collaborators Waddington and Marsden are historians, with Waddington's work focusing on how medical institutions can be read as 'social' institutions. Their work, taken together as a group of linked scholarly articles that aim to intervene in current illness narrative research, offers unique literary-historical interpretations of a range of illness narratives found in disparate locations and periods across both history and culture. In rethinking the ways that scholarship might approach narratives of illness they have uncovered unusual and distinctive historical narratives, revealed ways in which multiple narratives come into conflict with one another, questioned assumptions about narrative legitimacy and authority, and deconstructed contemporary narrative practices to reveal underpinning historical precedence. Their work is suggestive, interrogatory, and self-consciously aslant from existing illness narrative research. By cutting across present scholarship they aim to open avenues to new research methods and provide opportunities for an increasingly sophisticated and inclusive humanities approach to narratives of illness.

Reporting Dirt and Disease: Child Ill-Health in Seventeenth- and Eighteenth-Century England

Alysa Levene and Kevin Siena

Poor bodies were both worrying and threatening in the eighteenth century. Medical depictions of poverty in discussions of contagious diseases presented it as degrading the human constitution with dangerous ramifications for pathology. High levels of infant and child mortality also forced reflection about the seemingly precarious health of society's youngest. Thus the poor and children were each in their own ways portrayed as prone to illness and contagion in the eighteenth century. What, then, of poor children? Were they inherently sickly? The issue is not so simple for when the issues of poverty and childhood conjoined one encounters mixed messages. On the one hand, poor children were poor. In theory they presented similar contagious risks to those posed by their parents. And yet, certain elements that commonly coloured medical narratives about poverty were either absent in discussions of children or else deployed differently with different effects. Ambiguity thus characterises medical narratives on poor children, whether because discussions of children frequently lacked the heavy moralizing that so often characterised commentaries on the poor, or because different agents crafted such narratives in different contexts and with different concerns. This article will compare narratives found in medical treatises that sought to explain the causes of disease with a quite different viewpoint created by the authorities charged with the actual bodies of poor young children.¹

If, as cultural anthropologists argue, narratives give shape and meaning to human experience (Mattingly and Garro 1-5), then an exploration of how various commentators made their claims about poverty, age and sickness can shed light on their deeper concerns and assumptions, for example, about social order, governance and the state of the population. Doctors facing the possibility of epidemics were primarily concerned with identifying sources of infection. Thus they told tales, whether expressed as outbreak narratives or metaphorically rich medical theories, that emphasised the role of poverty and filth. The possibility that poor children might be inherently sickly was a by-product of narratives that emphasised heredity causes of disease, and at least one high profile example took these trends to their logical conclusion presenting sick children as a significant public health threat. However, men who were actually responsible for poor children addressed issues of health rather differently, being primarily concerned with reacting to the realities of spots, itches and fevers and how best to contain them. On the one hand, this article argues for differentiating between abstract theorists and pragmatists on the ground. However, this difference found expression not only in the content of the claims being made but in the form of those claims as well, for these latter commentators crafted narratives that allowed little space for seeing poor children in ways implied by medical theory. When thinking about narratives about the sickness of child paupers therefore, evidence suggests that their health was increasingly noted and valued; their bodies increasingly observed; and their ill-health largely divorced, at least on the ground, from the wider discourses about heredity, corruption and poverty seen in the contemporary medical tracts.

Paupers and Children in Published Medical Treatises

Studies of early modern or eighteenth-century theories of disease focus rarely on class.² This is unfortunate because seventeenth- and eighteenth-century doctors emphasised the social stations of the bodies they discussed. Scholarship has amply shown that those bodies were differently gendered. (Lacquer; Schiebinger; Stolberg). Whether one considers reproductive or nervous disorders the proclivity for particular diseases offered one of the more important means by which men's and women's bodies were distinguished (Houston; Martensen; Gilman et al.). And yet, as important as gender was in this regard, class, that oft-neglected sibling of a category, may have been even more pressing in early modern discussions of disease.

This bold claim hinges on the fact that it was class not gender that grounded theories about the most dangerous disease of them all, plague. Scholars of plague, especially Paul Slack, have stressed the links between poverty and pestilence. Here focus falls less on doctors' theories and more on the social dispersion of mortality rates (whereby the poor almost always dominated among plague deaths) or on how plague ordinances masked social policing (Slack 199-226, 252-253, 284-310 and 336-337; Champion). Yet doctors trying to explain epidemics – especially the vital phenomenon that plague raged most fiercely in poor neighbourhoods – forged a coherent set of principles about plebeian bodies, one that informed narratives about class and disease for nearly two centuries.

Theories on why infectious diseases seemed to target the poor stressed the concept of predisposition. It followed from the mortality figures that the poor must be "predisposed," their bodies having some peculiar quality rendering them especially susceptible (Wear 281-286). That quality was putridity. Plague was believed to arise from putrid or corrupt matter, especially from sources of filth: "stinking sewers, channells, gutters, privies, sluttish corners, dunghils, and uncast ditches" (Bradwell 4). When such matter entered bodies it corrupted the humours, sparking the internal putrefaction that doctors agreed was the essence of plague. But not everyone died in epidemics so this must have occurred only in certain cases, prompting the question: which bodies were most dangerous? Doctors like the Oxford physician Steven Bradwell, author of the 1625 plague treatise *A Watchman for the Pest*, argued that those bodies whose fluids were already of putrid nature were plague's primary targets; their blood was apt to putrefy since it was already partially corrupt. By that logic he named those most susceptible:

Poore People, (by reason of their great want) living sluttishly, feeding nastily on offals, or the worst & unholsoimest meates; and many times too long lacking food altogether; have bothe their bodies much corrupted, and their Sprits exceedingly weakened: whereby they become (of all others) most subject to this Sicknesse. And therefore we see the *Plague* sweeps up such people in greatest heapes. (46)

The poor absorbed filth from their dirty environments and ingested it as low quality food. Importantly, impoverished bodies could generate plague even with no external infection. Mirroring longstanding warnings about pathogenesis from blocked menstruation, paupers' fluids were believed to reach deadly levels of putrefaction if they did not sweat out their impurities.

[T]hey are most apt, whose veins and vessels are full of grose humours and corrupt juices, the evil matter (being thicke, and therefore cannot breath out

through the pores) increasth her putrefaction (by the heat within) unto the greater malignity, and so becometh Pestilent. (45-46)

We can read in Bradwell's treatise an attempt to make sense of the frightening phenomena he and his contemporaries faced in epidemics. As body counts mounted in poor neighbourhoods, men like Bradwell crafted stories in which they imagined the filth that surrounded paupers as necessarily having permeated the deepest inner reaches of their bodies. Bradwell transposes that filth inwardly and creates a narrative about stagnation and containment. The plebeian body becomes like a kind of prison; matter enters it but it cannot leave. But the body is also configured as a kind of improperly ventilated container. Lacking drainage for its "corrupt juices," the body becomes like a bottle stopped up for too long, its contents becoming rancid. With so many paupers dying in urban epidemics, the story becomes plausible to anyone observing the spread of diseases with some trepidation.

Versions of this theory provided key components in medical narratives highlighting the dangers of poor bodies throughout the seventeenth and eighteenth centuries. Pointing to food, physician Nathaniel Hodges argued that paupers' dietary practices "very much contribute to that Disposition of Body as made the pestilential Taint more easily take Place." (20, 58-59) Such thinking was especially prominent during the panic of the early 1720s when plague ravaged Marseilles and threatened to make the short journey to Britain. It was even endorsed by physician Richard Mead, the leading authority on plague. Mead advised London officials to "immediately send skilful Physicians to Visit the Houses in the Neighbourhood, especially of the *Poorer* sort, among whom this Evil generally begins" (38).

Plague eventually receded as a focal point of concern, but that did little to diminish medical emphasis on the biohazard of poor bodies. By mid-century forms of fever presented the most frightening diseases linked to class, as Candace Ward's exploration of fever narratives in medical texts and novels shows (100-148). Although military physician John Pringle, the leading theorist on such fevers, wrote more than a century after Bradwell, his language was remarkably similar, suggesting that the narrative of the inherently putrid pauper was potently durable despite considerable theoretical developments within medicine:

[T]he internal predisposing cause, [is] namely a more than ordinary putrescent state of the blood [. . .] this disease *caeteris paribus* prevails mostly among such as are of a scorbutic (that is a putrid) habit, or among the poorer people, who from foul air, bad diet and nastiness are most liable to putrid diseases. (252)

When doctors like William Cullen warned that inadequate activity increased such putrescence they reiterated Bradwell's earlier warning about inadequate perspiration, a mainstream medical tenet by the mid-eighteenth century (Risse 150-156). The idea's popularity and longevity owes much to its value for narratives pathologizing idleness, the cardinal sin of the early modern poor. Moralists forever presented idleness as the root of poverty, disorder and sin (Beier 4-7, 38, 165; Pugliatti 55-63). Doctors' comments about perspiration thus augmented narratives found in fiction or texts on welfare and crime that highlighted the dangers of laziness – the most famous of which must certainly be William Hogarth's series of engravings *Industry and Idleness* (1747) depicting the lives of two apprentices: the industrious Francis Goodchild, who works hard and becomes the Lord Mayor of London, and the

lazy Tom Idle, who slides into crime and dies in a hangman's noose. Here the deeper cultural work of medical narratives becomes clearer, as medical theory becomes a vehicle for moral condemnation. The author of the *New Discovery of Plague* (1720) would seem to offer support to those theories of narrative that suggest that "narrators moralise the events they recount" (Mattingly and Garro 11). He attributed pathogenic predisposition to "careless, nasty idlers, who live always on the Fruits of Laziness, [and] the most loathsome Food" (*New Discovery* 27). Mead concurred, including "Beggars and Idle Persons" in his advice to keep the streets "clean from *Filth, Carrion* and all Manner of *Nuisances*" (43).

Nuisance diseases like skin infections are also instructive, not least because they presented major problems for children, as the next section discusses. The disease known as the Itch, for example was recognised as highly infectious, however, physicians like Thomas Spooner argued that, like plague or fever, it could also be generated anew by those with putrid blood. He drew on seventeenth-century medical luminary Thomas Willis who in 1684 had identified failure to perspire as one of its causes. Those "of a sedentary life" were prone to it because their humours were not properly "eventilated" and thus corrupted like swamp water. (156). An apothecary who quoted Willis added: "which is the true Reason, why the Poor are most obnoxious to Disasters of this Kind" (P. L. 26, 34). Physicians crafted outbreak narratives that share qualities with those described by Prescilla Wald about Typhoid Mary, in which infectious diseases spread frighteningly across class lines through vectors like domestic servants (68-113).³ Such anxiety was well captured in William Ellis' family health manual which recommended strip-search examinations of prospective employees to punctuate the narrative of a teenage servant who spread the Itch to respectable families:

At *Gaddesden* he lived about a month before he was found out, then discharged and went to another, and so on, till he thus mightily spread this horrid Disease in *Hertfordshire*, because they neither inquired his Character, nor search'd his Body; if they had done the last they had found his Legs grievously scabbed, for he kept the Itch out of his Hands by now and then anointing them. The Servant-maid was one that thus brought the Itch into my Family, for she was in as bad a Pickle as the Boy, having her Arms and Hands clear, but her Legs sadly scabbed. (262-63)

Ellis thus harnesses the threat of infection to concerns about the rootless and mobile working class, here portrayed as untrustworthy invaders corrupting the sacred family home. Like stories crafted about Typhoid Mary the following century, Ellis's tale plays on the hidden nature of contagion. The devious, nay sinister, quality of these servants lies in their attempts to deceive by anointing the visible parts of their bodies, their hands, so as to conceal their lesions. All the while underneath their clothing – and by extension in their blood – lurks disease. In Ellis' narrative the lesions take centre stage, as they would in coming decades throughout medicine more generally, which saw the rise of pathological anatomy, a medical vision centred on identifying disease by morbid structural change (Foucault). Ellis thus embodies nascently a Foucauldian gaze, one that demands lesions be discovered, or because he advocated strip-searches, in this case literally un-covered.

The constitutional nature of many ailments associated with poverty – the belief that they rooted themselves in the blood – meant that they had the potential to be passed hereditarily. This presented another way for diseases to be presented as lurking

within, and it marks a potentially major issue for thinking about poor children. Syphilis made the danger of congenital transmission obvious, but so too did other putrid diseases, such as scurvy, of which Charles II's physician Gideon Harvey proclaimed, "Infants oft bring [. . .] Scorbutick Seminaries with them into the world" (8). However, it was not just that a diseased mother could impart her ailment to her fetus, rather sickly parents could also bestow their *predisposition*. Children of sick parents might be born ill, but they also might be born with a lurking quality that could lead them to become ill at some later date. As early as 1669 Thomas Coxe described how the vices of parents could have longstanding health effects, asking rhetorically:

What is more frequent than for weakly diseased Parents to be further tormented by seeing their Children labour under the same Infirmities; which are either rivitted into the Principles of their Constitution, or sucked in with their milk: from which dispositions they are hardly, if ever freed [?]. (95-98)

Pathological predisposition could thus be fixed permanently: "rivitted" into the constitution from birth.

Eighteenth-century physicians like Richard Blackmore stressed the danger of such hereditary 'taints':

[T]he Internal or Cogenite Causes [of fever and plague] may be Interwoven and complicated with the material Principles of the Body at its first Formation, as the Seeds of many Distempers are [. . .] we may therefore conceive with Ease that sometimes the Principles of Malignant Fevers are combin'd and closely united with the Original Parts of the Blood, and are afterwards awaken'd, let loose and freed from their Imprisonment, by the Help of irregular Agitations and Conflicts, that arise in the Blood. (21-22)

Earlier narratives imagined filth or rotten food imprinting their malignant qualities on plebeian bodies. Here, however, parents' sins are visited upon their children, the elements of disease imagined as fusing with the basic building blocks of the child's body, in this case the blood. Using a metaphor drawn from the textile trades, Blackmore depicts disease "interwoven" into the child's elemental fabric. His narrative is actually a smorgasbord of mixed metaphors. Disease is woven like a fabric, but it is planted like a "seed." It slumbers until "awakened," while simultaneously incarcerated until freed from "imprisonment." The addition of hereditary principles represented a deeper way in which class, not unlike race, could be conceived in increasingly essential terms, rooted in the blood and passed on at birth. Yet, as scholars who have explored the history of heredity have argued such formulations did not yet express the hard hereditarian theories witnessed in the nineteenth century (Müller-Wille and Rheinberger). Biology was not yet destiny in this regard. Poor children might carry the taint of their parents, yet it might never ignite into disease. To use Blackmore's metaphors, the seed might never grow, the slumbering monster might never awaken, the prisoner might never break free.

Poor children thus had the potential to present quite dangerous bodies. Daniel Defoe's core strategy in his *Due Preparations for the Plague* (1722) – calling for the evacuation of London's pauper children – is telling in this regard. Defoe's *Journal of the Plague Year* was, of course, the better known work. Weaving together elements of

history, journalism and the novel it famously complicates genres and contains much rich material for the study of medical narratives. However, the *Due Preparations*, published within months of the *Journal*, assumes the more didactic tone of the physician's treatise, although Defoe was no doctor. Calling impoverished bodies "the Fuel which the Fire of the Pestilence generally Feeds upon" (22), Defoe argued that it logically followed to rid the city of them when plague threatened. Along with felons and pensioners, Defoe listed category after category of poor children who must leave: children in orphanages, hospitals, schools, as well as "all the Children of the Poor, as are not in Condition to maintain them" (19-22). Defoe's plan crafts an outbreak-narrative in advance. While plague threatened from Marseilles, he wrote two books: one (*The Journal*) a depiction of the worst-case scenario employing the literary conventions of fiction and history, the other (*The Due Preparations*) a strident warning of what must be done to prepare. In this latter work he itemised London's most dangerous bodies, and poor children dominated the list. Defoe summarised the advantages of his scheme:

Tho' there would still be many Thousands of Inhabitants left, yet they would live at large, be unincumber'd with Poor, and with Children, and with all the Stench and Filth that attend those who want Conveniencies, and who would in such a Calamity only serve to Infect one another, and strengthen the Contagion in general (23).

It is intriguing that while doctors could have followed Defoe in portraying poor children as health risks, they did so infrequently. One must consider the context of Defoe's text; written during an epidemic panic it seems that theories of the pathogenic plebeian body reached a logical conclusion and coloured the depiction of poor children. However, narratives written in other contexts and in different genres often did not follow suit. Moreover, because medical narratives on the putrid plebeian body frequently offered moralizing condemnations thinly masked in medical jargon, it was hardly straightforward to apply such claims to children who were not typically regarded as blameworthy and on whom responsibility for filth and disease was harder to pin. Finally, plague never came to London in 1722, so Defoe's children were, to a great extent, fictions. His plan never came to fruition and thus remained merely an apocalyptic figment of his famously creative imagination. People encountering poor children in the flesh often told different stories.

Sickness Narratives in Practice: London's Pauper Children

It is clear from the foregoing that medical narratives about poor bodies called on a range of reference points to explain sickness, from heredity, to environment, to inherent 'putridity.' The evidence suggested that there was potential space for the bodies of poor children in these models because of the possibility of inheriting tainted blood from parents. This section will test how far these theories were referenced by those actually dealing with the bodies of the young poor, in this case, metropolitan parish officers inspecting the care of their pauper children being nursed outside London.

This system of paid nursing was legally formalised in 1767 at the instigation of social reformer and philanthropist Jonas Hanway. The law (the Act for the Better Protection of Parish Poor Children, otherwise known as 'Hanway's Act') applied only to the parishes covered by the London Bills of Mortality, although some larger parishes lying outside its remit adopted its terms voluntarily. The plan was modelled

on the London Foundling Hospital's system and mandated that young children would be sent out for care and regularly inspected (Levene). Not all parishes were so assiduous in inspecting them – or at least keeping good records that they were doing so – but those that did leave a valuable record of the ways that childcare was being managed, including episodes of sickness. And while they do not offer either patient-narratives in their purest form, in that they were not created by the children themselves, or the more classic form of narrative which is mediated by the practitioner, what they do provide is something quite new and quite different from the perspective typically found in doctors' published treatises.⁴ Thus they broaden the historical perspective on children, poverty and illness by allowing a different set of voices to speak.

