

**Classifying a Manic-Depressive Illness:  
Diagnosis, Treatment, and Representations of  
High and Low Mood States,  
1830-1902**

**Cerys Knighton**



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## Summary

This thesis examines medical and cultural constructions of severe high and low mood states to seek the conception of an inherently manic-depressive illness. Studies in the history of bipolar disorder have tended to look to categories that combined mania and melancholia, viewing these terms according to present mania and depression: as opposite poles on the emotional spectrum. However, by using a methodological approach that sees current diagnostic frameworks as still in motion instead of final, and remaining historically grounded by focusing on how diagnosis happens while prioritising patient case records from working institutions, this thesis uncovers a different finding. Instead of representing solely high mood, the greater specificity developed for nineteenth-century mania alongside the professionalisation of psychiatric practice was characterised by both high and low emotional states, including alternating mood, periods of lucidity, and features of psychosis traced by emotional themes. The classification of nineteenth-century mania as an inherently manic-depressive illness is my primary argument. Furthermore, this thesis uses an interdisciplinary approach, concurrently examining medical writing and literary texts to seek the classification and representation of a manic-depressive illness in different places and for different groups. The fluidity of exchange between nineteenth-century medical and literary writing makes an analysis of literary representations valuable for investigating mania's medical and cultural identity. The narrative style of patient case records, threading together the perspective of the patient, their relatives and friends, and the physician, can be examined to investigate whether literary texts similarly represented the symptoms and behaviours recorded in mania. Literary analysis can also investigate how these consistently recorded features were used to either normalise or challenge medical authority, types of treatment, care according to place and gender, the pathologizing of emotion in the context of different cultural beliefs, and social inclusion or exclusion.

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## Introduction

This thesis examines medical and cultural constructions of severe high and low mood states to seek the conception of an inherently manic-depressive illness. Histories of bipolar disorder have traditionally traced the origins of bipolar illness to Emil Kraepelin's 'manic-depressive psychosis', which was the basis for 'manic depressive reaction' in the first edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-I)* in 1952.<sup>1</sup> 'Manic depressive reaction' became 'manic-depressive illness' in the *DSM-2*, 1968, and bipolar disorder in the *DSM-3*, 1980.<sup>2</sup> However, historical studies have also looked for the roots of bipolar disorder in nineteenth-century French psychiatry. The translation of John-Pierre Falret's 1854 presentation of the symptomatology of *folie circulaire* into English for the first time in 1983 influenced new historical studies that identified the 'discovery' of bipolar disorder in 1854.<sup>3</sup> Such work looks to both John-Pierre Falret and Jules Baillarger. Falret's *folie circulaire*, or circular insanity, and Baillarger's *folie à double forme*, or dual-form insanity, were both presented in the first months of 1854. Both frameworks consisted of an illness moving in a specific pattern between mania, melancholia, and periods of lucidity. The similarities between the terms led to a claim for priority from Falret, and accusations of plagiarism from Baillarger – a dispute perpetuated by Baillarger until his death in 1890.<sup>4</sup>

Both historical and literary studies of manic-depressive illness tend to seek diagnostic categories that combined mania and melancholia, like Baillarger's *folie à double forme* and Falret's *folie circulaire*.<sup>5</sup> However, in doing so, such work identifies nineteenth-century mania and melancholia as early forms of mania and depression, which in current classifications denote two individual, opposing poles on the mood spectrum of bipolarity. This is problematic, because it does not unpick mania and melancholia within their nineteenth-century context, and

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<sup>1</sup> Brittany L. Mason, E. Sherwood Brown, and Paul E. Croarkin, 'Historical Underpinnings of Bipolar Disorder Diagnostic Criteria', *Behavioural Sciences*, 6.3 (2016), p. 14.

<sup>2</sup> Mason, Sherwood Brown, and Croarkin, 'Historical Underpinnings of Bipolar Disorder Diagnostic Criteria', p. 14.

<sup>3</sup> Tierry Haustgen, and Hangop S. Akiskal, 'French antecedents of "contemporary" concepts in the American Psychiatric Association's classification of bipolar (mood) disorders', *Journal of Affective Disorders*, 96.3 (2006), pp. 149-163.

<sup>4</sup> P. Pinchot, 'The Birth of the Bipolar Disorder', *European Psychiatry*, 10.1 (1995), pp. 1-10 (p. 7).

<sup>5</sup> See, for example: Linda McDaniel, 'The Manic-Depressive Father in George Meredith's *Harry Richmond*', *Victorian Literature and Culture* (September 2015), pp. 589-603 (pp. 589-592); David Healy, *Mania: A Short History of Bipolar Disorder* (Baltimore: The John Hopkins University Press, 2008); Tierry Haustgen, and Hangop S. Akiskal, 'French antecedents of "contemporary" concepts in the American Psychiatric Association's classification of bipolar (mood) disorders', *Journal of Affective Disorders*, 96.3 (2006), pp. 149-163; Pinchot, P., 'Circular Insanity, 150 Years On', *Bulletin de L'Académie Nationale de Médecine*, 188.2 (2004), pp. 275-84; G.E. Berrios, 'Of Mania: Introduction', *History of Psychiatry*, 15.1 (2004), pp. 105-124; P. Pinchot, 'The Birth of the Bipolar Disorder', *European Psychiatry*, 10.1 (1995), pp. 1-10.

has led to work suggesting there was no conceptualisation of an illness that moved episodically between extreme highs and lows of mood prior to 1854. My research into the history and representations of manic-depressive illness is unique in its argument that nineteenth-century mania and melancholia were not opposing poles on the mood spectrum. Instead, mania was characterised by both high and low mood states alongside symptoms of psychosis. My work is also original amid histories of bipolar in its focus on observations in working asylums rather than published diagnostic frameworks. Moreover, my methodology is unique, weaving a historically grounded approach with a dialogue with current classifications to shift the focus to the diagnostic process, how healthy and unhealthy mood states were constructed, and how disease identity was explored and represented across both medical and literary texts.

This Introduction will begin by setting out my methodological approach in dialogue with critical approaches to the history of illness.<sup>6</sup> I will propose a methodology that values both the current construction of diagnostic classifications and an examination of past diagnostic categories within their own context. The key element in this methodology is a recognition of diagnoses as probabilistic rather than apodictic judgements – diagnoses are more or less likely rather than true or false based on the human construction of boundaries between healthy and unhealthy mood.<sup>7</sup> Furthermore, these boundaries continue to be shifted, which makes a study of how lines are presently drawn valuable to studying the way they were placed in the past. The second section of the Introduction will therefore investigate current movements in the construction of bipolar disorder to expand on the framework of my methodology. The third section will go on to discuss the value of analysing asylum diagnostic practice, instead of solely published diagnostic frameworks, to examine the construction of a disease category, as well as the value of an interdisciplinary approach that interrogates representations of unhealthy mood states in both medical and literary writing. This third section will set out the scope of this thesis, which goes beyond examining the medical and cultural history of severe emotional states to interrogating the diagnosis, treatment, and representation of these states for different places

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<sup>6</sup> Including: Osamu Muramoto, 'Retrospective diagnosis of a famous historical figure: ontological, epistemic, and ethical considerations', *Philosophy, Ethics, and Humanities in Medicine*, 9 (2014) pp. 1-15; Piers D. Mitchell, 'Retrospective diagnosis and the use of historical texts for investigating disease in the past', *International Journal of Paleopathology*, 1 (2011), pp. 81-88; A. Karenberg, 'Retrospective Diagnosis: Use and Abuse in Medical Historiography', *Prague Medical Report*, 110.2 (2009), pp. 140-145; Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Houndmills: Palgrave Macmillan, 2004); Andrew Cunningham, 'Identifying Disease in the Past: Cutting the Gordian Knot', *Asclepio*, 54 (2002), pp. 13-34.

<sup>7</sup> This point draws from Osamu Muramoto's example using hypertension, which I will discuss in the next section. See: Osamu Muramoto, 'Retrospective diagnosis of a famous historical figure: ontological, epistemic, and ethical considerations', *Philosophy, Ethics, and Humanities in Medicine*, 9 (2014) pp. 1-15 (p. 5).

and different groups, using the study of the history of manic-depressive illness as a lens to contribute to studies of the history of culturally specific care and differences in care for women and men. I will set out the key sources for this study, including the primary institutions and the identification of literary texts for analysis. Finally, the closing section of the Introduction will set out a chapter breakdown.

Throughout this thesis, my use of ‘manic-depressive illness’ is to describe the concept of an illness characterised by movement between states of mood alongside symptoms of psychosis, rather than to describe the introduction of a specific term at a particular time. For example, when referring to Kraepelin’s framework, I will use ‘manic-depressive psychosis’, and if pointing to the use of the category ‘manic-depressive illness’ in the *DSM-2*, I will make it clear that I am using it in that specific context. Any other use of ‘manic-depressive illness’ is to discuss the idea of a type of illness consisting of extreme emotional states and psychosis.

## Methodology

My contribution to work on the medical and cultural history of bipolar disorder is original in its dialogue with recent classifications, while maintaining a historically grounded approach to examining diagnostic observations in their nineteenth-century context. Scholarship debating the use of recent medical classifications and retrospective diagnosis, often termed the ‘Cunningham debate’ after the important work of Andrew Cunningham in 2002, might consider this an impossible dual approach. However, I am going to set out both why this methodology is possible, and why it is useful to study the history and representations of illness. To do this, I will discuss other work that has contributed to this debate to situate my own approach within it.

Cunningham’s 2002 work, ‘Identifying Disease in the Past: Cutting the Gordian Knot’ sets out the problems with retrospective diagnosis and using present medical classifications to identify diseases in the past.<sup>8</sup> Problems identified by Cunningham include the ontological issue of ‘assum[ing] the continuous identity of past diseases with modern diseases’, questioning whether work using present classifications can ‘tell us anything at all about *the past*’,<sup>9</sup> or whether ‘they are simply projections backwards of present-day issues’.<sup>10</sup> Cunningham’s

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<sup>8</sup> Andrew Cunningham, ‘Identifying Disease in the Past: Cutting the Gordian Knot’, *Asclepio*, 54 (2002), pp. 13-34 (p. 13).

<sup>9</sup> Emphasis in original.

<sup>10</sup> Cunningham, ‘Identifying Disease in the Past’, p. 16.

concern, then, is about whether the use of retrospective diagnosis can be effective in studies of the social history of disease. To combat this, he suggests turning away from the history of a disease itself, instead examining the history of ‘*how diagnosis happens*’ to study the identity and experience of a form of disease in the past:<sup>11</sup>

For it is by the act of diagnosis that disease identity is given or established. The operations that humans perform in making diagnosis are not just the key to disease identity, but the source of disease identity. The only identity disease has is its operational identity.<sup>12</sup>

Cunningham points out that the purpose of a diagnostic label is not merely to ‘*recognise* the disease’, but rather its central purpose is operational.<sup>13</sup> Osamu Muramoto expands on this point, highlighting that a diagnosis is a ‘probabilistic judgement’ rather than an ‘apodictic judgement’.<sup>14</sup> A diagnosis is made based on being more or less likely, rather than being true or false, because the usefulness of a diagnosis is not necessarily “identifying” and “verifying” an underlying biological reality’, but instead its use is operational – to guide a patient’s treatment and to explain to a patient their condition.<sup>15</sup> The characteristics recorded in working hospitals to provide a diagnosis for a patient are key to investigating the experience and representation of a type of disease in any given context. This is central to my methodology, which is original in work on the history of bipolar by placing the central focus on observations recorded in working asylums. By examining observations recorded in patient case notes, it is possible to identify patterns in the categorisation of symptoms into a disease entity, and to examine the experience of the patient diagnosed.

Cunningham also draws attention to the role of medical authority, saying of diagnosis, ‘you die of what your doctor says you die of’.<sup>16</sup> As I will discuss in detail when I turn to hospital records in Chapter One, physicians in nineteenth-century asylums did not work to a uniform nosology for diagnosis. Instead, they were given space to form their own classifications for different types of mental illness through their encounters with patients. This practice was also reflected in instructional textbooks classifying types of mental illness, like Bucknill and Tuke’s *A Manual of Psychological Medicine* (1858), which provided a summary of a type of disease

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<sup>11</sup> Cunningham, ‘Identifying Disease in the Past’, p. 16. Emphasis in original.

<sup>12</sup> Cunningham, ‘Identifying Disease in the Past’, p. 16.

<sup>13</sup> Cunningham, ‘Identifying Disease in the Past’, p. 16.

<sup>14</sup> Osamu Muramoto, ‘Retrospective diagnosis of a famous historical figure: ontological, epistemic, and ethical considerations’, *Philosophy, Ethics, and Humanities in Medicine*, 9 (2014) pp. 1-15 (p. 6).

<sup>15</sup> Muramoto, ‘Retrospective diagnosis of a famous historical figure’, pp. 6-7.

<sup>16</sup> Cunningham, ‘Identifying Disease in the Past’, p. 17.



by noting the numerous variations in classifications according to different physicians instead of providing a single framework. Crucially, this fluidity in diagnostic classifications makes it possible to seek patterns to examine which features were consistently observed and recorded as important, and therefore which symptoms characterised a category of illness.

In this way, my methodology also follows Cunningham and Muramoto's views of diagnostic categories as socially constructed. In his work on retrospective diagnosis, Piers D. Mitchell argues that medical developments mean that modern diagnosis is a 'biological diagnosis', whereas past diagnosis is a 'social diagnosis'.<sup>17</sup> Muramoto argues against this point, and instead agrees with Cunningham that all diagnoses are socially constructed. To make this argument, Muramoto uses the example of hypertension:

Blood pressure reading is a continuous spectrum from low to high numbers, and the numbers themselves do not represent a disease or normalcy. It is a man-made cut-off point.<sup>18</sup>

While blood pressure can be measured, the line between health and illness is socially constructed. Bipolar is not quantifiable in quite the same way, though questions during the diagnostic process, and education about bipolar, tend to rely on mood scales to point to different levels of emotional severity. For example, the UK's national bipolar charity, *Bipolar UK*, employs a mood scale where 0 represents the most severe low mood, 10 the most severe high mood, and 5 a balanced state.<sup>19</sup> Scales like this are used during the diagnostic process to draw a line between normal and severe mood<sup>20</sup>, and mood charts are recommended to patients given a diagnosis of bipolar to keep a record of their emotional state.<sup>21</sup> The number on the scale cannot exist independently from the subjective experience of the person who records it. The process relies on the perspective of the patient, the observations of relatives, and the ultimate determination of the psychiatrist as to where the boundary sits between normal and severe mood. These conversations are used to make the diagnosis, a syndromic diagnosis with no confirmatory test, but one that is made based on personal experience and observed experience.

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<sup>17</sup> Piers D. Mitchell, 'Retrospective diagnosis and the use of historical texts for investigating disease in the past', *International Journal of Paleopathology*, 1 (2011), pp. 81-88 (p. 82).

<sup>18</sup> Muramoto, 'Retrospective diagnosis of a famous historical figure', p. 5.

<sup>19</sup> Bipolar UK, 'Mood Scale' <<https://www.bipolaruk.org/FAQs/mood-scale>> [accessed April 11, 2021].

<sup>20</sup> NHS, 'Diagnosis' <<https://www.nhs.uk/mental-health/conditions/bipolar-disorder/diagnosis>> [accessed April 11, 2021].

<sup>21</sup> Bipolar UK, 'Could Mood Swings Mean Bipolar?' <<https://www.bipolaruk.org/FAQs/leaflet-could-mood-swings-mean-bipolar>> [accessed April 11, 2021].

This present diagnostic process for bipolar disorder is not altogether different from the process in nineteenth-century working asylums, where both the patient and relatives were consulted, asked questions about any changes in emotional state, severity of emotional state, presence of hallucinations or delusions, and changes in behaviour. Like in present consultations, determining a diagnosis could not exist independently from the subjective experience of the patient and their relatives, who provided perceptions of the severity of mood. Asylum records include admission documents, which were to be completed by ‘parents or guardians with the assistance of medical attendant’ to provide observations of the patient prior to their admission, and patient case books, which included the testimony of the patient, relatives and friends, as well as the observations of the physician. In her study of puerperal insanity, Hilary Marland situates the value of patient cases in ‘tell[ing] us more than most other sources’ about ‘diagnosis and classification’ by including both a ‘medical viewpoint’ and ‘buil[d]ing on the reports of the family and friends of the patient’.<sup>22</sup> The similarities between past and present diagnostic systems in weaving the perspective of the patient, their relatives and friends, and the physician, makes it possible to examine where the lines around balanced and severe mood states were being drawn – where emotion moved from normal to diseased. This does not mean that it is possible to identify bipolar disorder as we understand and classify it today in nineteenth-century case notes, but rather that it is possible to analyse the socially constructed boundaries between normal mood state and mental illness.

I agree, then, with Cunningham and Muramoto that diagnoses are socially constructed, and that studies of the history of disease should examine the process of diagnosis rather than seek to transfer a disease in the form we recognise it today onto the past. However, I also suggest that there is room in this approach to include a dialogue with current classifications. One of the issues discussed by Cunningham and Karenberg in retrospective diagnosis is the view of present medical knowledge as superior and final.<sup>23</sup> Cunningham argues that work attempting to identify present disease in the past is problematic because we ‘naturally take our models of disease entity as the final, and thereby the only legitimate, models.’<sup>24</sup> This is not the way I approach present bipolar disorder. In the next section, I will discuss current diagnostic criteria to demonstrate how our present concept of bipolar disorder is not static. The focus of

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<sup>22</sup> Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Houndmills: Palgrave Macmillan, 2004), p. 96.

<sup>23</sup> Cunningham, ‘Identifying Disease in the Past’, p. 14; Karenberg, A., ‘Retrospective Diagnosis: Use and Abuse in Medical Historiography’, *Prague Medical Report*, 110.2 (2009), pp. 140-145, (p. 141).

<sup>24</sup> Cunningham, ‘Identifying Disease in the Past’, p. 14.

the discussion will be changing boundaries in the diagnostic classification for bipolar depression. To summarise, Goodwin and Jamison's textbook *Manic-Depressive Illness* (1990), provides data to demonstrate the presence of psychosis in bipolar depression. While the occurrence of psychosis in depression was lower than its occurrence in mania, it was clearly still a prominent feature. Despite this recognition, the *DSM-4*, published four years later in 1994, did not include psychosis alongside depression – this change in diagnostic criteria did not occur until 2013 in the *DSM-5*. Lines continue to be drawn around the classifications for bipolar illness – statistics can show the prominence of a feature, but diagnostic criteria can take time to catch up. It is also worth noting that the present diagnostic procedure for bipolar is far from faultless – it takes an average of 10.5 years after first accessing psychiatric treatment for a diagnosis of bipolar to be given, with patients initially misdiagnosed an average of 1-2 times.<sup>25</sup>

What I am proposing, then, is that there is a way to be faithful to Cunningham's view that the process of diagnosis should be a central focus, and faithful to Karenberg's view that the attention should be mostly on primary sources and historical context, but that it is also valuable to create dialogue with present classifications. Recognising that the present category for bipolar is not static, but that the categories continue to shift, shows how these boundaries are socially constructed. This makes it possible to seek the way lines were drawn and redrawn in their own context, but crucially means that current classifications are not relied on to identify patterns in the nineteenth century. For example, the current shift recognises psychosis presenting in depression as well as in mania. The visibility for this is often discussed in terms of mood-congruent psychosis, which means themes of psychosis presenting in accordance with the emotional state. As I will examine in Chapter One, the structure of questions on admission documents, and the narrative of observations of patients and testimony from patients and relatives, similarly traced the emotional themes of experiences of psychosis. Recognising changes in present classifications, and recognising patterns in the nineteenth century, is therefore not to say that a present experience of mood-congruent psychosis is the same as the experience recorded in the nineteenth century. Instead, it is valuable to analysing how the relationship between emotional states and psychosis in the nineteenth century was constructed and categorised in diagnosis.

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<sup>25</sup> 'Bipolar – The Facts', *Bipolar UK* <<https://www.bipolaruk.org/faqs/bipolar-the-facts>> [accessed April 11, 2021]

This fluidity of approach can make a valuable contribution to scholarship in both the history of psychiatry and literary studies. Examining how patients were diagnosed, and how categories were shaped, makes it possible to analyse how both symptoms and patients were represented in different types of texts beyond medical writing. Studies like Roger Luckhurst's *The Invention of Telepathy* demonstrate the importance of employing multiple threads of analysis to examining the construction of concepts.<sup>26</sup> To study the construction of mood states as illness in this nineteenth-century context, it is necessary to look across different spaces, different institutions, and different types of texts. Because the diagnostic system relied on language to express emotional experience, it is possible to analyse how language was used to represent symptoms in literary texts as well as in medical writing. Furthermore, identifying patterns across medical and literary texts strengthens an analysis of the key features of a disease's identity. Analysing literature which drew from medical ideas allows for further research into the representation of patients, psychiatric treatment, and diagnostic categories, and creates space to investigate whether literature challenged or normalised views about forms of treatment, medical authority, and the impact of mania on both an individual and on society. This methodological framework can also expose well-known texts to new analysis. For example, I offer new readings of texts such as Edgar Allan Poe's 'The Murders in the Rue Morgue' (1841) and Lewis Carroll's *Alice's Adventures in Wonderland* (1865).

In contribution to studies in the history of psychiatry, this methodological framework has revealed findings that appear to have been overlooked in the history of bipolar illness. The key finding in my thesis is that an examination of symptoms recorded in working asylums shows the prominence of both severe high and low mood states in the single diagnostic category of nineteenth-century mania, whereas work on the history of bipolar disorder has previously considered nineteenth-century mania and melancholia as synonymous with high and low mood, in the way we recognise mania and depression today. Because of seeing mania and melancholia as opposites on the mood spectrum, work on the history of bipolar disorder has looked to frameworks such as Falret and Baillarger's to seek the combining of mania and melancholia. Mitchell raises the point that identifying diseases in the past can be problematic because past categories might blend multiple diseases.<sup>27</sup> In the similar fashion of seeing the illness according to present identification, but turned on its head, historians have attempted to trace present mania and melancholia back in time to discover the point at which they were combined. By doing

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<sup>26</sup> Roger Luckhurst, *The Invention of Telepathy* (Oxford: Oxford University Press, 2002).

<sup>27</sup> Mitchell, 'Retrospective diagnosis and the use of historical texts for investigating disease in the past', p. 84.

this, this work has overlooked the observations in working asylums that characterised mania individually by both high and low mood states.

My methodology, then, is flexible in its approach as historically grounded, without turning away from present shifts in diagnostic classifications. A dialogue with current classifications makes it possible to recognise a disease category as still in motion. This recognition in turn allows for an analysis of how boundary lines were positioned, and were repositioned, between a healthy and unhealthy emotional state. This approach supports and strengthens the view of diagnostic categories as socially constructed. Moreover, it can reveal new findings in the history of types of illness by looking at patterns in the way diagnosis happens, rather than considering a present diagnostic category as static, and seeking other static diagnostic categories in the past, like connections drawn between the categories of Falret and Baillarger with present bipolar disorder. A framework that includes dialogue with present developments aids in an historically grounded approach by shifting the focus to how developments happen, identifying how lines are set between characterising features, and examining how these symptoms are represented. In the next section, I will examine present developments in detail to expand on the value of this approach.

### **Present Diagnostic Criteria for Bipolar Disorder**

Tierry Haustgen draws connections between the work of a number of French psychiatrists in the nineteenth century and the classifications for bipolar in the late twentieth century to point to the roots of different aspects of bipolarity, and ultimately argues that mood disorders are static: ‘mood and bipolar disorders represent a clinical group that is remarkably stable, unmodified either by history and even perhaps geography’.<sup>28</sup> In contrast, a key feature of my methodology is recognising that current bipolar disorder is not static, but instead continues to be constructed. The current increased attention to features of psychosis in bipolar depression, in both diagnostic criteria and in campaigns for bipolar education and awareness, is one example of the fluid nature of categorising symptoms associated with manic-depressive illness. Late twentieth-century work on the range of the bipolar spectrum was influenced by the *DSM-3* change from ‘manic depression’ to ‘bipolar disorder’, a change in an edition of the *DSM* characterised by disorders being ‘redefined – differentiated, fused, incorporated, or

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<sup>28</sup> Haustgen and Akiskal, ‘French antecedents of “contemporary” concepts in the American Psychiatric Association’s classification of bipolar (mood) disorders’, p. 159.

eliminated'.<sup>29</sup> Haustgen traces work from this late twentieth-century period of reshaping diagnostic categories to the multiplication and division of diagnostic frameworks in the mid nineteenth century. Rather than showing the origin of bipolar disorder, or suggesting that the spectrum is static, I argue that this illustrates the fluidity of categorising alternating mood alongside features of psychosis.

The current classification for bipolar depression establishes a key change in the occurrence of psychosis in a bipolar mood disorder (as opposed to unipolar). Previously, symptoms of psychosis, presenting in delusions and hallucinations, were mostly associated with high mood in bipolar illness. Current categories of high mood are divided into two terms: mania and hypomania. The key difference is that mania is considered more severe. Hypomania is differentiated from mania by being 'not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalisation.'<sup>30</sup> One of the primary differences relates to symptoms of psychosis. Mania is considered more severe because it can present with symptoms of psychosis, whereas hypomania does not: 'If there are psychotic features, the episode is, by definition, manic.'<sup>31</sup> The distinctions between mania and hypomania are important to distinguish between subtypes of modern bipolar disorder. Periods of mania are found in bipolar I, whereas periods of hypomania are found in bipolar II. The division of mania and hypomania, based on psychosis, classify mania as more severe, and hypomania as less severe. For this reason, bipolar I was considered more severe, whereas bipolar II was traditionally seen as a less severe subcategory of bipolar disorder.<sup>32</sup>

One of the key changes from the *DSM-4* to the *DSM-5* rethinks this previous division in severity through a shift in the diagnostic information for states of major depression in bipolar II. The *DSM-5* explains that recent developments mean bipolar II should no longer considered a less severe form of the illness:

Despite the substantial differences in duration and severity between a manic and hypomanic episode, bipolar II disorder is not a "milder form" of bipolar I disorder. Compared with individuals with bipolar I disorder, individuals with bipolar II disorder

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<sup>29</sup> Lisa Hermesen, *Manic Minds: Mania's Mad History and its Neuro-Future* (New Jersey: Rutgers University Press, 2011), p. 27.

<sup>30</sup> American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, 5<sup>th</sup> edn, 5 vols (Arlington: American Psychiatric Association, 2013), V (2013), p. 125.

<sup>31</sup> APA, *DSM-5*, p. 125.

<sup>32</sup> APA, *DSM-5*, p. 127.

have a greater chronicity of illness and spend, on average, more time in the depressive phase of their illness, which can be severe and/or disabling.<sup>33</sup>

The *DSM-5* makes it clear that the change from seeing bipolar II as the less severe bipolar subtype is based on the condition's states of depression. Observations leading to this change are the 'amount of time individuals with this condition [bipolar II] spend in depression', and the consequential 'serious impairment in work and social functioning'.<sup>34</sup> Moreover, while episodes of high mood are considered more severe in bipolar I, this subtype does not require an episode of major depression to be diagnosed. To meet the criteria for bipolar II episodes of both major depression and hypomania are required.<sup>35</sup> However, to meet the criteria for bipolar I, an episode of mania is all that is required for diagnosis.<sup>36</sup>

A key aspect of my thesis is examining representations of the relationship between emotional states and psychosis, to see how distinctions were made in the nineteenth century between healthy and unhealthy mood, and what part psychotic features played in this distinction. Current classifications for bipolar depression demonstrate a reshaping of criteria around emotional states and psychosis. In contrast to the *DSM-4*, the *DSM-5* includes psychosis in the list of possible features when recording a diagnosis of bipolar II.<sup>37</sup> Symptoms of psychosis in bipolar II are recognised in states of depression rather than high mood states. If psychosis is experienced in high mood, the episode is mania rather than hypomania, meaning the diagnosis from bipolar II would be changed to bipolar I.<sup>38</sup> Psychosis in bipolar II presents instead in low mood states. Moreover, in a possible list of features, psychosis is divided into 'mood-congruent psychotic features' and 'mood-incongruent psychotic features'.<sup>39</sup> This division in psychosis is also crucial to my thesis. Mood-congruent means that the nature of psychosis is consistent with the emotional state. For example, hallucinations or delusions in mania can be concurrent with feelings of invincibility, self-importance and a heightened belief in your abilities, leading to beliefs such as the ability to fly, or grandiose religious delusions. In contrast, psychosis in depression can present with themes of vulnerability, worthlessness and death, leading to beliefs of being under threat, and ideas such as the decay of your own body.

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<sup>33</sup> APA, *DSM-5*, p. 136.

<sup>34</sup> APA, *DSM-5*, p. 123.

<sup>35</sup> APA, *DSM-5*, p. 133.

<sup>36</sup> APA, *DSM-5*, p. 128.

<sup>37</sup> APA, *DSM-5*, p. 135.

<sup>38</sup> APA, *DSM-5*, p. 135.

<sup>39</sup> APA, *DSM-5*, p. 135.

Present attention to the presence of psychosis in both mania and depression, but in different forms, allows for new examination of nineteenth-century diagnoses. With this recognition that the construction of classifications is still in motion, it is possible to analyse developments in the construction of the relationship between mood states and psychosis in nineteenth-century diagnoses. Goodwin and Jamison's textbook *Manic-Depressive Illness*, published in 1990, illustrates the way present bipolar disorder continues to be constructed. While less frequent than in high mood states, Goodwin and Jamison present studies that recognise features of psychosis in bipolar depression. The data discussed show delusions present in fewer episodes of low mood than high mood: in 12 to 66 percent of bipolar depressive episodes, and in 44 to 96 percent of manic episodes.<sup>40</sup> Hallucinations are also described as 'relatively more frequent' in mania. The studies show hallucinations present in 6 to 50 percent of bipolar depressive episodes, and in 14 to 66 percent of manic episodes.<sup>41</sup> Though it is clear in these examples that features of psychosis are less frequent in states of bipolar depression, they are still recorded in a number of cases. The studies demonstrate the presence of delusions in up to 66 percent of bipolar depressive episodes, and the presence of hallucinations in up to 50 percent of bipolar depressive episodes. However, the *DSM-4*, published in 1994, and therefore published later than Goodwin and Jamison's *Manic-Depressive Illness* of 1990, does not include psychosis in the list of features to specify when recording a diagnosis of bipolar II. This change does not appear until twenty-three years later in the *DSM-5* (2013).

The greater attention paid to features of psychosis in bipolar depression continues in current campaigns and projects relating to bipolar education. For example, in 2020, a collaboration between the National Centre for Mental Health at Cardiff University, the Royal College of Psychiatrists Wales, and the charity Bipolar UK, created webinars as a feature of the National Centre for Mental Health's *Bipolar Education Programme Cymru*. This programme, catering for people with a diagnosis of bipolar and their families, is usually delivered in-person, but content for the course was made freely available online during the first lockdown period in the UK of the COVID-19 pandemic, because of an inability to provide in-person courses, and as a feature of an ongoing project for bipolar awareness. In the first of

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<sup>40</sup> Frederick K. Goodwin and Kay Redfield Jamison, *Manic-Depressive Illness* (Oxford: Oxford University Press, 1990), p. 43.

<sup>41</sup> Goodwin and Jamison, *Manic-Depressive Illness*, p. 43.



these webinars, information breaking down the different features of bipolar illness discussed the prominence of features of psychosis in states of both mania and bipolar depression.<sup>42</sup>

An understanding of the presence of psychosis in states of bipolar depression opens new perspectives for examining nineteenth-century classifications for mood states and psychosis. Some work on the history and representations of symptoms associated with manic-depressive illness has been problematic because of its limited view of psychosis. While much of the work examining madness in literature discusses symptoms we would now recognise as associated with bipolarity, work on representations of psychotic features often equates psychosis with schizophrenia. For example, Kylie Valentine's *Psychoanalysis, Psychiatry and Modernist Literature*, discusses the formation of contemporary psychology, but does not land on a specific illness or set of symptoms, and when discussing the term 'psychosis', cites schizophrenia.<sup>43</sup> Other work, such as Lillian Feder's *Madness in Literature*, unravels this term into symptoms such as delusion, mania, paranoia, hallucination and pathological guilt, but again cites only schizophrenia as a specific mental illness for analysis.<sup>44</sup> The distinction between psychosis in bipolar states and in schizophrenia is crucial to examining representations of psychotic features. According to the *DSM-5*: 'schizophrenia, schizoaffective disorder, and delusional disorder are all characterised by periods of psychotic symptoms that occur in the absence of prominent mood symptoms'.<sup>45</sup> In contrast, psychosis presents alongside severe mood in bipolar episodes.

Recognising that the relationship between emotional states and psychosis continues to be reshaped in current diagnostic criteria can be used to interrogate the framing of this relationship in nineteenth-century diagnoses. The following chapters will not focus on current diagnosis but on how emotional states were determined as unhealthy and categorised as a type of illness – the fluid nature of our contemporary diagnostic landscape allows questions to be asked about the nature of nineteenth-century conceptions of unhealthy mood, which is what this thesis will do. Observations of mood states, hallucinations and delusions will be examined in case notes to investigate the themes of psychotic features alongside both high and low emotional states. The examination of these observations will not rely on current classifications, but instead seeks patterns in their own context, identifying consistently recorded key features

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<sup>42</sup> National Centre for Mental Health, *Bitesize BEPC – Session 1*, online video recording, YouTube, 30 July 2020, <<https://www.youtube.com/watch?v=MIV50aGQHWs>> [accessed 21 January 2021]

<sup>43</sup> Kylie Valentine, *Psychoanalysis, Psychiatry and Modernist Literature* (London: Palgrave Macmillan, 2003), pp. 119-121.

<sup>44</sup> Lillian Feder, *Madness in Literature* (Princeton: Princeton University Press, 1980), pp. 26-29.

<sup>45</sup> APA, *DSM-5*, p. 138.

in the disease identity with an understanding that the categories are not static. This focus on how diagnosis happens, and how developments in classifications happen, makes it possible to analyse how a type of illness was conceptualised. In the next section, I will expand on the value of investigating diagnostic practice in working asylums, and the value of an interdisciplinary approach concurrently examining medical and literary writing, by setting out the key sources for this thesis.

### **A Medical and Cultural History of Severe Emotional States in Different Places and for Different Groups: Key Sources**

Histories of bipolar disorder have effectively drawn connections between published frameworks like *folie à double forme* and *folie circulaire* with present bipolar disorder, but have overlooked the lack of influence of these categories on day-to-day diagnostic practice.<sup>46</sup> Nineteenth-century institutions followed a flexible system for diagnosis that allowed physicians to continue to develop classifications for different types of psychiatric illness through their experiences with patients. However, these histories have tended to look to emerging frameworks combining mania and melancholia instead of classifications recorded in patient observations across institutions. My thesis is unique amongst historical and literary studies of manic-depressive illness by prioritising patient case records to seek patterns and developments in diagnostic categories observing high and low mood states with features of psychosis.<sup>47</sup>

One of the reasons for adopting this approach is that this thesis is less interested in the discovery of bipolarity, but instead seeks the way emotional states became considered severe and pathologized. A focus on the way emotional states were classified as mental ill health is enriched by considering different perspectives for different groups. This thesis therefore concentrates on case records of institutions to investigate patterns in everyday diagnoses, and has selected institutions that provide viewpoints of medical practices at different stages in

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<sup>46</sup> See, for example: David Healy, *Mania: A Short History of Bipolar Disorder* (Baltimore: The John Hopkins University Press, 2008); P. Pinchot, 'Tracing the Origins of Bipolar Disorder: From Falret to DSM-IV and ICD-10', *Journal of Affective Disorders*, 96 (2006), pp. 145-148; Thierry Haustgen, and Hangop S. Akiskal, 'French antecedents of "contemporary" concepts in the American Psychiatric Association's classification of bipolar (mood) disorders', *Journal of Affective Disorders*, 96.3 (2006), pp. 149-163; P. Pinchot, 'The Birth of the Bipolar Disorder', *European Psychiatry*, 10.1 (1995), pp. 1-10; G.E. Berrios, 'Of Mania: Introduction', *History of Psychiatry*, 15.1 (2004), pp. 105-124.

<sup>47</sup> This approach draws from Marland's use of patient cases from Royal Edinburgh Asylum in her study of puerperal insanity as a specific category of illness. See: Marland, *Dangerous Motherhood*.

development as well as adaptations in treatment according to place.<sup>48</sup> Keir Waddington's important essay about the value of regional analysis in the medical humanities explains that illness is inseparable from the place where it is experienced, and that place is continually formed by connections in identity through shared culture, language, and mythology.<sup>49</sup> These features contribute to perceptions about the divide between health and illness, and therefore to the procedure of determining a diagnosis through testimony from patients and relatives. Chapters Three and Four will focus on examining the history of severe emotional states in the context of culturally specific care to deepen the study of how severe emotional states were diagnosed, treated, and represented according to place.

Waddington's essay also contests attitudes of whiggism that see an active core implementing changes on a passive periphery.<sup>50</sup> The introduction of institutional care in Wales and the Scottish Highlands and Islands is an example of the non-linear relationship between core and periphery, where different languages, mythologies and customs according to place required adaptations in treatment. The implementation of new systems of institutional care required negotiation between core and periphery to make medical practices accessible. This dialogue can be examined to enrich a study of the history of diagnosing, treating, and representing a manic-depressive illness. Furthermore, an analysis of observations of severe emotional states in institutions designed to cater for shared language and mythology according to place can contribute to studies of the history of culturally specific care. An investigation of the pathologizing of high and low mood states is incorporated into these chapters as a lens to nuance the study of the introduction of asylum care in Wales, through the opening of the North Wales Lunatic Asylum in Denbigh in 1848, and to the Scottish Highlands and Islands, through the opening of the Inverness District Asylum in 1864.

These chapters continue to analyse the language used to record emotional behaviour in mania, across the mood spectrum, to interrogate the way mania was diagnosed in different places. Mania was among the most common diagnoses in these institutions, and there was a particular emphasis on the chronic form of mania. Chronic mania was the diagnosis given in cases when patients were deemed incurable, and many of the admissions to these two

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<sup>48</sup> My use of the terms 'space' and 'place' draws from Yi-Fu Tuan's space as abstract and place as inscribed with meaning by human experience. See: Yi-Fu Tuan, *Space and place: The Perspective of Experience* (Minneapolis: University of Minnesota Press, 1977).

<sup>49</sup> Keir Waddington, 'Thinking Regionally: Narrative, the Medical Humanities and Region, *Medical Humanities*, 41.1 (2015), pp. 51-56 (p. 52).

<sup>50</sup> Waddington, 'Thinking Regionally', p. 53.

institutions were considered incurable because of the time they had already lived with their mental ill health without access to institutional psychiatric treatment.<sup>51</sup> According to Dr Thomas Aitken, who would be appointed Inverness District Asylum's first medical superintendent, curability was determined by the duration of the illness without treatment rather than severity.<sup>52</sup> In this way, while acute mania could present as more severe, its symptoms appearing rapidly and with greater intensity, it was considered curable, whereas the less intense presentation of chronic mania was associated with symptoms having become ingrained because of time without treatment.

The North Wales Lunatic Asylum and Inverness District Asylum are key to this study because they were both established in response to calls for culturally specific care, and their introduction led to communities transitioning from care in community spaces to sending their relatives to institutions. In Wales, access was previously limited because there were no psychiatric hospitals apart from a small, converted gaol in Haverfordwest, which the Commissioners in Lunacy deemed inadequate for care.<sup>53</sup> Patients could be sent to asylums in England, but this was generally avoided both because of the cost and because of an absence of Welsh-medium treatment.<sup>54</sup> In the Scottish Highlands and Islands, access was similarly limited by cost, but also by the distance required to travel across the Highland line.<sup>55</sup> Both asylums were established following inquiries by Commissioners in Lunacy which identified a significant number of individuals living with mental illnesses without suitable access to institutional care – in Denbigh, as a result of the additional inquiries into the condition in Wales for the *Supplemental Report* of 1844, and in Inverness, as a result of the inquiries of the Scottish Lunacy Commission, presented to parliament in 1857.<sup>56</sup> The patients' duration without psychiatric treatment meant they were already considered incurable, but care was still deemed necessary within an asylum setting.

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<sup>51</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy, relative to the General Condition of the Insane in Wales* (London: Bradbury and Evans, 1844); *Report by Her Majesty's Commissioners Appointed to Inquire into the State of Lunatic Asylums in Scotland and the Existing Law in Reference to Lunatics and Lunatic Asylums in the part of the United Kingdom* (Edinburgh: Thomas Constable, 1857).

<sup>52</sup> *First Annual Report of the Inverness District Lunatic Asylum* (Inverness: Courier's Office, 1865), p. 13.

<sup>53</sup> T.G. Davies, "'Of all the Maladies': Episodes in the History of Psychiatry in Nineteenth-Century Pembrokeshire", *The Journal of the Pembrokeshire Historical Society*, 5 (1992), pp. 75-90.

<sup>54</sup> Pamela Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000* (Cornwall: MPG Books, 2003), p. 9.

<sup>55</sup> Chris Philo, 'Scaling the Asylum: Three Geographies of the Inverness District Lunatic Asylum (Craig Dunain)', in *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context*, ed. by Leslie Topp, James E. Moran and Jonathan Andrews (London: Routledge, 2007), pp. 105-130 (p. 108).

<sup>56</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy; Report by Her Majesty's Commissioners Appointed to Inquire into the State of Lunatic Asylums in Scotland*.

Chapters Three and Four will therefore analyse the case notes of the North Wales Lunatic Asylum and the Inverness District Asylum to investigate the culturally specific diagnosis, care, and recording of severe emotional states considered incurable. This extends both the study of the medical and cultural history of manic-depressive illness and the study of care specific to the shared identity of place, investigating the negotiating relationship between Commissioners in Lunacy, local authorities and medical practitioners, as well as place-specific anxieties in communities about the visibility of behaviours associated with severe high and low mood. Episodes of high and low mood and symptoms of psychosis were experienced in communities prior to the accessibility of institutional treatment. To investigate the historic medical and cultural identity of bipolarity, it is therefore crucial to extend analysis beyond published medical frameworks, to literary texts, local newspaper articles detailing campaigns for or against asylum treatment, parliamentary reports by Commissioners in Lunacy, and patient case notes in local working asylums.

The other key institutions for my study are Gartnavel Royal Asylum in Glasgow and the Royal Edinburgh Asylum. Records from Gartnavel Royal Asylum and the Royal Edinburgh Asylum are essential to this study because they are among the institutions that kept detailed patient observations prior to the 1845 Lunacy Act, when keeping case notes was made compulsory.<sup>57</sup> Archives for both asylums include registers with patients' diagnoses, admission documents with a series of questions about the onset of the individual's mental ill health, and case books with detailed observations of patients. Jonathan Andrews has written about the different practices of keeping records of patients in Scotland and England. Andrews points out that by 1845 case books were already being used in all Scottish Royal Asylums.<sup>58</sup> However, he suggests that there needed to be a law to stipulate the keeping of records in English asylums because England's 'lucrative trade in lunacy' made patient privacy a priority, whereas in Scotland case notes were used 'first and foremost with the intent of guiding and improving medical practice'.<sup>59</sup> Gartnavel Royal Asylum in particular is vital, as it 'appear[s] to represent one of the earliest and one of the most extensive series for any Scottish psychiatric institution', with case books for male patients kept from the asylum's opening in 1814, and case books for female patients kept from 1816.<sup>60</sup> The records from Gartnavel are therefore valuable to this

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<sup>57</sup> Jonathan Andrews, 'Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century', *Social History of Medicine: The Journal of the Society for the Social History of Medicine*, 11 (1998), pp. 255-81 (p. 258).

<sup>58</sup> Andrews, 'Case Notes, Case Histories,' pp. 258.

<sup>59</sup> Andrews, 'Case Notes, Case Histories,' pp. 259.

<sup>60</sup> Andrews, 'Case Notes, Case Histories,' pp. 257-58.

study of the construction of classifications for mood states and psychosis before the frameworks of Falret and Baillarger, because the patient records of Gartnavel demonstrate classifications for different mental illnesses in everyday psychiatric practice prior to the presentations of *folie circulaire* and *folie à double forme*.

In addition to seeking to enrich a study of the history of severe emotional states by examining institutions at different stages of medical practice and with different cultural requirements, this thesis will also interrogate differences in the diagnosis, treatment, and representation of women and men. Current diagnostic data for bipolar disorder shows that diagnoses occur roughly equally for women and men.<sup>61</sup> Some historical work studying mental illness in the nineteenth century has suggested that women were overrepresented in diagnoses as a form of punishing women for deviant behaviour.<sup>62</sup> Chapters Five and Six will similarly examine the occurrence of severe mood states for male and female patients. Chapter Five will interrogate patterns in features recorded in diagnoses to see if there were different classifications for a specifically male or female mania. Chapter Six will then analyse differences in forms of treatment for women and men in asylums. These chapters will also consider the impact of class on the diagnostic process. Most of the patient records examined see working-class patients observed through the middle-class perspective of a physician. In interrogating differences for women and men, these chapters will ask whether the energies and behaviours were considered differently for working-class women, who were already in a position considered at odds with Victorian gender ideals because of the requirement for them to fulfil both their own domestic duties as well as working outside of their household.<sup>63</sup> Interrogating differences in the diagnosis, treatment, and representation of women and men with extreme emotional states both enriches a study of the medical and cultural history of manic-depressive illness, as well as working to further the study of nineteenth-century mental illness according to gender.

Each of the institutions selected for this study represent differences in patient backgrounds according to place and class. Royal Edinburgh Asylum catered to both pauper and private patients but, other than the first two case book volumes, separated case notes

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<sup>61</sup> Bipolar UK, 'Women and Bipolar' <<https://www.bipolaruk.org/pages/faqs/category/women-and-bipolar>> [accessed December 5, 2022].

<sup>62</sup> Phyllis Chesler, *Women and Madness* (New York: Avon Books, 1973); Elaine Showalter, *The Female Malady: Women Madness and English Culture, 1830-1980* (New York: Pantheon Books, 1985); Denise Russell, *Women, Madness and Medicine* (New York: Polity press, 1995).

<sup>63</sup> Martin A. Danahay, *Gender at Work in Victorian Culture: Literature, Art, and Masculinity* (London: Routledge, 2016), p. 12.

according to West House, pauper, and East House, private, patients. In light of this thesis' interest in the intersection of class and gender, and because of limitations to archival research caused by the COVID-19 pandemic, I have focused on the Royal Edinburgh Asylum's pauper patients.<sup>64</sup> Prior to the new location of Gartnavel Royal Asylum in 1841, pauper patients' and private patients' notes were recorded in the same volumes. Because of this thesis' investigation of diagnostic classifications relating to severe mood prior to the introduction of Falret's and Baillarger's frameworks, and because of the inclusion of diagnoses as well as detailed sections for classification in Gartnavel Royal Asylum's case books between 1838-1841, I concentrated on this period of records, meaning a greater variation in patient background. The North Wales Lunatic Asylum also had different classes of patient admissions. However, the first two classes were limited to twelve and twenty patients respectively in an overall initial capacity for 200 patients.<sup>65</sup> By far the largest number were pauper patients. A significant proportion of these patients were those discovered by the inquiries of the Commissioners in Lunacy – many in a domestic setting, or receiving what was considered inadequate treatment, based on language provision, in institutions across the border.<sup>66</sup> Similarly, the majority of patients at the Inverness District Asylum were pauper patients.<sup>67</sup> Many had been identified by the Scottish Lunacy Commission's inquiries as facing inadequate treatment outside of an institutional setting, or were patients from the Highlands and Islands transferred from institutions including Gartnavel Royal Asylum and Royal Edinburgh Asylum to Inverness District Asylum to receive culturally adapted care.<sup>68</sup> Moreover, a working-class background varied according to place, particularly for female patients. For example, in the Scottish Highlands and Islands, many of the female patients worked in occupations outdoors. Questions in this thesis will therefore include to what extent asylum occupations catered to different forms of work for women and men, and how such adaptations were discussed by different figures of authority.

Occupation as a means of therapy became a key component of treatment in asylums moving away from bodily restraint. William Tuke, who founded the Retreat at York according to the principles of moral therapy, included employment as the 'most efficacious' tool for

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<sup>64</sup> The specific limitations to opening hours and access to materials is described in detail in this thesis' COVID-19 statement.

<sup>65</sup> Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000*, p. 55.

<sup>66</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*.

<sup>67</sup> Hester Parr, Chris Philo and Nicola Burns, "That awful place was home": Reflections on the Contested Meaning of Craig Dunain Asylum, *Scottish Geographical Journal*, 199.4 (2003), 341-360 (p. 344).

<sup>68</sup> *Report by Her Majesty's Commissioners Appointed to Inquire into the State of Lunatic Asylums in Scotland*.

progress towards recovery.<sup>69</sup> Moral therapy was a method in treatment that moved away from restraining patients to instead encouraging self-restraint and changes from behaviours associated with mental ill health.<sup>70</sup> While this approach saw patients removed from physical tools of restraint, it has also been condemned as a method of imprisoning and controlling people who acted in contrast to social ideals of behaviour.<sup>71</sup> Mechanical restraint was at odds with the principles of moral therapy. Debates about the use of restraint were sparked by Edward Parker Charlesworth and Robert Gardiner Hill of the Lincoln Lunatic Asylum during a lecture to the Lincoln Mechanics' Institute in 1838.<sup>72</sup> The non-restraint system gained further prominence through the influence of John Conolly in Hanwell Asylum.<sup>73</sup> While the changes in treatment created by moral therapy and non-restraint impacted all categories of mental illness in nineteenth-century asylums, I will examine how they affected treatment for the severe mood states of mania specifically. A successor of Charlesworth and Hill, F. D. Walsh, continued the non-restraint system at Lincoln Lunatic Asylum and stated that views on treatment for mania specifically were 'becoming to be considered the very reverse' of what they had been, now 'requiring nutritious diet and exercise in the open air'.<sup>74</sup> I will examine changes in treatment for mania alongside diagnostic observations to investigate whether changes in the term mania from a general form of madness to a specific diagnostic classification intersected with developments in treatment. Furthermore, mania's centrality to debates both in favour of and in opposition to restraint mean a focus on patient cases of mania can be used to further investigate the history of changes in nineteenth-century institutional treatment.

There are significant challenges to working with large bodies of hospital records. Unfortunately, these challenges were exacerbated for this thesis by the COVID-19 pandemic, which caused limited access to archival centres for primary research.<sup>75</sup> In consequence, I had to revise my research plan to prioritise different aspects of the research in my approach to archival materials. First was to prioritise patient case records over other hospital records to be

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<sup>69</sup> Tuke quoted in Jennifer Laws, 'Crackpots and Basket-Cases: A History of Therapeutic Work and Occupation', *History of the Human Sciences*, 24.2 (2011), pp. 65-81 (p. 67).

<sup>70</sup> Anne Shepherd and David Wright, 'Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint', *Medical History*, 46 (2002), pp. 175-196 (pp. 190-191).

<sup>71</sup> Michel Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason* (London: Vintage, 1988), p. 246.

<sup>72</sup> Leslie Topp, 'Single Rooms, Seclusion and the Non-Restraint Movement in British Asylums, 1838-1844', *Social History of Medicine*, 31.4 (2018), pp. 754-773 (p. 756).

<sup>73</sup> Topp, 'Single Rooms, Seclusion and the Non-Restraint Movement in British Asylums', p. 756.

<sup>74</sup> F. D. Walsh, 'On the Treatment of Mania', *British Medical Journal*, 3 (1855), pp. 33-34 (p. 33).

<sup>75</sup> The specific limitations to opening hours and access to materials is described in detail in this thesis' COVID-19 statement.



able to assess patterns in observations of emotional states for different patients across the four institutions. Where possible, this included prioritising volumes with detailed headings for assessing emotional states at different stages of mania, as well as sections interrogating the recurrent nature of mania and the history of episodes for individual patients, as this enriched an investigation of how physicians determined a diagnosis of mania and tried to understand the pattern of movement between episodes. It was also crucial to use the registers and case book volumes that included diagnostic information. In Gartnavel Royal Asylum, for example, this meant a focus on the period of Hutcheson's superintendence, particularly case books between 1838-1841, which included printed headings: 'Description: Personal [and] Premonitory'; 'Malady: Form, Hallucination [and] Propensities'; 'Causes: Predisposing [and] Exciting'; and 'Treatment'.<sup>76</sup>

Records from Royal Edinburgh Asylum and North Wales Lunatic Asylum included diagnostic information through a combination of registers of patients and case books, but additionally had examples of case books with printed headings that could be compared. In Royal Edinburgh Asylum this included, for example, volumes in 1880s, which asked for details of 'History: Causation, Disposition [and] Habits'; 'Previous Attacks no., Kind, Duration, Where Treated, Hereditary History – Insanity, Other Diseases, Predisposing [and] Exciting'; 'Symptoms: First: Mental [and] Bodily'; 'Symptoms: Recent: Mental [and] Bodily'; 'Symptoms: Insane Habits and Propensities, [whether] Suicidal, [whether] Dangerous, Duration of Existing Attack, Other Facts or Remarks [and] Facts of Medical Certificates'; 'State on Admission: Mental: Exaltation, Depression, Excitement, Enfeeblement, Memory, Coherence, Delusions [and] Other Abnormalities'; 'Bodily: Appearance, Skin, Eyes, Muscularity, Hair, Pupils, Fatness, Nervous System – Motor, Sensory, Special Senses, Reflect Actions, Retina, Lungs, Heart, Tongue, Bowels, Other Organs, Abnormalities, Bruises, Appetite, Urine, Menstruation, Pulse, Height, Temp, Weight'; 'Disease Classification' and, separately 'Skae's Classification'; 'General Bodily Health and Condition' and a 'Table for Predominant Features' which included 'Acute Delirium and Incoherence, Simple Excitement, Simple Depression, Stupor, Hypochondria, Strong Suicidal Impulses, Remittency [sic] or Intermittency, Chronic Movements, Hallucinations [and] Enfeeblement'.<sup>77</sup> In North Wales Lunatic Asylum, this also included, for example, volumes in the 1880s, with headings for 'Whether first attack, Duration of existing attack, Age on first attack, When and where under

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<sup>76</sup> HB13/5/11.

<sup>77</sup> LB57/51/38.

care and treatment'; 'History of case, Number of children, Number of children living, Is the disease hereditary, Relatives affected, Previous attacks if any, Supposed Cause: Predisposing [and] Exciting, Whether suicidal and in what manner, Whether epileptic, Threatened, Dangerous, Disposition and habits in health, Is there refusal of food, If destructive in what manner, Previous bodily health, Habits of parents, Bodily condition on admission'; and 'State of nutrition: Digestive system, Circulatory, Respiratory, Genito Urinary System [and] Special Conditions'.<sup>78</sup> While the Inverness District Asylum volumes I consulted did not include printed headings, from the opening of the asylum, in coordination with the register of patients, they included a consistent structure with diagnostic information, detailed sections of observations of the patients' history, patients' state on admission, emotional themes of psychosis, and the progression of patients' mental ill health within the asylum.

Priorities for this study also included investigating records both prior to and after the introduction of Falret and Baillarger's diagnostic labels, to interrogate whether the single diagnostic category of mania was characterised by both high and low mood prior to their frameworks, and to assess the impact of these new frameworks on everyday working asylums. For the records of Gartnavel Royal Asylum, seeking observations prior to *folie circulaire* and *folie à double forme* coincided a focus on records from the late 1830s to 1840s. Subsequently, I concentrated on case volumes for the remaining three institutions at different periods between the late 1840s to 1890s to seek the influence of Falret and Baillarger's diagnostic categories. Another priority was to investigate the conceptualisation of mania in places moving from community care to culturally specific institutional treatment – it was therefore crucial to analyse patient case books during the first years of operation for the North Wales Lunatic Asylum, which opened in 1848, and the Inverness District Asylum, which opened in 1864, particularly in light of the number of admissions of patients already considered incurable. Furthermore, I wanted to then analyse patient cases at a later stage in these institutions' development when there was a higher proportion of admissions of acute, or curable, rather than chronic, or incurable, mania. At the same time, it was important to be able to compare observations between institutions at a similar period, so I also concentrated on case books from similar years at these institutions between the 1870s to 1880s. The choice of this period was additionally influenced by North Wales Lunatic Asylum's and Royal Edinburgh Asylum's records with similar headings to compare in observations, as discussed above.

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<sup>78</sup> HD/1/362.

In looking across several decades, I was apprehensive about whether cases of mania characterised by solely low mood or alternating mood might be considered as representing extraordinary cases that appeared rarely amongst decades of case book volumes. For that reason, I focused on working through whole, individual case book volumes to be able to demonstrate the frequent and commonplace occurrence of this characterisation of mania. Each volume would typically cover between one to two years of admissions, but with patient histories included from years prior if previously admitted, and observations continued for several years depending on the timeline of a patient's recovery or death.<sup>79</sup> I selected individual case book volumes from different decades and institutions according to the priorities above, and the subsequent chapters demonstrate the numerous examples of cases of mania characterised by severity of mood across the emotional spectrum from within individual volumes, suggesting that mania diagnosed as solely a low mood state or as alternating mood states was a common classification. My approach to archival records, then, was to examine patterns in observations of mania both prior to and following the introduction of *folie à double forme* and *folie circulaire*, in different psychiatric institutions at various stages in development, in different places with different cultural specificities and with patients from different backgrounds, to seek how different emotional states became considered severe and observed as mental ill health.

In my analysis of patient case notes, I will use the patient's initials and date of admission to identify individual cases. Franca Iacovetta and Wendy Mitchinson have highlighted the difficult relationship between uncovering the histories of patients while simultaneously providing them with anonymity.<sup>80</sup> David Wright and Renée Saucier argue that this is especially poignant in research on patients with mental illness, because of 'social movements seeking to empower themselves through the commemoration of their history'.<sup>81</sup> Wright and Saucier refer to the work of Jacalyn Duffin, who takes issue with providing anonymity because patients' histories 'are not shameful'.<sup>82</sup> However, I remain unconvinced that a right to privacy is equivalent to perpetuating shame around mental illness. Historians such as Janet McCalman have pointed to a balance between examining a patient's history and maintaining a posthumous

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<sup>79</sup> Exceptions to this include earlier volumes at Gartnavel Royal Asylum and North Wales Lunatic Asylum, which could cover a ten-year period of admissions.

<sup>80</sup> Franca Iacovetta and Wendy Mitchinson, *On the Case: Explorations in Social History* (Toronto: University of Toronto Press, 1998).

<sup>81</sup> David Wright and Renée Saucier, 'Madness in the Archives: Anonymity, Ethics, and Mental Health History Research', *Journal of the Canadian Historical Association*, 23 (2012), pp. 65-90 (p. 69)

<sup>82</sup> Jacalyn Duffin quoted in Wright and Saucier, 'Madness in the Archives', p. 73.

right to privacy.<sup>83</sup> Moreover, Wright and Saucier discuss studies, such as the work of Yannick Ripa, Jonathan Ablard and Jonathan Sadowsky, which point to the right to privacy for the decedents of individuals as well as the individuals themselves.<sup>84</sup> I submit that it is possible to study the histories and representations of mental illnesses in a way that examines how stigma develops, and to still maintain a right to privacy for the people whose stories are uncovered and for their descendants.

Concurrently analysing medical and literary writing is valuable for scrutinising both the medical and cultural conception of a manic-depressive illness. The nineteenth century did not separate the arts and sciences in the presentation of ideas.<sup>85</sup> For example, instructional textbooks like Bucknill and Tuke's *A Manual of Psychological Medicine* (1858) used examples from Shakespeare to illustrate aspects of different psychiatric illnesses, and periodicals like *Blackwood's Edinburgh Magazine* included texts such as Samuel Warren's *Passages from the Diary of Late Physician* which, though fictional, was convincingly presented as factual patient case records until Warren revealed the texts' fictional nature in 1838, eight years after the series began in 1830.<sup>86</sup> This relationship between medical and literary writing allows for an investigation into how literary texts represented the key identifying patterns of mania – whether they challenged the pathologizing of emotion and medical authority, how this type of illness was depicted in different places, and how behaviours were illustrated in terms of social inclusion or exclusion and in terms of their impact on social responsibilities.

The literary texts I have identified for analysis include texts like Warren's, which are situated in a medical space, to investigate whether literary texts that diagnose a character with mania also classify mania according to both high and low mood states with psychosis. Moreover, I will also analyse texts that engage with the identifying characteristics of mania outside of a medical space. The purpose of this is to interrogate how literary texts used the identifying patterns of extreme emotional states and psychosis to explore or comment on other social issues. In this way, medical and literary texts can ask new questions of each other to enrich analysis of the diagnosis, treatment, and representation of a manic-depressive illness.

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<sup>83</sup> Janet McCalman, 'Writing the Women's Hospital History with Medical records', *Health and History*, 1.2 (1999), pp. 132-138, (p. 133).

<sup>84</sup> Yannick Ripa, Jonathan Ablard, and Jonathan Sadowsky quoted in Wright and Saucier, 'Madness in the Archives', p. 72.

<sup>85</sup> Jenny Bourne Taylor and Sally Shuttleworth, eds, *Embodied Selves: An Anthology of Psychological Texts 1830-1890* (Oxford: Clarendon Press, 1998), p. xv.

<sup>86</sup> Megan Coyer, *Literature and Medicine in the Nineteenth-Century Periodical Press: Blackwood's Edinburgh Magazine 1817-1858* (Edinburgh: Edinburgh University Press, 2017), p. 134.

For example, an examination of nineteenth-century patient cases reveals the ‘madness’ in Carroll’s *Alice’s Adventures in Wonderland* as specifically depicting the identifying factors of mania, leading to questions including: what impact does Carroll represent the symptoms and behaviours as having on Wonderland’s community, and why is Alice the only one who can recover? Similarly, how does Edgar Allan Poe’s ‘The Murders in the Rue Morgue’ explore the impact of restraint by depicting features of mania in the contrasting figures of an orangutan and a brilliant detective? Arthur Conan Doyle’s Sherlock Holmes is celebrated precisely because of his presentation of symptoms and behaviours associated with mania – could working class men in patient records be celebrated in the same way? The following Chapter Breakdown will set out the key focus of each chapter as well as the literary texts chosen for examination.

### **Chapter Breakdown**

Chapter One will argue the key finding of this thesis that, in the nineteenth century, mania and melancholia were not opposing poles on the mood spectrum. Instead, both high and low mood were key features of nineteenth-century mania, and were recorded both prior to and after the introduction of *folie à double forme* and *folie circulaire*. This chapter will examine the flexibility of diagnostic practice in nineteenth-century institutions to demonstrate the value of analysing asylum case records to an investigation of the classification of an illness moving between extreme highs and lows of mood. I will also evaluate the influence of Falret and Baillarger’s *folie circulaire* and *folie á double forme*. Despite their place in scholarship as points of discovery for current bipolar disorder, I will argue that an illness consisting of high and low mood states alongside psychosis was already present, and continued to be present after the introduction of *folie circulaire* and *folie á double forme*, in nineteenth-century mania as a single category for diagnosis. This characterisation of mania was also present in literary representations including Edgar Allan Poe’s ‘The Tell-Tale Heart’ (1843), and Joseph Sheridan Le Fanu’s ‘Green Tea’ (1869).

Chapter Two will move on to examining changes in treatment for nineteenth-century mania. Treatment for mania moved from bodily restriction, limiting nutrition, and blood-letting to the reverse: open air, exercise, a plentiful diet, and experimental treatments centred on encouraging activity. I will analyse debates about treatment in medical journals to argue that changes in treatment fuelled a shift from perceptions of manic-depressive patients as animalistic to restoring humanity and individuality. To make this argument, I will also analyse

visual representations and visual tools in treatment, as well as investigating literary challenges to forms of treatment and medical authority in Samuel Warren's 'The Spectre-Smitten' (1831), Edgar Allan Poe's 'The Murders in the Rue Morgue' (1841), and Joseph Sheridan Le Fanu's 'Green Tea' (1869).

Chapters Three and Four will continue to examine diagnostic classifications, forms of treatment, and medical authority, but will address the concern in this thesis about the experience of mania in different places, by analysing places with a lack of provision of accessible institutional care. These chapters will interrogate socio-spatial implications on individuals with mania transitioning from community spaces of care to institutional spaces, as well as the non-linear relationship between core and periphery in implementing changes in medical practice according to culturally specific requirements. Chapter Three will look to Wales, focusing on implications of social proximity in representations of mania, as well as the role of communication in treating mania, and therefore the role of the Welsh language in discussions about accessible treatment. Analysis will include both Welsh and English language texts, examining reports of the Commissioners in Lunacy, newspaper articles, records from the North Wales Lunatic Asylum, and literary texts including the anonymously authored 'Adventures of a Welsh Medical Student' (1832), Cymro Bach's, 'Hanes y Dyn yn y Lleuad' [The History of the Man in the Moon] (1830), and Lewis Carroll's *Alice's Adventures in Wonderland* (1865).<sup>87</sup> Chapter Four will look to the Scottish Highlands and Islands. This chapter will focus on types of treatment and ideas about curability, examining tensions between a perception of the domestic space as causing incurability, but simultaneous ideals in asylum reform about creating a domestic environment in institutions. Chapter Four will also focus on the relationship between place-specific beliefs and the themes of delusions and hallucinations, both in medical writing and through challenges in literary representations to the pathologizing of traditional customs. Literary analysis will include George MacDonald's 'The Portent', first published in 1860, before being expanded in 1864, and Margaret Oliphant's 'A Christmas Tale' (1857).

Chapters Five and Six will move on to examining differences in the diagnosis, treatment and representation of women and men. Chapter Five will focus on interrogating differences in patient cases to investigate whether there were any inherent differences in the classification for female and male mania in the context of the sharply defined gender roles in Victorian society.

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<sup>87</sup> Translations will be provided of the Welsh language material. The translations will be my own.

This chapter will also analyse how literary texts represented the experience of mania in the context of behaviour aligned with social gender norms. Literary analysis will include Denzil Vane's 'A Village Tragedy' (1886) and Lewis Carroll's *Alice's Adventures in Wonderland* (1865). Chapter Six will continue to interrogate differences in the female and male experience of mania in the context of treatment, and the focus in treatment on occupation and energy. This chapter will investigate tensions in the relationship between mania and work, with aspects of work included as causes of mania, an inability to work illustrated as a consequence of mania, and asylum employment perceived as a vital factor in progress toward recovery from mania. Literary analysis will examine illustrations of mania's relationship with work in terms of the different opportunities and responsibilities for Victorian women and men, including Charles Dickens's 'The Signalman' (1866), Margaret Oliphant's 'The Library Window', and Arthur Conan Doyle's Sherlock Holmes stories.

## Chapter One: The Mood Spectrum in Nineteenth-Century Mania

Historians of the term ‘mania’ have generally agreed on the multiplicity of its definition.<sup>88</sup> Mania was used historically to denote madness in a general form. In the nineteenth century, its definition was narrowed and developed specificity as a category of mental illness. Histories of bipolar disorder have often considered the terms mania and melancholia as early forms of mania and depression in the way we understand the terms today: as opposing poles on the mood spectrum.<sup>89</sup> However, my thesis is unique in arguing that, in the nineteenth century, mania and melancholia were not opposing poles on the mood spectrum. This chapter will engage with historical studies of the term mania to submit a new argument. The more precise definition of mania developed in the nineteenth century established an illness characterised by both high and low mood and symptoms of psychosis. Moreover, this definition of a manic-depressive illness was established before Falret and/or Baillarger ‘discovered’ bipolar disorder in 1854, and mania continued to be diagnosed in asylums with this definition after the introduction of Falret’s *folie circulaire* and Baillarger’s *folie à double forme*.

This chapter will examine patient case notes to argue that mania was characterised by both high and low mood in the nineteenth century. In the Introduction, I set out my methodological approach, which recognises diagnostic categories as probabilistic and fluid, and focuses on how categories are constructed. The first section of this chapter will examine the approach to diagnosis in nineteenth-century asylums. I will investigate the flexibility in diagnostic classifications and the space for physicians to continue to develop categories according to patient encounters, meaning that diagnostic labels, even in instructional textbooks, were not stable. In the second section, I will engage with historical studies that trace the origins of bipolar disorder to categories that combined mania and melancholia. In this section, I will analyse patient case records from working asylums to make a key argument in this thesis: that mania and melancholia were not opposing poles on the mood-spectrum in the nineteenth century, but instead that mania was characterised by both high and low mood states as an

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<sup>88</sup> See: Lisa Hermesen, *Manic Minds: Mania’s Mad History and its Neuro-Future* (New Jersey: Rutgers University Press, 2011); David Healy, *Mania: A Short History of Bipolar Disorder* (Baltimore: The John Hopkins University Press, 2008); G.E. Berrios, ‘Of Mania: Introduction’, *History of Psychiatry*, 15.1 (2004), pp. 105-124.

<sup>89</sup> See: Thierry Haustgen, and Hangop S. Akiskal, ‘French antecedents of “contemporary” concepts in the American Psychiatric Association’s classification of bipolar (mood) disorders’, *Journal of Affective Disorders*, 96.3 (2006), pp. 149-163; P. Pichot, ‘Tracing the Origins of Bipolar Disorder: From Falret to DSM-IV and ICD-10’, *Journal of Affective Disorders*, 96 (2006), pp. 145-148; G.E. Berrios, ‘Melancholia and Depression During the 19<sup>th</sup> Century: A Conceptual History’, *British Journal of Psychiatry*, 153 (1998), pp. 298-304 (p. 298); P. Pinchot, ‘The Birth of the Bipolar Disorder’, *European Psychiatry*, 10.1 (1995), pp. 1-10.



individual category. Moreover, I will argue that this characterisation of mania existed outside of medical texts in literary representations, analysing Edgar Allan Poe's 'The Tell-Tale Heart' (1843) and Joseph Sheridan Le Fanu's 'Green Tea' (1869) in dialogue with observations of patients. To expand on the argument that an illness consisting of high and low mood states existed prior to Falret's *folie circulaire* and Baillarger's *folie à double forme*, in the final section of this chapter I will interrogate the influence of these frameworks in the context of nineteenth-century diagnostic practice, to argue that mania was used to diagnose both high and low mood states alongside psychotic features both prior to and after the introduction of Falret and Baillarger's frameworks.

### **Approach to Diagnosis**

As I set out in the Introduction, my methodology focuses on analysing how lines between healthy and unhealthy mood were drawn to investigate the history and representation of manic-depressive illness. In contrast to other histories of bipolar, my thesis concentrates on asylum diagnostic practice to examine categories of psychiatric illness instead of looking to emerging diagnostic labels. The purpose of this focus is to analyse how symptoms of high and low mood states and psychosis were recorded and categorised. This approach is valuable because, while connections can be drawn between current bipolar disorder and nineteenth-century labels like *folie circulaire* and *folie à double forme*, these categories were not necessarily influential on everyday practice because institutions were given the space to construct their own lines around diagnostic categories. Therefore, if alternating high and low mood states and psychosis were already key features in an existing diagnostic category, emerging frameworks that categorised those symptoms might not be widely adopted in their place. I will argue in this chapter that this was the case with nineteenth-century mania. Before engaging with patient case notes observing high and low mood, I will examine the nature of diagnostic practice in nineteenth-century institutions, to demonstrate why an investigation of asylum diagnoses is more valuable to a study of the history of extremes of high and low mood.

Psychiatric textbooks in the nineteenth century illustrate a flexibility in shaping diagnostic categories. In her 2011 study of the history of mania, *Manic Minds: Mania's Mad History and its Neuro-Future*, Lisa Hermsen points to Bucknill and Tuke's *A Manual of Psychological Medicine* (1858) as 'one of the most popular textbooks' for the classifications

of types of mental illness.<sup>90</sup> However, the textbook provides multiple perspectives for the classification of a single diagnostic category, instead of an individual variation. The instructional textbook draws from a number of different physicians' classifications, highlighting the variations between them. For mania, Bucknill and Tuke quote from Esquirol, Pinel, Baillarger, Prichard, Chiaruggi, Broussais, Charon, Carpenter, Brierre, Arnold, Conolly, Bell, Ray, Benedict, and several other physicians, illustrating their different observations to give an overview of the diagnostic category, rather than to instruct a single, static framework.<sup>91</sup> In this still professionalising industry, individual physicians were given the space to form their own classifications, and to do so through work with patients. Textbooks like Bucknill and Tuke's did not set out a consistent view of mania, but instead collected different ways of classifying mania, creating a space for diagnostic categories to continue to develop.

Bucknill and Tuke's textbook highlights the development in mania from a general madness to a more precise diagnostic category. However, I argue that this precision does not lead solely to mania being characterised by a high mood state, but instead emphasises a severity of emotional state that could present across the mood spectrum. Hermesen argues that Bucknill and Tuke's classification maintains mania's connection to the idea of a raving madness, perpetuating anger or fury as the prominent state. According to Hermesen, Bucknill and Tuke 'make the point that fury is not identical with mania', but do 'note by their own observations, maniacs are more susceptible to fury'.<sup>92</sup> However, in the textbook's structure of drawing from the opinions of several physicians, the classification for mania touches on a variety of mood states. The textbook states that 'mania, in many instances, is a prolonged anger', but 'may, likewise, be altogether pleasurable in its manifestations'. The focus, for Bucknill and Tuke, appears to be the severity of the emotion rather than whether anger or exhilaration, describing the 'excess of joy' as 'not the less emotional in character' than that 'of anger'.<sup>93</sup> They also refer to low mood when drawing on the classification of mania from Esquirol. This reference to low mood is not as an ongoing feature of the condition, but rather a possible beginning to the episode; according to Esquirol: 'the maniac is, at the commencement of the malady, either sad or gay, active or indolent, indifferent or eager'.<sup>94</sup> As I will analyse later in this chapter, asylum

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<sup>90</sup> Hermesen, *Manic Minds*, p. 27.