The reasons that this system were put in place reveal quite a different set of concerns than those voiced by the doctors cited above, and provide a potentially competing framework for understanding what the bodies of pauper children represented for the authorities. The primary impetus came from empirical studies of infant mortality in London workhouses carried out by Jonas Hanway in the early 1760s. These had revealed appallingly high death rates of infants who were basically left to languish without proper care. Hanway was also an active governor at the London Foundling Hospital and so he naturally turned to the system of paid nursing in the countryside which had been used successfully there. However, Hanway's interest formed part of a wider focus on the strength of the nation which came about because of fears of population decline and the quantification of national productivity; a model in which the physical well-being of the working classes was particularly prized. Children's bodies were particularly important to this vision of national strength as they carried the potential for future greatness. Early death, and perhaps to an even greater degree, chronic and constitutional sickness, represented a national drain, especially considering the monies invested in pauper children by the parish. Many of the well-known pamphleteers of the second half of the century, including Hanway, Jeremy Bentham and Frederic Morton Eden, quantified the cost to the nation of every working class child whose adult labour was lost through early death. In Hanway's words the poor rates were thus "the instruments of preserving a vast number of subjects, particularly children, who are so much more valuable than the aged" (3). In these narratives poor children were framed not as public health risks but as vital national resources. The increased interest in doctoring and health was thus matched with a focus on economic value, profit and loss, which made the vitality of the young poor particularly potent.

The rest of this section will consider how far the sorts of narratives identified in the medical discourses were played out in the care and treatment of metropolitan pauper children. In particular, it will suggest that the poor law officers concerned with the daily treatment of child paupers crafted narratives in which pragmatic concerns outweighed more theoretical ideas about heritability of disease or constitution, and that where heredity was a factor, it was more commonly linked to moral behaviour than disease. However, the intentions of the 1767 Act can also be read as an attempt to divorce children from the physical and familial environment in which they had been born, and this provides an important part of the framework for thinking about disease among the poor.

The new system of nursing for London's pauper children affected from tens to hundreds of children every year across almost every parish in London. We are fortunate that several parishes set up committees of 'Guardians of the Infant Poor' in the wake of the 1767 Act to inspect their nurse-children, and their minutes contain

material which reveal the ways that the bodies of pauper children were being described and narrated. While they do not record the words or actions of the children themselves (this would be highly unusual for this period) they are highly revealing of narratives about sickness, robustness and poverty from the perspective of their caregivers and their supervisors. And while the regularity and comprehensiveness of inspections varied considerably, from regular visits out to the country parishes to a note of reports sent in from local representatives, there was a fair amount of consistency in what matters were deemed worthy of notice: most commonly, health, diet, clothing, the cleanliness of the children and the nurses' homes, and education. Together these provide a framework for thinking about the ways that narratives on pauper health were being created. The most high profile themes will be discussed in turn.

Consider culpability. We have seen that paupers attracted some degree of blame for their poor health in the medical literature, for example, by awakening a tendency to putridity and disease via poor diet or immorality. This is never seen in the documents on pauper children; instead if culpability is attributed anywhere it is to the nurse. For example, the St Botolph Aldgate Guardians recorded in February 1806 that they were dissatisfied with Mrs Hannah Meredith – who was caring for seven parish children – because she was “very dirty in her person and [that] her house [was] so filthy as makes it necessary that she should have a severe reprimand.” Things were deemed to be much improved on their next visit. However, on this occasion another nurse, Ann Hart, was singled out for blame, this time connected to a child's illness: “her beds very dirty and bad, her cupboard not sweet, children cloaths in bad Condition, and the Children dirty and Indisposed with the Itch” (St Botolph Aldgate Guardians' Visiting Book 4 February 1806 and 16 June 1806). That ill-health is here being so firmly connected with poor conditions and dirt, and that the nurse is blamed for the children's indisposition, suggests that the children themselves were not thought to be harbouring the predisposition – even for the ‘itch’ which featured prominently in medical narratives about the pauper body. It is of course worth pointing out that inspectors' reports represent a kind of official narrative, one that leaves no room for possible counter narratives, like, for example, ones by the nurses themselves. There is tantalizingly little known about the status and conditions of these women, but nursing for the parish *was not* a sought-after employment compared with childcare for private families. It is likely that they were not particularly well off, though that is not to say that their homes and housekeeping were substandard. Certainly the cases of poor conditions were reported as anomalous.

The culpability of nurses in spreading diseases had a long pedigree. Doctors had long recommended that parents take especial note of the health, physical robustness and character of potential wet-nurses lest they corrupt or infect their charges. The stress on inspection under Hanway's 1767 Act was specifically intended to banish the “indigent, filthy, or decrepit women” who had acted as parish nurses previously, who scrimped on provisions because they were paid so poorly, and whose neglect and ill treatment of their charges led to “the *State* [being] wounded in its *vital* parts” (Hanway, 43). Another commentator, Lewis Mansey made this link even clearer in his work *The Practical Physician* (1800):

It is no wonder [. . .] that infants are often affected with ulcers, the itch, scald heads and other cutaneous disorders, by nurses whose diet is irregular; or, if the nurses are afflicted with the venereal disease, that the children

contract the same; or are contaminated with pustles and eruptions, and a thousand other infirmities. (405)

This sounds very much like the mistrustfulness of the bodies of the poor drawn out in the previous section – but also by implication a *lack* of such preconceptions attached to the pauper children. Indeed, when Hanway reflected on the spread of diseases including the itch in the workhouse serving St. George's Middlesex, he crafted a narrative that makes it impossible to see the children as responsible in any way. They can only be victims when he says: "It is true that man hath but a short time to live and is cut down like a flower; but these poor infants were mowed down like grass" (42). Moreover, the reporting of infectious skin conditions is often very matter of fact about their ubiquity among children and there is no suggestion that there is a moral judgement being attached to their appearance beyond that attributed to some of the nurses. As Spooner, wrote in his *A Short Account of the Itch: the Itch is communicated [. . .] by means of lying in strange Beds, by Children of different families playing together, or by Servant Maids or Nurses &c. that have had this loathsome Disease, and come into Families before they are perfectly cured of it*" (3-4). Here, one pathway for contagion is presented as a natural, and therefore innocent, part of childhood; notably it is maids and nurses who are singled out as possible vectors.

However, in other cases, nurses were praised for their care of young children in sickness. After all, inspectors were concerned to police parish employees. Thus narratives admonishing faulty nurses sat aside others that recognised excellent care. Mrs Page, for example, the nurse of six parish children from St Dunstan in the West, was given 2s6d and 1s for her servant at one visit "from a Motive that she had taken Care of the Children and would continue to do so [. . .] the most part having been down with the Hooping Cough" (St Dunstan in the West Committee of the Guardians of Poor Children 10 July 1793). Here children's illness is framed not as the nurse's fault, but as a factor rendering her work more difficult and therefore laudatory. Even when one of the children died, the apothecary reported that nothing more could have been done. The London Foundling Hospital provides similar reports. One inspector reported to the hospital in 1759 that:

Ann Rosewell [a nurse] has had the misfortune of losing her last Child soon after she brought it home; it was so ill when given her that every body expected it wou'd have dy'd upon the Road [. . .] She really is a good nurse, & will do justice by the Children, the Hospital entrusts her wth, she was very much dispirited wth losing the Child so soon, but hopes the Governors wont have a bad Opinion of her as it was so ill when deliver'd to her, & if they'll be good as to let her have another, she'll take all the Care imaginable of it. (Foundling Hospital Correspondence 23 April 1759)

Here the inspector's narrative employs the nurse's emotional state – her sadness at the child's death – to evoke quasi-maternal qualities, in an effort to convince that she continue to be entrusted with surrogate motherly duties in the future. The child's illness (mentioned twice) serves not to warn about contagion but to exonerate the nurse of any guilt, employing the narrative structure of the hopeless case; nothing could be done. As a story, it is a tragedy, but one in which there can be no blame.

Even when children carried disease into nurses' households it was often not the nature of their bodies which was discussed. Rather, parish officers accepted

responsibility (probably because keeping the nurses' confidence was so important for the functioning of the system), and characterised the children's illness as a ubiquitous part of youth. St Sepulchre Holborn ordered that no children be sent out to nurses in December 1771 "in Consideration that the Small-pox now Rages in the Workhouse," for example (St Sepulchre Holborn Minutes of the Meetings of the Guardians of the Parish Poor 20 Dec. 1771). Instead of putridity or heredity, therefore, parish officers more often called on the natural age-distribution of disease as an explanation for sickness. When Hanway addressed the issue he actually employed the medical language of heredity, warning overseers to be on the lookout for children with "venereal taints" who might infect nurses. However, he immediately downplays the risk, assuring them this "but very rarely happens" and notes that screening the infants would give parish officials "a title to examine also into the state of the health of nurses, that no child be hurt by any of *them*, which is by far the more probable case" (66). It is perhaps not surprising that parish officials did not debate the origins of ill-health in their charges in the way that doctors did given their quite different backgrounds, but there is no evidence that they dwelt on causes beyond occasional references to cleansing workhouses and isolating infectious cases. These men were much more concerned to treat disease when it appeared than to worry about possible hereditary taints. Perhaps by these later decades of the century and after the publication of many works on fevers in gaols, ships and prisons, the tendency for poor bodies to breed disease was simply accepted. The very ubiquity of transmission between children, however, suggests that physical contact did form a part of this narrative.

There is just one comment in the surviving records which suggests another framework for explaining disease in children, and this can also be connected to age rather than class: humoural theory. It was reported in the context of the discovery by visitors from St Dunstan in the West parish that many of their children had "scabby heads." They were interrupted in mid-lecture to the nurses by the local apothecary, who explained "that it did not arise for want of attention of Cleanliness but from Humours in the Blood to which Children of that Age were often very Subject" (St Dunstan in the West Committee of the Guardians of Poor Children 30 Sept. 1803). Humoural predisposition in children has recently received detailed attention by Hannah Newton, who points out how live a narrative it continued to be well into the early modern period, and how overarching a framework for the explanation of disease in children (31-62). This, then, could be a different form of predisposition to that outlined in the earlier section, but, tellingly, one which had little reference to class. Once again, children seem to have remained relatively free from the notion that they were responsible for their own health as far as discussions by officers 'on the ground' were concerned, and those officers crafted their narratives in ways geared towards stressing this point.

This finding can be linked to a lack of culpability attached to children generally within the context of discussions on poverty. The poor laws, which originated in the Tudor period, did have a firm emphasis on self-responsibility, but this was attached to able-bodied adults. The sick, the elderly and the young were all members of the "deserving poor," the validity of whose relief was much less problematic (Lees 52-60). The situation for children was complicated by the feeling that some adults bred fecklessly and so large families could in themselves be signals of moral taint. However, blame fell squarely on the parents rather than the children.

The environment of the nurses' homes also clearly informed views of disease among pauper children, as several foregoing quotations have shown. This was

generally connected with dirty conditions and poor housekeeping rather than the sort of crowding and lack of sanitation implied in the medical literature. Again, this implies that a key element in the narratives about adult pauper disease – personal cleanliness – was not applicable to the young because they controlled neither the frequency of their washing nor their surroundings. However, this contrast raises an alternative view of environment which may be much more significant in the current case: the difference between London and the countryside.

The basic premise behind the move towards country nursing was that London was a poor environment for children, and especially so its workhouses which brought poor nursing care and a high risk of infection. While do not know whether a similar view was taken of the homes of the poor, certainly some medical treatises of the sort examined earlier cast them in a dangerous light. Consider bestselling physician William Buchan's narrative comparing working class homes to filthy prisons:

Nor are many of the holes, for we cannot call them houses, possessed by the poor in great towns much better than gaols. These low dirty habitations are the very lurking places of bad air and contagious diseases. Such as live in them seldom enjoy good health; and their children commonly die young. (58)

Nonetheless, the intentions behind the 1767 Act set the countryside up as a healthier place for the young than the capital; therefore the nurses' homes by definition offered a more benign environment for them. Like Defoe before him, Hanway (and also the London Foundling Hospital) made distinctions between the distances that different groups of children should be sent from London (babies and those without mothers should go the furthest), and later surveyed mortality among nurse children sent to different communities. (25-39, 78, 99-100) However, unlike Defoe, this seems to have been straightforwardly intended for the benefit of the children, rather than for the protection of Londoners. By the end of the century some of the larger parishes were operating houses in the countryside for their pauper children, which could be viewed within the same paradigm of confinement as was used for the mad and the refractory poor. However, in this case, there is little to suggest a reformatory role beyond a possible desire to remove them from their parents (Levene 91-106). In fact, it may say more about the logistics of childcare on a large scale than about either contagion or the transmission of moral values.

The question of heredity and family connections is the last of the major themes in the medical narratives about pauper bodies. Again, it remained unmentioned on by parish officers, but that is not to say that it was unimportant. The risk of contagion posed by families struck by infection was certainly a live issue: the records for several provincial infirmaries show parishes sending whole families with the Itch, for example (Levene et al.). Even closer connections were made in the case of venereal diseases, which were known to be transmitted *in utero*. One of the most pressing concerns about this group of diseases was the possibility for a husband to infect an innocent wife and children (Dunlap, Stewart); another pathway of concern was the transmission between nurses and infants, as Hanway's earlier comments showed.

In a wider sense, however, heredity was important for parish officers, but in quite a different way from that imagined by medical authors. Writers on poverty and the poor law instead focused on the transmission of moral habits from parents to children, and the danger of poverty becoming inherited by the observation of bad behavior. This was one reason why poor children were seen to be worth investing in:

if they could be educated in better ways they could be kept from falling on the poor rates later, and perhaps even act as a conduit for these teachings to travel back to their families. The short-lived Dispensary for the Infant Poor set up in the 1760s which apparently served many thousands of families also hoped that their teachings on childcare would improve the health of the whole family (Levene 143-4).

This aspect of heredity shares characteristics with the medical one: both had a moral aspect as well as a physical one, and both allowed for moral outlook to have an impact on the health and constitution. Lewis Mansey, quoted earlier warning about nurses infecting children, expressed a parallel concern about the nurse's moral impact, exemplifying the interconnected anxieties about physical and moral forms of contagion:

And since not only defects of the body, but of the mind also, are communicated by the depraved milk, it is certainly not uncommon for children, born of the best parents, sometimes to be corrupted with the worst morals. Thus I have known infants rendered drunkards, by sucking the milk of a nurse addicted to drinking. (405)

Parish officers did not overtly comment on either, but in the context of pressing financial concerns and the need to prioritise certain groups of the poor on the basis of need and likely chances of independence, it is likely that moral taint was more important than a latent medical or constitutional one. However, parish officers did not often enforce a separation between children and parents, implying that in neither case of heredity – moral nor physical – did this concern over-ride the natural rights of the family (or perhaps, the convenience of parents continuing to provide care). Parents were often able to get their children back after relatively short stays with nurses, and could usually choose to remain together even if this meant both leaving the workhouse. This was true even in cases where the parent's moral character was in some doubt, for example, in cases of drunkenness, homelessness or perceived fecklessness. While theories about class and predisposition may have played an important role in hardening theories of heredity in the nineteenth century, in the shorter term they seem to have had less influence on the actions of poor law authorities charged with the immediate material concerns of caring for sick children.

Conclusions

This article has shown both the fluidity of co-existing theories of disease among the poor, and a demarcation between the ways that this was projected onto the bodies of children and adults. In the case of pauper children these narratives largely failed to compete with pragmatic concerns about survival, and a much longer-held set of reference points about the deserving nature of poverty in childhood. While the bodies of adult paupers were worrying in general, those of children were viewed in quite a different context. There might have been more cross-over in ideas had there been more medical interest in the children of the poor: the published work on child health focused mainly on the higher echelons of society: although some authors who had experienced practice in hospitals and charities made passing reference to poor children, it was generally in the context of their *greater* physical robustness (see: Cadogan; Buchan). It was not until the final decades of the century that medical men started to observe the health of poor children in greater numbers, or visit their homes.

The primary narratives of ill-health used by doctors are therefore not reproduced in the documents generated by the inspectors of pauper children in the

second half of the eighteenth century. Much of this is probably due to the different nature of the sources: the Guardians of Poor Children were rarely medical men, and their minutes were not constructed as reflective documents. Their concerns included finances, logistics, and even discipline. The problem of sick or potentially sick pauper children loomed large, but when they wrote parish officials were less likely to present such children as inherently contagious threats. Their narratives emphasised the value of protecting a valuable resource or else presented children as victims in order to admonish bad parents or nurses. One has to rely on actions to reveal intentions in a way which they do not with the medical sources. However, what these sources do show us is whether and how medical discourses were put into practice. What the practice suggests is that parish officers were very much concerned with simply dealing with ill-health, and that the ubiquity of contagion and infectious disease among children was a much more pressing and valid framework for explanation than taint, environment or behaviour. The types of ill health that they saw most frequently were not the fevers which so exercised medical authors, but instead the Itch, scabby heads, and diseases like smallpox, whooping cough and measles. For these, they had a much readier explanation to hand: the vulnerability of young children to diseases transmitted by contact. Furthermore, many of the alternative explanations called upon in the medical texts: personal behaviour, diet and cleanliness, were not applicable to children, either for practical reasons, or because they did not fit with the on-going model of the causes of pauperism. Children were simply not culpable for their condition in the same way that adults were. This is proven further in the fact that the only people held up for blame for the children's sickness were their adult caregivers.