<sup>91</sup> J. C. Bucknill and D. H. Tuke, *A Manual of Psychological Medicine, containing the history, nosology, description, statistics, diagnosis, pathology, and treatment of insanity* (London: John Churchill, 1858), pp. 220-36.

<sup>92</sup> Hermesen, *Manic Minds*, p. 24.

<sup>93</sup> Bucknill and Tuke, *A Manual of Psychological Medicine*, p. 223.

<sup>94</sup> Esquirol quoted in Bucknill and Tuke, *A Manual of Psychological Medicine*, p. 224.

observations similarly recorded low mood at the commencement of mania in many cases, but also continued to frequently observe low mood as a defining characteristic as the condition progressed.

The emphasis on variations in the classification set out by Bucknill and Tuke provides an explanation for why observations of mood states in mania could vary. In his publications about diagnostic categories, David Skae, medical superintendent of the Royal Edinburgh Asylum, also conveyed the freedom for asylum physicians to set their own boundaries for types of mental illness. To explain Edinburgh's position as 'firmly at the forefront of psychological medicine' in the nineteenth century, Hilary Marland points to Skae as one of the primary influential figures in medical education, stating that Skae 'was the first to offer clinical instruction to medical students' which he achieved by 'demonstrating' with his patients.<sup>95</sup> Skae's views are therefore useful for investigating diagnostic practice and training. Discussing diagnostic classifications, Skae illustrated the varied ideas of different physicians: 'I venture to say there are no two Asylum Reports published in the Empire in which the same rules and distinctions are rigidly observed'.<sup>96</sup> He also emphasised the approach of forming classifications according to encounters with patients, saying of physicians in training:

[...] it has always struck me, that the moment they came into actual personal contact with the insane, all their preconceived notions of Insanity derived from our systemic works were found to be vague, misty.<sup>97</sup>

The inclusion of different classifications in Bucknill and Tuke's manual, which highlighted variations instead of reducing them to a single framework, reflects this ability for physicians to work with their own constructions.

There was not, then, necessarily a set boundary between instructional textbooks and the classification systems of different physicians. Instead, textbooks provided room for variations in classification, and therefore provided room for those classifications to continue to evolve. An analysis that looks beyond emerging frameworks is therefore more valuable to the study of the history and representation of a disease category. Examining observations across institutions drawn from patient treatment, and identifying consistently recorded characteristics, can reveal information about a disease's identity. I will now move on to engaging with studies of the

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<sup>95</sup> Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Houndmills: Palgrave Macmillan, 2004), p. 98.

<sup>96</sup> David Skae, *Of the Classification of the Various Forms of Insanity* (1863), p. 6.

<sup>97</sup> Skae, *Of the Classification of the Various Forms of Insanity*, p. 7.

history of mania and melancholia. I will discuss this work alongside an analysis of patient case records in working asylums to argue against the notion of mania and melancholia as opposing poles. I will then look beyond medical representations to literary depictions, to argue that both medical and literary texts characterised mania as consisting of high and low emotional states.

### **Mania Characterised by both High and Low Mood**

Histories of bipolar have overlooked the observations of both high and low mood in nineteenth-century mania as a single category by focusing on identifying diagnostic labels that combined mania and melancholia. G. E. Berrios argues that mania and melancholia did not represent opposites on the mood spectrum in antiquity, but states that the definition of melancholia became specifically associated with low mood in the nineteenth century.<sup>98</sup> Berrios uses this line of argument to situate melancholia as an opposite to mania in the nineteenth century.<sup>99</sup> However, while I agree that developments in psychological discourse in the nineteenth century made the new specificity for categorising types of illness such as mania and melancholia possible, I disagree that their narrowed definition led to the position of the two as opposites in mood features. In contrast, I argue that melancholia continued to be distinguished from mania based on being less severe. Moreover, rather than being opposites, I assert that observations of emotional states in diagnoses of mania and melancholia both featured low mood descriptors.

Berrios's argument that 'melancholia and mania were not polar opposites' in 'classical antiquity' is based on the absence of 'symptoms reflecting pathological effect (e.g. sadness)'.<sup>100</sup> Berrios draws on writing from Prichard in 1835, which stated that, 'anciently', melancholia 'conveyed no idea of gloom and dejection', but 'meant simply to be mad'.<sup>101</sup> In contrast, Berrios argues that "'depression" had become a synonym for melancholia' in the nineteenth century.<sup>102</sup> However, when describing depression as a synonym for melancholia, the example Berrios provides from Baldwin uses the term 'depression' to describe a feature of melancholia, rather than equating melancholia to depression. Depression is described by Baldwin as 'characterised by a sinking of the spirits, lack of courage or initiative, and a tendency to gloomy thoughts'.<sup>103</sup> While I do not consider this to be representative of depression as synonymous

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<sup>98</sup> G.E. Berrios, 'Melancholia and Depression During the 19<sup>th</sup> Century: A Conceptual History', *British Journal of Psychiatry*, 153 (1998), pp. 298-304 (p. 298).

<sup>99</sup> Berrios, 'Melancholia and Depression During the 19<sup>th</sup> Century', p. 298.

<sup>100</sup> Berrios, 'Melancholia and Depression During the 19<sup>th</sup> Century', p. 298.

<sup>101</sup> Prichard (1835) quoted in Berrios, 'Melancholia and Depression During the 19<sup>th</sup> Century', p. 298.

<sup>102</sup> Berrios, 'Melancholia and Depression During the 19<sup>th</sup> Century', p. 298.

<sup>103</sup> Baldwin (1901) quoted in Berrios, 'Melancholia and Depression During the 19<sup>th</sup> Century', p. 298.

with melancholia, it is clear that low mood was a *characteristic* of melancholia in the nineteenth century. The reason I argue against the use of depression as a synonym for melancholia, is because the descriptions of depression provided by Baldwin were also prominently recorded in diagnoses of nineteenth-century mania in working asylums.

Melancholia and depression were not interchangeable. Instead, depression was a feature of both melancholia and mania. My research reveals regular recordings of the term depression in cases of patients diagnosed with mania in Gartnavel Royal Asylum during the 1830s. Case notes from Gartnavel observed J.F., admitted in 1831, diagnosed with mania, and described with ‘depressed thoughts, want of sleep, laying in bed all day’.<sup>104</sup> His mood also moved into excitement in the form of violent anger, striking his brother, breaking furniture, and becoming ‘confused in his ideas’.<sup>105</sup> Low mood as a feature of mania was also observed in the case of N.S, admitted and diagnosed with mania in 1835. His attack was observed with ‘a depression of spirits’ which then progressed into the patient being ‘alternately depressed and elated’.<sup>106</sup> In Baldwin’s writing, drawn upon by Berrios for his argument, one of the indicators of depression was ‘gloomy thoughts’.<sup>107</sup> Similarly, the case notes of J.F., admitted to Gartnavel Royal Asylum in 1832 and diagnosed with mania, characterised the patient’s emotional state with ‘gloomy forebodings’ alongside threats ‘to hang, drown, or otherwise commit suicide’.<sup>108</sup>

The cases in Gartnavel recorded changes in the severity of emotion, and ongoing emotional states, as indications of mania. This included both high and low emotional states, as well as alternations between mood. The case of H.M., admitted in 1838, described her previous three attacks of mania, as well as her current attack. The notes stated that initially she was ‘generally affected with a great mental depression for about a year’ prior to experiencing ‘excitation’.<sup>109</sup> The history of her attacks was described as beginning when she was nineteen years old, with the next episodes at ‘intervals of twelve or thirteen years’, and the present attack occurring at age fifty-seven.<sup>110</sup> This demonstrates a classification of mania consisting of ongoing periods of severe low mood, severe high mood, and lucid intervals, across a period of thirty-eight years. Similarly, the case of M.G., admitted in 1838, noted changes between ‘spirits

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<sup>104</sup> HB13/5/21, p. 229; HB13/6/85, p. 826.

<sup>105</sup> HB13/5/21, p. 229; HB13/6/85, p. 826.

<sup>106</sup> HB13/5/20, p. 445; HB13/6/85, p. 1011.

<sup>107</sup> Prichard (1835) quoted in Berrios, ‘Melancholia and Depression During the 19<sup>th</sup> Century’, p. 298.

<sup>108</sup> HB13/5/21, p. 231; HB13/6/85, p. 828.

<sup>109</sup> HB13/5/11, pp. 47-48.

<sup>110</sup> HB13/5/11, pp. 47-48.

often greatly depressed or elevated' for two years.<sup>111</sup> The case of A.W., diagnosed with 'furious mania attended by bursts of crying of about a year's duration' presented initially with 'depression of spirits'.<sup>112</sup> Observations of S.M., admitted in 1838 and diagnosed with 'furious mania', record that 'her spirits were depressed' followed by her becoming 'gradually excited'.<sup>113</sup> These cases uncover the use of the term depression in observations of low mood in diagnoses of mania. Moreover, the cases demonstrate that alternating states of low and high mood were included in the classification of mania in the 1830s.

Admission documents and the structure of case notes indicated the features physicians considered key to determining a diagnosis. As I discussed in the methodological section of the Introduction, information was gathered by physicians through a combination of observations of the patient by relatives and friends, the testimony of the patient, and observations by the physician. Records from Gartnavel Royal Asylum include patient admission documents, which consisted of a series of questions to be completed 'by relatives or guardians under the direction of medical attendant'.<sup>114</sup> Communicating the experience of the disease, through both personal and observed experience, was the process used in nineteenth-century working asylums to determine a diagnosis – a process which is not dissimilar to the diagnostic process used today. The questions and answers included on these admission documents can be used to examine the communication of observed experience. An examination of these documents is therefore valuable to an examination of how the line between healthy and unhealthy mood was situated to form a disease identity.

Gartnavel Royal Asylum's admission documents connected depressed and elated mood. The documents initially asked whether there had been 'any unusual depression or elevation of spirits', or 'any alteration observed in the temper'.<sup>115</sup> In this question examining emotional state, low and high mood were combined. It could be suggested by historians who have considered nineteenth-century mania as synonymous with high mood, and nineteenth-century melancholia as synonymous with low mood, that the states are combined in this question with 'or' for the sake of determining a diagnosis of either mania or melancholia. However, as I have already demonstrated above in an analysis of the patient case notes, low mood was frequently recorded in diagnoses of mania. Moreover, cross-referencing the

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<sup>111</sup> HB13/5/11, p. 63.

<sup>112</sup> HB13/5/11, p. 71.

<sup>113</sup> HB13/5/11, p. 73.

<sup>114</sup> HB13/7/41.

<sup>115</sup> HB13/7/41.

admission documents and the patient case notes show patients observed as experiencing a depressed state were frequently diagnosed with mania. In addition, the second part of the question asks about alternation, demonstrating a recognition of the feature of alternating mood. Again, an alternation between mood states was a feature of mania analysed above in patient case notes.

Admission documents also reveal the recognition of lucid intervals, asking whether there had been lucid intervals and, if so, their duration and pattern of occurrence.<sup>116</sup> As analysed in the cases above, there was a recognition of the recurrent nature of mania and the possibility for lucid intervals between. Information about intervals in emotional states was also provided in detail in a section concerning the form of illness in patient case records, where the number of the attack was recorded as well as whether there had been lucid intervals or any remissions, whether the duration of the periods had been consistent, and whether the occurrence of the intervals were at either certain or uncertain times.<sup>117</sup> The admission documents and structure of patient case notes show a system of classification seeking patterns in the re-occurrence of emotional states and remissions. The nosology therefore recognised movement between low and high mood as well as lucid periods. Crucially, this was key in the diagnostic process prior to the introduction of Falret and Baillarger's categories and saw alternating high and low mood with lucid intervals receive a diagnosis of mania.

Observations of low mood continued to be present in diagnoses of mania at the time of the introduction of Falret and Baillarger's categories and in the decades afterwards. One of the descriptors of depression used in Berrios's argument was 'sinking of the spirits'.<sup>118</sup> However, in contrast to Berrios' argument, my research shows the presence of this observation in cases of mania. J. G., admitted to the Royal Edinburgh Asylum in 1858 and diagnosed with 'acute mania', was observed as 'dull and depressed in spirits' with suicidal ideation: 'he felt an impulse to throw himself from a cliff'.<sup>119</sup> Similarly, the only observation of emotional state recorded in the case of M.R., admitted to the North Wales Lunatic Asylum in 1850, and diagnosed with 'chronic mania', was 'very low spirited', and C.J., admitted to the Inverness District Asylum in 1871, was observed with 'depression of spirits'.<sup>120</sup>

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<sup>116</sup> HB13/7/41.

<sup>117</sup> HB13/5/11.

<sup>118</sup> Baldwin (1901) quoted in Berrios, 'Melancholia and Depression During the 19<sup>th</sup> Century', p. 298.

<sup>119</sup> LHB7/51/10, pp. 648-651.

<sup>120</sup> HD/1/506, pp. 15-17; HHB/3/5/2/5, p. 21.

Another descriptor from Berrios's argument was a 'lack of [...] initiative'.<sup>121</sup> H.G., admitted to the Royal Edinburgh Asylum in 1858 and diagnosed with 'acute mania', was 'dull', 'depressed' and 'refuse[d] to rise', instead 'lying in bed all day'.<sup>122</sup> H.A., admitted to the Royal Edinburgh Asylum in 1858 and diagnosed with 'mania', was observed as 'dull and listless' with notes that he that he was 'unwilling to rise or wash himself in the morning'.<sup>123</sup> Similarly, L.E., admitted to the North Wales Lunatic Asylum in 1854 and diagnosed with 'mania', was observed with 'low mood', with notes that she '[could not] be persuaded to occupy herself in any way'.<sup>124</sup> The descriptions in these cases are similar to those given by Berrios to assert that depression became a synonym for melancholia. However, all the observations above were recorded in either chronic mania or acute mania. Chronic and acute were two terms used to divide the category of mania according to curability: acute mania was curable, whereas chronic mania was not. I will focus on the distinction between curability and incurability in mania in Chapter Four. Crucially for this section, descriptions of low mood were recorded under both diagnostic categories.

Observations of low mood in cases of mania corresponded with the symptomatology provided by Falret in his classification for low states in *folie circulaire*. Thierry Haustgen points to the roots of bipolar disorder in Falret's *folie circulaire* through two tables comparing Falret's symptomatology with observations in the *DSM-4*. In the low mood state, Haustgen quotes from Falret:

- despondency more pronounced daily...emotions also very feeble
- the patient shows neither interest, nor aversion; if he is pushed, he lets himself fall
- appetite is decreased and the patient eats slowly; digestion is equally slow
- sleep is neither regular nor prolonged
- the patient loses all spontaneity. His movements are sluggish or absent ... one sometimes sees manic paroxysms ... characterised by constant pacing and inner turmoil
- the features sag, suggesting dejection rather than anxiety ... the senses seem numbed ... the limbs are torporous

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<sup>121</sup> Baldwin (1901) quoted in Berrios, 'Melancholia and Depression During the 19<sup>th</sup> Century', p. 298.

<sup>122</sup> LHB7/51/11, p. 765.

<sup>123</sup> LHB7/51/10, pp. 544-546.

<sup>124</sup> HD/1/506, p. 34.



- their humility may go so far as for them to refuse treatment in the belief that they do not deserve it
- the thought processes are very slow; rarely this may result in a complete cessation of all intellectual activity
- the affected individual remains isolated at home, speaks rarely, does virtually nothing<sup>125</sup>

However, like the examples given by Berrios of low mood, my research uncovered descriptions of low mood similar to those noted by Falret in cases of mania in the nineteenth century. Similar to the symptomatology of ‘despondency more pronounced daily’, patient J.L., admitted to the Royal Edinburgh Asylum in 1854, and diagnosed with ‘acute mania’, was described with ‘despondency’ from which her ‘feeling of depression increased’.<sup>126</sup> J.L. also had suicidal impulses, having attempted suicide by drowning prior to admission.<sup>127</sup> S.J., admitted to the North Wales Lunatic Asylum in 1853, and diagnosed with ‘chronic mania’, was similarly described in a ‘very low desponding way’ – a state which had progressed over ‘the last eight months’.<sup>128</sup>

In another comparison with the symptomatology given, my research revealed that a lack of appetite or refusal of food, as well as seldom speaking, were also common in observations of mania. H.A., admitted to the Royal Edinburgh Asylum in 1858 and diagnosed with ‘mania’, ‘very seldom [spoke] and [did] not take his food well’.<sup>129</sup> Notes in H.A.’s case book entry stated, ‘although he has not tasted food for eight hours he would not take any’.<sup>130</sup> M.H., admitted to the North Wales Lunatic Asylum in 1849, and diagnosed with ‘chronic mania’, was observed to have ‘laid in bed refusing her food’ for a ‘few days’.<sup>131</sup> The case book also noted that she ‘seldom speaks’.<sup>132</sup> E.M., admitted to the Inverness district asylum in 1876, was described as ‘quiet and depressed, seldom speaking’ and that she did not ‘reply even when questioned’.<sup>133</sup> H.G., admitted to the Royal Edinburgh Asylum in 1858 and diagnosed with ‘acute mania’ was ‘depressed and silent’ and ‘[took] her food ill’.<sup>134</sup> A.O., admitted to the North

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<sup>125</sup> Haustgen and Akiskal, ‘French antecedents of “contemporary” concepts in the American Psychiatric Association’s classification of bipolar (mood) disorders’, p. 153.

<sup>126</sup> LHB7/51/9, p. 679.

<sup>127</sup> LHB7/51/9, p. 679.

<sup>128</sup> HD/1/506, pp. 27-28.

<sup>129</sup> LHB7/51/10, p. 545.

<sup>130</sup> LHB7/51/10, p. 545.

<sup>131</sup> HD/1/516, p. 9.

<sup>132</sup> HD/1/516, p. 9.

<sup>133</sup> HHB/3/5/2/8, p. 508.

<sup>134</sup> LHB7/51/11, pp. 749-751.

Wales Lunatic Asylum in 1849, diagnosed with ‘chronic mania’ also ‘[did] not take her food so well’.<sup>135</sup> C.R., admitted to the Inverness District Asylum in 1879, and diagnosed with ‘acute mania’, ‘often refused food’.<sup>136</sup> Similarly, L.E., admitted to the North Wales Lunatic Asylum in 1854, ‘[would] not take any food’.<sup>137</sup>

A lack of interest and the descriptor of ‘doing virtually nothing’ in Falret’s symptomatology were also frequently observed in cases of mania, as demonstrated in examples alongside the description of ‘lack of initiative’ quoted by Berrios to describe depression. Moreover, sluggish or pacing movements were also observed. A.M., admitted to the Inverness District Asylum in 1866 and diagnosed with ‘chronic mania’, was described as ‘quiet’ and ‘mov[ing] slowly’.<sup>138</sup> A.R., admitted to the Inverness District Asylum in 1865 and diagnosed with ‘chronic mania’, was ‘generally seen marching backwards and forwards along the corridor’.<sup>139</sup> Slow thought process, a lack of intellectual activity, and want of expression in the patient’s features were also recorded. J.M., admitted to the Inverness District Asylum in 1876, diagnosed with mania, was described with ‘want of expression in the countenance’ and with ‘intelligence lessened’.<sup>140</sup> A.M., admitted to the Inverness District Asylum in 1866 and diagnosed with ‘chronic mania’, was described as ‘looking vacantly and straight before her’.<sup>141</sup> My research shows that the examples of language describing states of low mood given in arguments by Berrios and Haustgen were recorded in cases of patients diagnosed with mania.

States of low mood were also frequently recorded in cases that saw alternating mood. Berrios and Haustgen both attribute the origin of bipolar disorder to Falret’s *folie circulaire* because it encompasses alterations between high and low mood. In his table setting out Falret’s symptomatology for high mood in *folie circulaire*, Haustgen quotes:

- exaltation and hyperexcitability, exaltation of thought and feeling
- the patients...become mischevious, malicious
- lack of sleep; (their) prodigious activity is present at night as well as during the daytime
- patients ... overwhelming others with their loquacity, great affection is expressed for people towards whom the patient had previously felt indifferent

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<sup>135</sup> HD/1/506, pp. 4-5.

<sup>136</sup> HHB/3/5/2/12, pp. 108-109.

<sup>137</sup> HD/1/506, p. 34.

<sup>138</sup> HHB/3/5/2/3, p. 91.

<sup>139</sup> HHB/3/5/2/2, p. 138.

<sup>140</sup> HHB/3/5/2/9, pp. 16-18.

<sup>141</sup> HHB/3/5/2/3, p. 313.

- the profusion of ideas is prodigious
- the patients ... play all sorts of tricks, make plans which they impulsively carry out ... the senses acquire considerable acuity
- their movements are rapid and unceasing; the patient ... withstands ... all the activities and excesses he has indulged in
- if the patients are left to themselves, they turn over furniture, change apartments, dig up their garden
- such patients often remain in society ... when they are disorderly or mean, people say that they are in a bad temper<sup>142</sup>

However, my research into nineteenth-century patient case notes shows movement between high and low mood in diagnoses of mania, including the features of high mood set out above, but with a distinct absence of the use of either *folie circulaire* or *folie à double forme*. Observations of H.G., admitted to the Royal Edinburgh asylum in 1858 and diagnosed with ‘acute mania’, recorded movement between states of ‘excitement’ and states of being ‘depressed’ alongside delusions.<sup>143</sup> The case notes show periods of excitement, where the patient was ‘destructive’, ‘sleepless’, ‘excited’, ‘rapid and incoherent in her talk’, and sometimes ‘violent’, lasting between three and four months.<sup>144</sup> Between these periods of excitement, the case notes recorded ‘depressed’ states of mood, lasting between three and six months, in which the patient was ‘dull’, ‘refuse[d] to rise’, and laboured under delusions that ‘a patient who was discharged some time ago is constantly annoying her’.<sup>145</sup> The periods classified as ‘depression’ were described as ‘usually follow[ing] her prolonged excitement’.<sup>146</sup> There were also periods where the patient appeared to experience lucidity, characterised by being ‘much better, cheerful and industrious’.<sup>147</sup> This pattern of states between low mood and high mood, with the possibility of lucid intervals, corresponds to the general structure of *folie à double forme* or *folie circulaire*, but was recorded under the diagnosis of ‘acute mania’.<sup>148</sup>

The patterns observed in nineteenth-century mania show that it was not characterised solely by high mood, but instead by both high and low mood states. The examples I have

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<sup>142</sup> Haustgen and Akiskal, ‘French antecedents of “contemporary” concepts in the American Psychiatric Association’s classification of bipolar (mood) disorders’, p. 152.

<sup>143</sup> LHB7/51/11, pp. 765-767.

<sup>144</sup> LHB7/51/11, pp. 765-767.

<sup>145</sup> LHB7/51/11, pp. 765-767.

<sup>146</sup> LHB7/51/11, pp. 765-767.

<sup>147</sup> LHB7/51/11, pp. 765-767.

<sup>148</sup> LHB7/51/11, pp. 765-767; LHB7/35/2, p. 64.

examined show the prominence of both low and high emotional states, including some cases of mania observing only a low mood state. Moreover, observations of mania demonstrate a classification interested in the pattern between mood states and potential for periods of lucidity. Cases frequently observed movement between moods: W.M., admitted to Inverness District Asylum in 1879 and diagnosed with ‘mania’, was observed ‘with religious excitement alternating with attacks of depression’, E.M., admitted to Inverness District Asylum in 1877, and diagnosed with ‘mania’, was ‘alternately [...] glad and depressed’, A.M., admitted to Inverness District Asylum in 1866 and diagnosed with ‘chronic mania’ was ‘subject to alternate fits of depression and maniacal excitement’, E.L., admitted to the North Wales Lunatic Asylum in 1864, was observed as experiencing alternate ‘attacks of excitement and depression’ – to name a handful of cases.<sup>149</sup> Furthermore, admission documents and the structure of case notes interrogated patterns in the occurrence and duration of both mood states as well as periods of remission.

Movement between high mood, low mood, and lucidity were the features that characterised Falret’s and Baillarger’s frameworks. However, the cases I have examined were all categorised as mania. Moreover, tables in the annual reports of Royal Edinburgh Asylum, North Wales Lunatic Asylum and Inverness District Asylum did not include either *folie à double forme* or *folie circulaire*. Instead, they continued to record the diagnostic categories of mania, monomania and melancholia. Primary subcategories of the above included mania’s divide into acute and chronic. However, the new diagnostic categories from Falret and Baillarger did not appear. My research into the annual reports, registers, and case books in the Royal Edinburgh Asylum, North Wales Lunatic Asylum, and Inverness District Asylum revealed only one reference to either of the terms. *Folie circulaire* appears in the fifth annual report of Inverness District Asylum in 1869, but it does not appear in the table of types of diagnosis in the annual report for the same year.<sup>150</sup> I was unable to find a case record for this diagnosis while undertaking research into the patient case books of Inverness District Asylum, so it is unclear why this diagnosis was given, how it was different to observations in other asylum diagnoses, and whether it was given posthumously or during treatment.

As I discussed earlier, the nature of manuals for classification like Bucknill’s and Tuke’s offers an explanation for the absence of Baillarger’s and Falret’s categories. The web of classifications in instructional textbooks, weaving the different views of a variety of

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<sup>149</sup> HHB/3/5/2/12, pp. 74-75; HHB/3/5/2/9, pp. 508-510; HHB/3/5/2/3, p. 313; HD/1/517, p. 38.

<sup>150</sup> *Fifth Annual Report of the Inverness District Lunatic Asylum* (Inverness: Courier Office, 1869), p. 27.

physicians, forms an overview that encouraged the continued development of diagnostic classifications according to the results of patient treatment. While Baillarger's and Falret's terms consisted of a movement between mood states, an examination of patient case notes shows these features were already being recorded under diagnoses of mania. Falret's and Baillarger's categories for diagnosis would not necessarily be adopted if physicians already had an alternative diagnostic category for an illness consisting of both highs and lows of mood, possible lucid intervals and symptoms of psychosis. Physicians encountering these experiences diagnosed them as mania. Moreover, beyond working asylums, Baillarger's and Falret's new frameworks were not recorded in Bucknill's and Tuke's textbook. Baillarger was praised as a source on mania, Bucknill and Tuke stating 'we are glad to be able to cite so high an authority as Baillarger', but *folie à double forme* was not referred to throughout the textbook, and neither was *folie circulaire*.<sup>151</sup> Baillarger's system of classification as a whole was referred to earlier in the manual, but without any specific information, and with the note that it was 'decidedly too complex'.<sup>152</sup> I will explore the circulation and influence of Baillarger's and Falret's frameworks in further detail in the final section of this chapter.

In the context of working asylums, then, there is little evidence of the influence of Falret's and Baillarger's diagnostic terms. Instead, there is evidence of physicians already encountering patients experiencing both lows and highs of mood and, in their construction of classifications, considering this a characterisation of mania. This classification of mania existed prior to *folie à double forme* or *folie circulaire* and continued in the decades after their introduction. David Healy argues that the reason there is little evidence of the use of *folie circulaire* or *folie à double forme* in asylums is because this type of illness was rare.<sup>153</sup> In contrast, I argue that an illness consisting of both high and low mood was not rare, but rather that the category of mania was used to diagnose it. Despite the variations in classifications between physicians, my research shows that the consistently recorded key feature of mania was high and low mood states.

Symptoms of mood states and psychosis were also depicted in nineteenth-century literary texts, and frequently appear to have been influenced by medical ideas. Crucially, a characterisation of mania as consisting of high and low mood states was also present in literary representations. Details about diagnostic categories and asylum practice were prominent in

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<sup>151</sup> Bucknill and Tuke, *A Manual of Psychological Medicine*, p. 220.

<sup>152</sup> Bucknill and Tuke, *A Manual of Psychological Medicine*, p. 94.

<sup>153</sup> Healy, *Mania*, p. 86.

popular reading. Annual asylum reports, which included information from the medical superintendent about diagnoses, and regularly contained examples of a handful of cases, were commonly published in local newspapers. In addition, in the nineteenth century, it was common for literary and medical writing to share spaces, being published within the same periodicals and borrowing from one another in the presentation of ideas. Jenny Bourne Taylor and Sally Shuttleworth discuss the exploration of ideas across different journals, demonstrating how ‘nineteenth-century culture did not share our sense of disciplinary divisions between “arts” and “science” through the way that ideas in medical journals ‘were not only reported but developed in articles aimed at a wider readership’.<sup>154</sup> Among the examples is *Blackwood’s Edinburgh Magazine*, which is the source for several of the literary texts I discuss.<sup>155</sup>

This fluid dialogue between medical and literary writing was also demonstrated in the use of literary examples by medical writers. For example, Bucknill’s and Tuke’s *A Manual of Psychological Medicine* (1858) used Shakespeare’s *The Tempest* to express a feature of mania:

The emotions thus aroused and excited, in the words of Shakespeare, –

“Stiffen the sinews, summon up the blood,  
Lend fierce and dreadful aspect to the eye,  
Set the teeth close, and stretch the nostril wide,  
Hold hard the breath, and bind up every spirit  
To its full height –”<sup>156</sup>

Bucknill and Tuke described signs in the face and body of someone experiencing mania as indicative of ‘the commotion which is raging within’, using the example from Shakespeare to term this a ‘mental tempest’.<sup>157</sup> Literary writing was used by Bucknill and Tuke as a tool to illustrate the nature of mania in an instructional medical textbook. In return, literary writers also employed medical ideas, representing symptoms, and exploring diagnostic classifications, as well as mimicking the structure of medical documents such as case notes. While it is not always possible to know exactly what an author was reading, it would not have been uncommon for authors to engage with medical writing without requiring specialist knowledge because of the prominence of these ideas in popular periodicals like *Blackwood’s Edinburgh*

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<sup>154</sup> *Embodied Selves: An Anthology of Psychological Texts 1830-1890*, ed. By Jenny Bourne Taylor and Sally Shuttleworth (Oxford: Clarendon Press, 1998), p. xv.

<sup>155</sup> *Embodied Selves*, p. xv.

<sup>156</sup> Shakespeare, *The Tempest*, quoted in Bucknill and Tuke, *A Manual of Psychological Medicine*, p. 226.

<sup>157</sup> Bucknill and Tuke, *A Manual of Psychological Medicine*, p. 226.

*Magazine*. The fluidity of exchange between medical and literary texts makes an analysis of literary writing valuable for studying representations of illness, allowing for an interrogation of whether literary texts either normalised or challenged medical ideas, how the experience and treatment of illness was represented differently in different spaces, as well as how illness categories were constructed.

Mania was characterised by high and low mood states in literary examples as well as in asylum patient cases. Records of mania in the nineteenth century observe psychosis mood-congruent with both high and low states. In the section on current classifications for bipolar disorder in the Introduction, I discuss how psychosis mood-congruent with high emotional states presents with themes of invulnerability and elation, whereas features of psychosis mood-congruent with depressive states include themes of death, impending danger, decay, and vulnerability. This dialogue with present classifications is useful for examining the construction of the relationship between psychosis and mood states, which continues to be reshaped. The recognition of this construction as not static is valuable to examining the way the lines were drawn around mood states and psychosis in the nineteenth century, and how they were represented in both medical and literary writing. Nineteenth-century case records show physicians analysing the themes of delusional beliefs and hallucinations as a way of examining a patient's emotional state and as a way of classifying the form of a patient's mental illness. Moreover, analysis of these observations show psychosis associated with both high and low emotional states being categorised as mania in both patient cases and in literary depictions.

Edgar Allan Poe's 'The Tell-Tale Heart', published in 1843, and Sheridan Le Fanu's 'Green Tea' published in 1869, are two examples of texts illustrating severe emotional states alongside experiences of psychosis. Both authors engage with classifications of mental illness, and I will submit that in these texts they specifically explore the classification for nineteenth-century mania. I will focus on the illustration of the emotional themes of psychosis, putting 'The Tell-Tale Heart' and 'Green Tea' in dialogue with medical case notes. 'The Tell-Tale Heart' has primarily been read as illustrating crime and detection.<sup>158</sup> Thomas Joswick argues that the text focuses on 'the workings of law and moral order of the psyche', stating that the function of insanity in the short story is to illustrate crime, punishment and confession.<sup>159</sup> Furthermore, Julian Symonds argues that 'The Tell-Tale Heart' is an example of Poe

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<sup>158</sup> Julian Symonds, *The Tell-Tale Heart: The Life and Works of Edgar Allan Poe* (London: Faber and Faber, 1978), p. 209.

<sup>159</sup> Thomas Joswick, 'Moods of Mind: Tales of Detection, Crime and Punishment', in *A Companion to Poe Studies*, ed. Eric W. Carlson (London: Greenwood Press, 1996), pp. 236-256 (p. 245).

questioning the root of insanity through its narrative structure as the unravelling of a confession of murder.<sup>160</sup> While I agree that Poe is exploring insanity, I am not convinced that ‘The Tell-Tale Heart’ traces insanity in relation to an actual crime. Instead, Poe’s protagonist specifically illustrates the experience of psychosis in accordance with severe states of mood. The psychosis narrative presents the possibility that the crime itself is a feature of the protagonist’s delusion, and, instead of unravelling a confession, unravels the experience of psychosis alongside feelings of invulnerability and extraordinary ability, consistent with high mood states.

Hélio Afonso Teive focuses on Poe’s medical history to suggest Poe suffered himself with a bipolar mood disorder.<sup>161</sup> Similarly, in her discussion of manic-depressive illness and creativity, Kay Redfield Jamison uses a combination of medical classifications to argue that Poe was aware of such symptoms because of being among a number of writers and creatives experiencing symptoms on the bipolar spectrum.<sup>162</sup> However, my study of representations of manic-depressive illness is not reliant on an author’s experience of illness, but instead centres on the construction of diagnostic classifications. For this reason, instead of investigating a retrospective diagnosis for Poe, my analysis is based on the likelihood that Poe engaged with medical writing about mental illness. A feature from *Poe Studies* edited by Dana Medoro, entitled *Edgar Allan Poe and Nineteenth-Century Medicine*, discusses Poe’s engagement with medicine through a series of essays which are all based on Poe’s interest in scientific developments.<sup>163</sup> The papers trace Poe’s works to his ‘curiosity about medicine’ and the ‘rapidly developing world of medical professionals in which he lived’.<sup>164</sup> My analysis will also do this by putting Poe’s texts in dialogue with the classification of nineteenth-century mania.

The experience of mental ill health is a central feature across Poe’s works. My analysis in Chapter Two of Poe’s ‘Murders in the Rue Morgue’, first published in 1841, will demonstrate the striking similarities between the short story and Warren’s ‘The Spectre-Smitten’, one of the instalments of *Passages from the Diary of a Late Physician* published in *Blackwood’s Edinburgh Magazine* in 1831, to argue that Poe was drawing specifically from a representation of nineteenth-century mania. Poe’s drawing from Warren indicates an interest in medical case writing because Warren’s *Passages from the Diary of a Late Physician* was

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<sup>160</sup> Julian Symonds, *The Tell-Tale Heart: The Life and Works of Edgar Allan Poe*, p. 213.

<sup>161</sup> Hélio Afonso Teive, ‘Edgar Allan Poe and Neurology’, *Arquivos de Neuro-Psiquiatria*, 72.6 (June 2014), pp. 466-488 (p. 467).

<sup>162</sup> Kay Redfield Jamison, *Touched With Fire: Manic-Depressive Illness and the Artistic Temperament* (New York: Simon and Schuster, 1993), pp. 242-44.

<sup>163</sup> *Edgar Allan Poe and Nineteenth-Century Medicine*, ed. by Dana Medoro, *Poe Studies*, 50 (2017).

<sup>164</sup> *Edgar Allan Poe and Nineteenth-Century Medicine*, p. 3.



written in the style of case notes and, until 1838 when Warren's authorship was revealed, was presented as factual patient records. Megan Coyer shows that Warren's level of detail was convincing even to a medical audience, providing evidence of medical professionals who would 'confirm and praise his accuracy'.<sup>165</sup> We know without doubt that Poe engaged with both *Blackwood's Edinburgh Magazine* and Warren's writing, as he refers to *Passages from the Diary of a Late Physician* in his own *Blackwood's* publication, 'How to Write a Blackwood Article', published in 1838, prior to the publication of both 'The Murders in the Rue Morgue' and 'The Tell-Tale Heart', published in 1841 and 1843 respectively. Although Poe, unlike the other authors' work analysed in this thesis, was further away from the UK context of psychiatric classifications, his affiliation with *Blackwood's Edinburgh Magazine*, and the dialogue between fictional and medical writing, makes his work valuable to an investigation of depictions of mania in the UK.

Poe's protagonist in 'The Tell-Tale Heart' illustrates high mood and psychosis. The notion that the protagonist is experiencing mental illness is referenced and countered by the claims that his extraordinary abilities are beyond those of someone mad. The protagonist conveys a sense of grandiosity: 'Never before that night, had I *felt* the extent of my own powers – of my sagacity. I could scarcely contain my feelings of triumph'.<sup>166</sup> He reminds us of his 'cunning', 'care' and 'caution', asking, 'would a madman have been so wise as this?' (p. 229). He also demonstrates a belief in his invulnerability: 'I smiled, - for *what* had I to fear?', (p. 229). This grandiosity and invulnerability are connected to a belief that he possesses the power of divine communication: 'I heard all things in the heaven and in the earth. I heard many things in hell' (p. 228). The reference to both heaven and hell illustrates opposites in the nature of delusional beliefs experienced in high and low mood, where psychosis in high mood was often associated in patient case notes with visits to and communications with God and heaven, and in low mood with communication with the Devil and a belief of being destined to confinement in hell.

Observations of psychosis according to emotional state were discussed in an article in the *British Medical Journal* in 1841, based on French physician J. Moreau's treatment of hallucinations using datura stramonium. The value of Moreau as a source is due to both his

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<sup>165</sup> Megan Coyer, *Literature and Medicine in the Nineteenth-Century Periodical Press: Blackwood's Edinburgh Magazine 1817-1858* (Edinburgh: Edinburgh University Press, 2017), p. 134.

<sup>166</sup> Edgar Allan Poe, 'The Tell-Tale Heart' in *The Fall of the House of Usher and Other Writings* (London: Penguin Classics, 2003), pp. 228-233 (p. 229). All further references are to this edition and are given parenthetically in the body of the text.

influence on French psychiatric publications and his professional relationship with Baillarger – in 1843, they would be two of the founding members of the French psychiatric journal *Annales médico-psychologiques*. This 1841 article discussed the treatment of hallucinations, describing individual cases and illustrating the different forms of this symptom in relation to emotional states. A letter written by one patient shows clear elation:

Give me my liberty at once, that I may pursue my object and destroy all the kings of this earth. My earnest desire is to regenerate the human race, and I am destined to die at the head of a powerful republic. From the age of eight years upwards I have always resolved, like Romulus, to build a city in my native forest of Lorraine. For the last twenty years, heavenly voices announce to me the most curious particulars concerning the kings of the earth and my change at nurse.<sup>167</sup>

The language in the letter conveys elation through grandiosity, themes of invulnerability and the sense of being the only person capable of his goal. The patient believes in his unique position in this purpose, discussing his ‘earnest desire’, his resolve ‘from the age of eight years upwards’, his channel of communication to ‘heavenly voices’, his ability to ‘destroy all of the kings of this earth’, and his clearly stated belief that of this he is ‘destined’.<sup>168</sup>

However, within the same article, another of Moreau’s patients is diagnosed with mania, but with observations of low mood, showing again the prominence of low mood in mania. The patient is described as having a ‘morose disposition’, being ‘excessively timid’, and Moreau illustrates the prominence of a low emotional state by attributing ‘his present malady to grief’.<sup>169</sup> The patients’ psychosis also shows themes of low as opposed to high mood through features of grief and vulnerability. He sees the ‘ghost of his father, who died a few years back standing close to the bed’ and hears him through a ‘voice call[ing] loudly in his ear, “I am your father, whom you killed with grief”’.<sup>170</sup> In addition, the patient experiences symptoms of intense anxiety, with ‘palpitations and pains in his head’ and ‘the least thing excit[ing] terror’.<sup>171</sup>

Delusions and hallucinations associated with heaven and hell, in accordance with either high or low mood, were also recorded in asylum patient case notes. M.A., admitted to Gartnavel

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<sup>167</sup> J. Moreau, ‘On the Treatment of Hallucinations’, *British Medical Journal*, 1 (13 November 1841), pp. 126-127 (p. 126).

<sup>168</sup> Moreau, ‘On the Treatment of Hallucinations’, p. 127.

<sup>169</sup> Moreau, ‘On the Treatment of Hallucinations’, p. 126.

<sup>170</sup> Moreau, ‘On the Treatment of Hallucinations’, p. 126.

<sup>171</sup> Moreau, ‘On the Treatment of Hallucinations’, p. 126.

Royal Asylum in 1838, and diagnosed with mania, was described predominantly with excited mood, alongside the delusion that she ‘imagines herself to have power in heaven in consequence of which she is accustomed to threatening her relations or friends when contradicted or thwarted’.<sup>172</sup> Similarly, H.M., admitted to Gartnavel Royal Asylum in 1838, and diagnosed with ‘mania with great excitation’, was recorded as believing that she was able to make ‘visits to Heaven’.<sup>173</sup> In contrast, E.M., admitted to the Inverness District Asylum in 1876, and diagnosed with ‘mania’ was observed with states of both ‘depression’ and ‘excitement’.<sup>174</sup> Her delusional beliefs were recorded as refusing to return from a walk ‘under the delusion that they wanted to kill her in the asylum’, that she was ‘lost’, and that she ‘was to be burnt in the everlasting fire’, demonstrating instead a connection to hell.<sup>175</sup> I will discuss further examples of case observations relating to hell and communication with the Devil alongside an analysis of Le Fanu’s ‘Green Tea’.

Poe’s exploration of symptoms in ‘The Tell-Tale Heart’ also depicts sensory hypersensitivity, which was another feature recorded in cases of mania. The experience of psychosis in ‘The Tell-Tale Heart’ is tied to the unavoidable sound of a beating of a heart, believed by the protagonist to be the heart of his supposed murder victim. This has led literary scholarship to read the constant sound of the heart as a feature of guilt. However, sensory hypersensitivity is recorded in patient case notes as the constant experience of a voiceless sound, coinciding with and exacerbating experiences of hallucinations and delusions. In the article discussed earlier by Thomson, he discussed the ‘evident pervasion of sensation’ in mania.<sup>176</sup> He classified hearing, sight, smell and touch as ‘equally depraved in mania’ and connected all to a worsening of the patient’s hallucinations and ongoing delusional beliefs.<sup>177</sup> Moreu’s 1841 *British Medical Journal* article also discussed sensory hypersensitivity alongside hallucination in mania. He outlined the case of a labourer, who was admitted to the asylum because of hallucinating ‘numerous voices issuing from different parts of the chamber’.<sup>178</sup> There is a distinct sense of vulnerability clear in the hallucination, the patient claiming that ‘the voices accused him of different crimes, and told him that his right hand

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<sup>172</sup> HB13/5/11, p. 79.

<sup>173</sup> HB13/5/11, p. 47.

<sup>174</sup> HHB/3/5/2/8, p. 508.

<sup>175</sup> HHB/3/5/2/8, p. 508.

<sup>176</sup> Thompson, ‘Lectures on Medical Jurisprudence’, p. 887.

<sup>177</sup> Thompson, ‘Lectures on Medical Jurisprudence’, p. 887.

<sup>178</sup> M. J. Moreau, ‘On the Treatment of Hallucinations’, *British Medical Journal*, 1 (13 November, 1841), pp. 126-27 (p. 126).

would be cut off'.<sup>179</sup> The hallucination is observed alongside sensory disturbance. The patient, having woken, 'immediately noticed a strong ringing in the ears', and at the same time, 'heard the voice more distinctly'.<sup>180</sup>

Poe's protagonist similarly experiences an exacerbation in his symptoms of psychosis alongside sensory hypersensitivity. Initially considering himself mentally unwell, he claims: 'the disease had sharpened my senses – not destroyed – not dulled them' (p. 228). The overwhelming sound experienced in 'The Tell-Tale Heart' is not unlike the voiceless, repetitive, mechanical sound of ringing. It is described as 'a low, dull, quick sound – much such a sound as a watch makes when enveloped in cotton' (p. 229). Poe illustrates how sounds associated with sensory hypersensitivity can enhance delusion. This 'sense of hearing acute' is illustrated alongside his psychosis, tied to the experience of communications with heaven and hell (p. 229). The narrator also connects his experience of sound to his feelings of superiority, describing his experience of the sound as a superior ability of hearing: 'have I not told you that what you mistake for madness is but over acuteness of the senses?' (p. 230).

The view of the sound of the heart as a consequence of guilt is weakened by the portrayal of the supposed murder as a feature of psychosis. After describing the killing, the protagonist states, 'There was nothing to wash out – no stain of any kind – no blood-spot whatever' (p. 231). Having described himself beating the old man with a lantern and crushing him with the heavy bed, a lack of blood is surprising. In addition, the use of the phrase 'blood-spot', could be drawing a connection with Shakespeare's *Macbeth*. Lady Macbeth's guilt for plotting to murder the king is depicted in the play as unravelling her sanity, leading to symptoms including somnambulism with features of hallucination. Lady Macbeth's visual hallucination causes her to continue to see blood on her hands long after the murder, incessantly trying to clean at her skin whilst crying, 'out, damned spot!'.<sup>181</sup> This connection to Lady Macbeth's symptoms suggests that the murder sequence is a function of the narrator's psychosis.

Poe's 'The Tell-Tale Heart' represents an experience of symptoms of nineteenth-century mania commonly observed in asylum case notes, as well as in cases published in medical journals. The short story follows an experience of psychosis, illustrating the experience in accordance with a severe high mood state as well as sensory hypersensitivity. This shows a

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<sup>179</sup> Moreau, 'On the Treatment of Hallucinations', p. 126.

<sup>180</sup> Moreau, 'On the Treatment of Hallucinations', p. 126.

<sup>181</sup> William Shakespeare, *Macbeth*, ed. by Sandra Clark and Pamela Mason (London: Bloomsbury 2015), 5.1.19.

literary portrayal of symptoms of mania like those recorded in medical texts. ‘The Tell-Tale Heart’ illustrates a severe high mood state, but literary representations of symptoms of mania also represented low states. Le Fanu’s ‘Green Tea’ similarly represents the experience of psychosis alongside a severe emotional state, but does so with the representation of low mood rather than high mood, illustrating symptoms of psychosis with themes of vulnerability, a fear of impending danger, and communication with the Devil.

Sheridan Le Fanu’s short story ‘Green Tea’ was first published in the periodical *All the Year Round* in 1869. In a similar form to Samuel Warren’s *Passages from the Diary of a Late Physician*, ‘Green Tea’ is written to mimic the style of a physician’s recorded observations of a patient. The case is presented through a series of letters written by physician Martin Hesselius of his observations of Reverend Jennings, who is experiencing symptoms of psychosis. William Hughes’s article ‘The Origins and Implications of J. S. Le Fanu’s “Green Tea”’ similarly connects ‘Green Tea’ to Warren’s *Passages from the Diary of a Late Physician*.<sup>182</sup> Hughes does this to argue against the view of W.J. McCormack, who attributes the origin of ‘Green Tea’ to the 1841 article ‘German Ghosts and Seers’ published in *Dublin University Magazine*.<sup>183</sup> Hughes argues instead that *Passages from the Diary of a Late Physician* influenced ‘Green Tea’ through its ‘episodic nature and distinctive medical framing’.<sup>184</sup> Hughes draws connections specifically between Le Fanu’s ‘Green Tea’ and Warren’s ‘The Spectral Dog’ and ‘The Spectre-Smitten’, analysing the illustration of spectral encounters.<sup>185</sup>

My analysis of ‘Green Tea’ similarly connects to Warren’s ‘The Spectre-Smitten’. However, my analysis of both the texts places them in dialogue with nineteenth-century medical writing about manic-depressive illness specifically. As I set out earlier, my examination of Warren’s ‘The Spectre-Smitten’ in Chapter Two will compare the story to Edgar Allan Poe’s ‘The Murders in the Rue Morgue’, arguing that Poe was highly influenced by Warren, and that both Warren’s M and Poe’s orangutan specifically represent manic-depressive illness as animalistic. ‘Green Tea’ similarly uses an animal figure in the specific context of manic-depressive illness through the figure of hallucination as ‘a small black monkey’.<sup>186</sup> However, the separation of the animal figure from Jennings is both crucial and

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<sup>182</sup> William Hughes, ‘The Origins and Implications of J.S. Le Fanu’s “Green Tea”’, *Irish Studies Review*, 13.1 (2005), pp. 45-54.

<sup>183</sup> W.J. McCormack quoted in Hughes, ‘The Origins and Implications of J.S. Le Fanu’s “Green Tea”’, p. 45.

<sup>184</sup> Hughes, ‘The Origins and Implications of J.S. Le Fanu’s “Green Tea”’, p. 46.

<sup>185</sup> Hughes, ‘The Origins and Implications of J.S. Le Fanu’s “Green Tea”’, p. 48.

<sup>186</sup> Sheridan Le Fanu, ‘Green Tea’, *All the Year Round*, 2 (1869), pp. 501-504, 525-528, 548-552, 572-576 (p. 20).

intentional. I will expand on this point in Chapter Two when analysing representations of treatment and literary challenges to medical authority. For this section, I will focus on the illustration of Jennings's psychosis in accordance with low mood states, examining the short story in dialogue with medical case notes.

Jennings's psychosis is characterised by vulnerability, religious guilt, and communication with the devil – characteristics often recorded in cases of nineteenth-century mania alongside low mood states. Simon Cooke points out that we cannot be certain which texts Le Fanu was familiar with because of 'the absence of any details of his library or direct evidence of his reading'.<sup>187</sup> However, Cooke also discusses the popular nature of texts exploring hallucinations and the number of accessible texts of this kind 'intended for a non-specialist audience', suggesting it was 'possible that Le Fanu was influenced by real medical texts'.<sup>188</sup> The structure of 'Green Tea' in case notes, the illustration of medical authority and the diagnostic process, as well as the exploration of diagnostic classifications, would all indicate Le Fanu's interest in medical writing about forms of mental illness. Jennings is eventually posthumously diagnosed with 'hereditary suicidal mania'. The symptoms recorded across Hesselius's letters observe the development of Jennings's hallucination, which he believes to be the devil, alongside a low mood state.

A case in North Wales Lunatic Asylum is similar to the narrative of Jennings's hallucination. J.R., diagnosed with 'acute mania', was observed with the hallucination that she was 'followed by a dog which constantly was passing and repassing'.<sup>189</sup> The movement of the dog was like that of the monkey in 'Green Tea', who constantly reappears. Moreover, both patients attribute their hallucination to the same cause. Patient J.R. believed the dog 'must be the devil'.<sup>190</sup> Similarly, Jennings believes the monkey to be 'an evil spirit', trying to 'destroy' him and to make him 'a slave of Satan'.<sup>191</sup> Jennings's psychosis is associated both with a fear of being destroyed by the creature and religious guilt. The monkey tries to render Jennings's religious responsibilities impossible: 'when I was reading to the congregation, it would spring upon the book and squat there, so that I was unable to see the page', and 'it won't let me pray, it interrupts me with dreadful blasphemies'.<sup>192</sup> Jennings's feelings of guilt intensify the more

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<sup>187</sup> Simon Cooke, "'Metaphysical Medicine': de Boismont, Le Fanu and a Source for "Green Tea"", *The Victorian Web* (2011) < <https://victorianweb.org/authors/lefanu/cooke2.html> > [accessed 11 April 2021].

<sup>188</sup> Cooke, "'Metaphysical Medicine'".

<sup>189</sup> HD/1/506, p. 6.

<sup>190</sup> HD/1/506, p. 6.

<sup>191</sup> Le Fanu, 'Green Tea', pp. 525-526.

<sup>192</sup> Le Fanu, 'Green Tea', p. 552, 572.

he is interrupted by the monkey. Hesselius observes Jennings as believing the hallucination to be a sign that he had ‘been delivered over to spiritual reprobation’.<sup>193</sup> Jennings attributes his crime towards God as reading pagan literature, for which he is now being punished.<sup>194</sup> The psychosis experienced by J.R. and Jennings is characterised by low emotional state through themes of guilt, self-reproach, a fear of being pursued by the devil and, as a result, an irrational fear of injury, death, and hell.

Hallucinations of spirits, and attributing hallucinations to the devil, were features of psychosis frequently recorded in observations of mania in nineteenth-century patient case notes. M.F., admitted to the Inverness District Asylum in 1877, and diagnosed with ‘mania’, was recorded as believing ‘she is constantly beset by the devil’.<sup>195</sup> E.M., admitted to the Inverness District Asylum in 1877 and diagnosed with ‘mania’, ‘believes the devil is hunting her night and day’ and ‘hears spirits speaking to her’.<sup>196</sup> J.B., admitted to Gartnavel Royal Asylum in 1838 and diagnosed with mania, ‘communicated with spirits, and thinks that there is a design against her life’.<sup>197</sup> A.S., admitted to the Inverness District Asylum in 1875, initially diagnosed with melancholia, but re-diagnosed with ‘mania’, ‘thinks the devil is pursuing him’.<sup>198</sup> Delusions relating to evil spirits and the devil illustrate themes of impending danger relating to mood-congruent psychosis in depressive states. Moreover, the abuse of agents such as teas were also attributed to mental illness in nineteenth-century diagnoses. The ‘excessive use of strong tea’ was given as the cause of suicidal ideation in two cases in the Royal Edinburgh Asylum, recorded in the annual report of 1850.<sup>199</sup>

Poe’s ‘The Tell-Tale Heart’ and Le Fanu’s ‘Green Tea’ illustrate the relationship between psychosis and severe emotional states. The possible interest of both writers in medical ideas, and the explorations in their writing of specific symptoms, suggests a representation influenced by diagnostic classifications. Crucially, the texts demonstrate a pattern in nineteenth-century mania as being characterised by both high and low mood states, rather than solely high mood. Despite the power for physicians to have variable classifications for diagnostic categories, the presence of different mood states across both medical case notes and literary representations of mania supports the view that a consistent feature in mania was the

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<sup>193</sup> Le Fanu, ‘Green Tea’, p. 573.

<sup>194</sup> Le Fanu, ‘Green Tea’, p. 548.

<sup>195</sup> HHB/3/5/2/9, p. 460.

<sup>196</sup> HHB/3/5/2/9, p. 509.

<sup>197</sup> HB13/5/11, p. 15.

<sup>198</sup> HHB/3/5/2/8, p. 202.

<sup>199</sup> *Annual Report of the Edinburgh Royal Asylum* (1850), p. 23.

potential for both severe low and high mood. In the next section, I will turn to evaluating the reception of Falret's and Baillarger's frameworks, to expand on the argument that an illness characterised by low and high emotional states and psychosis was already established in the category of mania prior to *folie circulaire* and *folie à double forme*, making it unnecessary for Falret's and Baillarger's terms to be widely used in institutions' diagnostic practice.

### **Influence of *Folie à Double Forme* and *Folie Circulaire***

So far, I have argued that nineteenth-century mania was characterised by both high and low mood states in observations in patient case notes and in literary representations. I have argued that this classification for mania was used both prior to and after the introduction of Falret's and Baillarger's frameworks. Moreover, I have examined the approach of working asylums to constructing diagnostic classifications, and the nature of instructional manuals for classification, to argue that there was a fluidity of approach to diagnostic categories that allowed classifications to continue to develop based on encounters with patients. I have suggested that this could be a factor in the absence of Falret's and Baillarger's terms in asylum records, as well as for the absence of these terms in Bucknill's and Tuke's key textbook. To extend this argument, this section will analyse the circulation of medical classifications in medical journals to interrogate the influence, or lack of influence, of Baillarger's and Falret's *folie à double forme* and *folie circulaire*.

Both presented in 1854, Baillarger's *folie à double forme*, and Falret's *folie circulaire*, classified an illness moving between stages of mania and melancholia. Controversy emerged as a result of the presentations because Baillarger and Falret, both students of Esquirol, had presented diagnostic classifications with marked similarities. P. Pinchot has covered the timeline of events, and the ensuing dispute, in detail in a study of connections between *folie à double forme*, *folie circulaire* and modern bipolar disorder.<sup>200</sup> Baillarger's lecture was given first, on January 31<sup>st</sup>. However, in Falret's presentation, attempted on the 7<sup>th</sup> of February, but given on the 14<sup>th</sup> of February, he asserted that he had already described his framework for *folie circulaire* in a clinical lesson at Salpêtrière in 1850, which had been published in *Gazette des*

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<sup>200</sup> P. Pinchot, 'The Birth of the Bipolar Disorder', *European Psychiatry*, 10.1 (1995), pp. 1-10; P. Pinchot, 'Circular Insanity, 150 Years On' *Bulletin de L'Académie Nationale de Médecine*, 188.2 (2004), pp. 275-284; P. Pichot, 'Tracing the Origins of Bipolar Disorder: From Falret to DSM-IV and ICD-10', *Journal of Affective Disorders*, 96 (2006), pp. 145-148.



*Hospitaux* in 1851.<sup>201</sup> The lesson had since been revised by Falret and published in his book *Leçons cliniques de médecine mentale faites à l'hospice de la Salpêtrière*.<sup>202</sup> Falret therefore made a claim for priority, stating that his classification of *folie circulaire* had been established prior to Baillarger's *folie à double forme*.<sup>203</sup> Nevertheless, Baillarger countered that Falret had revised and expanded upon his original lectures, and insisted that Falret had modified his 'point of view' after hearing Baillarger's lecture, accusing Falret of plagiarism, and later alleging that this was a pattern of behaviour from Falret.<sup>204</sup> This controversy continued. While Falret maintained the position that, 'I do not want to embark on a controversy and content myself by reproducing my Lecture at the Academy', Baillarger 'reiterated and extend[ed] his accusations until his death'.<sup>205</sup>

In 1854, the *Journal of Psychological Medicine and Mental Pathology*, published in London, includes articles on both Baillarger's and Falret's work. The editor of the journal at this time was its founder, Forbes Winslow, a physician and specialist in insanity.<sup>206</sup> Jonathan Andrews demonstrates Winslow's influence in the development of psychological medicine: 'Through his journal and his prolific publications, Winslow contributed perhaps more than anyone to the dissemination of psychological medicine as a term and concept'.<sup>207</sup> In this way, the *Journal of Psychological Medicine and Mental Pathology* was influential in its evaluation of the development of diagnostic classifications. It analysed both national and international work, with regular features on 'Foreign Psychological Literature', translating and examining the most recent developments in European psychiatric discourse. The journal's pieces on the work of Baillarger and Falret can therefore be analysed for insight into the reception of the new diagnostic categories.

The articles published in the *Journal of Psychological Medicine and Mental Pathology* in 1854 about Baillarger and Falret paid little attention to *folie à double forme* and *folie circulaire*. While the table of classifications provided in the writing about Baillarger included the specific mention of *folie à double forme*, the article was more concerned with other areas

<sup>201</sup> Falret (1854) quoted in P. Pichot, 'Tracing the Origins of Bipolar Disorder: From Falret to DSM-IV and ICD-10', *Journal of Affective Disorders*, 96 (2006), pp. 145-148 (p. 145).

<sup>202</sup> P. Pinchot, 'The Birth of the Bipolar Disorder', *European Psychiatry*, 10.1 (1995), pp. 1-10 (p. 4)

<sup>203</sup> Pinchot, 'The Birth of the Bipolar Disorder', p. 4.

<sup>204</sup> Pinchot, 'The Birth of the Bipolar Disorder', p. 5.

<sup>205</sup> Falret (1864) quoted in Pinchot, 'The Birth of the Bipolar Disorder', p. 5.

<sup>206</sup> Jonathan Andrews, 'Winslow, Forbes Benignus (1810-1864), physician and specialist in insanity', *Oxford Dictionary of National Biography* (2004)

<<https://www.oxforddnb.com/display/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-29752>> [accessed November 27, 2022].

<sup>207</sup> Andrews, 'Winslow'.

of Baillarger's lecture. 'Insanity of double form', which was described as 'depression and excitation succeeding each other regularly in the same patient', was included in the table presented by Baillarger alongside 'monomania, melancholia, and mania'.<sup>208</sup> However, the article claimed that the tables 'sufficiently explain' the different classifications, so as to 'dispense us from the task of following him through a minute exposition of the various heads', which would include his description of *folie à double forme*. In reference to this part of the lecture, the article stated:

Under the common head of simple forms he preserves the old forms of monomania, melancholia, and mania, without disturbing the notions generally attached to these words.<sup>209</sup>

This short reference to the table, in an article spanning ten pages, suggests that the category of *folie à double forme* arrested little attention. This supports the argument that the concept of alternating emotional states did not seem entirely innovative. The note in the article that Baillarger forms this table 'without disturbing' the general understanding of subtypes of mania, implies that diagnosing the combined states of low and high mood was already common. The only other reference to this part of the table was that these categories were 'all ranked together as curable'.<sup>210</sup> Baillarger's thoughts on the nature of recovery are given the most attention in this article, which I will return to in Chapter Two alongside an analysis of literary challenges to treatment and medical authority.

Two years later, in 1856, there is a second reference to *folie à double forme* in the *Journal of Psychological Medicine and Mental Pathology*. Within a section on 'French Psychological Literature', an article by Legrand Du Saulle was included, which described 'a very graphic instance of the *folie à double forme* noticed by Baillarger in an interesting communication on the subject to the Academy'.<sup>211</sup> A key feature of this case was the rapid movement between the high and low emotional states. The longest period of time between different emotional states was recorded as six days, and the change was at times noted as occurring within the same twenty-four hour period: 'in the evening she was melancholic, possessed with religious feelings; in the morning, she was maniacal, shouting and swearing'.<sup>212</sup>

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<sup>208</sup> 'On the Classification of Mental Diseases', *Journal of Psychological Medicine and Mental Pathology*, 1 (1854), pp. 531-41 (p. 537).

<sup>209</sup> 'On the Classification of Mental Diseases', p. 539.

<sup>210</sup> 'On the Classification of Mental Diseases', p. 539.

<sup>211</sup> Legrand Du Saulle, 'French Psychological Literature: Alternating Mania and Melancholia cured by Quinine', *Journal of Psychological Literature and Mental Pathology*, 1 (1865), pp. 482-483 (p. 483).

<sup>212</sup> Du Saulle, 'Alternating Mania and Melancholia cured by Quinine', p. 482.

In between the high and low mood, some moments of wellness were also recorded. On February fourth, observations recorded that her ‘violence has given way to a consciousness of illness and weakness’ which ‘gradually subsided’ into ‘perfect calmness’ with ‘reason sound’ and ‘demeanour cheerful’ two days later on the sixth of February.<sup>213</sup> The delusion experienced during the periods of unwellness were associated with religious guilt. The patient as ‘heard a voice saying, “Fast, and though shalt be pardoned”, and therefore ‘refused nourishment’.<sup>214</sup> The feature of guilt in this delusion, which led to self-reproach through a refusal of food, demonstrates it as mood-congruent with a low emotional state.

This case is diagnosed as *folie à double forme*, but shows notable similarities to cases of mania I examined earlier in this chapter. Patient case notes in Gartnavel Royal Asylum, Royal Edinburgh Asylum, North Wales Lunatic Asylum and Inverness District Asylum frequently recorded alternating mania and depression and, more specifically, alternating maniacal excitement and religious depression.<sup>215</sup> Moreover, while the case above of *folie à double forme* demonstrated psychosis which was mood-congruent with depression through the theme of guilt and condemnation, another case, illustrated by Baillarger, with similar features, was diagnosed as a form of mania. The case, published in the French medical journal co-edited by Baillarger, *Annales Médico-Psychologiques*, and included in the *Journal of Psychological Medicine and Mental Pathology* in 1856, was based on a manuscript written by a patient examined by Baillarger. The patient’s psychosis was again mood-congruent with depressive states, centred on death, decay, and guilt. He wrote in the manuscript, ‘I often used to see myself dead, and assisted in imagination at my own burial’.<sup>216</sup> The sight of death exacerbated his symptoms: ‘The sight of a corpse produced a violent effect upon him, always preventing him from sleeping.’<sup>217</sup> The patient wrote that he was ‘often convinced’ that he ‘should die during the night’, and was always in fear of physical injury: ‘I foresaw a thousand dangers, from fearing to go blind, or to break a leg or an arm simply in walking’.<sup>218</sup> The case is similar to the case of *folie à double forme* in its association with religion. The patient writes: ‘I cannot rid myself of my constant ideas – death, the cemetery, the grave, God, and religious ideas.’<sup>219</sup>

<sup>213</sup> Du Saulle, ‘Alternating Mania and Melancholia cured by Quinine’, p. 482.

<sup>214</sup> Du Saulle, ‘Alternating Mania and Melancholia cured by Quinine’, p. 482.

<sup>215</sup> See, for example: LHB7/51/8; HB13/5/11; HHB/3/5/2/12; HHB/3/5/2/9; HHB/3/5/2/3; HD/1/517.

<sup>216</sup> Jules Baillarger, ‘Foreign Psychological Literature: The Theory of Automatism, with the Manuscript of a Monomaniac’, *Journal of Psychological Literature and Mental Pathology*, 1 (1856), pp. 299-301 (p. 299).

<sup>217</sup> Baillarger, ‘The Theory of Automatism’, p. 299.

<sup>218</sup> Baillarger, ‘The Theory of Automatism’, pp. 299-300.

<sup>219</sup> Baillarger, ‘The Theory of Automatism’, p. 300.

In his analysis of the manuscript, Baillarger drew attention to the function of the patient's guilt, using the illustration of guilt to show that the patient's concern with death and decay was more than hypochondria. He explained that the patient 'had delirious ideas besides those of a hypochondriacal nature [...] attributing to himself all unfortunate events; amongst others, the earthquake in 1839.'<sup>220</sup> The patient was fixated on death and injury, with visions of himself as already deceased. Baillarger identified this as more than hypochondria because the patient was unable to recognise their illness: 'instead of seeing in all which he felt a state of illness, he reproached himself' seeing it as 'his own fault'.<sup>221</sup> In addition to irrational guilt, a depressed emotional state was also emphasised by the patient's inability to find enjoyment or interest, and his inability to concentrate: 'he further describes himself as incapable of reading, or taking any interest in anything' and was 'not capable of a moment's attention.'<sup>222</sup> Baillarger diagnosed the patient with 'hypochondriacal monomania', the term monomania referring to a less severe form of mania in which the delusion has a single focus.<sup>223</sup>

This case differs from the case described of *folie à double forme* because it observes only a low mood state, rather than recording a succession between low and high mood. However, it is notable that the case explores the relationship between low mood states and psychosis, and arrives at a diagnosis of hypochondriacal monomania. Baillarger's *folie à double forme* combined mania and melancholia as representations of high mood states and low mood states. Therefore, a case like this, characterised by low mood, might be expected to render a diagnosis of a form of melancholia instead. This demonstrates, I think, that even with the emergence of *folie à double forme* and *folie circulaire*, mania, and types of monomania, maintained their associations with low mood. Cases like this one, diagnosed by Baillarger as hypochondriacal monomania, were observed in the patient case notes I investigated earlier in this chapter, where a patient's delusion was characterised by themes of guilt, impending danger, and a preoccupation with death, and their condition was observed with descriptions of a low mood state. These cases were diagnosed as mania, and could observe solely a low mood state, demonstrating mania's characterisation by mood states across the emotional spectrum. Baillarger's diagnosis of a case characterised by low mood as a form of monomania, rather than of melancholia, illustrates the fluidity of diagnostic categories, and reaffirms the construction of features of low mood in mania and monomania.

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<sup>220</sup> Baillarger, 'The Theory of Automatism', p. 301.

<sup>221</sup> Baillarger, 'The Theory of Automatism', p. 301.

<sup>222</sup> Baillarger, 'The Theory of Automatism', p. 300.

<sup>223</sup> Baillarger, 'The Theory of Automatism', p. 301.

Much of the work on the history of bipolar sees either *folie à double forme* or *folie circulaire* as the first descriptions of current bipolar disorder. It is notable, then, that a comparison between this case of hypochondriacal monomania, rather than *folie à double forme*, and current classifications for bipolar depression reveal marked similarities. As I discussed earlier in this chapter, current classifications for bipolar depression have been reshaped to include psychosis as a feature of bipolar depression, where psychosis was previously included in the diagnostic criteria for mania alone. The case of hypochondriacal monomania diagnosed by Baillarger illustrated a depressed emotional state, delusions about mortality, and guilt. Goodwin's and Jamison's 1990 textbook *Manic-Depressive Illness* described patients in a depressive state as feeling an overwhelming sense of guilt and desire for self-punishment, which was often either unexplainable or misplaced, and [could] intensify into delusional beliefs.<sup>224</sup> Goodwin and Jamison record depressive states as featuring 'self-denigration and guilt, confusion and indecision, marked fatigue, morbid obsessions, and irrational fears'.<sup>225</sup> Themes in psychosis of death and decay, guilt, and self-reproach are therefore recognised as characteristics of bipolar depression. The case of hypochondriacal monomania recorded all the features described by Goodwin and Jamison: the patient's delusions associated with mortality, his inability to concentrate, inability to find enjoyment, and his severe self-reproach.

These observations are also similar to the descriptions of depression provided by Berrios in favour of his argument that depression became a synonym for melancholia in the nineteenth century. However, this example, observed in 1856 by Baillarger, recorded observations of low mood and psychosis and provided a diagnosis of hypochondriacal monomania. I submit that depression was not equivalent to melancholia, but instead low mood was recorded as a characteristic in different subtypes of mania, as well as being a central characteristic of the category of mania itself. This case of hypochondriacal monomania demonstrates mood-congruent psychotic features in a depressed state because of the focus of the psychosis on themes of death, guilt, and vulnerability. As discussed in the previous section through an analysis of patient cases, similar observations of mood-congruent psychosis in low mood states were common in diagnoses of mania. Moreover, such observations were frequently accompanied by alternations between high and low mood, both prior to and after the introduction of *folie à double forme* and *folie circulaire*.

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<sup>224</sup> Goodwin and Jamison, *Manic-Depressive Illness*, p. 39.

<sup>225</sup> Goodwin and Jamison, *Manic-Depressive Illness*, p. 36.

## Conclusion

The contemporaneous and current attention paid to *folie circulaire* and *folie à double forme* is unsurprising given the intensity and longevity of Falret's and Baillarger's dispute over priority. However, the new diagnostic frameworks had a limited impact on patients admitted to asylums with states of alternating mood and psychosis. My research reveals that the symptomatology for both high and low mood states, which were used by critics to situate *folie circulaire* or *folie à double forme* as points of origin for current bipolar disorder, were recorded frequently in cases of patients diagnosed with mania. Case notes from Gartnavel Royal Asylum, Royal Edinburgh Asylum, North Wales Lunatic Asylum, and Inverness District Asylum all observed patients diagnosed with mania with states of high and low mood as well as symptoms of psychosis. This categorisation of mania was also visible in literary texts, such as Poe's 'The Tell-Tale Heart' and Le Fanu's 'Green Tea'.

The prominence of excited and depressed states with psychosis in nineteenth-century mania shows that mania and melancholia were not opposing poles on the mood spectrum in the nineteenth century. Instead, depressive features were also central to diagnoses of mania, with cases frequently recording solely low mood or alternating mood. The reception of the new frameworks combining mania and melancholia in medical journals, and the lack of evidence of their influence in patient registers, case books, and annual reports from working asylums, demonstrates their limited impact. Instead of Falret's and Baillarger's frameworks being entirely innovative, their new categories appear to be a feature of increased interest in discovering, reshaping, and dividing diagnostic criteria, in the context of an approach to diagnosis that allowed physicians room to form variations in their classifications according to encounters with patients. Fundamentally, patterns across asylum patient case records, medical journals, and literary representations, demonstrate that an illness consisting of recurring high and low mood states, possible periods of lucidity, and psychosis, was not rare, but was diagnosed as mania both prior to and following the introduction of *folie à double forme* and *folie circulaire*.

## **Chapter Two:**

### **“the very reverse of what it had been”:**

### **Animalistic Representations, Changes in Treatment, and Challenges to**

### **Medical Authority**

The change in the term ‘mania’ from a general form of madness to a more specific classification of mental illness sparked developments in treatment for this condition. The flexibility for asylum physicians to continue to develop nosologies according to patient encounters led to new approaches in forms of care. This chapter will examine the significant change in the treatment for mania which evolved from mechanical restriction, blood-letting, and limiting nutrition, to the very reverse: a focus on the benefits of open air, exercise, and a plentiful diet. Foucault’s study of the history of mental illness condemns developments that removed restraint in institutions as maintaining a system where any deviation from socially acceptable behaviour was punished.<sup>226</sup> The disuse of restraint in asylums was replaced with surveillance of patients, which Foucault saw as patients being ‘imprisoned in a moral world’ and forced to alter their behaviour for re-entry into society.<sup>227</sup> A body of revisionist histories emerged in response to Foucault, revising and expanding on problematic aspects of his work, such as a generalization of chronology and space which neglected the nuances that shaped institutions and treatments.<sup>228</sup> To interrogate confinement within asylum spaces, social studies of the history of psychiatry have demonstrated the value of examining individual institutions to understand how they were established, why patients were confined, and how patients were treated.<sup>229</sup> In this chapter, I will

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<sup>226</sup> Michel Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason* (London: Vintage, 1988), p. 246.

<sup>227</sup> Foucault, *Madness and Civilisation*, p. 269.

<sup>228</sup> Joseph Melling and Bill Forsythe eds., *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999); Hester Parr, Chris Philo and Nicola Burns, ‘Social Geographies of Rural Mental Health: Experiencing Inclusions and Exclusions’, *Transactions of the Institute of British Geographers*, 29 (2004), pp. 401-419; Roy Porter, ‘Foucault’s Great Confinement’, *History of the Human Sciences*, 3 (1990), pp. 47-54; Jennifer Laws, ‘Crackpots and Basket-Cases: A History of Therapeutic Work and Occupation’, *History of the Human Sciences*, 24.2 (2011), pp. 65-81; Leslie Topp, *Freedom and the Cage: Modern Architecture and Psychiatry in Central Europe, 1890-1914* (Pennsylvania: Penn State University Press, 2016).