The differences found between medical theory and the writings of welfare agents concern not just content but form as well. Physicians staring down the frightening spectre of epidemics were primarily concerned to identify, and thereby police, public health risks. They crafted their narratives accordingly, whether in case studies that take the form of the outbreak narrative or metaphorically rich theories that allowed them to speculate about what went transpired in the arteries and veins of the paupers who died by the thousands in epidemics. For these writers cause, and therefore culpability, was paramount. The high levels of mortality among paupers and children led Defoe to take this to a natural conclusion, metaphorically likening poor children's bodies to fuel for a fire, and calmly calling for their expulsion from the city in the name of public safety. Parish officials or children's advocates like Hanway, however, took an altogether different tack. Faced not with hypothetical tragedy, as Defoe was (for plague never came), but with the all too real tragedy of dead infants, they seem virtually incapable of seeing pauper children as culpable and yet they were simultaneously determined to pin blame somewhere. They structured their narratives to convey these impressions. This tendency may find one of its clearest expressions in the work of pauper children's great eighteenth-century champion, Jonas Hanway, in his *Earnest Appeal*. While he structured numerous arguments differently throughout the book, his most powerful strategy was to deploy a rhetorical technology that was becoming ever more common in enlightenment social science: the numerical chart. Page after page contain ledger lines and numbers conveying horrendous mortality rates. Comprised mainly of numerals rather than words, it is tempting to view them as the opposite of a narrative, even a kind of anti-narrative. However, this would be most misguided, for these charts tell stories, too. It is in Hanway's tables that his argument is made most forcefully. Reading them as narratives is potentially revealing for they express in dramatic terms what parochial inspectors' narratives also tried to convey. Pauper children, expressed here only as numbers, can bear no responsibility. They

cannot infect. They cannot transgress. They cannot act, immorally or otherwise. They can merely die, in some cases by the thousands. This very different form of storytelling leaves pauper children but one role, that of innocent victims, while it simultaneously cries out for blame to be placed, elsewhere.

Notes

1. This is a similar approach to that taken implicitly in Levene's collection of narratives from the London Foundling Hospital (which itself forms part of a wave of interest in plebeian autobiographical writing), but here is enriched by combination with doctors' voices and those of writers and parish officers.

2. Exceptions include those works exploring ailments of high society. See for example, Porter and Rousseau; Beatty.

3. 'Typhoid' Mary Mallon has become an ubiquitous public health story of the hazards of the asymptomatic disease vector. She infected dozens of people she encountered in her work as a domestic servant in the early years of the twentieth century (see Wald).

4. For a thoughtful critique of the different notions of patients and their histories and narratives see Condrau.

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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 halloo 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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Rethinking "Patient Testimony" in the Medical Humanities: The Case of *Schizophrenia Bulletin's* First Person Accounts

Angela Woods

Illness narratives are the object *par excellence* of classical medical humanities enquiry. Thanks in part to the wider 'narrative turn' in the humanities and social science (Bamberg), interest in narratives of/and illness has been growing steadily across a number of fields (Woods, "The Limits of Narrative"), including medical anthropology (Mattingly and Garro; Littlewood), medical sociology (Frank, *The Wounded Storyteller*; Atkinson "Illness Narratives Revisited"), and the philosophy of psychiatry (Fulford et al.). While the medical humanities draw energy and insight from this work, they are perhaps distinctive in bringing social-scientific and literary-philosophical approaches if not together then at least into conversation. Medical humanities researchers with training in the social sciences typically view illness narratives as data to be solicited through interviews and then transcribed, 'coded' and analysed using rigorous methodologies, many of which are aided by sophisticated computer programmes. As the field widens to include work that is more critically and politically engaged (Atkinson et al.; B. E. Lewis), temporal and spatial situatedness, and the complex interplay between 'individual' and 'collective' narratives of illness (Atkinson and Rubinelli), are also coming into focus. A second stream of medical humanities researchers trained in literary and cultural studies approach the study of illness narrative from a different perspective and so with different tools. Here, textual and intertextual, aesthetic and historical detail come sharply into focus, with close-readings of lengthy and polished autobiographical, biographical and fictional accounts of illness teasing out the complexities of these projected worlds (Belling; Ingram et al). Where these divergent approaches to illness narrative might otherwise remain largely indifferent to each other's existence, their intersection in the field of medical humanities affirms shared interests in treating the messy and complex subjective experience of illness as something distinct from the biological functioning of disease, and so in ensuring that these experiences and the ways we come to communicate them are given the recognition they deserve.

Mental illness and distress present a particular set of complications for medical humanities work on illness narrative (Woods, "Beyond the Wounded Storyteller"), and nowhere is this more obvious than in the case of schizophrenia. Schizophrenia names some of the most profound transformations in human experience (Sass, "Self and World in Schizophrenia"; Kean, "Silencing the Self") even if its status as illness, disease, disability or diagnostic label is still strenuously debated.¹ The constellation of schizophrenic symptoms includes experiences of depersonalization and derealisation, hallucinations and delusions, and disorders in the realms of perception, sensation, cognition and emotion. Schizophrenia affects at least one per cent of the global population (Metzl x-xi, 187-8), and yet with the exception of a handful of much-celebrated autobiographies (Schreber; Renee; Greenberg; Saks), narratives of schizophrenia are conspicuous by their absence from public discourse. One explanation for this is that schizophrenia has been construed as eliding, resisting, or opposing narrative. The idea that schizophrenia is somehow 'anti'-narrative has developed across five domains: (i) in psychiatry, where the concept of schizophrenia is, as Barrett has argued, profoundly associated with dementia, degeneration and

deterioration, states from which no coherent storytelling or meaning making is considered possible (Barrett, "Degeneration"; "Disintegration and Division"); (ii) in neuropsychology, through studies investigating schizophrenia's assault on the cognitive and affective underpinnings of narrative capacity (Gallagher; Gruber and Kring);² (iii) in the philosophy of psychopathology, particularly in work focussing on the breakdown in narrative identity and the dialogical self (Lysaker and Lysaker; Phillips; Thomas; Mackenzie and Poltera); (iv) in an aesthetic realm, where the 'mad narratives' or anti-narratives of schizophrenia have been celebrated for their failure to conform to the humanist conventions of either nineteenth-century realism or literary autobiography (Sass *Madness and Modernism*); and (v) in the socio-political domain, wherein stigma and outright discrimination have been seen to muffle if not completely silence those with stories of schizophrenia. With this in mind, the analysis of schizophrenia narratives – whatever these might be – acquires some urgency as a medical humanities undertaking, especially if the field is to break new ground in achieving the moral and political objectives of bringing first-person perspectives of health and illness to the fore.

Such an undertaking is, however, fraught with difficulties, especially for the researcher who refuses to regard narratives as mere objects of analysis. Where, then, to begin? This article addresses arguably the most prominent – if still desperately under-researched – archive of schizophrenia narratives: the "First Person Accounts" of *Schizophrenia Bulletin*. *Schizophrenia Bulletin* was founded by psychiatrist Loren Mosher – then chief of the US National Institute of Mental Health (NIMH) Centre for Schizophrenia Studies – in 1969. Today, it is one of the highest ranked academic journals publishing scientific research on psychosis. Interdisciplinary by necessity, the journal sees itself as engaged in acts of translation across the psychiatric field, bringing neuroscientists, clinicians, psychologists and geneticists into dialogue. In 1979, ten years after its launch, *Schizophrenia Bulletin* started to include among its experts people with a subjective experience of schizophrenia, publishing short pieces with the twin aims of deepening researchers' insights into "the issues and difficulties confronted by consumers of mental health care," and responding to "a continuing need for experiences to be shared among mental health professionals, families, and current and former patients" (qtd. in DuVal 631). Of the 119 First Person Accounts published over the last thirty three years, close to three quarters were written by ex/patients, the remainder by family members; twice as many authors identified themselves as women compared to men;³ seventeen people chose to publish anonymously; two withdrew their accounts following publication; and almost one quarter of authors worked or had worked in some aspect of mental health services.

This article does not offer the kind of in-depth textual reading of these accounts befitting of a more conventional literary inquiry, nor will it undertake a comprehensive 'coding' of these narratives to identify their key themes and variations. Indeed, what follows is less directed towards content than towards the enterprise of analysis itself; the question posed is deceptively simple, but no less urgent for being so. It is: how should these First Person Accounts be read? The normative thrust of this question is of particular interest when writing for and from a field which includes on the one hand those with a strong investment in positively influencing the practice of healthcare, and those who on the other have debated questions of reception, reader response, and authorial authority for over half a century. "By whom? In what context? And for what purpose?" are questions that must also be asked. With the overall aim of laying the conceptual groundwork for future academic analyses of this archive, this article proceeds through three linked discussions. Part

one addresses the paratextual dimensions of the First Person Accounts and the editorial policies shaping their publication. Part two explores the nature of the contract implied between author and reader in what I call a 'genre of insight.' After a narrative interlude, the final section of this article presents four possible models or modes of reading the First Person Accounts and asks what consequences and commitments arise from their adoption.

I. Paratext and Policies

Medical anthropologist Sue Estroff's "Subject/Subjectivities in Dispute: The Poetics, Politics, and Performance of First-Person Narratives of People with Schizophrenia" is one of very few articles to address the *Schizophrenia Bulletin* archive explicitly (see also: Geanellos; Hayne and Yonge). Considering a range of sources, including personal correspondence challenging the legitimacy of her research, Estroff argues that more must be done to do due diligence to the qualitative data generated by "consumers/survivors/ex-patients" in order to overcome issues of invisibility, invalidation, and incompatibility (Estroff 283). This is an important and commendable goal and Estroff's call for more research in this area should certainly be supported, provided that one widespread assumption is overcome. This is the idea, articulated most clearly in the work of Yvonne Hayne and Olive Yonge, that published first-hand accounts provide "the mechanism for *direct access* in coming to know the life of persons, their circumstances, and the meanings they associate with a life of persistent and enduring mental illness" (Hayne and Yonge 314) [my emphasis]. Such views are alarmingly common across the medical humanities, where there is a tendency to bracket literary studies' sophisticated accounts of the nature of representation and textual production, while at the same time ignoring warnings by sociologists that "We sell short ourselves and the possibility of systematic social analysis if we implicitly assume that autobiographical accounts or narratives of personal experience grant us untrammelled access to a realm of hyperauthenticity" (Atkinson, "Narrative Turn or Blind Alley?" 341). A more sophisticated approach to the study of illness narrative would see the critical convergence and mutual invigoration of social-scientific and literary perspectives, taking as its point of departure the idea that there is nothing natural or self-evident about narrative. In the case of the published narratives in *Schizophrenia Bulletin*'s First Person Accounts, such an approach would also entail paying close attention to the textuality of the text – its status as writing, published in a specific format, for a specific readership.

The paratext, in the now classic formulation of Gérard Genette, consists of all those textual and material elements which frame a literary text. From the title of a work to its typography, from the author's name to the accompanying information about the series to which the work belongs: the paratext exists, in the words of Philippe Lejeune as "the fringe of the printed text which, in reality, controls the whole reading" (qtd. in Genette 2) Attending to the paratext of *Schizophrenia Bulletin*'s First Person Accounts prompts recognition of what makes this collection of illness narratives so distinctive, namely, the scholarly context in which it appears. If typographically, these short prose pieces of between two and five pages are indistinguishable from the research articles they accompany, a close inspection of other elements of the paratext shows that they have been used to establish and police a distinction between 'subjective' and 'scientific' accounts of schizophrenia.

The series was launched in 1979 with the following editorial statement, printed in bold at the beginning of a piece entitled "First Person Account: Giving Love...and Schizophrenia":

The article that begins below is the first in a series of personal accounts to be published in the *Schizophrenia Bulletin*. We hope that mental health professionals – the *Bulletin's* primary audience – will take this opportunity to learn about the issues and difficulties confronted by consumers of mental health care. In addition, we hope that these accounts will give patients and families a better sense of not being alone in confronting the problems that can be anticipated by persons with serious emotional difficulties. Although there are a number of books and articles describing the personal experiences of patients and families with mental disorder, we believe there is a continuing need for experiences to be shared among mental health professionals, families, and current and former patients.

We welcome other contributions from patients, ex-patients, or family members. Our major editorial requirement is that such contributions be clearly written and organised and that a novel or unique aspect of schizophrenia be described, with special emphasis on points that will be important for professionals. Clinicians who see articulate patients, with experiences they believe should be shared, might encourage these patients to submit their articles to the *Bulletin's* new section, First Person Accounts.—The Editors. (qtd. in DuVal 631)

These two paragraphs create a discursive space which had not previously existed in mainstream clinical literature, a space which seeks explicitly to bring together two distinct sets of interests (the education of clinicians in “the issues and difficulties confronted by consumers of mental health care” and the provision of support to persons all too familiar with such issues). Particularly striking is the insistence upon clarity, originality and clinically relevant ‘take-home’ messages. This is at once an invitation for future contributors to adopt a style congruent with the conventions of academic writing, and, as this article goes on to discuss, a caution against the submission of anything which could be classed as ‘mad’ writing.

Reproduced with only minimal amendments until it was condensed into a single paragraph, the editorial introduction was for twenty-five years a consistent feature of the series and, alongside the naming of the narratives as such, the clearest paratextual assertion of the singular status of the First Person Account within a scholarly context. Explanatory notes on authorship also play their role during this period. In some cases, these short biographies depart from academic conventions by asserting the credentials of the author-as-life-writer alongside those of the author-as-mental-health-expert:

Barbara A. Turner is the single parent of three boys. She has worked with others with mental illness since 1984 and is currently with Places for People in St. Louis, MO. She has written several articles about her views and experiences as a person with schizophrenia and as a mental health professional. (Turner 650)

In others, degrees of anonymity are preserved (as when the author is to be contacted care of their psychiatrist (O'Neal)), and defended:

Author's note: After careful consideration, I have decided to publish this article anonymously, in the hope that by doing so, I will protect my family, my friends, and myself from any further embarrassment and discrimination. Protection against stigmatization is needed because our society does not feel "safe" for those of us who have been hospitalised for mental illness. As a former patient and employee of the National Institute of Mental Health, I am hopeful that this article will serve as a catalyst for needed change. ("First Person Account: Life after the Funny Farm" 544)

The paratext in all these instances makes authorship conspicuous, one might even say 'personal'; it is a frame which serves to assert a kind of authenticity distinct from that implied by the titles and institutional affiliations of the scientific contributors.

In 2005, Oxford University Press took over the publication of *Schizophrenia Bulletin* from the National Institute of Mental Health (NIMH) and all this changed. Gone was the editorial introduction, the notes on authorship and the inclusion of "First Person Account" in the title. Once located at the very back of the journal, as though an afterthought, or curiosity, the series now introduces the substantive matter of each issue. Genette writes that

Although we do not always know whether these [paratextual] productions are to be regarded as belonging to the text, in any case they surround and extend it, precisely in order to *present* it, in the usual sense of the verb but also in its strongest sense: to *make present*, to ensure the text's presence in the world, its "reception" and consumption. (1)

In the absence of any further editorial policy pertaining to the series,⁴ how are changes in the paratext of *Schizophrenia Bulletin*'s First Person Account – changes in the way that narratives of illness and recovery are 'made present' to the journal's readership – to be interpreted? Have the views and values expressed in the initial editorial statement become so unremarkable that no further rationale is required, or would it be more accurate to say that far from being absent or invisible, they are present, still, in shaping contours of an emerging genre?

II. Genre, Authority and Insight

The call to consider genre here goes beyond the cataloguing of sub-types of First Person Account. Certainly it is possible to distinguish, for example, life-narratives emphasising recovery and deliverance from psychosis; second-person accounts written by family members; philosophical investigations of "The Paradox of the Self and Suicidal Behaviour in Psychosis" (Kean, "Battling with the Life Instinct"); and policy-focussed pieces recommending "Best Practice in Access to Maternity and Mental Health Services" (Fox). Such taxonomic endeavours would also be useful when it comes to identifying what does *not* appear in this series so far (some obvious examples include the experiences of people who do not speak English, or who were diagnosed in a forensic context). However, accepting that the portrait of schizophrenia produced by these narratives will be neither comprehensive nor representative, it seems more pressing to understand the continuities between these accounts within the context of *Schizophrenia Bulletin* than it does to advance yet another general typology of illness narrative (Hawkins; Hanninen and Koski-Jannes; Frank "Reclaiming an Orphan Genre") or to add to the fifty-two genres of life writing (Smith and Watson).

Genre is best thought of not as fixed or static lists of properties but rather as a dynamic structure of intelligibility, one that encompasses the paratextual elements already described. For literary and cultural theorist John Frow, genre "is neither a property of (and located 'in') texts, nor a projection of (and located 'in') readers; it exists as a part of the relationship between texts and readers" as a "shared convention with a social force" (102). Genre constrains, structures and shapes meaning and value, it projects a particular kind of world, and, perhaps most importantly, it produces specific effects of truth and authority (73).

One of the key organising dimensions of genre in Frow's account is the "structured situation of address" between author and reader, a structure that refers to the power relations between speakers as well as the effects of "credibility, authority, and emotional tone" created by these relations (75). *Schizophrenia Bulletin's* First Person Accounts are in this respect marked by structural asymmetry: authors who have suffered mental distress, whether their own or their family member's, are writing primarily for clinical readers, addressing them as professional experts with the power to make decisions about people whose experience it is presumed they do not personally share.⁵ If all first-person or 'confessional' writing makes claims, implicit and explicit, to tell the truth, here the readers' clinical and scholarly authority carries an additional and distinctive weight. Some authors negotiate this by drawing on the rhetorical structures of academic argument: addressing psychiatrists and mental health policy makers directly, using sub-headings to introduce successive issues, backing up key points with examples from their own experience, and citing relevant sources (see ("Why Having a Mental Illness Is Not Like Having Diabetes"; Bockes; Gray). But even where authors make no use of such conventions, the speaking position or narrative voice of the First Person Accounts establishes a very particular kind of credibility: that of "insight."