<sup>229</sup> See, for example: Pamela Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000* (Cornwall: MPG Books, 2003), Andrews, Jonathan, ‘Case Notes, Case Histories, and the Patient’s Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century’, *Social History of Medicine: The Journal of the Society for the Social History of Medicine*, 11 (1998), pp. 255-81; Hester Parr, Chris Philo and Nicola Burns, “‘That awful place was home’: Reflections on the Contested Meaning of Craig Dunain Asylum, *Scottish Geographical Journal*, 199.4 (2003), 341-360; Lorraine Walsh, “‘The Property of the Whole Community’: Charity and Insanity in Urban Scotland: The Dundee Royal Lunatic Asylum, 1805-1850’, in *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* ed., by Joseph Melling and Bill Forsythe (London: Routledge, 1999).

suggest the value of investigating mania as an individual diagnostic category to a study of confinement and changes in treatment.<sup>230</sup> The finding that mania was characterised by both high and low mood states can be used to examine how treatment changed to manage both the abundance of energy attributed to high mood, and absence of energy attributed to low mood.

Changes in perceptions of manic-depressive illness can also be investigated alongside new approaches in treatment. This chapter will argue that developments in both the classification and treatment for mania fuelled changes in representations, from being previously animalistic to restoring a patient’s individuality and humanity. To investigate changes, I will analyse a combination of asylum patient case notes, articles in medical journals, visual representations, and depictions in literary examples including Samuel Warren’s ‘The Spectre-Smitten’ (1831), Edgar Allan Poe’s ‘The Murders in the Rue Morgue’ (1841), and Sheridan Le Fanu’s ‘Green Tea’ (1869). I will also examine the role of medical authority, and the increase in focus on patient perspective and communication, to investigate how representations challenged the authority behind forms of treatment in the context of flexibility around diagnostic classifications. This furthers the primary concerns in this thesis about the diagnosis, treatment and representations of a mental illness classified by both high and low mood states.

### **Mania and Bodily Control**

Early-nineteenth-century treatment for mania focused on bodily restraint, blood-letting, and limiting nutrition. This treatment was outlined in hospital cases, debated in medical journals, and depicted in literary examples. Studies in the history of psychiatry discuss the use of restraint, and the changes moving away from restraint, in treatment for different mental illnesses in nineteenth-century asylums.<sup>231</sup> This chapter aims to add to this conversation by examining the importance of mania specifically in conversations about both the use and disuse of restraint. To do this, I will build on the analysis of Chapter One, which examined the characterisation of nineteenth-century mania by both high and low mood states. This chapter

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<sup>230</sup> This approach follows Hilary Marland’s study of puerperal insanity as a specific type of illness mental illness. See: Marland, *Dangerous Motherhood*.

<sup>231</sup> Leonard Smith, *Cure, Comfort, and Safe Custody: Public Lunatic Asylums in Early Nineteenth Century* (Leicester: Leicester University Press, 1999); Anne Shepherd and David Wright, ‘Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint’, *Medical History*, 46 (2002); Laws, ‘Crackpots and Basket-Cases’; Leslie Topp, ‘Single Rooms, Seclusion and the Non-Restraint Movement in British Asylums, 1838-1844’, *Social History of Medicine*, 31.4 (2018), pp. 754-773 (p. 756).



will examine the justification for restraint in the treatment of mania, arguing that mania was central to conversations about the need for restraint in psychiatric treatment because extremes of emotional state, whether high or low mood, were perceived as bestial.

Debates about the use of restraint began with the work of Edward Parker Charlesworth and Robert Gardiner Hill of the Lincoln Lunatic Asylum, who advocated for the abolition of restraint in a lecture presented by Hill to the Lincoln Mechanics’ Institute in 1838, published the following year as *The Total Abolition of Personal Restraint in the Treatment on the Insane*.<sup>232</sup> While the asylum at Lincoln was a small institution, in her study of the role of seclusion in early-nineteenth-century psychiatric treatment, Leslie Topp points out that Charlesworth and Hill of Lincoln in turn inspired John Conolly, medical superintendent of the ‘more nationally prominent Hanwell Asylum’, an institution which had a greater potential for national influence.<sup>233</sup> Letters from medical attendants in asylums across the UK debating the use of restraint followed, published in medical journals including the *Lancet*, *British Medical Journal*, and *Edinburgh Medical and Surgical Journal* through the 1840s. The debates were later facilitated by the Commissioners in Lunacy, who sought the opinions of physicians from different asylums about the use of restraint, particularly in the context of mania, sending circulars to superintendents of all the asylums in England and Wales – for example, in 1847, ‘requesting information as to the treatment of various kinds of insanity and mania’, and in 1854, ‘requesting information as to the employment or disuse of instrumental restraint and seclusion in the treatment of the insane’.<sup>234</sup>

The Eighth Annual Report of the Commissioners in Lunacy included answers to the 1854 circular, which were then published in the *Journal of Psychological Medicine and Mental Pathology* across two issues in 1854 and 1855. The *Journal of Psychological Medicine and Mental Pathology*, published in London, was founded in 1848.<sup>235</sup> The editor of the journal at this time was its founder, Forbes Winslow, a physician and specialist in insanity.<sup>236</sup> In his work on Winslow, Jonathan Andrews described the journal’s ‘sceptical stance towards the central

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<sup>232</sup> Topp, ‘Single Rooms, Seclusion and the Non-Restraint Movement in British Asylums’, p. 756.

<sup>233</sup> Topp, ‘Single Rooms, Seclusion and the Non-Restraint Movement in British Asylums’, p. 756.

<sup>234</sup> F. D. Walsh, ‘On the Treatment of Mania’, *British Medical Journal*, 3 (1855), pp. 33-34; ‘On Non-Mechanical Restraint in the Treatment of the Insane’, *Journal of Psychological Medicine and Mental Pathology*, 1 (1854), pp. 541-571.

<sup>235</sup> Andrews, ‘Winslow’.

<sup>236</sup> Andrews, ‘Winslow’.

lunacy commissioners’ policy on non-restraint in the care of the insane’, thus demonstrating the journal’s interest and situation within conversations about changes in treatment.<sup>237</sup>

I will discuss arguments against the use of restraint in the second part of this chapter, focusing on the importance of mania specifically to the debate. For this section, I will concentrate on arguments in favour of restraint as an effective tool in the treatment of mania. Restraint was described as necessary because of perceptions of mania as causing feral, uncontrollable behaviour. The use of restraint was justified as limiting the risk of patient self-injury as well as protecting members of staff. However, animalistic depictions of patients additionally conveyed an attitude of contempt and a desire for control.

Replies to the 1854 circular from the Commissioners in Lunacy demonstrated the centrality of mania to arguments in favour of restraint. Of the physicians who were ‘in favour of a qualified application of mechanical restraint in treatment in peculiar and special cases of insanity’, where an example was given of a type of insanity that benefited from mechanical restraint, the illness noted most frequently was ‘acute mania’.<sup>238</sup> Notes from physicians included perceptions of mechanical restraint as ‘a very essential part of the treatment’ of ‘acute mania’, claiming that restraint was ‘both unnecessary and hurtful in all cases except acute mania’, that mechanical restraint should be employed only in ‘severe cases of acute mania’, or ‘only in cases of acute mania [...] in which danger of injury is apprehended to the patient himself’, and so on.<sup>239</sup> In this form of mania – characterised, as opposed to chronic mania, as being curable and of a shorter, but more intense, duration – the use of mechanical restraint was considered useful in treatment. For example, ‘to prevent violent attempts [of a patient] to injure herself in a paroxysm of acute mania’, to prevent patients ‘sit[ting] up all night tearing their bedclothes’, and encouraging sleep as they will ‘sooner lie down, and sleep overcome them’, to limit the risk of a patient ‘sinking from the exhaustion’ brought on by the malady, and to prevent destructive behaviour because, in ‘acute mania [...] everything is a source of discomfort and irritation’.<sup>240</sup>

Justifications for the use of bodily restraint in cases of mania focused on limiting the risk of patient exhaustion, destructive behaviour, self-injury, and suicide attempts. Letters written by asylum medical attendants and published in the *Lancet* in 1840 set-out the benefits

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<sup>237</sup> Andrews, ‘Winslow’.

<sup>238</sup> ‘On Non-Mechanical Restraint in the Treatment of the Insane’, pp. 551-568.

<sup>239</sup> ‘On Non-Mechanical Restraint in the Treatment of the Insane’, pp. 551-568.

<sup>240</sup> ‘On Non-Mechanical Restraint in the Treatment of the Insane’, pp. 551-568.

of restraint for the goal of limiting patient activity. In a case of ‘violent mania’, a straight-waistcoat was described as having ‘speedily induced quietude and repose’, where the patient would otherwise have ‘struggled for hours’, and consequently ‘sunk at the last from muscular effort and fatigue’.<sup>241</sup> Letters argued the importance of restraint for ‘diminishing the immediate danger to the patient himself and to others’ by stopping activity which could otherwise have caused exhaustion, or injury to either the patients or those in charge of their care.<sup>242</sup> However, the importance of restraint was also argued through depictions of patients with mania as unhuman. The behaviours described as necessary to prohibit were compared to the actions of animals. One letter described a case of mania where there was an ‘irresistible desire in the individual to run, like an infuriated bull, head foremost against the wall of his apartment’.<sup>243</sup> As a result of being stopped from doing so, the symptoms instead manifested themselves in ‘efforts to bite not only the attendants who were employed in protecting him, but his own flesh’.<sup>244</sup> Consequently, the patient was secured in a ‘stuffed chair [...] to counteract his continued efforts to injure himself’.<sup>245</sup> The repetition and determination of actions were portrayed as uncontrollable and ferocious to argue that physical restraint was required.

Bestial illustrations of patient behaviour included an element of contempt. A letter in the *Lancet* in 1841 entitled, ‘Bodily Restraint is Imperative’, suggested a justification for restraint alongside animalistic perceptions of patients with mania.<sup>246</sup> The author of the letter, named only as ‘a medical superintendent’, stated that ‘bodily restraint, by means of some mechanical contrivance’ was ‘absolutely necessary’ in patients ‘addicted to those odious solitary vices [...] which break up the strength of the body and the remaining mental powers of the patient’.<sup>247</sup> Again, restriction was described as vital for prohibiting the patient from ‘rapidly throw[ing] away his strength’ by acting on his symptoms, arguing for the benefits of restraint as a tool that could prevent patients exhausting themselves. However, the author’s language conveyed his attitude toward patients. There was a strong sense of culpability on the part of the patient illustrated through comments such as questioning how, without restraint, would patients be prevented from ‘following their corrupt practices?’.<sup>248</sup> The author stated that

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<sup>241</sup> Anon., ‘On the Proper Mode of Treatment of Insanity’, *Lancet*, 1 (1840), pp. 450-51 (p. 451).

<sup>242</sup> ‘On the Proper Mode of Treatment of Insanity’, p. 451.

<sup>243</sup> Anon., ‘The Humane System of Treating the Insane’, *Lancet*, 1 (1840), pp. 451-53 (p. 452.)

<sup>244</sup> ‘The Humane System of Treating the Insane’, p. 452.

<sup>245</sup> ‘The Humane System of Treating the Insane’, p. 452.

<sup>246</sup> Anon., ‘Bodily Restraint is Imperative’, *Lancet*, 1 (1841), pp. 544-45 (p. 544).

<sup>247</sup> ‘Bodily Restraint is Imperative’, p. 544.

<sup>248</sup> ‘Bodily Restraint is Imperative’, p. 544.

even the ‘strictest surveillance’ would not prohibit patients ‘from slowly destroying themselves by following their respective wretched propensities’.<sup>249</sup> Language such as ‘odious’ and ‘corrupt’ showed a feeling of contempt and absence of compassion.<sup>250</sup> A desire for control was implied by the suggestion from the author that he would compromise and agree that not all of an institution’s staff should be able to physically restrain patients, but followed by stating that if bodily restraint must not be ‘indiscriminate’, then it should only be used under ‘the direction of medical superintendents’ such as himself.<sup>251</sup>

Restraint in mania was not solely considered necessary when symptoms were associated with high, excitable mood. A letter published in the *Lancet* in 1841 by Dr Edward J. Seymour, physician at St. George’s Hospital and a previous Metropolitan Lunacy Commissioner, outlined the need for restriction in low mood. Seymour was interested in the domestic treatment of insanity, believing that many patients would benefit more from treatment in familiar surroundings as opposed to being sent to psychiatric institutions.<sup>252</sup> However, despite this attitude towards confinement in an asylum, Seymour advocated for the use of physical restraint in cases of what he referred to as ‘raving mania’.<sup>253</sup> According to Seymour, this type of mania was characterised by ‘despair’ and ‘a gloomy despondency’, therefore indicating a low mood state.<sup>254</sup> Seymour discussed the case of a patient who was seized by despair after becoming bankrupt, and ‘made a desperate attempt to cut his throat’.<sup>255</sup> He stated that without ‘strong restraint [...] this man would have dashed his brains to atoms on the floor, or broken his ribs against the wall’.<sup>256</sup> This was a more sympathetic view of patients, because it focused entirely on preventing patients from harming themselves, but it maintained a representation of symptoms associated with manic-depressive illness as ‘violent’, ‘abnormal’, and in need of careful, bodily control.<sup>257</sup>

Patient case records of mania in Gartnavel Royal Hospital observed behaviour like the descriptions in medical journals. J.B., admitted in 1838, was recorded as believing she ‘communicated with spirits’ and therefore had a new ‘disposition to command’, including

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<sup>249</sup> ‘Bodily Restraint is Imperative’, p. 544.

<sup>250</sup> ‘Bodily Restraint is Imperative’, p. 544.

<sup>251</sup> ‘Bodily Restraint is Imperative’, p. 544.

<sup>252</sup> Edward J. Seymour, *Observations on the Medical Treatment of Insanity* (London: Longman, Rees, Orme, Brown, and Co., 1832).

<sup>253</sup> Edward J. Seymour, ‘Clinical Remarks by Dr Seymour Delivered in St. George’s Hospital: Insanity and its Treatment’, *Lancet*, 1 (2 January, 1841), pp. 784-86 (p. 784).

<sup>254</sup> Seymour, ‘Clinical Remarks by Dr Seymour Delivered in St. George’s Hospital’, p. 784.

<sup>255</sup> Seymour, ‘Clinical Remarks by Dr Seymour Delivered in St. George’s Hospital’, p. 784.

<sup>256</sup> Seymour, ‘Clinical Remarks by Dr Seymour Delivered in St. George’s Hospital’, p. 784.

<sup>257</sup> Seymour, ‘Clinical Remarks by Dr Seymour Delivered in St. George’s Hospital’, p. 786.

‘irritability of temper’, ‘violence’, ‘raving’, ‘loud stamping with her feet’, being ‘prone to tear clothes or break windows and furniture’, and a note that she ‘kicks and bites’.<sup>258</sup> R.L., admitted in 1841, was observed with alternating mood, recorded as an ‘absence and depression of mind’ followed ‘subsequently by excitement and violence’, which included a note that he had ‘broken windows’ and ‘frequently attempted to strike and bite those about him’.<sup>259</sup> Similarly, J.F., admitted in 1838, was ‘prone to bite, strike, break, and tear’ amid ‘fits of violence’ and ‘laughter’.<sup>260</sup> The case of J.C., also admitted in 1838, included the note that she experienced ‘bursts of violence or outrage’, and that she ‘strikes all her family indiscriminately’.<sup>261</sup>

Whether in low or high mood, the behaviours of mania were perceived as wild and relentless. In the period between the late 1830s and 1840s, when debates began to emerge about restraint, physicians mostly expressed uncertainty about how to manage the determination of action in mania without physical control. Treatment therefore focused on limiting movement to minimise a patient’s ability to act. It is unclear whether a view of patients as bestial was formed because of uncertainty about how to manage the behaviours of mania, or whether an already-existing attitude towards patients with mania as unhuman fuelled a reliance on tools for bodily restraint. However, it is clear that, even when physicians’ views were presented with some sympathy, the determination of action in mania, whether directed by low or high mood, was considered a regression from human behaviour. This view led to aims in treatment of prohibiting movement, and therefore underpinned the concept that physical control of patients with mania was justifiable.

Representations of patients with mania as wild and uncontrollable were not limited to medical writing but were also present in literary examples. In the Introduction and Chapter One, I discuss the relationship between medical and literary writing, where medical writers used literary examples to describe states of mental ill health – such as Bucknill and Tuke’s use of Shakespeare’s *The Tempest* to illustrate mania – and literary writers replicated the form of medicals. Samuel Warren’s literary series *Passages from the Diary of a Late Physician*, published in *Blackwood’s Edinburgh Magazine* from 1830-1837, is an example of fiction written in the form of patient case notes. Moreover, the series was not only written in the form of a medical case history, but claimed to be factual as opposed to fiction. Until the 1838

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<sup>258</sup> HB13/5/11, p. 17.

<sup>259</sup> HB13/5/25, p. 53.

<sup>260</sup> HB13/5/11, p. 31.

<sup>261</sup> HB13/5/11, pp. 37-38.

Edinburgh edition, where his authorship was finally revealed, Warren claimed he was merely the editor of the papers and, as Meegan Kennedy points out, this claim of being edited for a ‘lay audience’ meant that ‘one could not definitively declare [the cases] fictional rather than nonfictional, literary rather than medical in nature’.<sup>262</sup> Furthermore, Megan Coyer shows that the detail in Warren’s presentation of case records was enough to deceive medical professionals who ‘confirm[ed] and praise[d] his accuracy’.<sup>263</sup>

Both Kennedy and Coyer’s studies examine *Passages from the Diary of a Late Physician* in the context of the increasing professionalisation of medicine in Britain in the early nineteenth century. Kennedy argues that Warren’s literature is problematic, because in presenting the physician as ‘sensitive’ and ‘caring’, the medical writing becomes overly-emotional at a time when medical discourse was trying to move away from eighteenth century sentimentality.<sup>264</sup> Coyer, on the other hand, argues that Warren manages to combine emotion with scientific writing, constructing ‘a professional medical man of feeling’.<sup>265</sup> I aim to expand on this discussion, so as to argue that Warren’s emotional representation of the physician in ‘The Spectre-Smitten’ highlights bestial perceptions of patients with mania.

As with the rest of the series, Warren presented ‘The Spectre-Smitten’ as a factual case. The chapter begins by establishing the physician’s authority on the subject of insanity, opening with a note to the ‘wide and contradictory speculation’ about madness, for which ‘experience is the only substratum of real knowledge’.<sup>266</sup> ‘The Spectre-Smitten’ focuses on the ‘subtle, almost inscrutable disorder – *mania*’ and the importance of careful observation of patients with this condition to be able to understand it (p. 361). The text points to the importance of recognising in mania the ‘smaller features, those more transient evanescent indications’ (p. 361). Subsequently, the text creates a detailed depiction of the symptoms and behaviours exhibited by a patient with mania. This begins with a description of the onset of the illness, whereby despite the patient’s ‘transient exhilaration’ and ‘animated discussion’, he finds himself ‘the subject of a most unaccountable depression of spirits’ (p. 361). Using language similar to institutional patient case records, Warren’s ‘The Spectre-Smitten’ illustrates both

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<sup>262</sup> Meegan Kennedy, ‘The Ghost in the Clinic: Gothic Medicine and Curious Fiction in Samuel Warren’s Diary of a Late Physician’, *Victorian Literature and Culture*, 32 (2004), pp. 327-51 (p. 329).

<sup>263</sup> Megan Coyer, *Literature and Medicine in the Nineteenth-Century Periodical Press: Blackwood’s Edinburgh Magazine 1817-1858* (Edinburgh: Edinburgh University Press, 2017), p. 134.

<sup>264</sup> Kennedy, ‘The Ghost in the Clinic’, p. 330.

<sup>265</sup> Coyer, *Literature and Medicine in the Nineteenth-Century Periodical Press*, p. 126.

<sup>266</sup> Samuel Warren, ‘Passages from the Diary of a Late Physician: Chapter VII, The Spectre-Smitten’, *Blackwood’s Edinburgh Magazine* (1831), pp. 361-75 (p. 361). All further references are to this edition and are given parenthetically in the body of the text.

high and low emotional states in observations of mania. Beginning with testimony from the patient’s friends that he had ‘been the subject of high excitement’, we then see a movement towards low mood, as ‘his heart seemed to grow heavier and heavier’ (pp. 361-62). Warren’s representation shows the importance of emotion from across the mood spectrum to the individual diagnosis of mania in a case, though fictional, he convincingly presented as factual.

The episodic nature of the condition is also echoed in ‘The Spectre-Smitten’. Like records from case notes, the patient, identified in the story as M, experiences ‘lucid intervals’ within the period of observation (p. 370). Despite notes on recovery and the patient being released from the asylum, the chapter closes with a note about relapse. Five years on, despite ‘enjoy[ing] excellent physical health’ and marrying, M dies by suicide, having ‘destroyed himself in a manner too horrible to mention’ (p. 375). Moreover, hallucination is also an important feature of mania in this literary depiction. M’s psychosis begins after he has fallen into a depression, and with themes of death, vulnerability and decay it is presented as mood-congruent with a depressive state. M sees a figure sitting in the arm-chair of his sitting-room, who ‘turned slowly towards M’, revealing eyes ‘blazing [...] with a most horrible lustre’ (p. 362). The ‘ghastly hue’ as well as the figure’s hands which were ‘white as alabaster’ suggest that the figure appeared dead but animated (p. 362). M also depicts decay in the spectre, crying out ‘he is surely – *damned* [...] the flames have reduced his face to ashes!’ (p. 363). The sense of fear and vulnerability from M is intensified as the figure ‘slowly rose from its seat, stretched out both its arms, and seemed approaching him’ (p. 362). His belief that the spectre means to do him harm is conveyed as he ‘mutter[s] fiercely [...] “Oh save me from him – save me – save me!”’ (p. 364).

Warren’s illustration of mania conveys the key patterns consistently recorded in institutional cases. The text also interrogates the use of restraint in treatment. Like debates in medical writing, the physician highlights the risk to the patient’s energy, stating that M’s frantic behaviour left him ‘in a state of the utmost exhaustion’ (p. 363). Furthermore, a risk to safety is depicted when M’s psychosis leads to him threatening harm to himself and to others with a razor. Bodily control is depicted as necessary to prevent either suicide or murder. Warren portrays restriction as primarily beneficial to the patient by presenting M as insisting on its necessity in treatment himself, warning of his spiralling loss of control: ‘secure me! tie me! make me fast, or I shall burst upon you and destroy you all – for I’m going mad’ (p. 363).

Warren’s text drew from medical writing to create a depiction of mania that could be believed as factual, and in doing so created a space to investigate bestial perceptions and

treatment of patients. M’s warnings are confirmed as his case moves into a representation of wild behaviour. The contrast between an ability to warn of the progression of his mental ill health and his later erratic behaviour creates a dual representation of a patient with mania in the context of restraint. The initial warning coming from M rather than the physician emphasises the perceived movement in mania from socially sensitive, civilized behaviour to uncontrollable actions. M is presented in the text as moving to a space between human self-control and feral lack of control. However, literary representations did not solely normalise attitudes towards patients with mania, but also created a space to challenge perceptions and to pose questions about the role of restraint in causing rather than managing patients’ behaviour. The next section will focus on the space carved between human and animal in depictions of mania, comparing Warren’s text with a literary representation that draws from ‘The Spectre-Smitten’ to challenge the use of restraint in mania.

### **The Voice of a ‘Madman’: Mania and the ‘Orang-Outang’**

Literary representations of the use of restraint to treat symptoms of mania highlighted perceptions of patients’ behaviour as relentless and injurious. Representations of M’s behaviour in ‘The Spectre-Smitten’ echoed the animalistic view of patients conveyed in publications in medical journals arguing in favour of the use of bodily restriction because of a move from considered to uncontrollable behaviour. To continue my analysis of bestial representations of mania, I will concurrently analyse ‘The Spectre-Smitten’ with Edgar Allan Poe’s 1841 short story, ‘The Murders in the Rue Morgue’. I submit that Poe draws specifically from Warren’s text to interrogate representations of mania as occupying a state between civilized human and wild animal through the specific use of the orangutan.

Literary analysis of the role of the murderer, an orangutan, in Poe’s detective story has understood the orangutan as a representation of slavery and of misogynistic violence. Chris Peterson points out that, ‘given the widespread curiosity in the eighteenth and nineteenth centuries with the perceived similarities between humans and orangutans’, it is not accidental that Poe ‘centre[s] his story on an orangutan rather than a member of another animal species’.<sup>267</sup> Peterson argues that the nature of the behaviour and violence of the orangutan relates to racial ideas. He states that the orangutan represents the position of the slave, and that the ‘bestial

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<sup>267</sup> Christopher Peterson, ‘The Aping Apes of Poe and Wright: Race, Animality, and Mimicry in “The Murders in the Rue Morgue” and *Native Son*’, *New Literary History*, 41 (2010), pp. 151-71 (p. 153).



violence’ is not a ‘natural given’ but is ‘produced precisely by those racist discourses that purport only to describe it’.<sup>268</sup> Lawrence Frank, on the other hand, reads the orangutan’s position as representing violence towards women. Frank argues that the orangutan’s imitation of his master, the sailor, when attempting to shave with the razor, transforms the creature into the ‘Double of its master’, and is therefore ‘acting out his fantasies against women’.<sup>269</sup> Furthermore, Frank argues that the destruction of the women’s organs of speech – the daughter’s tongue having been bitten through and the mother’s throat severed – ‘denies their status as human beings’, and therefore confirms ‘the darkest implications of male attitudes towards women’.<sup>270</sup>

I will also examine nineteenth-century fascination with the orangutan, the orangutan’s imitation of his master, and the significance of language in ‘The Murders in the Rue Morgue’. However, I submit that the orangutan represents attitudes towards mental illness, specifically symptoms associated with nineteenth-century mania. Poe uses the figure of the orangutan to interrogate illustrations of patients with mania as somewhere between human and animal, drawing, with remarkable similarities, from the language used by Warren to depict M. Poe had a greater distance from the UK context of psychiatric treatment and classifications, but his relationship with *Blackwood’s Edinburgh Magazine*, and the periodical’s relationship with fictional and medical writing, makes his work valuable to an analysis of UK representations of mania. It is almost certain that Poe had read ‘The Spectre-Smitten’, evidenced by both the parallels between the texts, and by his specific reference to *Passages from the Diary of a Late Physician* in ‘How to Write a Blackwood Article’ published in *Blackwood’s Edinburgh Magazine* in 1838, prior to the publication of ‘The Murders in the Rue Morgue’ in 1841, and after Warren’s series had been published in full.<sup>271</sup>

Nineteenth-century fascination with the orangutan was centred on its relation to humans. Before evolutionary theory was introduced, from the seventeenth century there were investigations into the similarity between humans and orangutans.<sup>272</sup> Peter C. Kjærgaard and

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<sup>268</sup> Peterson, ‘The Aping Apes of Poe and Wright’, p. 161.

<sup>269</sup> Lawrence Frank, “‘The Murders in the Rue Morgue’: Edgar Allan Poe’s Evolutionary Reverie’, *Nineteenth Century Literature*, 50.2 (September 1995), pp. 168-188 (p. 181).

<sup>270</sup> Frank, ‘The Murders in the Rue Morgue’, p. 182.

<sup>271</sup> Edgar Allan Poe, ‘How to Write a Blackwood Article’, *Blackwood’s Edinburgh Magazine* (1838), pp. 279-87 (p. 280).

<sup>272</sup> In this context, orangutan could also bonobos, which were not classified as separate species until 1930. See Kjærgaard, Peter C. and John van Wyhe, ‘Going the Whole Orang: Darwin, Wallace and the Natural History of Orangutans’, *Studies in History and Philosophy of Science Part C: Studies in History and Philosophy of Biological and Biomedical Sciences*, 51 (2015), pp. 53-63 (p. 53).

John van Wyhe have traced this history.<sup>273</sup> Jacobus Bontius, a Dutch physician working in Java in the early seventeenth century, ‘reported that the local name for the wild apes on the island was “Ourang Outang” or “man of the forest”’.<sup>274</sup> Kjærgaard and Wyhe point out that one of the remarkable features about Bontius’s portrayal of the orangutan was that he presented ‘a human feature, the ability to talk’.<sup>275</sup> Bontius remarked that orangutans remained silent intentionally: ‘the Javanese claimed that the Ourang-Outangs could talk, but that they did not want to because they did not want be forced to work’.<sup>276</sup>

Debates about the ability for the orangutan to use language continued into the eighteenth and nineteenth centuries. The folklore origin of the term ‘man of the forest’ referred to ‘hairy, wild and dangerous creatures, half human, half beast’.<sup>277</sup> Language was considered the vital trait that meant these creatures were part human. Swedish taxonomist Carolus Linnaeus classified humans alongside the orangutan, distinguishing two types of human species: ‘Homo sapiens (Homo diurnus) and Homo troglodytes (Homo nocturnus)’, with the latter including ‘H. sylvestris Orang-Outang’.<sup>278</sup> Linnaeus categorised in this way because he considered the orangutan’s ‘hissing sounds’ as a form of speech.<sup>279</sup> Furthermore, French philosopher Jean-Jaques Rousseau suggested that the orangutan might be ‘a race of genuine wild men [...] still living in the primitive state of nature’.<sup>280</sup> This implies a conception of orangutans as human, but simply behind in their development into civilisation, leaving them wild. Scottish judge James Burnett strengthened this notion by arguing that orangutans had the ‘feeling of humanity in a strong degree’ on the basis that they had made ‘serious cultural progress building huts, used sticks as weapons, used fire and buried their dead’.<sup>281</sup> He claimed that they were ‘indeed of the same species as humans’, and that their use of language was only a matter of time.<sup>282</sup>

Falling somewhere between the human and animal was central to representations of patient’s diagnosed with mania. In ‘The Spectre-Smitten’, the physician’s ‘heart-ached’ to look at his patient, who was ‘only a few days before, the delight of refined society’, but was now

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<sup>273</sup> Kjærgaard and Wyhe, ‘Going the Whole Orang’.

<sup>274</sup> Kjærgaard and Wyhe, ‘Going the Whole Orang’, p. 53.

<sup>275</sup> Kjærgaard and Wyhe, ‘Going the Whole Orang’, p. 53.

<sup>276</sup> Jacobus Bontius (1658) quoted in Kjærgaard and Wyhe, ‘Going the Whole Orang’, p. 53.

<sup>277</sup> Kjærgaard and Wyhe, ‘Going the Whole Orang’, p. 53.

<sup>278</sup> Carolus Linnaeus (1758) quoted in Kjærgaard and Wyhe, ‘Going the Whole Orang’, p. 54.

<sup>279</sup> Carolus Linnaeus (1758) quoted in Kjærgaard and Wyhe, ‘Going the Whole Orang’, p. 54.

<sup>280</sup> Jean-Jaques Rousseau (1755) quoted in Kjærgaard and Wyhe, ‘Going the Whole Orang’, p. 55.

<sup>281</sup> James Burnett (1795) quoted in Kjærgaard and Wyhe, ‘Going the Whole Orang’, p. 56.

<sup>282</sup> James Burnett (1795) quoted in Kjærgaard and Wyhe, ‘Going the Whole Orang’, p. 56.

reduced to a ‘savage fiend’ because of the symptoms of mania (p. 370). The development of madness is represented as a regression in dignity and socially acceptable behaviour:

Oh, how deplorable to see a man of superior intellect – one whose services are really wanted in society – the prey of madness! (pp. 371-2).

Mania is illustrated as causing a regression in M’s intellect, and crucially diminishing his ability to function within society. This represents a similar notion to that of the orangutan as a species of human that has not yet developed into civilised behaviour, but is reversed, so that mania causes a regression from civilised society to bestial behaviour.

The idea of being somewhere in between human and animal was also present in nineteenth-century visual representations associated with madness. Charles Bell’s *Anatomy and Philosophy of Expression*, first published in 1806 but extended and republished in 1824 and 1844, examined the potential for expressions of emotion in humans and animals based on bodily systems. Allister Neher discusses the work’s ‘noteworthy example of how science and art have interacted in the pursuit of a common end’, through its dual purpose to discover how ‘a language of bodily expression could be articulated’, as well as working as a handbook for artists to achieve ‘a more realistic approach to the depiction of human beings’.<sup>283</sup> Neher additionally points to the work’s importance and reception in its time, the ‘success of the first edition almost earn[ing] [Bell] the position of professor of anatomy at the Royal Academy’, and receiving praise from figures including Charles Darwin, who ‘said that it shaped the development of his book *The Expression of the Emotions in Man and Animals*’.<sup>284</sup> While Bell’s work was not primarily concerned with the expression of mental ill health, the work included a section on the ‘physiognomy of madman’.<sup>285</sup> Moreover, the pursuit of a language to read the expression of emotion tied to physiognomy was also present in an asylum context – for example, the first work in the UK on this subject was by Surrey County Lunatic Asylum medical superintendent Alexander Morison, who sought to map out emotional expression to be able to identify signs of the beginning of mental health problems, the progression of mental illness, as well as signs of recovery.<sup>286</sup> I will discuss the work of Morison later in this chapter, alongside the work of his successor, Hugh Welch Diamond.

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<sup>283</sup> Allister Neher, ‘Sir Charles Bell and the Anatomy of Expression’, *Canadian Art Review*, 33 (2008), pp. 59-65 (p. 59).

<sup>284</sup> Neher, ‘Sir Charles Bell and the Anatomy of Expression’, p. 59.

<sup>285</sup> Charles Bell, *Essays on the Anatomy and Philosophy of Expression* (London: J Murray, 1824), p. 121.

<sup>286</sup> Alexander Morison, ‘The Physiognomy of Mental Diseases’ (1838) in *Embodied Selves: An Anthology of Psychological Texts 1830-1890*, ed. by Jenny Bourne Taylor and Sally Shuttleworth (Oxford: Clarendon Press, 2003), pp. 262-264.

Bell’s discussion of the expression of emotional states associated with mental illness was concerned with vacancy, which he connected to animal expression. Bell discussed the capabilities of expression in both humans and animals, arguing that, in contrast to animals, in humans ‘there seems to be a systematic provision for that mode of communication and that natural language’ of expression, and for that reason human expression ‘is an index of the mind, having expression corresponding with each emotion’.<sup>287</sup> However, when talking about mania specifically, Bell described the emotional expression as closer to that of animals, stating that it is associated instead with a form of restraint of expression, a ‘vacancy of mind, and mere animal passion’.<sup>288</sup> I.S.L Loudon writes that Bell believed ‘that man had certain muscles, absent in other animals, whose sole function was the rich variety of facial expression of which man is capable.’<sup>289</sup> Bell’s representation of a vacancy of expression in mania therefore illustrated a sense of regression from the rich capacity for communication of expression in humans, to a limit of expression in animals, conveying in mania a state of being in between human and animal. According to Bell, ‘expression is to passion what language is to thought’, but the severity of mood in mania limited the communication of emotion through expression, so that a person with mania’s expression became unhuman through ‘vacancy’, ‘want of meaning’, and, similar to the illustration of Warren’s M, an ‘utter wreck of the intellect’.<sup>290</sup> Consequently, a person with mania’s expression was ‘reduced to the state of brutality’ like ‘the lower animals’.<sup>291</sup> Bell described this in both low and high mood states, referring to both the potential for a ‘death-like fixed gloom’, or an ‘inflamed eye’ with ‘an inexpressible wildness and ferocity’.<sup>292</sup>

Attitudes towards patients with mania as less than human were also reflected in conditions of treatment. An article in the *British Medical Journal* entitled ‘On the Treatment of Mania’, written in 1855, but discussing treatment and practices in the 1840s, conveyed a desire in staff to have separation from and control of asylum residents with mania. The patients were:

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<sup>287</sup> Bell, *Essays on the Anatomy and Philosophy of Expression*, p. 122.

<sup>288</sup> Bell, *Essays on the Anatomy and Philosophy of Expression*, p. 122.

<sup>289</sup> I. S. L. Loudon, ‘Sir Charles Bell and the Anatomy of Expression’, *British Medical Journal*, 285 (1892), pp. 1794-96 (p. 1795).

<sup>290</sup> Bell, *Essays on the Anatomy and Philosophy of Expression*, p. 123.

<sup>291</sup> Bell, *Essays on the Anatomy and Philosophy of Expression*, p. 123.

<sup>292</sup> Bell, *Essays on the Anatomy and Philosophy of Expression*, p. 122.

shut up in a dark room, with a hole in the door for their keepers to put a little food through, instructions to mind their eyes, lest they should have the curiosity to peep at some naked, ragged, or dirty individual.<sup>293</sup>

This case showed patients treated like animals without the dignity of clothing. Staff were encouraged to be fearful, warned that patients were ‘almost certain to poke out their eyes for their curiosity’, with ‘instructions for attendants to take care of their faces when they fed patients’.<sup>294</sup> Similarly, an article in the *British Medical Journal* in 1841 discussed patients’ treatment in St Luke’s Hospital. One patient described being ‘frequently [...] so much in want of food’ that they were forced to take ‘scraps to eat that [had] been sent for the cat from the keeperess’s table’.<sup>295</sup> Sharing scraps intended for the cat further demonstrates an unhuman perspective of patients, and their placement alongside animals on the social hierarchical scale.

‘The Spectre-Smitten’ creates an animalistic image of M as his mental state worsens. He is described as having torn away his clothing and ‘stood stark-naked before the glass, with a razor in his right hand’, and with an expression similar to the inflamed eye illustrated by Bell: ‘the wild fire of madness flashing from his staring eyes’ (p. 365). Like the notes on treatment in medical writing, the risk of being in close proximity to patients is also depicted: the physician tried to gain control of the situation by ‘standing like a statue – motionless – silent’, but as another person pushes the door open, ‘peeping through it’, it creates a ‘frenzy’ in the patient. The physician emphasises the danger, ‘whisper[ing]’ to the others, ‘At the peril of your lives – of mine – shut the door [...] or we are all murdered’ (p. 366).

‘The Murders in the Rue Morgue’ challenges perceptions of mania as a state in regression from civilized to primitive by interrogating the impact of restraint in treatment. Kjærgaard and Wyhe argue that Poe goes against the notion of an orangutan as a less-developed form of human species by depicting ‘a wild brute’ committing violent murders. However, the marked similarities between Poe’s descriptions of the orangutan in ‘The Murders in the Rue Morgue’ and patient M in ‘The Spectre-Smitten’ reveals Poe representing mania. Poe specifically depicts symptoms and behaviours observed in mania, interrogating the perspective of individuals with this mental illness as being in a state between human and animal by drawing on early-nineteenth century discourse about the orangutan.

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<sup>293</sup> F. D. Walsh, ‘On the Treatment of Mania’, *British Medical Journal*, 3 (1855), pp. 33-34 (p. 33).

<sup>294</sup> Walsh, ‘On the Treatment of Mania’, p.33.

<sup>295</sup> Anon., ‘Treatment of the Insane’, *British Medical Journal*, 1 (1841), pp. 460-61 (p. 461).

Poe first draws a connection in ‘The Murders in the Rue Morgue’ between insanity and the orangutan based on speech, the same primary factor in discourse connecting the orangutan to human beings. Witnesses in the aftermath of the murder describe the voice of a Frenchman as well as a voice they cannot recognise, each describing a ‘foreigner’ but suggesting a different language among German, Spanish, English Russian and Italian.<sup>296</sup> When detective Dupin asks the protagonist who could have ‘a voice foreign in tone to the ears of men of many nations, and devoid of all distinct or intelligible syllabification’, he replies that it must be ‘a madman [...] some raving maniac’ (pp. 36-37). The voice of a maniac is illustrated as the only explanation for a voice so limited in ability to communicate that it is identified as foreign to several people who speak between them several languages. The voice heard was of course that of the orangutan. Confusion between the voice of an orangutan and a mentally ill individual associates the limitation and regression of communication in mania to the uncertainty about an orangutan’s capacity for speech.

Poe highlights animalistic perceptions of patients with mania. A ‘ferocity brutal’ and ‘a butchery without motive’ also contribute to the theory that the culprit is labouring under maniacal symptoms (p. 36). Moreover, the violent behaviour of the orangutan and M are similar in their use of a razor. It was not uncommon to find instances consisting of the violent use of a razor by patients diagnosed with mania. Medical reports and newspaper articles included depictions of both suicide attempts and violence towards others. In the article examined earlier, published in the *Lancet* in 1841 with a discussion by Seymour of using restraint to prevent suicide, the patient he observed had attempted suicide by cutting his throat with a razor.<sup>297</sup> There was a similar case in the *British Medical Journal* in 1841, where suicide was attempted by a patient with mania who cut his throat ‘from ear to ear with a razor’.<sup>298</sup> There was also a case of attempted murder by razor in the *North Wales Chronicle and Advertiser for the Principality* in 1843. The culprit was described as a ‘young painter who [had] already been subject to some fits of madness’.<sup>299</sup> After spending ‘above a quarter of an hour [...] amusing himself’ by ‘lowering’ his victim’s ‘cravat and collar’, he ‘then drew from his pocket an

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<sup>296</sup> Edgar Allan Poe, ‘The Murders in the Rue Morgue’, in *A Modern Detective* (London: Penguin Classics, 2016), pp. 1-48 (pp. 15-19). All further references are to this edition and are given parenthetically in the body of the text.

<sup>297</sup> Seymour, ‘Clinical Remarks by Dr Seymour Delivered in St. George’s Hospital’, p. 784.

<sup>298</sup> Anon., ‘Case of Attempted Suicide: Cut Throat – Injury of the Neck’, *British Medical Journal*, 1 (1841), p. 190.

<sup>299</sup> *North Wales Chronicle and Advertiser for the Principality*, ‘Miscellaneous’ (September 19, 1843), p. 4.

excellent razor, and set about cutting the throat of the unfortunate Frenchman’.<sup>300</sup> Prior to this, the culprit had also cut the throat of his father.<sup>301</sup> In ‘The Spectre-Smitten’, the physician describes the ferocity with which M brandishes the razor: ‘He might, in an instant, almost sever his head from his shoulders, or burst upon me or his sisters, and do us some deadly mischief!’ (p. 365). This is similar to the description of the corpse of Madame L’Espanaye in ‘The Murders in the Rue Morgue’, whose ‘throat [was] so entirely cut that, upon an attempt to raise her, the head fell off’ (p. 13), and the later description of the orangutan committing the murder, whereby with ‘one determined sweep’ he ‘nearly severed her head from her body’ (p. 46).

The mannerisms of M and the orangutan are also similar. The orangutan reacts to his master in a way that is comparable to M’s reaction to his hallucination, and subsequently to the medical professionals around him. At the sight of his master, in order to escape the orangutan ‘sprang at once through the door of the chamber, down the stairs, and thence, through a window’ (p. 44). Similarly, while threatening with the razor and planning escape, M is described as jumping around animalistically, ‘leap[ing] several times successively in the air, brandishing the razor over his head’ in a ‘frenzy’ (p. 366), ‘springing like a lion from his lair’ (p. 367), and later positioned ready to ‘spring out’ of the window (p. 369). In addition, M is described with ‘the wild fire of madness flashing from his staring eyes’ (p. 365), as well as ‘gnash[ing] his teeth’ as ‘the foam issued from his mouth (p. 369). Remarkably similar is the description of the orangutan, who is ‘gnashing its teeth and flashing fire from its eyes’ in ‘wandering and wild glances’ (p. 46). At the reemerging sight of the spectre in his hallucination, M reacts ‘in an agony of apprehension’ (p. 366); upon seeing his master, the orangutan reacts ‘in an agony of nervous agitation’ (p. 46).

The orangutan additionally portrays behaviour connected to symptoms of mania outside of the representations included in ‘The Spectre-Smitten’. In his fear, the orangutan starts ‘breaking the furniture’ (p. 46). Damaging and destroying furniture was a common observation of patients diagnosed with mania in Gartnavel Royal Asylum’s medical case records. In addition to the cases discussed earlier, J.F., observed in 1831, was recorded as having broken the ‘furniture in his father’s home’ after acting violently towards his father and brother.<sup>302</sup> T.J., observed in 1835, had also violently ‘broken furniture’.<sup>303</sup> M.B., observed in

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<sup>300</sup> *North Wales Chronicle and Advertiser for the Principality*, ‘Miscellaneous’, p. 4.

<sup>301</sup> *North Wales Chronicle and Advertiser for the Principality*, ‘Miscellaneous’, p. 4.

<sup>302</sup> HB13/5/21, p. 230.

<sup>303</sup> HB13/5/28, p. 486.

1830, was noted as having broken ‘some frames of glass and furniture’, and J.B., observed in 1838, was recorded as being ‘prone to tear clothes or break windows and furniture’, as well as ‘stri[king], kick[ing], and bit[ing] her attendants’.<sup>304</sup> J.C., also observed in 1838, was recorded as having ‘broken all the doors in the house’ and, similar to both Warren’s M and Poe’s orangutan, had ‘attempted to throw herself over a window’.<sup>305</sup> The regular recording of breaking furniture as a feature of mania was also highlighted by its presence on the Gartnavel Royal Asylum admission documents, which asked: ‘Is the Patient prone to tear clothes, or to break windows or furniture?’, and with cases of mania frequently recording affirmative answers.<sup>306</sup>

Poe refers to ideas about the orangutan as existing somewhere between a human and animal condition through an illustration of the orangutan mimicking his master. The orangutan does this by beginning to use the razor innocently:

Razor in hand, and fully lathered, it was sitting before a looking-glass, attempting the operation of shaving, in which it had no doubt previously watched its master through the keyhole of the closet. (p. 42)

The orangutan is merely imitating human behaviour and attempting to mimic human appearance, bridging the gap between the wild ‘man of the forest’ and the civilised man of society. It is only with the sight of his master that he decides to escape. Similarly, when entering the home of Madame and Mademoiselle L’Espanaye, the orangutan does not intend harm. He uses the razor again to mimic human behaviour ‘in imitation of the motions of a barber’ (p. 46). It is his fear of Madame L’Espanaye as she ‘screams and struggles’ and, again, the sight of his master, that propel him into a ‘phrenzy’ (p. 46). Representing the orangutan’s violence as a consequence of fear of his master draws a parallel with M’s violence, which is a result of the fear caused by his hallucination. This analysis is strengthened by the similar descriptions of the master and the spectre: the master’s ‘countenance of death itself’ (p. 42) is similar to the spectre’s ‘ghastly hue’ and hands as ‘white as alabaster’ (p. 362).

The correlation between the orangutan’s violence and the appearance of his master is not dissimilar to the relationship between patients and those in charge of their confinement. In ‘The Spectre-Smitten’, as discussed earlier in this chapter, both the physician and M himself initially advocate for the use of restraint for the safety of M and the medical staff. However,

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<sup>304</sup> HB13/7/41, p. 440; HB13/5/11, p. 127.

<sup>305</sup> HB13/5/11, p. 39.

<sup>306</sup> HB13/7/47.



Warren later provides an argument against the use of restraint in the treatment of mania, through an illustration of bodily restriction causing M’s desire for violence to become more severe. M states: ‘I am conscious of feeling at those times in constant fury arising from absence of personal constraint’ and that he wished to ‘strangle someone who was giving [him] medicine’ (p. 375). In addition, restraint is depicted as causing further psychotic symptoms, causing M to develop a hallucination of being ‘constrained by a snake’ (p. 375).

Arguments against restraint similarly stated that bodily restriction exacerbated symptoms of mania. One of the letters among the debates about restraint in the *Lancet* in 1840 argued that restraint was harmful in treating mania because even ‘the most insane [were] not without their moments, their hours, and even their days and weeks of reason’.<sup>307</sup> In this time, patients would ‘reflect upon their condition and their treatment’, and the anonymous author of the letter suggested that the ‘bitterness’ of patients’ thoughts would be the feeling that they had been ‘treated worse than brutes’, and ‘exposed to the insults and barbarity of ignorant keepers’.<sup>308</sup> In this context, a patient would see their medical officer not as a ‘friend’ but as the ‘author of [their] oppression’, potentially inspiring violence towards them.<sup>309</sup> In addition, he suggested that the thought in lucid intervals of the threat of being confined once again could transform a patient ‘from harmless insanity’ back to ‘wild, impassioned mania’.<sup>310</sup> This view suggested that the direction of treatment by an underlying fear of wild behaviour was not justified but instead self-fulfilling, in that the use of restraint caused relentless and animalistic behaviour in patients who were both determined to escape and reacting to being treated inhumanely.

In the context of the debates, restraint was defined as restriction beyond tools such as the straight-waistcoat or the use of manacles and fetters, but also confinement within the space of treatment itself. An article in the *British Medical Journal* in 1841 stated that ‘confinement within the walls of an asylum’ was ‘in itself a restraint’, because a patient’s ‘personal liberty was so far interfered with, and to the same degree his feelings are liable to become outraged’.<sup>311</sup> In this context, the orangutan’s violence, as connected with symptoms of mania, can be analysed as a contribution from Poe to debates about the use of restraint in the treatment of mania. Poe’s orangutan is described as being ‘securely confined’ by his master in a closet,

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<sup>307</sup> Anon., ‘The Humane System of Treatment for the Insane’, *Lancet*, 1 (1840) pp. 262-64, (p. 262).

<sup>308</sup> ‘The Humane System of Treatment for the Insane’, p. 262.

<sup>309</sup> ‘The Humane System of Treatment for the Insane’, p. 262.

<sup>310</sup> ‘The Humane System of Treatment for the Insane’, p. 262.

<sup>311</sup> Anon., ‘Restraint of the Insane’, *British Medical Journal*, 2 (1841), pp. 457-60 (p. 458).

where he can only look out ‘through a keyhole’ (p. 44). This is not unlike the description in the *British Medical Journal* of patients who can only look out from their restriction through a ‘hole in the door’.<sup>312</sup> When the orangutan is sat at the looking-glass ready to shave, he has been able to escape from this prison, but, as discussed earlier, only becomes agitated at the sight of his master. It is at this point that he jumps from the window, suggesting that he is afraid of being confined once again by his own author of oppression. Furthermore, when the orangutan enters the home of Madame and Mademoiselle L’Espanaye, the master at first ‘rejoiced’ (p. 45). This is because ‘he had strong hopes now of recapturing the brute, as it could scarcely escape from the trap into which it had ventured’ (p. 45). Describing the home as a trap illustrates the orangutan as once more at risk of being confined. The fact that he only becomes aggressive when Madame L’Espanaye’s reaction makes him fearful, and when he sees that his master is in close enough proximity to recapture him, suggests that his violence echoes that outlined in arguments against the use of restraint – namely, that symptoms of mania were exacerbated by the fear of restriction, rendering restraint ineffective in treatment.

The notion that Poe is arguing against the use of restraint is also strengthened by the ties between the orangutan and brilliant detective Dupin. Kjærgaard and Wyhe’s argument that Poe does not represent the orangutan as similar to human is based on Poe’s contrast between ‘the beastly orangutan’ and the ‘intelligence of [...] Dupin’. However, my reading of ‘The Murders in the Rue Morgue’ uncovers connections between the depictions of the orangutan and Dupin in the context of representations of mania. The protagonist describes Dupin’s ‘wild fervour’ and the ‘vivid freshness of his imagination’. In ‘The Spectre-Smitten’, the physician reflects in the narrative that ‘strong intellects’ and ‘imagination’ are the traits which are most liable to insanity (p. 372). Furthermore, the protagonist discusses ‘observing [Dupin] in his moods’ which are described as contrasting and presenting in a ‘double Dupin’, conveying a sense of opposites not unlike the movement between high and low emotional states in mania (pp. 7-8). The protagonist goes on to directly connect this to psychiatric illness, stating that Dupin has an ‘excited, or perhaps a diseased, intelligence’ and, of their discussions stating, ‘we should have been regarded as madmen’ (p. 8). Highlighting similarities in Dupin and the orangutan through a connection to symptoms of mania alerts us to the differences in their circumstances – Dupin, who is free to use his temperament to focus on detection is successful, whereas the orangutan, who is confined, becomes violent and wild in fear. While Warren offers

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<sup>312</sup> Walsh, ‘On the Treatment of Mania’, p. 33.

both sides of the debate on restraint in his representation of mania, Poe highlights the injurious nature of confinement and bodily control.

### **Changes in Treatment and Dynamics of Authority**

Debates about the use of restraint fuelled a change in treatment that moved away from a perception of patients with mania as unhuman. Following debates in the 1840s and 1850s about restriction, ideas about treatment for mania specifically were reversed to a focus on open air, exercise, a plentiful diet, and avoiding the use of instruments of bodily control. Debates about changes in patient care occurred across institutions and across diagnostic categories. However, an examination of the debates demonstrates that mania was central to arguments both in favour of, and opposed to, the disuse of bodily restriction. Crucially, mania was central to these debates based on both its high and low mood states, which connects to the key finding in this thesis that mania was constructed as a manic-depressive illness moving across the emotional spectrum. While studies in the history of psychiatry have investigated changes in treatment in asylums in the nineteenth century, no previous work has focused on mania specifically as a lens to investigate key concerns relating to the categorisation of symptoms in debates about restraint.<sup>313</sup>

Changes in attitudes towards mania were notable in developments in treatment. Risks of patient exhaustion, self-injury, and aggression towards staff members were the primary factors used in debates to justify mechanical restraint. These features were represented as uncontrollable, bestial behaviours in patients, which required tools for careful control in treatment. However, developing ideas about ways to treat the intensity, repetition, and determination of actions in patients with mania moved away from animalistic representations. I will assert that changes in the treatment of mania illustrated developments in perceptions which restored patients’ humanity and individuality, allowing for greater trust in the patient’s role in their treatment and their perspective of their mental wellbeing.

In my earlier discussion of arguments in favour of restriction, I point to the vital role of Charlesworth and Hill of the Lincoln Lunatic asylum in sparking the debate about abolishing restraint in 1838. The work of a successor of Charlesworth and Hill, F. D. Walsh, house surgeon

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<sup>313</sup> See, for example: Melling and Forsythe eds., *Insanity, Institutions and Society*; Smith, *Cure, Comfort, and Safe Custody*; Anne Shepherd and David Wright, ‘Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint’, *Medical History*, 46 (2002), pp. 175-196; Topp, ‘Single Rooms, Seclusion and the Non-Restraint Movement in British Asylums’.

and later medical superintendent of the Lincoln Lunatic Asylum, is valuable to an investigation of developing ideas about treating mania in particular. To examine why F. D. Walsh was a key voice on the treatment of mania, it is important to consider the debates about seclusion that formed in replies to advocacy for the abolition of restraint. Opponents of the non-restraint system called into question the use of seclusion in the place of mechanical restriction, suggesting either that it was hypocritical to confine a patient in isolation while condemning bodily restriction, or that it was both ineffective and dangerous to seclude a patient without also limiting their ability for movement. Leslie Topp points out that, while Conolly advocated for the therapeutic benefits of seclusion in psychiatric treatment, Hill had instead included seclusion as a form of restraint during his lecture in 1838, only ‘conced[ing] that it could be used in cases where the conditions for total abolition of restraint did not exist’.<sup>314</sup>

Hill’s successor as house surgeon, and Walsh’s direct predecessor, William Smith, was responsible for abolishing the use of seclusion in Lincoln Lunatic Asylum. The case of ‘Miss A’, who had been subject to both restraint and seclusion during her time at Lincoln for symptoms of violence and self-harm, had been pointed to as an example of hypocrisy by opponents of the non-restraint system when the use of restraint was stopped in her treatment, but her seclusion continued.<sup>315</sup> Smith used this case as an experiment, deciding to stop the use of seclusion in Miss A’s treatment.<sup>316</sup> From the experiment, he concluded that ‘solitary confinement, as a means of control, may be successfully and usefully dispensed with in this Institution [...] as instrumental restraint has already been’.<sup>317</sup> Smith also wrote that Miss A’s case demonstrated the inefficiency of seclusion due to the continued ‘violent collisions during the long period of [her] seclusion’.<sup>318</sup>

Walsh, when in the position of house surgeon at Lincoln, would build on Smith’s results by conducting an experiment of his own. Walsh’s investigation would relate to the treatment of mania specifically. Smith talked fondly of his ‘esteemed friend’ and successor Walsh’s views on the inefficiency of seclusion in an article for *The Medical Times* in 1849.<sup>319</sup> Smith

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<sup>314</sup> Topp, ‘Single Rooms, Seclusion and the Non-Restraint Movement in British Asylums’, p. 763.

<sup>315</sup> Topp, ‘Single Rooms, Seclusion and the Non-Restraint Movement in British Asylums’, pp. 759-763.

<sup>316</sup> Appendix C (two letters from William Smith to the Lincoln Asylum Board of Governors), letter dated 25 October 1841 in *State of the Lincoln Lunatic Asylum (Annual Report)* quoted in Topp, ‘Single Rooms, Seclusion and the Non-Restraint Movement in British Asylums’, p. 763.

<sup>317</sup> Letters from William Smith in *State of the Lincoln Lunatic Asylum (Annual Report)* quoted in Topp, ‘Single Rooms, Seclusion and the Non-Restraint Movement in British Asylums’, p. 763.

<sup>318</sup> Letters from William Smith in *State of the Lincoln Lunatic Asylum (Annual Report)* quoted in Topp, ‘Single Rooms, Seclusion and the Non-Restraint Movement in British Asylums’, p. 763.

<sup>319</sup> William Smith, ‘Practical Observations on the Treatment of Insanity’, *The Medical Times*, 20 (1849), pp. 197-199 (p.198).

included an outline of the experiment from a letter written by Walsh. In the letter, Walsh wrote to Smith about a challenge he had received from an unnamed German physician which asked how he would treat ‘dancing mania’ without mechanical restraint.<sup>320</sup> ‘Dancing mania’ was characterised by Walsh as a form of mania in which the patient began ‘dancing and knocking his fists or his legs against the wall’.<sup>321</sup> He promised a form of treatment for this case which did not implement either bodily restraint nor seclusion.<sup>322</sup> The results of the experiment were presented by Walsh before the Midland Branch of the Provincial Medical and Surgical Associations.<sup>323</sup> Published in 1855, the full results were explained in the *British Medical Journal* article, discussing two cases treated in 1847.<sup>324</sup>

Walsh situated mania as central to debates about treatment:

There is probably no disease or imperfection of the human body which has been so little understood, or so badly treated, as that disease or imperfection which produces maniacal symptoms.<sup>325</sup>

Symptoms of manic-depressive illness were positioned by Walsh as central to developments in psychiatric practice because of the ‘long-continued failure in’ treating this form of mental disease.<sup>326</sup> Symptoms of extreme emotional states, delusions, destructive behaviour, suicidal ideation, as well as self-harm and threats of harm towards others, were previously seen as justifying patients being ‘chained up’, ‘starved’, and ‘shut up in a dark room’.<sup>327</sup> However, Walsh discussed changing attitudes in the treatment of these symptoms. He pointed to the circular sent to superintendents of all the asylums in England and Wales by the Commissioners in Lunacy in 1847, which ‘request[ed] information as to the treatment of various kinds of insanity and mania’.<sup>328</sup> Walsh demonstrated the importance of mania in these discussions by stating that the replies to the circular ‘certainly see a new light thrown upon the nature and treatment of mania’, naming this diagnostic category specifically. He explained that ‘the nature of mania is becoming to be considered the very reverse of what it had been’, now being seen

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<sup>320</sup> Walsh quoted in Smith, ‘Practical Observations on the Treatment of Insanity’, p. 198.

<sup>321</sup> Walsh quoted in Smith, ‘Practical Observations on the Treatment of Insanity’, p. 198.

<sup>322</sup> Walsh quoted in Smith, ‘Practical Observations on the Treatment of Insanity’, p. 198.

<sup>323</sup> Walsh, ‘On the Treatment of Mania’, p. 33.

<sup>324</sup> Walsh, ‘On the Treatment of Mania’, p. 33. This article was also discussed earlier in this chapter, examining the summary provided by Walsh of previous attitudes towards mania as wild, and the consequent direction and conditions of treatment for patients.

<sup>325</sup> Walsh, ‘On the Treatment of Mania’, p. 33.

<sup>326</sup> Walsh, ‘On the Treatment of Mania’, p. 33.

<sup>327</sup> Walsh, ‘On the Treatment of Mania’, p. 33.

<sup>328</sup> Walsh, ‘On the Treatment of Mania’, p. 33.

as ‘requiring nutritious diet and exercise in the open air’.<sup>329</sup> Following the examples of Hill and Smith, Walsh included ‘seclusion in a dark room’ as a form of restriction.<sup>330</sup> He stated that mechanical restriction, seclusion, and limiting diet, were ‘generally injurious’ and, more specifically, ‘the very things a case of mania does not require’.<sup>331</sup>

Sitting within debates about treatment, the article asserted that freedom to exercise in the open air, a nutritious diet, and avoiding any form of restraint were more effective in the treatment of mania by outlining two cases. The cases were deemed notable by Walsh as including the symptoms discussed most in answers to the circular as requiring restraint, such as risks of injury and destructive behaviour.<sup>332</sup> The two patients, one male and one female, were described as being ‘about the same age, with very similar symptoms’.<sup>333</sup> These symptoms were depicted as ‘a great propensity for muscular action, as jumping, dancing, breaking furniture and windows, raving obscenely, and with various delusions, tearing at their clothes and bedding’.<sup>334</sup> The female patient was treated with the tools described by the article as injurious. She was treated at first with opium, ‘but, when this failed, unfortunately, other remedies were tried’.<sup>335</sup> These included being ‘bled behind the ears with leeches and blistered’, with ‘digitalis tried to a dangerous extent’ making it difficult ‘to revive the patient with stimulants’, ‘tartrate of anatomy rubbed on the back of her neck; a seton was put into her arm’, and in terms of both bodily and nutritional restriction, the patient ‘was kept in seclusion under treatment until she became pale and emaciated’.<sup>336</sup> Her treatment was demonstrated to be ineffective: the article ended its discussion of the female patient by stating, ‘she never recovered’.<sup>337</sup>

Both the treatment and outcome for the male patient were significantly different. The experimental nature of the approach to the male patient’s case was described as the ‘system of curing mania, or rather letting mania cure itself’.<sup>338</sup> Initially, the patient’s mania was made ‘much worse, and violent’, by the use of treatments similar to those used in the female case. As a result of seclusion and the use of sedative medication, the patient was left in ‘a miserable state’, leading to him ‘breaking the furniture’, and commencing to ‘knock his fists, his knees,

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<sup>329</sup> Walsh, ‘On the Treatment of Mania’, p. 33.

<sup>330</sup> Walsh, ‘On the Treatment of Mania’, p. 33.

<sup>331</sup> Walsh, ‘On the Treatment of Mania’, p. 33.

<sup>332</sup> Walsh, ‘On the Treatment of Mania’, p. 33.

<sup>333</sup> Walsh, ‘On the Treatment of Mania’, p. 33.

<sup>334</sup> Walsh, ‘On the Treatment of Mania’, p. 33.

<sup>335</sup> Walsh, ‘On the Treatment of Mania’, p. 33.

<sup>336</sup> Walsh, ‘On the Treatment of Mania’, p. 33.

<sup>337</sup> Walsh, ‘On the Treatment of Mania’, p. 33.

<sup>338</sup> Walsh, ‘On the Treatment of Mania’, p. 33.

and his feet against the wall’.<sup>339</sup> The article stated that this mode of treatment was both ineffective and damaging to the patient’s mental health, exacerbating his destructive behaviour. One of the arguments made by advocates for restraint was to prevent manic patients from suffering with exhaustion by limiting their ability to move.<sup>340</sup> Tools of restraint could be used to limit the ability to expend energy, for example through making patients incapable of destructive behaviour. However, this case argued that the patient’s destructive behaviour had been made worse by restriction. An experiment was therefore conducted to reverse the approach to treatment, and, instead of limiting patient action, to allow the patient to tire himself through activity. Reflecting on the patient’s energy and excitement, a suggestion was made to let ‘the poor fellow out and about for two or three hours’, so that ‘he would run it all off’.<sup>341</sup>

The male patient was eventually allowed outside to test the use of free movement, exercise and fresh air as treatment. The case described him as having ‘rushed out in excessive joy’.<sup>342</sup> The attendants used his fixation on dance as a means to experiment with a form of treatment that combined activity and music: they had a ‘violin played to him’, and he began to ‘dance as usual’.<sup>343</sup> The energy expended from dancing and fresh air led to immediate improvement. As a result of this treatment, he was tired and ‘slept during the night’ for the first time ‘since his admission’.<sup>344</sup> His appetite was also revived and he began requesting food, a ‘liberal diet’ noted in the case as vital to his improvement.<sup>345</sup> Walsh stated the patient recovered as a result of this new approach to treatment. He emphasised that a sense of liberty was key, recording ‘the commencement of improvement’ as ‘dat[ing] from the time he was allowed to leave his room’.<sup>346</sup> This case demonstrated a development in treatment from being fearful of a patient losing energy, to recognising healthy ways of expending energy through exercise. The use of exercise allowed for a revival of strength, by improving symptoms of sleeplessness and reviving the patient’s appetite. Moreover, a significant change in attitude evident in this treatment was greater trust towards the patient to move freely in the asylum grounds.

Changes in attitudes towards patients alongside changes in treatment restored a sense of individuality, moving away from a perspective of patients as unhuman. In Walsh’s case,

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<sup>339</sup> Walsh, ‘On the Treatment of Mania’, p. 33.

<sup>340</sup> ‘On Non-Mechanical Restraint in the Treatment of the Insane’, pp. 551-568.

<sup>341</sup> Walsh, ‘On the Treatment of Mania’, p. 33.

<sup>342</sup> Walsh, ‘On the Treatment of Mania’, p.33.

<sup>343</sup> Walsh, ‘On the Treatment of Mania’, p.33.

<sup>344</sup> Walsh, ‘On the Treatment of Mania’, p.33.

<sup>345</sup> Walsh, ‘On the Treatment of Mania’, p.33.

<sup>346</sup> Walsh, ‘On the Treatment of Mania’, p.33.

treatment was partly directed by the patient’s specific desire to dance, and the ability to pursue this action and to expend energy encouraged sleep, appetite, and eventually recovery. Similarly, asylum case records demonstrated physicians listening to patients to seek forms of occupation that could aid towards their recovery. For example, the case of J.M., admitted to the Inverness District Asylum in 1864 and diagnosed with mania, recorded the patient’s delusion as believing he was ‘sent by the Almighty to convert the world’.<sup>347</sup> As a result of this delusion, J.M. had spent two years prior to his admission to the asylum for treatment ‘wander[ing] about the west coast as a self-constituted missionary’.<sup>348</sup> In the asylum, his case notes recorded ‘his greatest delight’ as ‘address[ing] the pigs whom he calls ministers and whom he most faithfully attends and who are regarded by him as human’. As a result, J.M. was employed in ‘tending to the pigs’.<sup>349</sup> This employment was described as an effective part of his treatment, and demonstrated an approach of trust in the patient, stating that he ‘require[d] no supervision and [was] let out in the morning and return[ed] regularly at meal time’.<sup>350</sup> Similarly, in the annual report of 1865, an unnamed patient diagnosed with mania who was previously a ‘schoolmaster’, but ‘no longer capable of acquiring new ideas’, found ‘the highest pleasure in a return to his old habits’, by spending his days ‘prepar[ing] with the greatest care [...] lessons he intend[ed] to bestow upon the pupils he ha[d] collected by his own enthusiasm at night’.<sup>351</sup> Beyond being directed by the individual interests and desires of the patients, these examples show trust being placed in the patients and an encouragement of activity – a significant change from the perception of patients’ actions as uncontrollable and therefore requiring bodily control.

The development in perceptions of patients created a shift in the power dynamic between the authority of the physician and the authority of the individual with mania. Alongside changes in treatment that placed a greater emphasis on the wants of the patient and their ability to be active, greater attention was paid to a patient’s own perspective of their mental wellbeing. An article in the *Journal of Psychological Medicine and Mental Pathology* in 1854 discussed Baillarger’s work on patient perception in recovery. Baillarger explained in a lecture that it was ‘not rare, when an insane patient has recovered, to see him preserve a

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<sup>347</sup> HHB/3/5/2/1, p. 132.

<sup>348</sup> HHB/3/5/2/1, p. 132.

<sup>349</sup> HHB/3/5/2/1, p. 133.

<sup>350</sup> HHB/3/5/2/1, p. 133.

<sup>351</sup> *Second Annual Report of the Inverness District Lunatic Asylum* (Inverness: Courier Office, 1866), p. 17.



residuum of his disease’.<sup>352</sup> He presented an example of a patient who suffered her mental illness over the course of ‘seven or eight months’, and had since ‘recovered’.<sup>353</sup> However, ‘she preserved a very serious symptom of her original affection’.<sup>354</sup> Baillarger illustrated that patients can be deemed recovered while continuing to experience symptoms of psychosis if they are aware that the symptoms are a feature of their illness:

She remains subject to hallucinations of the sense of hearing; but she perfectly accounts to herself for the phenomenon she experiences. [...] When she was mad or insane, she had not the consciousness that her understanding was impaired, she did not appreciate the errors of her condition, or else she held them for realities [...] Now, on the contrary, she judges of her hallucinations in the same manner as the physician himself judges of them; she recognises them as sensations without object; the sick woman knows herself to be sick, and that is enough to make her no longer mad.<sup>355</sup>

Baillarger represented a view of curability dependent on a patient’s ability to understand their symptoms as a feature of illness. This patient continued to experience auditory hallucinations, but her ability to recognise the experience medically as hallucination meant, according to Baillarger, that she was no longer insane. Instead, her awareness of her hallucination as a symptom of illness meant her actions were not directed by the hallucination.<sup>356</sup> Baillarger stated that the features of psychosis could continue, but a patient could be considered cured as long as they could recognise the experience as psychosis and would therefore not react to it, emphasising the importance of a patient’s perspective on their mental ill health. The reception of Baillarger’s work in the *Journal of Psychological Medicine and Mental Pathology* showed that this perspective of the importance of a patient’s account of their condition was already in practice in the context of psychiatric treatment in the UK. The article was critical of Baillarger’s classification of recovery on the basis that it was not innovative, arguing that both the ‘terms [and] the form employed’ were similar ‘to those in common use’, and that the basis of his idea was ‘what has long been said by others’.<sup>357</sup>

A focus on the patient’s view of their mental state was crucial to the visual work of Hugh Welch Diamond in asylum treatment. Earlier in this chapter, in my analysis of the work

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<sup>352</sup> ‘On the Classification of Mental Diseases’, p. 533.

<sup>353</sup> ‘On the Classification of Mental Diseases’, p. 534.

<sup>354</sup> ‘On the Classification of Mental Diseases’, p. 534.

<sup>355</sup> ‘On the Classification of Mental Diseases’, p. 534.

<sup>356</sup> ‘On the Classification of Mental Diseases’, p. 534.

<sup>357</sup> ‘On the Classification of Mental Diseases’, p. 535.

of Charles Bell, I refer to physiognomy in an asylum context and, particularly, to the work of Alexander Morison, medical superintendent at the Surrey County Asylum. According to Morison, expression could help physicians diagnose patients because the experiences of emotional states became ingrained in patients’ features:

The appearance of the face is intimately connected with and dependent upon the state of the mind; the repetition of the same ideas and emotions, and the consequent repetition of the same movements of the muscles of the eyes and of the face give a peculiar expression.<sup>358</sup>

Ongoing emotional states were discussed by Morison as staining patient expression. Consequently, Morison believed that expression could be analysed at different stages – a warning of developing symptoms, that expression could confirm diagnosis, and also could show signs of recovery.<sup>359</sup>

In Morison’s work, the physician held the role of reading patient expression. However, Morison’s successor, Hugh Welch Diamond, shifted the role so that patients analysed their own expressions. Diamond took a series of photographs of his patients. His use of photography moved from using expression as a map for a physician, to a means of self-reflection for patients. He wrote about taking photographs at different stages of a patients’ ill health and stated that showing these images to the patients had a positive impact on their chances for recovery.<sup>360</sup> Like Baillarger, Diamond tied recovery to a patient recognising their illness. His use of photography became a means of shifting the authority over their mental state to the patients, through patients analysing their own expressions.

A shift in the dynamic between the physician’s authority and the patient’s authority encouraged a form of self-management of mania by patients. In an annual report in 1885, Thomas Aitken, medical superintendent of the Inverness District Asylum, described a view similar to the ideas of Baillarger and Diamond, which emphasised the importance of a patient’s account of their mental ill health for recovery. Aitken used the case to outline the recurrent nature of mania:

Another striking feature of these recurrent cases [is] the reappearance during the attacks of the same symptoms and delusions. An illustration of this is presented in a girl

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<sup>358</sup> Morison, ‘The Physiognomy of Mental Diseases’, p. 262.

<sup>359</sup> Morison, ‘The Physiognomy of Mental Diseases’, p. 262.

<sup>360</sup> Hugh. W. Diamond, ‘On the Application of Photography to the Physiognomic and Mental Phenomena of Insanity’ *Royal Society*, 8 (1856), p. 117.

admitted for the 7<sup>th</sup> time, and at which periods varying from 10 months to two and a half years. With the appearance of her paroxysms there is the return of an enmity and dislike of her friends, a belief that she is ill-used by them, and that Satan pursues and tempts her. Of all this, however, she is to some extent conscious, describes to the officers when she is admitted the exact stage of her excitement, talks with apparent composure of the state she is in, and disposes herself to endure for a period, knowing that her feelings will ultimately disappear.<sup>361</sup>

This case illustrated a form of self-management, in which there was a shared understanding between the patient and her medical attendants that her experience with mania was recurrent, and that the episodes would ultimately pass. After the episodes, the patient was recorded as recovered, with an understanding that another episode would likely appear with similar symptoms, during which time she would return to the asylum and give an account of her mental condition. The recording of this case from Aitken demonstrates the importance placed on a patient’s awareness of their symptoms, as well as the trust placed in patients to give an account of the stage of their mental ill health.