When it is used in clinical contexts, the concept of insight has five clearly related dimensions: "the patient's awareness of mental disorder, awareness of the social consequences of disorder, awareness of the need for treatment, awareness of symptoms and attribution of symptoms to disorder" (Mintz, Dobson and Romney, 75). In mainstream psychiatry, schizophrenia is strongly associated with a *lack* of insight, a failure to recognise that one is ill and in need of medical care that is regarded as itself symptomatic of the condition. Insight is an ambiguous, highly-charged and frequently contested concept (Amador and David) and there are many who worry that "insight" in practice means "possessing and accepting psychiatric knowledge" while displaying "unquestioning acceptance and trust in whatever treatment the doctor deems fit to administer" (Galasinski and Opalinski 1460). Possessing insight can require both a "giving up" and a "giving in to":

The goal of my treatment seems to be the eradication of my meanings and the acceptance of my society's. I am supposed to learn "insight." Medication is supposed to suppress my Deep Meaning and replace it with saneness. (Hawkes 1109)

Insight is something that authors of the First Person Accounts discuss, as in the passage just quoted, but at a deeper level it is also performed across all dimensions of this genre, establishing continuity not only between first and second-person reports, but between these accounts and the clinical and scientific research of *Schizophrenia Bulletin*.⁶ Schizophrenia can be associated with very real *changes* to people's experience of time, of space, of their own bodies and relations with other people, and

the representation of these experiences within these narratives seems carefully controlled. The temporality of the First Person Accounts establishes a narrative present separated, if not quarantined, from the distressing, unstable, "symptomatic" past; the enunciative position emphasises clarity and consistency of communication; the projected world is one recognisable to anyone familiar with late twentieth- and early twenty-first century mental health services. The only First Person Account to depart from these conventions testifies to the consistency of their operation. "I have also with my own eyes seen at least 7 or 8 women who look [sic] me (my clones)," K Pushpa writes, and "that has reinforced my belief that the injections split me":

The coma injections or tablet-equivalent of them are given to make the patient comatose or – this is a guess! – to make a patient disappear! Maybe the patient disappears into another space-time dimension, and many events occur after which he/she appears back on the psychiatric couch or bed and opens his/her eyes without remembering anything of what had happened in the intervening period. Or perhaps – this is yet another guess – psychiatrists and neurosurgeons do things to the brain and body of the "patient." Sometimes secret brain transplants (partial or whole transplants) may be done – the lobe/s or certain parts of the brain may perhaps be exchanged with the brain parts of other persons! (3)

It seems highly probable that the author of this First Person Account, who appears to be the only writer in this series resident in the Global South, would be viewed by clinical readers as lacking insight and still in the 'grip' of delusional thinking. "Schizophrenia – A Victim's Perspective" points to the absence of "mad writing" from the series as a whole; the absence of particular kinds of claims (regarding experiences of cloning, for example) but also the absence of playfulness, irony, fantasy, figurative language, the appearance of other narrative voices, non-linear structures, and visual or typographic innovation. It would seem that fundamental to the 'genre of insight' is the exclusion of *anything*, even the fictional or fanciful, which might be perceived as in any way symptomatic of schizophrenia.

Recovering from, understanding and coping with schizophrenia are the most prominent themes in these accounts, where, as with most forms of illness narrative, the emphasis is on overcoming adversity. I have no wish to question the importance of this kind of storytelling but simply want to call attention to its specificity, to show that here, as elsewhere, there is nothing natural or self-evident about its operation. Indeed, narratives published in *Schizophrenia Bulletin* are not simply and spontaneously produced *for* the clinical professionals who are the journal's primary audience, but produced in collaboration *with* them. Many authors give explicit acknowledgement to the psychiatrists who have helped support the pieces to publication ("Taking the First Step"), and in an article which also, somewhat curiously, appeared in the space usually assigned to First Person accounts, Rudnick and colleagues provide a step-by-step guide for professionals seeking to help facilitate this. The collaboration between a 'content' expert (the person with schizophrenia) and a 'process' expert (the person with experience in the publication of scholarly work) they suggest has five steps: establishing a relationship; clarifying the themes and structure; writing, revision and submission. Rudnick and colleagues describe writing as "a creative act" (Rudnick et al. 2) about which it is difficult to give concrete guidance, yet the process they describe – while aimed at empowering the person who suffers "mental health

challenges" – is certainly not open to experiences, modes or methods which fall outside the model of academic co-authorship upon which it is based.

Narratives of schizophrenia have been marginalised, dismissed, and otherwise ignored by certain powerful sections of the psychiatric establishment. "What is at stake" in this conflict, as Estroff (283) observes, "is authority and authenticity concerning identity, definition, meaning, and experience in schizophrenia – and ultimately what happens to and about people with schizophrenia." The final part of this article is an exploration of the dynamics of this conflict beginning with a detailed discussion of one First Person Account which brings these issues to the fore.

III. Grand Rounds

Marcia Murphy's "Grand Rounds" opens with the description of her careful preparation for an intensive public performance: her presentation as a case in the grand rounds of her local teaching hospital:

I typed up what I might say and sent it to [my psychiatrist]. Dr. G said it was fine, but I worked on it some more. I changed and lengthened it considerably. I also practiced reading it out loud, speaking into a mini-cassette recorder. Playing it back, I could hear what parts needed work.

I wondered how the Rounds would go. My audience would be mainly psychiatrists, psychiatric residents, and medical students who viewed mental illness from the disease (biological) model. Will I be able to communicate my view of recovery? Will I be allowed to say what is important to me? Will they hear and be convinced by my story? (Murphy 657)

When the day finally arrives, Marcia is ushered onto the stage of a 200-seat lecture theatre. The interviewing psychiatrist, Dr Chapman, speaks in the language of clinical authority: "Describe the symptoms that you had in the early stages of your illness and how they affected you."; "Give your recovery story." The performance of Marcia's well-rehearsed narrative begins:

When I was in my teens, I was very depressed. I cut my wrists, and then, on one occasion, I overdosed on a bottle of aspirin. I believe this was a reaction to the emotional and physical violence in my home. Needing to get away, after high school I joined a religious cult, which operated under the pretence of being Christian but, in reality, was not. At one point, while in my early twenties and staying in New York City, I became psychotic. (658)

A brief period of hospitalization and sixteen years of suffering culminated in:

"a near-fatal suicide attempt in 1993. I then began to realise I had a decision to make. It was an intellectual choice, but became a matter of heart. I decided to commit myself to Christ. This decision and the events that followed transformed my life. At this time, I also began a new antipsychotic called Risperdal—"

"Risperdal is a good medication. Maybe your life turned around because you were started on this," Dr. Chapman interjected.

"I agree it's a good drug, but not a cure-all. I have a friend on heavy doses of antipsychotics, including Risperdal, and she still hears voices and

has other severe problems. I believe my condition improved because of the combination of Risperdal and my religious faith." (659)

Marcia is thanked for her participation and escorted from the lecture theatre. The Grand Rounds continue in the form of a closed debate amongst professionals as to the role of religious faith in recovery from psychosis. Using printouts of the formal presentation, and verbal reports from the participants, Marcia's First Person Account includes a record of this discussion:

"Marcia is not cured. I'm not sure I understand what you mean by your concept of 'recovery' [one resident objects].

"In psychiatric terms, we are generally taught that recovery means cure, but that is not the concept that people in the 'recovery movement' have," Dr. G said. "These people are 'life-oriented.' They see recovery as finding meaning and purpose in life. Instead of focusing on schizophrenia, the disease, they emphasise the potential for growth in the individual. [. . .] As providers, we need to listen to the stories of people with mental illness. Because of their lived experiences, they lend unique insight into mental illness and what makes recovery possible." (660)

Marcia Murphy's "Grand Rounds" functions as a double testimony – it records, for the benefit of a clinical audience, the experience of being called upon to present one's 'recovery story' as a form of clinical evidence. The narrative dramatises tensions inherent in the dialogue between patients and psychiatrists: Marcia is asked to tell her story on the condition that it conforms to the strict protocols of the psychiatric interview, but is prohibited from hearing, much less discussing, the official clinical story of her experience, her case history. The clinical gaze – here literally embodied by the dozens assembled for the grand rounds – fixes her as an object of attention, analysis and instruction; but it is precisely by being summoned to perform the role of 'the good patient' that Marcia is able to disrupt the conventions of the role. "Will I be able to communicate my view of recovery? Will I be allowed to say what is important to me? Will they hear and be convinced by my story?" As she has over twenty-five years of experience of psychiatric services, these are not idle questions. Overcoming her anxiety and apprehension, however, Marcia succeeds in telling her story, which is to say that she succeeds in challenging the authority both of her interviewer and of the dominant biomedical account of schizophrenia by insisting on the importance of religious faith in her recovery from psychosis.

As a long-established medical practice, the grand rounds is both an occasion and a set of conditions for a very specific kind of storytelling. Here, it requires that the patient take up a position of clinical scrutiny and detachment with respect to her own experiences: if it is to have pedagogic value, then suffering, assessed for its clinical relevance, will ideally be presented in a manner which minimises any manifestation of distress. The patient is called to articulate her experience, but she is not the final authority on its meaning; rather, it is the audience, and specifically the presenting psychiatrist, who will determine the way in which it is to be interpreted. For the patient, the event is singular; for the clinicians, it is repetition – the person before them is an iteration of "the patient," and for the ritual to be enacted successfully, the distinctive features of an individual case must be comprehensible within the existing horizon of clinical experience and expectation. Although an increasingly large number of readers of *Schizophrenia Bulletin* will have little if any contact with the people

whose illness they are researching (Thaker), for those doing clinical work first-person accounts are seen to play an important role in enhancing communication skills (Armstrong).

IV. Testimony

The grand rounds thus provide a powerful framework through which to approach the First Person Accounts but it is by no means definitive. Most scholars and practitioners in the medical humanities would advocate instead a reading of these texts as illness narratives or '(auto)pathographies' in the manner advocated for by figures like Howard Brody, Thomas Couser, Arthur Frank, Ann Hunsaker Hawkins, and Rita Charon.⁷ In contrast to the formality and didacticism of the grand rounds, theorists like Arthur Frank are committed to a "pedagogy of suffering" premised on thinking with stories (Frank, *The Wounded Storyteller* 23,144-145). For Frank

The most immediate problem of those who tell stories of illness is to be heard, to find others who will answer their story's call for a relationship. [. . .] Storytellers do not call for their narratives to be analyzed; they call for other stories in which experiences are shared, commonalities discovered, and relationships built. (Frank, "The Standpoint of the Storyteller" 355)

It is difficult to judge the extent to which readers of *Schizophrenia Bulletin* recognise or respond to the call of the "wounded storyteller." The dynamics of testimony alluded to by Frank seem more likely to arise when First Person Accounts are taken up and circulated in contexts not structured around the hierarchies of the clinical encounter, such as peer support groups, as the generic features outlined above – particularly those which inscribe the accounts within a broader framework of academic publishing – function to promote a more dispassionate detachment. Is this idea of a "pedagogy of suffering" something which therefore requires more active championing?

For many researchers and clinicians engaged in the medical humanities the answer would surely be in the affirmative, that 'narrative competence' in clinical and other settings is not simply a question of attending to the content of a patient's story but bearing witness to their suffering (Charon; B. Lewis). However, this approach is not without its critics:

What we are invited to endorse [by Frank and others] is a celebration of some – but by no means all – narratives. These are stripped of social context and social consequences. They are understood in terms of an individualised view of the self. Narratives are the means whereby the narrating subject, autonomous and independent of the medical profession, can achieve authenticity. Narratives are the means whereby illness may be transcended and turned into an apotheosis through self-mythologizing. This represents an almost total failure to use narrative to achieve serious social analysis. (Atkinson, "Narrative Turn or Blind Alley?" 339)

Atkinson's appeal is to shift the focus of analysis from a humanist and empathic engagement with the affective dynamics of the individual's story to one which locates and uses these narratives within a wider social context. Such a call might resonate strongly with the many writers in *Schizophrenia Bulletin* whose narratives present schizophrenia not simply in terms of specific symptoms or complaints, but as

inextricable from experiences of hospitalization, poverty, homelessness, stigma and discrimination (Hummingbird; MacPherson). At the same time, the stance advocated by Atkinson is potentially in tension with accounts, such as Marcia Murphy's, which seek recognition from their readers of the courage, resilience and fortitude shown in surmounting these experiences.

Although it may seem radical in the context of mainstream medical humanities research, Atkinson's approach to illness narratives neither interrogates nor ventures beyond the clinical framework of patients and illness. For this, we must turn to a fourth way of reading *Schizophrenia Bulletin's* First Person Accounts advocated by activists and scholars in the psychiatric survivor movement. Peter Campbell, founder of the UK group Survivors Speak Out, explains that the term "survivor" was taken up in a mental health context "partly because we survive in societies which devalue and discount our personal experiences and perceptions. But [. . .] chiefly because we have survived an ostensibly helping system which places major obstacles across our path to self-determination" (117). So, what would it mean to approach *Schizophrenia Bulletin's* First Person Accounts not as a collection of illness narratives written by patients, consumers and users of mental health services, but as the testimony of people who identify as survivors of distress, trauma and inadequate or inhumane psychiatric care?

"'Survivor' knowledge," as Mark Creswell has shown, challenges the "official" knowledge of psychiatry by emphasising "individual experience, the traumas of the life-course, and the personal testimony of the survivor as itself expert data" (1669). What distinguishes this approach from those already discussed is the emphasis on testimony. Drawing on the seminal work of Shoshana Felman, Dori Laub and Cathy Caruth, Creswell argues that:

In order to grasp the specificity of testimony as a truth-claim, we have first to see it as a performative discourse, not as, say, an expression of autobiographical fact. In testimony, the survivor does not express her unique historical knowledge, which the receiver accepts as a "given." Rather, testimony aims to bring into being a state of affairs in which the survivor's truth is witnessed as an event about which "something ought to be done." In "surviving" the performance of testimony, the receiver is simultaneously called upon to do something about it. That is testimony's political point. (1671-2)

To read *Schizophrenia Bulletin's* First Person Accounts as testimony would be to recognise not just the legitimacy of a certain form of knowledge, but, more radically, to be called to a particular form of (anti)psychiatric politics, and called upon to do something as a consequence.⁸ In the mode of the grand rounds we are called upon to learn from and about the patient; in Frank's model, to experience an empathic communion with the wounded storyteller; following Atkinson, to inquire into the social, economic and institutional forces which shaped the illness experience. Here, in recognising that we are witnesses to testimony, we are challenged to respond directly to the claim that psychiatry itself can be the cause of suffering and injustice; more profoundly, we are required through this engagement to reflect upon and take responsibility for our own 'position' with respect to the conceptualisation, categorisation, and treatment of mental distress.. Lucy Costa and colleagues have argued that mental health professionals have a tendency "to absorb resistance accounts, sanitise them, and carry them forward in ways that are useful for them,

without disrupting their dominant practices" (Costa et al. 87). The recovery narratives which are produced and consumed in certain clinical and advocacy settings tend to be highly formulaic stories of an individual's journey through and triumph over particular difficulties. Testimony, by contrast, is less reliant on linear or normative models of health. Crucially, as Costa and colleagues suggest, to be open to the dynamics of testimony is to start to recognise one's own position within the matrix of power-relations in which conflicts over the nature and meaning of mental ill-health, suffering and trauma are articulated. Reading first-person accounts of schizophrenia as testimony also allows space for the collision and coexistence of multiple ways of understanding unusual experience, including those which celebrate mad pride and mad culture (Curtis et al.).

The authors of *Schizophrenia Bulletin's* First Person Accounts are writing at a time when the public appetite for so-called 'misery memoirs' is matched if not exceeded by intense interdisciplinary interest in the study of narratives of illness and the practice of narrative medicine and narrative psychiatry. It is also a time marked by unprecedented opportunities for sharing first-person accounts of schizophrenia and mental distress with audiences across the world. While there is growing recognition that doing so can have personal, therapeutic, pedagogic, political and social value, activists and academics are also urging psychiatric survivors to 'recover' their stories and halt their circulation as 'patient porn' within a mental health system that recognises lived experience only as fits within biomedical or a neo-liberal recovery agendas (Costa et al.). It has not been my intention here to sanction a particular way of reading *Schizophrenia Bulletin's* First Person Accounts, or to downplay their diversity and the variety of contexts in which they will be encountered and purposes they might serve. What I have sought to do is to start to explore how these texts function as texts published within the specific context of a scientific journal, and how a 'genre of insight' serves to make them intelligible in ways that foreclose certain perspectives and modes of representation. This focus on textuality is a reminder to those in the medical humanities that first-person accounts are not a mechanism for providing 'untrammelled' or 'direct' access to people's experience; conversely, my discussion of the kinds of stances academic readers might adopt towards these accounts has endeavoured to tease out some of the attendant ethico-political commitments of such positions. In short, my appeal is for a more critical medical humanities; for more nuanced interdisciplinary approaches to the analysis of illness narrative; and for literary scholars to pursue more mutually illuminating dialogue with experts by experience as well as by clinical and academic profession. What remains now is the larger and more complex task of looking carefully, responsibly and comprehensively at what it is the authors of these First Person Accounts have to say about lives lived with schizophrenia.

Notes

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1. In my previous work (especially *The Sublime Object of Psychiatry*) I have discussed at length the controversies surrounding schizophrenia and its validity as a diagnostic category. These debates have been well-rehearsed (see Boyle; Bentall) including in the First Person Accounts which are the focus of this paper. Aware that the ongoing use of the term 'schizophrenia' risks continuing, to quote the Campaign to Abolish the Schizophrenia Label, "to perpetuate the myth that when talking about 'schizophrenia' we are discussing something that actually exists" (COPE Initiative) I have chosen not to abandon it on the grounds that the narratives I am examining here come into being as an archive precisely through their shared status within Schizophrenia Bulletin as first- or second-person accounts of something called 'schizophrenia.'