The examples I have discussed show a greater authority for patients in the direction of their treatment and account of their mental state. Developments in treatment and attitudes towards patients appear to coincide with the greater specificity developed for mania through the nineteenth century, which moved away from a general, furious madness to seeking patterns in movement between mood states and periods of lucidity, emphasising distinctions between emotional states, and recording the emotional themes of psychosis. The greater attention paid to the emotional themes of psychosis additionally led to further subtypes of mania being classified in the form of different types of monomania. Types of psychosis also gained greater nuance through new distinctions between hallucinations and delusional beliefs. For example, the *Journal of Psychological Medicine and Mental Pathology* praised Baillarger’s ‘distinction between delirious conceptions and hallucinations’, which the article stated were ‘usually confounded in this country under the common name of delusions’.<sup>362</sup> The distinction was broken down in the journal article to indicate its usefulness: ‘delirious conceptions’ were

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<sup>361</sup> *The Twenty-First Annual Report of the Inverness District Asylum* (Inverness: Courier Office, 1885), pp. 10-12. Chapter Four, which will focus on spaces of care in Scotland and curability in mania, will examine the opening of the Inverness District Asylum in 1864, which initially primarily admitted incurable cases. Aitken explained in annual reports that mania became incurable as a result of the duration of the illness without treatment, which allowed for emotional states and delusions to become rooted in patient behaviour. However, by the late 1880s, the asylum at Inverness received more acute cases, which were considered curable.

<sup>362</sup> ‘On the Classification of Mental Diseases’, p. 538.

categorised as ‘consisting in false ideas, extravagant, ridiculous and absurd, impossible of execution’, and ‘hallucinations’ were categorised as a ‘disorder of the organs of sense’, in which ‘sensations were perceived in the absence of all external excitation’ or ‘certain real excitations of the senses convey to the mind impressions widely different from their real nature’.<sup>363</sup> Explaining the common use of the single term ‘delusion’ for both of these categories, the article noted that, in both delusion and hallucination, the patient’s ‘judgement is perverted, and [they are] unable to appreciate correctly the error of ideas and the false suggestion of the senses’.<sup>364</sup> However, the article highlighted that the ‘distinction [was] useful’ and that ‘it deserve[d] to be more attended to than is usual among us’.<sup>365</sup> This highlights a development in distinguishing between features of psychosis. Moreover, it demonstrates this development in direct conversation with perceptions about curability, because the article included Baillarger’s work on a patient’s perception of their mental condition.

Changes in treatment, classifications, and dynamics between the physician’s and patient’s authority were investigated in literary texts. Sheridan Le Fanu’s short story ‘Green Tea’ (1869) challenged medical authority in the context of developments in treatment and flexible systems of diagnosis. As I discuss in my analysis of ‘Green Tea’ in Chapter One, my reading of Le Fanu’s short story connects to Warren’s ‘The Spectre-Smitten’ (1831) and Poe’s ‘The Murders in the Rue Morgue’ (1841) because of their animalistic representation of destructive behaviour and tensions in communication, which draw specific connections to nineteenth-century discourse about the orangutan. Similarly, in ‘Green Tea’ Jennings’s hallucination is illustrated as ‘a small black monkey’.<sup>366</sup> Crucially, unlike in the other texts, the animal figure in ‘Green Tea’ is separated from Jennings. This separation is vital in the representation of medical authority, the diagnostic process, and views about curability in the text. Moreover, the illustration of Jennings’s psychosis represents the new distinction for psychotic symptoms during this period, specifically describing the experience as ‘hallucination’.<sup>367</sup> This specificity strengthens the argument I made in Chapter One that Le Fanu was interested in and influenced by medical writing.

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<sup>363</sup> ‘On the Classification of Mental Diseases’, p. 538.

<sup>364</sup> ‘On the Classification of Mental Diseases’, p. 538.

<sup>365</sup> ‘On the Classification of Mental Diseases’, p. 538.

<sup>366</sup> Sheridan Le Fanu, ‘Green Tea’, *All the Year Round*, 2 (1869), pp. 501-504, 525-528, 548-552, 572-576 (p. 20).

<sup>367</sup> Le Fanu, ‘Green Tea’, p. 550.

By separating the animal figure in ‘Green Tea’, Le Fanu establishes a dialogue between Jennings and his hallucination. In doing this, Le Fanu explores and poses a challenge to perspectives of curability. During their first encounter, Jennings describes the monkey as ‘cre[eping] swiftly along the wall, at exactly my pace’.<sup>368</sup> Jennings ‘quickens [his] pace’, but the monkey ‘continued to keep up with [him]’, so much so that he feared at ‘every moment’ he might ‘tread upon it’.<sup>369</sup> In this way, the monkey is illustrated as a shadow or a companion, but remains separate to the manic-depressive figure. Le Fanu represents a dialogue between Jennings and his hallucination in accordance with perspectives about patient recovery, posing the question of whether Jennings can recognise the monkey as hallucination, or whether he can only identify his vision as an evil spirit. Ideas explored by Baillarger, Diamond, and Aitken assert that recovery has taken place when a patient is able to recognise their experience as a symptom of illness, even if they continue to experience hallucinations. The separation between the monkey and Jennings suggests that his identification of the monkey as a hallucination would be sufficient to restore him to sanity. However, Jennings questions the term hallucination and ultimately rejects it. He attempts to achieve recovery by ‘repeating again and again the assurance, “the thing is purely a disease”’.<sup>370</sup> However, he states that he believed this ‘no more than any other miserable being ever did who is once seized and riveted in this satanic captivity’.<sup>371</sup> Jennings illustrates a dialogue between the patient and their hallucination in an attempt towards recovery, but makes limited progress because of his inability to identify the monkey as an hallucination.

The representation of mood and psychosis in ‘Green Tea’ questions what can be deemed recovery from this type of mental illness, interrogating the role of medical authority in defining recovery, and examining divisions in categorising and defining symptomatology. The short story forms these challenges to medical authority by showing the different definitions of Jennings’s experience by different medical professionals. Jennings’s first encounter with a physician encourages him to identify his symptom as a hallucination for the sake of cure. However, Jennings’s inability to do this leads to frustration. The physician defines the hallucination with a discussion of ‘optic nerves, and of spectral illusions’. However, Jennings is insistent that the monkey is an ‘evil spirit’.<sup>372</sup> Consequently, Jennings searches for a

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<sup>368</sup> Le Fanu, ‘Green Tea’, p. 550.

<sup>369</sup> Le Fanu, ‘Green Tea’, p. 550.

<sup>370</sup> Le Fanu, ‘Green Tea’, p. 550.

<sup>371</sup> Le Fanu, ‘Green Tea’, p. 550.

<sup>372</sup> Le Fanu, ‘Green Tea’, p. 572.

physician who will provide a different classification for his experience. He finds Hesselius, whose specialism in ‘metaphysical medicine’ leads to different ideas about the appearance of the monkey. ‘Green Tea’ represents uncertainty around recovery, and multiplicity of diagnostic classifications, through the lack of clarity in Hesselius’s classification of Jennings’s illness. In a 2007 article for the *British Medical Journal*, writer and retired physician Theodore Dalrymple points out that Hesselius ‘makes it unclear as to whether he believes the black monkey with red eyes is a hallucination pure and simple, or an actually existing entity’.<sup>373</sup> Hesselius traces the cause of the hallucination to the excessive use of ‘green tea’.<sup>374</sup> However, as demonstrated by Dalrymple, Hesselius’s opinion that ‘one of the effects of the tea is to influence the brain so that “disembodied spirits may operate in communication more effectively”’ renders his stance on whether the monkey is an hallucination unclear.<sup>375</sup> In addition to Hesselius’s uncertainty about the appearance of the monkey, his diagnosis and views on treatment for Jennings illustrate contradictions. Hesselius confidently asserts, ‘I have not any doubt that I should have cured him perfectly in eighteen months’, pointing to his treatment of ‘fifty-seven cases of this kind of vision’.<sup>376</sup> In this discussion, Hesselius continues to attribute the appearance of the monkey to the ‘abuse’ of ‘such agents as green tea’.<sup>377</sup> In this way, he is classifying the vision of the monkey as ‘communication’ with ‘disembodied spirits’, rather than as an hallucination.<sup>378</sup>

The illustration of Hesselius highlights dynamics in medical authority by stating that Jennings would have needed ‘confidence’ in his physician to be able to recover. According to Hesselius, if the patient aligns with the physician’s view of treatment, and ‘does not array himself on the side of the disease, his cure is certain.’<sup>379</sup> However, despite his observations of Jennings, and several conversations on the subject of his illness, Hesselius asserts, after Jennings’s suicide, that Jennings had not yet been under his care, because, although Hesselius was ‘thoroughly investigat[ing] his case’, he had not yet ‘begun to treat’ him.<sup>380</sup> Hesselius’s own classification of the appearance of the monkey was uncertain during his observations of Jennings. However, after his suicide, he asserts that Jennings’s cure would have been

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<sup>373</sup> Theodore Dalrymple, ‘Green Tea and Monkey Business’, *British Medical Journal*, 334 (5 May, 2007), p. 957

<sup>374</sup> Le Fanu, ‘Green Tea’, p. 576.

<sup>375</sup> Dalrymple, ‘Green Tea and Monkey Business’, p. 957.

<sup>376</sup> Le Fanu, ‘Green Tea’, p. 575.

<sup>377</sup> Le Fanu, ‘Green Tea’, p. 576.

<sup>378</sup> Le Fanu, ‘Green Tea’, p. 576.

<sup>379</sup> Le Fanu, ‘Green Tea’, p. 576.

<sup>380</sup> Le Fanu, ‘Green Tea’, p. 572-576.

achievable had he begun treatment. Hesselius at this point disregards the appearance of the monkey, claiming that the cause of Jennings’s suicide amounts to a separate diagnosis: ‘that catastrophe was the result of a totally different malady, which, as it were, projected itself upon the disease which was established’.<sup>381</sup> After his death, Hesselius diagnoses Jennings with ‘hereditary suicidal mania’.<sup>382</sup> ‘Green Tea’ illustrates different classifications of symptoms and poses questions about the nature of recovery according to different medical authorities. The representation of psychosis and curability in ‘Green Tea’ illustrates the multiplication of diagnostic categories, and the implications of different classifications by different physicians on patient treatment, challenging the role of medical authority. The two physicians Jennings seeks help from express different classifications for his experience, and both ultimately fail him in treatment.

My research into the Royal Edinburgh Asylum archives uncovered uncertainty about specificities of diagnostic categories. The Patient Case Register of the Royal Edinburgh Asylum moved from having the entry in the register for diagnosis left blank for patients through much of the 1840s, to being completed for every patient beginning in the first years of the 1850s.<sup>383</sup> In addition to being completed in detail, the register, as well as the patient case books, also demonstrated an interest in new divisions in diagnostic categories by the frequent occurrence of diagnoses being crossed out and replaced with a new diagnosis.<sup>384</sup> This crossing out and re-diagnosing happened most frequently with diagnoses of mania and its subtypes. Patient G.G., admitted in 1859, was initially diagnosed with ‘melancholia’, but this diagnosis was crossed out and replaced with ‘mania’.<sup>385</sup> Her illness was characterised by being ‘suspicious of receiving injury from her mother and sister especially and also people in general’, demonstrating a feeling of being under threat common in low mood states.<sup>386</sup> H.A., admitted in 1858, also received an initial diagnosis of ‘melancholia’, before this was replaced with ‘mania’.<sup>387</sup> Like G.G., the observations for this case were characterised by features of low mood. He was observed as ‘dull’, doing ‘little work’, that he ‘seldom speaks’, and ‘does not take his food well’.<sup>388</sup>

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<sup>381</sup> Le Fanu, ‘Green Tea’, p. 576.

<sup>382</sup> Le Fanu, ‘Green Tea’, p. 576.

<sup>383</sup> LHB7/35/2.

<sup>384</sup> LHB7/35/2.

<sup>385</sup> LHB7/35/2, p. 33.

<sup>386</sup> LHB7/51/11, p. 811.

<sup>387</sup> LHB7/35/2, p. 42.

<sup>388</sup> LHB7/51/10, p. 544.

Many of the changes in diagnosis occur in categories of monomania either being re-diagnosed as different types of monomania or replaced with diagnoses of mania. H.G., admitted in 1858, was first diagnosed with ‘monomania of suspicion’, before this was replaced with ‘acute mania’.<sup>389</sup> Her symptoms were characterised by cycles of alternately being ‘depressed’ and ‘elated’ alongside delusions.<sup>390</sup> I.B., admitted in 1858, was initially diagnosed with ‘monomania of suspicion’, before being re-diagnosed with ‘mania’.<sup>391</sup> Her notes observed ‘groundless suspicions’, destructive behaviour including ‘breaking locks of doors’ and ‘windows’, and being ‘confused’.<sup>392</sup> E.D., admitted in 1858, was initially diagnosed with ‘melancholia’, but this was crossed out and replaced with ‘monomania of suspicion’, which was then also crossed out and replaced with ‘monomania of unseen agency’.<sup>393</sup> Her illness was characterised by being suicidal, she was observed ‘hear[ing] voices of people calling her’, believing ‘that men are pursuing her for the purpose of injuring her’, and wrongly believing that she had been ‘charged with murder’.<sup>394</sup>

The frequent changes in diagnosis indicate uncertainty around classifying mania and its subtypes. The regular recording of diagnostic information in the patient register, after a long period of that section of the register being left blank for all patients, also suggests a renewed interest in diagnostic categories. At this time, a range of types of monomania were recorded. These included monomania of suspicion, of unseen agency, of fear, of pride, hypochondriacal monomania, and occasionally a diagnosis of ‘monomania’ without any further information. ‘Green Tea’ highlights the impact of uncertainties in diagnosis on treatment. Instead of representing mania as between a human and animal state, ‘Green Tea’ depicts fragile dynamics between physician and patient authority, challenging the flexibility and uncertainty in diagnostic systems by illustrating a patient failed by his physician. Le Fanu conveys the concept of recovery as being achieved by a patient’s awareness of their symptoms by separating the figure of the monkey from Jennings, and through Jennings’s initial attempts to convince himself that the monkey is an hallucination. However, Le Fanu also represents problems with the dynamics in medical authority by demonstrating Hesselius’s uncertainty as ultimately causing injury to Jennings.

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<sup>389</sup> LHB7/35/2, p. 64.

<sup>390</sup> LHB7/51/11, p. 765.

<sup>391</sup> LHB7/35/2, p. 17.

<sup>392</sup> LHB7/51/11, p. 767.

<sup>393</sup> LHB7/35/2, p. 32.

<sup>394</sup> LHB7/51/11, p. 769.



## Conclusion

Treatment for mania in the nineteenth century experienced a significant change that saw a reversal in approach to patient care. Debates about the use of restraint beginning in the late 1830s were centred on mania, with acute mania commonly named as the condition that benefited most from the use of bodily restriction and used in arguments in favour of the necessity of retaining restraint in asylums. Restraint was justified in mania on the basis that both high and low mood states were perceived as causing animalistic behaviour in patients. Literary representations challenged this by suggesting animalistic behaviour was a result of restraint and animalistic treatment. ‘The Spectre-Smitten’ and ‘The Murders in the Rue Morgue’ highlight the perception of mania as occupying a state between civilized human and wild animal, connecting to discourse about the orangutan as somewhere between a human and animal condition, and speculating that wild behaviours were a response to inhumane conditions of treatment.

Mania was also key to arguments against restraint, which claimed that restriction exacerbated symptoms. Debates about restriction inspired developments in the treatment of mania, which saw a reversal from restriction of movement and diet to a focus on plentiful nutrition, open-air, and expending energy through activity. This approach demonstrated a development in perceptions of patients with mania through a greater emphasis on the individuality of patients, encouraging the activities and occupations that would be most beneficial to patients based on their skills, interests, and even their delusional beliefs. Changes in treatment also showed a development in the dynamic between physician and patient authority. Greater trust was placed in patients to move freely in asylum grounds, as opposed to previous physical control, and there was an emphasis on a patient’s awareness of their mental state in ideas about recovery. In the context of this dynamic, literary representations posed a challenge to the nature of medical authority. While ‘Green Tea’ highlights a change from animalistic perceptions of patients, Le Fanu’s short story also depicts the fragility in dynamics of authority in the context of uncertainty around diagnostic classifications, illustrating a patient failing to achieve awareness of their condition, and therefore recovery, as a result of their physician’s own uncertainty about diagnosis and treatment.

Though changes in treatment occurred in the nineteenth century across different diagnostic categories, mania was central to both justifications for the continued use of bodily

restraint, and arguments in favour for the abolition of restriction. Moreover, mania’s centrality to the debates and developments in institutional treatment were focused on both high and low mood states and appear to coincide with the greater specificity developed for mania through the nineteenth century, connecting to the major finding in this project that mania was characterised by emotional states across the mood spectrum, and therefore constructed as a characteristically manic-depressive illness. A focus on mania in an interrogation of changes in treatment therefore contributes to the wider work on the history of institutional psychiatric treatment. Moreover, this work furthers an analysis of the history of conceptualising a manic-depressive illness by interrogating the relationship between developments in diagnostic classifications, in treatment, and in social depictions. To continue this analysis, the following four chapters will examine treatment in places moving from systems of community care to introductions of institutional care, and then investigate the similarities and differences in the female and male experience of mania, furthering the concerns of this thesis about the construction of a manic-depressive illness and the experience of this illness in different places and groups. Chapter Three will focus specifically on Wales to examine representations of community care moving to accessible asylum treatment amid concerns about communication in the treatment of mania.

### **Chapter Three:**

## **Leaving Wonderland: Manic-Depressive Illness between *Cymorth* and Institutional Treatment in Wales**

Chapter Two's focus on mania contributes a nuanced analysis to the body of scholarship on asylum treatment, as well as to the history of the construction of an illness characterised by movement between severe emotional states. However, at the time of debates about restraint and developments in treatment for mania, there was still a lack of accessible institutional care in parts of the United Kingdom. The centrality of mania to debates about restraint was replicated in the use of mania as a key category in inquiries into systems of care in different parts of the United Kingdom. Drawing from Chapter One and Chapter Two, the following two chapters will investigate the diagnosis, treatment, and representations of a manic-depressive illness in Wales and the Scottish Highlands and Islands during times of transition between treatment situated within the community and care in an institutional setting, to analyse socio-spatial implications of institutional spaces on people experiencing mania who had previously been limited to care in a rural domestic or community setting, furthering a key concern in this thesis about the experience of mania in different places and in different groups. My use of the terms space and place are based on the definitions of Yi-Fu Tuan, who sees space as abstract and without meaning, and place as a cluster of space ascribed meaning by human experience.<sup>395</sup>

Studies of the history of psychiatry in the United Kingdom have tended towards being Anglocentric or, if moving beyond a focus on England, have looked to Edinburgh. However, in recent years studies have widened this focus, creating a more nuanced analysis of the history of psychiatric treatment by examining differences in the histories of Wales, Scotland, Ireland, and England – sometimes termed the Four Nations approach.<sup>396</sup> An element of the previously somewhat Anglocentric view had been a preoccupation with psychiatric care in urban settings. Waddington points out the importance of region in narratives of health interconnected by 'geography, memory, emotion, and identity', viewing regions as 'discursive formations that

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<sup>395</sup> Tuan, *Space and Place*.

<sup>396</sup> Waddington, 'Thinking Regionally', p. 52. See, for example: Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000*; Parr, Philo and Burns, "'That awful place was home'"; Oonagh Walsh, "'The Designs of Providence': Race, Religion and Irish Insanity", in *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective*, ed. by Joseph Melling and Bill Forsythe (London: Routledge, 1999), pp. 223-242. For more on the 'Four Nations Approach', see also: Makenzie MacDonald, 'Irish, Scottish, Welsh and English Worlds? The Historiography of a Four Nations Approach to the History of the British Empire', in *Race, Nation and Empire: Making Histories 170 to the Present*, ed. by C. Hall and K. McClelland (Manchester: Manchester University Press, 2010), pp. 133-153.

influenced ideas and perceptions of health and illness'.<sup>397</sup> Illness cannot be separated from the place where it is experienced, and the place is continually formed by connections in identity through shared culture, language, and mythology, all contributing to perceptions of the divide between health and illness. As I discuss in the Introduction and Chapter One, diagnostic practices relied on testimony from patients, relatives, and friends, to reach a probabilistic diagnosis based on the subjective view of whether the symptoms experienced indicated a healthy or unhealthy emotional state. The narrative of such testimonies, and the interpretation from the physician of which side of the constructed line between healthy and unhealthy mood the patient's experience was placed, were tied to the place where the illness was experienced.

Waddington also discusses tensions between regions considered core and periphery, suggesting that the relationship is not as linear as the periphery being influenced by and taking on the changes implemented by the core, but the periphery also having an influence in negotiating medical practices, adapting them to 'regional needs and cultures'.<sup>398</sup> Previous concentration on urban centres such as London and Edinburgh had been a result of seeing these cities as the influential core at the forefront of changes in medical policy and practice. However, work like Waddington's on medical history in different parts of Wales reveals the value of examining how different places negotiated, resisted, or adapted medical changes according to regional requirements and social attitudes, providing a fuller analysis of the impact of medical developments on different communities.<sup>399</sup>

While the two places I have decided to focus on for analysis are greater than the level of region, I have chosen to focus on Wales and the Scottish Highlands and Islands specifically because of the transitions in these places from systems of community care to institutional psychiatric provision. In Wales, while there was a small asylum in Haverfordwest in a converted gaol from 1824, it was considered entirely unfit for the treatment of mental illness and criticised by Commissioners in Lunacy until its closure in 1860, and in Scotland, while there were numerous asylums across the south of the country and parts of the north-east, there was an absence of institutional provision beyond the Highland line.<sup>400</sup> In both Wales and the

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<sup>397</sup> Waddington, 'Thinking Regionally', pp. 53-55.

<sup>398</sup> Waddington, 'Thinking Regionally', p. 51.

<sup>399</sup> Waddington, 'Thinking Regionally'.

<sup>400</sup> *Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor*, (London: Bradbury and Evans, 1844); *Report by Her Majesty's Commissioners Appointed to Inquire into the State of Lunatic Asylums in Scotland and the Existing Law in Reference to Lunatics and Lunatic Asylums in the part of the United Kingdom* (Edinburgh: Thomas Constable, 1857); T.G. Davies, "'Of all the Maladies": Episodes in the History of Psychiatry in Nineteenth-Century Pembrokeshire', *The Journal of the Pembrokeshire Historical Society*, 5

Scottish Highlands and Islands, inquiries by the Commissioners in Lunacy led to the discovery of significant numbers of people experiencing mental illness without suitable access to institutional care, which led to the opening of the North Wales Lunatic Asylum in 1848, and the Inverness District Asylum in 1864.<sup>401</sup> However, both asylums were established with the goal of providing culturally specific forms of care for their Celtic populations, who were considered to have a particular experience of mental illness according to place, mythology, language, and identity.<sup>402</sup>

The decision to focus on Wales and the Scottish Highlands and Islands is therefore to examine how these perceived particular experiences of mental ill health impacted the representations and treatment of mania specifically, as well as to interrogate tensions in the relationship between core and periphery in the role of Commissioners in Lunacy recommending institutional centres of treatment based on the results of their inquiries. A study of mania specifically means that the following two chapters will contribute a more detailed analysis of the experience of an illness characterised by both high and low mood states, by examining contrasts in experience in different places. Moreover, these chapters will also make useful contributions to studies of the changes in psychiatric provision and treatment in places where there was a delay in implementing institutional care, and where rural societies previously provided their own systems of care in domestic and community spaces.

These chapters will therefore analyse both the representation of mania in different places, and as the implications of different systems of care on perceptions of people with mania. Hester Parr, Chris Philo, and Nicola Burns have written about the complex ‘patchwork’ of inclusion and exclusion for those experiencing mental ill health in rural communities, with a specific focus on the Scottish Highlands.<sup>403</sup> They contest work about *Gemeinschaft* social relations, which view rural communities as forming social intimacy and therefore fostering an environment of mutual care, to argue that close social ties do not necessarily lead to inclusive spaces for those with mental illnesses because of tensions between duties of care and the greater

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(1992), pp. 75-90; Chris Philo, ‘Scaling the Asylum: Three Geographies of the Inverness District Lunatic Asylum (Craig Dunain)’, in *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context*, ed. by Leslie Topp, James E. Moran and Jonathan Andrews (London: Routledge, 2007), pp. 105-130.

<sup>401</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy; Report by Her Majesty’s Commissioners Appointed to Inquire into the State of Lunatic Asylums in Scotland*.

<sup>402</sup> Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000*; Parr, Philo and Burns, ““That awful place was home””, p. 344.

<sup>403</sup> Hester Parr, Chris Philo and Nicola Burns, ‘Social Geographies of Rural Mental Health: Experiencing Inclusions and Exclusions’, *Transactions of the Institute of British Geographers*, 29 (2004), pp. 401-419.

visibility and ‘fear’ of perceived socially ‘deviant’ behaviour.<sup>404</sup> While this specific work concentrates on contemporary service users, Parr, Philo and Burns also use their argument to suggest that Foucault’s spatial history ‘neglect[s] [...] multiple relational spaces between Reason and Unreason’, or between mental health and mental illness, because of his view of exclusion as constructed by the ‘closed spaces’ of institutional treatment.<sup>405</sup> In contrast, they argue that ‘exclusion has to be accomplished at a local level’.<sup>406</sup>

The following chapters, then, will draw on the work of Waddington, Parr, Philo, and Burns, to investigate the particular experience of mania in different places and the implications of transitions between community systems of care and institutional treatment on representations of mania. Chapter Three will focus on Wales, while Chapter Four will focus on the Scottish Highlands and Islands. In Wales, early-nineteenth century psychiatric care relied on the system of *cymorth*, which translates as ‘support’ or ‘care’. The basis of this system was that family, neighbours, or members of the wider community were given financial support by parishes to care for the insane.<sup>407</sup> Patients either faced bodily restriction in their carer’s home or were free to roam in the landscape. The accessibility of care was also limited by a lack of Welsh-medium treatment. Welsh patients were occasionally sent to asylums across the border, but treatment was ineffective because it was through the medium of English. Towards the mid nineteenth century, North Wales saw a transition from *cymorth* to institutional treatment with the opening of the North Wales Lunatic Asylum in Denbigh in 1848, a transition which was seen on a wider scale throughout Wales going further into the nineteenth century, as a result of the inquiries of the Commissioners in Lunacy from 1844-1845.<sup>408</sup>

This chapter will analyse different spaces of treatment for manic-depressive illness – from the indoor/outdoor spaces of *cymorth*, to unfamiliar spaces of institutional care across the border, and finally the introduction of asylum spaces in Wales. In doing this, this chapter will argue that medical and literary representations of manic-depressive illness in Wales were tied to explorations of spaces: the polarisation of inside/outside unravelling into boundaries between confinement and freedom; mother-tongue and alien communication; home and

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<sup>404</sup> Parr, Philo and Burns, ‘Social Geographies of Rural Mental Health’, p. 409.

<sup>405</sup> Parr, Philo and Burns, ‘Social Geographies of Rural Mental Health’, p. 413.

<sup>406</sup> Parr, Philo and Burns, ‘Social Geographies of Rural Mental Health’, p. 413.

<sup>407</sup> Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000*, p. 9.

<sup>408</sup> Pamela Michael and David Hirst, ‘Establishing the “Rule of Kindness”: the Foundation of the North Wales Lunatic Asylum, Denbigh’, in *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective*, ed. by Joseph Melling and Bill Forsythe (London: Routledge, 1999).

institution. What was the impact on depictions of mania when care was in the hands of relatives, neighbours, and the wider community, without accessible institutional treatment? I will argue that representations in Wales were more sympathetic towards patients because of a system based on community care. Family members did not want to part with their insane relatives, and reports from physicians and the Commissioners in Lunacy were sympathetic towards those suffering with manic-depressive illness on the basis that Welsh patients had no access to suitable care, and therefore did not have the means to improve their circumstances.

I will also interrogate literary representations, arguing that literary texts depicted a combination of sympathy for patients unable to access adequate treatment, contempt for English-medium medical treatment, and anxiety about the presence of symptoms of mania in community spaces to social order. I will analyse cases discussed in Welsh newspaper articles, reports of the Commissioners in Lunacy, and patient case notes from the North Wales Lunatic Asylum concurrently with literary examples from Welsh periodical press, including the anonymously authored *Adventures of a Welsh Medical Student* (1831) and Cymro Bach's *Hanes y Dyn yn y Lleuad* [The History of the Man in the Moon] (1830). Finally, this chapter will present a new interpretation of Lewis Carroll's *Alice's Adventures in Wonderland* (1865) based on research into manic-depressive illness in Wales. I will argue that Wonderland is exploring spaces of psychiatric care with a specific depiction of Welsh spaces of treatment and symptoms associated with mania.

### **Spaces of *Cymorth*: Social Proximity and Visibility**

The history of systems of care in Wales has traditionally been overlooked, combined instead with studies of psychiatric history in England. However, recent research, such as studies by Pamela Michael, David Hirst, T.G. Davies, C. Barber, D.W Howell, and Andy Croll, show significant differences in Welsh provisions of treatment in the nineteenth century.<sup>409</sup> In terms of psychiatric illness, these differences are primarily highlighted in a lack of accessible institutional care in the early nineteenth century. Notably, Michael and Hirst point to the 1843

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<sup>409</sup> See: Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000*; C. Barber, and D. W. Howell, 'Wales', in *The Cambridge Social History of Britain, 1750-1950*, ed. by F. Thompson (Cambridge, 1990), 1, Regions and Communities, 281–254; Andy Croll, "'Reconciled Gradually to the System of Indoor Relief': The Poor Law in Wales during the "Crusade against out-Relief", c. 1870 – c. 1890', *Family & Community History*, 20 (2017), 121–44; T.G. Davies, "'Of all the Maladies": Episodes in the History of Psychiatry in Nineteenth-Century Pembrokeshire', *The Journal of the Pembrokeshire Historical Society*, 5 (1992), pp. 75-90.

findings of Poor Law Commissioners that in England, ‘42.2 per cent’ of people with mental health difficulties were being treated in the institutional spaces of ‘either asylums or licensed houses’, whereas in Wales the figure was ‘only 6.5 per cent’.<sup>410</sup> Prior to the opening of the North Wales Lunatic Asylum in Denbigh in 1848, Wales had only one public asylum, Haverfordwest Asylum, opened in 1824 in Pembrokeshire.<sup>411</sup> However, when visited by the Commissioners in Lunacy in 1842, their report described the asylum as ‘deficient in almost every comfort and accommodation which a Lunatic Asylum should possess’.<sup>412</sup> Formerly a small gaol, it was appropriated instead for the reception of mentally ill people; however, the commissioners note that ‘it did not appear that any addition or alteration whatever had been made, so as to adapt it to the accommodation of patients’.<sup>413</sup> Re-visiting in 1843, the commissioners reported that ‘although symptoms of some improvement’ had been made based on their recommendations, the asylum remained ‘wholly unfit for the treatment and care of the insane’.<sup>414</sup> This remained the state of the asylum long-afterwards; a report prior to its closure in 1860 continued to describe the ‘total unfitness of the place for the purpose to which it is applied’.<sup>415</sup>

While patients would occasionally be sent to English asylums, Pamela Michael points out that this was resisted by parishes because of the high expense.<sup>416</sup> As I will explore in detail in the next section, an average of two out of three of the inhabitants of Wales were monolingual Welsh-speakers in 1851, meaning English-medium treatment over the border was another problematic factor.<sup>417</sup> In addition to the issue of distance between patients and relatives, individuals would be subject to treatment in a different language.<sup>418</sup> Consequently, those suffering with mania in Wales relied on *cymorth*, which saw parishes give financial support to family members or neighbours to care for pauper lunatics.<sup>419</sup> As a result, those suffering with psychiatric illness, including mania, were either left to roam in the community and countryside, or restrained by their caregivers. This section will look specifically at both the indoor and

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<sup>410</sup> Michael and Hirst, ‘Establishing the “Rule of Kindness”, p. 166.

<sup>411</sup> Davies, “Of all the Maladies”.

<sup>412</sup> *Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor*, (London: Bradbury and Evans, 1844), p. 49.

<sup>413</sup> *Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor*, p. 46.

<sup>414</sup> *Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor*, p. 52.

<sup>415</sup> *Fifteenth Report of the Commissioners in Lunacy to the Lord Chancellor* (7 June, 1861), p. 3.

<sup>416</sup> Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000*, p. 9.

<sup>417</sup> Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000*, pp. 3-4.

<sup>418</sup> I will investigate communication in treatment in detail in the next section in light of a negotiating relationship between core and periphery in implementing medical change.

<sup>419</sup> Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000*, p. 3.



outdoor spaces of the system of *cymorth* to examine how Welsh representations of mania depicted the socio-spatial implications of greater social proximity leading to greater visibility of mental illness within communities, drawing from the work of Parr, Philo, and Burns.<sup>420</sup> Moreover, this section will argue that Welsh representations were mostly sympathetic towards patients, on the basis that patients were considered unable to improve their circumstances due to a lack of accessible institutional care.

An article entitled ‘Insanity in Wales’, written by Samuel Hitch, Resident Physician of the Lunatic Asylum for the county of Gloucester, highlighted the problems with Wales’s system of *cymorth*. Hitch was the founder of The Association of Medical Officers of Asylums and Hospitals of the Insane, now known as The Royal College of Psychiatrists. Founded in 1841, he began the plans for the association in 1841 with a circular letter to twenty asylums and hospitals in England, eleven in Ireland, and seven in Scotland. The association’s objective was to improve the treatment of the insane by communicating experiences between physicians.<sup>421</sup> Hitch’s investigation of the treatment of insanity in Wales therefore had the weight of the association behind it. Taking a consensus of the availability of care in Wales would also appear to have been influenced by the lack of institutions available in Wales to invite to join the association, and his own experience of treating Welsh patients sent across the border to Gloucester. Michael’s and Hirst’s discussion of Hitch’s inquiries points out that they were requested by the Home Secretary, indicating wider concern about the situation in Wales.<sup>422</sup> Furthermore, his inquiries’ impact was demonstrated by Hitch’s contribution to the *Supplemental Report of the Metropolitan Commissioners in Lunacy, relative to the General Condition of the Insane in Wales*, presented to the Lord Chancellor in 1844.<sup>423</sup> This report was supplemental to the full parliamentary report of 1844, where initial inquiries into Welsh systems of care revealed the ‘very destitute and neglected state of the insane’.<sup>424</sup> Consequently, Commissioners in Lunacy announced further ‘special inquiries’ in Wales.<sup>425</sup>

The article, originally addressed to the Editor of *The Times*, and republished in the *North Wales Chronicle and Advertiser for the Principality* in 1842, discussed Hitch’s visit to the North Counties of Wales, drawing attention to the different circumstances of treatment.

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<sup>420</sup> Parr, Philo and Burns, ‘Social Geographies of Rural Mental Health’.

<sup>421</sup> GB 2087 Royal College of Psychiatrists Records.

<sup>422</sup> Michael and Hirst, ‘Establishing the “Rule of Kindness”’, p. 165.

<sup>423</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 8.

<sup>424</sup> *Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor*, p. 199.

<sup>425</sup> *Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor*, p. 203.

Visiting Anglesey, Carnarvon, Denbigh, Flint, Merioneth, and Montgomery, Hitch 'sought information on the state of the insane poor', and highlighted the contrast in institutional care between Wales and England.<sup>426</sup> Taking a consensus of the insane poor in these counties, Hitch found that out of the 654 people, 300 were being cared for by relatives or neighbours. In addition, 303 were 'living with strangers', described by Hitch as 'farmed out to these at various weekly sums, accordingly to the degree of utility they could be to their respective masters', suggesting that the insane poor in these circumstances were treated as commodities rather than taken in for care. A significantly smaller group of 32 resided in workhouses. Just 19 were receiving institutional treatment, and all had been sent across the border to English asylums.<sup>427</sup>

The different spaces of *cymorth* show a complex relationship of inclusion and exclusion for people with mental illnesses in Wales. Hitch's article drew attention to the different spaces of care and the movement between the indoor and outdoor. He was concerned by the insane being left to 'roam uncontrolled about the country', describing the 'frightful exhibition of the demented amongst our Welsh neighbours'.<sup>428</sup> Looking to indoor spaces, Hitch was also concerned with the 'severe restriction' of pauper lunatics by their caregivers, noting that those deemed 'unsafe to the public and themselves' would be 'chained to the wall or the floor'.<sup>429</sup> He described cases where pauper lunatics were confined to their chamber with 'their food and clothing supplied to them through some narrow opening', and those who, confined to the outhouse, enjoyed only 'the society of smaller animals'.<sup>430</sup> The reluctance to part with relatives by sending them to institutions across the border derived from a combination of concern about expense, language, and distance. In their study of inclusion and exclusion of people with mental illnesses in rural areas, specifically in the Scottish Highlands, Parr, Philo, and Burns argue that 'spatial proximity' in urban areas 'does not necessarily beget social proximity', and in the same way, 'social proximity' in rural areas 'is itself no guarantee of festering deeper inclusionary relations' with those people viewed as 'different' or 'deviant' because of mental health problems.<sup>431</sup> In areas with greater social proximity, they identified the consequent issue of greater visibility of people with mental illnesses.<sup>432</sup> As a result, they detected tensions between

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<sup>426</sup> Samuel Hitch, 'Insanity in Wales', *North Wales Chronicle and Advertiser for the Principality* (18<sup>th</sup> of October, 1842) p. 2.

<sup>427</sup> Hitch, 'Insanity in Wales', p. 2.

<sup>428</sup> Hitch, 'Insanity in Wales', p. 2.

<sup>429</sup> Hitch, 'Insanity in Wales', p. 2.

<sup>430</sup> Hitch, 'Insanity in Wales', p. 2.

<sup>431</sup> Parr, Philo and Burns, 'Social Geographies of Rural Mental Health', p. 414.

<sup>432</sup> Parr, Philo and Burns, 'Social Geographies of Rural Mental Health', p. 413.

the ‘intense pressures of caring obligations [...] and the highly visible proximate horror or rural “madness” or mental illness’.<sup>433</sup> Hitch’s description of the spaces of *cymorth* indicated this relationship between duties of care and anxieties about behaviours associated with mental ill health, showing concern for both the presence of mental illness without supervision in communities, as well as the method of domestic bodily restraint for the sake of supervising and confining the unwell.

Reports like Hitch’s pointed to differences in the Welsh provision of psychiatric treatment. Differences can also be drawn out of the attitudes conveyed in reports towards people living with mania in Wales in comparison with the cases discussed in previous chapters. Despite anxieties about visibility in community spaces, representations of mania in Wales were mostly sympathetic because those suffering were unable to access suitable care, and were therefore perceived as powerless to improve their circumstances. An article written by R. Lloyd Williams and published in the *North Wales Chronicle and Advertiser for the Principality* sympathetically discussed cases where injury could have been avoided if suitable asylum care was available, advocating for asylums to be built across Wales. An influential physician in North Wales, R. Lloyd Williams worked closely with the Commissioners in Lunacy to open the North Wales Lunatic Asylum and would become the first visiting physician of the institution.<sup>434</sup> During the commissioners’ investigations into psychiatric care in Wales, Williams would act as an interpreter, and was instrumental both in the plans for the asylum and as a voice to influence a change of views in Wales about the system of *cymorth*.<sup>435</sup> The importance of Williams’s role, as well as the influence of this article, was further demonstrated by its inclusion in the original parliamentary report of 1844, where it was used as a means of justification for further inquiries in Wales.<sup>436</sup>

Published in 1844, the year building began on the asylum, ‘Suggestions of the Commissioners in Lunacy’ was a piece drawn from reports by Williams and the Commissioners in Lunacy. One case saw a woman confined by her neighbour, ‘tied down in bed’. She ‘made violent struggles to get away’, and was consequently injured as she ‘fractured her head’ when falling down the stairs.<sup>437</sup> Another case addressed the issue of bodily health and

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<sup>433</sup> Parr, Philo and Burns, ‘Social Geographies of Rural Mental Health’, p. 414.

<sup>434</sup> *The First Annual Report of the North Wales Lunatic Asylum* (Denbigh: Thomas Gee, 1849).

<sup>435</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*.

<sup>436</sup> *Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor*, pp. 201-202.

<sup>437</sup> R. Lloyd Williams, ‘Suggestions of the Commissioners in Lunacy’, *North Wales Chronicle and Advertiser for the Principality* (16 July, 1844), p. 3

hygiene, describing a man who was ‘once a student of Oxford’ being ‘confined in a small room, unshaved and uncleaned for nearly twenty years’.<sup>438</sup> The inclusion of the patient’s educational background would suggest an attempt to demonstrate social value, adding to the sympathetic portrayal by emphasising a loss of potential because of his lack of access to institutional treatment. Whereas representations in Chapter Two showed male patients slipping from social status into animalistic depictions, this portrayal retains the social standing of the patient, suggesting his social role could have been restored with what Williams and the commissioners viewed as adequate practices of care. Both cases were illustrated with sympathy to represent the value of institutional care, suggesting that the female patient would have been free from harm, and the male patient could have reclaimed his prospects in education.

Sympathetic portrayals extended to cases of violence as a result of mania. A case of a murder in an article in the *Cambrian Quarterly Magazine and Celtic Repertory* in 1844 described a father who had murdered his four young children. The article included a graphic description of the aftermath of the violence: ‘the youngest was found in a pan of water, with its heels in the air, and the other three upstairs with their skulls fractured’.<sup>439</sup> However, despite his violence, the description of the father is sympathetic. ‘Three medical men’ quoted in the article emphasised the fact that he was suffering from mania, his delusion meaning ‘he was induced to believe that the dreadful act in question was praiseworthy, and not a crime’.<sup>440</sup> The father was quoted as stating ‘I am guilty in the eyes of man, but not of God’, and ‘I killed them to put them out of their misery poor things’.<sup>441</sup> The article also emphasised that he was acquitted of the crime on the basis of his insanity.<sup>442</sup> Despite the violence in his actions, this representation was sympathetic because suitable asylum treatment was not available for him. With only his wife to treat him in a domestic care setting, in her ‘temporary absence’ he had been able to ‘murder them all’.<sup>443</sup>

A similar depiction was given in a case of self-violence. Published in the *North Wales Chronicle and Advertiser for the Principality* in 1842, two years before building began on the North Wales Lunatic Asylum, an article entitled ‘The Lunatic Asylum Question’ discussed the case of W.L. who, ‘in a fit of mania, inflicted very extensive injuries upon his person’, some

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<sup>438</sup> Williams, ‘Suggestions of the Commissioners in Lunacy’, p. 3.

<sup>439</sup> *Cambrian Quarterly Magazine and Celtic Repertory*, ‘Murders’ (10 August, 1844), p. 1.

<sup>440</sup> *Cambrian Quarterly Magazine and Celtic Repertory*, ‘Murders’, p. 1.

<sup>441</sup> *Cambrian Quarterly Magazine and Celtic Repertory*, ‘Murders’, p. 1.

<sup>442</sup> *Cambrian Quarterly Magazine and Celtic Repertory*, ‘Murders’, p. 1.

<sup>443</sup> *Cambrian Quarterly Magazine and Celtic Repertory*, ‘Murders’, p. 1.

of which ‘he will suffer for the rest of his life’.<sup>444</sup> The article noted that it is ‘painful to reflect’ that he ‘had been a lunatic for some time antecedent to the receipt of his injuries’.<sup>445</sup> Advocating for asylum care, the article suggested, ‘had he been confined to an asylum this might have been avoided’, because mania can have a ‘very rapid cure at asylum’.<sup>446</sup> Like in the previous case, the article was sympathetic towards the patient’s violence, focusing instead on the need for institutional care by stating that, left to roam with the ‘periodical’ nature of mania, with ‘no coercive measures’ provided by the parish, the patient was ‘allowed to act as his madness directs him’.<sup>447</sup> In addition to self-injury, the article described a case of neglect by a caregiver, in which a combination of restraint and a lack of food meant that a man ‘was left to die in a ditch by his daughter’.<sup>448</sup>

Similar attitudes towards mania were present in literary texts in this period. An anonymously authored short story from Welsh periodical *The Cambrian Quarterly Magazine and Celtic Repertory*, ‘Adventures of a Welsh Medical Student’, told the story of a Welsh medical student training in England, who returned to Wales for a visit. Written in 1832 and with notes similar to a case history, it could be among the serial stories inspired by Warren’s *Passages from the Diary of a Late Physician*. In this second instalment of the three-part series, the medical student comes across a ‘maniac maid’.<sup>449</sup> Like the cases discussed in the reports of commissioners and physicians, the maid shows the risk of self-injury, ‘tearing her hair [...] in desperation’ (p. 325). However, unlike the aggressive behaviour of M in ‘The Spectre-Smitten’ from *Passages from the Diary of a Late Physician* as discussed in Chapter One, she is ‘wailing [...] in distress’, creating the image of someone calling for help. (p. 325). The initial depiction of maid is unthreatening: in ‘her frenzy’ she is described as still ‘appear[ing] beautiful’ (p. 325).

In the same way as Warren’s text, the depictions of mania in this short story are like the observations seen in patient cases. Observations in cases of mania in institutions outside of

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<sup>444</sup> Lewis Jones ‘The Lunatic Asylum Question’, *North Wales Chronicle and Advertiser for the Principality* (May 21, 1844), p. 1.

<sup>445</sup> Jones ‘The Lunatic Asylum Question’, p. 1.

<sup>446</sup> Jones ‘The Lunatic Asylum Question’, p. 1.

<sup>447</sup> Jones ‘The Lunatic Asylum Question’, p. 1.

<sup>448</sup> Jones ‘The Lunatic Asylum Question’, p. 1.

<sup>449</sup> *Cambrian Quarterly Magazine and Celtic Repertory* ‘Adventures of a Medical Student, Founded on Fact’, 14 (1832), pp. 324-34 (p. 324). All further references are to this edition and are given parenthetically in the body of the text.

Wales<sup>450</sup> included A.H., admitted in 1830, who was ‘subject to alternate highness and lowness of spirits’, marked by ‘want of sleep, restlessness, violent language and actions, dislike of friends and various delusions’.<sup>451</sup> The case of J.F., admitted in 1832, recorded ‘gloomy forebodings’, ‘fears’, and that he had ‘acted violently to others’.<sup>452</sup> His ill health was attributed to ‘having lost a son and daughter’, since which he had ‘never been in the right mind’.<sup>453</sup> M.A., admitted in 1838, ‘exhibited considerable irregularity of spirits’, and believed ‘she was an object of hatred to others around her’.<sup>454</sup> Her behaviour included being destructive by ‘destroying her clothes’, ‘pull[ing] up everything she can lay her hands on in the garden’, as well as having ‘threatened violence’ and ‘struck her friends’.<sup>455</sup>

In addition to mood states and behaviours, patient case records traced changes in behaviours during progress towards recovery and periods of remission. The case of E.M., admitted in 1842, recorded that she ‘sleeps little’, ‘wanders about’, ‘raves on various subjects’ including a belief that ‘her late husband’ was still ‘alive’, and attempted to cut the throat of a young girl’.<sup>456</sup> Her progress towards recovery was recorded as a change to being able to answer questions ‘relevantly’ and to talk ‘quite coherently’.<sup>457</sup> The case of J.T., admitted in 1842, recorded that she ‘raves incoherently on all subjects’ and that she ‘talks very incoherently and answers questions irrelevantly’.<sup>458</sup> Her progress towards recovery was similarly described as a restoration of coherence and recognition of her illness – that she instead ‘talks and answers questions more relevantly’ with her ‘mind rational’, and that she was able to ‘recollect the state she was in on admission’.<sup>459</sup> Lucid intervals were often recorded in cases of mania, with patient records noting the number of the attack and recording whether there had been periods of remission between attacks.<sup>460</sup> For example, the case of E.M., discussed above, noted that she had her first attack in 1815, and had been in the asylum ‘8 times for succeeding attacks’, with remissions recorded in between, the case of A.D., admitted in 1842, noted that she had since

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<sup>450</sup> The following cases are from Gartnavel Royal Asylum in Glasgow. I have used these cases as examples because the North Wales Lunatic Asylum was not opened until after the publication of this short story. I will analyse cases from the North Wales Lunatic Asylum in the final section of this chapter.

<sup>451</sup> HB13/5/12, p. 34.

<sup>452</sup> HB13/5/21, p. 231.

<sup>453</sup> HB13/5/21, p. 231.

<sup>454</sup> HB13/5/11, pp. 79-80.

<sup>455</sup> HB13/5/11, pp. 79-80.

<sup>456</sup> HB13/5/15, p. 27

<sup>457</sup> HB13/5/15, p. 27

<sup>458</sup> HB13/5/15, p. 9.

<sup>459</sup> HB13/5/15, p. 9.

<sup>460</sup> *Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor*, p. 103.

‘1829 [...] been six times in the asylum’ and was experiencing her seventh attack of mania, and C.M., admitted in 1838, was recorded as having ‘lucid intervals each second day’.<sup>461</sup>

Like in patient cases, the maid experiences a ‘lucid interval’ (p. 325). This allows her to recount her experience. Crucially, this period of lucidity is achieved by being moved to a medical space and communicating with a physician. It is in this space of treatment that she is able to coherently describe her delusion and recognise her insanity. Her ability to recognise features of her mental ill health and speak coherently tie to ideas about recovery, as discussed in Chapter Two in the context of Baillarger’s work, which claimed that patients could be considered cured even if their symptoms persisted, as long as they could recognise them as features of ill health. The short story emphasises the importance of adequate medical treatment by showing these signs of recovery after the maid is moved into a medical space.

The portrayal of the maid’s experience begins sympathetically by describing the losses that led to her illness. She suffered heartbreak when the man she loved ‘bled and died in his country’s cause’ (p. 328). Subsequently, she also suffered the loss of both her mother and father, leaving her an orphan (p. 329). Like in patient cases, her experience shows the spectrum of emotion in nineteenth-century mania, beginning with low mood – she describes ‘a dark, gloomy sullenness on the lakes’, that the ‘flowers no longer bloom’, and that ‘the birds have ceased to sing’ (p. 329). The so far unthreatening and vulnerable depiction of the maid makes her sudden desire for violence all the more striking. In ‘suddenly meeting with [her] parents’ grave’, she ‘formed a most dreadful and diabolical project, of murdering the individual who has caused all [their] misery’ (p. 330). She discusses the features of her madness, stating that ‘cunning and malice’ were ‘almost the only features of mind left me’ (p. 330). Upon approaching her sleeping intended victim, she sees ‘an infant child in innocent sleep rested in his arms’ (p. 332). Initially, this spurs her on as she ‘grinned with demoniacal delight’, ‘raised the weapon’, and stated, ‘they whom most you love shall shriek upon your mangled corpse’ (p. 333). She sees the child as a symbol that her ‘prayers to the Almighty’ for revenge have been answered (p. 333). It is only as the child ‘seemed to clasp [his father] more firmly’ in ‘sympathy for its parent’s safety’ that the maid is unnerved, and becomes ‘powerless’ to fulfil her violent intentions (p. 333). She leaves her intended victim, returning to the countryside.

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<sup>461</sup> HB13/5/15, p. 27; HB13/5/15, p. 11; HB12/5/11, p. 93.

The representation of mania in ‘Adventures of a Welsh Medical Student’ illustrates anxieties about the presence of mania in community spaces and the need for adequate psychiatric treatment. Initially unthreatening, the maid’s alternation to violence as an exacerbation of her ill health suggests a danger in the system of *cymorth* to the wider community through individuals with mania being left without access to treatment. As with ‘The Spectre-Smitten’ and ‘The Murders in the Rue Morgue’, the representation of the maid becomes wild with her aggression. However, her portrayal is still primarily sympathetic. Despite her violence, the focus of the short story is the impact of being without institutional treatment. This is achieved by showing the potential for her treatment, which is illustrated as she is discovered by the medical student, and able to recount and recognise the symptoms of her illness because of the psychiatric care she receives. Like the reports of commissioners and physicians, as well as local newspaper reports of cases, this literary depiction is sympathetic on the basis that the system of *cymorth* is not sufficient to treat symptoms of mania, rendering patients helpless to improve their circumstances due to the lack of availability of institutional care.

**Communication in the Treatment of Mania: “siarada iaith dy fam, gwnai di” [won’t you speak your mother tongue]**

Sympathetic representations were also seen in discussions about communication in treatment. In addition to the high cost of sending the insane poor to English asylums, a significant factor in the decision to refrain from asylum treatment was the absence of Welsh-medium care and the ineffectual nature of English-medium treatment for Welsh-speaking patients. The early nineteenth century saw attempts to eradicate the Welsh language in areas such as education; however, Commissioners in Lunacy and English physicians were among those advocating for the use of the Welsh-language in medical treatment because of the integral role of communication in treating symptoms of mania.<sup>462</sup> Michael’s and Hirst’s important work on institutional changes in Wales notes that the successful implementation of the North Wales Lunatic Asylum was ‘remarkable’ in the context of fierce resistance to the New Poor Law System.<sup>463</sup> In reaction to the resistance, they explain how The Commission Inquiry for South Wales, which was ‘appointed in the wake of the Rebecca Riots to investigate the effects of the

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<sup>462</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 17.

<sup>463</sup> Michael and Hirst, ‘Establishing the “Rule of Kindness”’, p. 165.



1834 Poor Law Amendment Act', was disparaging about the language of Wales, connecting 'the low standard of educational provision to the obstacle represented by the Welsh language'.<sup>464</sup> In contrast, plans for the North Wales Lunatic Asylum recognised the importance of Welsh-medium treatment for effective and accessible care.

Drawing from Waddington's essay about the importance of regional analysis in the medical humanities, as well as the work of Michael and Hirst, this section will argue that the concern for Welsh-medium treatment as crucial for accessible institutional care in Wales is a significant example of the non-linear relationship between core and periphery.<sup>465</sup> This section will analyse the negotiating relationship between core and periphery in the Welsh transition from *cymorth* to institutional care, arguing that institutional care was not simply imposed by the core, but adapted in dialogue between core and periphery through the Commissioners in Lunacy, English physicians, and Welsh physicians, to ensure its suitability for Welsh patient care. In addition, this section will analyse tensions between core and periphery in literary representations of medical treatment in the context of mania and communication.

While writing about his experience treating Welsh individuals as Resident Physician of the psychiatric institution in Gloucester, Hitch additionally discussed the issue of English-medium treatment for Welsh patients with mania. He stated that English-medium treatment could make the patient's insanity worse, arguing that the Welshman was 'submitted to the most refined of modern cruelties' in an English asylum, 'by being doomed to an imprisonment amongst strange people' with whom he was 'prohibited from holding communion'.<sup>466</sup> As a result, he stated that the 'Welchman is the most turbulent patient whenever he happens to become an inmate', because he became 'irritated' when 'appealed to by sounds he cannot comprehend' and was 'harassed by wants which he cannot make known'.<sup>467</sup> In the context of debates about insanity, Hitch stated that the 'moral humane treatment is in vain', because the patient was already 'suspicious' because of the nature of the illness, and could not understand the directions given to him.<sup>468</sup> The patient therefore 'resents [medical staff] with violence, and opposes them on the principle of self-defence'.<sup>469</sup>

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<sup>464</sup> Michael and Hirst, 'Establishing the "Rule of Kindness"', p. 167.

<sup>465</sup> Waddington, 'Thinking Regionally', p. 52.

<sup>466</sup> Hitch, 'Insanity in Wales', p. 2.

<sup>467</sup> Hitch, 'Insanity in Wales', p. 2.

<sup>468</sup> Hitch, 'Insanity in Wales', p. 2.

<sup>469</sup> Hitch, 'Insanity in Wales', p. 2.

The issue of Welsh-medium treatment was also addressed by the Commissioners in Lunacy. The article ‘Suggestions of the Commissioners in Lunacy’, which was included in the original parliamentary report of 1844, recognised that ‘the state of the Welsh lunatic in general is the most pitiable and miserable’, because of having ‘no place of protection in his own country’.<sup>470</sup> The article described the need for Welsh-medium treatment, noting that ‘no real good can be effected’ in an English asylum for a Welsh-speaking patient.<sup>471</sup> Referring to the case of a woman ‘under great excitement from the mischievous teasing of a crowd of boys and girls’, the article noted that she had previously been an inmate in an English asylum, but that treatment was ineffective without ‘her native tongue’.<sup>472</sup> To prevent ‘the poor creature from inflicting injury upon herself and others’, she was ‘chained by her husband in a cottage for many weeks’.<sup>473</sup> Similarly, Hitch claimed that English-medium treatment was not only ineffective, but potentially harmful, stating that the Welsh patient ‘should leave at least no better, and often worse, than when he entered’. To show the benefits of Welsh-medium treatment, he provided the example of a case where a Welsh patient was treated successfully, stating ‘his own language’ created for the ‘Welsh lunatic comfort’ and that he therefore ‘made progress towards recovery’.<sup>474</sup> Despite being previously ‘violent and dangerous’, there was ‘tranquillity’ on hearing ‘his native tongue’.<sup>475</sup>

A letter in the *North Wales Chronicle and Advertiser for the Principality* in 1844, written by Lewis Jones, highlighted the importance of communication in treating symptoms of psychosis, and therefore the need for Welsh-medium communication in treating symptoms of mania:

Few medical men, at present age, at all acquainted with mental diseases, would maintain that an interchange of ideas in the same language is not almost pre-requisite to the permanent removal of the lunatic’s hallucination.<sup>476</sup>

Jones claimed that the ability for a physician to ‘trace by converse and observation’ the nature of delusions and hallucinations was vital to aiding the patient’s recognition of their illness ‘for

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<sup>470</sup> Williams, ‘Suggestions of the Commissioners in Lunacy’, p. 3.

<sup>471</sup> Williams, ‘Suggestions of the Commissioners in Lunacy’, p. 3.

<sup>472</sup> Williams, ‘Suggestions of the Commissioners in Lunacy’, p. 3.

<sup>473</sup> Williams, ‘Suggestions of the Commissioners in Lunacy’, p. 3.

<sup>474</sup> Hitch, ‘Insanity in Wales’, p. 2.

<sup>475</sup> Hitch, ‘Insanity in Wales’, p. 2. In their study, Michael and Hirst explain that Hitch’s examples of the success of Welsh-medium treatment were made possible by a Welsh Chaplain at Gloucester Asylum, Mr Evans, who aided Hitch as a translator. See: Michael and Hirst, ‘Establishing the “Rule of Kindness”’, p. 168.

<sup>476</sup> Jones ‘The Lunatic Asylum Question’, p. 1.

a rapid and permanent cure of insanity'.<sup>477</sup> The importance of this letter was demonstrated by its publication at the request of Mr. Clough, the secretary of the Denbighshire Lunatic Asylum Fund. The publication of the letter shows that accessible communication was a primary consideration in plans for the asylum, as well as being used as a means for justifying its expense.

As discussed earlier, the Commissioners in Lunacy's inquiries led to the opening of the North Wales Lunatic Asylum. To make their inquiries, they were accompanied by Welsh-speaking physician, R. Lloyd Williams, who I discussed in the previous section. As well as supporting the inquiries as a physician, Williams was their translator, indicating a mediated dialogue between the inquirers and the people visited. In their *Supplemental Report*, the commissioners highlighted the reluctance of family members to part with their insane relatives because of English-medium treatment across the border. Their report stated that this reluctance would be 'greatly lessened, and in time entirely removed, were Asylums established in North Wales', as this would create a medical space in which 'patients who speak and think in Welsh, could be treated and attended by those acquainted with their habits and language, and capable of ascertaining their wants'.<sup>478</sup> Despite the attempts to limit and eradicate the use of the Welsh in other institutions such as education, the negotiating relationship here between core and periphery shows the Commissioners in Lunacy, as core, recognising the benefits of the Welsh language in psychiatric care and therefore advocating for its use.

Opening four years later in 1848, the North Wales Lunatic Asylum showed its dedication to Welsh-medium treatment to ensure accessible communication between physician and patient. The first rule stipulated that: 'All of the Officers of this Institution whether Male or Female and whether Medical or otherwise are required to have a thorough colloquial knowledge of the Welsh language'.<sup>479</sup> Williams, who continued to advocate for asylum care and Welsh-medium treatment following the inquiries, was appointed the first visiting physician. Moreover, reports from the Commissioners in Lunacy into the conditions of care in the asylum reaffirm their support for Welsh-medium treatment, stating: 'We are glad to learn

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<sup>477</sup> Jones 'The Lunatic Asylum Question', p. 1.

<sup>478</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 16.

<sup>479</sup> Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000*, p. 58.

that all attendants speak Welsh.’<sup>480</sup> It was also common for patient case records to include the note ‘Welsh only’ to indicate requirements in treatment.<sup>481</sup>

The dialogue between core and periphery in the inquiries process, plans for the asylum, and supervision of the asylum’s accessibility, demonstrates a negotiation between the system of institutional care established by the core and its suitable adaption for periphery. Waddington situated the value of regional analysis in contesting the attitudes of whiggism that see an active core implementing changes on a passive periphery.<sup>482</sup> In the case of establishing institutional psychiatric care in Wales, the rejection of the Welsh language seen in other aspects of society was reversed, the use of Welsh instead encouraged and praised because of the importance of communication for treating symptoms of mania.

Tensions between core and periphery were also depicted in literary representations of mania, communication, and medical treatment. Chapter Two analysed animalistic representations of patients with mania as a product of treatment focused on restraint, limiting activity, and limiting diet. Animalistic representations were partly grounded in views about an individual with mania’s ability to communicate, tied to ideas about orangutans and speech. Like the animalistic representations discussed in Chapter Two, depictions of communication in the treatment of mania were also tied to animalistic behaviour in Welsh examples. Like Edgar Allan Poe’s, ‘The Murders in the Rue Morgue’, Welsh examples also explored the possibility, or impossibility, for communication in the boundary between human and animal communication. However, Cymro Bach’s Welsh-language short story ‘The History of the Man in the Moon’ [*Hanes y Dyn yn y Lleuad*], published in *Seren Gomer* in 1830, explored communication and mania with a focus on the medium of treatment, and specifically the inaccessibility of English-medium treatment.

‘The History of the Man in the Moon’ is a short story about a newly trained Welsh physician who spoke English to his Welsh patients. In addition to a lack of psychiatric hospitals, there were also no medical schools in Wales in this period. Medical students therefore had to study in England. The short story highlights its focus on language through plays on words throughout. The physician is named as the man in the moon, suggesting that he is some way alien. However, the play between the words *Lloer*, moon, and *Lloegr*, England,

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<sup>480</sup> *The Eleventh Annual Report of the North Wales Lunatic Asylum* (Denbigh: Thomas Gee, 1860), p. 13.

<sup>481</sup> HB13/5.

<sup>482</sup> Waddington, ‘Thinking Regionally’.

suggest that this foreignness is more associated with having travelled to England to study medicine and communicating in English upon his return.<sup>483</sup> He is met with resistance as he greets the crowd in English, with one person challenging him ‘won’t you speak your mother-tongue’ [*siarada iaith dy fam, gwnai di*], suggesting immediate resistance to English-language treatment (p. 207).

The short story then specifically refers to psychiatric medical care through the depiction of the physician with symptoms associated with mania. The community describe him as showing ‘mania’ [*gwallgofrwydd*], and the illustration of his behaviour aligns with observations in case records (p. 207). Patient case records<sup>484</sup> included J.B., admitted in 1838, characterised by ‘occasional violence’, ‘raving’ and ‘loud stamping with her feet’.<sup>485</sup> The case of E.C., admitted in 1842, was ‘excited’, noted that she was ‘destructive to furniture’, and that she ‘raves on various subjects’ including the grandiose belief that ‘the whole earth belongs to her’.<sup>486</sup> J.P., admitted in 1842, was ‘exceedingly violent in her temper’, ‘brandishes about knives’, ‘tears clothes, breaks windows’, destroys furniture’, and ‘attempted to leap out of a window’.<sup>487</sup> Her behaviour was attributed to the delusion she ‘imagines that numerous individuals have conspired to break her peace of mind and to destroy her.’<sup>488</sup> As the crowd antagonise him, the physician’s behaviour similarly becomes ‘terribly angry’ [*ffromi yn aruthr*] and he starts ‘jumping around’ [*ysboncio oddiamgylch*], much like M in ‘The Spectre-Smitten’, the orangutan in ‘The Murders in the Rue Morgue’, and observations in patient cases (p. 207). The protagonist of the short story connects the doctor’s behaviour to someone who is ‘manic’ [*gwallgof*] but unaware of their own madness (p. 207).

The physician offers ‘medical treatment to people and animals’ [*cynghorion meddygol i ddynion ac anifeiliaid*] (p. 207). There is an emphasis on communication through an illustration of the individual sound each animal makes to communicate: the pigs grunt [*rhochian*], the cows bleat [*brefu*], and the horses ‘complain to the best of their ability’ [*cwyno gorau medrent*] (p. 207). All of these animals fit in the context of Welsh farming communities.

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<sup>483</sup> Cymro Bach, ‘Hanes y Dyn yn y Lleuad’, *Seren Gomer* (1830), pp. 206-09 (p. 206). All further references are to this edition and are given parenthetically in the body of the text.

<sup>484</sup> Like my analysis of ‘Adventures of a Welsh Medical Student’ (1831), the case records examined concurrently with ‘The History of the Man in the Moon’ (1830) are from Gartnavel Royal Hospital, because the North Wales Lunatic Asylum had yet to open.

<sup>485</sup> HB13/5/11, p. 15.

<sup>486</sup> HB13/5/15, p. 57.

<sup>487</sup> HB13/5/15, p. 10.

<sup>488</sup> HB13/5/15, p. 10.

However, in his anger, and in an attempt to gain authority, the physician challenges the crowd with a grandiose view of his abilities, saying that there is ‘no one of his kind in the world that can medically treat the illnesses of animals of all kinds, especially the orangutan’ [*nad oedd mo’i fath yn y byd i feddyginiaethu doluriau anifeiliaid o bob math, yn enwedig yr ourang outang*] (p. 207). The specific mention of the orangutan amongst animals that otherwise fit into the context of Welsh agriculture, and amid the description of the physician’s behaviour, is striking. Based on the views of orangutans discussed in Chapter Two, which saw the possibility of their potential for speak amid ideas that they were unwilling to do so, the physician’s connection to the orangutan suggests a subversion by the crowd of medical authority, rendering him incapable of treating and unwell himself, because of his refusal to speak to them in Welsh.

Despite attempts to convince them of his abilities, the community remains unconvinced, and the physician’s behaviour associated with mania worsens, so that both the offer of English-medium treatment and the physician’s own condition render his claims about ability untrue as he is incapable of providing treatment. Moreover, an absence of medical schools in Wales meant there were fewer physicians, leading to an issue with ‘quacks’, or untrained physicians. In addition to the crowd challenging him, the physician is mocked by the ducks, following after him with ‘*quack quack, quaaak*’, relating perhaps to both the lack of Welsh training, and the contempt for the physician’s unwillingness to provide accessible Welsh-medium treatment (p. 207).

Similar to representations discussed in Chapter Two, the orangutan is depicted in the context of communication and mania specifically. ‘The History of the Man in the Moon’ conveys a view of English-medium treatment as ineffective as well as indicating contempt towards English-medium care in Welsh communities. The short story subverts the power dynamic between physician and patient based on accessibility of treatment, reversing the roles so that the physician is animalistic and presenting in behaviours associated with mania because of practising through the medium of English. The physician is the one who becomes animalistic, incoherent, and irrational, while the patients ask him to speak in Welsh. Unlike the examples in Chapter Two, the use of the orangutan is to explore the boundaries of communication between different languages. The physician is represented as incapable of effective communication because of refusing to speak Welsh, and therefore regresses into symptoms of mania represented alongside animalistic behaviour.

The power dynamic of medical authority and of core and periphery in medical practice, in relation to the Welsh physician's English training, is reversed. The physician fails in his professional role – failing to treat his patients and becoming unwell himself – as a consequence of his refusal to provide Welsh-medium treatment in a Welsh community. In contrast, the implementation of institutional care in the North Wales Lunatic Asylum demonstrated negotiation between core and periphery through advocacy for Welsh-medium treatment. The previous lack of accessible treatment was discussed with sympathy for patients.

### **Leaving Wonderland: Tensions in the Transition from *Cymorth* to Institutional Treatment**

Wales's transition from the system of *cymorth* to institutional treatment in the mid nineteenth century meant both medical and literary texts scrutinised different spaces of psychiatric treatment, interrogating boundaries between indoor and outdoor, mother tongue and alien communication, caring responsibilities and anxieties about the visibility of mental illness, and the relationship between core and periphery. To build on an examination of representations of mania in different spaces, the final section of this chapter will investigate illustrations of mania during the transition between *cymorth* and institutional psychiatric provision. While the North Wales Lunatic Asylum opened its doors to patients in 1848, the asylum's annual reports and newspaper articles reveal a continuation of families being hesitant or unwilling to part with relatives experiencing mental ill health, and therefore a continuation of confinement within the domestic space or presence within outdoor spaces. This section will therefore interrogate whether attitudes towards mania became less sympathetic with the new accessibility of asylum care. Whilst this chapter has dealt with mostly unknown literary texts from Welsh periodical press, an examination of representations of mania in nineteenth-century Wales also allows for new analysis of Lewis Carroll's *Alice's Adventures in Wonderland* (1865). In this section, I will continue an examination of a transition in Welsh systems of care through close analysis of patient case notes and annual reports from the North Wales Lunatic Asylum, *Alice's Adventures in Wonderland*, and the Commissioners in Lunacy's *Supplemental Report*, which was co-authored by Robert Wilfred Skeffington Lutwidge, Lewis Carroll's uncle, in his role as one of two commissioners conducting additional inquiries in Wales.

*Alice's Adventures in Wonderland* has received a significant amount of critical attention. Feminist readings include Kristina Aikens's analysis of Alice's curiosity as at odds

with expectations for Victorian women, as well as respective work by Judith Little and Megan S. Lloyd viewing Alice as resisting ideals of womanhood and motherhood.<sup>489</sup> On the other hand, Carina Garland has used feminist psychoanalysis to argue that Alice's interactions with the women of Wonderland expose Carroll's misogynistic fears of adult women and female sexuality.<sup>490</sup> Flair Donglai Shi has expanded on this view, arguing against feminist readings of Alice by demonstrating her redirection into the Victorian domestic space and conformity with Victorian gender roles when leaving Wonderland.<sup>491</sup> Work by Jennifer Karlsson and Shi has also pointed out the different expectations for Victorian women and Victorian girls. Shi argues that Wonderland is 'an anti-feminist fantasy that served to fulfil Carroll's own paedophilic obsession with girlhood' as well as detailing 'his misogynistic fear towards womanhood'.<sup>492</sup>

The incoherence, violence, and disorder of *Alice's Adventures in Wonderland* has also been read through a post-colonial lens. Daniel Bivona sees Alice as a 'child-imperialist', rejecting the disorder of Wonderland and trying to apply typical Victorian rules and order.<sup>493</sup> Richard Kelly argues that Alice 'chooses not to understand' Wonderland by taking on the figure of a separate 'explorer encountering strange cultures'.<sup>494</sup> Catherine Siemann, on the other hand, analyses the Alice texts in the context of the nineteenth-century legal institution, arguing that Wonderland is 'governed according to British notions of rules and order albeit British notions presented in a distorted manner'.<sup>495</sup> Furthermore, Aihong Ren argues that the disorder of Wonderland is Carroll 'expos[ing] and challeng[ing] the power relationships of adult/child',

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<sup>489</sup> Kristina Aikens, 'How Wanderer Alice Became Warrior Alice, and Why', *Bitch Magazine*, 48.3 (2010), pp. 26-31; Judith Little, 'Liberated Alice: Dogson's Female Hero as Domestic Rebel', *Women's Studies*, 3 (1976), pp. 195-205 (p. 195); Megan S. Lloyd, 'Unruly Alice: A Feminist View of Some Adventures in Wonderland', in ed., Richard Brian Davis, *Alice in Wonderland and Philosophy: Curiouser and Curiouser* (Hoboken: Blackwell Publishing, 2010).

<sup>490</sup> Carina Garland, 'Curious Appetites: Food, Desire, Gender and Subjectivity in Lewis Carroll's Alice Texts', *The Lion and the Unicorn*, 32.1 (2008), pp. 22-39.

<sup>491</sup> Flair Donglai Shi, 'Alice's Adventures in Wonderland as an Anti-Feminist Text: Historical, Psychoanalytical and Postcolonial Perspectives', *Women: A Culture Review*, 27.2 (2016), pp. 177-201; I will return to this point in an analysis of the Duchess, Alice, and Alice's sister in the context of Victorian gender ideals in Chapter Five.

<sup>492</sup> Karlsson, 'Alice's Vacillation between Childhood and Adolescence in Lewis Carroll's *Alice's Adventures in Wonderland*'; Shi, 'Alice's Adventures in Wonderland as an Anti-Feminist Text', p. 198. For further discussion of Lewis Carroll's fondness of young girls and dislike of adult women, see: Martin Gardner, *The Annotated Alice* (New York: Bramhall House, 1960) and Robert Douglas-Fairhurst, *The Story of Alice: Lewis Carroll and the Secret History of Wonderland* (London: Harvill Secker, 2013)

<sup>493</sup> Daniel Bivona, 'Alice the Child-Imperialist and the Games of Wonderland', *Nineteenth-Century Literature*, 41.2 (1986), pp. 143-171.

<sup>494</sup> Richard Kelly, *Lewis Carroll* (Boston: Twayne Publishers, 1990)

<sup>495</sup> Catherine Siemann, 'Curiouser and Curiouser: Law in the Alice Books', *Law and Literature*, 24.3 (Fall 2012), pp. 430-455 (p. 434).



thus breaking from the tradition of Victorian children's literature as guiding children to socially acceptable behaviour.<sup>496</sup>

Franziska Kohlt's research has brought new light to the study of Carroll's Wonderland texts by connecting them to Victorian psychiatric practice. Kohlt draws this connection through a study of Carroll's relationship with his uncle, arguing that Lutwidge's role as a Commissioner in Lunacy gave Carroll an awareness of methods of treatment in Victorian asylums, as well as creating a pathway for his 'intellectual engagement' with attitudes towards pauper asylum patients.<sup>497</sup> Lutwidge held his position as Lunacy Commissioner until his death in 1873, and Kohlt argues that Carroll's diaries reveal a close-relationship with his uncle building from 1850.<sup>498</sup> This would suggest that Carroll developed a familiarity with nineteenth-century psychiatric practice, specifically through the lens of his uncle's role.

No work analysing the Wonderland texts in the context of nineteenth-century psychiatric practice has examined the connection between Lutwidge and Welsh psychiatric care. However, Lutwidge played a vital role in establishing institutional psychiatric care in Wales. He was one of the primary lunacy commissioners visiting and investigating systems of psychiatric treatment in Wales – he contributed to the section about Wales in the full parliamentary report to the Lord Chancellor in 1844, and was one of the two members of the board asked to continue special inquiries in Wales, co-authoring the *Supplemental Report* discussed throughout this chapter.<sup>499</sup> Lutwidge therefore encountered and reported on cases of patients in Wales first-hand, working closely with Williams on the campaign to open the North Wales Lunatic Asylum.<sup>500</sup> Furthermore, Lutwidge continued in his role in North Wales after the asylum opened, dealing with cases of families who still refused to send their insane relatives to institutions during the transition from *cymorth* to asylum treatment, and visiting different parts of Wales where no county asylums had been constructed.<sup>501</sup> In light of this, Carroll's

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<sup>496</sup> Aihong Ren, 'Power Struggle between the Adult and Child in *Alice's Adventures in Wonderland*', *Theory and Practice in Language Studies*, 5.8 (2015), pp. 1659-1663 (p. 1659). For further discussion about subversion of authority and child agency in Wonderland in the context of coercive communication in children's literature, see: Cătălina Bălinișteanu, 'Subversions of Authority in *Alice's Adventures in Wonderland*', *Speech and Context*, 2 (2013), pp. 69-78.

<sup>497</sup> Franziska E. Kohlt, '"The Stupidest Tea-Party in All My Life": Lewis Carroll and Victorian Psychiatric Practice', *Journal of Victorian Culture*, 21 (26 April 2016), pp. 147-167 (pp. 147-148).

<sup>498</sup> Kohlt, 'The Stupidest Tea-Party in All My Life', p. 148.

<sup>499</sup> *Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor; Supplemental Report of the Metropolitan Commissioners in Lunacy*.

<sup>500</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*.

<sup>501</sup> *The Fifth Annual Report of the North Wales Lunatic Asylum* (Denbigh: Thomas Gee, 1854), p. 11.

awareness of psychiatric treatment through the perspective of his uncle's work would almost certainly have led to a thorough knowledge of the circumstances in Wales. In addition, it is well known that Carroll had a particular interest in North Wales because of the real Alice Liddle's holiday house in Llandudno.

This section will therefore aim to draw on Kohlt's argument to expand on the analysis of Wonderland as connected to psychiatric treatment. I argue that Carroll's exploration of Victorian psychiatric practice is specifically connected to the transition from a system of *cymorth* to institutional care in Wales. Like the other literary criticism discussed above, I will analyse the manipulation of Alice's body by Carroll, the incoherence, violence, and disorder of Wonderland, and the process that allows Alice eventually to leave. To do this, I will analyse Wonderland's depiction of confinement, movement between indoor and outdoor spaces, and the violent nature of Alice's physical changes, concurrently with cases encountered by Lutwidge and recorded in the *Supplemental Report*, as well as concerns about the persistence of domestic restraint discussed by Lutwidge and Williams in the North Wales Lunatic Asylum's annual reports. Moreover, I will analyse the behaviours depicted by Wonderland's inhabitants alongside observations recorded in patient case notes in the North Wales Lunatic Asylum, to argue that Wonderland is dealing specifically with symptoms of mania in its exploration of spaces of care. The text depicts issues of inclusion and exclusion for people with mania through anxieties about the impact of behaviours on social spaces, as well as highlighting the relationship between core and periphery in establishing culturally specific care through Alice's position as outsider, making a concurrent analysis of the text with medical reports and cases valuable to a study of attitudes towards patients with mania during a transition between different systems of care.

Co-authored by Lutwidge, the *Supplemental Report* established a scrutiny of spaces of care, discussing both the indoor and outdoor spaces for patients under the system of *cymorth*. A.T. from St Asaph was one of many patients recorded as being confined in a small, locked room by relatives. Her space of restraint was described as 'a dark hole or closet', with 'the door strongly fastened by a hasp and staple'.<sup>502</sup> John Wynne, a surgeon based in St Asaph, stated for the report: 'I consider the ill-treatment she receives likely to aggravate her complaint, but I do not consider her to be in a fit state to be at large.'<sup>503</sup> This representation sets up the two spaces

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<sup>502</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 54.

<sup>503</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 54.

of *cymorth*: confined by relatives or neighbours without adequate psychiatric care, or left to ‘wander about the country in an insane state’.<sup>504</sup> The nature of the restraint is depicted as both cruel and harmful, but the report additionally demonstrates anxiety about the presence of mental illness outside of confinement, conveying tensions between responsibilities of care and fear of behaviours associated with mental ill health being unsupervised in the community. In addition to fears that those labouring under insanity might cause injuries to others, numerous cases in the *Supplemental Report* warned of the risk of self-injury or death as a result of escaping restriction or being left to roam. For example, one case in Bangor saw a man ‘addicted to wander about found drowned’.<sup>505</sup>

Cases in the *Supplemental Report* also recorded injuries caused by indoor spaces of confinement. One case had a particularly strong impact on Lutwidge and Waterfield. Many of the cases in the report were recorded across only a single paragraph. However, this case was given greater attention, and a far more extensive narrative. This single case was detailed across seven pages of the report, which suggests a similar relation of significance to the report’s authors. The case was used as a key example both in the report and for the public. Based on the publicity of the case, and because of an association between the name of the woman described in the case with a character in Wonderland, I will provide her name as opposed to only her initials: Mary Jones.

The significant impression Mary Jones’s case had on Lutwidge suggests it would be a case Carroll was made particularly aware of. Lutwidge and Waterfield recorded their initial visit to Jones, with interpreter Williams, as well as many subsequent repeat visits. In the report, they highlighted this example, wanting ‘to call the special attention of the Board to the case’ as an example of ‘atrocious cruelty’.<sup>506</sup> The ‘poor creature’ had been confined for at least fifteen years in a ‘dark and offensive room’ with ‘a bolted door’.<sup>507</sup> In addition to her restriction, Jones was unable to see outdoors, because ‘the only window was closed up by boards’, allowing ‘only a feeble glimmering of light’.<sup>508</sup> Asked whether she ‘would like to go into the air?’, the enthusiasm of her affirmative reply was demonstrated by the note, ‘although I am no Welshman, there was no mistaking this answer’.<sup>509</sup>

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<sup>504</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 26.

<sup>505</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 27.

<sup>506</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 16.

<sup>507</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 38.

<sup>508</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 38.

<sup>509</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 40.

Jones was ‘sat in a bent and crouching posture’.<sup>510</sup> The report goes on to describe the damage of this restriction:

Long and close confinement had produced in Mary Jones’s person the most frightful distortions. The chest bone protruded forwards five or six inches beyond its natural place and there was an excoriation of the parts below. The legs were bent backwards, and the knee joints were fixed and immovable. The ankles and feet also were greatly twisted and deformed.<sup>511</sup>

The report illustrated the permanent physical damage suffered by Jones as a consequence of the shape she was forced into by confinement. An interview with her mother noted that Jones was previously employed as ‘a servant in the family of the late Clerk of the Peace’, and described her as ‘free from deformity’ and ‘straight as an arrow’ prior to restriction.<sup>512</sup> Moreover, the report associated the ongoing physical consequences with sustained damage to Jones’s hopes for recovery from mental ill health. Drawing on curability, observations in the report suggest that ‘she might have been restored if only commonly treated’, and that this ‘misery’ might have been ‘spared to her’ if ‘temporary assistance from an Hospital for the Insane’ had been available.<sup>513</sup> The report drew attention to different spaces of treatment by suggesting that institutional care might have spared further mental and physical damage to this patient, allowing for potential recovery.

Jones’s case of injury was not isolated. To illustrate her treatment in the domestic space as a pattern in *cymorth*, the report directly compared her case with another, which I will again name due to its publicity and connection to a character in Wonderland, a comparison I will discuss later in this section. Like Jones, Anne Hughes’s confinement ‘did not admit her of stretching out her legs’, which therefore ‘were contracted, though not so rigidly as poor Mary Jones’s’.<sup>514</sup> The report later noted similar cases in South Wales. For example, A.A., ‘having been long kept down in a crouching posture, her knees were forced up to her chin’, meaning ‘much excoriation was caused upon her chest and stomach’.<sup>515</sup> The physical damage was to such an extent that, having died, ‘it required very considerable dissection to get her pressed

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<sup>510</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 38.

<sup>511</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 39.

<sup>512</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 39.

<sup>513</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 41-42.

<sup>514</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 44.

<sup>515</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 59.

into a coffin'.<sup>516</sup> Physical distortions as a result of confinement in indoor spaces were commonly recorded in the report, and described as evidence of both unnecessary physical injury and damage to, rather than treatment of, mental illness and hopes for recovery. Lutwidge and Waterfield's report was clear in viewing the damage as a repercussion of the spaces of care in the system of *cymorth*, and therefore arguing for the necessity of accessible institutional treatment in Wales.

Opening in 1848, as a result of the findings of Lutwidge and Waterfield's *Supplemental Report*, the North Wales Counties Lunatic Asylum in Denbigh was against the use of physical restraint in treatment. Debates about the use of bodily restraint were prominent in medical journals from the late 1830s, and, in response to circulars from the Commissioners in Lunacy, individual institutions were able to take a stance on the use or disuse of restraint and seclusion, as discussed in Chapter Two. Mania was central to debates both in favour of and against the disuse of restriction. Subsequent developments in the treatment of mania saw a change from bodily restriction and limiting diet, to a focus on open air, exercise, and plentiful nourishment. The North Wales Lunatic Asylum was clear on its position of being against the use of restraint, and in using seclusion as sparingly as possible. Williams, Lutwidge and Waterfield's translator and the first physician of the North Wales Lunatic Asylum, responded to the circular stating that, since the asylum had opened, they had 'never had cause to deviate' from the policy of 'avoiding the slightest mechanical restraint in treatment', and that 'seclusion [had] been confined to as few cases as possible' and only used for 'short periods'.<sup>517</sup>

Continuing to be involved with psychiatric care in Wales, in 1857, and then again from 1860-1862, Lutwidge completed the report of the Commissioners in Lunacy for the *Annual Report of the North Wales Counties Lunatic Asylum*. In these reports, there was a focus on the institution's stance on restraint. In 1857 Lutwidge noted that, 'mechanical restraint is never employed', and that 'two patients only [...] each only on one occasion' have 'been placed in seclusion during maniacal excitement'.<sup>518</sup> His report also reflected on indoor and outdoor spaces within institutional care. He drew attention to the use of outdoor space, noting that 'about 25 of the female patients take walks in the country weekly', that 'the great majority of the patients take exercise daily in the grounds', and that 'the 14 additional acres of land referred

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<sup>516</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 59.

<sup>517</sup> R. Lloyd Williams in 'On Non-Mechanical Restraint in the Treatment of the Insane', *Journal of Psychological Medicine and Mental Pathology*, 5.1, 1854, pp. 541-571

<sup>518</sup> *The Eighth Annual Report of the North Wales Lunatic Asylum* (Denbigh: Thomas Gee, 1857), p. 9.

to by the last Visiting Commissioners have been brought under cultivation'.<sup>519</sup> In addition, the asylum's garden was tended to by some of the male patients as a form of employment.<sup>520</sup> The report therefore outlined the perceived benefit of outdoor recreation and employment in the treatment of mental illness, when situated within the confines of a psychiatric institution.

Spaces of *cymorth* continued to be scrutinised during the transition to institutional care. After the opening of the North Wales Counties Lunatic Asylum, continued public scepticism about institutional care meant many some families were still unwilling to send their relatives to institutions for treatment. The asylum report of 1854 contained a letter, signed by Lutwidge and Williams, using the case of E.R. as an example of the necessity for greater public awareness about the benefits of asylum treatment. The letter showed frustration, stating it was 'deplorable' that 'after the repeated generous efforts made by the press, both Welsh and English' to 'diffuse useful knowledge upon the subject of insanity' that this man had been 'chained by both his legs in a miserable shed for seven long years'.<sup>521</sup> The damaging influence of his domestic confinement was recorded: 'the effect of such treatment would have been to make him worse'.<sup>522</sup> Instead, the letter advocated for the stance of non-restraint and access to open air outdoors provided in the institution: 'the appearance of the poor man was pale and pasty, like a plant long deprived of air and solar influence'.<sup>523</sup> The frustration in the letter suggests a change to less sympathetic attitudes because of the new accessibility of Welsh-medium asylum treatment.

Carroll's *Alice's Adventures in Wonderland* creates a less sympathetic literary representation of mania in community spaces, depicting the damage caused by the spaces of *cymorth* and the consequences of untreated symptoms associated with mania on social order. The text establishes its exploration of spaces of psychiatric care through movement between the indoor and outdoor. Alice's fixation on reaching the 'beautiful garden' is a key feature in *Alice's Adventures in Wonderland*.<sup>524</sup> Her confinement begins at the end of her fall into the rabbit-hole. While there are 'doors all round the hall', they are 'all locked', and Alice is left 'wondering how she was ever to get out again' (p. 7). From her place of confinement, Alice

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<sup>519</sup> *The Eighth Annual Report of the North Wales Lunatic Asylum*, p. 9.

<sup>520</sup> *The Eighth Annual Report of the North Wales Lunatic Asylum*, p. 9.

<sup>521</sup> *The Fifth Annual Report of the North Wales Lunatic Asylum*, p. 10.

<sup>522</sup> 'Extraordinary Case of False Imprisonment', *North Wales Chronicle and Advertiser for the Principality*, 1 July 1853, p. 3.

<sup>523</sup> *The Fifth Annual Report of the North Wales Lunatic Asylum*, p. 10.

<sup>524</sup> Lewis Carroll, *Alice's Adventures in Wonderland* (London: Macmillan, 2014), p. 145. All further references are to this edition and are given parenthetically in the body of the text.

longs to reach outdoor space. She is able to see out from the ‘dark hall’ to ‘the loveliest garden you ever saw’, and ‘longed’ to ‘wander about among those beds of bright flowers and those cool fountains’ (p. 8). The negative impact of confinement on Alice’s emotional state is demonstrated by her ‘shedding gallons of tears’ when she is unable to escape to outdoor space (p. 15). Her tears, which create ‘a large pool all round her, about four inches deep and reaching half down the hall’ also highlight the dangers of self-injury when patients are free to roam the landscape. Alice finds herself ‘up to her chin in salt water’, stating, ‘I wish I hadn’t cried so much! [...] I shall be punished for it now, I suppose, by being drowned in my own tears!’ (p. 20). This risk of drowning, in relation to her desperation to escape confinement and reach outside space, connects to cases of drowning and self-injury in the *Supplemental Report*.<sup>525</sup>

Like the *Supplemental Report*, Alice’s spaces of confinement also depict the potential for injury in an indoor space. Alice, like Mary Jones, faces physical distortions alongside confinement. She finds her way into ‘a little room’ in the White Rabbit’s house, where she discovers a bottle to drink from to change her size (p. 39). The description of her change is violent, causing a rapid change ‘sooner than she had expected’ so that ‘before she had drunk half the bottle’ she found ‘her head pressing against the ceiling’ (p. 39). Alice finds herself confined once again in an indoor space: ‘I hope I sha’n’t grow any more – As it is, I ca’n’t get out the door’ (p. 40). The distress caused to Alice’s body in this space of confinement risks serious injury: she ‘had to stoop her neck to save it from being broken’ (p. 39). Her physical distress appears endless as ‘she went on growing, and growing, and very soon had to kneel down on the floor’, with ‘no sort of chance of her ever getting out of the room again’ (pp. 40-41). The illustration of bodily restriction and physical consequences connect to the injuries faced in the cases of Mary Jones and Anne Hughes. In addition, Alice’s entry to the White Rabbit’s house is a result of being mistaken for his housemaid, ‘Mary Ann’ (p. 39). While there is no way to know whether the names in the reported cases influenced Carroll’s choice for the name of the White Rabbit’s housemaid, the name ‘Mary Ann’ is notable given the comparison drawn in both the *Supplemental Report* and in the press between Mary Jones’s and Anne Hughes’s cases.

Unlike Alice, Mary Jones’s view into outside space was taken away from her. The report explained that her window was boarded up because the ‘village boys’ would ‘see the

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<sup>525</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 27.

poor creature at the window calling for food'.<sup>526</sup> As a result, 'it was the custom' of the boys to feed her through the window, giving her 'meat on the prongs of a pickle, with a long handle'.<sup>527</sup> In doing this, the boys became a sign of care, providing food for Jones who was described as 'emaciated in the last degree'.<sup>528</sup> While confined in the White Rabbit's house, Alice similarly receives communication and treatment through a window. The creatures outside throw what initially appears to be 'a shower of little pebbles' through the window into the room (p. 47). However, like in the case of Jones, the pebbles are in fact food: 'Alice notices with some surprise that the pebbles were all turning into little cakes' (p. 47). Like the nourishment provided to Jones, the cakes thrown through the window to Alice are a sign of care. They allow her to shrink in size, and therefore to escape restraint. The cakes cross the boundary between indoor and outdoor, reflecting on the spaces of care under *cymorth*. By providing relief from confinement, and embodying a symbol of nourishment, the cakes mirror developments in institutional treatment which, in the North Wales Lunatic Asylum, saw treatment encouraging a more substantial diet and freedom from bodily restriction.

Outside of confinement, Alice's encounters in Wonderland illustrate social anxieties about the visibility of behaviours associated with mental illness. In its exploration of the spaces of *cymorth*, Wonderland specifically illustrates symptoms of nineteenth-century mania, representing concerns about the impact of untreated symptoms on social spaces. Cases of mania admitted to the North Wales Lunatic Asylum reveal observations like those analysed previously in this thesis, including a characterisation of mania based on mood episodes across the emotional spectrum. Cases observed alternating emotional states: for example, E.L., admitted in 1864, had 'attacks of excitement and depression', E.J., admitted in 1863, was 'generally low but at times excited for several days together', and A.H., admitted in 1865, was 'constantly varying from excitement to depression' and was 'fairly lucid [...] occasionally for a short time' outside of 'alternations of high and low spirits'.<sup>529</sup>

Behaviour in high mood states included J.J., admitted in 1853, observed as 'excited' and 'extremely incoherent and irrational'.<sup>530</sup> R.J., admitted in 1865, was described as 'destructive' and 'incoherent', that he 'tears his clothes' as well as 'talking and muttering and

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<sup>526</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 42.

<sup>527</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 42.

<sup>528</sup> *Supplemental Report of the Metropolitan Commissioners in Lunacy*, p. 39.

<sup>529</sup> HD/1/517, p. 38; HD/1/518, p. 34; HD/1/518, p. 46.

<sup>530</sup> HD/1/517, p. 5.



laughing to himself', and 'always quarrels and shouts before eating his food'.<sup>531</sup> Similarly, J.J., admitted in 1868, was recorded as 'perfectly irrational and incoherent', 'always talkative', with 'ideas very much mixed up', and 'wandering' at 'dinner time'.<sup>532</sup> He was also observed with a 'nasty temper', 'frequently striking' and 'quarrelsome'.<sup>533</sup> The case of E.W., admitted in 1866, included the note: 'cannot get a rational answer of any kind out of her'.<sup>534</sup> Moreover, A.O., admitted in 1848, was 'restless and mischievous', 'muttering to herself', 'strolling around' and 'constantly picking up rubbish which she eats'.<sup>535</sup> S.F., admitted in 1858, was 'very incoherent and noisy, talking to herself'.<sup>536</sup> A.W., admitted in 1865, was observed as 'irrational, talking to herself' and being 'at times cross'.<sup>537</sup> D.J., admitted in 1848, was observed as 'incoherent' on 'the subject of his delusions', as well as indicating confusion about his identity in that he 'does not acknowledge his own name'.<sup>538</sup>

The different forms of restriction Alice faces in Wonderland cause changes in her emotional state, and present as symptoms associated with mania. During her initial confinement in the hall, after going through the process of growing and shrinking and feeling helpless to escape, Alice, like observations in patient cases, begins to question her identity and talks to herself. She asks, 'Who in the world am I?' and begins to question whether she may 'have been changed' for any of 'the children she knew' (p. 17). To test this, she tries to recite a verse, but what she recites is incoherent as she cannot find 'the right words' (p. 18). Indicating alternating mood, Alice's inability to leave the hall also leads to a change to low mood, in which she cries so extensively she risks drowning in her tears (p. 20). Alice's confusion about her identity, talking to herself, incoherence, and changes in emotional state, are illustrated as being caused by the structure of Wonderland, which she describes as inherently incoherent: 'everything is so out-of-the way down here' (p. 21.) She is confined to the hall because she struggles to regulate her growing and shrinking using the bottle, and consequently she faces emotional and behavioural changes alongside physical restrictions, including an inability to recite a verse that was previously familiar, and uncertainty in her perception of self.

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<sup>531</sup> HD/1/517, p. 44.

<sup>532</sup> HD/1/517, p. 57.

<sup>533</sup> HD/1/517, pp. 57-58.

<sup>534</sup> HD/1/518, p. 57.

<sup>535</sup> HD/1/518, p. 1.

<sup>536</sup> HD/1/518, p. 19.

<sup>537</sup> HD/1/518, p. 47.

<sup>538</sup> HD/1/516, p. 3.

In addition to growth forcing her to become trapped in the White Rabbit's house, Alice's change in size is also depicted with violence, restriction, and emotional repercussions after her meeting with the Caterpillar. The Caterpillar offers Alice a way to regulate her size, telling her that one side of a mushroom 'will make you grow taller, and the other side will make you grow shorter' (p. 61). However, the incoherent rules of Wonderland are emphasised by Alice's inability to 'make out which were the two sides of it' as it was 'perfectly round', facing new physical distortion when trying to control the growing and shrinking due to inconsistency across parts of her body (p. 61). Upon trying 'a little of the right-hand bit', Alice 'felt a violent blow underneath her chin; it had struck her foot!' (p. 62). The physical damage Alice faces in these situations is paired with an inability to regulate her emotional behaviour. When confined in the White Rabbit's house, she acts with irritability and aggression towards the White Rabbit and other creatures outside, repeatedly making a 'snatch in the air', which ends each time in 'shrieks' and 'sounds of broken glass', giving Bill 'a sharp kick', and threatening to 'set Dinah [her cat] at [them]!' (pp. 43-46). With the Caterpillar, Alice conveys fear and vulnerability. She is 'frightened by this very sudden change', and its danger is demonstrated by her 'shrinking rapidly' (p. 62). She tries to save herself by 'set[ting] to work at once to eat some of the other bit' of the round mushroom, but she is restricted again by her physical change: 'Her chin was pressed so closely to her foot, that there was hardly room to open her mouth' (p. 62).

Alice initially finds freedom from restriction with a bite from the other side of the mushroom: 'Come, my head's free at last!' (p. 62). However, this new change in size causes further physical difficulty and further emotional change. Alice's 'delight [...] changed to alarm in another moment' when she 'found that her shoulders were nowhere to be found' (p. 62). All she could see was 'an immense length of neck', which she tried 'bend[ing]' and 'curving' in an attempt to reach her hands (p. 63). Rather than her whole body growing or shrinking, Alice suffers physical distortion as her neck alone is affected by growth. Adding to the injury of her physical change, and to confusion about her identity within Wonderland, a pigeon mistakes her for a serpent, making a 'sharp hiss' and 'beating her violently with its wings' (p. 63). Alice's physical distress continues even after she escapes the pigeon. Once again, she is forced into a 'crouch[ing]' position, and becomes restricted because 'her neck kept getting entangled among the branches, and every now and then she had to stop and untwist it' (p. 66).

Alice's behaviour leads to rejection and isolation from the inhabitants of Wonderland at the beginning of her journey. She is accused of speaking incoherently by the Mouse who

tells her, ‘you insult me by talking such nonsense’, after a conversation in which the Mouse begins talking about its ‘long and sad tale’, but Alice focuses on its ‘tail’ instead of its history (pp. 32-34). She is portrayed, like the case records, as quarrelsome, having ‘quite a long argument with the Lory’ (p. 26). She is also perceived as a threat by the creatures on the bank when talking about her cat, Dinah’s, prowess catching mice and birds. Consequently, ‘on various pretexts they all moved off, and Alice was soon left alone’ (p. 36). Her isolation leads to another change in emotional state: ‘here poor Alice began to cry again, for she felt very lonely and low-spirited’ (p. 36). The Wonderland community perceive Alice in line with symptoms associated with mania – incoherent, quarrelsome, and both offensive and threatening in her comments about Dinah. Their exclusion of Alice creates a setting exploring unease about the presence of mania in community spaces.

Alice similarly faces rejection in the tea party, where she is again accused of incoherence. However, her company at the tea party, The Mad Hatter, Dormouse, and March Hare, mirror the symptoms that caused Alice’s initial exclusion by the creatures on the bank. Like patient cases, a pattern of being talkative, incoherent, restless, and irritable, are represented in the Mad Hatter, March Hare, and Dormouse. Alice conveys their incoherence, feeling ‘dreadfully puzzled’ by the ‘Hatter’s remark’, which, ‘seemed to her to have no sort of meaning in it, and yet it was certainly English’, and being ‘so confused’ by the Dormouse, that she ‘let [him] go on for some time without interrupting’ (p. 88, p. 96). Their irrationality is shown through behaviours such as damaging the Mad Hatter’s watch by adding butter, and crumbs, to the works with a breadknife, and trying to remedy the damage by dipping the watch into ‘his cup of tea’ (p. 87). Consequently, their behaviours are depicted as causing a greater disorder of time and limiting them socially – the Mad Hatter’s claims that, having ‘quarrelled’ with ‘Time’, ‘he wo’n’t do a thing I ask! It’s always six o’clock now,’ (pp. 90-91). As a result, ‘it’s always tea-time’, and they have ‘no time to wash the things between whiles’. (p. 92).

Beyond incoherence, the Mad Hatter and March Hare also behave with restlessness and irritability, repeatedly pinching the Dormouse and pouring ‘hot tea upon its nose’ when he falls asleep, so that he ‘woke up again with a little shriek’ (p. 85). They also continually ‘mov[e] round’ the table to a new place amid quarrelling with one another, while answering Alice ‘contemptuously’ and ‘indignantly’ (pp. 84-96). The presentation of behaviours associated with mania in the other inhabitants suggest that Alice’s own presentation of similar behaviours is a reaction to the incoherence of Wonderland. Like when confined in the hall because of being

incapable of regulating her size according to the rules of this new place, her behaviour is depicted as a consequence of the disorder of Wonderland itself – her inability to understand the Mad Hatter, Dormouse, and March Hare’s incoherence is perceived by them as *her own* incoherence.

Wonderland creates a setting where Alice cannot avoid the presence of mania. Behaviours associated with mania are not limited to the Mad Hatter, Dormouse, and March Hare. Other members of the Wonderland community illustrate the range of behaviours associated with both high and low mood states. For example, patient cases also illustrated aggressive behaviour alongside incoherence, irrationality, and irritability. W.D., admitted in 1868, was recorded with ‘excitement’, being ‘quarrelsome’, ‘cross’ and ‘walking about continually’, while ‘gesticulating violently and muttering to himself’, such that, despite the North Wales Lunatic Asylum’s position of using seclusion as sparingly as possible, ‘on one occasion he required seclusion’.<sup>539</sup> E.H., admitted in 1860, was described as ‘by far the most violent and destructive patient in the house’ due to ‘constantly fighting, tear[ing] her clothes’, and being ‘very cross if spoken to’.<sup>540</sup> A.L., admitted in 1861, was observed with ‘attacks of hallucinations’ during ‘maniacal excitement’, at which times she was ‘very vicious’ and would ‘kick and strike’.<sup>541</sup> E.L., admitted in 1861, was ‘irrational’, ‘very violent and obstinate and quarrelsome’, ‘bad tempered and dangerous’ and ‘cross if disturbed’.<sup>542</sup> J.J., admitted in 1876, was observed with a ‘wild expression of countenance’, ‘showing her teeth’, and ‘threaten[ing] to strike some people in the house’.<sup>543</sup>

Incoherence and aggression were also associated in case records with grandiose delusions. M.J., admitted in 1861, was ‘noisy and troublesome’, ‘order[ing] everyone about’ based on a delusion that ‘she is the king’s sister’.<sup>544</sup> A.W., admitted in 1864, was recorded with the delusion that she was ‘a little girl of royal birth’ as well as being ‘quarrelsome’, and E.W., admitted in 1864, with ‘delusions strong’, believed she was a ‘queen’.<sup>545</sup> The case of A.J., admitted in 1865, included the note ‘delusions strong’ in connection to having ‘a great opinion of herself’.<sup>546</sup> It was also noted that she ‘shouts and threatens, repeats every statement twice or

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<sup>539</sup> HD/1/517, p. 69.

<sup>540</sup> HD/1/518, p. 22.

<sup>541</sup> HD/1/518, p. 144.

<sup>542</sup> HD/1/518, p. 28.

<sup>543</sup> HD/1/331, pp. 13-14.

<sup>544</sup> HD/1/518, p. 29.

<sup>545</sup> HD/1/518, p. 37; HD/1/518, p. 62.

<sup>546</sup> HD/1/518, p. 45.

more', and was 'very incoherent' and 'extremely excited'.<sup>547</sup> A.O., admitted in 1849, had a delusion that 'she is persecuted', and that the asylum was 'murdering the people'.<sup>548</sup>

Irritability, aggression, incoherence, and delusions are all depicted by the Queen of Hearts. She speaks 'severely' and 'impatiently', in a 'shrill, loud voice' and with a 'voice of thunder' (pp. 102-105). She is depicted with animalistic aggression, turning 'crimson with fury', and 'glaring [...] like a wild beast' before repeatedly 'screaming', "'Off with her head! Off with –'" (p. 103). The low threshold of justifications for executions according to the Queen include 'bringing the cook tulip-roots instead of onions', planting a 'white [rose tree] by mistake' instead of a red one, and players having 'missed their turns' in croquet, illustrating a combination of irritability, irrationality, and aggression (pp. 100-110). Moreover, like patient case records of delusional themes, the Gryphon indicates that the Queen's behaviour is associated with grandiose delusional thinking about status, by suggesting her level of power and authority is not what she believes it to be: 'It's all her fancy, that: they never executes nobody, you know' (pp. 121-122). The implication of a false sense of authority adds to the suggestion in the text that a community presence of symptoms of mania damages social order.

The inhabitants of Wonderland also illustrate symptoms associated with low mood in mania. Observations of low mood in patient records included the case of W.R., admitted in 1862 with observations that he was 'low spirited', spending 'the greater part of the day on his knees' while 'crawling' and 'all the time muttering to himself incoherently', but otherwise 'rarely talking'.<sup>549</sup> R.G., admitted in 1860, was 'very low', 'quiet', 'apathetic' and recorded as 'sleeping badly'.<sup>550</sup> H.E., admitted in 1866, was 'low spirited', 'kneeling all day in a corner'.<sup>551</sup> The case of L.E., admitted in 1854, was characterised by continuing in the 'same low mood', and wanting 'to be shot or drowned'.<sup>552</sup> L.W., admitted in 1862, was described as 'absent minded' 'indisposed', and that she 'sat still and often sighed'.<sup>553</sup> M.J., admitted in 1854, 'sighs in an absurd manner'.<sup>554</sup> Like case notes discussed in previous chapters, delusions in low mood were associated with being subject to danger. The case of H.J., admitted in 1882, was characterised by being 'low-spirited' with a belief in the 'hopeless state of his soul', and

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<sup>547</sup> HD/1/518, p. 45.

<sup>548</sup> HD/1/516, p. 4.

<sup>549</sup> HD/1/517, p. 149.

<sup>550</sup> HD/1/517, p. 10.

<sup>551</sup> HD/1/517, p. 51.

<sup>552</sup> HD/1/518, p. 34.

<sup>553</sup> HD/1/518, p. 32.

<sup>554</sup> HD/1/518, p. 13.

therefore intending to take his own life.<sup>555</sup> M.R., admitted in 1874 experienced the delusion that her family ‘constantly try to poison her’, and therefore would ‘not take food unless it is forced upon her’.<sup>556</sup>

Behaviours associated with low mood in mania are represented by the Mock Turtle. When Alice first sees the Mock Turtle, he is ‘sitting sad and lonely on a little ledge of rock [...] sighing as if his heart would break’ (p. 122). Like observations in case records, he is initially hesitant to speak – he ‘looked at them with large eyes full of tears’ but ‘said nothing’ (p. 122). When he does respond, it is in a ‘deep, hollow tone’ of voice amid ‘heavy sobbing’ (pp. 122-123). Moreover, the Mock Turtle indicates a feeling of threat to his existence by positioning himself as food, singing about ‘turtle soup’ (p. 140). He also confesses a delusion about identity: ‘Once,’ said the Mock Turtle at last, with a deep sigh, ‘I was a real turtle’ (p. 123). In the same way as he discusses the Queen of Heart’s delusion in a high mood state, the Gryphon points out that the Mock Turtle’s belief is delusional, stating in ‘very nearly the same words as before, “It’s all his fancy, that: he hasn’t got no sorrow, you know”’. (p. 122).

Like the structure of Wonderland as itself incoherent, members of the Wonderland community represent different aspects of nineteenth-century mania. The various inhabitants of Wonderland are depicted by Carroll as a function of the place’s disorder, suggesting the risk of the presence of symptoms of mania in community spaces. Parr, Philo, and Burns argue that a reason for exclusion of individuals with mental illness for rural communities with close social proximity is because it makes the visibility of mental illness ‘unavoidable’.<sup>557</sup> Wonderland portrays this unavoidability through the patchwork of behaviours associated with the spectrum of emotional states presented by a range of inhabitants. After being excluded herself, Alice later draws attention to the concern about encountering mentally ill individuals when trying to decide which path to take, remarking, ‘But I don’t want to go among mad people,’ (p. 80). In response, the Cheshire Cat tells Alice that is unavoidable, ‘Oh, you ca’n’t help that [...] we’re all mad here’ (p. 80).

The Cheshire Cat includes himself and Alice in the mental ill health of Wonderland: ‘I’m Mad. You’re mad.’ (p. 80). However, Alice’s behaviour is depicted as a function of trying to understand Wonderland’s disorder. Carroll positions Alice as a visiting outsider, and her

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<sup>555</sup> HD/1/362, p. 24.

<sup>556</sup> HD/1/331, p. 12.

<sup>557</sup> Parr, Philo and Burns, ‘Social Geographies of Rural Mental Health’, p. 413.

attempts to navigate wonderland as causing her to mirror behaviours associated with mania because of the behaviour of the other inhabitants. Alice, in contrast, ‘wonder[s] if anything would *ever* happen in a natural way again’, drawing attention to the disorder of Wonderland in comparison to her experience of typical Victorian social practice (p. 138).<sup>558</sup> The text therefore suggests that the unavoidable presence of mania in community spaces impairs social coherence, including impacting the behaviour of others.

Alice’s own progress through Wonderland emphasises this point by representing her separating herself from nonsense and gradually asserting her own sense of order, alongside a depiction of her recovery from symptoms associated with mania. Shi, using Derrida’s theory of phallogocentrism, argues that ‘Carroll’s gradual phallicization’ of Alice, including the manipulation of her body, ‘provides her with [...] imitations of masculine power that allow her to assert control and domination over Wonderland’.<sup>559</sup> Instead, I argue that Alice’s ability to regulate her size ties instead to ideas about curability and the ability to regulate her emotions and behaviours. By identifying and contesting Wonderland’s disorder, much like a patient recognising a delusion or hallucination as a function of their illness, Alice is able to progress towards recovery and leave Wonderland. At first, during her encounter with the Caterpillar, Alice presents again with uncertainty in her perception of self, unable to provide an answer to the Caterpillar’s repeated questions about her identity (p. 53). She also presents with incoherence, again failing to repeat a familiar rhyme because the ‘words have got altered’, and with irritability, to which the Caterpillar tells her: ‘Keep your temper’ (pp. 55-59). However, Alice begins to regulate her emotions by ‘swallowing down her anger as well as she could’, and starts perceiving Wonderland as the cause of her change in disposition, recognising that she has been ‘changed several times’ since entering the place, and, in relation to the inhabitants, reflecting that she ‘had never been so much contradicted in all her life before’ (p. 60).

After beginning to identify the cause and nature of her behaviour, Alice shows a progress towards recovery by calling out Wonderland’s incoherence, and gradually asserting her coherence and sense of self. After being attacked by the pigeon, Alice states, ‘I’m *not* a serpent’, and begins to recover from previous uncertainty about her identity: ‘I-I’m a little girl’ (pp. 63-65). In addition, after trying to understand and participate in the tea party with the Mad Hatter, Dormouse, and March Hare’s, Alice eventually becomes assertive, countering their

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<sup>558</sup> Emphasis in original.

<sup>559</sup> Shi, ‘*Alice’s Adventures in Wonderland* as an Anti-Feminist Text’, p. 191.

perception of her inability to understand as her own incoherence, to herself as coherent and them as nonsensical: 'it's the stupidest tea-party I ever was at in all my life!' (p. 98). Following this assertion, Alice leaves and finds herself back in the hall, but states, 'I'll manage better this time' and does – she is now able to regulate her size, using the mushroom without issue, to avoid confinement and, as a result, can get into the 'beautiful garden' (p. 98).

Finally, in the trial, Alice is confident to contest incoherence. She 'more boldly' tells the Dormouse, 'Don't talk nonsense' (p. 147). She is also able to change her size for the first time without requiring tools from Wonderland. As a feature of her argument about Carroll's phallicization of Alice, Shi suggests that Alice's ability to change size for the first time without 'consuming any food' is a 'direct result of her anger towards the perceived dictatorial illogicality and ridiculousness of the Queen and Wonderland in general'.<sup>560</sup> While I agree that Alice's new regulation of size is associated with her firm opposition to incoherence, this establishes a change from Alice trying to participate in the practices of Wonderland to rejecting its customs and favouring the rules of her familiar social dynamic instead. Crucially, this signals her recovery from experiencing symptoms of mania. She recognises the irrationality of Wonderland, reclaims her perception of self, as well as her ability to regulate both her body and her emotions, and undermines Wonderland's authority, saying 'Stuff and nonsense' in response to the trial, and refusing the Queen of Hearts's insistence that she 'hold her tongue' (p. 163). Ultimately, she achieves this and removes any previous feeling of being subject to threat, by contesting the calls for her arrest and escaping Wonderland as if recognising a delusion: 'You're nothing but a pack of cards' (p. 163).

Work that sees Alice as imperialistic cites her rejection of Wonderland's practices and attempts to impose a typical Victorian social order.<sup>561</sup> This attempt to impose relates specifically to medical practices and the imposition of a new system of treatment perceived superior by core onto periphery. However, unlike the actual negotiating dialogue between core and periphery in implementing a new institutional provision of care in Wales – seen in the relationship between Welsh physicians, English physicians, and Commissioners in Lunacy, including Lutwidge – Carroll's Wonderland presents an unwillingness to accommodate or negotiate through Alice's complete rejection and escape. The incoherence of Wonderland,

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<sup>560</sup> Shi, 'Alice's Adventures in Wonderland as an Anti-Feminist Text', p. 191.

<sup>561</sup> See, for example: Daniel Bivona, 'Alice the Child-Imperialist and the Games of Wonderland', *Nineteenth-Century Literature*, 41.2 (1986), pp. 143-171; Shi, 'Alice's Adventures in Wonderland as an Anti-Feminist Text'.



created and perpetuated by the behaviours of its inhabitants, is portrayed such that Alice's attempts to understand it initially cause her own experience of symptoms related to mania. In this way, the text suggests the unavoidable community presence of mania as a danger both to social structure and to new visitors. Representations of treatment in Wales, including those by Lutwidge, were mostly sympathetic to patients based on a lack of availability of institutional care, and therefore individuals' inability to improve their condition. However, frustration began to enter writing by Lutwidge and Williams in response to a persistence by families to refuse to send their relatives to the North Wales Lunatic Asylum for treatment, despite the efforts of the press. A similar frustration can be read in Carroll's text, which is unsympathetic in its representation of inhabitants by illustrating their behaviours as causing disorder.

## **Conclusion**

Treatment for mania in Wales's transition from domestic to institutional care is a significant example of the non-linear relationship between core and periphery. Despite attempts to remove the Welsh-language from other institutional settings, campaigns for the North Wales Lunatic Asylum by Commissioners in Lunacy, English Physicians and Welsh physicians advocated for the use of Welsh-medium treatment due to the necessity for communication in the treatment of mania. Literary representations also showed contempt for the lack of provision of Welsh-medium treatment, challenging medical authority in terms of accessible communication.

In addition, despite social anxiety about the visibility of mania in communities, individuals with mania in spaces of community care in Wales were represented with sympathy due to a lack of accessible institutional care. However, while the campaign for the asylum was successful, a continued hesitancy to seek institutional treatment led to the emergence of frustration in representations of mania in Wales in both the reports of Lutwidge and Williams for the North Wales Lunatic Asylum, and in literary representations of mania as a risk to social coherence. Chapter Four will continue an investigation into the experience of mania in different places, by examining a similar transition from community care to institutional care in the Scottish Highlands and Islands.

## **Chapter Four:**

### **Beyond the Highland Line: Spaces of Curability and Culturally Specific Care**

Chapter Four will continue to examine representations of mania in different places by turning to the Scottish Highlands and Islands.<sup>562</sup> Though there were established asylums elsewhere in Scotland, a lack of provision beyond the Highland line meant the 1857 Scottish Lunacy Commission's inquiries discovered many individuals outside of institutional care.<sup>563</sup> This chapter will focus on types of treatment and views on curability to argue that spaces of care became a key concern in discussions about mania specifically. The reversal in priorities for treating mania, from limiting diet and movement to encouraging activity and nutrition, were implemented in institutions, but not realised in domestic care.<sup>564</sup> Domestic spaces continued to use bodily restriction and were unable to provide sufficient nutrition because of insufficient financial support from parishes. Consequently, the domestic space perpetuated modes of care that had since been considered injurious in institutions. The report therefore emphasised the need for greater institutional provision in the Highlands and Islands. However, because ideas about curability included the necessity for quick intervention, the duration individuals discovered by the report had spent in domestic care meant they were already considered incurable, leading to wider questions about the presence of mania in society: whether individuals could be kept by relatives, whether they could be cured in institutions and re-integrated into society, or whether a space for institutional treatment became a permanent place for an 'incurable' community.

The association between the domestic space and incurability is at odds with ideas in asylum reform that prioritised embedding a sense of domesticity in institutions.<sup>565</sup> This chapter will investigate treatment in the Inverness District Asylum, which opened in 1864 following the report, to interrogate tensions between incurable perceptions of domestic care and shaping the asylum according to reform theories. I will also continue to draw from the work of Parr, Philo, and Burns to analyse social perceptions of mania in a transition from domestic to

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<sup>562</sup> My use of the terms 'space' and 'place' continues to draw from Tuan's space as abstract and place as inscribed with meaning by human experience. See: Tuan, *Space and Place*.

<sup>563</sup> Chris Philo, 'Scaling the Asylum: Three Geographies of the Inverness District Lunatic Asylum (Craig Dunain)', in *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context*, ed. by Leslie Topp, James E. Moran and Jonathan Andrews (London: Routledge, 2007), pp. 105-130.

<sup>564</sup> See Chapter Two of this thesis for a detailed examination of changes in practices for treating mania.

<sup>565</sup> Katherine Fennelly, *An Archaeology of Lunacy: Managing Madness in Early Nineteenth-Century Asylums* (Manchester: Manchester University Press, 2019).

institutional treatment. Furthermore, perceptions of difference in the populations of the Highlands and Islands meant, like the North Wales Lunatic Asylum, the asylum at Inverness was established to provide culturally specific care. Continuing to draw from Waddington's work, the second section of this chapter will investigate representations of the particular experience of mania for individuals beyond the Highland line according to shared mythology. I will argue that medical superintendent Thomas Aitken's analysis of the relationship between psychosis and place-specific beliefs was a factor in creating accessible care at Inverness. In accordance, I will argue that literary representations explored tensions between a view of experiences as either psychosis or fact, and challenged the pathologizing of cultural traditions by outsiders.

### **Domestic Care and (In)Curability: A Home from Home for Chronic Cases at Inverness District Asylum**

On the third of April, 1855, a report was commissioned to inquire into the state of lunatic asylums in Scotland. Published in 1857, the report opened with a reflection on the different spaces occupied by those suffering with mental illness. Nana Tuntiya writes that the report formed 'two classes of lunatics [...] one *in*, and one *out of* Asylums'.<sup>566</sup> Initial research demonstrated to commissioners the need to look beyond psychiatric settings to community spaces to investigate fully the state of lunacy, to research 'the condition of the Insane throughout the whole country, whether placed in asylums or elsewhere'.<sup>567</sup> Chris Philo points out that the report was 'punctuated by a strong sense of the overall regional geography' of psychiatric provision in Scotland, with an 'obvious blank space on the institutional map that was the Highlands'.<sup>568</sup> Like Wales's system of *cymorth* prior to institutional treatment, care in the Scottish Highlands and Islands included domestic confinement. However, in contrast to the lack of institutional treatment available in Wales, Scotland had established psychiatric hospitals at this time in Aberdeen, Dumfries, Edinburgh, Glasgow, Montrose, and Perth, and a small asylum space in Elgin.<sup>569</sup> There was therefore a divide in treatment across different parts of the

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<sup>566</sup> Nana Tuntiya, 'In and Out of Asylums: Mental Health Care of Nineteenth Century Scotland in the Writings of Sir Arthur Mitchell, the Commissioner in Lunacy', *International Journal of Epidemiology*, 39.6 (2010), 1429-1432 (p. 1429).

<sup>567</sup> *Report to Inquire into the State of Lunatic Asylums in Scotland*, p. 2.

<sup>568</sup> Philo, 'Scaling the Asylum', pp. 107-110.

<sup>569</sup> *Report to Inquire into the State of Lunatic Asylums in Scotland*, p. 49.

country, where, ‘in remote districts, having no asylums [...] a large proportion of the patients [were] placed with relatives and strangers’.<sup>570</sup>

The report demonstrated this divide in a comparison between counties with and without chartered asylums. In the county of Forfar, with a population of 191,247, out of 309 pauper lunatics, a total of 253 were in chartered asylums, 1 in a licensed house, 4 in poorhouses, and just 51 living with relatives and strangers.<sup>571</sup> In contrast, combining the counties of Caithness, Sutherland, Ross and Cromarty, and Inverness, with a joint population of 245,472, out of 373 pauper lunatics, only 70 resided in chartered asylums, 24 in licensed houses, 5 in poorhouses, and a total of 274 lived with relatives, strangers, or alone.<sup>572</sup> The report explains that, ‘while there are two chartered asylums in the county of Forfar, there is not one in any county within the Highland line – the only provision beyond Aberdeen being the small pauper institution at Elgin’.<sup>573</sup> While it was possible for patients to travel to asylums in other parts of the country, ‘remoteness from an asylum afford[ed] a temptation to detain the insane poor at home’.<sup>574</sup> Like in Wales, there was a reluctance in counties without asylums to part with insane relatives, and parishes were hesitant to intervene and remove patients to institutional spaces because ‘removal to an asylum would entail a greater expense’.<sup>575</sup> As I will discuss later in this chapter, like in Wales, language was a concern due to a lack of provision of Gaelic-medium treatment.<sup>576</sup>

According to the report, persons in spaces of care outside of asylums received sparse medical attention, and it was common for there to be little awareness of their mental illnesses by medical professionals. In ‘a very considerable number’ of cases outside of institutions, ‘there was no official record of any kind’ of persons suffering with mental ill health.<sup>577</sup> In order to extend inquiries to patients outside of asylums, the commissioners had to apply for assistance from the rural police rather than medical practitioners because, ‘in the Highland districts, especially, there was reason to fear this result, as there are so few medical men in those localities’ that any information would likely be incomplete.<sup>578</sup> In counties without ‘organized police’, ‘especially in Orkney and Shetland’, the commissioners required the assistance of

<sup>570</sup> *Report to Inquire into the State of Lunatic Asylums in Scotland*, p. 55.

<sup>571</sup> *Report to Inquire into the State of Lunatic Asylums in Scotland*, p. 55.

<sup>572</sup> *Report to Inquire into the State of Lunatic Asylums in Scotland*, p. 55.

<sup>573</sup> *Report to Inquire into the State of Lunatic Asylums in Scotland*, p. 63.

<sup>574</sup> *Report to Inquire into the State of Lunatic Asylums in Scotland*, p. 64.

<sup>575</sup> *Report to Inquire into the State of Lunatic Asylums in Scotland*, p. 170.

<sup>576</sup> Parr, Philo and Burns, “‘That awful place was home’”.

<sup>577</sup> *Report to Inquire into the State of Lunatic Asylums in Scotland*, p. 32.

<sup>578</sup> *Report to Inquire into the State of Lunatic Asylums in Scotland*, pp. 32-33.

‘ministers of various denominations’ and ‘sheriff-officers’.<sup>579</sup> These different figures were asked to make detailed returns relating to restriction and diet, about whether the persons they discovered were ‘sufficiently clothed and fed, and otherwise well cared for’, and to ‘particularly mention those cases in which it is necessary to confine or bind the lunatic [...] to prevent mischief’.<sup>580</sup> Of 7403 ‘insane poor’ in Scotland, 3798 – a proportion of just over fifty percent – were recorded in the report as under the care of relatives or strangers, or living alone.<sup>581</sup> The report became a study into implications of care in different spaces: the condition of institutions, but also the conditions within communities.

In the same way that debates about the non-restraint system, which began in the late 1830s, were centred on symptoms of mania as examples both in favour of and in opposition to the use of restraint in institutions, fears about allowing patients to roam in community spaces, and advocations for restraint in domestic spaces, were discussed particularly in relation to mania. Excitement, destructive behaviour, and risk of self-injury or injury to others alongside delusions, were symptoms perceived to require restraint in domestic care. A case from Helmsdale and Brora was recorded in the report as well as published in *John o’ Groat Journal* of Caithness, to illustrate an example of the many individuals under the care of relatives. Patient J. T. was diagnosed with ‘mania’ and recorded as having ‘been insane for 14 years’.<sup>582</sup> Her case included the delusion that ‘her husband had murdered her’, and a risk of self-injury or injury to others because she was ‘managed with some difficulty’ and ‘becomes violent at times’.<sup>583</sup>

Like in Wales, a system of care in the rural spaces of the Highlands and Islands with less spatial proximity, but greater social proximity, saw concerns arising from the tensions between duties of care, and anxieties about the presence of mental illness in community spaces.<sup>584</sup> The report highlighted examples where social anxiety about the visibility of behaviours associated with mania led to individuals being permanently restrained. For example, a patient who had been ‘subject to fits of passion at irregular periods’ for ‘about 40 years’, during which ‘he cries loudly, stamps with his feet, and fences with his arms’ was

<sup>579</sup> *Report to Inquire into the State of Lunatic Asylums in Scotland*, p. 34.

<sup>580</sup> *Report to Inquire into the State of Lunatic Asylums in Scotland*, p. 34.

<sup>581</sup> *Report to Inquire into the State of Lunatic Asylums in Scotland*, pp. 31-35.

<sup>582</sup> ‘Lunacy in the Northern Counties’, *John o’ Groat Journal* (29 May, 1857), p. 3.

<sup>583</sup> ‘Lunacy in the Northern Counties’, p. 3.

<sup>584</sup> In my analysis of socio-spatial implications of a community-based system of care in nineteenth-century Wales I am indebted to the work of Parr, Philo and Burns about rural experiences of exclusion for people with mental illnesses. Their work is a study of present inclusion and exclusion for service users in the Highlands and Islands. See: Parr, Philo and Burns, ‘Social Geographies of Rural Mental Health’.

‘chained beside the kitchen fire [...] by his right ankle’.<sup>585</sup> While the report does not provide evidence that complaints within communities were widespread, it does draw attention to the implications of social attitudes on fostering exclusion, stating that while the patient ‘never tries to strike, and has never hurt anyone’, his family ‘were obliged to confine him’ because people were frightened’ – though he ‘was first allowed to go about the neighbourhood’, because ‘complaints were made of him, he was chained’.<sup>586</sup> This was not an isolated incident – a similar case involved a patient who had also been ‘insane for the last 40 years’, but had ‘for ten years after he had become insane’ been free to ‘wander about the country’.<sup>587</sup> The patient was eventually ‘put under restraint in consequence of a complaint’ by the ‘procurator-fiscal’.<sup>588</sup> The report is clear in its disapproval of this course of action, stating the patient was ‘kept in the most wretched description’, which was described as a space only ‘about 9 feet by 7’ with ‘no window’ and ‘no furniture [...] except the bed to which the lunatic is confined by his chain’.<sup>589</sup>

Care outside of an asylum was discussed in the report in terms of social attitudes towards the visibility of mania in the community, but equally pointed to the damage of home confinement as well as the damage of being unable to access outside space. The report stated that several of the patients investigated were ‘quite capable of deriving benefit and enjoyment from out-door exercise’, but were ‘kept within doors’ partly due to ‘neglect’, and also as a result of fears that they ‘might prove dangerous’ or ‘run away’.<sup>590</sup> For example, the report emphasised that the patient discussed above had ‘never left the bed to which he is chained’, and had ‘not been out of the house since he was first confined’.<sup>591</sup> While, like the *Supplemental Report* in Wales, the report of the *Scottish Lunacy Commission* was somewhat sympathetic, describing cases of confinement where a patient was kept at home ‘out of a desire to keep him beside his friends’, it was also clear in its stance that domestic confinement causes only damage to a patient’s hopes for recovery, instead being ‘aggravated by his treatment’.<sup>592</sup>

Newspaper reports about the Scottish Lunacy Commission’s inquiries discussed the damage of care in the domestic space in the context of the beneficial developments in institutional treatment. One article, initially published in *The Times* in 1857 was clearly

<sup>585</sup> *Report to Inquire into the State of Lunatic Asylums in Scotland*, p. 272.

<sup>586</sup> *Report to Inquire into the State of Lunatic Asylums in Scotland*, p. 272.

<sup>587</sup> ‘Lunacy in the Northern Counties’, p. 3.

<sup>588</sup> ‘Lunacy in the Northern Counties’, p. 3.

<sup>589</sup> ‘Lunacy in the Northern Counties’, p. 3.

<sup>590</sup> *Report to Inquire into the State of Lunatic Asylums in Scotland*, pp. 181-82.

<sup>591</sup> ‘Lunacy in the Northern Counties’, p. 3.

<sup>592</sup> *Report to Inquire into the State of Lunatic Asylums in Scotland*, p. 192.

influential through its republication in numerous Scottish newspapers, including the *Glasgow Herald*, *The Scotsman*, *Paisley Herald and Renfrewshire Advertiser* and *Inverness Courier*.<sup>593</sup> The article connected the injurious aspects of domestic care to features of previous institutional care: ‘Under the old barbarous style of treatment’, which ‘relied on bread and water and starvation, this fare would be considered most appropriate’.<sup>594</sup> However, now that developments in treatment recognised that ‘stinted nourishment [was] the destruction’ of prospects for recovery, the offer of 4 1/3 d for the maintenance’ of an individual within a domestic space, was ‘but an offer to maintain and confirm’ mental illness.<sup>595</sup> The article also highlighted the damage of restraint, describing the old practices of ‘physical restraint’ and ‘lowering diet’ as ‘horrible’, ‘most cruel’ and ‘only serv[ing] to develop [the patient’s] malady’.<sup>596</sup>

Both low maintenance payments and the need for restraint were blamed by the article on a lack of support by officials, claiming that ‘the paltry assistance’ of ‘the Poor-law officer’ was ‘culpable in the extreme’, because a ‘lack of surveillance of the insane’ led to disruption in social spaces.<sup>597</sup> The disuse of restraint was replaced in institutional spaces by the close supervision of patients.<sup>598</sup> A lack of surveillance by community officials was therefore another perceived weakness in care outside of an asylum in comparison with developments in institutional treatment. The placement of blame on officials again indicated sympathy for families and mentally ill individuals with limited access to alternative treatment, but ultimately the domestic space was represented as incapable of providing either sufficient nourishment or supervision, ergo being incapable of implementing the changes to restraint and diet that had proved beneficial in institutional care – relying instead of methods that were now considered injurious to prospects for recovery.

The damage of domestic confinement to a patient’s illness was also represented in literary texts. George MacDonald’s *The Portent* was first published serially across an issue of *The Cornhill Magazine* in 1860, and then extended and published as a novella in 1864. While MacDonald is a celebrated Victorian Scottish author whose fantasy novels and fairy tales have

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<sup>593</sup> ‘Scotch Pauper Lunatics’, *Glasgow Herald* (Monday 21 December, 1858), *The Scotsman* (Wednesday 23 December, 1857), *Paisley Herald and Renfrewshire Advertiser* (Saturday 26 December, 1857) and *Inverness Courier* (Thursday 31 December, 1857).

<sup>594</sup> ‘Scotch Pauper Lunatics’, *Inverness Courier* (Thursday 31 December, 1857), p. 7.

<sup>595</sup> ‘Scotch Pauper Lunatics’, p. 7.

<sup>596</sup> ‘Scotch Pauper Lunatics’, p. 7.

<sup>597</sup> ‘Scotch Pauper Lunatics’, p. 7.

<sup>598</sup> Fennelly, *An Archaeology of Lunacy*.

been widely written about, *The Portent* has typically gained less critical attention. The subject of the tale is *an da shealladh*, or second sight, a concept from the Highlands about the ability of premonition. MacDonald adds to this tradition by changing the sensory experience of characters Duncan and Alice to sound rather than sight, through the repeated sound of a horseshoe that they believe is a premonition of danger relating to their shared ancestry. However, MacDonald additionally connects the tradition of second sight to psychiatric illness through his characters' questioning about whether their experiences are associated with premonition or mental illness. While I have been unable to find evidence of MacDonald's reading specifically about spaces of psychiatric treatment, he indicates an interest in classifications for mental illness through the connections drawn between second sight, or hearing, with hallucinations and delusions, and through the representation of characters' experiences within different spaces of care. The wide reporting of the Scottish Lunacy Commission's inquiries in newspapers could point to the likelihood of MacDonald's awareness of the investigations. A knowledge of the circumstances of care combined with *an da shealladh*'s cultural specificity to the Highlands could be read as a place-specific exploration by MacDonald of tensions between traditional beliefs, classifications for mental illness, and transitioning care between the domestic and institutional space.

Critical discussions of *The Portent* have investigated the uncertainty around whether Duncan and Alice are experiencing the Highland tradition of premonition, or whether they are instead subject to hallucination. Midori Kihara discusses the representation of 'the second sight', or 'second hearing' in *The Portent* in the context of the 'legendary motifs' of the Highlands to argue that this tale is specifically a 'Scottish Gothic Romance'.<sup>599</sup> In doing this, Kihara discusses the relationship between Duncan's second hearing and the experience of hallucination, pointing out that 'whether the sound is an exaggeration of the noise around him, or a pure auditory hallucination, is not clearly defined'.<sup>600</sup> Similarly, John Docherty discusses the uncertainty around the characters' mental state, which 'at times leads them to doubt whether some of their encounters actually happened'.<sup>601</sup>

I will also analyse the uncertainty around Duncan and Alice's mental state, as well as their own speculation about their mental wellbeing. However, I will build on this critical

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<sup>599</sup> Midori Kihara, 'George MacDonald's *The Portent*: A Scottish Gothic Romance', *Reading*, 35 (2014), pp. 24-38 (p. 24).

<sup>600</sup> Kihara, 'George MacDonald's *The Portent*: A Scottish Gothic Romance', p. 29.

<sup>601</sup> John Docherty, 'George MacDonald's *The Portent* and Colin Thubron's *A Cruel Madness*', *North Wind: A Journal of George MacDonald Studies*, 13 (1994), pp. 19-23 (p. 20).



discussion by analysing the representation of the characters' mental state concurrently with medical representations in the nineteenth century. In the introduction to their edited collection, *Rethinking George MacDonald: Contexts and Contemporaries*, Christopher MacLachlan, John Patrick Pazdziora, and Ginger Stelle argue that George MacDonald's work has typically been critically viewed 'only in terms of what came before or what has come since', but that 'his place in his own time remains virtually untouched'.<sup>602</sup> I aim to examine *The Portent* within its Victorian context, by situating it within discussions about spaces of treatment, symptoms, and curability of mania.

Second sight is depicted in *The Portent* in association with symptoms of mania, with uncertainty from Duncan and Alice about whether their experiences are premonitions or symptomatic of mental illness. Their shared experience of premonition is associated in the tale with both psychiatric illness and mythology of place, their experience thought to be connected to a shared ancestry in Scotland which saw the two lovers' ancestral figures parted and killed by a jealous brother. The experience of the sound of the horseshoe is characterised by being subject to threat, and causes behaviour that re-enacts that of their ancestral figures. I will discuss the correlation between beliefs and delusional themes later in this chapter alongside medical writing about culturally specific care. For now, I will concentrate on the illustration in the novel of the implications of domestic confinement.

Like the ancestral figures involved in their shared second sight or hallucination, Alice and Duncan become parted. Duncan's search for Alice explores different spaces of psychiatric treatment and the potential for damage to an individual's mental ill health in a domestic setting of care. At the close of the shorter publication of *The Portent*, which was featured in volumes one and two of *The Cornhill Magazine* in 1860, Duncan hears 'a cry which [he] knew', and believes he sees Alice's face in the 'barred window' of 'an Asylum for the insane'.<sup>603</sup> Unable to find her there, Duncan draws attention to different spaces of care in the remainder of his searches: 'hopelessly [...] lurking about madhouses', and 'often begging [his] way from house to house in wild regions'.<sup>604</sup> The places Duncan searches relate to different spaces of care for

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<sup>602</sup> *Rethinking George Macdonald: Contexts and Contemporaries*, ed. Christopher MacLachlan, John Patrick Pazdziora, and Ginger Stelle (Glasgow: Scottish Literature International, 2013), p. v.

<sup>603</sup> MacDonald, 'The Portent', p. 83. Unlike my analysis of other literary texts throughout this thesis, I will not provide references parenthetically in the text for either the initial serialised publication of 'The Portent', or the extended novella of *The Portent*, to avoid confusion when quoting from the different versions.

<sup>604</sup> MacDonald, 'The Portent', p. 83.

mental ill health: the institutional space, and the domestic space in remote areas without accessible asylum treatment.

In the extended version of *The Portent*, published in 1864, Duncan eventually discovers that Alice is still in her home, and that she is described in gossip as ‘altogether [...] crazy’.<sup>605</sup> MacDonald explores forms and spaces of treatment through Alice’s representation in the domestic space. Initially, she is described as ‘raving’, ‘wild’, and ‘wanting to get out’, but, having ‘had her liberty now for a long time’, she ‘gave that over altogether’.<sup>606</sup> However, Lord Hilton’s impending return causes Alice’s current carer, Mrs Blakesley, to fear the possible changes to the condition of her treatment: ‘They won’t let her go wandering about wherever she pleases, I doubt. And if they shut her up, she will die.’<sup>607</sup> The method of confining her is conveyed as being likely to cause fatal injury to her condition, while the gossip about her in the community indicates social unease about mania.

The perceived injuries of domestic care were not just considered ineffective but as causing incurability. The report stated that ‘the probability of recovery depends in a very great degree on the nature of the treatment’ and emphasised that ‘early treatment is absolutely necessary’.<sup>608</sup> The potential for cure was believed to be dependent on the length of time an individual had lived with mental illness without access to institutional treatment. While patients previously under the care of relatives were occasionally sent to asylums, this was ‘only when they become ungovernable’.<sup>609</sup> As a result, ‘in the meantime, the malady has become confirmed, and neglect has established many bad habits’, so that ‘when they at length find their way to southern asylums’ patients are ‘generally incurable’.<sup>610</sup> In consequence, individuals who had for some time been in domestic care were perceived with little hope of recovery when admitted to an institution. Discussing the patients sent from Orkney and Shetland to the Royal Edinburgh Asylum, assistant physician James C. Howden stated, ‘they are incurable, from being too long detained at home’.<sup>611</sup>

A correlation between domestic spaces and incurability is at odds with asylum reform theories, which strove to create a domestic atmosphere in institutions. Reformists advocated for asylum structures to move away from incarceration by being more like domestic spaces,

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<sup>605</sup> MacDonald, *The Portent*, p. 75.

<sup>606</sup> MacDonald, *The Portent*, pp. 67-68.

<sup>607</sup> MacDonald, *The Portent*, p. 86.

<sup>608</sup> *Report to Inquire into the State of Lunatic Asylums in Scotland*, p. 36.

<sup>609</sup> *Report to Inquire into the State of Lunatic Asylums in Scotland*, p. 64.

<sup>610</sup> *Report to Inquire into the State of Lunatic Asylums in Scotland*, p. 64.

<sup>611</sup> ‘Lunacy in the Northern Counties’, p. 3.

replacing restraint with close surveillance of patients.<sup>612</sup> Katherine Fennelly argues that being ‘separate in character and practice from prisons was paramount’, and this separation was envisioned in ‘the asylum as “home”’.<sup>613</sup> Moreover, Fennelly points out that these concerns were tied to prospects for cure: ‘an interior that was recognisably domestic’ was a crucial factor in creating an ‘environment’ in which patients could ‘get better.’<sup>614</sup> There are tensions, then, between an actual domestic space being perceived as incapable of providing sufficient care, because of changes in institutional treatment regarding restraint, diet, surveillance, and activity, and an institutional space needing to feel domestic in order to cure. The implications of these tensions raise questions about Inverness District Asylum in particular, because it was opened partly for the purpose of admitting the many individuals discovered by the report who were already considered incurable. For the final part of this section, I will investigate how the institution navigated these tensions, and the experience of the patients diagnosed with incurable mania.

Opening on May 18<sup>th</sup>, 1864, the Inverness District Asylum, like the North Wales Lunatic Asylum, was established in response to the findings of lunacy commissioners about the number of individuals in the Highlands and Western Isles under community systems of care. As a result, the asylum at Inverness became a space taking in patients of whom the majority were already considered incurable because of the duration of their living with mental ill health prior to having access to institutional care. In consequence, the primary function of Inverness District Asylum was not initially for the cure of patients. Medical superintendent Thomas Aitken’s focus on curability within his annual reports shows a concern about providing care for those patients believed incapable of restoration. Discussing those patients who had been previously lived under the care of relatives, strangers, or living alone in Inverness District Asylum’s *First Annual Report*, he states that ‘of the 54 cases placed for the first time under treatment [...] by far the larger proportion must be looked upon as offering no room for successful treatment’.<sup>615</sup>

Drawing a connection between the duration of the illness and removal to an asylum, Aitken states that patients must be ‘treated early’ to be ‘treated successfully’, providing statistics that ‘nearly 70 per cent may be restored to health’ if treated ‘within three months’,

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<sup>612</sup> Fennelly, *An Archaeology of Lunacy*; Leslie Topp, *Freedom and the Cage: Modern Architecture and Psychiatry in Central Europe, 1890-1914* (Pennsylvania: Penn State University Press, 2016)

<sup>613</sup> Fennelly, *An Archaeology of Lunacy*, p. 146.

<sup>614</sup> Fennelly, *An Archaeology of Lunacy*, p. 145.

<sup>615</sup> *First Annual Report of the Inverness District Lunatic Asylum* (Inverness: Courier’s Office, 1865), p. 11.

but that ‘cures fall so low as from 40 per cent to 45 per cent’ if the affection has lasted between ‘three and twelve months’, and that ‘curability diminishes’ again to between ‘15 percent [and] 20 per cent’, if the ‘disease has been above one year’.<sup>616</sup> A majority of incurable admissions continued to be a problem five years after the asylum opened. Reflecting on the progress of the institution, the fifth annual report broke down the divide in curable and incurable patients. In five years of operation, ‘476 patients have been admitted’, many previously ‘kept in their homes without treatment’, so that ‘of the whole number only 135 could be regarded as curable’.<sup>617</sup> Aitken expressed hope in his fifth annual report that ‘the chronic outlying cases in the district are now exhausted, and that the Asylum in the future will become more and more an hospital for the treatment of mental disease in its more acute forms.’<sup>618</sup> However, a number of admissions continued to be deemed with little hope of recovery, because there was a continued reluctance to access asylum treatment. Aitken points out the need for better education among the public about asylum care, stating that ‘hesita[ncy] to place an individual under treatment, in whom marked symptoms of insanity have shown themselves’ is both ‘unjust to the sufferer’ and ‘unjust to the community’.<sup>619</sup> He again stressed the necessity of prompt treatment, explaining that the risk of the disease becoming chronic ‘does not so much bear a relation to severity as the duration of the attack’.<sup>620</sup>

Aitken therefore shared the view of care in the domestic space as associated with incurability. However, he was influenced in his practice by asylum reform theorist W.A.F. Browne in creating domesticity within an institutional space. A native of Dumfries in the Scottish borders, Aitken was appointed as medical superintendent to the Inverness District Asylum in the Highlands in 1859. He held the post for thirty-three years, until his death in 1892. Having studied medicine at the University of Edinburgh, Aitken’s first role was as assistant to Browne in Crichton Royal Asylum, an institution in Dumfries, where he was likely influenced by Browne’s attitudes towards treatment. Andrew Scull points out that Browne was himself influenced by the ‘new system of moral treatment pioneered by William Tuke at the York Retreat and Philippe Pinel and Esquirol in Paris’.<sup>621</sup> Scull argues that Browne formed his methods for treatment alongside this system, limiting restraint and instead following the

<sup>616</sup> *First Annual Report of the Inverness District Lunatic Asylum* (1865), p. 13.

<sup>617</sup> *Fifth Annual Report of the Inverness District Lunatic Asylum* (Inverness: Courier’s Office, 1869), p. 12.

<sup>618</sup> *Fifth Annual Report of the Inverness District Lunatic Asylum* (1869), p. 12.

<sup>619</sup> *Fifth Annual Report of the Inverness District Lunatic Asylum* (1869), p. 13.

<sup>620</sup> *Fifth Annual Report of the Inverness District Lunatic Asylum* (1869), p. 13.

<sup>621</sup> Andrew Scull, ‘Browne, William Alexander Francis (1805-1885), alienist’, *Oxford Dictionary of National Biography* (2004) <<https://www.oxforddnb.com/display/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-46958?rskey=31oe5b&result=2>> [accessed November 27, 2022].

example of ‘employ[ing] carefully designed techniques and a controlled environment to induce patients to collaborate in their own recovery’.<sup>622</sup>

Browne became an influential figure in discussions about psychiatric treatment, described by Philo as ‘one of Scotland’s best-known nineteenth-century pioneers in lunacy reform’.<sup>623</sup> Scull describes Browne’s ‘considerable success’ with new forms of treatment, as well as the ‘national and international attention’ received by his series of public lectures in 1836, and published in 1837, *What asylums were, are, and ought to be*.<sup>624</sup> It was from these lectures that Browne achieved his role as superintendent for the Crichton Royal Asylum, for which he was able to ‘play a major role in designing, equipping, and staffing’, and, ‘over the next eighteen years’ tuning ‘into an actual example of his utopian vision of the perfect asylum.’<sup>625</sup> Aitken’s role in achieving Browne’s vision, through his position as assistant in Crichton Royal Asylum, suggests that his views on treatment would have been influenced by Browne’s. Crichton Royal Asylum’s annual report for 1852 details some of these methods. Regarding the purpose of the asylum space, the report reads:

The first and grand object should be to restore intelligence; but almost equal to this importance is the development of sources of calm and contentment, where restoration cannot be effected.<sup>626</sup>

These goals demonstrate both an experience with incurable patients, and a belief in the importance of providing support for patients perceived to have little hope of recovery. The ‘almost equal’ placing of these two aims, to provide cure or to provide comfort where no cure could be achieved, shows the dedication of the asylum to support those patients who had been rendered incurable. The report goes on to state that ‘it is practicable to create a new and artificial modification of society adapted to the altered dispositions and circumstances of the insane’, conveying the practice in the asylum of finding occupations for the patients as a part of their treatment. I will expand on the use of occupation in Inverness District Asylum in the treatment for mania later in this section.<sup>627</sup>

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<sup>622</sup> Scull, ‘Browne’.

<sup>623</sup> Philo, *Scaling the Asylum*, p. 113.

<sup>624</sup> Scull, ‘Browne’.

<sup>625</sup> Scull, ‘Browne’.

<sup>626</sup> ‘Twelfth Annual Report of the Crichton Royal Institution for Lunatics, Dumfries’, *John o’ Groat Journal*, 30 January 1852, p. 4.

<sup>627</sup> ‘Twelfth Annual Report of the Crichton Royal Institution for Lunatics, Dumfries’, p. 4.

Browne was also one of the commissioners in lunacy that inspected the suitability of Inverness District Asylum and gave permission for it to open its doors to patients.<sup>628</sup> Philo points out the ‘highly unusual absence of perimeter walls sealing off Inverness District Asylum and its grounds from the wider world’<sup>629</sup>, which was reported in the *Inverness Courier* with pride:

in no public asylum in the kingdoms is the freedom from restraint and from the old system of imprisoning lunatics within high walls more carried out than here.<sup>630</sup>

Browne’s vision in asylum reform was that an institution ‘should resemble as much as possible a private dwelling’ – he gave Inverness District Asylum as an example because of the absence of a ‘wall or fence round its extensive grounds’.<sup>631</sup> Leslie Topp has discussed the way a sense of freedom was created within confinement in asylum spaces. Drawing on Foucault’s ‘caged freedom’ and Patrick Joyce’s ‘rule of freedom’, Topp argues that the denial of freedom by confinement within an asylum was ‘acknowledged as a problem’, so that institutions looked for ways to enable ‘free movement within the institution’s boundaries’, to create ‘an impression, or appearance, of freedom’ for both ‘patients and the public’.<sup>632</sup> Institutional admission for incurable cases, then, attempted to create comfort by allowing some liberty within a supervised space.