2. Gallagher writes: "Normal generation of narrative self depends on the proper functioning of a variety of cognitive capacities, including capacities for short-term temporal processing (working memory), self-awareness, episodic memory and reflective metacognition. Neuropsychological research suggests that in schizophrenia the mechanisms responsible for each of these elements are frequently disrupted. It should not be surprising that, as a result, schizophrenic narratives, and the self that is constituted through them, are problematic, both in structure and content" (336).

3. 64% women, 30% men, with gender undetermined in the remaining 6%.

4. The editorial policy on the journal web site simply states that "The Bulletin will publish first person accounts" but does not define these nor indicate the selection criteria used ("About the Journal"). In a personal communication, Professor Guntant Thaker clarified that unsolicited manuscripts were reviewed by the editor, and only "in rare instances sent out for reviews" (Thaker).

5. This asymmetry is further reinforced by the lack of open access to Schizophrenia Bulletin articles; for the first twelve months following publication, First Person Accounts are available only to those with expensive institutional or personal subscriptions.

6. However, judging from the relatively low number of citations of First Person Accounts in other contributions to Schizophrenia Bulletin, this rhetorical continuity functions to conceal rather than to bridge the epistemic gulf between these different forms of evidence.

7. This body of scholarship has focussed almost exclusively on somatic illness (but see Kleinman) and in many cases privileges the extended life narratives in published autobiographies; formally, in the context of their publication and at the level of content, the First Person Accounts could therefore constitute a hermeneutic challenge for scholars in this field.

8. In his more recent work with Helen Spandler on the psychiatric survivor movement, Creswell has posited a distinction between the "'academic intellectual' of social movements," and the "'organic intellectual' [who] becomes the 'activist' located *within* social movements," producing "knowledge *for* and *within* the social movement, not *about* it and *of* it." In doing this, they argue, the 'organic intellectual' confronts the imperative questions: "*Which side are you on?* and *What is to be done?*" (4, 5).

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Imaginary Investments: Illness Narratives Beyond the Gaze

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Samuel Beckett, in his partly-autobiographical novel, *Murphy* (1957), uses his narrator to describe a series of hospital encounters intended to uncover the medical condition underlying a cardiac complaint. Without success, he tells the reader, his "irrational heart" was "inspected, palpated, auscultated, percussed, radiographed and cardiographed" (3). Although Beckett would not have described *Murphy* as an illness narrative, he captures very accurately the dominant perspective on the history of the modern medical encounter. Murphy is subject to the objectifying gaze of medical professionals and their visual technologies while at the same time he is characterised as the "irrational" patient solely defined by his specific pathology. This positioning of medical authority and patient submission is precisely the totalizing relationship of the clinical gaze as determined by Foucault in *The Birth of the Clinic*. Foucault's conceptualization of a paradigm shift in Western medicine has been endorsed by studies of nineteenth- and twentieth-century clinical medicine, which describe a significant reorientation in the balance of power between patient and doctor around 1800 (Ackerknecht; Fissell; Jewson) and the growing dominance of an 'object-oriented' medical cosmology. It is this construction of the medical encounter and the growing dominance of biomedicine that Foucault seeks to chronicle that scholars of illness narratives have long sought to overturn. In this scholarship patient narratives are neither irrational nor passive but instead actively and subjectively valuable stories of illness that give both meaning and context to the conditions of illness from the patient's perspective. While the methods by which such narratives might be analysed and interpreted have led to scholarly disagreement, Arthur Frank captured a consensus when he argued that "narratability means that events and lives are affirmed as being worth telling and thus worth living. Being narratable implies value and attributes reality" ("Why Study" 111). Despite its efforts to reassess, and indeed to respect and value the patient story, illness narrative scholarship has rarely sought to do so by rejecting the orthodoxy of Foucault's vision of the emergence of the clinical gaze that led originally to the dismissal of the patient perspective that it seeks to re-inscribe. Critics have, of course, followed Habermas in his judgement that Foucault's reading of the historical evolution of the modern hospital was overbearingly structural and lacking in specific example (Kennedy, *Revising* 9-10; Rylance, 256; Jones and Porter). However, there has been little attempt to consider whether those aspects of the clinical medical encounter that Foucault claimed had been rejected by the beginning of the nineteenth century did, in fact, disappear or whether they were maintained, and continue to be so, in illness narratives of varying type and form.

The Birth of the Clinic argues that key to the emergence of the clinical gaze was the loss of a "visionary space" (Foucault x) which is evoked through a language both fantastical and myth-making, a language that both gave room for the imagination and privileges the imaginative, historicised metaphor as providing access to truths about medical encounters and illness. These are the "imaginary investments" (Foucault xii) from which the future of medical encounters depart. For Foucault a change occurs around the beginning of the nineteenth century whereby the visionary space becomes encapsulated entirely within the body of the patient and is thereafter wrestled with and ultimately controlled by the gaze (and the narrative that inscribes

the gaze) of the medical professional. This difference, Foucault argues, and the progress of his argument is vital here, "is both tiny and total. For us, it is total" (xi). But what if the difference in "imaginary investments" were simply tiny? Indeed what if there *was* little discernible difference?

This article argues that the "imaginary investments" that Foucault so offhandedly rejected did not disappear into the imprisoning cavities of the human body to be made subject to the clinical gaze. By thinking about the narratives produced by family members – actors beyond the binary of the doctor and patient – it suggests these "imaginary investments" continued to perform their myth-making and imagining in disparate medical narratives which undermine the gaze's totality to consider illness narratives as writing and their contribution to both the historical record of illness and the literary canon of somatic fictions. Although these fugitive narratives, and their metaphors of resistance, have not previously been considered in medical humanities scholarship, their existence can be read as evidence of a continuing project of communal imaginative acts of history-making that offer an alternative to the present understanding of narrative praxis in the field. Just as Foucault examined third-person narratives – the doctor's – describing the medical encounter, this article explores a further set of third-person narratives – that of the family member as carer – commonly ignored in the medical humanities.

Building on a literature that draws attention to the role of the family in structuring medical care, and on scholarship that explores how the medical encounter invariably involved more actors than just the patient and the doctor, the article places narratives generated by family members and carers written in 2010 and 2011 in South Wales, UK, at the centre of its analysis. It offers a unique interdisciplinary perspective that brings into dialogue sociological and historical studies with literary theory. By doing so the article extends the reach of present writing on illness narratives and offers a significant new model for the assessment of writing about illness across disciplinary boundaries. While scholars have drawn attention to how the sick and their families negotiated care in the early modern medical marketplace, families remained important in making decisions about the nature of the medical encounter in the nineteenth and twentieth century. Families were widely consulted over illness and exchanged advice and treatments, while medical practitioners would often only address female patients through their fathers, brothers or husbands. Families were crucial actors, as studies of the Victorian asylum and workhouse show, in determining when institutional care was necessary and the boundaries of that care, as well as what happened to the patient's body after death (Porter and Wright; Wright; Hurren). Equally sociological studies of illness narratives in the 1980s and 1990s pointed to the support networks that benefit patients (Zola; Viney and Bousfield). Just like the patient, families and those involved in these networks constructed their own narratives, using them to negotiate the medical encounter and to make sense of illness and their experiences.

Narratives of illness and the medical encounter that reveal their resistance to the clinical gaze take different formal structures and can be found in varied contexts. They exist both within the classic medical encounter (between doctor and patient) and also at a remove from it (in the writing of patients' family members and carers, for example). What they share, however, is an articulation of that visionary space, often evoked through metaphorical and imaginative connection to already existing histories and literatures, that Foucault and others argue was redacted into the patient body and laid claim to only by biomedical authority. Such narratives invest in the authenticity of imagined encounters outside the clinic or hospital; encounters with alternative

modes of reality situated both within history and the objective/subjective binary that occupies medical exchanges rather than simply within the later. One example of this alternative imaginative landscape is the 2011 narrative of a patient's wife (Marie) who, intent on spending the night in visitor accommodation on a hospital site still largely imagined by contemporary visitors as Victorian in its architectural formation, leaves the clinical space of the patient bedside in search of her room:

I realised I had to walk back to the accommodation block in the dark so I left as soon as the football started and returned to the silent room. I felt glad that David was settled and relaxed. He had his place, he was meant to be there. I walked back through the modern part of the building which was now deserted, and out to the dark, empty walkway. I noticed to my right that there was a modern block of some considerable size stretching away from me in a part of the hospital I had not yet seen. Low, warm lights were glowing against the dark night. That must be where the bald children were. The corridor in the accommodation block was eerily quiet. Trips to the communal toilet were quite scary. I sensed the presence of others but saw no-one.²

Marie's narrative is particularly interesting as it hints at a subtle and disquieting surveillance that might easily be read as exemplifying the clinical gaze and efforts to fashion the hospital as an disciplined clinical space. Yet its reference point is neither the modern hospital nor its culture of observation but rather than being clinical *per se* it is evocative of late-nineteenth century ethnographic writing suggested to the author by the Victorian architecture of many of the hospital buildings, which after 1850 were increasingly designed around the principles of order and surveillance. This medical encounter can be located within the linguistic and thematic organization of mid-late Victorian urban ethnographic journalism, Charles Dickens's and W.T. Stead's amongst the best-known of these types, as the author registers the alien nature of the hospital geography, their own displacement in that space, and the radical difference between themselves and other imagined yet unseen inhabitants. In imagining the hospital in this way, the author echoes the sense of alienation experienced by the families of Victorian hospital patients and the unfamiliar geography of the hospital, access to which was carefully controlled through visiting hours and how the internal space of the hospital was organised. The particular reification of young cancer sufferers as the much more uncanny "bald children" strikingly separates the author from any sense of recognition or empathy with those also visiting or admitted into the hospital. This is enforced primarily through the repetitive "he had...he was" that implies difference as much as it is supposed to assert satisfaction.

Further than the ethnographic journalism that acts as historic inter-text this illness narrative also evokes a fictional account of alienation that was already a further mediation of ethnography. In his 1853 novel *Bleak House*, Dickens uses his experience of ethnographic journalism to imagine the experience of the slum-child Jo in the alienating environment of London's East End: "It must be a strange state to be like Jo! To shuffle through the streets, unfamiliar with the shapes and in utter darkness to the meaning, of those mysterious symbols, so abundant over the shops, and at the corners of streets [. . .] to feel that it would be perfectly true that I have no business here, or there, or anywhere; and yet to be perplexed by the consideration that I am here somehow, too, and everybody overlooked me" (124). The resonance between Dickens's reflections on Jo and the contemporary narrative is striking: both suggest

personal exclusion and employ the image of darkness to enhance the solitude that such exclusion engenders. There is, though, a more specific parallel that goes beyond this general sense of alienation. Dickens is suggesting an alienation that comes about through the absence of language (Jo's inability to read) and is also putting in place here the denial of access to care, particularly medical care, from which Jo (already a carrier of disease) will later suffer. Marie's story emerges in this intertextuality with Dickens as particularly aligned to concerns both about the writing of an illness narrative and the accessibility to the pastoral support of the clinical space. While this parallel may not be one consciously introduced by the writer of the contemporary narrative, there is nevertheless a similar aesthetic at work in both; a Dickensian aesthetic that recalls the meaning of aesthetic as knowledge emerging from the body (Eagleton, 14; Dixon).

To regard Dickens's fiction as a further imaginative texture within the illness narrative therefore also increases the potential for understanding its own subtle politics. Its sense of alienation is not, when read in the context of *Bleak House*, simply a product of the unfamiliar geography of the hospital, it is also that the author has been, in Dickens's word, "overlooked". The narrative therefore reflects upon the author's own sense of marginalization from the medical encounter, ejected from the bedside into the dark spaces of the outer medical environment which is self-consciously imagined as Victorian. While this may seem to suggest that the narrative itself recognises and even accedes to Foucault's understanding of the powerful clinical gaze, it is important to recognise that the narrative does not place the author only in the position of subject but also as the writer/observer in a deliberate act of imagination into another person's subject position; Dickens the novelist rather than Jo the disenfranchised slum-dweller. The author has power, both as a producer of narrative, and as a writer whose work is in dialogue with layers of other historical and literary writing.

The very existence of this brief story, and its empirical evidence, should act as a reminder that narratives of illness and encounters with clinical spaces are not only constructed at the bedside, or even only within the tripartite structure of patient, doctor and disease, as, in another context, Paul Atkinson has argued (339). Nor do they work within the formulation of the clinic as Foucault conceived it. Rather, they provide alternative forms of knowledge; as our analysis of three varying narratives will show this knowledge is both historically and creatively situated and invested with the myth-making power of the imagination.

Situated Narratives

Scholarly work on illness narratives is quick to situate them within a range of categories which, scholars argue, emerge from the themes and structures of the narratives themselves. Mike Bury, for example, finds illness narratives in three distinct forms: contingent narratives that deal with the effects of illness on everyday life, moral narratives that deal with personal change and selfhood, and core narratives that focus on the relationship between personal illness experience and its cultural meanings (268-80). All of these categories are essentially sociological – they oscillate between and across a personal and social politics of identity. Similarly, Frances Rapport, ostensibly offering fresh perspectives on the methodological study of illness narratives, finds that stories of illness are best "broken down" into a series of categories that themselves are drawn from larger socio-cultural knowledge paradigms. So, for Rapport, it is useful to consider the "cultural" aspects of narratives, which, she clarifies, means "according to ethnic or social groupings" (39). What fails to emerge

from this insistence on a cataloguing of typologies is any analysis of illness narratives as *writing*; their contribution to both the historical record of illness and the literary canon of somatic fictions. Even where the literary appears to be the subject of analysis, as it is in the early work of Arthur Frank who sees illness narratives as situated generically as quest, restitution and chaos narratives (Frank, *Wounded*), there remains a tendency toward typology that ignores language and its specific historical valency. Of course, other scholars, particularly those whose work has been represented in publications such as the journal *Literature and Medicine*, have attended to such representations. This work, however, tends to focus on what could be called professional narratives: either the work of novelists and poets or the records of clinicians and other medically-authorized figures. There is, therefore, a gap between the sociological and the medico-literary scholarship where the illness narratives written by members of the greater social population receive no attention as narrative acts with particular historical resonance and productive literary force. Moreover, the sociological scholarship's organisation of these narratives into types is, ironically, an act of depersonalisation that reinforces rather than calls into question the "authority of the 'grand narratives' of science and medicine" that are the foundation of Foucault's claims for clinical authority (Bury 265).

There are other ways to express the situated-ness of illness narratives that do not re-inscribe either the reductive historical frame of illness as increasingly depersonalised from the late eighteenth century onwards (Jewson) or the Foucauldian paradigm of a disenchanted medicine dominated by nosological categorization and technological observation (Hydén 48). Specifically, the places and spaces that are documented within illness narratives should be read not as depictions of "environment" (Rapport 39) as though they were unmediated reports of the materiality of clinical sites but as structures of feeling that take their place within history. "Clara's Story," a narrative written in a common poetic verse form of rhyming couplets, indicates the potential relationships between a longer history and sense of place and the experience of the medical encounter. Clara writes as the daughter of an ailing mother whose condition has led to hospitalization:

Through dirty glass the morning haze reveals
Pillgwenlly slumbering grey towards the sea
Where giant turbines grind like drab pin-wheels
Observed in dreadful solitude by me,
Oppressive heat surrounds me as I hear
The hissing of the mattress where you lie
Wide-eyed. You watch me, helpless, full of fear.
I know the 'Trust' will simply let you die.

This narrative expresses some of those themes familiar to scholars of illness narratives. The writer's despair, depersonalization and alienation within the medical space are clearly registered, as is the sense of helplessness when faced with severe illness. The medical staff are regarded only as part of a bureaucratic and impersonal medicine, depicted as the 'Trust', under the power of which even the writer, who thinks but does not speak, is made voiceless. It was by way of such analysis that Arthur Kleinman and Arthur Frank (*Wounded*) reintroduced illness narratives into contemporary scholarship and from which they argued for reading such narratives as authentic performances of those 'silenced' patients whom medicine had disregarded.

Yet just as vital is the geographic location of this narrative in the South Wales town of Newport, and particularly its placement in Pillgwenlly, the area of Newport that includes that town's docklands. Indeed the medical encounter is entirely contingent upon that place: it is with a view of Pillgwenlly, gained through the dirty glass with its connotations of neglect, which the poem opens rather than with an observation of the hospital ward. Although there is no explicit discussion of the history of Pillgwenlly, it is how that history relates to the medical encounter that reveals how situated this illness narrative is within a longer history and understanding of place. Pillgwenlly's "slumbering grey" connotes the former dockland industries, long departed, whose waste materials are still visible along the line of the land as it meets the Severn estuary. The industry that the poem registers is wind-farming, but the turbines secured to the sea-bed are "drab" and exist in "dreadful solitude," offshore and therefore outside Pillgwenlly's social relations. The "grind" of the wind turbines are recast, via a similar technological sonority, as the "hissing" mattress of the hospital bed, with its associations with medical technology, and this in turn also renders the "dreadful solitude" ambiguous. It might now refer not only to the turbines but also to the patient and to the writer. Similarly, within this brief but powerful urban history, the poem also draws a connection between the untrustworthy medical organisation and those other large institutions, such as the docklands industries, that cannot or could not be relied upon to provide adequate care for Pillgwenlly's communities. Indeed, the verse implies parallels of another order, too. There is continuity between the forces of industrialisation with its concomitant technologies that refashioned the landscape as an industrialised one and the effects of these same technological forces on the experience of the patient and by extension their carer. Just as industrialisation caused major disruption to the established social systems of the nineteenth century so too, the poem implies, has the technologisation of medicine disrupted normative relations between Clara and her mother.

Such an analysis may be charged with placing in dialogue two different and unrelated forms of social critique; although the fact that the poem itself does this already militates against such an argument. However, as Roy Porter and others have shown ("Patient's View", *In Sickness*; Condrau; Warner; Risse and Warner), the history of medicine cannot ignore either the perspective of the patient or the social, economic and cultural situations within which the practices and performances of healthcare and the medical encounter take place. Breaking with an approach that placed stories of progress, knowledge and breakthroughs at the centre of the history of medicine, an approach scholars in the medical humanities implicitly accept when critiquing the rise of biomedicine, the historical categories of patient, medical practice and disease were revisited and resituated to show how they were as much part of the 'social' as they were the 'medical.' Viewed from within an attentive history of medicine, "Clara's story" is an illness narrative less about the authenticity of the narrative self and more about the social conditions of illness formed over time. Interestingly, the retrospective formation of illness is also at the centre of one of the poem's key phrases: "dreadful solitude." Placing these two words together has become so common as to become cliché, but their literary history can be traced most famously to the Romantic poet John Keats, who used them in a letter to describe his experience of what was to be his final illness in Rome in 1821 (Scott). As Grant Scott has shown, Keats's posthumous reputation led several biographers to negotiate around that phrase and its suggestions of desperation that worked to undermine the cultural view of Keats as a poet of healthy philosophies. The use of this phrase in the poem, when allied to the social history that gives the narrative its focus, reveals that it is in

the combination of histories – literary, social and economic – that situates the illness narrative both within the medical encounter but also, and in ways that are crucial, extensively beyond it into networks that are unconstrained by depersonalised medicine.

A more explicit example of the importance of place within the medical encounter is “Emily’s Story”, a narrative that follows the formal structure of a diary to describe Emily’s relationships with medical institutions during her mother’s illness. At first, Emily, herself a professional nurse, professes frustration and anger at the care her mother received after suffering a stroke and being treated at a large urban hospital. While we might expect a nurse to side with medical authority, Emily tells the story of her struggles to have her mother treated, as she saw it, with appropriate professional diligence:

Mum was eventually moved to an assessment/admissions ward where we were told she would be monitored overnight. When we walked onto the unit we were greeted warmly enough. However after the handing over nurse took the accepting nurse aside there was a palpable change in the atmosphere. We both felt we were an unwanted presence. We were not welcome and it was as if our fame had spread. I found them defensive and disingenuous. Health care professionals love to label people. I’m one of them, I have done so. We describe patients and families as being difficult or demanding. Nurses only came to mum in pairs- for safety perhaps! An exaggeration I admit, but they were very cautious with us which made it very difficult to have any sort of relationship with them. This was something I had never experienced before and it was a real eye opener for me being on the other side.

Later, after her mother is discharged, but once again deteriorated, she is admitted to a smaller, rural hospital nearer to her family home:

Maybe it’s a [Welsh] Valleys thing, perhaps we share a humour that binds us and sees us through such times or maybe it was just because it’s a smaller hospital and I was known there, whatever the reason our experiences here could not have been more different. We had an easy relationship with the staff. We could laugh and chat and be consoled in equal measures. Every member of staff porters, domestics, care assistants, nurses and doctors seemed to pick up and respond to our needs and pain.

The surveillance culture, sense of disenfranchisement, and deepening understanding that Emily articulates about her own categorization as a family carer rather than as a fellow professional are all familiar generic tropes of illness narratives and speak directly to the characterization of the medical encounter as dominated by an authoritarian medical culture. At the same time, however, Emily’s opening narrative also registers what historians have argued for some time: that such authority has always been contested by patients, their families and the public who expressed doubts about medical practitioners’ claims to expert knowledge. Such doubts were voiced in early modern medical satires, in attacks on medical practices, such as dissection, in nineteenth-century protests against vaccination and vivisection, and in the growth of alternative medicine. Notions of credibility were inextricable linked to social reputation and the status of medical practitioners and their privileged understanding of

disease remained uncertain into the nineteenth century. Although efforts were made to present orthodox practitioners as Fildes's family doctor they were often imagined as vampires, butchers, rapists and murderers who fed on the bodies of the poor, anxieties that were embodied in late-Victorian Gothic literature and in speculations that Jack the Ripper was a mad doctor or medical student (Durbach; Frayling). Although Victorian medical practitioners invested in a professional rhetoric that asserted their expertise, that expertise remained subject to challenge into the twentieth century as the public used criteria different from those adopted by doctors to judge professional standing and expertise. Indeed Emily contests medical authority from one of the most common positions for resistance – expert knowledge – but frames this expert knowledge differently. Yet this narrative does not only place Emily in a long tradition of patients' struggles for their own agency. It also shows, rather uniquely, how place can significantly alter the clinical medical encounter. The second part of Emily's narrative suggests that it is both the relationships of power in the encounter with medical authority, and where that encounter takes place – rather than the nature of medical authority (as Foucault maintained) – which can either produce tensions or promote productive sets of interactions.

The ideal space of the second hospital is defined in Emily's narrative in a number of inter-related ways. There is first a sense of the local in "a Valley's thing," which gains its own credence from a communal emotional understanding amongst local people who "share a humour that binds us." It is also, though, a condition of size and familiarity, which works in two directions, both from the carer to the hospital and from the medical staff to the carer. Emily finds the "smaller" hospital more manageable, but is also relieved by the fact not that she knows the medical staff, but that they know her. These examples of a "banal" nationalism (Billig), here articulated as localism, radically redefine the medical encounter, entirely excising medical authority in its Foucauldian sense. It is replaced by a sense of belonging that is almost utopian: "Every member of staff porters, domestics, care assistants, nurses and doctors seemed to pick up and respond to our needs and pain." This is clearly set against (and indeed gains some of its heightened emotional intensity from) the uncanny urban hospital of the first part of the narrative.³ The structure of the narrative – its movement from the entirely clinical space of the first hospital to the social and cultural familiarity of the second – also interestingly parallels the evolving historiography of hospitals and their functions or meanings. Since the 1980s and especially in the early twenty first century, historians have revised their view of the hospital as place responding only to advances in medicine to take account of the hospital also as a social and political space (Granshaw and Porter; Henderson et al.; Waddington 144-65). By placing the wider socioeconomic and political contexts at the centre of hospital history, historians revealed how there was more to the hospital than medical encounters, medicalization, or ideas of social control. As the hospital increasingly came to be viewed as "a microcosm of society," they emerged as important local institutions that were embedded in local networks of support and medical care (Granshaw and Porter 4). Close associations developed between hospitals and the communities they served. New types of institution, such as the cottage hospital, emerged in the second half of the nineteenth century to meet local medical needs (Cherry), but even general hospitals remained firmly embedded in their locality in the early twentieth century. Emily's narrative therefore not only offers a specific instance of a form of medical contestation noted by historians but also provides a unique example of the kinds of evidence that support new revisionist histories of hospital culture.

Aesthetic Epistemology

One further context into which Emily's narrative may be placed, and which sociological studies of illness narratives have emphasised, is the "collective experience" (Hydén 59) of patients and their support network (Zola; Viney and Bousfield). This scholarship regards illness not as an individual experience but rather as located within social contexts or communities, a view that echoes debates among historians of medicine about how experiences of disease are socially constructed (Jordanova; Harley). Certainly Emily's narration of the local hospital appears a good example of such communitarian medicine and the social embeddedness of medical narratives. While this is undoubtedly valuable in enabling sociologists to understand how identities are created and maintained in the struggle against illnesses that can be effacing it fails to take account, once again, of the writing itself. Studies of social context from this perspective tend to read illness narratives as matters of fact, or at least of biographical truth; as "life histories" (Hydén 59) that draw the narratives out of the private sphere (the authentic individual self-experience) and into the realm of useful social or empirical data. There is a utilitarian sensibility to employing illness narratives in this way (where narratives are interrogated for their accomplishments and broader relevance) that ignores their aesthetic achievements as well as the new knowledge that an aesthetic epistemology can offer. For example, Emily's choice of vocabulary in describing her experience in a large urban hospital, rather than the facts of her narrative, reveals how the medical environment had become spectral. She notes the "atmosphere," her "unwanted presence" and how ultimately she felt "on the other side." This growing sense of herself as ghost-like draws on gothic tropes to articulate a corporeal, emotional knowledge of her own disempowerment. Such understanding is essentially aesthetic; once again in its original meaning as a discourse of the body that comes to reason through a materiality and psychology of feeling, allowing us to bridge the conceptual gap between the operation of social or cultural 'discourses,' and the bodies and subjectivities of individuals.

"Charlotte's Story," the narrative of a medical encounter of a family member with the clinical spaces used to treat kidney patients, provides an even more acute gothic aesthetic:

As we entered the ward I'm sure that my face must have betrayed all that I felt inside. I could barely breathe; such was the level of emotion and anxiety I was experiencing. The room was filled with beds, each inhabited by a very sick looking person who was hooked up to a large, ugly machine. There was a constant low level hum and my strongest visual memory is of blood. Blood being pumped through tubes, out of arms, into machines and back again. And sad yellow faces, out of which stared dull, lifeless eyes.

Charlotte's response to the clinic is a directly aesthetic one: she feels the experience in and through her body. Despite the fact that the narrative claims to be a "visual memory" its textual and textural complexity cannot fully be realised by reading it within the observational paradigms of Foucauldian medical discourse which negotiates the terrain of the objective and subjective clinical experience. As Meegan Kennedy highlights, even mid-nineteenth century clinical case histories were never just about the objective or subjective experience but shared the "romantic discourse of the Gothic" ("The Ghost" 327). Just as the nineteenth century clinical case history was both a historical and literary construct, "Charlotte's Story" must be recognised as one already filled with literary and historical knowledge and specifically with a gothic

mythology of the pathological body. This is to read the narrative entirely against the grain of certain scholarly perceptions of illness narratives. Arthur Bochner, writing in response to Paul Atkinson's call for objective approaches to narrative data, argues that the work of analyzing narratives is entirely subjective: "When I sit down to analyse a story, there's the story, and there's me. The meaning of the story is not immanent in the text" (135). Yet in Charlotte's narrative the meaning is entirely encapsulated within the text itself and how that text suggests its relationships to other texts, especially popular myths.⁴ Meaning emerges not in the relation between text and critic but in the text's richness and 'originality' – its seeking out of pre-existing origins in other textual forms.

Although it is implied rather than revealed, the aesthetic discourse of Charlotte's narrative links history with myth-making fiction to construct a vision of disease and its sufferers as monstrous. For instance, Charlotte's bodily experience of the dialysis ward leads her to an aesthetic that focuses on blood. This initial 'visual' and visceral stimulus parallels the moment in Bram Stoker's gothic novel, *Dracula*, where the narrator sees the monstrous vampire for the first time:

And then I saw something which filled my very soul with horror. There lay the Count, but looking as if his youth had been half restored. For the white hair and moustache were changed to dark iron-grey. The cheeks were fuller, and the white skin seemed ruby-red underneath. The mouth was redder than ever, for on the lips were gouts of fresh blood, which trickled from the corners of the mouth and ran down over the chin and neck. Even the deep, burning eyes seemed set amongst swollen flesh, for the lids and pouches underneath were bloated. It seemed as if the whole awful creature were simply gorged with blood. (51)

There is more to the parallel between Charlotte's narrative and Stoker's influential vampire myth than the repetition of blood. Like Stoker's narrator, Charlotte is encountering the monstrous effects of transgressive blood circulation for the first time. And also like Stoker's narrator Charlotte is confronted by the possibility of bodily transformation and its monstrous effects, which resonate with late Victorian Gothic concerns about the instability of the body (Halberstam; Hurley). Later in her narrative, she asks herself "Was it really possible that he would soon be yellow and sad like them?" The yellowing effect on the skin of kidney disease is not only referred to in this question but also prior to that, in the "sad yellow faces, out of which stared dull, lifeless eyes." This image, too, has its intertextual referent. In particular it is reminiscent of another gothic narrative of monstrosity, Mary Shelley's novel *Frankenstein*. Shelley's description of the monstrous creature created by Victor Frankenstein's new science tells us that:

His yellow skin scarcely covered the work of muscles and arteries beneath; his hair was of a lustrous black, and flowing; his teeth of pearly whiteness; but these luxuriances only formed a more horrid contrast with his watery eyes, that seemed almost of the same colour as the dun-white sockets in which they were set. (56)

Frankenstein's remembrance of the yellow skin and the eyes, which frame his description, is markedly similar to Charlotte's memory of the dialysis patients, who

are themselves the same complex combination of humanity and artificiality that marks out Victor Frankenstein's creature as monstrous.

The intertextual aesthetic parallels with *Dracula* and *Frankenstein* reveal how far Charlotte's own narrative is one of monstrosity; the horror of being identified as monstrous, and the fear of becoming the monster. Nowhere does her narrative explain this, or make explicit those concerns, but the effects on her body (as she narrates them) clearly indicate that it is within a longer fictional mythology that such ideas take root and through which they become expressed to reveal the shared narrative and aesthetic arena between illness narrative and the gothic. Charlotte's narrative can therefore be viewed as part of a historical tradition in which disease is characterised as monstrous and an invader (Gilman; Hardy; Healey; Lindemann; Sontag). This depiction of disease can be found, for example, in early modern ideas about monstrous births, eighteenth century representations of gout, Victorian discussions of cholera or physical deformity, or contemporary impressions of cancer. The historical scholarship on disease representation stresses that identifying disease as monstrous is a way of understanding the social and personal implications of illness and its effects on individual identity (Deutsch; Durbach). The use of imaginative metaphors of monstrosity is a way of making disease comprehensible and to understand its relations to the self and others. Charlotte's imaginative investments perform this role in her narrative; but additionally they connect her experience to similar historical experiences. Her story, then, is not inscribed within the boundaries of clinical experience or under the power of the medical gaze but instead extends far beyond her particular medical encounter by placing her story in an imaginative community within history and fiction.

For Bochner, Charlotte's story would have none of these important associations, for the text itself would offer nothing of value beyond its access to the storyteller as an authentic individual or the scholar as an analyst of that individual (and of his/her own practice in analysis): "The process of theorizing, analyzing, and categorizing personal narratives is shot through and through with the imagination and ways of seeing of the interpreter" (136). While Bochner's point here is to stress the importance of observer reflexivity, in direct opposition to the scientific objectivity proposed by Atkinson, it also indicates a particularly Foucauldian relation between the scholarly analyst and the illness narrative and its writer. Bochner's claim that meaning must be imposed upon an illness text by the reader tends towards the same relationship of power that Foucault identified as the medical gaze. That is, it is the observer who has control and authority while the text or patient is silenced. Despite Bochner's championing of the authentic illness writer and his (admirable) quest to see their narratives as meaningful, his methodological stance undermines that project by adhering to a structure of relations that replicate the clinical encounter he is writing against.

Even illness narratives that are written from within the most tightly controlled form of the medical encounter still produce text that has the kind of imaginary investment that produces connections to its literary and historical predecessors and thereby allow it to accrue meaning beyond the gaze. Medical and psychiatric case notes are notoriously restrictive in their form and content, offering mainly "therapeutic instructions" and serving to reinforce the "representational ideals" of the depersonalised medicine that emerged in the second half of the nineteenth century (Andrews; Warner n.p.). One set of case notes from 1912, held in the Bethlem Royal Hospital Archive, details the final year of a patient called Abraham Raphael who had been admitted with "dementia of the general paralytic" (1).⁵ Raphael's case is typical:

"patients with GPI were admitted to countless private and public asylums during the period and Raphael is just one such example" (Waddington, "General Paralysis" 367). Yet within the case notes recorded by Raphael's attending physicians there is, as with Charlotte's story, a bodily aesthetic that emerges as belonging very clearly to Raphael himself. While the majority of the notes present a medicalised account of Raphael's deteriorating condition (marked by medical language and the standard physician's shorthand) his own voice is also given narrative purchase, even if this is supposed only to exemplify the increasingly debilitating dementia from which he suffers.

Emerging from Raphael's discussions with his physicians, probably best described as reported monologues, is first his religious affiliation to Judaism. He describes himself as "the chosen of God" and a "perfect man" (3). He also related a series of extraordinary stories which feature mathematics (his former professional role was as a school headmaster): these include his claims to have drunk "1,000,000 bottles of wine" in an Italian café, and to have bought "more than 1,000 eggs for his schoolchildren" (3). The notes also include (as inserts) scraps of paper on which Raphael has attempted unsuccessfully to complete multiplication sums (5). Unlike the reported monologues these sums are diagnostic tools for Raphael's physicians which, they believe, indicate his increasing dementia. Although there is no indication in the case notes of the meaning of Raphael's incongruous comments they are clearly connected to the sums: they are reported, it is reasonable to assume, in order to register his growing mental derangement. To consider these from Raphael's perspective is clearly more difficult. The narratives are provided by his physicians, after all, even if the sums are his own. Yet it does appear that his mathematical fantasies are efforts to claim some kind of control over his own bodily and mental deficiencies. His narratives, even second-hand, are at least partly somatic fictions designed to offer some kind of resistance to the self-recognised deterioration of his condition. To that extent, Raphael's reported narratives work in parallel to Charlotte's contemporary story; they, too, are aesthetic responses emerging out of a bodily disruption that provides Raphael with a particular construction of self-knowledge as mediated through his disease. Rather than regarding these reported narratives only from within the perspective that authorised medicine placed on them, they might be read as imaginary investments in a myth of mathematical order that Raphael employs to counter the pathological schema of his dementia.

However, a more powerful historical myth also invades Raphael's narratives: the myth of the perpetrator of the Whitechapel Murders of 1888, who had been given the name Jack the Ripper. Following from his discussion of his Jewish religion, Raphael, his physicians report, "says that he has prevented a great many unmarried women from becoming pregnant by passing a lancet and an electric lamp up the rectum and then removing the uterus, ovaries and fallopian tubes, this is also apparently to prevent them suffering from syphilis" (3). As many social and cultural historians have shown the modern mythology of the Whitechapel murderer was already being constructed even as the murders continued across the later months of 1888 (Curtis; Frayling; Oldridge). Central to that mythology both at the time, and in the 1910s when Raphael was being cared for at Bethlem, was the relationship between the murders, the murderer and medicine, and in particular to a style of medicine associated with physiology and the laboratory, seen as essential components in the emergence of modern biomedicine. The murders were thought to be horrific transgressions of medical practices in their hideous desecration of the female body and its reproductive system (Walkowitz). The murderer, it was speculated, may have been a man with medical knowledge and training, perhaps even a practising

physician, surgeon or a "physiologist delirious with cruelty" (Power Cobbe). Indeed the name given to the unknown perpetrator, Jack the Ripper, encapsulated that understanding of the close relation between medicine and the murders by using a common term for the ancient practice of anatomical dissection (to rip). One other key feature of the Whitechapel murders was the suspicion that fell on those communities in the area regarded as non-British, and in particular the East End's Jews.