My research into the archival records of Inverness District Asylum included the *Register of Escapes*. These volumes revealed numerous attempts to escape, often detailing serial offences by the same patients, with a note about how the patients were able to escape and whether they were returned. A number of the recorded escapes happened during walking parties, where patients, without an external wall around the grounds, were able to get ‘into the wood’ and walk significant distances. For example, patient H.G. was recorded as having ‘walked straight to Nairn’, which is over 18 miles away from Dunain Hill where the institution was built.<sup>633</sup> Nevertheless, walking parties continued, as did the absence of a perimeter wall in aid of the asylum’s vision for a sense of freedom within confinement and provision of open air and exercise in treatment. Instead, the blame for escapes during walking parties was primarily attributed to the ‘negligence of the attendants’ who were required to supervise patients,

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<sup>628</sup> *Inverness Courier* (1864) in Philo, *Scaling the Asylum*, p. 110.

<sup>629</sup> Philo, ‘Scaling the Asylum’, p. 113.

<sup>630</sup> *Inverness Courier* (1864) in Philo, ‘Scaling the Asylum’, p. 113.

<sup>631</sup> Browne in Philo, ‘Scaling the Asylum’, p. 113.

<sup>632</sup> Topp, *Freedom and the Cage*, p. 3. See also: Patrick Joyce, *The Rule of Freedom: Liberalism and the Modern City* (London: Verso, 2003).

<sup>633</sup> HHB/3/5/1/18/1, p. 445.

indicating the significance of surveillance in replacing methods of restraint.<sup>634</sup> An obituary to Aitken in the *British Medical Journal* stated that Inverness District Asylum had ‘always enjoyed a high reputation, thanks to the admirable management and skill of its superintendent’.<sup>635</sup> An example given to indicate this referred specifically to the degree of freedom within outdoor space: ‘In suitable cases he believed in allowing his patients a considerable measure of liberty, and afforded them every opportunity for healthy outdoor exercise.’<sup>636</sup>

The structure of Inverness District Asylum with the absence of a perimeter wall, and the reputation of Aitken, all contribute to the view of an institution aiming to create a sense of freedom within confinement. However, while the absence of a wall around the grounds has been discussed in studies of the history and architecture of the institution, another interesting feature has received less attention. Additional housing for patients was acquired in the asylum’s first year of operation, within the grounds but outside of the primary residence. One purpose of the cottages was to supervise those ‘capable of being dismissed’ to test whether they could be discharged.<sup>637</sup> However, the great number of incurable cases at Inverness meant that the cottages were additionally set up as a place for those who were ‘likely to be permanent residents in the community’.<sup>638</sup>

The use of the word ‘community’ demonstrates the intention for these cottages to create a home from home for the incurable. Aitken detailed that ‘married attendants with their families should reside’ in the cottages, ‘and that with them should be placed a number of patients’, in a group no more numerous than ‘a moderately large family’.<sup>639</sup> Residency in the cottage would therefore mean that patients could be supervised, but that they would also have a sense of freedom, independence and purpose. Aitken emphasised that they had an active role within their home: ‘They ought to be made to feel that they have really become useful members of a household, and that their interest in it is appreciated.’<sup>640</sup> The cottages therefore created a place where patients deemed incurable as the result of an actual domestic space, and therefore incapable of reintegration into society outside of the asylum grounds, could form a meaningful household with those supervising them to create a smaller, contained community.

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<sup>634</sup> HHB/3/5/1/18/1.

<sup>635</sup> Obituary: Thomas Aitken’, p. 795.

<sup>636</sup> Obituary: Thomas Aitken’, p. 795.

<sup>637</sup> *First Annual Report of the Inverness District Lunatic Asylum* (1865), p. 15.

<sup>638</sup> *First Annual Report of the Inverness District Lunatic Asylum* (1865), p. 19.

<sup>639</sup> *First Annual Report of the Inverness District Lunatic Asylum* (1865), p. 19.

<sup>640</sup> *First Annual Report of the Inverness District Lunatic Asylum* (1865), p. 19.

A similar provision of cottages was established by Skae in 1856 at the Royal Edinburgh Asylum in response to the number of chronic patients admitted from different parts of Scotland, limiting the institution's capacity for new admissions. Skae attributed his influence for this to Bucknill's use of additional housing in the asylum at Devon.<sup>641</sup> Topp has also written about a similar 'villa system' in Germany at the end of the nineteenth century which was imported into Prague in the early twentieth century, so that 'so-called quiet patients' could 'live in relative freedom while remaining in confinement'.<sup>642</sup> The system was therefore not unique to Aitken and Inverness, but a study of its use at Inverness is valuable to investigate a navigation of methods of care in an institution opened mainly in response to significant numbers of incurable patients, especially in the context of the perceived correlation between the actual home space and incurability, but the creation of supervised households situated within the asylum as a response.

Occupation was an important part of the micro households. Aitken adds: 'in whatever they may be employed, they ought to be encouraged to act as free and responsible individuals, and not as if their lives were regulated by the will of another'.<sup>643</sup> Occupation was used as a means of managing patients' responses to emotional states and psychosis, even if they were considered incurable. In his work on curability, Aitken discussed the implications of time without psychiatric treatment on mania specifically, through examples where patients developed dangerous habits in response to their emotional states, delusions, and hallucinations. In diagnoses of mania, the divide between curability and incurability was distinguished by cases being termed either 'acute' or 'chronic'.<sup>644</sup> In chronic cases, characterised by the illness having been experienced for some time without psychiatric treatment, emotional states, delusions, and hallucinations, were believed to become increasingly ingrained in the behaviour of the patient. An example was illustrated in the case records of A.R., admitted to the Inverness District Asylum in 1864 and diagnosed with 'chronic mania'.<sup>645</sup> His delusion was related to 'excitement' and of a grandiose nature, believing he was 'emperor of the world', and that 'he

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<sup>641</sup> See: *Annual Report of the Royal Edinburgh Asylum* (Edinburgh: Royal Asylum Press, 1855); *Annual Report of the Royal Edinburgh Asylum* (Edinburgh: Royal Asylum Press, 1856). For a study of practices in the asylum at Devon, see: Bill Forsythe, Joseph Melling and Richard Adair, 'Politics of Lunacy: Central State Regulation and the Devon Pauper Lunatic Asylum, 1845-1914', in *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective*, ed. by Joseph Melling and Bill Forsythe (London: Routledge, 1999).

<sup>642</sup> Topp, *Freedom and the Cage*, p. 1.

<sup>643</sup> *First Annual Report of the Inverness District Lunatic Asylum* (1865), p. 19.

<sup>644</sup> *First Annual Report of the Inverness District Lunatic Asylum* (1865).

<sup>645</sup> HHB/3/5/2/1, p. 138.



alone possesse[d] the power of doubling things that he looks at', which he achieved by looking at the sun.<sup>646</sup> The patient case notes observe him as 'looking at the sun constantly because of the simulacra of itself that appears to pass from its surface in immense numbers and variations of colours'.<sup>647</sup> This habit became obsessive for A.R. because it affirmed the belief that he possessed a unique ability. However, the damage of the habit was also demonstrated as it nearly led to 'the loss of an eye', having caused an 'ulceration of the cornea'.<sup>648</sup>

Aitken explained: 'the necessity for promptitude in most cases' is to prevent 'the delusions or caprices to form the habits of the patient'.<sup>649</sup> In going without institutional treatment, delusions and corresponding behaviours could 'take root' and were therefore more difficult to tear out.<sup>650</sup> He provided a striking illustration of this by including the following case in his first annual report:

The death of her husband appears to have induced premature labour, and the birth of a child upon the same day was followed by haemorrhage to such an extent that syncope occurred. The feelings of instability accompanying the last conscious sensations of this state were converted, by a mind naturally predisposed to disease and already disturbed by the loss of her husband, into a delusion that she had been plunged into Loch-Ness, and to save herself from sinking she seized, in imagination, a stone. From that moment this idea has been persistent, and she was admitted with her hands firmly closed. As persuasion proved of no avail, it was determined to compel the patient to open them, and it was then found that the nails had in their growth forced their way half through the palms, whilst the closed hands had been made the receptacle of chicken bones, pearl buttons, small pieces of rags, stones, etc., which the patient treasured. From this time – and as the extension of the fingers, considerably contracted at their joints, appeared to give great pain – she was made to carry rounded pieces of wood, which have been gradually enlarged, and the patient can now nearly open her hands to their full extent, and daily engages in sewing or knitting.<sup>651</sup>

In this example, it is possible to trace the repercussions of a delusion taking hold through the physical consequences for the patient. Emotional repercussions from the death of her husband

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<sup>646</sup> HHB/3/5/2/1, p. 138.

<sup>647</sup> HHB/3/5/2/1, p. 138.

<sup>648</sup> HHB/3/5/2/1, p. 139.

<sup>649</sup> *First Annual Report of the Inverness District Lunatic Asylum* (1865), p. 13.

<sup>650</sup> *First Annual Report of the Inverness District Lunatic Asylum* (1865), p. 14.

<sup>651</sup> *First Annual Report of the Inverness District Lunatic Asylum* (1865), p. 14.

and the premature birth of her child led to the patient collapsing. As a result, a delusion was formed in relation to mortality, consistent with delusions in depressive states, in the patient's belief that she had been plunged into a body of water and faced drowning. The delusion progressed into an attempt to escape from deterioration through grounding, in which the patient believed she had been able to save herself by physically holding onto a stone. Time without treatment meant the delusion was able to become ingrained in the behaviour of the patient – the gradual rooting of the delusion mirrored in the growth of her nails through her palms. In consequence, the patient was incapable of opening her hands or, in her view, releasing her grip from the stone. The difficulty of reversing the rooting of the delusion was shown through the need to slowly open her hands through the placement of pieces of wood which were steadily increased in size. This gradual physical restoration led eventually to the ability for the patient to use her hands for sewing and knitting, which were roles of employment in the asylum. Aitken noted that, while a chronic case might not be cured, modes of 'occupation' could 'exercise a beneficial effect' by 'distracting the mind from the morbid ideas and delusions occupying it'.<sup>652</sup> In this instance, the grip of the patient's hands on the stone was substituted by the use of her hands in occupation, creating distraction from her delusion.

Aitken described the use of occupation in a way that was specific to the patient's delusion. For example, patient J.M., was observed with the delusion that he was 'sent by the Almighty to convert the world'.<sup>653</sup> His behaviour in the asylum was characterised by 'a grotesqueness and absurdity', with 'fits of the most uncontrollable laughter', and 'grimaces and gesticulations'.<sup>654</sup> He was illustrated as being already 'three years insane', with notes about his time outside of asylum treatment: 'for two years he wandered about the west coast as a self-constituted missionary'.<sup>655</sup> As discussed by Aitken in his *First Annual Report*, chances for curability were perceived to be between just 15 and 20 percent when the disease had been experienced for over the duration of one year and left untreated.<sup>656</sup> In light of this perception, J.M.'s three years of mental ill health would place him with a small chance of recovery.

However, an occupation was discovered for J.M. which helped manage his delusion, while also finding comfort in the asylum space. His eagerness to spread his message about the Almighty meant that 'all over the grounds his voice [was] heard', and he found an audience in

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<sup>652</sup> *First Annual Report of the Inverness District Lunatic Asylum* (1865), p. 15.

<sup>653</sup> HHB/3/5/2/1, p. 132.

<sup>654</sup> HHB/3/5/2/1, p. 132.

<sup>655</sup> HHB/3/5/2/1, p. 132.

<sup>656</sup> *First Annual Report of the Inverness District Lunatic Asylum* (1865), p. 13.

the form of the pigs kept within the institution's grounds.<sup>657</sup> The case notes observed that 'his greatest delight [was] to address the pigs whom he call[ed] ministers and whom he most faithfully attends and who are regarded by him as human'.<sup>658</sup> J.M. was encouraged to maintain his company with the pigs, and saw 'tending to the pigs' as 'his peculiar care'.<sup>659</sup> This encouragement was further indicated by the note that the patient 'require[d] no supervision and [was] let out in the morning and return[ed] regularly at meal time', demonstrating the freedom allowed to him to focus on this occupation.<sup>660</sup> The fact that this freedom led to no attempts to escape, which were not infrequent in Inverness District Asylum, and that McLennan returned regularly without supervision, would also suggest that pursuing this occupation was beneficial to his mental wellbeing.

These two cases indicate ways forms of employment in the asylum were used in relation to that patient's particular delusion. Foucault argued that forms of work within an asylum were 'deprived of any productive value', but instead 'imposed as a moral rule'.<sup>661</sup> However, these examples at Inverness emphasised the relationship between occupation and managing symptoms of mania. While sewing and tending to the livestock of the asylum were not uncommon occupations, in these two examples, the occupations served the specific purpose of aiding a patient's delusional beliefs.<sup>662</sup> In the case of the female patient, whose hands were clasped tightly shut because of her delusion, the gradual opening of her hands allowed her to be occupied in a new way. Once her hands had been sufficiently opened, she was encouraged to use sewing to distract from the specific delusion. In the male case, tending to the pigs could be perceived as fulfilling the delusion, by allowing the patient to share his message with creatures he saw as ministers, while being given a sense of freedom to move through the asylum grounds. In both cases, the use of occupation in relation to delusion was represented as beneficial to the patients' mental ill health. The creation of micro households, and finding occupations that helped manage the rooted behaviours of patients diagnosed with chronic mania, indicates specific forms of care at Inverness in response to its provision for many incurable cases. In the next section, I will continue my analysis of Aitken's writing on delusions

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<sup>657</sup> HHB/3/5/2/1, p. 133.

<sup>658</sup> HHB/3/5/2/1, p. 133.

<sup>659</sup> HHB/3/5/2/1, p. 133.

<sup>660</sup> HHB/3/5/2/1, p. 133.

<sup>661</sup> Foucault, *Madness and Civilization*, p. 269.

<sup>662</sup> For work on occupation within institutions, see for example: Pamela Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000* (Cornwall: MPG Books, 2003), p. 71; Stef Eastoe, 'Playing Cards, Cricket and Carpentry: Amusement, Recreation and Occupation in Caterham Imbecile Asylum', *Journal of Victorian Culture*, 24.1 (2018), pp. 1-17

to argue that the institution also provided specific care in terms of shared mythologies grounded in place.

### **‘Deviating as the Celtic Population Do’: Culturally Specific Care**

Beyond its role admitting the incurable cases identified by the Scottish Lunacy Commission, Inverness District Asylum was also established to provide care specific to place. Parr’s, Philo’s and Burns’s study of the history of the asylum discusses its response to ‘localised calls for culturally specific forms of care’, providing an example from *A copy of a memorial from the inhabitants of Inverness to the Secretary of State* (1857):<sup>663</sup>

differing, as the Celtic population do, in their mother tongue, manner and habits of thought, from their fellow countrymen, they require, when morbidly afflicted in mind, to be particularly dealt with.<sup>664</sup>

Differences in language and culture led to the belief that patients from the Highlands and Islands required specific care.<sup>665</sup> Like concerns about Welsh, an article in *John o’ Groat Journal* in 1857 highlighted a lack of Gaelic-medium treatment as one of the reasons for reluctance in the Highlands and Islands to access institutional treatment. In addition to concerns about ‘removing their friends to so great a distance’, in ‘Gaelic-speaking counties’, there were concerns about the ‘great discomfort to the patient’ with no access to treatment where ‘their own language is spoken by the attendants’.<sup>666</sup>

The annual reports of Inverness District Asylum, as well as the annual Lunacy Commissioner Reports for the asylum, detailed ways treatment was structured to cater specifically for patients from the Highlands and Islands. Like in Wales, language was one of the notable differences. The first Lunacy Commissioner Report noted that several of the staff and attendants spoke Gaelic.<sup>667</sup> The other mention of Gaelic in the reports regarded worship – from the second year of the asylum, services were given ‘alternately in English and Gaelic, instead of formerly only in English’.<sup>668</sup>

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<sup>663</sup> Parr, Philo and Burns, “‘That awful place was home’”, p. 344.

<sup>664</sup> *A Copy of a Memorial* quoted in Parr, Philo and Burns, “‘That awful place was home’”, p. 344.

<sup>665</sup> *A Copy of a Memorial* quoted in Parr, Philo and Burns, “‘That awful place was home’”, p. 344.

<sup>666</sup> ‘Lunacy in the Northern Counties’, p. 3.

<sup>667</sup> James Cox, ‘Report of the Commissioner in Lunacy’ in *First Annual Report of the Inverness District Lunatic Asylum* (1865), p. 4.

<sup>668</sup> *Second Annual Report of the Inverness District Lunatic Asylum* (Inverness: Courier’s Office, 1866), p. 27.

Parr, Philo, and Burns argue that, despite the indicated purpose of the institution to provide particular care for the language and culture of the Highlands and Islands, ‘there is little evidence (beyond some staff being able to speak Gaelic) that culturally sensitive care was practised’.<sup>669</sup> However, I argue that, while language may appear to have been less of a priority in Inverness than in the North Wales Lunatic Asylum, there are other signs of provisions of specific care at Inverness indicating adaptations in care between periphery and core.<sup>670</sup> First, as argued in the previous section, the institution created its system of additional housing in part to create micro households for chronic patients who had previously been subject to a system of community care. I argue that this was a form of negotiation in the transition to institutional care, where the actual home space was seen as causing incurability, but a domestic atmosphere within the institution could create comfort, if not cure. Moreover, in relation to occupation as a means of managing the impact of ‘rooted’ delusions, the institution provided outdoor occupation for women who had previously been outdoor workers. This was connected in the first annual report by lunacy commissioners to differences in the female population of the Highlands and Islands: ‘an effort should be made to have [the female patients] more in the open air’, because a ‘great many’ of the female patients ‘lead at their own homes a life which is a peculiarly an out-of-door one.’<sup>671</sup> The view of peculiarity highlights difference according to place. Furthermore, the suggestion of finding ways to accommodate, despite the view of peculiarity, demonstrates adaptations for culturally specific treatment.<sup>672</sup>

Waddington’s work on regional analysis highlights the role of shared mythologies according to place in illness narratives.<sup>673</sup> Accordingly, a key feature of the institution at Inverness’s provision of culturally specific care was tied to the influence of Highland culture on the shape of delusions. Individuals from beyond the Highland line were seen as fundamentally different because of their beliefs. In the *Sixth Annual Report* of asylum, the Commissioner in Lunacy report claimed ‘it is necessary to bear in mind the habits of the community from which the patients have been drawn’, specifying ‘their superstition’.<sup>674</sup> Aitken’s part in this discussion focused on the impact Highland beliefs had on the shape of patients’ delusions and hallucinations. The influence that informed the theme of delusions was

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<sup>669</sup> Parr, Philo and Burns, ““That awful place was home””, p. 354.

<sup>670</sup> Waddington, ‘Thinking Regionally’.

<sup>671</sup> *Seventh Annual Report of the Inverness District Lunatic Asylum* (Inverness: Courier Office, 1871), p. 7.

<sup>672</sup> I will expand on this point in a discussion of differences in the experience of mania for women and men in Chapter Six.

<sup>673</sup> Waddington, ‘Thinking Regionally’.

<sup>674</sup> James Coxe, ‘Report of the Commissioner in Lunacy’ in *Sixth Annual Report of the Inverness District Lunatic Asylum* (1870), p. 11.

widely interrogated in medical writing. A prominent idea was that both the specific beliefs of the patient, as well as current events, influenced the shape a delusion would take. For example, Skae, superintendent of the Royal Edinburgh Asylum, wrote about the impact of royal visits on delusional beliefs. In the asylum's *Annual Report* of 1850, he stated that 'the prevailing delusions of the insane derive their character from the most engrossing topics of the current events of the day' based on the asylum's population of 'no less than seven queens, of whom three claim to be Queen Victoria, and three Empress of the World', with 'three of those admitted' having become mentally unwell 'at the time of the Queen's last visit to Scotland'.<sup>675</sup>

Aitken contributed to this medical discussion in Inverness District Asylum's annual reports by analysing the influence of Highland culture on the form of delusions. Like Skae, Aitken noted that delusions could be 'moulded by current events'.<sup>676</sup> However, he added that 'the influence of ancient superstitions in determining the nature of delusions' had been 'frequently verified since the opening of the Asylum'.<sup>677</sup> Aitken provided examples of the relationship between psychosis and place-specific beliefs in annual reports. A male patient was observed with the delusion that three of his neighbours were 'witches' and that they had formed a *corp-criadha*, which in Highland tradition is a clay-body not unlike a voodoo doll.<sup>678</sup> The patient believed his neighbours 'were anxiously awaiting the gradual decay of his body as the clay image wasted', and claimed to have 'evidence' of the 'exact spot into which the first pin had been placed, in an inflamed spot under the bridge of his nose'.<sup>679</sup> In addition, a female patient was recorded as believing she was part cat, which Aitken connected to 'a condition associated with Lycanthropia, or wolf madness', and he relates this condition to place-specific beliefs by stating: 'traces of which still live in many of the traditions handed down to the present time'.<sup>680</sup> He recorded the way the delusion directed her behaviour: 'imitat[ing] the habits of [...] cats allowed to inhabit the wards', by moving 'on all fours', 'call[ing] from time to time like her feline associates' and 'mew[ing] between every spoonful of food'.<sup>681</sup>

Aitken's recognition of links between culture and the form of psychosis is crucial to unpicking Inverness District Asylum's provision of culturally specific care. His appreciation of mythologies as grounding a belonging to place, and in influencing the shape taken by

<sup>675</sup> *Annual Report of the Royal Edinburgh Asylum* (Edinburgh: Royal Asylum Press, 1850), p. 20.

<sup>676</sup> *Annual Report of the Royal Edinburgh Asylum* (1850), p. 20.

<sup>677</sup> *Fourth Annual Report of the Inverness District Lunatic Asylum* (Inverness: Courier's Office, 1868), p. 22.

<sup>678</sup> *Third Annual Report of the Inverness District Lunatic Asylum* (Inverness: Courier's Office, 1867), p. 22-23.

<sup>679</sup> *Third Annual Report of the Inverness District Lunatic Asylum*, pp. 22-23.

<sup>680</sup> *Third Annual Report of the Inverness District Lunatic Asylum*, p. 22.

<sup>681</sup> *Third Annual Report of the Inverness District Lunatic Asylum*, p. 22.

patients' hallucinations and delusions, shows a physician's perspective on different experiences of mania according to place. His own awareness of traditions indicates an approach that recognised the importance of being able to understand beliefs to be able to treat individuals. In addition to a necessity for communication, as seen in discussions about language, there is a suggestion that a need to understand the culture that influenced the shape of delusions and hallucinations was a factor in accessible treatment. Unlike some of the comments in the lunacy commissioners' reports for Inverness District Asylum, which were disparaging about patients from the Highlands and Islands' 'ignorance', 'want of general culture', 'superstition', and 'consequent resistance of civilising influence',<sup>682</sup> Aitken's writing about the relationship between cultural beliefs and psychosis appears to be written without judgement, but instead as an exploration seeking to develop understandings of the nature of delusions and hallucinations and an ability to treat them.<sup>683</sup>

The influence of beliefs on delusions and hallucinations was also recorded in literary representations of mania. Furthermore, literary representations also interrogated tensions in medical authority by illustrating experiences with ambiguity about whether they were delusions and hallucinations, or whether they were grounded in fact. Returning to MacDonald's *The Portent*, second sight was a belief in premonition specific to Highland culture. John Gregorson Campbell, known for his dedication to collecting tales of Highlands legends, wrote extensively about this ability, collecting tales about the mythology from oral sources. Elizabeth Ritchie points out that Campbell's own comments were minimal, focusing instead on the voices of individual storytellers.<sup>684</sup> Campbell described the 'gift of second sight' as 'being "spectre-haunted"', or liable to "spectre illusions".<sup>685</sup> Crucially, he stated that second sight could occur, and 'often does', in 'persons of sound mind', setting up two branches of explanation:<sup>686</sup>

The phenomena in both cases are the same; the difference is in the explanation given of them. In the one case the vision is looked on as unreal and imaginary, arising from

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<sup>682</sup> James Coxe, 'Report of the Commissioner in Lunacy', p. 11.

<sup>683</sup> While there is limited writing on Aitken as a figure, his interest in the Highlands as a place, and his role within the community at Inverness, are conveyed in an obituary in the *British Medical Journal*: the obituary attributes his interest in the Highland to his interests 'as archaeologist and geologist' as well as physician, and he was described as 'familiar' with the 'North of Scotland', being a 'frequent contributor of papers [...] to the Field Club'. Moreover, the local society at the Inverness Field Club was formed in 1875 because of Aitken's suggestion in a letter to *The Inverness Courier*. See: 'Obituary: Thomas Aitken', *British Medical Journal*, 2 (1892), p. 795; 'Inverness Field Club', *Open Lectures: Natural History Societies*.

<sup>684</sup> Elizabeth Ritchie quoted in Graeme Morton and Trevor Griffiths, *A History of Everyday Life in Scotland, 1800-1900* (Edinburgh: Edinburgh University Press, 2010), p. 13.

<sup>685</sup> John Gregorson Campbell, *Witchcraft & Second Sight in the Highlands & Islands of Scotland: Tales and Traditions Collected Entirely from Oral Sources* (Glasgow: James MacLehose and Sons, 1901)

<sup>686</sup> Campbell, *Witchcraft & Second Sight in the Highlands & Islands of Scotland*.

some bodily or mental derangement, and having no foundation in fact, while the other proceeds on a belief that the object is really there and has an existence independent of the seer.<sup>687</sup>

Campbell explained that the experience of second sight was perceived either as being a symptom of mental illness, or of being an experience rooted in fact. These two options are set up as opposing poles: either the experience is real, or it indicates a break from reality. He tied this to a difference between science and superstition: ‘science has accepted’ the cause of mental illness ‘as the true and rational explanation’.<sup>688</sup> Moreover, Campbell discussed the medical view of ‘spectral illusions’ in the context of severe emotional states, pointing specifically to ‘strong emotions’ as ‘causes that lead to hallucination and delusion’, tying to the classification for mania.<sup>689</sup>

Through second sight, those with the gift, referred to as seers, had the ability to ‘see the ghosts of the dead revisiting the earth, and the fetches, doubles, or apparitions of the living’.<sup>690</sup> Spectres were able to cause harm to those they haunted. Campbell transcribed examples of punishment if a spectre was ignored: ‘the phantom came regularly every evening for him, and if its call was disregarded it gave him next evening a severe thrashing’.<sup>691</sup> Another similar example explained that if the ‘anger of the spectre was roused’ but the ‘dreadful thrashing’ was ‘resisted’, the person haunted ‘grasped but a shadow, was thrown down repeatedly in the struggle, and bruised severely’.<sup>692</sup> This illustrated both the risk of violence from a spectre, and the seer’s vulnerability to it. Moreover, it portrayed the notion of being pursued by a spectre, and the difficulty of escaping from it.

The combination of sensory hallucinations and delusional beliefs on the subject of being pursued by some form of evil spirit were frequently recorded in Inverness District Asylum. J.M., admitted in 1875, was observed as being subject to visual ‘hallucinations’.<sup>693</sup> He was described with ‘a desire to escape observation’, as a result of which he ‘covers his face’.<sup>694</sup> In reaction to his hallucinations, he was observed with an ‘expression of fear’ in ‘anticipation of evil’, while ‘muttering and talking of things that are imaginary’, and ‘looking thoroughly

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<sup>687</sup> Campbell, *Witchcraft & Second Sight in the Highlands & Islands of Scotland*.

<sup>688</sup> Campbell, *Witchcraft & Second Sight in the Highlands & Islands of Scotland*.

<sup>689</sup> Campbell, *Witchcraft & Second Sight in the Highlands & Islands of Scotland*.

<sup>690</sup> Campbell, *Witchcraft & Second Sight in the Highlands & Islands of Scotland*.

<sup>691</sup> Campbell, *Witchcraft & Second Sight in the Highlands & Islands of Scotland*.

<sup>692</sup> Campbell, *Witchcraft & Second Sight in the Highlands & Islands of Scotland*.

<sup>693</sup> HHB/3/5/2/8, p. 16.

<sup>694</sup> HHB/3/5/2/8, p. 16.



about him' with the appearance of being 'afraid of injury'.<sup>695</sup> Damage to his wellbeing was indicated by his duration under domestic care. His wife explained that 'it was necessary for some time to have him under restraint' within the domestic space.<sup>696</sup> Time without treatment, the impact of bodily restriction, and the habit of a 'melancholy [...] posture' because of his hallucinations were given as potential causes for his 'considerable difficulty walking at times'.<sup>697</sup> Similarly, patient M.F., admitted in 1877, was recorded as being subject to 'hallucinations of sight' alongside the belief that she was 'constantly beset by the devil'.<sup>698</sup> Her fear leads to her being 'destructive and coming out of bed at night'.<sup>699</sup> Like J.M., M.F.'s behaviour in response to her hallucinations resulted in a marked deterioration in her wellbeing: 'she can only walk with difficulty owing to her exhaustion'.<sup>700</sup>

Another example sees E.M., admitted in 1876, whose emotional state was described as 'alternately glad and depressed'.<sup>701</sup> Her symptoms included 'hear[ing] her mother speaking to her', and 'spirits speaking to her'.<sup>702</sup> In his writing on second sight, Campbell pointed out that the spectres could include spirits of deceased family members. Campbell related the story of a woman from the island of Coll who, 'lying ill [...] had strange feelings of oppression and sickness'.<sup>703</sup> Her husband's father, a seer, 'told her she had herself to blame for her sickness', because it was being 'caused by the spirit of her dead father coming and lying its weight upon her'.<sup>704</sup> In addition, another tale, from Perthshire, told of a woman who, 'being ill-treated by her husband' wished for her brother 'who has some time previously died in Edinburgh'.<sup>705</sup> A spectre of her brother soon appeared when she was alone. Upon hearing from his sister why she had called upon him, she saw his spirit going towards her husband, 'and when it reached, her husband fell dead'.<sup>706</sup>

Duncan's second hearing in *The Portent* similarly illustrates persecution by a spectre. The spirit belongs to a 'fierce rider', who became 'mad with rage', killing his brother because

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<sup>695</sup> HHB/3/5/2/8, p. 16.

<sup>696</sup> HHB/3/5/2/8, p. 16.

<sup>697</sup> HHB/3/5/2/8, p. 17.

<sup>698</sup> HHB/3/5/2/9, p. 460-462.

<sup>699</sup> HHB/3/5/2/9, p. 460.

<sup>700</sup> HHB/3/5/2/9, p. 460.

<sup>701</sup> HHB/3/5/2/9, p. 509.

<sup>702</sup> HHB/3/5/2/9, p. 509.

<sup>703</sup> Campbell, *Witchcraft & Second Sight in the Highlands & Islands of Scotland*.

<sup>704</sup> Campbell, *Witchcraft & Second Sight in the Highlands & Islands of Scotland*.

<sup>705</sup> Campbell, *Witchcraft & Second Sight in the Highlands & Islands of Scotland*.

<sup>706</sup> Campbell, *Witchcraft & Second Sight in the Highlands & Islands of Scotland*.

the woman he loved, Elsie, loved his brother instead.<sup>707</sup> Lifting Elsie upon his horse, he accidentally causes her death when her ‘long hair’, which was ‘shaken loose’ and ‘trailing on the ground’ becomes tangled and she is trampled upon.<sup>708</sup> The rider and the horse are found dead alongside Elsie the following day, ‘at the foot of a cliff, dashed to pieces’.<sup>709</sup> There is uncertainty about whether the death was suicide, or whether the ‘loose and broken’ hind-shoe of the horse was the cause of the fall.<sup>710</sup> Duncan’s second hearing, or hallucination, centres on repeatedly hearing the ‘iron-shod hoofs of a horse, in furious gallop along an uneven rocky surface’, and a ‘peculiarity’ in the sound, that indicated ‘one of the shoes being loose’.<sup>711</sup> The sound causes him to feel ‘a strange terror’.<sup>712</sup> Alice shares this ability for hearing, stating, ‘I too am afraid of hearing things’, as a result of also ‘hear[ing] the sound of a loose-horse shoe’, which ‘betokens some evil’.<sup>713</sup> Like the patients at Inverness District Asylum, the habits formed in reaction to the hallucination cause harm to Duncan and Alice. The ‘agony of fear’ caused by the ‘clank of a loose shoe’ causes Duncan to act in a way that re-enacts the death of Elsie. In his fear, Duncan ‘caught [Alice] up in [his] arms’, and ‘sped with her’.<sup>714</sup> However, like Elsie, ‘her hair, which had got loose, trailed on the ground’, and, like the rider, as Duncan ‘fled, [he] trampled upon it and stumbled’.<sup>715</sup>

The presentation of Duncan and Alice’s sensory experience is not described as being either certainly the gift of second hearing, or certainly symptoms of mental illness. Instead, the representation of the sound, and the speculation of the characters about their own wellbeing, moves between the two branches of ideas about second sight set out by Campbell: that it is either real or a break from reality. Duncan’s old foster-mother, who possesses the gift of second sight, reacts fearfully to Duncan’s description of the sound of the broken horseshoe. She is the person who tells him the tale of the rider, warning him of ‘persecution’ by the spectre, who she believes caused the death of Duncan’s mother in childbirth.<sup>716</sup> Although troubled by the sound of the horseshoe, Duncan initially ‘could not help doubting her sanity’.<sup>717</sup> Later, following a repeated and intensified experience of the sound and feeling of being pursued, Duncan’s doubts

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<sup>707</sup> George MacDonald, ‘The Portent’, *The Cornhill Magazine*, 1 (1860), pp. 622-623.

<sup>708</sup> MacDonald, ‘The Portent’, p. 624.

<sup>709</sup> MacDonald, ‘The Portent’, p. 624.

<sup>710</sup> MacDonald, ‘The Portent’, p. 624.

<sup>711</sup> MacDonald, ‘The Portent’, p. 619.

<sup>712</sup> MacDonald, ‘The Portent’, p. 619.

<sup>713</sup> George MacDonald, ‘The Portent’, *The Cornhill Magazine*, 2 (1860), p. 81.

<sup>714</sup> MacDonald, ‘The Portent’, p. 676.

<sup>715</sup> MacDonald, ‘The Portent’, p. 676.

<sup>716</sup> George MacDonald, *The Portent* (1864), p. 16.

<sup>717</sup> MacDonald, *The Portent*, p. 16.

extend to himself, expressing ‘sometimes I questioned my own sanity’.<sup>718</sup> In addition, after their separation, he questions whether Alice had been real, or if she had simply been another spectre, ‘having vanished with all the other phantoms of a sick brain’.<sup>719</sup> By representing the sensory experience with uncertainty, MacDonald invites analysis of the relationship between cultural beliefs and psychiatric classifications.

A further aspect leading to ambiguity about the experience is a representation in *The Portent* of recovery. Alice is able to unroot the behaviours caused in response to her hallucinations. She hears again the ‘the horse with the clanking shoe’, but is demonstrated as breaking the habits formed in reaction to the sound.<sup>720</sup> She asserts to Duncan, ‘My brain is all right. It is come again. But they shall not part us this time. You follow me for once.’<sup>721</sup> Alice’s lead allows them to escape and, once over the Scottish border, they ‘never again heard the clanking shoe’.<sup>722</sup> The importance of place is indicated through their achievement of peace, or recovery, through a return to the place that characterised their second hearing, or hallucination. The final note from Duncan that Dr. Ruthwell ‘considers [him] sane enough now’ because of changes in condition resulting from their return, suggests the importance of care sensitive to the shared meanings of place.<sup>723</sup>

A view of *The Portent* as exploring treatment according to place is supported by the connection between the story and *Alice’s Adventures in Wonderland*. R.B. Shaberman records that Carroll’s and MacDonald’s friendship ‘extended for more than twenty years’ and was at its ‘most intimate immediately before and during the writing of the *Alice* books’.<sup>724</sup> Moreover, Shaberman claims that MacDonald and his wife ‘must be granted a foremost place’ among those who ‘[brought] about the publication of the first *Alice* book’ because of an entry in Carroll’s diary on May 9, 1863 that described their ‘wish for [Carroll] to publish’ after reading a copy lent to them.<sup>725</sup> Based on my analysis of *Wonderland* as exploring symptoms of mania within Welsh spaces of care, a connection can be drawn in particular with the extended sections of *The Portent* in 1864, in which MacDonald’s Alice’s means of escape, like Carroll’s Alice, is a result of becoming assertive in identifying symptoms of mania. She changes her

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<sup>718</sup> MacDonald, *The Portent*, p. 56.

<sup>719</sup> MacDonald, *The Portent*, pp. 56-57.

<sup>720</sup> MacDonald, *The Portent*, p. 92.

<sup>721</sup> MacDonald, *The Portent*, p. 92.

<sup>722</sup> MacDonald, *The Portent*, p. 93.

<sup>723</sup> MacDonald, *The Portent*, p. 93.

<sup>724</sup> R. B. Shaberman, ‘Geroge MacDonald and Lewis Carroll’, *North Wind: A Journal of George MacDonald Studies*, 1 (1982), pp. 10-30 (p. 17).

<sup>725</sup> R. B. Shaberman, ‘Geroge MacDonald and Lewis Carroll’, p.18.

behavioural response to the sound of the horseshoe, in the same way that Wonderland sees Alice contesting her arrest and calling out the pack of cards.<sup>726</sup>

Tensions between place-specific beliefs and classifications for mental illness were also explored in the work of another celebrated Scottish author. Margaret Oliphant's 'A Christmas Tale' was first published in 1857 in *Blackwood's Edinburgh Magazine*, the same year the inquiries of the Scottish Lunacy Commission were taking place. This short story is more sceptical about the implementation of medical classifications and practices from outsiders, or core, onto communities, or peripheries, with shared beliefs and traditions. The tale sees its protagonist stranded in a remote village after missing his train, and encountering a mysterious and possibly violent tradition in the succession of male heirs in the Witcherley household. The visiting stranger is stunned by his conversation with the Old Squire, who tells him that every marriage in the Witcherley line will bear a single male heir, and once that heir is married, the father will cease to be. The visitor tries to calm himself with the explanation that the Old Squire is experiencing monomania. However, the visitor's own behaviour that becomes increasingly associated with observations in patient case records of mania. Like the physician in Cymro Bach's 'Hanes y Dyn yn y Lleuad' [The History of the Man in the Moon], analysed in Chapter Three, it is the visitor who presents with behaviours associated with mania, while trying to impose his own view of medical classifications onto a community with unfamiliar customs and beliefs.

Though there is a substantial body of literary scholarship on Oliphant's writing, 'A Christmas Tale' appears to have received little critical attention. However, scholarship on other examples of Oliphant's writing has shown the possible influence of medical writing on her work. Simon Cooke connects Oliphant's 'The Library Window' to "'female madness" as defined by male theorists', examining the short story alongside Henry Maudsley's *The Pathology of Mind* (1895) and *Body and Mind* (1870).<sup>727</sup> Cooke points out that 'there is no external evidence that Oliphant read these writers' books', but makes a case for the influence

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<sup>726</sup> See Chapter Three for analysis of Alice's Adventures of Wonderland and Welsh spaces of care.

<sup>727</sup> Simon Cooke, 'Margaret Oliphant's "The Library Window" and the Idea of Adolescent Insanity', *Victorians Institute Journal*, 34 (2006), 244-57 (p. 244). Similarly, the 2019 *Broadview* edition of 'The Library Window' includes texts such as E. J. Tilt's *On The Preservation of the Health of Women at the Critical Periods of Life* (1851), and G. Stanley Hall's *Adolescence: Its Psychology and Relations to Physiology, Anthropology, Sociology, Sex, Religion and Education*, vol. 2 (1904), to contextualise medical ideas about female madness, and suggests the influence of these ideas on Oliphant – see: Margaret Oliphant, 'The Library Window', ed. By Annmarie Drury (Ontario: Broadview Press, 2019).

of this concept of female madness, defined by male medical authority, on Oliphant's writing.<sup>728</sup> I argue that 'A Christmas Tale' also demonstrates Oliphant's challenges to medical authority.<sup>729</sup>

The visitor's sense of authority is based on differences in place. Though not named as a physician, his movement from the urban space of education and knowledge, to a 'very rural' space with 'an unreasonable time to wait' for a train, unsophisticated hospitality, and speech in a 'strange' dialect, is depicted as traversing back in time.<sup>730</sup> The train is described by the protagonist as 'an entirely new institution in this primitive corner of the country', and 'not so extreme a novelty in other parts of the world as in Witcherley' (p. 76). In contrast, the Old Squire disapproves of this new feature in favour of the 'good old coach' (p. 76). In this 'primitive place', the visitor's knowledge is set against the Old Squire's 'some little knowledge of the world' (p. 77). This contrast in knowledge becomes centred on medical ideas, specifically diagnostic categories, when the visitor appeals to the owners of the Witcherley Arms about the Old Squire's condition (p. 77). Giles states that the visitor cannot understand the customs because he is a stranger: 'It comes strange to the likes of you; for it takes a deal of studyin' to larn Witcherley ways' (p. 83). However, the visitor dismisses this, answering to himself that the 'Witcherley ways' must be 'a delusion – a monomania' (p. 83).

Beyond delusions and hallucinations characterised by mythology, patient case records in Inverness District Asylum showed observations in cases of mania like those examined throughout this thesis. High mood was described with features such as grandiose delusions, restlessness, irritability, and incoherence. For example, J.S., admitted in 1864, was observed with 'incoherence' as well as delusions that she had 'unbounded wealth' and needed to 'protect herself from secret enemies'.<sup>731</sup> I.F., admitted in 1888, was 'excited' and 'restless' such that it was 'with difficulty that she can be induced to keep her seat', and she would 'wander through the ward in every direction'.<sup>732</sup> She was also observed as 'incoherent' and 'talking and shouting at the top of her voice'.<sup>733</sup> A.R., admitted in 1864, experienced 'attacks of excitement' including delusions about being 'commander in chief' of 'England', and restlessness in being 'generally seen marching backwards and forwards along the corridor'.<sup>734</sup> Low mood was associated with

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<sup>728</sup> Cooke, 'Margaret Oliphant's "The Library Window" and the Idea of Adolescent Insanity', p. 244.

<sup>729</sup> I will analyse 'The Library Window' in the context of mania and occupation in Chapter Six so support the argument that Oliphant engaged with classifications and treatment of psychiatric illness.

<sup>730</sup> Margaret Oliphant, 'A Christmas Tale', *Blackwood's Edinburgh Magazine*, 81 (1857), pp. 74-86 (pp. 74-75). All further references are to this edition and are given parenthetically in the text.

<sup>731</sup> HHB/3/5/2/1, p. 105.

<sup>732</sup> HHB/3/5/2/22, p. 334.

<sup>733</sup> HHB/3/5/2/22, p. 334.

<sup>734</sup> HHB/3/5/2/1, p. 138.

vulnerability and fears of being subject to danger, alongside a lack of movement and speech. E.M., admitted in 1866, was ‘very quiet and depressed, seldom speaking’, and was ‘under the delusion that they wanted to kill her in the asylum’.<sup>735</sup> D.M., admitted in 1878, ‘imagine[d] his life in danger from friendly neighbours’.<sup>736</sup> Similarly, J.N., admitted in 1879, experienced ‘depression’ characterised by being ‘very quiet and absent looking’, and being ‘troubled by bad dreams such as that his wife died suddenly, and that his children were killed’.<sup>737</sup>

The suggestion of monomania is raised by the visitor in place of the claim that the Witcherley system of succession is a traditional custom. As discussed in Chapter One, monomania was a subtype of mania characterised by a single type of delusion. The visitor suggests that the Old Squire is experiencing monomania, because he considers the Old Squire’s belief about the succession of heirs in his family to be a singular delusion amongst his otherwise ‘gravely reasonable’ state (p. 83). Setting up a binary distinction between rational, scientific explanation and traditional belief, he notes that monomania was ‘the most reasonable explanation’ and suggests it is the superior answer because ‘everybody had heard of such’ (p. 83). By doing this, the visitor illustrates a diagnostic label being given by someone with self-perceived knowledge or authority. However, this authority is contrasted with his own behaviour, which signals mental ill health according to observations of mania. The visitor ‘crie[d] aloud’ and ‘rose from [his] chair’, reacting to the Old Squire with ‘confused and bewildering excitement’ (p. 81). He is reproached by the Old Squire who tells him: ‘Sir, you are excited’, immediately asking that he leaves (p. 81). The visitor demands help from other members of the village, accusing them of already being aware of the ‘mysterious danger’: “‘I suspect you already know more than I do,” cried I, impatiently’ (p. 83). He demonstrates a preoccupation with danger, crying out that ‘at this very moment the old man may be in peril of his life’, and ‘revolving a hundred wild schemes of rescue’ (p. 81). However, the other members of the village similarly reproach him.

The visitor settles on the idea that the Old Squire is a monomaniac, but it is his own mental unrest that intensifies. That night, he is troubled by ‘visions of the Old Squire’ in danger, ‘standing with the knife or the poison, struggling with assassins, or stretched upon a horrible deathbed, red with murder’ (p. 83). Like the fears and hallucinations recorded in cases of mania, the visitor’s visions extend to involving those close to him instead of only the Old Squire, the

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<sup>735</sup> HHB/3/5/2/3, p. 509.

<sup>736</sup> HHB/3/5/2/10, p. 276.

<sup>737</sup> HHB/3/5/2/11, p. 446.

visitor seeing ‘someone better known to me in [the Old Squire’s] place’ (p. 83). Furthermore, he is troubled by terrors ‘revived out of the oblivion of childhood’, which are illustrated as a preoccupation with vulnerability and death: ‘the creeping stream of blood from some closed door, the appalling pistol-shot, the horror of the death-gasp and cry’ (p. 83). This ‘miserable night’ exacerbates his behaviour the following day. His ‘mind immediately rebounded with excitement and eagerness’ upon waking, finding it ‘impossible to bear this tantalising bewilderment’ when again demanding answers and left ‘unsatisfied’ (p. 84). He becomes ‘unable to restrain [himself]’ (p. 85). He acts in contrast to socially accepted behaviour, going into the house with a ‘hasty step’ despite having ‘no right to enter another man’s house after this fashion’ (p. 85). However, he sees in himself a justified ‘authority’, like the beliefs in superior authority recorded in case notes observing high mood in mania. He also proceeds ‘in [his] excitement’, to ‘pace up and down the room [...] excited beyond the reach of all personal consideration’ (p. 85). He demands answers: ‘Where is he? What have you done with him?’, and threatens action: ‘I’ll rouse the country. I’ll have you all indicted for murder, every soul in the house’, but is answered by Joseph asking him to ‘be quiet’, and ‘to leave this house’, telling the visitor: ‘you’re dreaming’ (p. 85).

‘A Christmas Tale’ draws attention to the authority that classifies behaviour associated with mental ill health. The visitor’s knowledge of medical ideas is illustrated in sharp contrast with his lack of awareness about his own behaviour and mental state. The culmination of the tale as being the feature of a dream leaves room to question the mental state of the visitor, because it leaves his interpretation of the Old Squire unanswered. We do not find out whether, as the visitor fears, the Old Squire has died by suicide, murder, or some supernatural force, and the focus instead becomes on the visitor’s reaction to these ideas. Like *The Portent*, ‘A Christmas Tale’ is ambiguous in its exploration of the relationship between diagnostic classifications and traditional beliefs according to place. However, ‘A Christmas Tale’ is bold in its unease about outsiders pathologizing customs unknown to them. The coinciding timing of the short story with commissioners’ inquiries, and national concerns about the provision of institutional care beyond the Highland line, strengthen a view of the text’s challenge to medical authority in implementing new medical practices.

## Conclusion

The 1857 report of the Scottish Lunacy Commission discovered many patients outside of institutional care in the Highlands and Islands. The inability to implement sufficient surveillance and nutrition or to remove restraint in the domestic space meant domestic care was considered injurious to the extent of causing mania to become chronic, or incurable, represented in both medical and literary texts with sympathy for individuals and families, alongside social unease about the presence of mania in communities. While the domestic space was associated with incurability, asylum reform theories sought to shape institutions with domestic comforts – within this tension between domesticity and curability/incurability, the Inverness District Asylum removed its perimeter wall to create a greater sense of freedom within confinement and created micro households outside of the institution's main residence for incurable patients to live alongside those who supervised them. The institution also sought ways to manage patients with chronic mania's 'rooted' psychosis through occupation specific to the nature of their delusions and hallucinations.

Culturally specific care extended to the recognition by Aitken of the influence of place-specific mythology on the shape taken by hallucinations and delusions, which he wrote about with a comparable lack of judgement in the context of lunacy commissioner reports. Aspects of culturally specific care were practised at the Inverness District Asylum – including Gaelic-speaking attendants and Gaelic religious services, the provision of outdoor occupation for female patients, and explorations of the relationship between place and psychosis. Literary texts similarly depicted the relationship between traditional beliefs and psychosis, but conveyed this relationship with an ambiguity that invited speculation about whether the experiences were based in illness or in fact. This ambiguity interrogated the relationship between core and periphery in classifying experiences as mania.



## **Chapter Five:**

### **An Absence or Abundance of Energy:**

### **Diagnosing and Observing Female and Male Mania**

To further an examination of the experience of mania in different places and groups, the following two chapters will interrogate differences in the classification and treatment for female and male mania. Studies of the history and representation of female mental illness have suggested female confinement was disproportionate to men to punish deviance by women.<sup>738</sup> In opposition, other work has sought to counter the view that asylum diagnoses were dependent on social perceptions of the inherent differences between men and women or that female admissions were overrepresented.<sup>739</sup> For example, Joan Busfield argues against the ‘statistical overrepresentation of women among the mentally ill’, which Elaine Showalter claimed to have ‘been well documented’, by analysing data from Hanwell Asylum, Ticehurst Asylum, as well as registers of lunacy, which all indicated a balance between diagnoses of mental illnesses in men and women across numerous categories.<sup>740</sup> David Wright, in a study of Buckinghamshire Asylum, similarly demonstrated the ‘close similarity in the breakdown, by gender, of classification and sub-classification’ of diagnoses, therefore ‘challeng[ing] assertions as to the “widespread” use of new female-oriented psychiatric classifications’.<sup>741</sup> Crucially, Wright’s study goes on to interrogate whether categories were ‘gendered’ – for example, whether records would include the ‘same cluster of symptoms in women Melancholics and men Melancholics’, and ultimately concludes that there was ‘no compelling evidence’ that the diagnosis varied according to gender.<sup>742</sup>

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<sup>738</sup> Chesler, *Women and Madness*; Showalter, *The Female Malady*; Russell, *Women, Madness and Medicine*.

<sup>739</sup> Joan Busfield, ‘The Female Malady? Men, Women and Madness in Nineteenth-Century Britain’, *Sociology*, 28.1 (February 1994), pp. 259-277 (p. 259); David Wright, ‘Delusions of Gender?: Lay Identification and Clinical Diagnosis of Insanity in Victorian England’, in *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*, ed. by Jonathan Andrews and Anne Digby (New York: Rodopi, 2004), pp. 149-176 (p. 160).

<sup>740</sup> Busfield, ‘The Female Malady?’, pp. 263-268.

<sup>741</sup> Wright, ‘Delusions of Gender?’, p. 160.

<sup>742</sup> Wright, ‘Delusions of Gender?’, pp. 160-165.

In this chapter, I aim to contribute to this critical conversation through an analysis of whether the diagnosis and observation of mania varied between women and men. Like Busfield and Wright, my research has indicated a balance in admission records of mania. Figures 1.1-1.4 indicate this balance across the four primary institutions of study for this thesis:

MALE PATIENTS, RECENT CASES.								
CLASSIFICATION of Cases when admitted.	HOW DISMISSED.					STATE of those Remaining.		TOTALS of the several Classifications.
	Cured.	Relieved.	By desire.	Unfit.	Died.	Improved.	Continuing the same.	
Maniacs, .....	3	2	0	0	0	1	0	6
Maniacs, Furious, .....	4	6	0	0	3	3	0	16
Melancholics, .....	3	2	0	0	0	3	0	8
Melancholics, Irascible, .....	3	0	1	0	1	1	1	7
Imbecile, .....	0	0	0	0	0	0	1	1
Fatuous, .....	0	0	0	0	0	0	0	0
Total, .....	13	10	1	0	4	8	2	38

FEMALE PATIENTS, RECENT CASES.								
CLASSIFICATION of Cases when admitted.	HOW DISMISSED.					STATE of those Remaining.		TOTALS of the several Classifications.
	Cured.	Relieved.	By desire.	Unfit.	Died.	Improved.	Continuing the same.	
Maniacs, .....	4	2	0	0	0	0	0	6
Maniacs, Furious, .....	8	4	1	0	1	2	0	16
Melancholics, .....	1	1	1	0	0	1	0	4
Melancholics, Irascible, .....	1	0	0	0	0	0	1	2
Imbecile, .....	0	0	0	0	0	0	0	0
Fatuous, .....	0	0	0	0	0	0	0	0
Total, .....	14	7	2	0	1	3	1	28

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Figure 1.1<sup>743</sup>

<sup>743</sup> *Twenty-First Annual Report of the Directors of the Glasgow Royal Asylum for Lunatics* (Glasgow: James Hedderwick and Son, 1835), p. 9.

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TABLE II.

*Showing the form of disease in 87 cases admitted.*

			Males.	Females.	Total.
Mania acute	-	-	11	15	26
„ puerperal	-	-	0	2	2
„ chronic	-	-	22	17	39
„ with general paralysis			3	0	3
Epilepsy	-	-	1	0	1
Melancholia	-	-	2	6	8
Idiots	-	-	5	3	8
Total	-	-	44	43	87

Figure 1.2<sup>744</sup>

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TABLE VII.

FORMS OF DISEASE OF PATIENTS

	Males.	Females.	TOTAL.
Idiocy . . . . .	0	1	1
Dementia . . . . .	5	2	7
„ with Epilepsy . . . . .	1	0	1
General paralysis . . . . .	1	0	1
Mania . . . . .	10	14	24
„ with Epilepsy . . . . .	1	0	1
Melancholia . . . . .	10	12	22
Monomania of suspicion . . . . .	2	0	2
	30	29	59

Figure 1.3<sup>745</sup><sup>744</sup> *The Sixth Annual Report of the North Wales Lunatic Asylum* (Denbigh: Thomas Gee, 1855), p. 11.<sup>745</sup> *The Sixth Annual Report of the Inverness District Asylum* (Inverness: Courier Office, 1870), p. 32.



TABLE XI.—*Showing the Form of Mental Disorder on Admission in the Admissions, Recoveries, and Deaths of the Year 1889, and the Form of Mental Disorder of the Inmates on 31st December 1890.*

FORM OF MENTAL DISORDER.	Admissions.			Recoveries.			Deaths.			Remaining in Asylum.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Congenital or Infantile Mental Deficiency—												
„ a, with Epilepsy ...	1	1	2	0	0	0	0	0	0	5	3	8
„ b, without Epilepsy, ...	1	2	3	1	1	2	0	0	0	7	7	14
Epilepsy acquired ...	2	7	9	0	0	0	5	7	12	24	16	40
General Paralysis of the Insane...	22	6	28	0	0	0	22	3	25	31	6	37
Mania—												
„ Simple ...	42	48	90	18	26	44	16	11	27	61	59	120
„ Acute ...	12	17	29	4	12	16	4	4	8	9	14	23
„ Delusional ...	7	10	17	0	1	1	1	3	4	57	46	103
„ Chronic ...	0	0	0	0	0	0	0	1	1	11	73	84
„ Homicidal ...	0	1	1	0	1	1	0	0	0	3	0	3
Melancholia—												
„ Simple ...	21	27	48	10	12	22	4	4	8	26	29	55
„ Hypochondriacal ...	2	1	3	2	1	3	1	0	1	9	3	12
„ Delusional ...	8	14	22	4	5	9	0	5	5	19	31	50
„ Excited ...	5	11	16	1	2	3	2	3	5	4	13	17
„ Suicidal ...	17	17	34	9	8	17	5	0	5	18	20	38
„ Homicidal ...	2	0	2	0	0	0	0	0	0	1	0	1
„ Resistive ...	0	2	2	0	0	0	1	1	2	3	12	15
„ Stuporose ...	7	7	14	2	6	8	0	1	1	5	3	8
Dementia—												
„ Secondary ...	5	6	11	0	0	0	2	2	4	108	85	193
„ Organic ...	1	0	1	0	0	0	1	0	1	0	0	0
Total...	155	177	332	51	75	126	64	45	109	401	420	821

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Figure 1.4<sup>746</sup>

The data illustrates a consistently balanced distribution of diagnoses of mania for women and men, across different asylums in different parts of the UK, and across the nineteenth century. Gartnavel Royal Asylum recorded an equal number of male and female cases relating to mania in 1835, with 6 female and 6 male cases of ‘maniacs’, and 16 female and 16 male cases of ‘maniacs furious’; the North Wales Lunatic Asylum recorded a near equal number of female and male cases across their categories of ‘acute mania’, ‘chronic mania’, ‘puerperal mania’ and ‘mania with general paralysis’ in 1855, with a total of 34 female cases and 36 male cases; Inverness District Asylum similarly recorded a near equal number of female and male cases across their listed categories associated with mania in 1870, with 14 female cases and 11 male cases; and the Royal Edinburgh Asylum, though having slightly more female cases, also

<sup>746</sup> *Seventy-Eighth Annual Report of the Royal Edinburgh Asylum for The Insane* (Edinburgh: Royal Asylum Press, 1890), p. 39.

recorded a near balance between female and male cases across a number of subcategories of mania, with 76 female cases and 61 male cases in 1890.

This chapter, then, will investigate whether there were any marked differences in the classification for female and male mania through an examination of patient records. One of the emerging diagnostic labels associated specifically with women in the nineteenth century was puerperal mania, its cause attributed to features of pregnancy, childbirth, or nursing.<sup>747</sup> I will therefore additionally analyse whether there were any key differences, other than cause, between the observations of emotional behaviour recorded in cases of puerperal mania and mania. An examination of whether mania was diagnosed differently for women and men will attempt to answer one of the concerns of this thesis about the experience of mania in different places and groups, while building on the primary finding of this thesis that mania was characterised by both high and low mood states, and continuing the primary method of this study through examining diagnostic procedures. In accordance, Chapter Six will investigate whether social views of gender had a greater impact on treatment than on disease classification. To investigate social perceptions, I will also analyse literary representations to ask whether literary texts were a space that explored or challenged variations in the experience of mania according to gendered social views.

Class is also a crucial factor to consider in variations between female and male patients. In a study of masculinities in the nineteenth century, John Tosh argues that ‘polarized notions of sexual character did not sit well with dual-income households, which were the reality in a majority of working-class families’, but also states that ‘intensified discourse on sexual difference’ meant that ‘distinctions between men and women were more fundamental than divisions between classes’.<sup>748</sup> Working-class women would likely have been employed outside of their homes, but were still subject to perspectives of the natural characteristics of women as maternal, associated with the domestic setting, and still responsible for the domestic work within their own household. Martin Danahay’s study of Victorian masculinity points out that while women continued to work in areas such as mining, attempts were made to define these ‘certain forms of labour’ as ‘inappropriate for women’, so that they were instead associated solely with masculinity, and Sonya Rose discusses the influence of male unionists on attempting to restrict female opportunities in these roles.<sup>749</sup> For the purpose of this study, which

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<sup>747</sup> Marland, *Dangerous Motherhood*.

<sup>748</sup> Tosh, ‘Masculinities in an Industrialising Society’, pp. 337-342.

<sup>749</sup> Martin A. Danahay, *Gender at Work in Victorian Culture: Literature, Art, and Masculinity* (London: Routledge, 2016) p. 13; Sonya Rose, *Limited Livelihoods: Gender and Class in Nineteenth-Century England*

includes asylums catering primarily to working-class patients unable to contribute to the cost of their treatment, it is important to consider the diagnostic procedure of testimony from patients, relatives and friends being analysed through the lens of middle-class physicians to make a probabilistic diagnosis based on changes in emotional state and behaviour. Diagnoses and observations recorded by physicians would be subject to a tension in class perspectives. This chapter will therefore consider social views on the inherent differences between men and women and their influence on the working and middle classes, including the Protestant work ethic, developments in nineteenth-century biology, and medico-legal perspectives on the use of pleas of insanity, with a focus on ideas about energy and violence, to examine the extent to which social views influenced classifications of male and female mania.

### **Cycles of Emotional States: An Absence or Abundance of Energy**

Cases examined in this thesis have revealed a characterisation of mania as including severe mood states from across the emotional spectrum. Individual cases were diagnosed based on high mood, low mood, or alternating episodes of mood, alongside symptoms including hallucinations and delusions. The symptoms of psychosis were frequently observed as mood-congruent, associating high mood with themes of grandiose beliefs in extraordinary abilities, status, and wealth, and low mood with vulnerability, guilt, danger, and death. Low and high mood in patient records also indicated certain patterns of behaviour, with low mood being associated with despondency, an unwillingness to speak, refusal to eat, and lack of activity, and high mood being associated with loud, incoherent speech, exaggerated movements, violence, and destructive behaviour. In this way, severe low mood was recorded as causing behaviour associated with a loss of energy, and high mood as causing an abundance of energy. This section will investigate these patterns in patient case records to interrogate whether there were, or were not, key differences in the diagnosis and observation of mania in female and male cases.

To identify severe mood states and symptoms of psychosis, physicians looked for changes in the habits, affections, and dispositions of patients. Asylum case records and admission documents sought testimony from patients' relatives, neighbours, and patients themselves, to make a probabilistic judgement on whether a patient's mood was healthy or

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(Berkley: University of California Press, 1992), p. 57. For an analysis of the visibility of nineteenth-century female factory workers, see: Patricia E. Johnston, *Hidden Hands: Working-Class Women and Victorian Social-Problem Fiction* (Ohio: Ohio University Press, 2001).

unhealthy based on such changes. In other words, a diagnosis of mania was constructed by physicians discovering behaviour that was at odds with a patient's natural characteristics. In a society constructed by views on the inherent differences between men and women, it is valuable to a study of the history and representations of manic-depressive illness to consider whether the concept of looking for changes in habits and dispositions aligned with social views on the separate characteristics attributed based on gender.<sup>750</sup>

To begin with episodes characterised by low mood, both female and male cases observed patients whose illness was marked by a 'depression of spirits', 'despondency', 'sullen' and 'gloomy' disposition.<sup>751</sup> Delusions and hallucinations in these cases conveyed themes associated with fear or being under threat, guilt, and a focus on death. In both male and female cases, there were frequent low mood episodes with features of psychosis centred on religious beliefs. Examples of female cases of this kind include M.A., admitted to Gartnavel Royal Asylum in 1841, whose illness was 'marked by despondency', 'religious raving' and an 'expression indicative of apprehension of impending evil' that was associated with being 'frightened' by hallucinations of 'the devil whom she occasionally fancies she sees'.<sup>752</sup> Another female case, E.J., admitted to North Wales Lunatic Asylum in 1875, was noted with a 'sullen [...] disposition', and 'anxious appearance', as a consequence of a delusion that she 'had sold her soul' and was 'afraid of her soul being burnt'.<sup>753</sup> Male cases of this kind showed no difference from female cases, similarly recording low mood with hallucinations and delusional beliefs associated with religion, guilt, and a fear of being under threat. For example, H.J., admitted to North Wales Lunatic Asylum 1882, described as 'low-spirited', was of the 'determined opinion of the hopeless state of his soul', and intended to take his own life in consequence, while male patient R.M., admitted to the Inverness District Asylum in 1871, was concerned about 'salvation' and 'hell' with visual hallucinations of 'the devil'.<sup>754</sup>

A lack of speech, or unwillingness to speak, were also consistent across male and female cases. C.B., admitted to Inverness District Asylum in 1888, was 'sullen', 'morose', and 'would not enter upon a conversation', and J.S., admitted to the Royal Edinburgh Asylum in 1886 experienced 'fits of depression' with observations that she 'won't speak'.<sup>755</sup> Male cases

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<sup>750</sup> Tosh, 'Masculinities in an Industrializing Society', p. 330.

<sup>751</sup> This includes cases where there were episodes alternating between low mood and high mood, but focusing on the observations during descriptions of low, depressed spirits.

<sup>752</sup> HB/13/5/14.

<sup>753</sup> HD/1/331, p. 8.

<sup>754</sup> HD/1/362, p. 24; HHB/3/5/2/5, p. 328.

<sup>755</sup> HHB/3/5/2/22, p. 336; LHB7/51/46, p. 313.

included similar observations. J.M., admitted to Inverness District Asylum in 1878 was ‘low-spirited’ and it was ‘impossible to get him to join in conversation’, and D.T., admitted to the Royal Edinburgh Asylum in 1882, was described as ‘despondent’, with a note that he could ‘hardly be got to speak at all’.<sup>756</sup> Female and male cases also both recorded changes in appetite and problems with sleep. The case of female patient E.R., admitted to Inverness District Asylum in 1879, was marked by ‘want of sleep’ and ‘refusal to eat’, and female patient F.R., admitted to the Gartnavel Royal Asylum in 1841, was marked by ‘want of sleep’ and ‘loss of appetite’.<sup>757</sup> Similarly, the case of male patient S.C., admitted to the Gartnavel Royal Asylum in 1841, was also marked by ‘want of sleep’, and ‘want of appetite’, and J.N., admitted to Inverness District Asylum in 1868, noted ‘want of sleep’ and that the patient ‘takes little food’.<sup>758</sup>

The implication of the changes in behaviour associated with severe low mood, in both male and female cases, was a loss of energy in accordance with a loss of will, interest, and affection. Feelings of guilt and being under threat led to changes in a patient’s hope and motivation – for example, the case of male patient H.J., mentioned above, recorded that while he had previously ‘tried hard and prayed’, he had now ‘given up on his soul’ and desired death.<sup>759</sup> Similarly, female patient J.M., admitted to the Inverness District Asylum in 1879, believed that ‘her soul [was] lost and that the devil would have her’, and as a result had become ‘quite careless about her children’, indicating a change in affection for her family as well as a loss of will for her domestic duties, and W.I., admitted to the Royal Edinburgh Asylum in 1882 was ‘depressed’ and believed ‘her friends [were] plotting against her’ with ‘poison’, and as a result while she was ‘formerly cheerful, sociable, kind-hearted, and industrious’ was ‘of late dull, retiring and neglectful of her family’.<sup>760</sup> Changes in affection towards family members as a result of delusions of being under threat also led to sleeplessness and refusals to eat because of a fear of poison. Male case R.C., admitted to Royal Edinburgh Asylum in 1881, intended to ‘live without food or sleep’ because of a delusion that ‘his life [was] in danger from poison’ and that his parents would ‘mix poison with his food for the purpose of destroying him’.<sup>761</sup> Similarly, the case of female patient E.R., admitted to the Inverness District Asylum in 1879,

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<sup>756</sup> HHB/3/5/2/10, p. 388; LHB7/51/38, p. 632.

<sup>757</sup> HHB/3/5/2/11, p. 400; HB/13/5/14, 56.

<sup>758</sup> HB/13/5/25, p. 16.; HHB/3/5/2/4, p. 446.

<sup>759</sup> HD/1/362, p. 24.

<sup>760</sup> HHB/3/5/2/12, p. 396; LHB7/51/39, p. 394.

<sup>761</sup> LHB7/51/38, p. 77.



recorded 'fits of depression', 'sleeplessness' and avoidance of food and drink because of the belief that 'her husband' intended to give her 'poison'.<sup>762</sup>

Feelings of guilt, fear, and vulnerability in low mood episodes were therefore associated with a change in hope, affection, and will, presented in a loss of energy which was exacerbated by a lack of sleep and nutrition. An absence of energy and will was emphasised in the case of T.H., admitted to Royal Edinburgh Asylum in 1882. He was described as 'very sullen', that he would 'not reply to any question put to him', and under the subheading 'depression' it was noted: 'considerable - will not speak or move unless pushed'.<sup>763</sup> Cases also emphasised a loss of energy as a change in the habits and disposition of patients. Female patient M.G., admitted to Gartnavel Royal Asylum in 1838 was 'frequently disposed to confine herself to bed' when 'greatly depressed', showing a change from being usually 'cheerful and industrious'.<sup>764</sup> Similarly, male patient E.H., admitted to North Wales Lunatic Asylum in 1882, observed that 'his manner and conduct [were] totally at odds with his usual habits, from being a most industrious and active man' to having 'become apathetic'.<sup>765</sup>

High mood, in contrast to the loss of energy in episodes of low mood, was described in both male and female cases instead as an abundance of energy. High mood was associated with being 'excited' and restless'.<sup>766</sup> In lieu of feelings of guilt and being subject to threat, hallucinations and delusions were associated with invincibility and special status. Instead of fears of the devil and of their souls being lost, both female and male cases frequently recorded hallucinations of positive divine communication and delusions about entry to heaven. Female patient M.A., admitted to Gartnavel Royal Asylum in 1838, was observed with delusions 'chiefly on religious subjects' including 'imagin[ing] herself to have power in heaven'.<sup>767</sup> E.D., admitted to North Wales Lunatic Asylum in 1875, was recorded as 'continually speaking to Saint Peter', with the belief that she was 'going to heaven' with 'angels singing around her'.<sup>768</sup> Similarly, male patient I.R., admitted to the Gartnavel Royal Asylum in 1841, believed that the 'Holy Spirit [...] control[led] his will', giving him the power to 'destroy [...] all who oppose

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<sup>762</sup> HHB/3/5/2/11, p. 401.

<sup>763</sup> LHB7/51/38, p. 653.

<sup>764</sup> HB13/5/11, p. 63

<sup>765</sup> HD/1/362, p. 25.

<sup>766</sup> Including, for example: HD/1/331; HHB/3/5/2/21.

<sup>767</sup> HB13/5/11, p. 79.

<sup>768</sup> HD/1/331, p. 6.

him'.<sup>769</sup> W.K., admitted to the Royal Edinburgh Asylum in 1881, stated he had 'heard from heaven' and was told 'that he [was] a son of God'.<sup>770</sup>

Sleeplessness was also recorded in high mood states, but alongside restlessness and shows of energy through continuous noise and movement. M.R., admitted to North Wales Lunatic Asylum in 1876, was 'very much excited' and, although 'sleepless', was recorded as continuously 'singing and shouting in a most incoherent manner, repeating over and over the same words'.<sup>771</sup> Similarly, I.M., admitted to the Inverness District Asylum in 1888, was recorded as 'excited', that she 'does not sleep', and that she was so 'restless [...] it is with difficulty that she can be induced to keep her seat', that she would be 'clapping her hands', 'singing', 'shouting at the top of her voice' and would 'wander through the ward in every direction'.<sup>772</sup> Male cases showed similar patterns. A.B., admitted to Inverness District Asylum in 1888, was subject to 'excitement'.<sup>773</sup> This caused him to be 'restless', with the note that he 'sleeps very little' and was 'always wishing to get out and walk about'.<sup>774</sup> J.G., admitted to Inverness District Asylum in 1868, was 'excited and talkative', and instead of sleeping 'he commonly spent [the night] in making a noise and singing', and was 'restless in his movements', sometimes 'disarranging everything in his room'.<sup>775</sup> R.E., admitted to the North Wales Lunatic Asylum in 1865 was recorded with 'attacks of excitement' during which he was 'sleepless often' and 'rushe[d] about making a noise like an engine and propelling one arm in imitation of a crank'.<sup>776</sup> A lack of sleep in high mood episodes was therefore associated with an increase, rather than a decrease, in energy.

Destructive behaviour was one of the primary features of high mood states recorded in both male and female cases associated with an unlimited, wildness of energy. J.D., admitted to North Wales Lunatic Asylum in 1882, was 'very excited', 'restless and unsettled' and 'very destructive', 'tear[ing] his clothes and bed clothes and anything he [could] get hold of', and D.C., admitted to the Inverness District Asylum in 1889, was described with 'extreme restlessness', 'breaking windows or articles of clothing he can get a hold of'.<sup>777</sup> Destructive behaviour in female cases matched that of male cases. J.C., admitted to Gartnavel Royal

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<sup>769</sup> HB/13/5/25, p. 29.

<sup>770</sup> LHB7/51/38, p. 655.

<sup>771</sup> HD/1/331, p. 18.

<sup>772</sup> HHB/3/5/2/21, p. 334.

<sup>773</sup> HHB/3/5/2/22, p. 459.

<sup>774</sup> HHB/3/5/2/22, p. 459.

<sup>775</sup> HHB/3/5/2/4, p. 73.

<sup>776</sup> HD/1/517, p. 40.

<sup>777</sup> HD/1/362, p. 32; HHB/3/5/2/22, p. 149.

Asylum in 1838, was recorded as having ‘broken all the doors in the house’.<sup>778</sup> J.B., admitted to Gartnavel Royal Asylum in 1838, was recorded as ‘raving’, ‘loud stamping with her feet’, and being ‘prone to tear clothes or break windows and furniture’.<sup>779</sup> I.M., admitted to the Inverness District Asylum in 1872, was recorded as ‘throwing everything she can get a hold of in every direction’ and ‘making strong effort to break as many windows as she possibly can’.<sup>780</sup> The descriptions of destructive behaviour, for both male and female cases, were again illustrated as excessive, conveying an uncontrollable abundance of energy. High and low mood states of mania therefore varied in their depiction of either an increase or decrease in energy, and associated changes in behaviour. However, there was no difference in the patterns recorded in cases of mania in terms of a capacity for either an absence or abundance of energy in female and male patients.