Raphael's narrative of invasion of the female body clearly resonates with the Whitechapel Murders in several ways. First, Raphael's status as London Jew allied him with those who came under intense scrutiny in 1888. Second, his fantasised violence against female reproduction, and its associations with aberrant sexuality leading to sexually-transmitted disease, repeats the activities of the Whitechapel murderer. Yet his narrative is also more complex than this. By narrating a clearly fictional version of himself as a latter-day Jack the Ripper, Raphael is associating himself both with the medical profession and the sexual psychopath who may have committed the crimes. The reason for the latter association is self-evident: Raphael is himself suffering from syphilitic dementia that has already undermined his mental stability. He presents this, from a patient's fearful perspective, within the condition of an historical myth that stresses the gothic horror of such suffering as well as the gothic associations with the institution (Bedlam) in which he found himself. At the same time his present medical encounter colours his relationship with the attending physicians, and he incorporates into his myth-making fiction a view of their clinical investigations of his illness made equally horrific and transgressive. Indeed what Raphael's historical analogy with the Whitechapel murderer achieves here is to offer an extreme critique of the depersonalised medical gaze by making that gaze monstrous and destructive, reinforcing the idea that the patient must be conceptualised as an integral part of biomedicine (Armstrong; Warner 1999).⁶ More radical, however, is Raphael's association of his own position with the female victims of the Whitechapel murders. It is, after all, he and they, in his narrative, who are potential victims of both syphilis and medical intervention (horrifically perceived as that is). What this allows Raphael to register is both a fantasy of good health and recognition of the horror of illness. His re-enactment of Jack the Ripper is a mode of prevention in which the women (and he) are saved from the dangers of syphilis. Yet to imagine the women (and himself) as victims of Jack the Ripper is to acknowledge, too, his own destruction. To read Raphael's fantastic narratives in the case notes from an historically-informed perspective is to gain access to his self-understanding of his condition in ways not otherwise possible. His Jack the Ripper narrative is an aesthetic enactment that comes to knowledge through collaboration with a myth-making history that exists beyond the medical encounter. To limit the narrative either to clinical concerns, or to presentist readings of the patient within the moments of the clinical experience, would be to deny it that knowledge.

Re-enchanting Narrative Medicine

One of the key concerns of scholarly work on illness narratives has been to retrieve the wonder of the patient perspective from the depersonalizing clinical voice. This has been articulated – via Max Weber's influential reading of the effects of twentieth century science – as an effort to re-enchant patient narratives (Weber). Frank, in particular in his 2002 essay on the study of stories, argues that patient narratives are "acts of reenchantment" (110) while Warner more recently claimed that greater attention to both writing and observational practices in the study of case notes provides an opportunity to "re-enchant the art of healing" (n.p.). For these writers re-

enchantment is implicitly a response to the disenchantment brought about by bureaucratic and professional discourses within medicine, of the type that Foucault employs as further evidence of the emergence of a domineering clinical gaze. To re-enchant, therefore, is to reclaim the aesthetic and imaginative qualities from a system that reduces illness narratives (and healthcare more broadly) to nothing more than a further set of utterances that provide specialist medical data. Both Frank and Warner are right to promote the potential for enchantment that exists within narratives of illness. Nevertheless, their method for achieving a form of re-enchantment is implicitly to accept Foucault's construction of the medical encounter and seek out methods of study that might manage to construct some sense of struggles against it. For both scholars this necessitates a promotion of the individual; the individual observer and the observed subject for Warner and "the authenticity of the personal" narrator for Frank (116). There is, however, another way to approach the enchantment of the narratives produced around illness and the clinical medical encounter, and that is, as this article has shown, to reject Foucault's paradigmatic insistence on the totality of the medical gaze and reveal that the enchantments and "imaginary investments" have always been there in the narratives themselves.

This is undoubtedly a reversal of much that has been written of illness narratives. In particular it demands thinking about narratives in a way that disrupts their very existence as narrative forms; a disregarding of their linear temporality, their cohesion of the self or selves, and their sense of progress towards greater individual truth or understanding. The narratives discussed in this article have not been read as narratives but rather as episodes – independent aesthetic moments given life in language – in whose interstices other episodes of historical and literary significance have been revitalised and given new meaning. There is, after all, no reason to accept that lives are lived only as narratives: a point that the philosopher Galen Strawson makes very persuasively. For Strawson "it's just not true that there is only one good way for human beings to experience their being in time. There are deeply non-Narrative people and there are good ways to live that are deeply non-Narrative" (429). Indeed, for Strawson narrativity "close[s] down important avenues of thought" (429) and the tendency to seek for individual identity in narrative cohesion is "a gross hindrance to self-understanding" (447). In the same ways as Strawson, if not articulated quite so starkly, revisionist historians of medicine find cohesive and progressive understandings of the past suspicious as they seek to problematise the nature of medicalization and shake off the idea that modern biomedicine is essentially correct. Likewise, in a literary context, Catherine Belling has called for greater attention to the lyricism in fictions of medicine rather than their identifiably narrative experiences (2-6).

Illness writing – whether in official medical case notes or in fictional and non-fictional patient stories – can be investigated as an individual instance of the imagination that connects the clinical encounter to history and to fiction. Illness narratives read in this way take us past the patient (authentic or otherwise) and beyond the traditional boundaries of the medical encounter by investing in a different kind of textual community where historical artefacts, mythologies and fictional representations meet. This association is as vital a form of authority for the patient or their family member as the on-going project to give credence to their stories through the promotion of their moral authenticity. Indeed this textual community of history and fiction reveals that the "unnatural act of violence against the body" (Harland 103) that Foucauldian paradigms continue to circulate as the truth of medical encounters is

not its totality. There remains far more that does, and always has invested in the powerful enchantments of other stories, historical and fictional, myth and imagination.

Notes

1. Martin Willis is principal author, Keir Waddington co-author and Richard Marsden corresponding author.

2. This narrative, entitled "Marie's Story", along with others to follow throughout the article, was produced for the Off Sick Project, a collaborative research initiative investigating contemporary illness narratives related to the medical encounter. The narratives were entirely self-generated, sometimes with the support of a creative writing workshop, and sometimes without. The participants were given no specific criteria for their narratives other than to consider their experience of the medical encounter, as they perceived that. The project was funded by the Universities of Glamorgan and Cardiff and led by the authors. All the participants in the project agreed for their narratives to be used in research publications. All names have been altered to provide anonymity to the writers. The project's work, and the complete narratives, can be viewed at www.officksproject.co.uk. Unless otherwise specified all the narratives presented in the article are drawn from this project.

3. A similarly uncanny experience can be found in the published illness narrative of Welsh poet, Gwyneth Lewis. In *A Hospital Odyssey*, a contemporary pastiche of Homer, Lewis depicts a large urban hospital as a vast and unknown landscape which must be traversed in order to reach the safety of home.

4. In discussions with Charlotte based on the analysis of her narrative presented here she avowed no explicit intention to alert readers to the inter-texts that we identify, nor indeed any intention on her part to draw from those narratives in constructing her own. The meanings that therefore emerge in this analysis do not do so from any authorial position.

5. Raphael's general paralysis of the insane (GPI) or paralytic dementia occurred as a result of his having contracted syphilis. He was admitted to Bethlem on 11 Feb 1910 and died there on 25 Dec 1912. The authors would like to thank the Bethlem Art and History Collections Trust for permission to quote from the Male "Case Notes" and Colin Gale at the Bethlem Royal Hospital Archive and Museum Services for his help and support in making them available for research purposes.

6. If the medical gaze actually performed in the powerful way Foucault describes then Raphael's narrative would not exist in the case notes to the extent that it allows for this interpretation to be brought out. The very existence of the critique of the medical gaze fundamentally undermines the position it is presumed to hold.

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Daniel Cordle, “Protect/Protest: British Nuclear Fiction of the 1980s.” *The British Journal for the History of Science* 45.4 (2012): 653-669.

Contained within a special issue of *The British Journal for the History of Science* on ‘British Nuclear Culture’, Daniel Cordle’s article provides a valuable assessment of the nuclear referent within a selection of British writings during the 1980s. Both Cordle’s article and the special issue more broadly outline an emerging area of scholarship which aims to unpick the ways in which nuclear technology and weaponry influenced British cultural life during the Cold War. Cordle’s article focuses on a series of socio-political events during the eighties – notably the “hard-lines stances” (655) of Margaret Thatcher and Ronald Reagan towards the Soviet Union and increasing reaction to the British government’s 1976 civil defence pamphlet *Protect and Survive* – and evaluates how these wider issues filtered into literary representation.

Cordle opens with an assessment of Maggie Gee’s novel *The Burning Book* (1983). He notes that the work is not a direct appraisal of nuclear defence policy, ostensibly offering “a conventional family saga” (653), yet argues that “periodically the narrative of the family’s lives is interrupted by voices from Hiroshima, [. . .] and at the end the family’s stories are violently truncated as a nuclear war breaks out” (653). Using Gee’s novel, Cordle describes a particular Cold War sensation whereby “nuclear threat shadows and threatens everyday life, but is largely unnoticed until crisis breaks out” (654). His key point in relation to 1980s fiction in Britain is that it articulates, uniquely, “a politics of vulnerability” (654) whereby literary works do not necessarily produce extended polemics against nuclear warfare but rather communicate the helplessness felt by individuals and communities in the event of thermonuclear conflagration. Cordle sees this literary strategy as emerging parallel to increased public scrutiny of the recommendations contained within *Protect and Survive*, arguing that “in order to construct a narrative of national civil security” (655) the pamphlet was required to highlight “the vulnerability of the country to nuclear attack” (655) as a means of legitimising the purpose of civil defence. Cordle continues by providing an excellent analysis of *Protect and Survive*, outlining how increasing media attention as well as E.P. Thompson’s counter pamphlet *Protest and Survive* (1980) and the rejuvenation of CND elevated a previously unnoticed government publication and made it “part of the iconography of 1980s nuclear culture in Britain” (656). *Protect and Survive*, Cordle argues, became a powerful symbol as its supposed reassurances about surviving nuclear war were overwhelmingly offset by its demonstration of “the vulnerability of ordinary citizens in a decade in which the threat of nuclear war came to seem much more urgent” (656).

The final part of Cordle’s article turns to a survey of nuclear fiction and contemplates a selection of major themes: “gender and family,” “the environment” and “society and socio-economic organisation.” He picks out a variety of works, such as the television drama *Threads* (1984), Raymond Briggs’ graphic novel *When the Wind Blows* (1982) and Ian McEwan’s *The Child in Time* (1987) as well as providing interesting readings of two post-apocalyptic young-adult novels which have largely escaped critical attention – Louise Lawrence’s *Children of the Dust* (1985) and Robert Swindell’s *Brother in the Land* (1984). The analysis of these two works ties in with

the article's earlier critique of *Protect and Survive* as their grim visions of post-nuclear war communities – Cordle argues that fiction for teenagers in the eighties was “impressively robust” (658) in portraying the realities nuclear apocalypse – highlights the extreme vulnerability of individuals and communities when confronting thermonuclear exchange. Cordle concludes by returning to Gee's *The Burning Book* and an examination of the political activism described in the run-up to the novel's catastrophic dénouement. Citing Gee's evocation of a fictional yet recognisable Greenham Common protest where a group of women lie down in front of missiles, Cordle remarks that the tactic flaunts vulnerability as a way of de-legitimizing *Protect and Survive* and helping to “strip away the illusion of both protection and survival, to gamble naked flesh against the nuclear holocaust that awaits” (669). In this final point, Cordle re-emphasises how British nuclear literature of the 1980s rarely adopted overt political standpoints, but instead utilised human vulnerability as a means of communicating the general absurdity of nuclear stand-off.

If there is one minor criticism of Cordle's otherwise excellent article it is found in a reluctance to place the fiction of the eighties in a broader literary historiography of British Cold War fiction. While Nevil Shute's *On the Beach* (1957) and Peter Watkins' docu-drama *The War Game* (1965) are briefly discussed, Cordle does not explore how works such *Children of the Dust* and *Brother in the Land* correspond in terms of form and theme with British disaster narratives from earlier 'hot' moments of the Cold War – notably, it may have been appropriate to cite John Christopher's *The Death of Grass* (1956), which although about ecological disaster, sees worldwide terror accentuated by the British government's use of nuclear weapons on its own people and ends with the protagonist inadvertently killing his own brother. However, this is a small point that does not detract from a fine article. Cordle skilfully outlines an area of British literary studies that has otherwise been overlooked while, at the same time, appropriately argues for a historical reassessment of the 1980s as a decade haunted by nuclear anxieties.

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Jonathan Hogg, “The Family that Feared Tomorrow’: British Nuclear Culture and Individual Experience in the late 1950s.”
The British Journal for the History of Science 45.4 (2012): 535-549.

Jonathan Hogg’s examination of the impact of nuclear issues upon individual experience in Britain during the 1950s is a valuable piece of research into a period of Cold War history that has predominantly been considered through the American post-war suburban experience. Hogg begins by recalling an event in 1957 where Elsie and Andrew Marshall gassed their three children before entering into a suicide pact and jumping into the sea. Hogg then notes how a subsequent article in the *Daily Mirror* entitled “The family that feared tomorrow” outlined the contents of the suicide note, which cited the threat of human extermination as a key factor in the couples’ actions. This incident, Hogg argues, provides a powerful example of how developing nuclear technologies produced a wide-range of cultural and personal responses while also demonstrating how “profound preoccupations with nuclear danger straddled class boundaries” (536). Hogg’s article therefore utilises Gabrielle Hecht’s (2006) use of the term ‘nuclearity’ (Hecht uses it to refer to the extent to which a nation is classed as ‘nuclear’) but re-appropriates it to reveal “the shifting set of assumptions held by individual citizens on the dangers of nuclear technology, assumptions that were rooted firmly in context and which circulated in, and were shaped by, national discourse” (537). ‘Nuclearity’ thus becomes a way of assessing the degree to which the nuclear referent was encoded within cultural activities.

Following on from these initial observations, Hogg’s first sub-heading “Rational anxieties” sets out the extent of public understanding on nuclear issues, noting that by the close of the 1950s “every adult in Britain had some knowledge of atomic bombs” (538), with individuals aware of “the instantaneous and lasting damage that atomic and thermonuclear weapons could inflict on themselves and their loved ones” (538). Hogg then insightfully sets out his position in relation to a selection of academic writings on nuclear threat, providing a thoughtful critique of Frank Kermode’s argument in *The Sense of an Ending* (1967) that there are distinct similarities between modern fears of nuclear apocalypse and those of the ancient world. Hogg counters Kermode by observing the historical specificity of nuclear anxiety, which is “uniquely modern in that it is a response to a man-made threat of unprecedented magnitude” (539). Extending this argument, Hogg moves on to survey a variety of cultural responses to the thermonuclear era in fifties Britain, listing a collection of science fiction productions – notably Nigel Kneale’s *The Quatermass Experiment* (1953) and J.B. Priestley’s *Doomsday for Dyson* (1958) – as well as, fascinatingly, the giveaway of toy atomic submarines in packs of Cornflakes in 1957, which highlighted how “popular discourse was already dependent on a range of assumptions over the excitement and awe surrounding nuclear technology” (541). In picking out varying cultural phenomena Hogg therefore demonstrates the ways “nuclear culture coloured day-to-day life” (542) through various mediums.

While Hogg’s survey of nuclear culture in Britain during the 1950s is informative and thorough, he does not necessarily supply a sustained examination of each of the cultural artefacts cited. However, the final two sections do provide a skilful and detailed analysis of a series of articles from the *Daily Express* and *Daily*

Mirror, with Hogg arguing that the reporting of nuclear issues invariably combined an allegiance with “official” attitudes while also providing occasional nods towards broader public anxieties about thermonuclear destruction. Hogg writes: “while reinforcing ‘official’ nuclear vocabulary, newspapers also contained ‘counternarratives’ that reflected popular attitudes on nuclear technology” (544). He concludes by returning to the *Daily Mirror*’s reporting of the suicide pact and observes that many journalistic comments contained “an implicit understanding of the negative aspects of nuclear culture” (547), which, nonetheless, produced an assumption that “these negative intellectual and emotional characteristics had become a normalised component of British individual experience in the late 1950s” (547).

Hogg provides a comprehensive evaluation of cultural and individual responses to the rapid proliferation of nuclear technologies during the late 1950s. The use of the term “nuclearity” is, however, a little unclear and is not sufficiently mapped out. Hecht’s initial usage is only briefly mentioned and other than a short general definition, the article lacked a detailed explanation of precisely what “nuclearity” represented in relation to specific texts or artefacts. In articulating how certain articles, films, books or cultural productions “contributed to the concept of nuclearity” (545) it occasionally felt as though certain works were being viewed as symptoms of a broader sociological phenomenon rather than as unique representations that sustained a complex dialogue with their social and political contexts. Nonetheless, this is not to detract from a fascinating article which provides a much needed change of perspective when researching British cultural life in the 1950s. By moving away from canonical literary texts and exploring oral history, Hogg skilfully exposes how the nuclear referent seeped into the vocabulary of everyday life.

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Gowan Dawson, “Literary Megatheriums and Loose Baggy Monsters: Paleontology and the Victorian Novel.” *Victorian Studies* 53. 2 (2011): 203-230.

Henry James’s characterisation of Victorian serialised novels as “large loose baggy monsters” has become an accepted term of reference in literary criticism, whether critics deemed the serialised novel an apt response to a sprawling, multifarious Victorian world, or whether, like James, they took the New Critical view that equated serialisation with sloppy structure and formal incoherence. Despite the recurrence of James’s epigram in twentieth-century criticism, there has been little scholarly attention paid to the sources of his analogy. Gowan Dawson’s article addresses this, and in doing so demonstrates how James’s remark grew out of much older critical discourses based on complex, well-established analogies between novelistic design and Cuvierian methods of comparative anatomy.

Contemporary reviewers of the serial novel grappled with the problem of how the whole might be judged from its parts and saw a lack of design and coherence in serialisation that precluded it from consideration as high art. Dawson shows how book reviewers in the 1840s and 1850s began to depict “serial novels in similar terms to those used to portray lumbering, ungainly prehistoric creatures” (205). At the same time, Cuvier’s “paleontological method of functional correlation” (205), which had been adopted with stunning effect in Britain by Richard Owen, provided a powerfully persuasive model for recognising design in the most unlikely assemblage of parts. The consummate example of awkward monstrosity in palaeontology was found in the Megatherium. Owen’s remarkable reconstruction of this creature revealed it to be bizarre and ill-proportioned; however, it also demonstrated that the Megatherium, despite its apparent absurdity, was wholly adapted to its environment. This rationalisation of seemingly discordant parts, Dawson argues, offered writers an affirming critical context whereby what “had seemed merely incongruous, ungainly, and awkward” could be regarded instead as exhibiting “harmonious and perfectly integrated design” (208).

The Megatherium appears regularly in William Makepeace Thackeray’s writings and Dawson demonstrates how over the course of Thackeray’s personal associations with Owen and Louis Agassiz such references became increasingly sophisticated, from Thackeray’s “sardonic play with the ‘Megatheria of history’” (211) in the 1840s, to *The Newcomes* (1853-55) and Arthur Pendennis’s comparison of narrative construction with Owen’s articulation of fossil fragments. While Pendennis’s ruminations have been read as deriding comparative anatomy’s claim to inductive reasoning, Dawson demonstrates how Thackeray’s careful composition of serial instalments can be read as evidence of his recognition that “authorial practice bore an uncanny resemblance to [. . .] paleontological procedures” (215). Thus, through Pendennis’s speculations on “Owen’s functionalist elaboration of the Megatherium’s perfectly integrated anatomy,” Thackeray offered a “means of appreciating novelistic design and structure that [. . .] vindicated the aesthetic credentials of serialised fiction on precisely the grounds on which it had been most vociferously condemned” (217).

Disparaging criticism of serialised novels as ill-shaped monstrosities intensified, Dawson asserts, “especially among a coterie of prominent American

commentators on literary taste who grew increasingly antagonistic to the stylistic conventions of the mid-Victorian novel” (219), and the second half of the article traces the use of the analogy by the American poet James Russell Lowell. While Lowell found in comparative anatomy an “appropriate parallel for the Romantic conception of the suggestive power of the fragmentary,” he failed to see the “perfectly integrated Megatheroid structure” of Thackeray’s *The Newcomes*. Rather for Lowell, such “literary Megatheriums” indicated a “vulnerability to extinction” (221). Personal connections between Lowell and Henry James lead Dawson to an examination of James’s own use of “images of prehistoric megafauna” (222) to indicate aesthetic monstrosity, and to the conclusion that mid-Victorian writers, readers and critics familiar with contemporary discourses in comparative anatomy were much more inclined to perceive coherent design in the disparate parts of the serialised novel than later critics less accustomed to paleontological methods.

Dawson’s article is not only a fine piece of research, it also challenges recent critical readings of the serial novel as corresponding to Darwinian models of the unfolding of species through evolutionary process, positing alternatively a persuasive argument for the primacy of comparative anatomy in the shaping of the serialised form and critical responses to it. The article offers a timely reminder that there is still much to be recovered in the exchanges between literature and science in the years before 1859, and that those exchanges were not nullified by the event of Darwinism, but continued asserting powerful influences far beyond 1859. It reminds scholars that the shadow of Darwinism has been retrospectively cast over the Victorian world by modern critics whose valuable research has, nevertheless, tended to obscure other highly pertinent literary/scientific exchanges. Dawson pieces back together and re-articulates a rich and intricate critical discourse, one that will have an important part to play in scholarly research into both Victorian and early twentieth-century critical understanding of the relationship between novelistic design and scientific method.

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**Janine Rogers and Charlotte Sleigh, “‘Here is my Honey-Machine’:
Sylvia Plath and the Mereology of the Beehive.” *The Review of
English Studies* 63.259 (2012): 293-310**

Janine Rogers and Charlotte Sleigh breathe new life into Sylvia Plath's 1962 poetic sequence of "bee poems" by developing a relevant and unique methodology that primarily draws upon entomological theories put forward by the poet's father Otto Plath, and his doctoral advisor William Morton Wheeler, where "connections between the social insects [. . .] and human society proved irresistible" (299). Rogers and Sleigh refreshingly eschew dominant critical trends that see Plath's biography and writings as intrinsically interlinked; and instead base their study within an interdisciplinary framework that analyses Plath's work in context with scientific philosophy. Rogers and Sleigh's intelligent and nuanced argument suggests that Plath's 'bee poems' reveal layered contemplations on "formative, figurative and linguistic levels" (294), as well as commentaries about poetic ownership of language, the tradition of lyric poetry, and even scholarly entomological work of the mid-twentieth century.

Citing an award-winning Master's Thesis by Amanda Jernigan ("Wholes and Parts (All Puns Intended): The Mereological Vision of Richard Outram's Poetic Sequences") as a template, Plath's poetry is thus examined through the concept of mereology – the study of wholes and parts. Making the connection between the cooperative 'part' played by a hive bee in relation to its hive 'whole', and the role played by an individual poem within a poetic sequence; the authors cleverly uncover a direct link between the structure of Plath's 'bee poems' and scientific theories espoused by her deceased father. Rather than using this connection as an example of Otto Plath's personal role as Plath's fatherly poetic muse however, Rogers and Sleigh instead suggest that the poet's fixation with bees and bee-keeping (which they note can be traced back to June 1958) offers an understanding of "the mereological concept of identity: the self as an individual and as part of society" (299). This insight, it is argued, is integral to understanding the themes Plath's 'bee poems' and her wider literary corpus investigate.

Rogers and Sleigh also devote attention to hypotheses made by sociologists contemporary to Plath's era who suggest that, while hive bees are serenely socialised as obliging parts within a whole structure, this social structure leaves no anomalies: "insect societies had no lunatics or criminals, but they had no geniuses either" (299). Opening this to a wider debate and drawing on views formulated at Ivy League interdisciplinary colloquiums, as well as Plath's own critical essays, Rogers and Sleigh question the idea of poetic ownership – if the poet is akin to the hive bee; and the poem, like the hive, is superorganismic, then who is its owner? Plath herself hints at the "self-composition of the poem once its subject is in place" (301), predating what MIT Professor Lewis Thomas would later suggest in 1974: "language is simply alive, like an organism [. . .] words are the cells of language, moving the great body, on legs" (301). Rogers and Sleigh endeavour to show how Plath's 'bee poems' reflect these concerns. The people who populate her poetry, specifically in "The Bee Meeting" are reminiscent of dumbly socialised hive bees as they are, "described for their social roles just like insects" (302). Indeed the entire poetic sequence is rife with the poet's struggle to own the "language hive" (305), with Plath's lapse into repetitive

chants, for example, demonstrating the difficulty of articulating words that hold meaning or make sense.

It is these anxieties of language and reflections on the self that tie Plath's 'bee poems' to the lyric tradition – where the “unconscious production of language and text [. . .] pours out of the poet as a pure emotive response” (307). Rogers and Sleigh extend bee and honey metaphors to lyric poetry, situating Plath's pastoral settings within Yeatsian and Dickensian realms, amongst others. What is most compelling, however, is the assertion that Plath's perceived castigation of husband and fellow poet, Ted Hughes in these 'bee poems' can actually be interpreted as a comparison between her work and that of the long lyric tradition – which Hughes is said to represent. “He [Hughes/the lyric tradition] has worked too hard and perhaps attempted ownership of language, which, as we have seen, is something of a fool's errand [. . .] when he encounters words/bees in their uncomfortable reality, they swarm onto him” (309). This analysis and re-evaluation of Hughes's position within Plath's oeuvre is timely, interesting and indicative of the strong arguments outlined in this article.

Rogers and Sleigh offer a fascinating analysis of Plath's 'bee poems'. As scholars working respectively in the disciplines of literary studies and the history of science their unique methodology illustrates the possibilities of interdisciplinary collaboration and points to the many avenues of exploration that still require scholarly attention within the field. This article is well researched and lively, and marks a remarkable new contribution of knowledge to Sylvia Plath studies.

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Cristina Hanganu-Bresch and Carol Berkenkotter, “Narrative Survival: Personal and Institutional Accounts of Asylum Confinement.” *Literature and Medicine* 30.1 (2012): 12-41.

In the 1980s and 1990s, scholars of the nineteenth century with an interest in incarceration and its literary or cultural representation – often inspired by Michel Foucault’s influential studies of the historical rise of penal and medical discourse – tended to focus on how institutions construct identities for those confined within them. More recently, we have seen a growing concern with what Foucault called “the insurrection of subjugated knowledges,” that is “historical contents that have been buried or masked in functional coherences or formal systematizations” (“*Society Must Be Defended*”: *Lectures at the Collège de France, 1975-76* 7). Cristina Hanganu-Bresch and Carol Berkenkotter’s article usefully combines both of these critical agendas, reading the institutional case histories of two men simultaneously incarcerated at Ticehurst House Asylum in Sussex, England, in the 1870s against the former patients’ “‘survivors’ narratives” (12).

Drawing on archival research at the Wellcome Institute for the History of Medicine in London, and a theoretical framework involving the history of psychiatry, genre, narrative and speech act theory, Hanganu-Bresch and Berkenkotter analyse accounts of incarceration around Herman Charles Merivale, “a barrister with literary ambitions” (15) and Walter Marshall, “a gentleman of no declared profession” engaged in election politics (17). The article compares and contrasts institutional documents with Merivale’s anonymously published memoir *My Experiences in a Lunatic Asylum by a Sane Patient* (1879) and Marshall’s testimony to the Parliament’s Select Committee on Lunacy Law in 1877. Using the concepts of emplotment, causality and narrative time, the authors read these two accounts as “counter-narratives” that “function rhetorically as oppositional to the linear institutional chronicle of a patient’s confinement” (19). Hanganu-Bresch and Berkenkotter show that the former patients’ narratives reverse causality by challenging the idea that the men had been incarcerated because they were insane and arguing instead that it was confinement in itself that almost drove them mad. Readings of memoir and testimony suggest that while the “‘insanity’ master plot governing asylum psychiatry typifies the madman as an insalubrious influence and a danger to civilised society” (21), the two men refuted the definitions of behaviour emerging from their case notes and offered alternative explanations for their conduct. Literary scholars in particular will enjoy Hanganu-Bresch and Berkenkotter’s discussion of Merivale’s intertextual references, including William Shakespeare, Charles Dickens and Charles Reade, and his use of Menippean satire to make sense of his asylum experience.

As the article remarks – perhaps somewhat obviously in the wake of the ‘narrative turn’ – the clinical notes “are by no means ‘just the facts,’ or even the raw materials of observation” (18); asylum staff in charge of these accounts “background[ed] certain details and foreground[ed] others” (18). However, Hanganu-Bresch and Berkenkotter are careful not to glorify the patient narratives as an uncomplicated truth either, demonstrating that they, too, were subject to omission and selection by their authors. According to the article, “counter-narratives” by patients, which developed in the second half of the nineteenth century alongside “the decline of

asylums for psychiatric treatment,” intrigued the Victorian reading public and “along with journalistic exposés and novels, shaped public opinion as well as English law” (12). While a detailed discussion of this larger context is arguably beyond the scope of the article, some brief cross-references might have been useful here, for instance to the highly publicised Georgina Weldon case in 1878 – when Weldon’s husband unsuccessfully tried to commit her to a lunatic asylum with the help of psychiatrist F. Forbes Winslow – which coincided with the publication of Merivale’s memoir in serial form. As the authors rightly note in passing, Ticehurst offered psychiatric care for the rich only, resulting in “close supervision and extensive documentation” impossible in public asylums (37). This raises questions for future research regarding how the treatment of and case notes on the wealthy might have differed from “common” patients and how class – alongside other factors such as gender – impacted on Merivale’s and Marshall’s ability to obtain a discharge and make their voices heard.

Merivale’s memoir and the record of Marshall’s oral testimony provide compelling examples of how creative writing and self-expression can empower (former) patients. The power of creative writing (and reading) is increasingly recognised in current approaches to mental illness, but such “bibliotherapy” does not necessarily encourage the patient’s questioning of contemporary institutional discourse. It is here that Hanganu-Bresch and Berkenkotter’s analysis of two nineteenth-century “counter-narratives” offers potentially intriguing lessons not only for historians of medicine and scholars of life-writing, but also for present-day psychiatric practice. What Hanganu-Bresch and Berkenkotter’s article implicitly conveys is that all narratives of mental illness are historically contingent.

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Kay Young, “Wounded by Mystery’: Dickens and Attachment Theory.” *English 61* (2012): 234-247.

In this stimulating article, Kay Young explores the identity, self-awareness and psychic life of Esther Summerson in Dickens’s *Bleak House* (1853) via Attachment Theory. For Young, Esther’s guilt, shame and crises of identity flow from the wound of having had no mother. Esther suffers a traumatising upbringing at the hands of her unloving godmother who provides her with only scanty, censoring descriptions of her origins. Young argues that Esther’s character articulates and endures the painful “*psychic experience of feeling unattached*” (237), of having forgone the primary, ideally loving attachment that secures the growth of an assured selfhood. With no introjected mother to answer the primary question, ‘Who am I?’ Esther confronts a double mystery: the identity of her lost mother and the less resolvable enigma of her unknown and unknowable self.

With its underpinnings in nineteenth-century neurophysiology, Freudian psychoanalysis foregrounds the biological and orientates psychological life around the physical drives. However, Freud also explored the psyche in terms of objects, incorporation and introjection, thus facilitating the development of overlapping theories of object relations, attachment and relationality. According to these approaches, which have largely supplanted Freud’s drive model, our earliest attachments form the basis of mental life via a complex, on-going intra-psychic mediation between the external and internal. Consequently, Attachment Theory’s primary exponents – John Bowlby, Melanie Klein and Donald Winnicott – shifted attention from father-son rivalry to (equally fraught) mother-infant attachment, while emphasising intersubjectivity, affect and lived experience.

Young opens with Freud’s foundational 1917 paper “Mourning and Melancholia”. Here, Freud argues that loss can instigate “a fundamental cleavage” (237) within the self with the ego, which is identified with the lost loved one, becoming a “forsaken object.” Young argues that Esther has undergone such a bifurcation and is “mourning for her *self*” (238). Bereaved infants, such as Esther, are haunted by an “absent memory” (239) and Young describes how Esther experiences a different, unthinking way of knowing her lost mother. If Esther famously, self-deprecatingly and, perhaps, disingenuously opens her narrative with “I know I am not clever,” Young posits that “what Esther knows is *beyond* clever – remarkably, she knows what she has not known” (246). Thus, although urged to forget, Esther intuitively recognises Lady Dedlock as her mother.

Young analyses Esther’s relationship with her godmother, deploying the psychotherapeutic notion of ‘malattunement’, by which the primary caregiver is unable, or unwilling, to provide the infant with a securing love. With her evangelicalism, which only envisages Esther’s origins as shameful, Esther’s godmother holds her “in a state of detachment, not just to herself as the ‘mother’ figure, but to Esther’s self as a person” (241). Young cites the analyst Robert Stolorow, who argues that, without the “affect-integrating capacity” of the soothing caregiver, painful and frightening feelings overwhelm the infant, while she develops an unconscious certainty that her rage and unfulfilled yearnings towards the deficient caregiver are manifestations of innate badness. Esther’s conviction that she is irremediably defective is sublimated into her willed embodiment of the “industrious, content, and kind” (246) angel of the home.

Dickens's coterie of orphans, mistreated children and woeful caregivers certainly seem ripe for the insights of relational psychoanalysis. For Young, *Bleak House* anticipates and confirms "the significance of the mother-child relation to identity formation" (237). However, we do not necessarily require the occasionally banal insights from relational psychoanalysis to appreciate that Esther's harsh early life has sculpted a personality marked by self-abnegation and compensatory caregiving. Furthermore, Young's analysis perhaps underappreciates that Esther is more insightful, critical and self-reflexive than her own narrative persona (consciously?) reveals. Psychoanalysing Dickens's characters also assumes a high level of mimetic realism in Dickens's work, downplaying his melodramatic representation of character and locating in his fiction universal psychological truths that 'prove' the insights of psychoanalysis. Psychoanalytic accounts also tend to foreground (and pathologise) the individual psyche, neglecting historical, social and cultural determinants; Esther's 'malattunement' is, arguably, densely interwoven with historically particular socio-sexual norms. Indeed, the validity of universalising applications of psychoanalytic ideas might be queried here. While psychoanalysis offers a rich, imaginative mode for understanding Dickens's characters, it may be more useful for scholars working in the field of literature and science to excavate the medico-scientific and literary-artistic contexts in which he developed his representations of the human mind. Juliet John, for example, has persuasively argued that Dickens's use of a melodramatic aesthetics precludes the sort of depth psychology that is the foundation of psychoanalysis. Dickens's work, in other words, may actually challenge and undo some of the assumptions that underpin psychoanalysis, complicating its supposed universality. Despite these ongoing critical debates, this well-crafted, intelligent and insightful article usefully expands psychoanalytic and feminist accounts of loss, attachment and identity in Dickens's novels, while making a stimulating contribution to those modes of critical analysis.

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