Energy was an important component of views about the differences between Victorian women and men, but the role of energy in the experience of mania appears to be subject to no variation between genders in patient case records. Nineteenth-century biology discussed a capacity for energy as a key biological difference between men and women that was used to reinforce gendered social duties. While industrialisation earlier in the century led to calls from unionists for limitations on female work, working-class women were still required to work where the male ‘breadwinner’ could not provide fully for the household.<sup>781</sup> However, these women were also expected to fulfil the domestic role in their own homes.<sup>782</sup> This ideology was underpinned by the Protestant work ethic, which hailed work as ‘heroic’, ‘masculine’, and ‘muscular’, and attempted to limit women in roles of labour.<sup>783</sup> Later in the nineteenth century, science played an increasing role in sharpening gender distinctions. In her extensive work on Darwin’s sexual selection, Evelleen Richards argues that the legitimisation of gendered social roles was giving way to ‘a secular redefinition of the world’ which saw ‘science increasingly [take] over from religion the task of defining and upholding the moral and social order’, and identifies the importance of energy in Darwin’s distinction between women and men in *The Descent of Man* (1871).<sup>784</sup>

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<sup>778</sup> HB13/5/11, p. 39.

<sup>779</sup> HB13/5/11, p. 55.

<sup>780</sup> HHB/3/5/2/6, p. 335.

<sup>781</sup> Rose, *Limited Livelihoods*, p. 57.

<sup>782</sup> Rose, *Limited Livelihoods*, p. 57.

<sup>783</sup> Danahay, *Gender at Work*, p. 4.

<sup>784</sup> Evelleen Richards, *Ideology and Evolution in Nineteenth Century Britain: Embryos, Monsters, and Racial and Gendered others in the Making of Evolutionary Theory and Culture* (London: Routledge, 2020), p. 222.

The ideas that preceded Darwin's biologically based points of difference are important to understanding the influence of the existing Victorian gender roles on his hypothesis. Richard's social constructivist approach argues that, while late-nineteenth century Darwinism would be weaponised by some of his following 'Darwinians' against the threat of feminism, his own hypothesis on the biologically based inferiority of women was not formed according to an aim to combat feminism, but was instead a product of his social expectations of women through the experience of his own domestic relationships, including his wife Emma's role as 'perfect nurse' and her care for his ill-health.<sup>785</sup> Arguing against the defence of Darwin's hypothetico-deductive method from scientist Michael Ghiselin, and against the feminist criticism from, for example, biologist Ruth Hubbard, which condemned Darwin's work as 'motivated by anti-feminism', but which 'maintained the standard view of science as objective and value-free', Richards instead argues that existing socially ascribed gender roles 'entered into Darwin's evolutionary theorising'.<sup>786</sup> Richards argues, then, that Darwin's hypothesis of female inferiority based on biological difference was both influenced by existing social gender roles, and continued to shape them through the influence of his work, and the use of his work by other 'Darwinians'.<sup>787</sup>

This included an influence on nineteenth-century feminism. In her work on the impact of Victorian science on women, Flavia Alaya argues that scientific support for the different roles of men and women 'not only strengthened the opposition to feminism but disengaged the ideals of feminists themselves', so that women's claims for intelligence had to be based on a particular type of ability drawn from the ascribed maternal instincts of women.<sup>788</sup> In addition, in her study of the content of nineteenth-century feminist periodicals, Artemis Alexiou points out that 'it was widely accepted amongst advanced women of the period that in order to make progress in their cause, they had to retain the womanly qualities', making their case from a point of difference.<sup>789</sup> Darwin's hypothesis on the biologically-based difference between men

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<sup>785</sup> Richards, *Ideology and Evolution in Nineteenth Century Britain*, pp. 13-14, p. 193, p. 217.

<sup>786</sup> Richards, *Ideology and Evolution in Nineteenth Century Britain*, p. 14, p. 190, p. 192. See also: Michael Ghiselin, *The Triumph of the Darwinian Method* (Berkeley: University of California Press, 1972); Ruth Hubbard 'Have Only Men Evolved?', in Ruth Hubbard ed., *Women Look at Biology Looking at Women: A Collection of Feminist Critiques*, (Boston: G.K. Hall, 1979).

<sup>787</sup> Richards, *Ideology and Evolution in Nineteenth Century Britain*, p. 222.

<sup>788</sup> Flavia Alaya, 'Victorian Science and the "Genius" of Woman', *Journal of the History of Ideas*, 38 (1977), pp. 261-80 (pp. 261-262).

<sup>789</sup> Artemis Alexiou, 'Women's Words, Women's Bodies: Late-Nineteenth Century English Feminisms in the "Interview" Column of the *Women's Penny Paper/Woman's Herald*, Oct. 27, 1888- Apr. 23, 1892), *Women's History Review*, 29.7 (2020), pp. 1149-1181 (p. 1153).

and women became a key feature of both male and female discourse about the opportunities available according to gender roles.

It is doubtful that the concept of energy used by Darwin himself and other Darwinians had any particular concern with the experience of mania. However, the influence of such ideas in emphasising separation in gendered social roles creates a valuable point of analysis for whether the observations recorded in asylums could have been impacted by them. In his notion of the inferiority of women, Darwin highlights a particular lack in women's capacity for 'energy' and perseverance' in *The Descent of Man*.<sup>790</sup> For Darwin, this presented in a lesser potential for both intelligence and strength.<sup>791</sup> These precise characteristics were also used directly in opposition to Harriet Taylor and John Stuart Mill's *The Subjection of Women*. Darwin repeatedly attempted to use biologically based distinctions to refute Taylor and Mill's *The Subjection of Women* (1868), which instead saw differences between women and men as socially manufactured.<sup>792</sup> Richards points to a footnote in *The Descent of Man* which directly responds to a section of *The Subjection of Women*: 'The things in which man most excels woman are those which require most plodding, and long hammering at single thoughts' – Darwin asks of Mill: 'What is this but energy and perseverance?'.<sup>793</sup>

Not all Darwinians agreed with Darwin's views on sexual selection, but the notion of energy was also a factor in following ideas from nineteenth-century biologists about points of difference between men and women.<sup>794</sup> Scottish biologists Geddes and Thomson's popular *The Evolution of Sex* (1889) distanced themselves from areas of Darwin's sexual selection, but also emphasised the biological foundation for differences in social roles for men and women based on the concept of energy.<sup>795</sup> They described men as 'active, energetic, eager, passionate', and women as 'passive' as well as 'sluggish and stable'.<sup>796</sup> Sara Delamont and Lorna Duffin highlight the importance of energy to Geddes and Thomson's 'biological basis of social order', summarising the biologists' view of men as 'katabolic' and women as 'anabolic' as the idea

<sup>790</sup> Richards, *Ideology and Evolution in Nineteenth Century Britain*, p. 190.

<sup>791</sup> Richards, *Ideology and Evolution in Nineteenth Century Britain*, p. 190.

<sup>792</sup> Richards, *Ideology and Evolution in Nineteenth Century Britain*, p. 14, p. 190, p. 192.

<sup>793</sup> Richards, *Ideology and Evolution in Nineteenth Century Britain*, p. 205.

<sup>794</sup> Richards, *Ideology and Evolution in Nineteenth Century Britain*, p. 234. See also: Rosaleen Love, 'Darwinism and Feminism: The "Woman Question" in the Life and Work of Oliver Schreiner and Charlotte Perkins Gilman', in David Oldroyd and Ian Langham ed., *The Wider Domain of Evolutionary Thought* (New York: Springer, 1983); Linda K. Schott, *Reconstructing Women's Thoughts: The Women's International League for Peace and Freedom Before World War II* (Stanford: Stanford University Press, 1997); Lesley Hall, 'Hauling Down the Double Standard: Feminism, Social Purity and Sexual Science in Late Nineteenth-Century Britain', *Gender and History*, 16.1 (2004), pp. 36-56.

<sup>795</sup> Richards, *Ideology and Evolution in Nineteenth Century Britain*, p. 234.

<sup>796</sup> Patrick Geddes and J. Arthur Thomson, *The Evolution of Sex* (London: Walter Scott, 1889), p. 270.

that ‘females lack the energy required to participate actively in society’.<sup>797</sup> The wide reception of Geddes’s and Thomson’s work is also pointed out by Delamont and Duffin, through its ‘three printings and two editions in England’, highlighting its potential influence on social perceptions.<sup>798</sup>

The situation of working-class women in this discourse is subject to tension. Many working-class families were dual-income, but working women would also be responsible for the care of their own homes.<sup>799</sup> In this way, working-class women had to be active in work both within and outside of their homes, whilst additionally being subject to increasing attempts to associate work with masculinity, so that there were limits on opportunities for employment, and social pressure for men to be primary providers fulfilling the role of ‘breadwinner’.<sup>800</sup> The prominence of discourse on the inherent differences between men and women, even if less influential in practice on working-class families that required both partners to provide income, would suggest its influence on the perspectives of middle-class physicians on gender differences. However, the centrality of either a lack or abundance of energy as characterising the low and high mood states of mania indicates a balance in energy between men and women in an asylum setting that is at odds with social ideas. It is surprising, given the role of energy in biological hypotheses underpinning the capacity for female activity, intelligence, and strength, that psychiatric observations would record women as equally destructive and wild as men, and men as equally despondent and unwilling to engage in activity as women. Certainly, institutions could not be immune from ingrained social views. However, the construction of mania as a transgression of acceptable behaviour, and therefore of gender norms, could explain why the classification for mania appeared to avoid gendered difference. The absence of a specifically female or male classification of mania could also be partially explained by the perception of working-class women as already existing in a space outside of social gender ideals, by requiring the energy to meet both their own domestic responsibilities and separate employment outside of their homes.

Another ingrained perception of difference between Victorian women and men was centred on violence. Victorian women were considered naturally predisposed to maternal, caring instincts – nothing was more at odds with natural female characteristics than violence.

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<sup>797</sup> Sara Delamont and Lorna Duffin, *The Nineteenth-century Woman: Her Cultural and Physical World* (London: Routledge, 2012), p. 63.

<sup>798</sup> Delamont and Duffin, *The Nineteenth-century Woman*, p. 63.

<sup>799</sup> Tosh, ‘Masculinities in an Industrialising Society’, p. 337.

<sup>800</sup> Rose, *Limited Livelihoods*, p. 132.

Victorian female violence was therefore often explained by diagnoses of mental ill health and women made use of pleas of insanity in court. A medico-legal perspective is useful to an analysis of the relationship between social views of female violence and mental illness. Samantha Pegg has written about the use of pleas of insanity for cases of murder by women, explaining that ‘the strong social presumption of the female as a nurturing caregiver’ meant that ‘social constructions of femininity collided with homicide’.<sup>801</sup> This collision led to a willingness to neatly explain female violence as mental illness. While there were also cases of men murdering their children and wives, cases of familial murder by women were far more likely to achieve a successful insanity plea in court.<sup>802</sup> Juries, made up of men, more readily reached a verdict of insanity in cases of female violence because of the social perspective of murder as entirely at odds with femininity.

Violence, like destructive behaviour, was an important characteristic in the diagnosis of mania. Case notes for each patient recorded whether there was a risk of destructive behaviour, self-violence, or violence towards others, with these features usually recorded together. As I pointed out in my earlier analysis of the illustration of energy in mania, the conceptualisation of mania as causing a change in the habits and disposition of the patient means it is unsurprising that, though supposed to be instinctively opposed to violence, women would also exhibit violent behaviour as a result in the change caused by experiencing this mental illness. However, perhaps what is surprising is that – like the capacity for either a heightened or lessened energy – women’s violence again matched that of men’s in the observations of asylum case records, with no clear difference in the representation of violence.

Violence in patient case records was represented as influenced by the features I discussed earlier in this section. For example, in low mood, violence was often observed as a consequence of changes in affection towards family members as well as feelings of being subject to threats of danger from relatives and therefore actions perceived by patients to be in self-defence. In contrast, in high mood, violence was often associated with feelings of superiority as a result of delusions about status and wealth, including beliefs in the power to destroy those who patients perceived to be opposed to them. For example, the cases of I.G. and M.S., admitted to the Royal Edinburgh Asylum in 1886, both believed their mothers were poisoning their tea, and both retaliated by threatening their mothers’ lives, and A.D.L, admitted

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<sup>801</sup> Samantha Pegg, “‘Madness is a Woman’: Constance Kent and Victorian Constructions of Female Insanity”, *Liverpool Law Review*, 30 (2009), pp. 207-223 (p. 215).

<sup>802</sup> Pegg, “‘Madness is a Woman’”, p. 221.

in 1887, recorded the patient as having taken ‘an aversion to her mother and an aunt’, as well as ‘doubt[ing] the identity of her brother’, and therefore ‘violently assault[ing] her mother with the fire-irons’.<sup>803</sup> M.J., admitted to the North Wales Lunatic Asylum in 1875, also experienced a change in affection towards her family, being ‘unable to recognise’ her sister, and ‘attempt[ing] to throw her [mother] downstairs’.<sup>804</sup> M.N., admitted to Gartnavel Royal Asylum in 1841, ‘raved about money supposing that she had a right to great wealth’, and ‘threatened serious injury to others by a knife or otherwise’.<sup>805</sup>

Male cases show similar presentations and severity of violence as the female cases. P.D., admitted to the Royal Edinburgh Asylum in 1881, believed there was ‘poison in his tea’ and therefore ‘threatened to shoot his father’.<sup>806</sup> R.M., admitted to the Inverness District Asylum in 1889 experienced ‘delusions about religion’, speaking ‘incoherently about heaven’ and ‘Christ’, and ‘struck his mother down violently’.<sup>807</sup> J.R., admitted to the Gartnavel Royal Asylum in 1841, believed he was in possession of ‘enormous wealth’, and threatened the lives of ‘his wife and child’.<sup>808</sup> As with the representation of energy in asylum case notes, the capacity for violence from men and women was balanced. The change in habits and dispositions caused by the extreme emotional states of mania appears to have created a space where the presentation of energy and violence could be enacted equally by female and male patients.

Outside of the asylum, the greater success of the insanity plea in cases of murder by women indicates the legal institution as affirming gendered social differences.<sup>809</sup> Furthermore, literary representations were a space where perceived gender differences could be explored and challenged in the context of experiences of mania. Literary representations highlighted the tension between perceptions of women as instinctively nurturing and female violence in illustrations of mania. One example that depicts a change in affection and violence is Denzil Vane’s ‘A Village Tragedy’, published in *Red Dragon* in 1886. *Red Dragon* was a Welsh periodical published in Cardiff between 1882-1887, combining literary and scientific writing with social and political commentary.<sup>810</sup> Malcolm Ballin’s study of English-medium Welsh

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<sup>803</sup> LHB7/51/46, p. 61; LHB7/51/46, p. 125; LHB7/51/47, p. 738.

<sup>804</sup> HD/1/331, p. 5.

<sup>805</sup> HB/13/5/14, p. 32.

<sup>806</sup> LHB7/51/38, p. 74.

<sup>807</sup> HHB/3/5/2/22, p. 305.

<sup>808</sup> HB13/5/25, p. 29.

<sup>809</sup> Pegg, ““Madness is a Woman”, p. 221.

<sup>810</sup> Malcolm Ballin, *Welsh Periodicals in English: 1882-2012* (Caerdydd: Gwasg Prifysgol Cymru, 2013), p. 21.



periodicals points out that *Red Dragon* ‘provided an outlet’ for women writers including Amy Dillwyn, Kate Dodd, Jeanette Forsyth and Ella Egerton.<sup>811</sup> One of the women writers published was Denzil Vane, the pseudonym for Fanny Du Tertre.

There is minimal scholarly work on the literature of Denzil Vane, but *A Database of Victorian Fiction, 1837-1901* includes useful biographical information. Born in Nice, France, in 1856, Vane was living with her widowed mother and two sisters in London by 1862.<sup>812</sup> Vane experienced mental illness and was admitted to an asylum ‘at least thrice’ in 1881, 1891, and 1895, although to which asylum remains unknown.<sup>813</sup> As indicated on *A Database of Victorian Fiction*, the inability to trace Vane after this, combined with the self-description of her husband in the 1911 census as married rather than widowed, suggests that she was later kept in an asylum space permanently.<sup>814</sup> Valuable for an analysis of ‘A Village Tragedy’ is the recognition that this short story was published between her first and second asylum stays, and therefore after an experience of treatment as well as encounters with other patients, indicating Vane’s awareness of different categories of mental illness as well as her own ill health.

Told from the perspective of a male protagonist romantically pursuing a young woman, ‘A Village Tragedy’ illustrates female violence a result of mania. The text illustrates violence from a young woman towards household members as completely at odds with the Victorian perception of women, and therefore explainable only by mania, while highlighting social expectations of women through the contrasting depictions of Julia and her domestic servant Sarah. Julia is described by the protagonist as a girl of ‘no more than nineteen or twenty years of age’, who is ‘remarkably good looking, tall, well-made, and extremely graceful’, with ‘delicate features’.<sup>815</sup> The protagonist’s portrayal of her suggests that her transition from childhood to adulthood has equipped her to meet her expected social role: ‘she looked every inch a lady’ (p. 564). Moreover, a generous and giving nature, consistent with the view of natural, maternal female characteristics, is conveyed by her enthusiasm to give charitably despite a lack of wealth. The protagonist orchestrates his first meeting with Julia by visiting under the guise of asking for donations, having heard that ‘Julia, though not rich, was a most charitable young lady, and was ever ready to help the sick and poor’ (p. 564). Proving this,

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<sup>811</sup> Ballin, *Welsh Periodicals in English*, p. 22.

<sup>812</sup> ‘Author: Fanny Du Tertre (1856-1918)’, *A Database of Victorian Fiction, 1837-1901* <[https://www.victorianresearch.org/atcl/show\\_author](https://www.victorianresearch.org/atcl/show_author)> [accessed September 12, 2021].

<sup>813</sup> ‘Author: Fanny Du Tertre (1856-1918)’, *A Database of Victorian Fiction, 1837-1901*.

<sup>814</sup> ‘Author: Fanny Du Tertre (1856-1918)’, *A Database of Victorian Fiction, 1837-1901*.

<sup>815</sup> Denzil Vane, ‘A Village Tragedy’, *Red Dragon* (1886), pp. 563-570 (p. 564). All further references are to this edition and are given parenthetically in the body of the text.

upon the request, Julia gives a donation ‘at once’, and expresses that, if in a position to do so, she ‘would give a larger donation’ (p. 566).

Julia is positioned in contrast to the nature of her domestic servant, Sarah. Unlike the kindness of Julia, Sarah is described as ‘a very hard-featured old woman’ and a ‘sour-visaged servant’, who communicates ‘coolly’ and ‘knows nothing of polite’ social norms (pp. 565-567). However, while Julia is warm and giving, and Sarah is sour and cold, the text reveals Julia as at odds with female characteristics through her acts of violence, whereas Sarah fulfils her maternal role through the proxy of caregiver. Pegg explains that the expectations for maternal instincts in women extended beyond biological mothers, and therefore included other women in the household who could take on a caregiver role. Pegg provides evidence for this through cases of insanity defences where women employed to care for children were also considered susceptible to mental illness resulting in violence towards children, caused by factors including hormonal changes or the loss of a child, stating ‘postpartum depression or depression after the death of a child was applied not only to the mother but could be extended to other female caregivers’.<sup>816</sup> For example, Pegg describes the case of Catherine Muir, who murdered 5-year old Bruce Logan, one of the children she was employed to care for. Muir’s insanity defence was based on the ‘loss of a child’, claiming her mental ill health was caused by the death of Bruce Logan’s infant sibling to whom she was ‘reportedly devoted’, and her subsequent dismissal following the infant’s death.<sup>817</sup> Pegg explains that the Lord Chief Justice ‘accepted’ this defence, considering Muir ‘to be in a clear state of insanity brought on by an impending separation from the children she loved’.<sup>818</sup> In ‘A Village Tragedy’ Sarah is portrayed as the primary caregiver, and the negative descriptions of her are partly based on the way that she ‘openly disapproved’ of the relationship between Julia and the protagonist, and her demands that his ‘visits to the cottage must cease’ (p. 567). However, her view is based on an aim to protect them both. It is revealed that Julia brutally murdered her father who was ‘found dead in his bed, with his throat frightfully gashed’ (p. 568). Sarah feared for the safety of the protagonist, as well as the possible consequences of Julia being admitted to an asylum:

to think that my pretty darling, the child I had nursed and reared to womanhood, should be locked in an asylum – treated cruelly, perhaps (p. 570).

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<sup>816</sup> Pegg, “Madness is a Woman”, p. 217.

<sup>817</sup> Pegg, “Madness is a Woman”, p. 218.

<sup>818</sup> Pegg, “Madness is a Woman”, p. 218.

Sarah, though described in contrast with expected female social behaviours, meets maternal expectations through aiming to protect. She takes on the role of caregiver to Julia, aiding her transition from childhood to adulthood, and intending to protect her from the consequences of mental ill health.

It is also Sarah, Julia's maternal, caregiving figure, who is violently attacked. Attacks by daughters on parental figures were common in asylum case records of mania, as demonstrated in the case notes discussed earlier in this section. Among the descriptions of Julia as kind, giving, graceful, and beautiful, there is a hint to the emotional cycle of mania through her 'expression of mingled pride and sadness' (p. 565). Case records discussed throughout this thesis have observed pride as an aspect of high mood in mania, and expressions of sadness in accordance with low mood in records of mania. Discovering the body of Sarah 'bathed in blood', the protagonist goes on to describe the wild severity of Julia's violence:

her face was white, her lips were drawn back in a hideous smile, her eyes were dilated and glittering with a strange fire (p. 569).

This illustration of Julia is animalistic, and continues as she is described as 'springing to her feet [...] with a long, sharp knife', and as having 'sprang at [Sarah's] throat like a tigress' (pp. 569-570).

Like the cases discussed earlier, the case of E.J., admitted to the North Wales Lunatic Asylum in 1875, similarly describes a 'change in habits, dispositions and affections' of the patient, observed primarily in relation to violence towards her parental figures.<sup>819</sup> E.J. is recorded as 'wishing for [her parents'] death', with the note that she 'brandished a knife over [her father's] head', while saying that she 'would cut his throat'.<sup>820</sup> Similarly, H.M., admitted to the Inverness District Asylum in 1868, was noted as threatening violence by 'showing her teeth' and 'giving a sort of threatening growl, like an animal'.<sup>821</sup> The contrast between Julia's violence and Sarah's role as caregiver continues as Sarah maintains, after the attack and Julia's subsequent suicide, that she 'loved the child as if she had been [her] own', and that she 'would have died gladly for her' (p. 570).

'A Village Tragedy' highlights the relationship between the image of a Victorian woman as instinctively caring and maternal, and the female experience of mania as a violent break from perceived natural instincts. The short story does this by introducing Julia as warm

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<sup>819</sup> HD/1/331, p. 8.

<sup>820</sup> HD/1/331, p. 8.

<sup>821</sup> HHB/3/5/2/4, p. 121.

and caring, and Sarah as cold and sharp, but revealing Julia as violent because of mania, and Sarah as committed to the role of maternal caregiver. The change in affection from Julia towards Sarah is not unlike the changes in behaviour and threats of violence towards relatives and caregivers illustrated in case records of mania.

Perceptions of male violence were also subject to some change in the nineteenth century. In his work on Victorian masculinity, John Tosh suggests a decrease in male violence. However, Tosh highlights the divisions in class amongst changing perceptions of aggression. Middle-class masculinity encouraged a ‘declining investment in physical violence’, and use of ‘physical self-restraint’, but violence was still enacted by working-class men: ‘only in the “rough” working class did a culture of physical confrontation persist’.<sup>822</sup> Nevertheless, Tosh also suggests that divisions in class were less important than divisions in gender and the prescribed traits of men and women, because ‘class division was ameliorated by an essentializing ideology of gender’.<sup>823</sup> Violence in male mania was a social deviance from the new identity of masculinity as shaped by the middle classes and identified by middle-class physicians, but a deviance not uncharacteristic in perceptions of working-class men. In contrast, the sharper distinction between gender than in distinctions between class meant that female violence was more than social deviance but an act in complete conflict with the perceived natural instincts of Victorian women.

Patient case notes show little difference in the diagnosis and observation of male and female patients with mania. Despite social perceptions of inherent differences between women and men, there is no significant evidence of a distinction in classifications for mania according to gender. Patient records show similar patterns across both high and low mood states. Despite social views, the capacity for either an abundance or absence of energy, and for ferocity of violence, was balanced across female and male cases. This lack of difference could be explained by the characterisation of mania as a change in habits or dispositions, and therefore that the behaviours associated with mania would be in opposition to the socially prescribed behaviours for women and men. In contrast, literary representations were a space where ideas about female and male characteristics could be explored in the context of mania, illustrating tensions between the wild violence of mania and the maternal instincts of the ideal Victorian woman.

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<sup>822</sup> Tosh, *Masculinities in an Industrialising Society*, pp. 333-334.

<sup>823</sup> Tosh, *Masculinities in an Industrialising Society*, p. 342.

My research into asylum case books has identified only one key difference in the presentation of features of mania. This distinction is in the means by which male and female patients realised wealth and status within grandiose delusions. Women with mania were rarely observed in asylum records to believe they had or would achieve fortune or power through brilliance in business ventures or scientific discovery – my research indicates that delusions relating to these fields were mostly confined to the case records of male patients, whereas female patients were more likely to name themselves royalty or relatives of powerful people, or discover special abilities relating to religion. The characteristics of the delusions were similar in that both the female and male cases believed in a right to or realisation of wealth and status, but the path to those gains presented as related to employment primarily in male cases. I will investigate this difference in further detail in the next chapter, which will focus on the relationship between mania and work both inside and outside of the asylum. In the next section, I will continue with the argument that mania mostly presented with little variation in observations in male and female case records through an analysis of puerperal mania specifically.

### **A Threat to Social Order: Puerperal Mania and Mania in Male Figures of Authority**

Puerperal mania has been among the diagnostic labels included by feminist studies in the history of psychiatry as evidence of new categories, like hysteria, that punished female behaviour because of its specific relation to female patients.<sup>824</sup> Situating her work away from this scholarship, Hilary Marland has written extensively on puerperal insanity in the nineteenth century. Marland discusses the role of both midwifery practitioners and alienists in treating puerperal mental ill health, noting that, in terms of perceived causes of puerperal mental illness, both groups ‘referred to influences other than biological’, and that case histories placed ‘a great deal of emphasis’ on ‘stress and environmental and social factors’.<sup>825</sup> Marland forms a nuanced analysis of the diagnosis and treatment of different types of puerperal insanity, contextualising puerperal mental illness amid fears about the fulfilment of female domestic roles: through puerperal insanity, ‘the angel of the household was converted into a threatening presence, a

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<sup>824</sup> See: Chesler, *Women and Madness*; Showalter, *The Female Malady*; Russell, *Women, Madness and Medicine*. For a useful critique of this notion of new widespread diagnostic labels to pathologize female behaviour, see Wright, ‘Delusions of Gender?’

<sup>825</sup> Marland, *Dangerous Motherhood*, p. 39.

risk to herself and her newborn'.<sup>826</sup> A condition characterised by causing a loss of interest, neglect, and even violence towards her infant and household, puerperal insanity was a threat to the role of the wife and mother within the Victorian domestic setting.

One of the categories of nineteenth-century puerperal insanity was puerperal mania. In a review of Marland's *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain*, Margaret L. Arnot suggested that:

Marland's historical argument about [patients diagnosed with puerperal insanity's] perceived difference from other psychiatric patients would have been strengthened by comparing the case notes of women classified as suffering with puerperal ailments with those of patients classified differently.<sup>827</sup>

The aim of this section is to partially contribute to the work suggested by Arnot by comparing the classification of puerperal mania specifically with mania through an analysis of patient case records.<sup>828</sup> Following the argument in the first section of this chapter that the diagnosis of female and male mania showed little variation despite social beliefs in significant differences between men and women, this section will argue that there was also very little variation in observations of puerperal mania beyond its ascribed cause. I will also continue to examine whether literary depictions were a space for exploring gendered social roles in the context of the experience of mania. To do this, this section will analyse a literary representation of puerperal mania in Carroll's *Alice's Adventures in Wonderland* as presenting in a neglectful, destructive mother, tying to Marland's analysis of social attitudes towards puerperal illness as a threat to the domestic space. To compare anxieties about the social repercussions of both female and male mania, I will also analyse a depiction of the consequences of male mania in the same text.

Outside of the 'exciting cause' as relating to pregnancy, childbirth, or nursing, my research into archival records shows that observations recorded in puerperal mania presented with little difference to other cases of mania. Prior to the widespread use of puerperal mania as a diagnostic category, my research has uncovered cases diagnosed as mania which would name

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<sup>826</sup> Hilary Marland, 'Under the Shadow of Maternity: Birth, Death and Puerperal Insanity in Victorian Britain', *History of Psychiatry*, 23.1 (2012), pp. 78-90 (p. 78).

<sup>827</sup> Margaret L. Arnot, 'Review of Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain*', *History of Psychiatry*, 18.4 (2004), pp. 503-510 (p. 506).

<sup>828</sup> This includes the types of mania discussed previously in this section and throughout the thesis: 'chronic mania' – characterised by being considered incurable – and 'acute mania' – characterised by being curable. Some cases also include 'recurrent mania' – similar to acute mania in that there were patterns in periods of recovery but with the expectation that there would be another episode in the future. For a further discussion of these subcategories of mania, see Chapter One of this thesis.

an aspect of pregnancy, childbirth or nursing as the cause of the mental illness, but with otherwise similar observations of emotional state and behaviour as that of other records of patients diagnosed with mania. Furthermore, when the label of puerperal mania began to be commonly used, there was no significant difference between those cases and either the previous cases of mania associated with childbirth, or the other cases within those volumes diagnosed as mania. Crucially for the focus in this chapter on whether the classification of mania was different for male and female cases, this included cases of mania experienced by men.

Before the use of puerperal mania, cases in Gartnavel Royal Asylum diagnosed as mania were often associated with pregnancy and childbirth. For example, J.H. admitted to Gartnavel Royal Asylum in March 1841, was diagnosed with 'mania' rather than puerperal mania, but 'has been delivered of a 'new child' was listed as the only 'exciting cause'.<sup>829</sup> The observations in the case show no deviation from the cases of mania analysed throughout this chapter. Her illness was 'marked by incoherent and constant raving', she was 'destructive to [her] clothes' and 'attempted to snatch the caps off of the other patients and tear them'.<sup>830</sup> Similarly, M.M. admitted to Gartnavel Royal Asylum in 1838 was diagnosed with 'mania' as opposed to puerperal mania, but 'childbirth' was given as the only exciting cause.<sup>831</sup> Again, her case is like the patient records discussed in the last section, characterised by a 'depression of spirits', that she 'scarcely took any food', and was 'crying and sobbing', which alternated to 'excitement, violence and incoherent raving'.<sup>832</sup> She was noted to have 'attempted suicide', and when excited 'strikes those around her and is disposed to tear clothes and destroy furniture'.<sup>833</sup> Moreover, this case indicated a recognised pattern in childbirth as causing mania, listing the previous illnesses of this patient following separate occasions of childbirth: 'Two previous attacks, both of which followed parturition'.<sup>834</sup> The earliest use of puerperal mania I have found during my research was in a case admitted in October 1841 in Gartnavel Royal Asylum. The observations were similar to both those noted above and the cases of mania discussed earlier in this chapter: A.C. was 'excited', 'slept little', was 'continually out of bed [...] singing and wandering about the room', 'refused food', and 'tears her clothes'.<sup>835</sup>

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<sup>829</sup> HB13/5/14, p. 25.

<sup>830</sup> HB13/5/14, p. 25.

<sup>831</sup> HB13/5/11, pp. 43-44.

<sup>832</sup> HB13/5/11, p. 43.

<sup>833</sup> HB13/5/11, p. 43.

<sup>834</sup> HB13/5/11, p. 43.

<sup>835</sup> HB13/5/14, pp. 117-118.

Cases of puerperal mania later in the century showed little difference. J.H., admitted to the Inverness District Asylum in 1871 and diagnosed with ‘puerperal mania’ was recorded as ‘dull and depressed’ with a fear of being subject to injury: ‘thinks her husband is about to injure or poison her’, and therefore retaliating with violence: ‘attempted several times to take her husband’s life’.<sup>836</sup> H.D., admitted to Royal Edinburgh Asylum in 1883 and diagnosed with ‘puerperal mania’, was observed with hallucinations and delusions: ‘saw faces on the wall, and fancied dead objects were alive’, as well as believing ‘there was poison in the food’, that ‘everyone is conspiring to kill her’, and being ‘sleepless’ with a ‘loss of appetite’.<sup>837</sup> Observed with high mood, A.N, admitted to the Inverness District Asylum in 1873 and diagnosed with ‘puerperal mania’, was observed to believe ‘herself to be the saviour of the world’ and that ‘God protects and surrounds her with a troop of angels’.<sup>838</sup> E.B., admitted to the Royal Edinburgh Asylum in 1883, was observed with ‘restlessness and excitement’, that she was ‘very violent at times, throwing about the room whatever she can lay hold of’, ‘tears her clothes’, ‘refuses food and medicine’.<sup>839</sup> E.R., admitted to the Inverness District Asylum in 1879 and diagnosed with ‘puerperal mania’, was observed as being ‘reckless’ and ‘excited’ at which times ‘she frequently barks like a dog and attempts to bite’, and ‘depressed’, at which times she believes ‘her husband gave her poison’.<sup>840</sup> These cases show little difference between the previous cases diagnosed as mania associated with pregnancy and childbirth. In addition, they present with the main patterns observed in the cases discussed earlier in this chapter, in both low and high emotional states, without any significant deviation. This implies no fundamental difference between the characterisation of puerperal mania and mania other than the cause being related to pregnancy, childbirth, and nursing. It also strengthens the argument that the observation and diagnosis of mania showed little variation in male and female cases, because the notes in cases of puerperal mania were like those recorded in the cases of both men and women with mania.

Advocations for the use of chloroform as pain relief in childbirth, because of some evidence of its use in reducing the chances of developing puerperal mania, highlight an instance of negotiation between developments in medical treatment and social views of gender. Medical superintendent of the Royal Edinburgh Asylum, Dr David Skae, was a friend of Sir James

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<sup>836</sup> HHB/3/5/2/5, p. 153.

<sup>837</sup> LHB7/51/39, p. 690.

<sup>838</sup> HHB/3/5/2/7, p. 237.

<sup>839</sup> LHB7/51/39, p. 565.

<sup>840</sup> HHB/3/5/2/12, p. 402.



Simpson, who discovered the use of chloroform as an anaesthetic in 1847 and would encourage its use during childbirth. Skae was one of the friends of Simpson who took part in experiments with chloroform on themselves.<sup>841</sup> The use of chloroform during labour went against the grain of the traditional belief that it should be a painful experience for women, leading to debates about the fate of women to suffer during childbirth because of ‘the curse of Eve’, but also the potential medical benefits of pain relief.<sup>842</sup> Although the provision of chloroform and childbirth itself took place outside of the asylum, Skae was a voice of support for the use of chloroform during labour, and suggested evidence from within the asylum setting to provide his support. In the *Annual Report* for 1854, he suggested that the use of chloroform decreased the risk of developing puerperal insanity, including puerperal mania, based on the argument that ‘only one’ out of ‘forty four’ cases of puerperal insanity ‘since the introduction of chloroform into medical practice’ had seen ‘this anaesthetic [...] administered during labour’.<sup>843</sup> In the *Annual Report* for the following year, Skae defends this suggestion: ‘of the six cases of puerperal mania, none had taken chloroform during labour’.<sup>844</sup> Furthermore, Skae’s support for chloroform as a preventative tool against puerperal mania was published in *The Asylum Journal of Mental Science* in 1856: recounting the statistics, Skae remarks:

This fact surely leads to the inference, that the use of chloroform does not conduce to the development of puerperal mania; otherwise in Edinburgh, where it is so freely and extensively used, many cases of puerperal mania would have been brought to the asylum in which this agent had been given. Instead, from the absence of such cases in the statistics of this asylum, and the fact that only one case in fifty of puerperal mania had received chloroform during labour, it may rather be inferred that chloroform diminishes instead of increases the tendency to this disease after parturition.<sup>845</sup>

The advocacy for the use of pain relief in childbirth was at odds with the ingrained social view that women should receive no relief while giving birth. However, in the interest of pain relief as a potential preventative measure against developing puerperal insanity, advocations

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<sup>841</sup> Frank Fish, ‘David Skae, M.D., F.R.C.S., Founder of the Edinburgh School of Psychiatry’, *Medical History*, 9.1 (1965), pp. 36-53 (p. 37).

<sup>842</sup> H.R. Woolcock, M.J. Thearle and K. Saunders, “‘My Beloved Chloroform’: Attitudes to Childbearing in Colonial Queensland”, *Social History of Medicine*, 10.3 (1997), pp. 437-57 (p. 449). For a discussion of nineteenth-century feminist approaches to pain relief in childbirth, see also: G. A. Skowronski, ‘Pain Relief in Childbirth: Changing Historial and Feminist Perspectives’, *Anaesthesia Intensive Care*, 43.1 (2015), pp. 25-28.

<sup>843</sup> *Annual Report of the Royal Edinburgh Asylum for the Insane* (Edinburgh: Royal Asylum Press, 1855), p. 26.

<sup>844</sup> *Annual Report of the Royal Edinburgh Asylum for the Insane* (1855), p. 27.

<sup>845</sup> David Skae quoted in ‘Reports of the Irish, Scotch, and American Asylums’, *The Asylum Journal of Mental Science*, 2 (1856), p. 422.

from within the asylum suggest a willingness for negotiation between gendered social views and developments in medical care.

The diagnosis and observation of puerperal mania was not significantly different from mania, but social views of women's domestic responsibilities created specific concerns about the relationship between this diagnosis and a risk to the domestic space. Outside of the asylum, the threat of puerperal mania to the Victorian household was illustrated in literary representations, including *Alice's Adventures in Wonderland* (1865). The following part of this section will draw on my analysis of *Wonderland* in Chapter Three, in which I argue that Carroll's depiction was specifically about the experience of mania in Wales during the transition between *cymorth*, a system of community care, and the introduction of accessible institutional treatment through the opening of the North Wales Lunatic Asylum, for which his uncle, Robert Wilfred Skeffington Lutwidge, played a key role as a Commissioner in Lunacy, by making enquires and writing the supplemental report for Wales to advocate for suitable psychiatric care.<sup>846</sup> In his illustration of mania in this place without structured, psychiatric care, Carroll demonstrates the impact of mania on female and male characters deviating from and failing in their expected roles according to socially constructed gender norms. I will analyse the depiction of the role of female caregiver through an examination of the Duchess in contrast with Alice and Alice's sister, arguing that the illustration of the Duchess is a warning of the consequences of a lack of institutional treatment and, therefore, a depiction of the threat of puerperal mania to society. However, though the roles are different, I will also argue that Carroll simultaneously depicts the experience of male mania as a threat to social order through his illustration of the King, who is depicted as ineffective in his role of social authority because of the experience of mania.

One of the features of puerperal mania – though not exclusive to this category and present in others diagnoses of mania, as seen in earlier cases in this chapter – was a change of affection or loss of interest associated with domestic duties and the patient's child. For example, E.B. of the Royal Edinburgh Asylum, discussed above, 'lost interest in her child', and J.M., admitted to the Inverness District Asylum in 1879, was observed as 'quite careless about her children'.<sup>847</sup> J.T., admitted to the Royal Edinburgh Asylum in 1882 was 'restless', 'excited', 'talked incoherently', 'behaving very violently', and 'took no interest in her child', and H.W., admitted to the Royal Edinburgh Asylum in 1889 was 'excited', 'incoherent',

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<sup>846</sup> See *Supplemental Report of the Metropolitan Commissioners in Lunacy*.

<sup>847</sup> LHB7/51/39, p. 565; HHB/3/5/2/12, p. 396.

‘sleepless’, with ‘no appetite’, and ‘took no interest in her child’.<sup>848</sup> Case records also described this behaviour as a change in characteristics according to emotional changes: W.I.H, admitted to the Royal Edinburgh Asylum in 1882, was described as ‘formerly cheerful’ and ‘at one time industrious’, but ‘of last year dull, retiring and neglectful of her family’, I.H., admitted to the Royal Edinburgh Asylum in 1886, was observed with ‘low spirits’ and ‘showed no regard for her children’, and A.O, admitted to the North Wales Lunatic Asylum in 1849, was previously ‘cheerful’ and ‘a very industrious person’, but had ‘of late given away to domestic affection’.<sup>849</sup>

Alongside changes in affection and neglect for domestic responsibilities, asylum records repeatedly observed destructive behaviour in the domestic space in cases of women with mania and puerperal mania. S.M.M., admitted to Gartnavel Royal Hospital in 1838, was described as ‘prone to throw whatever comes her way at those around her and to break windows and dishes’.<sup>850</sup> In some cases, destructive behaviour led to violence: E.G., admitted to the Royal Edinburgh Asylum in 1886 was recorded to ‘throw the crockery out of the house windows’ and ‘threatened [her husband’s] life with a knife’.<sup>851</sup> Similarly, C.R., admitted to the Inverness District Asylum in 1878, ‘broke all the dishes and furniture within her reach’, ‘attack[ed] every person coming within her reach’, and ‘threatened to kill her own child’.<sup>852</sup>

The Duchess similarly illustrates a combination of a loss of interest in domestic responsibilities, a loss of affection and neglect towards her baby, and a desire for violence. Like the case records, the scene in the Duchess’s kitchen is full of destructive behaviour. Alice’s opportunity to enter the house comes as a result of ‘a large plate [...] skimming out’.<sup>853</sup> The breaking of crockery continues, the cook ‘throwing everything within her reach’ including ‘fire-irons’ and ‘a shower of saucepans, plates, and dishes’ (p. 74). Though it is not the Duchess who throws them, the cook’s target is ‘the Duchess and her baby’, and the Duchess’s compliance is noted by her taking ‘no notice of them’, despite Alice ‘jumping up and down in an agony of terror’ that the baby would come to harm (p. 74). Moreover, the Duchess is described as behaving violently towards her child. She ‘addressed [...] the baby’ as ‘Pig!’ with ‘such sudden violence that Alice quite jumped’, ‘kept tossing the baby violently up and down’

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<sup>848</sup> LHB7/51/39, p. 229; LHB7/51/51, p. 312.

<sup>849</sup> LHB7/51/39, p. 349; LHB7/51/46, p. 389; HD/1/506, p. 4.

<sup>850</sup> HB13/5/11, p. 73.

<sup>851</sup> LHB7/51/46, p. 352.

<sup>852</sup> HHB/3/5/2/10, p. 294.

<sup>853</sup> Lewis Carroll, *Alice’s Adventures in Wonderland* (London: Macmillan, 2014), p. 72. All further references are to this edition and are given parenthetically in the body of the text.

and, when ‘singing a sort of lullaby’, gave the child ‘a violent shake at the end of every line’ (pp. 73-75). In addition, the first two lines of the ‘lullaby’ indicate physical abuse:

Speak roughly to your little boy,  
And beat him when he sneezes (p. 75)

The Duchess is set within a domestic space, and is holding her child and singing a lullaby, but each of her behaviours towards the child indicates neglect and aggression. Moreover, upon reading an invitation to play croquet with the Queen, the Duchess takes the first opportunity to leave the domestic space and her child, ‘flinging the baby’ at Alice and ‘hurr[ying] out of the room’ (p. 76).

Alice’s own maternal instincts are also brought into question by her encounter with the Duchess. Alice recognises the danger that the child could be killed by the neglect of the Duchess, believing ‘they’re sure to kill it in a day or two’, and ‘wouldn’t it be murder to leave it behind?’ (p. 77). She illustrates the figure of female caregiver by deciding initially to take the child away with her. However, Alice also demonstrates similar behaviour to the Duchess by changing her mind and abandoning the child when she sees it as a pig. Alice portrays a change or loss of affection by moving quickly from wanting to care for the child to leaving it behind. As I argued in Chapter Three, Alice is subject to changes of severe emotional states, self-perception, and perceptions of reality consistent with nineteenth-century mania during her time in Wonderland. Therefore, through her sudden loss of affection for the Duchess’s child, Alice conveys the change in mania from the role of female nurturing caregiver to neglect towards children, like the Duchess. This is not dissimilar to the way changes in affection were recorded in patient case notes, as discussed earlier. For example, M.L.K., admitted to the Royal Edinburgh Asylum in 1886, was destructive and spoke ‘nonsense’, with a note that she ‘nursed [her] child until one week ago’, but ‘since then has neglected it’ alongside experiencing ‘delusions that her child has been changed’, and M.M., admitted to the Inverness District Asylum in 1885, who was recorded with ‘antipathy to friends’ being ‘unsettled in habits’, singing in rhymes ‘with a very good voice’ but in words that had ‘no meaning’, and that she ‘took [her] child’ and ‘placed it at another house and left it.’<sup>854</sup>

Unlike the Duchess, Alice realises recovery when she leaves Wonderland. Upon waking, Alice finds herself ‘lying in the bank with her head on the lap of her sister’, who takes on the role of caregiver, ‘brushing away some dead leaves’ from ‘her face’ (p. 164). Flair

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<sup>854</sup> LHB7/51/47, p. 21; HHB/3/5/2/18, p. 296.

Donglai Shi points out that Alice's sister directs her back into the Victorian domestic space, telling her: 'now run in to your tea; it's getting late' (p. 164).<sup>855</sup> Being directed back into this space signals Alice's recovery from mania. In her sister's vision for Alice's future, unlike the Duchess, Alice displays love and affection for her children, in that she 'would feel with all their simple sorrows, and find a pleasure in all their simple joys' (p. 167). Aihong Ren argues that, unlike other children's literature of the time, *Alice's Adventures in Wonderland* is not instructive.<sup>856</sup> However, I argue that, in its depiction of roles of women, the text is an instruction to Alice Lidell herself. Shi argues that *Alice's Adventures in Wonderland* demonstrates Carroll's own misogynistic fears about women through his contrast between adult female figures, such as the Duchess and the Queen of Hearts, and Alice as a female child.<sup>857</sup> I agree with this argument about Carroll's insecurities towards adult women, and argue that Carroll demonstrates this specifically through depicting the experience of mania in each of these female characters, but in Alice also demonstrates recovery with the instruction that as a 'grown woman', 'she would keep [...] the simple and loving heart of her childhood' (pp. 166-167).

Alice therefore illustrates both the loss of affection for children because of mania, as well as the regaining of affection through recovery when returned to structured Victorian society. This dual perspective from Alice demonstrates the dangers of untreated symptoms of mania in society according to Carroll. It also depicts, with warning and instruction, the female experience of mania as failing to meet the caregiving, domestic role for women expected in Victorian society through the illustration of puerperal mania as a vicious cycle when untreated – puerperal mania was caused by childbirth, but goes on to cause neglect and violence towards both the baby and domestic space.

Alice achieves recovery by being reintegrated into a structured Victorian domestic space, away from the untreated mania of Wonderland and the Duchess, and instead returned to the positive, nurturing figure of her sister instructing her as caregiver. The key features portrayed in Alice's recovery are her willingness to conform to the structured space, and the vision for her future of fulfilling her maternal role and feeling affection for her own children. However, the depiction of the Duchess's experience of mania as a threat to the domestic space is far from being the only portrayal of a risk to social order. Alice's recovery begins through

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<sup>855</sup> Flair Donglai Shi, 'Alice's Adventures in Wonderland as an Anti-Feminist Text: Historical, Psychoanalytical and Postcolonial Perspectives', *Women: A Culture Review*, 27.2 (2016), pp. 177-201 (p. 185).

<sup>856</sup> Aihong Ren, 'Power Struggle between the Adult and Child in Alice's Adventures in Wonderland', *Theory and Practice in Language Studies*, 5.8 (2015), pp. 1659-1663 (p. 1659).

<sup>857</sup> Shi, 'Alice's Adventures in Wonderland as an Anti-Feminist Text', p. 189.

questioning and undermining the legal proceedings during the trial of the Knave of Hearts. The character who demonstrates the most significant contrast to Alice's coherence and clarity of mind in the courtroom is the King, who fails in his dual role as both monarch and judge because of symptoms of grandiose beliefs like the observations of high mood recorded in patient cases of mania.

Grandiose delusions combined with an inability to realise the skills or powers expressed were common observations in nineteenth-century case notes. W.K., admitted to the Royal Edinburgh Asylum in 1881, was recorded as stating he was 'a miracle of God' and that he was 'sent for the good of the place', particularly because of his ability in business.<sup>858</sup> However, the 'exciting cause' of his mental ill health was noted to be 'ill success in business'.<sup>859</sup> Similarly, J.H., admitted to Gartnavel Royal Asylum in 1835, was described as believing himself 'able for great bouts of genius', but that the 'exciting cause' for his condition was 'the loss of fortune and destitution of his circumstances'.<sup>860</sup> Moreover, H.K., admitted to the Royal Edinburgh Asylum in 1873, was described as experiencing delusions 'of personal greatness', believing 'everything in the newspapers referred to him' and, working as a lawyer, 'consider[ed] himself too good for his profession' and in need of greater responsibility.<sup>861</sup> A.M., admitted to the Inverness District Asylum in 1865, similarly experienced 'delusions of exalted greatness' and, as a result, 'frequently [wrote] letters [...] giving instruction about the government of the country', for which he believed he had authority.<sup>862</sup>

Among the different inhabitants of Wonderland, who illustrate various features of both the high and low mood states of mania, the King's delusion represents grandiose beliefs which are associated with high mood states. Catherine Siemann has examined the depiction of legal procedures both inside and outside of the courtroom trial in *Alice's Adventures in Wonderland* and *Through the Looking Glass*, and argues that the depiction provides 'a legal history of nineteenth-century Britain' through which 'the arbitrary and peculiar nature of the nineteenth-century British system becomes evident'.<sup>863</sup> I aim to build on this work, as well as build on my argument that Alice is able to undermine the legal proceedings and leave Wonderland because she demonstrates signs of recovery from her experience of symptoms of mania, by arguing that

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<sup>858</sup> LHB7/51/38, p. 132.

<sup>859</sup> LHB7/51/38, p. 132.

<sup>860</sup> HB13/5/20, p. 440.

<sup>861</sup> LHB7/51/23, p. 2.

<sup>862</sup> HHB/3/5/2/2, p. 191.

<sup>863</sup> Catherine Siemann, 'Curiouser and Curiouser: Law in the Alice Books', *Law and Literature*, 24.3 (Fall 2012), pp. 430-455 (p. 434).

the King depicts the incapacitating consequences of mania in the male experience, and therefore an illustration of mania's threat to social authority. Siemann argues that the texts show a 'generalized anxiety about the law', but my reading suggests instead an anxiety about the impact of this specific mental illness.<sup>864</sup>

The King's delusion is characterised by grandiosity. He represents two systems of power by embodying the dual role of both monarch and judge, wearing 'his crown over the wig' (p. 145). However, the King's enacting of his responsibilities is illustrated instead with an air of over-confidence that demonstrates his incompetence in deduction and ignorance of the proceedings he is responsible for ensuring. After the accusation is read, the King immediately asks the jury to 'Consider your verdict', leading to the White Rabbit 'hastily interrupt[ing]' that, 'There's a great deal to come before that!', in an attempt to retain order and procedure (p. 145). Furthermore, when examining evidence, the King's inability to draw logical conclusions is emphasised. The initial suggestion from the White Rabbit that the paper 'seems to be a letter', causes the King to settle on the conclusion that it must be 'written by the prisoner to somebody', because it 'isn't usual', for it to be 'written to nobody' (p. 157). Seeing that the paper 'isn't directed at all', with 'nothing written on the outside', the White Rabbit corrects his earlier presumption: 'It isn't a letter, after all: it's a set of verses' (pp. 157-158). However, the King cannot accept that the verses are not a letter, nor that they were not written by the Knave of Hearts.

The King continues to follow his own line of thought, unwilling to accept the White Rabbit's corrections about evidence or the contradictions in his deductions. When the White Rabbit confirms that the verses are 'not' in 'the prisoner's handwriting', the King asserts, 'He must have imitated somebody else's hand' (p. 158). Moreover, when the Knave of Hearts contests that he 'didn't write it' and 'they can'n't prove I did: there's no name signed at the end', the King claims 'that only makes the matter worse', arguing that the unsigned verses are crucial evidence of the Knave of Heart's guilt because he '*must* have meant some mischief', otherwise he would 'have signed [his] name like an honest man' (p. 158).<sup>865</sup> Despite the correction from the White Rabbit that the verses were not a letter, and no evidence that the Knave of Hearts had any connection to the verses, the King demonstrates a lack of competence in his role, asserting: 'That's the most important piece of evidence we've heard yet' (p. 160).

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<sup>864</sup> Siemann, 'Curiouser and Curiouser', p. 431.

<sup>865</sup> Emphasis in the original text.

The King's confidence is conveyed as a delusion by his incapacity to fulfil the roles of authority he represents.

The King's incompetence illustrates a threat to social order. Alice challenges his authority by openly contradicting him in front of the courtroom and her ability to undermine the proceedings with coherence and logic leads to her escape from Wonderland and return to domestic order, because it signals her recovery from symptoms associated with mania. In contrast, the King's insistence of both his ability and of imposing his own will illustrates the persistence of his own symptoms in a way that represents the male experience of mania as a threat to society. Pascal Bruckner and Nathan K. Bracher argue that the characters of Wonderland 'do the opposite of what we expect from them' in the way that they 'blatantly disregard their given role'.<sup>866</sup> I argue that, rather than disregarding his role, the King's grandiose delusions convey an incapacity to meet the responsibilities of either judge or monarch, and therefore the threat of such symptoms in figures of authority to social order. When wearing both the crown and wig simultaneously, we are told 'he did not look at all comfortable' and that the combination 'was certainly not becoming' (p. 143). Siemann argues that the look of discomfort described is a result of 'the merging of monarchy and judiciary' being 'a violation of legal principle'.<sup>867</sup> In addition to this, I argue that combining the roles signals his inflated sense of ability, and that the discomfort illustrates a risk to society according to Carroll in consequence of such symptoms remaining untreated.

*Alice's Adventures in Wonderland* conveys anxieties specific to female and male social roles in the context of mania. Puerperal mania is depicted as a threat to the domestic space, highlighting social fears about the impact of female mania on domestic responsibilities. Nevertheless, Carroll also illustrates the experience of male mania as a threat to society. The King's authority is undermined because of the repercussions of symptoms associated with mania, disrupting the legal proceedings he is responsible for overseeing, and threatening his two roles of social power and status. Both the female and male experience of mania are portrayed as dangerous to structures of Victorian society. While the setting of the threats to social order are different, Wonderland represents a balance in terms of the incapacitating influence of mania on fulfilling socially ascribed gender roles for both women and men. Literary representation was therefore a space to explore the specific repercussions of mania in

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<sup>866</sup> Pascal Bruckner and Nathan J. Bracher, 'On *Alice in Wonderland*', *South Central Review*, 38.3 (Fall 2021), pp. 23-28 (p. 23).

<sup>867</sup> Siemann, 'Curiouser and Curiouser', p. 439.



men and women according to social perspectives of gender difference, but ultimately both female and male mania were associated with a failure to align with social responsibilities.

## Conclusion

There was not a distinctive female or male classification for mania. Instead, the diagnosis and observation of this mental illness in patient records showed the same patterns of symptoms and behaviours across both high and low mood states. Despite a capacity for energy and violence underpinning views of gender difference, mania saw a balanced capacity for either an abundance or absence of energy as well as violence. This might be explained by the characterisation of mania as a change in habits and dispositions, and therefore a deviation from behaviours aligned with social norms. A part of the explanation for this balance might also be the different expectation for working-class women, who were already perceived as occupying a space outside of Victorian gender ideals by needing the energy to fulfil both their own domestic duties, as well as being employed outside of their household for the sake of income.

The diagnostic classification for mania created a space for similarity between women and men in terms of the experience of symptoms and consequent behaviours. This argument is strengthened by a comparative analysis of mania and puerperal mania, the latter associated with diagnostic classifications specific to the female experience and sometimes analysed in historical studies as one of the emerging categories used to punish and confine deviant female behaviour. However, my research indicates that, outside of the cause ascribed to features of pregnancy, childbirth, and nursing, the diagnosis and observation of puerperal mania in patient cases showed little variation from cases diagnosed as mania. Crucially, this similarity was consistent across the cases of both female and male patients.

Beyond the asylum, literary representation explored social perspectives of gender difference in the context of mania. While diagnostic procedures in asylums indicated balance, literary texts were a space to explore the experience of female and male mania in relation to social points of difference between men and women. Vane's 'A Village Tragedy' challenged views of inherent female characteristics by presenting Julia as warm and caring, and Sarah as cold and sharp, but ultimately revealing Julia as violent in the context of mania, and Sarah as the unconditionally protective caregiver. Furthermore, Carroll's *Alice's Adventures in Wonderland* conveyed social anxieties about the threat of puerperal mania to the domestic space, illustrating the Duchess as a neglectful, destructive, and violent mother because of

behaviours associated with mania. However, *Alice's Adventures in Wonderland* additionally depicts the male experience as a risk to social order. While the Duchess disrupts the domestic space, the King's incapacity to fulfil his dual roles of authority as monarch and judge are conveyed as dangerous for social authority, Alice undermining the procedures and ultimately escaping from Wonderland recovered from her own experience of symptoms associated with mania by demonstrating coherence of mind. Wonderland's depiction therefore represents mania as a threat to social order in both the female and male experience, illustrating mania as incapacitating both the Duchess and the King in their ascribed social responsibilities, whereas Alice's recovery returns her with obedience to Victorian social structures. Literary representation therefore explored anxieties specific to female and male social roles, but fundamentally represented both male and female mania as disrupting nineteenth-century society.

For both men and women, mania was characterised by an abundance or absence of energy according to high and low mood states. The consequence of behaviours associated with these severe mood episodes was an incapacitating effect on an ability to meet responsibilities in terms of work and familial affection. Expending energy was perceived as key to restoring a balance from either a lack or abundance. In the next chapter, I will draw on this chapter's analysis of energies in mania to examine progress towards recovery through occupation in female and male cases. I will argue that there was a greater difference in the male and female experience of mania in treatment than in diagnostic classification, seen through the segregation of asylum occupation.

## **Chapter Six:**

### **Capacity to Work and Progress Towards Recovery: Mania and Occupation**

This final chapter will extend and complicate the argument that there was not a distinct female or male classification of mania by focusing on the relationship between mania and occupation, arguing that there was a greater difference in the male and female experience of mania in treatment than in diagnosis. Using energy through occupation and activity was paramount to ideas in institutional treatment for restoring normal levels of energy from either a lack or excess. Changes in treatment that moved to a non-restraint system were not exclusive to mania, but mania specifically was fundamental to the debates beginning in the late 1830s both in favour of and against the disuse of restraint in asylums.<sup>868</sup> The reason mania was particularly important to these arguments was its characterisation by heightened or lessened energy. Bodily restraint had previously been considered vital to preventing patient exhaustion by limiting the capability for destructive behaviour, as well as necessary for protection against self-violence or violence towards others. However, developments in ideas about treatment realised the benefits of healthy expenditure of energy through activity and occupation to encourage sleep and appetite in cases characterised by either low, high, or alternating mood episodes. Progress towards recovery was traced by continuous work as a sign of a return to industriousness and an associated renewed interest in responsibilities, coherence of communication, and affection towards others.

Occupation was therefore central to treating mania, but occupation was also a feature of listed causes for developing mania. This chapter will argue that there was a difficult relationship between mania and work in its cycle from anxieties about finding work, employment responsibilities, and working conditions, to the incapacitating impact of the energies and behaviours of mania on an ability to work effectively, and to an occupational routine as vital to demonstrating recovery and indicating an ability to reintegrate into society. In addition, social perspectives of gendered labour division, which saw attempts to limit the types of employment opportunities available to working-class women and to limit female work to the domestic space of other households, as well as working women's responsibilities to their

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<sup>868</sup> For studies of changes in institutional treatment in the context of various diagnostic categories, see, for example: Smith, *Cure, Comfort, and Safe Custody*; Shepherd and Wright, 'Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint'; Topp, 'Single Rooms, Seclusion and the Non-Restraint Movement in British Asylums'. For analysis of mania's centrality to these debates, see Chapter Two of this thesis.

own households, meant female occupation in asylums was also mostly related to domestic roles.<sup>869</sup> Historians Pamela Michael and Stef Eastoe have discussed the division of employment and recreational activities for female and male patients in their respective studies of the North Wales Lunatic Asylum and Caterham Imbecile Asylum, showing that female occupation was generally in work associated with the household space, whereas outdoor occupational roles were more readily available to male patients.<sup>870</sup>

My research into the North Wales Lunatic Asylum, Gartnavel Royal Asylum, Royal Edinburgh Asylum, and Inverness District Asylum, has similarly shown female occupation as typically associated with domestic work, such as employment in settings including the kitchen and laundry. This indicates occupation in the asylum was influenced by social divisions in labour according to ideas about gender difference, conforming to nineteenth-century gender ideals and suggesting a more significant difference in treatment for female and male patients than in the classification and observation of mania. Place also impacted divisions of labour. In the Inverness District Asylum, the Royal Edinburgh Asylum, and reports from the Scottish Lunacy Commission, there was an inclination to create opportunities in outdoor occupation for female patients who had previously been outdoor workers within their communities. Foucault's renowned view of asylum confinement as patients 'freed from their chains' but 'imprisoned' by coercion to performing ideal 'values of family and work' has influenced several studies of the asylum space, which have nuanced and revised some of the views in *Madness and Civilisation*.<sup>871</sup> In the context of occupational treatment for mania, I will argue that these cases of a willingness to accommodate women according to culture suggests the asylum setting aimed to return patients to their previous habits and dispositions, based on the characterisation of mania as a change in behaviour according to severe emotional states, rather than attempting to reshape patients from different cultural backgrounds according to Victorian social ideals.

Beyond tensions in influence on the institutional space, literary representation again created a space for exploring mania in the context of specific female and male experiences.

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<sup>869</sup> For discussions of attempts to limit the types of employment available for working-class women because of associations between work and masculinity, see, for example: Danahay, *Gender at Work in Victorian Culture*; Rose, *Limited Livelihoods*.

<sup>870</sup> Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000*; Stef Eastoe, 'Playing Cards, Cricket and Carpentry: Amusement, Recreation and Occupation in Caterham Imbecile Asylum', *Journal of Victorian Culture*, 24.1 (2018), pp. 1-17 (p. 13).

<sup>871</sup> Foucault, *Madness and Civilisation*, p. 269. See, for example: Roy Porter, 'Foucault's Great Confinement', *History of the Human Sciences*, 3 (1990), pp. 47-54; Andrew Scull, 'Psychiatry and its Historians', *History of Psychiatry*, 2 (1991), pp. 239-250; Parr, Philo and Burns, 'Social Geographies of Rural Mental Health'; Laws, 'Crackpots and Basket-Cases; Topp, *Freedom and the Cage*.

This chapter, then, will continue to analyse literary texts in comparison with institutional medical records to interrogate literary illustrations of the relationship between mania and occupation. I will begin by following from the last section of the previous chapter – which examined representations of mania as causing an inability in both the female and male experience to fulfil social roles – to analyse the cycle of mania as being both caused by features of work and causing an inability to work effectively. Following this, the second section will trace progress towards recovery and the use of occupation in the asylum to prepare patients for rehabilitation into their communities. Alongside this discussion, I will examine a literary challenge to the separation of occupational opportunities for women and men in the context of mania, medical authority, and ideas about energy and idleness. Finally, the third section will further explore a point of difference raised in Chapter Five about the shape of delusions experienced by men and women in high mood episodes of mania: men were more likely to be recorded with grandiose delusions relating to employment, whereas grandiose delusions in female cases, though with the same result of realising power, wealth, and status, had a different path to superiority. The third section will consider the impact of contemporary social events on the form of delusions, as well as arguing that literature created a space where mania could be positively related to work through brilliance in ability.

### **Emotional States, Energies, and Capacity to Work**

The relationship between mania and occupation was both an important feature in the diagnosis of this mental illness and its treatment in an institutional setting. Mania was recorded in patient case records as impairing an ability to work – both in terms of domestic work and employment outside of the home – and as a result was associated with a risk of failing in gendered responsibilities to family units and wider society. Though working-class women were often employed outside of their home, employment opportunities were commonly in domestic roles in the houses of higher-class families, and working-class women were additionally responsible for the domestic work in their own homes, meaning female work was mostly associated with the home setting.<sup>872</sup> Women did continue to work in outdoor labour, but this kind of employment was increasingly seen as unsuitable for women, so that there were attempts made to limit such employment roles for female workers.<sup>873</sup> The key argument in this thesis that mania was characterised by both high and low mood allows for a more nuanced investigation

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<sup>872</sup> Danahay, *Gender at Work in Victorian Culture*, p. 12.

<sup>873</sup> Danahay, *Gender at Work in Victorian Culture*, p. 16; Rose, *Limited Livelihoods*, p. 57.

of features of occupation in the classification and treatment of mania, by allowing for analysis of the perceived repercussions of severe states of mood across the emotional spectrum. Despite differences in types of employment, there was a similar conception of mania as causing an inability to fulfil social responsibilities either because of heightened or lessened energy. Features of both severe high and low emotional states were recorded as changing attitudes towards work by both male and female patients.

Female case records of mania frequently recorded an unwillingness to fulfil domestic duties. J.B., admitted to Gartnavel Royal Asylum in 1838, was observed as ‘unsettled’ and ‘restless’, destructive in having ‘torn her clothes’, raving ‘chiefly on religion’, and these features perceived as causing an ‘inattention to her domestic duties for a considerable time’.<sup>874</sup> M.G., admitted to Gartnavel Royal Asylum in 1838, experienced ‘spirits often greatly depressed or elated’, and in low mood was ‘frequently disposed to confine herself to bed’.<sup>875</sup> A.O., admitted to the North Wales Lunatic Asylum in 1849, was previously ‘very industrious’ and ‘cheerful’, but had ‘of late given way to domestic affection’, and the case of M.D., admitted to the North Wales Lunatic Asylum in 1874, recorded a change in disposition from being usually a ‘thoroughly good wife and mother’ to now taking little interest in her family or domestic duties.<sup>876</sup> The case of M.M., admitted to the Inverness District Asylum in 1888, recorded the patient as taking ‘no interest in [her] home’ and threatening to set fire to her neighbour’s home to ‘kill his children’.<sup>877</sup> J.S., admitted to the Inverness District Asylum in 1870, was observed as ‘imagin[ing] herself some great person’ and therefore ‘always refused to work’.<sup>878</sup> The case of A.M., admitted to the Inverness District Asylum in 1888, was ‘characterised by extreme restlessness and excited’ with the note that she was therefore ‘unfit to attend to herself or her work except under observation’.<sup>879</sup> L.W., admitted to the Inverness District Asylum in 1885, was observed as excited and incoherent, singing ‘parts of a song in a rambling, incoherent manner’, with the note that ‘for the last fortnight she has taken no interest in her business and house’.<sup>880</sup>

Similarly, male case notes frequently observed an unwillingness or incapacity to work or seek employment. The case of J.L., admitted to the Gartnavel Royal Asylum in 1841,

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<sup>874</sup> HB13/5/11, p. 55.

<sup>875</sup> HB13/5/11, p. 63

<sup>876</sup> HD/1/506, p. 4; HD/1/331, p. 10.

<sup>877</sup> HHB/3/5/2/22, p. 326.

<sup>878</sup> HHB/3/5/2/4, p. 113.

<sup>879</sup> HHB/3/5/2/22, p. 354.

<sup>880</sup> HHB/3/5/2/18, p. 238.

recorded ‘absurd ideas as to his being a supernatural being’ and a belief that ‘he [had] died’, leading to ‘indifference to work’ and being ‘incapable of exertion’.<sup>881</sup> A note about changes in behaviour in the case of W.W., admitted to the North Wales Lunatic Asylum in 1865, stated that he would no longer work because of a belief that he was ‘defrauded of some property’.<sup>882</sup> D.T., admitted to the Royal Edinburgh Asylum in 1891, was recorded under the sub-heading ‘depression’ as becoming ‘despondent because he [had] not been able to get work’, but a change in behaviour was also recorded prior to admission when he began to stay ‘in bed all day’, and believed he was ‘looking for work when he [was] lying in bed’.<sup>883</sup> Similarly, the admission records of O.W., admitted to the North Wales Lunatic Asylum in 1854, stated: ‘will not do work’, T.M., admitted to the Inverness District Asylum in 1872 ‘refused to work’, and J.N., admitted to the Inverness District Asylum in 1879 was recorded prior to admission as ‘keep[ing] to his bed and [would] not work’.<sup>884</sup> Like the case of D.T. in Edinburgh, the case of J.N. connects an unwillingness to work specifically to low mood, recording a pattern in his case that ‘an attack of excitement [was] followed by depression’ and stating that his periods of ‘depression’ coincided both inside and outside of the asylum with a ‘refusal to work’.<sup>885</sup> A change in attitude towards work was also recorded alongside high mood: the case of H.K., admitted to the Royal Edinburgh Asylum in 1881, noted he had ‘done no regular work for some years’ because he ‘consider[ed] himself too good for his profession’, and D.S., admitted to the Royal Edinburgh Asylum in 1882, similarly believed he ‘ought not to work’.<sup>886</sup>

In both female and male cases, an inability to work was recorded as a feature of both high and low mood states. Low mood was associated with changes in affection, interest and despondency, which led to patients refusing to work either inside or outside of their home, being unwilling to look for work, and either claimed or believed because of delusions that they were seeking work despite staying in bed. On the other hand, high mood was associated with restlessness, destructive behaviour, and changes in attitude relating to superiority. Such case records therefore observed patients being too restless and excited to be able to settle and concentrate on their responsibilities either inside of or outside their homes, being a risk to their responsibilities because of destructive behaviour or violence, as well as feeling a level of superiority that meant they should not have to work because of delusions about power, status

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<sup>881</sup> HB/13/5/25, pp. 57-58.

<sup>882</sup> HD/1/517, p. 42.

<sup>883</sup> LHB7/51/54, p. 591.

<sup>884</sup> HD/1/517, p. 7; HHB/3/5/2/6, p. 114; HHB/3/5/2/12, p. 446.

<sup>885</sup> HHB/3/5/2/12, p. 446.

<sup>886</sup> LHB7/51/38, p. 2; LHB7/51/38, p. 585.

and wealth. The relationship between mania and work was tied to the characterisation of mania as either an absence or abundance of energy. An incapacity to work was presented in case notes alongside low mood as a lack of energy, whereas in high mood a similar incapacity to work was associated with heightened energy.

Patient case notes also recorded circumstances of employment as factors in causing mania. In a study of Middlesex County Asylum, Akihito Suzuki has written about mental illness in working-class men. Suzuki points out that causes were often listed as anxieties about ‘poverty and work’, as well as ‘grief over economic losses and unemployment’.<sup>887</sup> Suzuki argues that these causes ‘throw light on the structure of expectation and fear of working-class men’, whose expected social role was to be the primary household provider.<sup>888</sup> For these men, ‘unemployment affected the entire household’, and an inability to find employment was a failure to provide.<sup>889</sup> Though many working-class households were dual-income<sup>890</sup>, attempts to exclude women from some areas of employment, and the prevailing notion of the man as breadwinner, led to social pressure on men to aim to be sole providers.<sup>891</sup>

While Suzuki does not concentrate on mania specifically, my research into the case notes of a selection of working asylums revealed similar listed causes for mania. For example, R.M., admitted to Gartnavel Royal Asylum in 1835, was recorded as ‘constantly raving about the want of employment’.<sup>892</sup> The emotional impact of being unable to find work led to him developing delusions, ‘imagining his wife and family dead’ and attempting suicide.<sup>893</sup> Similarly, A.G., admitted to the Royal Edinburgh Asylum in 1882, was recorded as being ‘depressed in consequence of his having been out of work for some time’, while the case of J.C., also admitted to the Royal Edinburgh Asylum in 1882, noted the cause of his ‘depression’ as having ‘been out of work for some months’.<sup>894</sup> Like the female cases, these cases also recorded a change in affection and new suspicion towards family members. R.M. at Gartnavel was recorded as displaying ‘great bursts of outrage’ towards his family, A.G. at Edinburgh was

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<sup>887</sup> Akihito Suzuki, ‘Lunacy and Labouring Men: Narratives of Male Vulnerability in Mid-Victorian London’ in *Medicine, Madness and Social History: Essays in Honour of Roy Porter*, ed. by R. Bivins and J. Pickstone (London: Palgrave Macmillan, 2009), pp. 118-128 (p. 121).

<sup>888</sup> Suzuki, ‘Lunacy and Labouring Men’, p. 127.

<sup>889</sup> Suzuki, ‘Lunacy and Labouring Men’, p. 121.

<sup>890</sup> Tosh, *Masculinities in an Industrialising Society*, p. 337.

<sup>891</sup> Rose, *Limited Livelihoods*, pp. 132-135.

<sup>892</sup> HB13/5/20, p. 442.

<sup>893</sup> HB13/5/20, p. 442.

<sup>894</sup> LHB7/51/38, p. 697; LHB7/51/38, p. 589.



noted as believing ‘all his relatives [were] against him’, and J.C. at Edinburgh believed his mother was trying to poison him and others through the toffy she sold.<sup>895</sup>

Concerns about work also affected female cases of mania. Skae of the Royal Edinburgh Asylum reflected on anxieties about work, both within and outside of the home, as contributors to causing mania in female cases specifically in the asylum’s *Annual Report* for 1853, his comments republished in the *Journal for Psychological Medicine and Mental Pathology* in 1855 because of being ‘replete with valuable and interesting matter’.<sup>896</sup> Skae recorded causes in female cases of mania as including ‘anxieties and responsibilities of which they were incapacitated’, relating sometimes to ‘early marriages’ as well as employment as ‘servants’ in other households.<sup>897</sup> According to Skae, these factors were made worse by ‘habits of over-exertion, combined often with insufficient nourishment’ and ‘poverty’.<sup>898</sup>

Working conditions and accidents at work were also recorded as having an impact on mental wellbeing. The cause of T.J.’s mania, admitted to Gartnavel Royal Asylum in 1835, was recorded as a ‘shipwreck’ he survived as a sailor, as well as ‘the hard life he endured’ because of conditions at work.<sup>899</sup> Moreover, the case of J.H., admitted to the Royal Edinburgh Asylum in 1881, illustrated the repercussions of managing responsibilities in employment. J.H. was ‘responsible’ for a mill which was accidentally ‘burned down’.<sup>900</sup> The patient was recorded as ‘blam[ing] himself for the accident and as a result becoming unwell’.<sup>901</sup> The weight of the responsibility and the accident were recorded as characterising his delusions, being ‘full of delusions about the mill’ and continuing to feel the responsibility for it, ‘believing he [had] the keys’.<sup>902</sup> In consequence, he became suicidal.<sup>903</sup>

Patient case records therefore illustrated mania as both the cause of an incapacity to work, as well as the consequence of anxieties about employment, responsibilities, and working conditions. Fears about being able to fulfil expected social roles, the burden of employment responsibilities, and accidents at work, were recorded as causes in cases of mania. Moreover, symptoms included changes in attitude such as an unwillingness to work or conversely as being

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<sup>895</sup> HB13/5/20, p. 442; LHB7/51/38, p. 697; LHB7/51/38, p. 589.

<sup>896</sup> David Skae quoted in ‘British Asylums for the Insane’, *Journal of Psychological Medicine and Mental Pathology* (1855), pp. 1-29 (p. 26).

<sup>897</sup> Skae in ‘British Asylums for the Insane’, p. 26.

<sup>898</sup> Skae in ‘British Asylums for the Insane’, p. 26.

<sup>899</sup> HB13/5/20, p. 486.

<sup>900</sup> LHB7/51/38, p. 292.

<sup>901</sup> LHB7/51/38, p. 292.

<sup>902</sup> LHB7/51/38, p. 292.

<sup>903</sup> LHB7/51/38, p. 292.

too good to work. As demonstrated by Suzuki, anxieties about work as a cause for mental health problems were not unique to cases of mania.<sup>904</sup> However, it is in mania specifically where the dynamic between work and mental ill health was illustrated as a vicious cycle: anxieties about employment could cause mania, but mania could then cause an impairment in ability to work – a cycle not dissimilar to the construction of puerperal mania in women that saw childbirth as a common cause for mania, and the resulting symptoms including a loss of affection, neglect, and potential violence towards their children. Literary representations of mania also depicted this cycle. In ‘The Signalman’ Charles Dickens illustrates a vicious cycle in the relationship between employment and the male experience of mania specifically. Dickens does this by demonstrating the impact of working conditions as a cause for mania, but also the repercussions of mania on the ability to fulfil employment responsibilities, even in individuals who previously excelled in their positions of employment.

Dickens’s ‘The Signalman’ was first published in the 1866 Christmas issue of *All the Year Round* as one of the tales in ‘Mugby Junction’. The publication of ‘The Signalman’ occurred a year after Dickens survived a railway accident near Staplehurst, Kent. Jill L. Matus points out that the accident was a result of human error: the arrival time of the train was ‘miscalculated’ amid repair work, and the signalman was ‘unable to give adequate warning of the train’s approach’.<sup>905</sup> In consequence, ten people lost their lives and fifty were injured.<sup>906</sup> Dickens, his mistress, Ellen Ternan, and her mother, all survived, and Matus writes that Dickens ‘minister[ed] to the many who lay injured and dying’.<sup>907</sup> Many literary scholars have therefore connected Dickens’s ‘The Signalman’ to the railway accident. Matus and David Ellison have written about Dickens’s experience and ‘The Signalman’ in the context of trauma theory.<sup>908</sup> Karen M. Odden discussed the story amid representations of railway accidents and trauma in medical writing and sensation novels, Matthew Wilson Smith’s analysis discussed the narrative conventions of melodrama, Norris Pope focused on anxieties around signalling and information transfer, and Simon Cooke read ‘The Signalman’ as locating ‘terror not in the strange and the magical’ but instead ‘in the everyday’ in the context of anxieties about railway

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<sup>904</sup> Suzuki, ‘Lunacy and Labouring Men’.

<sup>905</sup> Jill L. Matus, *Shock, Memory and the Unconscious in Victorian Fiction* (Cambridge: Cambridge University Press, 2009), p. 83.

<sup>906</sup> Simon Cooke, ‘Anxious Travelers: A Contextual Reading of “The Signalman”’, *Dickens Quarterly*, 22.2 (June 2005), pp. 101-108 (p. 102).

<sup>907</sup> Matus, *Shock, Memory and the Unconscious in Victorian Fiction*, p. 83.

<sup>908</sup> Matus, *Shock, Memory and the Unconscious in Victorian Fiction*; David Ellison, ‘The Ghost of Injuries Present in Dickens’s “The Signalman”’, *Textual Practice*, 26.4 (2012), pp. 649-665.

travel.<sup>909</sup> More recently, Seda Coşar Çelik has analysed ‘The Signalman’ alongside medical writing about the safety of railway working conditions.<sup>910</sup> In this section, I aim to build on the connections drawn between ‘The Signalman’ and Dickens’s own experience of a railway accident, drawing on Çelik’s work in particular, as well as my research into patient case notes, to argue that the short story depicts both the impact of working conditions as a factor in causing mental ill health, as well as the consequences of symptoms associated with low mood in mania as impairing an ability to work effectively.

Patterns recorded in cases of mania marked by low mood included being despondent, sullen, staring vacantly, being unwilling to engage in conversation or answer questions, and experiencing delusions and hallucinations associated with a feeling of being subject to danger. W.M., admitted to the Inverness District Asylum in 1878 was observed with a ‘vacant look’ and ‘instead of replying to questions’ would ‘stare vacantly right before him’, J.C., admitted to the Royal Edinburgh Asylum in 1881 was described with a ‘vacant [...] expression’ with a note that he would not reply to questions, and T.H., admitted to the Royal Edinburgh Asylum in 1873 was observed as ‘obstinately quiet’, that he ‘[would] not reply to any question put to him’, ‘refuse[d] to speak’, and was ‘very sullen and suspicious by the movement of his eyes’.<sup>911</sup> In addition, D.M., admitted to the Inverness District Asylum in 1878, had delusions that ‘his life is in danger from friendly neighbours’, M.M., admitted to the Inverness District Asylum in 1872 believed ‘she [had] been killed’ by ‘spirits’, and W.W., admitted to the Royal Edinburgh Asylum in 1882, was recorded with delusions that he was subject to threat by ‘spirits’ who he stated, ‘always tear at his jaw to dislocate it’, his symptoms recorded as causing ‘a trouble to his friends and employer’.<sup>912</sup> Similarly, Dickens’s unnamed signalman presents with symptoms associated with low mood in mania as recorded in patient case notes. The narrator describes him with an unwillingness to respond, conveying ‘a singular air of reluctance’ and ‘look[ing] up [...] without replying’.<sup>913</sup> Moreover, he is described as a ‘sallow man’ with a ‘curious look’ in his ‘hollow’ and ‘fixed eyes’ dividing ‘grave, dark regards [...] between [the narrator] and

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<sup>909</sup> Karen M Odden, ‘25 August 1861: the Clayton Tunnel Rail Crash, the Medical Profession, and the Sensation Novel’, *Victorian Review*, 40.2 (Fall 2014), pp. 30-34; Matthew Wilson Smith, ‘Victorian Railway Accident and the Melodramatic Imagination’, *Modern Drama*, 55.4 (Winter 2012), pp. 491-522; Norris Pope, ‘Dickens’s “The Signalman” and Information Problems in the Railway Age’, *Technology and Culture*, 42.3 (July 2001), pp. 436-461; Cooke, ‘Anxious Travelers’, p. 107.

<sup>910</sup> Seda Coşar Çelik, ‘Railways, Ghosts and Charles Dickens’ “The Signalman”’, *Journal of Narrative and Language Studies*, 6.10 (June 2018), pp. 124-132.

<sup>911</sup> HHB/3/5/2/10, p. 316; LHB7/51/23, p. 197; LHB7/51/38, p. 653.

<sup>912</sup> HHB/3/5/2/10, p. 276; HHB/3/5/2/6, p. 455; LHB7/51/38, p. 580.

<sup>913</sup> Charles Dickens, ‘The Signalman’, *All the Year Round* (1866), pp. 312-322 (p. 312). All further references are to this edition and are given parenthetically in the body of the text.

the fire’ (pp. 313-314). In addition, the signalman hallucinates a spectre which he associates with a premonition of danger – specifically, that an accident will occur on the railway.

The signalman’s surroundings are represented as at odds with the type of space considered positive for mental wellbeing. Beneficial surroundings were important to developments in treating mania, which realised the positive impact of open air, light, and activity. The value placed on these aspects on treatment was highlighted in asylum records – for example, Inverness District Asylum’s *Register of Escapes 1868-1977* recorded numerous attempts to escape during walking groups by both female and male patients.<sup>914</sup> However, fresh air and exercise were considered important enough to continue to allow patients who had attempted numerous times to escape on these occasions to return to the walking groups, leading to repeat offences.<sup>915</sup> These instances included patients with a variety of diagnoses. However, activity and occupation outdoors were crucial to the treatment for mania specifically as a means of expending energy and reengaging interest. Furthermore, Aitken indicated the importance of light surroundings in treatment in the Inverness District Asylum’s *Annual Report* for 1867: ‘patients – long secluded from light – are rarely susceptible of mental improvement’.<sup>916</sup> In contrast, the signalman’s surroundings are described as a cold, dark, isolated place of confinement. A ‘dripping-wet wall of jagged stone’ blocks nearly all of the light by ‘excluding all but a strip of the sky’, so that the only light comes from the danger light, ‘a gloomy red light’ (p. 313). There is ‘so little sunlight’ that there is ‘an earthy, deadly smell’ and ‘so much cold wind rushed through it’ that the narrator states, ‘it struck chill to me’ (p. 313). The air of death in the smell, the cold chill, and the only light indicating danger, as well as the narrator’s description of a ‘barbarous, depressing, and forbidding’ atmosphere, connect to the themes of death, decay, and vulnerability in hallucinations and delusional beliefs recorded in nineteenth-century mania, as well as depicting surroundings believed to be damaging to mania (p. 313). Moreover, a sense of confinement and isolation is illustrated through the description of the station as a ‘solitary [...] great dungeon’ and the signalman’s reference to his working pattern of ‘many long and lonely hours’ (pp. 313-314). The surroundings appear to have a negative effect on the narrator after being exposed to them for only a short time as he indicates a loss of grip on the reality around him, feeling as ‘if [he] had left the natural world’, and experiencing the ‘monstrous thought that the signalman ‘was a spirit, not a man’ (p. 313).

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<sup>914</sup> HHB/3/5/1/18/1.

<sup>915</sup> HHB/3/5/1/18/1.

<sup>916</sup> *Third Annual Report of the Inverness District Lunatic Asylum* (Inverness: Courier Office, 1867), p. 14.

Beyond the negative effect of the surroundings, the signalman conveys the impact of the weight of responsibility in his role alongside a sense of confinement and isolation. The narrator asks if ‘when on duty’ he must ‘always [...] remain in that channel of damp air’ or whether it was possible for him to go up to the ‘sunshine from behind those high stone walls?’ (p. 314). To move beyond those high walls into the light conveys leaving the confinement of the station. However, though the signalman expressed his desire to ‘choose occasions for getting a little above these longer shadows’, his heavy responsibility, working alone for ‘hours of the day and night’, meant that he was ‘at all times liable to be called by his electric bell’ so that, having escaped to glimpses of light, he would still be confined by the requirement of ‘listening for it with redoubled anxiety’ (p. 314).

Çelik refers to articles from the *British Medical Journal* to analyse the impact of railway working conditions. One of the articles examined in 1883, ‘Sleepy Signalmen’, claimed that the ‘circumstances’ of the signalmen ‘render[ed] the exercise of vigilance’ required of them ‘difficult or impossible’.<sup>917</sup> Among the working conditions causing mental ill health, the article noted the ‘continuous and exhausting night-work’ as well as the need to bear the responsibility in isolation. As Çelik demonstrates, the numerous railway accidents led to a change in employment conditions for signalmen later in the nineteenth century. Another article examined by Çelik, published in the *British Medical Journal* in 1896, explained that the ‘sickness-rate among signalmen [...] was becoming excessive’ so that, ‘at great expense’, it became a requirement that ‘two men’ must occupy each post.<sup>918</sup> Furthermore, the article stated that, while it was initially feared that the ‘men would talk, and lark and neglect their duties’, the end to working in isolation, and instead the shared weight of responsibility, meant that ‘the sickness stopped’.<sup>919</sup>

Dickens emphasises the impact on his signalman by reminding the reader of his ability and previous excellent work. The narrator describes him with the sense of being over-qualified for his position, the signalman having ‘been well educated’ and ‘educated above that station’ (p. 314). The signalman highlights that this was true in ‘large bodies of men’ in different fields of employment, and that ‘he knew it was so, more or less in any great railway staff’ (p. 314). The suggestion that this signalman, and railway employees collectively, were working in positions below their abilities, illustrates a sympathetic view of the accidents caused by human

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<sup>917</sup> *British Medical Journal* in Çelik, ‘Railways, Ghosts and Charles Dickens’ ‘The Signalman’”, p. 127.

<sup>918</sup> *British Medical Journal* in Çelik, ‘Railways, Ghosts and Charles Dickens’ ‘The Signalman’”, p. 128.

<sup>919</sup> *British Medical Journal* in Çelik, ‘Railways, Ghosts and Charles Dickens’ ‘The Signalman’”, p. 128.

error, because it places the accountability on the working conditions rather than the ability of employees. The narrator highlights the signalman's capability, stating, 'in the discharge of his duties, I observed him to be remarkably exact and vigilant' (p. 321). Moreover, other railway workers are shocked to see him in an accident at the end of the text because 'no man in England knew his work better' and 'I knew him to be very careful' (p. 321). The narrator emphasises that the impairment of the signalman's work is a result of his circumstances causing mania, stating 'I should have set this man down as one of the safest of men to be employed in that capacity' except that he witnessed the signalman twice 'turn[ing] his face towards the little bell when it did *not* ring' with 'a fallen colour', in reaction to his hallucination.

David Seed argues that the accidents on the railway during the signalman's employment cannot be explained by mental illness, but instead only by the supernatural. Seed argues this because the signalman 'performs his duties in a remarkably conscientious and efficient manner', and when the narrator suggests that the signalman is mentally unwell 'no sooner is that explanation formed' than the signalman describes the premonition proving to be true through an accident, and therefore 'undermines' the explanation.<sup>920</sup> However, an analysis of 'The Signalman' in the context of patient case notes from working asylums demonstrates the features of mania in the characterisation of the signalman, allowing for a new reading of the text as well as a contribution to representations of mania in relation to social responsibility and employment. I argue, in contrast to Seed, that the reminders about the signalman's effective work emphasise the sympathetic depiction from Dickens of the impact of poor working conditions on mental health problems, and the vicious cycle of such problems impairing an ability to work in the case of mania specifically.

Mitsuharu Matsuoka discusses Dickens's awareness of and interest in mental illness, arguing that Dickens's writing on 'madness [...] combined sympathy with pragmatism and regarded it as an illness', as well as demonstrating Dickens's aim to 'bring to the general public a greater awareness of how mental illness was being treated'.<sup>921</sup> In his depiction of the signalman, following Dicken's own traumatic experience of surviving a railway accident, he is sympathetic by creating a character who excels in his position, but who is let down by his working conditions, ultimately developing symptoms of mania, and losing his life as a result. The accidents the signalman was previously involved in also have fatal consequences, and

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<sup>920</sup> David Seed, 'Mystery in Everyday Things: Charles Dickens' "Signalman"', *Criticism*, 23.1 (Winter 1981), pp. 42-57 (pp. 51-52).

<sup>921</sup> Mitsuharu Matsuoka, 'Bedlam Revisited: Dickens and Notions of Madness', *The Dickensian* 109.491 (Winter 2013), pp. 225-239 (p. 230).

Dickens illustrates his desperation to prevent further fatalities: ‘What is the danger? Where is the danger? [...] What can I do?’ (p. 319). The narrator reacts sympathetically, noting that it was the ‘mental torture of a conscientious man’ attempting to bear ‘an unintelligible responsibility involving life’ (p. 319).

The accidents that occur on the railway following the premonitions from the spectre are not evidence of the supernatural, but rather the cycle of an exacerbation in the signalman’s symptoms, indicated by his hallucination, leading to an impairment in his work and therefore to an error causing an accident. The narrator refers to the risk to ‘public safety’, but emphasises that this behaviour is the result of ill health in reaction to the conditions of the signalman’s work:

I had proved the man to be intelligent, vigilant, painstaking, and exact; but how long might he remain so, in his state of mind? (p. 320)

The narrator reminds us of his capability, and states that his impaired ability is the result of the consequences on his mental wellbeing, resolving to ‘accompany him’ to a ‘medical practitioner’ (p. 320). Dickens illustrates an awareness of ideas about recovery, which were associated with a patient being able to recognise their experiences of hallucinations and delusions as symptoms of illness, when the narrator expresses hope for the signalman’s condition, stating it is possible for ‘troubled patients’ to ‘become conscious of the nature of their affliction’ (p. 317). However, the signalman’s experience of mania is illustrated as a vicious cycle in which he develops mania because of the conditions of his employment, and becomes incapable of fulfilling his employment duties when his symptoms go untreated, which ultimately leads to his death.

Patient case records indicate the concept of features of employment as factors in causing mania. Anxieties about finding employment, meeting employment responsibilities, and working conditions were all recorded as contributors in case records towards the development of symptoms of mania. The perception of mania’s impact on a capacity to work depicts a cycle in which factors relating to employment could cause mania, but mania itself, both in high and low mood states, caused an inability to work because of behaviours associated with either a lack of or heightened energy. Social pressure on men to be primary providers was likely a pressurising factor in anxieties about employment, but working-class women were also often also employed while being additionally responsible for the domestic work within their own homes. As a result, patient case records indicate a similar unwillingness or incapacity to fulfil work responsibilities in both male and female cases, but with a greater focus in female

cases on domestic duties, and in male cases on roles of employment that impacted both their ability to provide and could cause risks to wider society through safety concerns. Dickens's 'The Signalman', though sympathetic towards the factor of working conditions as causing a decline in mental health, depicted the consequences of employees facing an incapacity to work as a repercussion of mania through an illustration of accidents on the railway caused by human error amid symptoms of this mental illness, and therefore the relationship between mania and occupation as a risk to public safety. However, in the vicious cyclical relationship between mania and work, occupation was also a central feature in treatment as a form of using energy. In the next section, I will analyse case records tracking patients' progress towards recovery alongside occupational roles available within the asylum for male and female patients.

### **Progress Towards Recovery: From 'Idle' or 'Restless' to 'Industrious'**

Work on the history of asylums has demonstrated the use of occupation in the treatment for women with a variety of diagnoses.<sup>922</sup> Studies of asylum treatment have additionally traced the significant changes in treatment amid debates about the use of bodily restraint.<sup>923</sup> In their respective studies of the North Wales Lunatic Asylum and Caterham Imbecile Asylum, Pamela Michael and Stef Eastoe discuss the occupational roles of women in the asylum as mostly involved in domestic work, whereas male asylum occupation included outdoor labour.<sup>924</sup> In cases of mania, my research into archival cases has shown that encouraging occupation was concerned with both using energy and with regaining interest in responsibilities and familial affection. Crucially, the use of activity and occupation was considered vital to treating both high and low mood states. Consequently, the types of occupation advised for women and men were concerned with preparing them for reintegration into society and into fulfilling their social roles. While working-class women might work outside of their homes as well as being responsible for the domestic work of their household, their employment was frequently listed in asylum registers as 'domestic servant', working in the households of higher-class families. Due to the domestic focus on a woman's role in nineteenth-century society, occupation for women within the asylum was generally situated around household work roles, such as in the

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<sup>922</sup> Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000*; Laws, 'Crackpots and Basket-Cases'; Eastoe, 'Playing Cards, Cricket and Carpentry'.

<sup>923</sup> Smith, *Cure, Comfort, and Safe Custody*; Shepherd and Wright, 'Madness, Suicide and the Victorian Asylum'; Topp, 'Single Rooms, Seclusion and the Non-Restraint Movement in British Asylums'.

<sup>924</sup> Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000*, p. 71; Eastoe, 'Playing Cards, Cricket and Carpentry', p. 13.



laundry or kitchen, whereas for men reintegration was generally about re-joining employment outside of the home space in outdoor labour, working, for example, in areas of farming or gardening within the asylum grounds.

One marked exception to the generally domestic work undertaken by female patients in asylums were the women of the Inverness District Asylum who has previously been employed in outdoor work within their communities. In their study of Inverness District Asylum, Hester Parr, Chris Philo, and Nicola Burns discuss the role of this asylum as providing ‘culturally specific forms of care’ for the populations of the Scottish Highlands and Islands.<sup>925</sup> They argue that, in practice, there was ‘little evidence (beyond some staff being able to speak Gaelic) that culturally sensitive care was practised’.<sup>926</sup> However, I would argue that the provision of outdoor employment opportunities within the asylum grounds was considered by the medical staff and Scottish Lunacy Commissioners as providing culturally specific treatment for the sake of rehabilitation. The populations of the Scottish Highlands and Islands and Wales were seen as requiring different types of treatment based on their language, communities, and different cultural beliefs. In the Inverness District Asylum, then, treating women with mania and preparing them for reintegration into their communities required preparation for a return to outdoor work. In the Inverness District Asylum *Annual Report* for 1871, the lunacy commissioner report refers to the suggestion that ‘an effort should be made to have [the female patients] more in the open air’, because a ‘great many’ of the female patients ‘lead at their own homes a life which is a peculiarly an out-of-door one.’<sup>927</sup> Despite the description of outdoor occupation for women as peculiar, this report conveys an awareness and willingness for the need of forms of treatment to prepare patients for reintegration into the roles and responsibilities within their own communities.

Selected roles of outdoor occupation were additionally available to women in the Royal Edinburgh Asylum, which also admitted a number of patients from the Scottish Highlands and Islands prior to the opening of the Inverness District Asylum in 1864. David Skae, medical superintendent of the Royal Edinburgh Asylum, wrote in the *Annual Report* for 1851 that ‘the most beneficial as a means of cure is undoubtedly active occupation in the open air’.<sup>928</sup> Though some outdoor roles were mostly reserved for the male patients, Skae illustrates that outdoor occupation was also considered valuable for certain female patients who ‘frequently afforded

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<sup>925</sup> Parr, Philo and Burns, ““That awful place was home””, p. 344.

<sup>926</sup> Parr, Philo and Burns, ““That awful place was home””, p. 354.

<sup>927</sup> *Seventh Annual Report of the Inverness District Lunatic Asylum* (Inverness: Courier Office, 1871), p. 7.

<sup>928</sup> *Annual Report of the Royal Edinburgh Asylum for the Insane* (Edinburgh: Royal Asylum Press, 1851), p. 35.

bands of cheerful and active workers' in roles such as 'weeding, picking, and other suitable out-door occupations'.<sup>929</sup> Furthermore, in his comments about factors relating to work causing mania in female cases, Skae draws attention to women from the Scottish Highlands being employed elsewhere in Scotland in domestic roles:

Three were servants, brought up in the innocence and seclusion of [...] the remote north, and suddenly exposed to worry [...] attendant upon service in metropolitan houses.<sup>930</sup>

Skae's comments suggest that changes in culture and place in the context of work could be contributors to developing mania. Skae's theory might explain an inclination to accommodate outdoor work roles for women who would be returning to outdoor employment when recovered, to provide occupation that was familiar and would therefore aid in rehabilitation rather than risk a decline in mental wellbeing through a change in routine. Despite a general focus on female domestic occupation within asylums, the examples at Inverness District Asylum and the Royal Edinburgh Asylum indicate there was a willingness in some institutions to vary forms of occupation based on their usefulness to social reintegration for patients from different places.

For both men and women, progress towards recovery was traced as working steadily, conversing rationally, and regaining interest in both relatives/friends and social responsibilities. While those responsibilities varied based on gender, class, and place, a move from either a lack of energy and loss of interest in low mood, or a heightened energy in restlessness and destructive behaviour in high mood, to becoming industrious was a constant feature in patient case records that realised recovery. A.R., admitted to the Inverness District Asylum in 1870 and diagnosed with puerperal mania, was observed with 'alternate depression and excitement' and a loss of affection through 'not [having] the slightest recollection of her family'.<sup>931</sup> Her recovery was described as being achieved through occupation and returning to being an 'industrious woman'.<sup>932</sup> A.M., admitted to the Inverness District Asylum in 1888 and diagnosed with mania, 'was discharged as recovered' after she 'worked steadily and uniformly at her work [...] for the last two months'.<sup>933</sup> Similarly, I.M., admitted to the Inverness District Asylum in 1888 and diagnosed with mania, was described as recovered within a year by

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<sup>929</sup> *Annual Report of the Royal Edinburgh Asylum for the Insane* (1851), p. 35.

<sup>930</sup> Skae in 'British Asylums for the Insane', p. 26.

<sup>931</sup> HHB/3/5/2/4, p. 307.

<sup>932</sup> HHB/3/5/2/4, p. 307.

<sup>933</sup> HHB/3/5/2/21, p. 329.

‘mak[ing] herself useful’, which led to her ‘sle[eping] well and [taking] her food’ as well as ‘tak[ing] an interest in her husband, her home and family’.<sup>934</sup> J.B., admitted to the Royal Edinburgh Asylum in 1882, was ‘discharged recovered’ after the record that she ‘works diligently’.<sup>935</sup>

Male cases recorded similar progress: The case of R.M., admitted to the Inverness District Asylum in 1871, recorded ‘almost no improvement’ in his case, until ‘he was sent to work’ – from this point on, ‘his progress was very rapid and satisfactory’.<sup>936</sup> Similarly, C.B., admitted to the North Wales Lunatic Asylum in 1860, improved once employed in ‘the gardens [...] in which all his interest [was] centred’.<sup>937</sup> The case of J.C., admitted to Royal Edinburgh Asylum in 1882, tracked his improvement from beginning ‘work in the joiner shop’, to consistently ‘working well’, to him having ‘obtained work outside’ and therefore being ‘discharged recovered’.<sup>938</sup> Progress towards recovery in the case of R.L., admitted to the Gartnavel Royal Asylum in 1841, included notes that he ‘works with a spade in the garden’, ‘is quiet and industrious’, and had a renewed affection for his friends, who he treats ‘favourably’.<sup>939</sup>

Outside of the asylum, literary representations challenged the separation of female and male roles of occupation in the context of mania, energy, idleness, and medical authority. For the final part of this section, I will analyse Margaret Oliphant’s essay writing about expectations for ‘women’s work’, as well as her short story ‘The Library Window’ (1896) to argue that Oliphant highlights tensions between the need for activity in the treatment of female mania and the limits placed on the types of occupation deemed suitable for most women in comparison with those available to men. Oliphant demonstrates an awareness of diagnostic categories associated with mania in ‘A Christmas Tale’ (1857), which I examine in Chapter Four. A valuable feature of Chapter Four’s analysis for this section is the argument that Oliphant challenges medical authority in different places, and that she was specifically influenced by the inquiries of the Scottish Lunacy Commissioners which led to the opening of the Inverness District Asylum in 1864.<sup>940</sup>

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<sup>934</sup> HHB/3/5/2/21, p. 334.

<sup>935</sup> LHB7/51/39, p. 55.

<sup>936</sup> HHB/3/5/2/5, p. 328.

<sup>937</sup> HD/1/517, p. 11.

<sup>938</sup> LHB7/51/38, p. 591.

<sup>939</sup> HB/13/5/25, p. 37.

<sup>940</sup> Previous literary scholarship has also drawn connections between Oliphant’s ‘The Library Window’ and medical writing about female mental ill health. For example, see: Simon Cooke, ‘Margaret Oliphant’s “The Library Window” and the Idea of Adolescent Insanity’, *Victorians Institute Journal*, 34 (2006), 244-57, which

‘The Library Window’ challenges the limits placed on the types of occupation deemed suitable for women in the context of mania specifically. The short story is centred on a girl who experiences visions of a spectre in the window of the library across the street while staying with her Aunt Mary in Scotland. The visitors to Aunt Mary’s home are in continuous contention about whether it is ‘a real window with glass in it’, if it ‘is merely painted’ or ‘if it once was a window, and has been built up’.<sup>941</sup> Amid debates about the window, the protagonist develops visions of the spectre alongside behaviours like those recorded in patient cases of mania, but stays silent about what she sees. Observations of hallucinations in asylum case records were often recorded under headings about sensory experience. For example, questions and headings in the structure of patient case records in the Royal Edinburgh Asylum included ‘sensory’ and ‘special senses’.<sup>942</sup> Notes in these headings included answers such as ‘exaggerated’ and ‘heightened’ in the context of ‘hallucinations of sight and hearing’.<sup>943</sup> The protagonist of ‘The Library Window’ talks of her own particular sensory ability, ‘a sort of second-sight’, making her ‘conscious of things to which [she] paid no attention’, and able to ‘see all sorts of things’ even if, ‘for a whole half-hour [she] might never lift [her] eyes’ (p. 252).

Second sight connects to the traditional Highlands belief in the ability of premonition, but it is also connected in the short story to the medical explanation of a visual hallucination, indicating a tension between medical authority and traditional cultural beliefs. The protagonist believes because of her sensory ability she can see the reality of the window, which is a true window framing the figure of a man sat at a desk writing. Her vision is conveyed in accordance with the specific experience of mania. The protagonist experiences a sequence of seeing and unseeing the figure based on her emotional state, connecting to observations in patient case records of hallucinations associated with the mood state of the patient, and the exacerbation of the experience of psychosis according to the severity of emotional state. When she sees for the first time ‘something living’ through the window, she describes a sense of fear and vulnerability repeatedly recorded in case records alongside hallucinations: ‘it seemed to strike

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connects the short story to Henry Maudsley’s *The Pathology of Mind* (1895) and *Body and Mind* (1870), and the 2019 *Broadview* edition of ‘The Library Window’, ed. by Annmarie Drury, which includes E. J. Tilt’s *On The Preservation of the Health of Women at the Critical Periods of Life* (1851), and G. Stanley Hall’s *Adolescence: Its Psychology and Relations to Physiology, Anthropology, Sociology, Sex, Religion and Education*, vol. 2 (1904) to contextualise contemporary ideas.

<sup>941</sup> Margaret Oliphant, ‘The Library Window’, *Stories of the Seen and the Unseen* (Edinburgh: William Blackwood and Sons, 1902), pp. 247-316 (p. 254). All further references are to this edition and are given parenthetically in the body of the text.

<sup>942</sup> See, for example: LHB7/51/39.

<sup>943</sup> See, for example: LHB7/51/39.

right through me, and I gave a little cry' (p. 267). Moreover, the experience of seeing a 'flicker' of the spectre for the first time changes her affections towards Aunt Mary, who, with concern, puts her hand on her shoulder with 'the softest touch in the world', but a touch that rouses hostility in the protagonist who 'could have flung it off angrily' (p. 267). The protagonist describes her emotional state as 'so vexed [she] could have cried', and 'much annoyed', so that she lashes out at her Aunt Mary, accusing her of 'spoil[ing] it all' (p. 267). The illustration of irritability and hostility towards family members again connects to the patient records of mania. Moreover, the protagonist illustrates this behaviour as something uncharacteristic, stating that she 'did not mean of course to say these words' but rather that they were 'forced out' of her, associating the experience with the characterisation of mania as a change in habits and affections (p. 267). Furthermore, the protagonist ties her ability to see through the window to 'a superiority' and 'particular insight', conveying the sense of superiority and grandiose beliefs repeatedly observed alongside high mood states.

Crucial to the characteristic of the spectre is that he is engaged in writing. Elsie Michie has written about Oliphant's engagement with the works of Sir Walter Scott in the context of Scott's *Waverley* (1814) and Oliphant's *Kirsteen* (1890).<sup>944</sup> Moreover, Tamar Heller discusses the specific reference to Scott, Oliphant's 'major male predecessor' in 'The Library Window', in which the spectre writing is compared by the protagonist to an image of Scott recorded 'in a famous anecdote in Lockhart's canonizing *Memoirs*' which describes passers-by as 'mesmerized' by the sight of Scott 'sitting near the window tirelessly writing'.<sup>945</sup> I also argue that a connection to Scott is key, but see the vision as specifically exploring the relationship between mania and occupation in the female experience. The protagonist refers to the importance of being occupied for the sake of mental wellbeing. She states: 'My mother thought I should always be busy, to keep nonsense out of my head' (p. 252). Engaging in activity and occupation was key in the treatment of mania to use energy. However, 'The Library Window' highlights the limits of suitable occupations for girls and women in the household setting. The protagonist describes the activities deemed acceptable for her in the eyes of her mother as household work such as a 'basket' of needlework, 'running about' to 'fetch something which I was quite sure she did not want', or 'to carry some quite unnecessary message to the housemaid' (pp. 250-252). In contrast, she wishes to be engaged in reading and writing, stating

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<sup>944</sup> Elsie Michie, 'History After Waterloo: Margaret Oliphant Reads Walter Scott', *ELH*, 80.3 (2013), pp. 897-916.

<sup>945</sup> Tamar Heller 'Textual Seductions: Women's Reading and Writing in Margaret Oliphant's "The Library Window"', *Victorian Literature and Culture*, 25.1 (1997), pp. 23-37 (p. 27).

‘I used to get through volume after volume’, but that her ‘mother would not have let [her] do it’ (p. 251). She explains that ‘everybody has said’ that she ‘was fantastic and fanciful and dreaming’, which she translated as ‘a girl who may happen to like poetry, and to be fond of thinking’, which ‘so often made people uncomfortable’ (p. 252). While her father is a ‘great writer’ so ‘everybody says’, the protagonist must instead be occupied in domestic work (p. 278).

Outside of her fictional work, Oliphant wrote about women’s domestic work in non-fiction writing. Ann Heilmann writes about Oliphant’s simultaneous ‘cautious support for, and mistrust of, nineteenth-century feminism’.<sup>946</sup> Heilmann argues that Oliphant ‘became more sympathetic to some of the aims of the women’s movement’ towards the end of the nineteenth century, highlighting her views on ‘women’s professional and political rights’ and writing about female domestic responsibilities.<sup>947</sup> While Oliphant maintained the position that married women should conform to domestic responsibilities, she also highlighted the nature of ‘women’s work’ as ‘unpaid’ as well as ‘entirely unregulated’ in ‘hours and conditions’, and neither ‘defined or regarded as work’ in the same way as male employment.<sup>948</sup> Oliphant challenged the ‘divided duty’ of women between domestic work and professional opportunities, and insisted that ‘all the professions of men be open to [...] all widowed or permanently single women’.<sup>949</sup> In the figure of ‘The Library Window’s protagonist, a young girl who could remain permanently single, the option of occupation in writing should be available, but Oliphant illustrates a limited access to writing for the protagonist in the context of depictions of symptoms and behaviours associated with mania.

A reference to the importance of occupation and dangers of idleness for mental wellbeing specifically are highlighted through the comparison between images of the protagonist’s father writing and of the spectre writing. The protagonist suggests that her father is ‘idle’ in his writing, becoming distracted by ‘watch[ing] a fly and help[ing] it over a difficulty’ or ‘play[ing] with the fringe of the curtain’ and ‘a dozen other nice, pleasant, foolish things’, while ‘waiting for a word’ (p. 278). In contrast, the spectre:

was so absorbed in his writing, never looked up, never paused for a work, never turned round in his chair, or got up and walked about the room as [her] father did

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<sup>946</sup> Ann Heilmann, ‘Mrs Grundy’s Rebellion: Margaret Oliphant between Orthodoxy and the New Woman’, *Women’s Writing*, 6.2 (1999), pp. 215-237 (p. 215).

<sup>947</sup> Heilmann, ‘Mrs Grundy’s Rebellion’, p. 216.

<sup>948</sup> Heilmann, ‘Mrs Grundy’s Rebellion’, p. 221.

<sup>949</sup> Oliphant in Heilmann, ‘Mrs Grundy’s Rebellion’, p. 215, 219.

(p. 278).

The protagonist illustrates the spectre's dedication to occupation, as opposed to the idleness in occupation of her father. As scholarly work has suggested, the engagement of the spectre in writing and the protagonist's desire to see him may indicate a desire for writing rather than romantic desire. The protagonist sees writing as an occupation that should be open to her. Though idleness is warned against for the sake of her mental wellbeing, the different attitudes towards domestic work and activities such as reading and writing illustrate the limits placed on occupation for women. In addition, by seeing a desire for herself in the spectre, the protagonist aligns herself with the energy and perseverance of the spectre's engagement with work, and against the idle working habits of her father, challenging the features of energy and perseverance in nineteenth-century discourse about biologically based differences between women and men from biologists such as Darwin, Geddes, and Thomson.<sup>950</sup>

The protagonist's desire for writing is also illustrated through references to traditional folklore. Following the fluctuations of emotional states and visions of the spectre, the 'great event' associated with the spectre happens on 'Midsummer Day – the day of St John' (p. 271). Traditionally, Midsummer, or St John's Eve, was 'seen as a time when the veil between this world and the next was thin'.<sup>951</sup> Crucially, this symbolised a time where you could 'either gain the powers of a bard' or 'end up utterly mad'.<sup>952</sup> Oliphant's specific use of Midsummer as the timing for the climax of events point to this binary between the powers of literature or the experience of madness, and does so to emphasise that the ability to engage in writing is not an option for the protagonist, and therefore mania instead is her inevitable fate. Visiting the building in which the window resides, the protagonist discovers that the figure writing is not real, but instead is a vision of a spectre.

'The Library Window' challenges the separation in female and male roles of employment in the context of mania, by pathologizing a vision of the desire to write alongside ideas about the dangers of idleness. The short story represents the difficult relationship between mania and work with a focus on the limits of female employment opportunities in society, aligning with some of the goals of nineteenth-century feminism for more professional

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<sup>950</sup> Evelleen Richards, *Ideology and Evolution in Nineteenth Century Britain: Embryos, Monsters, and Racial and Gendered others in the Making of Evolutionary Theory and Culture* (London: Routledge, 2020); Sara Delamont and Lorna Duffin, *The Nineteenth-century Woman: Her Cultural and Physical World* (London: Routledge, 2012).

<sup>951</sup> 'The Fires of Midsummer', *True Highlands* <<https://www.truehighlands.com/the-fires-of-midsummer/>> [accessed June 15, 2021].

<sup>952</sup> 'The Fires of Midsummer', *True Highlands*.

opportunities and opportunities in higher education for women.<sup>953</sup> In the asylum, female occupation was mostly associated with domestic roles, relating to the occupations of patients both outside of their homes as domestic servants, as well as relating to working women's responsibilities within their homes. Nevertheless, some institutions also accommodated alternate outdoor roles, for example working in the gardens, for women who had previously held outdoor employment positions in their communities for the sake of reintegration following recovery. However, outside of the asylum, concerns in nineteenth-century feminism about the ability to balance domestic duties and professional opportunities created a challenge to ideas about the division of female and male roles, as well as a challenge to the discomfort caused to society by women who wanted to be occupied in thinking and writing, as depicted in 'The Library Window'.

In contrast, literary representations of mania and male occupation created a different space in which a positive illustration of the relationship between mania and work was possible, unlike the incapacitating impact of mania on occupation recorded in patient case notes. In the next section, I will argue that the different literary depictions of male and female mania were underpinned by professional opportunities within society. While asylum records suggest that there was not a specifically male or female version of mania, the employment opportunities available outside of the asylum could influence the shape taken by patients' grandiose delusions and, despite patient records maintaining the repercussions of mania as an inability to work, literary representations created a space for male mania to be associated with brilliance.

### **'Current Events of the Day': Delusions of Brilliance**

Discussions by asylum physicians of the way delusions and hallucination took shape related patients' psychosis to contemporary social circumstances. As a feature of the culturally specific care of the Inverness District Asylum for the populations of the Scottish Highlands and Islands, Aitken reflected in *Annual Reports* on the marked 'influence of ancient superstitions' associated with place on the delusions and hallucinations of patients.<sup>954</sup> Aitken also discussed the influence of 'current events' in determining the form taken by patients' symptoms of psychosis.<sup>955</sup> Seeing these patterns in cases, Aitken wrote of his agreement with Esquirol's view, which he described as the cases being an 'illustration [...] that it is possible to write the

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<sup>953</sup> Heilmann, 'Mrs Grundy's Rebellion', pp. 215-229.

<sup>954</sup> *Third Annual Report of the Inverness District Lunatic Asylum* (Inverness: Courier Office, 1867), p. 22.

<sup>955</sup> *Third Annual Report of the Inverness District Lunatic Asylum*, p. 22.



history of a period from the delusions of the patients admitted into Asylums'.<sup>956</sup> In addition, Skae of the Royal Edinburgh Asylum also emphasised that delusions were drawn from social circumstances. In the *Annual Report* for 1850, he provided examples of cases to demonstrate 'how far the prevailing delusions' observed 'derive their character from the most engrossing topics of the current events of the day'.<sup>957</sup> These included 'no less than seven queens', of whom 'three [...] claim to be Queen Victoria', and 'became insane at the time of the Queen's latest visit to Scotland'.<sup>958</sup> Skae also included a case of puerperal mania in which the patient 'believed that, in consequence of her confinement having taken place on such a remarkable occasion, she must have given birth to a person of royal or divine dignity'.<sup>959</sup>

The nature of delusions and hallucinations as being drawn from social events, encounters, traditions, and beliefs of patients might explain why male patients were observed with grandiose delusions relating to professional success to achieve wealth and status, whereas delusions observed in cases of female patients relating to wealth and status rarely related to success in employment, but were instead associated with fortune and power deriving from sources such as being royalty, religious power, or being destined to a great wealth through familial relationships or marriage. Delusions observed in female cases included M.B., admitted to the Royal Edinburgh Asylum in 1882 and 'believing herself the Queen of Ireland', 'Queen of the Cannibals' with a warning to the physician 'to take care she does not bite [him]', as well as the record from her mother that the patient 'told her she was God on sabbath last', and E.E., admitted to the Royal Edinburgh Asylum in 1886 with 'delusions that she is Queen Victoria'.<sup>960</sup> In the case of S.M., admitted to Gartnavel Royal Asylum in 1838, her sense of superiority and status was attributed to the belief that she lived 'with the Duke of Hamilton'.<sup>961</sup> J.S., admitted to the Inverness District Asylum in 1870, who was observed with 'a mistaken idea of her own importance', experienced the delusion 'that she had the power to blow up the house and send all present to hell', while E.C., admitted to the Royal Edinburgh Asylum in 1883, believed herself to be 'a spirit' and asked that she be 'worship[ed]'.<sup>962</sup>

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<sup>956</sup> *Third Annual Report of the Inverness District Lunatic Asylum*, p. 22.

<sup>957</sup> *Annual Report of the Royal Edinburgh Asylum for the Insane* (Edinburgh: Royal Asylum Press, 1850), p. 20.

<sup>958</sup> *Annual Report of the Royal Edinburgh Asylum for the Insane* (1850), p. 20.

<sup>959</sup> *Annual Report of the Royal Edinburgh Asylum for the Insane* (1850), p. 20.

<sup>960</sup> LHB7/51/39, p. 273; LHB7/51/46, p. 344.

<sup>961</sup> HB13/5/11, p. 73.

<sup>962</sup> HHB/3/5/2/5, p. 112; LHB7/51/39, p. 741.

Male cases also included these types of observations: W.J., admitted to the North Wales Lunatic Asylum in 1861 had ‘fixed delusions that he will marry the Queen’.<sup>963</sup> Similarly, A.R., admitted to the Inverness District Asylum in 1864, believed his ‘first wife’ was ‘a daughter of George IV’ and that he had another wife who was a ‘cousin of Sir Walter Scott’.<sup>964</sup> Later in his case records, dated 1866, A.R.’s delusions were recorded as taking on ‘a more religious character’ in which he then believed that his first wife had ‘risen again’ from her place of burial, and that Eve was made ‘in his wife’s image’.<sup>965</sup> D.F., admitted to the Royal Edinburgh Asylum in 1882, was observed with the delusion that he was the ‘chosen vessel of the lord’ and was destined ‘to conquer the kingdom of the devil’.<sup>966</sup> T.M., admitted to the Inverness District Asylum in 1866, ‘considered himself to be the supreme God’.<sup>967</sup> However, delusions about success relating to business and employment were more common in male rather than female cases. For example, J.H., admitted to the Gartnavel Royal Asylum in 1841 was recorded with the delusion that he was to ‘realise a great fortune’ in ‘business’, and J.R., also admitted to the Gartnavel Royal Asylum in 1841, believed he was in possession of ‘enormous wealth’ with ‘a number of men employed by him’ and therefore ‘raved incoherently chiefly on his own supposed importance’.<sup>968</sup> A.D., admitted to the Royal Edinburgh Asylum in 1882, had delusions relating to ‘experimenting in medical science’ which presented in thinking ‘he [was] making silver coins by a chemical process of his own invention’.<sup>969</sup> Similarly, F.H., admitted to the Inverness District Asylum in 1881, ‘talk[ed] in a rather grand way about his numerous inventions’ and believed his success was a threat to others, so that he ‘was obliged to carry a revolver to protect himself from the men whose trade would be injured by his inventions.’<sup>970</sup>

While the classification for mania mostly showed little difference between the diagnosis of male and female patients, the features of delusions associated with grandiose beliefs demonstrated some variation. Based on the contemporary theory discussed by Aitken and Skae that the shape taken by delusions and hallucinations was socially influenced, the lack of beliefs associated with success in occupation recorded in female cases could be explained by the view of an absence of opportunities of this kind for the working-class women who were patients. Such opportunities might have been perceived as unlikely in the cases of working-

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<sup>963</sup> HD/1/517, p. 15.

<sup>964</sup> HHB/3/5/2/1, p. 138.

<sup>965</sup> HHB/3/5/2/1, p. 139.

<sup>966</sup> LHB7/51/39, p. 689.

<sup>967</sup> HHB/3/5/2/3, p. 36.

<sup>968</sup> HB13/5/25, pp. 29-30.

<sup>969</sup> LHB7/51/39, p. 761.

<sup>970</sup> HHB/3/5/2/13, p. 78.

class men, and therefore could form features of grandiose delusions, but for the female patients perhaps they were so out of reach that they were rarely present even in the sphere of delusion.

Beyond the asylum, literary examples interrogated the relationship between symptoms associated with mania and forms of occupation. While patient beliefs about success in professional settings were recorded as delusions in the asylum and therefore considered untrue, a space was created in literature exploring mania where grandiose beliefs relating to professional brilliance could be realised through extraordinary abilities. A space was carved for an association between manic-depressive illness, eccentricity, and brilliance in Arthur Conan Doyle's detective Sherlock Holmes. While there already existed significant work on the connections between artistic talent and different forms of mental ill health predating the nineteenth century, Doyle specifically connects nineteenth-century mania with a form of genius that interlaces logical deduction with skill at observation based on extraordinary sensory ability. Holmes solves mysteries through a logical collection of facts, but is represented as possessing an individual brilliance of skill in perception with a sense of grandiosity not unlike the claims of special abilities recorded in patients observations of nineteenth-century mania. The difference in the representation of Holmes is that his abilities are proven to be true. In the first Sherlock Holmes story, *A Study in Scarlet*, despite Watson's initial 'lurking suspicion' that 'the whole thing was a prearranged episode intended to dazzle me', Holmes proves his unique abilities of detection, which are illustrated as a function of his temperament.<sup>971</sup> In this section, I will argue that Doyle specifically connects symptoms associated with manic-depressive illness with brilliance. Furthermore, I will argue that Doyle creates an association between genius and mania by drawing on the very discourse that conceived of patients with mania as animalistic, and from literary texts that challenged animalistic representations.

Chapter Two argued that animalistic representations were based on the idea that mania caused a reversion in patients to a position somewhere between human and animal. This idea drew specifically on discourse about orangutans. In addition, the significant changes in treatment for mania existed alongside changing representations in literary texts, medical writing, and visual representations, which moved away from images of wildness to restoring patients' humanity and individuality. My examination of Doyle's Sherlock Holmes texts will invoke this analysis. One of the literary challenges to animalistic representations I examined

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<sup>971</sup> Arthur Conan Doyle, 'A Study in Scarlet', *Beeton's Christmas Annual* (1887), p. 34.

was Poe's 'The Murders in the Rue Morgue', featuring his detective, Auguste C. Dupin. Anna Neill argues that Doyle's Holmes is:

the invention of a new kind of detective – a scientific investigator who also possesses the primitive gifts of supernormal vision<sup>972</sup>

Neill argues this based on a connection between Holmes, mental ill health, primitive states, and genius. However, Doyle was influenced by Poe's Dupin specifically in his creation of Holmes. Doyle particularly draws from the representation of mania alongside both brilliance and animalism, as mirrored in Poe's Dupin and orangutan.

A number of literary scholars have connected Poe's and Doyle's detective fiction, based on both the temperaments of the detectives and the methods of deduction used in the tales. For example, Greg Sevik has written about Poe's and Doyle's detective fiction in the context of traditions of the Enlightenment and Counter-Enlightenment, and Joseph B. Kadane has connected Dupin and Holmes in an examination of Bayesian thought in detective fiction.<sup>973</sup> Stephen Bertman has written about the ways in which Doyle acknowledged his debt to Poe for the creation of Holmes.<sup>974</sup> According to Bertman, Doyle referred to 'Poe's masterful detective' as being 'from boyhood' one of his 'heroes'.<sup>975</sup> Moreover, Doyle paid tribute to Poe's contribution to detective fiction, stating while each writer 'may find some little development' of their own, the 'main art must trace back to those admirable stories of Monsieur Dupin'.<sup>976</sup>

Holmes and Dupin are both illustrated with characteristics recorded in cases of nineteenth-century mania. They are both portrayed to the reader by a separate character in the role of narrator, who works with them to solve their mysteries, and observes both their exceptional skills of deduction and their temperaments. The changeable 'moods' of Dupin are conveyed as creating a 'Bi-Part soul' or 'double Dupin', described as moving from a 'fantastic gloom' to a 'wild fervour' as features of an 'excited, or perhaps diseased, intelligence'.<sup>977</sup> Similarly, Holmes's changeable moods are described by Watson:

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<sup>972</sup> Anna Neill, 'The Savage Genius of Sherlock Holmes', *Victorian Literature and Culture*, 37 (2009), pp. 611-626 (p. 624).

<sup>973</sup> Greg Sevik, 'Enlightenment, Counter-Enlightenment: Detection, Reason, and Genius in Tales of Edgar Allan Poe and Arthur Conan Doyle', *A Journal of Detection* 31.2 (Fall 2013), pp. 20-31; Joseph B. Kadane, 'Bayesian Thought in Early Modern Detective Stories: Monsieur Lecoq, C. Auguste Dupin and Sherlock Holmes', *Statistical Science*, 24.2 (2009), pp. 238-242.

<sup>974</sup> Stephen Bertman, 'Kindred Crimes: Poe's "The Murders in the Rue Morgue" and Doyle's *The Sign of Four*', *The Edgar Allan Poe Review*, 15.2 (Autumn 2014), pp. 205-210.

<sup>975</sup> Doyle in Bertman, 'Kindred Crimes', p. 205.

<sup>976</sup> Doyle in Bertman, 'Kindred Crimes', p. 206.

<sup>977</sup> Edgar Allan Poe, 'The Murders in the Rue Morgue', in *A Modern Detective* (London: Penguin Classics, 2016), pp. 1-48, (pp. 7-8).

He was bright, eager, and in excellent spirits, a mood which in his case alternated with fits of the blackest depression.<sup>978</sup>

In both the representation of Holmes and Dupin, there is a move between high and low mood states. The alternating nature of the highs and lows, as well as their severity, are like the observations of alternating emotional states in case notes of patients diagnosed with nineteenth-century mania.

Doyle draws specifically from Poe because of a broader interest in the discourse representing the experience of mania as connected to primitive animalism. Poe's 'The Murders in the Rue Morgue' was published in 1841, when representations of patients with mania were mostly animalistic, and bodily restraint was still widely used in treatment. In contrast, Doyle's first Sherlock Holmes novel, *A Study in Scarlet* was published in *Beeton's Christmas Annual* in 1887, when both representations and treatment of patients had become more sympathetic, with restraint used far less frequently, if at all, and a greater focus on a patient's role in their recovery and awareness of their mental ill health. In addition, at the time of Doyle's writing about Holmes, discourse about animalistic features of mania had moved to conveying a reversion to primitive states as key to the potential for genius and extraordinary abilities in spiritualist writing. Neill argues that Holmes's genius 'invokes the figure of the savage' through an analysis of Doyle's texts in the context of connections in spiritualist discourse between mental ill health, primitive states, and genius, and discusses Doyle's role in the Society for Psychical Research, becoming a member in 1891, though points out that 'his interest in spiritualism developed a good decade earlier' and therefore predated the first Holmes tale.<sup>979</sup> In addition, Neill examines spiritualist writing by Doyle as well as one of his colleagues in the society of 'profound spiritualist faith', Fredrick Myers.<sup>980</sup> Myers's ideas were concerned with the 'primitive reality' manifest in experiences of mental illness as also having the potential to 'take the form of profound inspiration or genius'.<sup>981</sup> Furthermore, Myers argued that, while a repression of the emotional states and sensory abilities of mental ill health created the circumstances for normal employment, the connection between these states and genius meant

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<sup>978</sup> Arthur Conan Doyle, 'The Sign of Four' in *Lippincott's Monthly Magazine*, 1 (February 1890), pp. 145-223 (p. 156).

<sup>979</sup> Neill, 'The Savage Genius of Sherlock Holmes', p. 611, p. 616.

<sup>980</sup> Neill, 'The Savage Genius of Sherlock Holmes', p. 616.

<sup>981</sup> Myers, *The History of Spiritualism*, in Neill, 'The Savage Genius of Sherlock Holmes', p. 617.

that a repression limited the ability to excel.<sup>982</sup> Aligning with this, Doyle represents Holmes's genius as tied to symptoms associated with mania.

Observations in patient case records illustrate grandiose beliefs alongside heightened senses of sight and hearing. Royal Edinburgh Asylum case books included a specific heading for 'special senses' and 'sensory', which consisted of answers relating to hallucinations of sight and sound as well as sensory hypersensitivity.<sup>983</sup> Beliefs about heightened sensory ability and intuition were recorded in case notes alongside high mood and an inflated sense of ability. C.G.M., admitted to the Inverness District Asylum in 1865, was recorded as believing himself 'omniscient, omnipotent, omnipresent' and, as a result, to be 'gifted with a profound insight into the laws which govern all things', to be able to 'see everything more in harmony with [nature]', and that he had 'been able to reach a state of perfection hitherto unattainable by any other person', and was 'so perfect', that 'he [could not] go wrong'.<sup>984</sup> Similarly, W.M., admitted to the Royal Edinburgh Asylum in 1881 was recorded with grandiose beliefs in his abilities, and under the heading 'sensory' was noted as 'exaggerated'.<sup>985</sup> G.M., admitted to the Inverness District Asylum in 1869, 'fancie[d] himself wiser and more clever than any in his parish' and believed he had a unique ability to see and hear divine messages.<sup>986</sup>

Holmes represents a sense of grandiosity not unlike observations in patient case records, through self-belief in his genius, as well as through Watson's comments on his egotism. Holmes sees his abilities as exceptional and individual, stating that when others are 'out of their depths', which he considers, 'their normal state', he, in contrast, has the ability to solve the case, and therefore 'the matter is laid before [him]' specifically.<sup>987</sup> Connecting to Myers's ideas about primitive states, mental illness, and genius, as moving beyond a normal capacity for work and creating the environment for brilliance, Holmes describes his need for 'mental exaltation' to avoid 'the dull routine of existence'.<sup>988</sup> Furthermore, he emphasises that his abilities are unique by claiming he '[chose his] own particular profession, or rather created it,' because he is 'the only one in the world' with the ability to do it, and that 'finding a field for [his] peculiar powers, is [his] highest reward'.<sup>989</sup> Watson comments on Holmes's inflated

<sup>982</sup> Myers, *The History of Spiritualism*, in Neill, 'The Savage Genius of Sherlock Holmes', pp. 617-618.

<sup>983</sup> See, for example: LHB7/51/38.

<sup>984</sup> HHB/3/5/2/2, p. 15.

<sup>985</sup> LHB7/51/38, p. 161.

<sup>986</sup> HHB/3/5/2/4, p. 332.

<sup>987</sup> Doyle, 'The Sign of Four', p. 148.

<sup>988</sup> Doyle, 'The Sign of Four', p. 148.

<sup>989</sup> Doyle, 'The Sign of Four', p. 148.

sense of ability, confessing to being ‘irritated by the egotism’ he demonstrates in reaction to Watson’s pamphlet about ‘A Study in Scarlet’, which Watson considers a ‘demand’ from the detective that the ‘pamphlet should be devoted to his own special doings.’<sup>990</sup> Holmes connects his skills to sight in particular, as well as to an individual ability to see what others do not: ‘Perhaps I have trained myself to see what others overlook.’<sup>991</sup> Although his uncovering of visual clues is framed in the tales as the collection of miniature details, Neill points out that Holmes’s sensory abilities are portrayed as ‘supernormal’ and ‘intuitive’, claimed by him to be a ‘train of thoughts [that] run so swiftly through [his] mind’ that he arrives at ‘the conclusion without being conscious of intermediate steps’.<sup>992</sup> The excellent skills of perception possessed by Holmes are therefore portrayed both as a logical collection of clues, and as a unique, particular ability that involves a level of unconscious intuition.

Holmes’s abilities, unlike the observations in patient case records, are proven to be as brilliant as he believes. After initial doubts, following the ‘extraordinary circumstances connected with the Study in Scarlet’, Watson ‘had so many reasons to believe’ in Holmes’s ‘powers’, that he has a newly assured faith in him. Watson also expresses that he sees Holmes’s abilities as almost unlimited: ‘it would be a strange tangle indeed which he could not unravel.’<sup>993</sup> The Sherlock Holmes novels and short stories indeed go on to show the detective primarily succeeding in solving mysteries where others fail. The characterisation of Holmes places features of mania as a function of his brilliance, conveying grandiose beliefs of an individual ability for perception and intuition that Holmes is able to prove time and time again.

The illustration of the unique abilities of Holmes as fulfilling the grandiose beliefs of mania aligns with Myers’s ideas of connections between mania, genius, and primitive animalism. Doyle’s representation of mania as fuelling eccentric genius is illustrated in association with animalistic representations in *The Hound of the Baskervilles*, first published serially from 1901-1902 in *The Strand Magazine*. An escaped convict, found guilty of violence, is described with a ‘terrible animal face’, a ‘bristling beard’, and ‘matted hair’, so that he resembled ‘one of those old savages who dwelt in the burrows on the hillsides’.<sup>994</sup> However, Holmes also embodies one of the traditional inhabitants of the Moor who are illustrated in

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<sup>990</sup> Doyle, ‘The Sign of Four’, p. 149.

<sup>991</sup> Arthur Conan Doyle, ‘Adventures of Sherlock Holmes: Adventure III – A Case of Identity’, *The Strand Magazine* [need vol] (September 1891), pp. 248-259 (p. 249).

<sup>992</sup> Doyle, ‘A Study in Scarlet’ in Neill, ‘The Savage Genius of Sherlock Holmes’, p. 620.

<sup>993</sup> Doyle, ‘A Case of Identity’, p. 255.

<sup>994</sup> Arthur Conan Doyle, ‘The Hound of the Baskervilles’, *The Strand Magazine*, 22.132 (December 1901), pp. 603-612 (p. 611).

terms of human states outside of society, described in the tale as ‘savages’ of the Moor.<sup>995</sup> Unknown to Watson, Holmes has been living as one of the inhabitants secretly during the investigation, leading to others mistaking him as one of the primitive human figures outside of society. Neill points out that ‘Watson expects to see crawl out a “skin-clad, hairy man”’ from the ‘Neolithic wigwams’, but they ‘instead house Holmes’.<sup>996</sup> Neill argues that this ‘substitutes the detective for the criminal’, but, in addition to this, I argue that it draws a connection between Holmes and animalistic representations.<sup>997</sup>

*The Hound of the Baskervilles* sees violence perpetrated by an animal under the influence, whether of fear or instruction, of their keeper. The hound commits violence, but the accountability for the violence is shifted to their master through the hound’s use as an instrument of violence. Furthermore, Holmes embodies the primitive figure of somewhere between human and animal during his disguised time on the Moor. Despite this animalistic connection, Holmes ultimately excels in solving of the mysteries where others fail. Holmes embodies the primitive in a way that realigns the representation of mania, so that a regression to a state somewhere between human and animal creates a space for brilliance. Neil Pemberton argues that Holmes’s sensory abilities and depiction aligning with animalism connect him to nineteenth-century attitudes towards bloodhounds.<sup>998</sup> Pemberton highlights the recognition in the Holmes stories of the ‘supreme [...] sense of smell’ of bloodhounds, connecting this to the depiction of Holmes’s sensory abilities and behaviour – for example, when he ‘growls’, ‘sniffs’ and ‘barks’.<sup>999</sup> Beyond the feature of heightened sensory ability, this behaviour is also similar to observations of mania, in both male and female cases. For example, H.M., admitted to the Inverness District Asylum in 1868, was recorded as ‘giving a sort of threatening growl, like an animal’, and E.R., admitted in 1879 and diagnosed with ‘puerperal mania’, ‘frequently barks like a dog and attempts to bite’.<sup>1000</sup> Unlike the concern for this type of behaviour in an institutional setting, it is illustrated positively in the character of Holmes because of its connection to his extraordinary sleuthing ability.

Pemberton builds his argument to suggest that Holmes’s animalistic behaviour and engagement with violence is enabled because he is depicted as ‘the protector of the English

<sup>995</sup> Doyle, ‘The Hound of the Baskervilles’, p. 611.

<sup>996</sup> Doyle in Neill, ‘The Savage Genius of Sherlock Holmes’, p. 621.

<sup>997</sup> Neill, ‘The Savage Genius of Sherlock Holmes’, p. 621.

<sup>998</sup> Neil Pemberton, ‘Hounding Holmes: Arthur Conan Doyle, Bloodhounds and Sleuthing in the Late-Victorian Imagination’, *Journal of Victorian Culture*, 17.4 (2012), pp. 454-647.

<sup>999</sup> Doyle, *The Adventure of the Creeping Man*, in Pemberton, ‘Hounding Holmes’, p. 462.

<sup>1000</sup> HHB/3/5/2/4, p. 121; HHB/3/5/2/12, p. 401.



upper classes, becoming their loyal and sympathetic hound'.<sup>1001</sup> In my analysis drawing on nineteenth-century mania, this instead is a key difference between the animalistic, violent behaviour of Holmes and the patients within asylums: unlike the patients, Holmes's grandiose sense of brilliance is proven to be true and therefore useful. The function of grandiose delusions in patient case records was in obtaining status and wealth, as seen in both the delusions relating to professional ability, which were mostly seen in male case records, and the delusions relating to being royalty, related to people of great power, or possessed of unrivalled religious knowledge, seen in both female and male cases. In the Holmes stories, Doyle grants Holmes this realisation of status because his individual abilities offer protection to powerful members of society, and they are therefore willing to protect him and accept behaviour related to mania in return. In *The Sign of Four*, while admiring Holmes's brilliance, Watson comments 'I could not think what a terrible criminal he would have made had he turned his energy and sagacity against the law instead of exerting them in its defence'.<sup>1002</sup> Holmes's decision to use his ability to aid the establishment, even if his methods include behaviour associated with mania, which would usually be associated with a need for institutional treatment, lead to him being protected by the elite because of his own protection of their interests.

Drawing from discourse associating primitive states with mental illness and genius, as well as literary challenges to animalistic representations of mania, Doyle represents mania, eccentricity and brilliance in Holmes alongside animalistic features. This position of eccentricity is possible because Holmes is depicted as fulfilling the extraordinary beliefs often observed in records of grandiose delusions in patients with mania. He is therefore able to excel in his line of work, where he is portrayed as individually gifted. Unlike attitudes towards normal working men experiencing mania recorded in asylum case records, and unlike the literary representation in Dickens's 'The Signal-Man' of mania as causing an incapacity for employment, Holmes signals a space to celebrate eccentricity and mania as contributors to genius. Moreover, Holmes's behaviour is accepted and protected by elite members of society because his ability serves a beneficial purpose. Although grandiose delusions relating to professional opportunities were more common in male case notes, the desired realisation of status and membership to elite circles is not dissimilar to the features of grandiosity recorded in female case records. Contemporary ideas in asylums about the influence of social circumstances on the shape taken by delusions might explain why female cases were less

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<sup>1001</sup> Pemberton, 'Hounding Holmes', p. 465.

<sup>1002</sup> Doyle, 'The Sign of Four', p. 148.

influenced by pathways to success through professional opportunities, even in the sphere of delusion, because of social ideas about gender difference.

## **Conclusion**

The relationship between mania and work was difficult. Anxieties about finding employment, meeting employment responsibilities, and working conditions, were all listed as contributors to developing mania. In addition, the characterisation of mania as an abundance or absence of energy presented in high and low mood states was associated with a loss of interest in and incapacity to work. In low mood, despondency, vacancy of mind, unwillingness to communicate, lack of movement, and a feeling of being subject to threat were recorded as causing a loss of interest or refusal to work. High mood, on the other hand, was associated with a surplus of energy resulting in restlessness, destructive behaviour, feelings of invincibility and superiority, that were associated with patients being unable to settle to work, requiring supervision in their work, or grandiose delusions causing patients to believe they were too good to work or misjudging their abilities. Representations of the consequences of experiencing mania on a capacity to work depicted a cycle in which factors relating to employment could cause mania, but mania itself, both in high and low mood states, also caused an inability to work because of behaviours associated with either a lack of or heightened energy. 'The Signal-Man' depicted this cycle with sympathy, but ultimately represented mania as both caused by poor working conditions and as causing a threat to public safety through impairment in work ability.

Occupation was also central to treatment as a means of using energy to restore balance. While the classification for mania showed no marked difference between female and male patients, treatment for patients was subject to social influence in terms of divisions in labour within the asylum. Occupational roles for women were generally associated with domestic work, whereas there were more opportunities for male patients to engage in work outdoors. However, there were some exceptions based on place, seen in an inclination in some institutions to provide outdoor work roles for female patients who had previously worked outdoors in their communities. This accommodation was associated with the previous habits and dispositions of patients from the Scottish Highlands and Islands according to culture and place. The characterisation of mania as a change in habits and dispositions according to severe emotional states, and the associated increase or decrease in energy, meant the goal of treatment was to restore normal energy levels to return patients to their previous state. The provision of

types of occupation that were considered ‘peculiar’ for women in the context of Victorian labour division suggests a willingness for negotiation between forms of treatment and gender ideals in asylums for the sake of reintegrating patients into their previous communities.

Outside of the asylum, ideas about the types of occupation that were suitable for women and men influenced the shape taken by delusions. Despite the similarity in classification for male and female mania, delusions of achieving superiority through wealth, status, and power were generally realised through different methods in male and female cases. While female cases would typically realise power through religious ability, royal ancestry, or marriage, male cases, as well as sharing the same features as female grandiose delusions, were more likely than female cases to realise superiority through professional success. Contemporary ideas about delusions and hallucinations saw the themes of psychosis as relating to social circumstances and current events. In this way, social ideas about employment opportunities for women and men meant male patients were more likely to have delusions influenced by ideas of professional brilliance, whereas for female patients this was mostly out of mind, even in the realm of delusion.

Literary representations were also concerned with ideas about the different types of work available to men and women in the context of mania. ‘The Library Window’ challenges ideas about medical authority, energy, and the dangers of idleness in the context of mania and occupation, highlighting concerns in nineteenth-century feminism about the ability to balance domestic duties and professional opportunities through a vision associated with a desire to write. In contrast, the Sherlock Holmes stories create a space for mania to be associated with brilliance in a work environment. Holmes is presented with grandiose delusions about his own talents, but, unlike patient case records, proves his extraordinary abilities to be true. The different literary depictions of male and female mania were underpinned by professional opportunities within society. Whereas ‘The Library Window’s’ protagonist is perceived as subject to the fate of mental illness and limited from opportunities to write, Holmes is protected and enabled because of the protection he can offer in return to powerful members of society – his behaviours associated with mania are therefore accommodated as long as he continues to be useful.

## Conclusion

Studies in the social history of psychiatry that examine individual institutions, like Pamela Michael's study of the North Wales Lunatic Asylum at Denbigh, and Hester Parr's, Chris Philo's, and Nicola Burns's study of Inverness District Asylum, have shown the benefits of this focus to interrogating the circumstances that led to institutions being established, the different positions of power in both the planning and running of institutions, and scrutinising how patients were admitted and treated.<sup>1003</sup> Drawing from Hilary Marland's examination of puerperal insanity as a particular type of mental illness, this thesis has argued the value of instead focusing on a specific diagnostic category for analysis.<sup>1004</sup> By focusing on the greater specificity developed for mania as an individual category for diagnosis during the nineteenth century, it has been possible to seek the influence of mania's disease identity on changes in treatment, its treatment according to place, and experiences according to gender.

Mania's previous association with a general madness began to change with the new specificity for mania that characterised this illness according to severe high and low mood states. Identifying factors of extreme mood states across the emotional spectrum led to reflections on the energies of mania, either a lack or abundance, and how to approach treatment in a way that could either expend or reinvigorate energy through occupation. Instead of using restraint to limit movement, surveillance and occupation were used to track emotional states and behaviours to restore balance by regulating energy and emotion. The focus in this thesis on mania is therefore valuable to uncovering the importance of high and low emotional states to changes in treatment that shifted from animalistic perceptions to a restoration in patients' humanity and individuality. While changes from restraint to surveillance were not limited to mania, this focus on an individual category achieves a nuanced study of factors that fuelled new ideas in treatment.

Combining a focus on an individual diagnostic category with a specific selection of institutions has also been beneficial to interrogating the experience of mania according to place. Investigating case records in institutions at the core of psychiatric developments, like Royal Edinburgh Asylum and Gartnavel Royal Asylum in Glasgow, allows for an examination of diagnostic procedures at the forefront of medical practices. Moreover, seeking institutions

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<sup>1003</sup> Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000*; Parr, Philo and Burns, "“That awful place was home”". See also: Eastoe, 'Playing Cards, Cricket and Carpentry'; Walsh, "“The Property of the Whole Community”"; Andrews, 'Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum'.

<sup>1004</sup> Marland, *Dangerous Motherhood*.

established in response to a lack of accessible institutional care, in places considered inherently different according to their culture, like the North Wales Lunatic Asylum in Denbigh and the Inverness District Asylum, enriches a study of both mania and the history of institutions by being able to interrogate the way mania was diagnosed, treated, and represented in these places of transition between community forms of care and institutional care, and how they were established to offer culturally specific treatment. This focus has uncovered at times surprising levels of negotiation between Commissioners in Lunacy and local authorities – transitions in spaces of care in Wales and the Scottish Highlands and Islands are significant examples of the non-linear relationship between core and periphery in implementing changes in medical practice, based on factors in the treatment of mania. Both Welsh-medium and Gaelic-medium treatment were important factors in adapting practices for cultural requirements, despite attempts elsewhere in society to remove the use of these languages, because of the importance of communication in mania. Furthermore, exceptions in asylum occupation for women were based on cultural background, and there was an appreciation of the relationship between place-specific beliefs and the shape of delusions and hallucinations.

This thesis's focus has also been valuable to investigating the history of psychiatric illness according to gender. Studies of institutions have outlined the segregation in occupation for women and men within asylums, with roles for women typically limited to domestic work.<sup>1005</sup> Other than the exceptions I have discussed according to place, this thesis does not contend this viewpoint. However, while my focus on mania mostly corroborates differences in forms of occupation according to gender, it has also revealed a lack of difference according to diagnostic classifications. Observations and behaviours in case records of both men and women consistently included the same identifying features. The similarity for classifying female and male mania is surprising in a society built on views of inherent differences in behaviour according to gender. Nevertheless, this lack of difference was grounded in the very conception of mania as a manic-depressive illness, because unhealthy high and low emotional states were understood as presenting in changes from usual habits and behaviours.

An interdisciplinary approach concurrently analysing medical and literary writing has enriched this thesis's scrutiny of the medical and cultural conception of a manic-depressive illness. These different types of texts are transformative of one another by asking new questions of each other. The narrative style of patient case records, threading together the perspective of

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<sup>1005</sup> Michael, *Care and Treatment of the Mentally Ill in North Wales 1800-2000*, p. 71; Eastoe, 'Playing Cards, Cricket and Carpentry', p. 13.

the patient, their relatives and friends, and the physician, can be examined to ask whether literary texts similarly represented the observations and behaviours that were recorded in mania, strengthening an investigation of mania's medical and cultural identity. Moreover, analysing literature set both inside and outside of a medical space can offer more than a reinforcement of the primary identifying patterns of mania, it can extend the scope of analysis to investigate how these consistently recorded features were used to represent and challenge types of treatment, medical authority, and mania's impact on both an individual and on society – seeking how this framework of illness was used to explore social order and disorder, inclusion and exclusion, the fulfilling of gender roles, care according to place, and the pathologizing of emotion in the context of different cultural beliefs. Wonderland's 'madness' is not labelled as mania nor is there a depiction of institutional treatment, but these very omissions are at the heart of the text's illustration of the impact of severe emotional states and psychosis without access to treatment. The shared experience of Wonderland's inhabitants of symptoms specifically associated with mania are what form and reinforce Wonderland's social disorder, portrayed as creating vicious motherhood and incapacitated figures of authority. The protagonist in Oliphant's 'The Library Window' similarly presents with the behaviours recorded in mania, but the text uses this framework to comment on the pathologizing of female desires for types of occupation mostly disallowed to women, representing the symptoms instead as the cultural belief of second sight shared by the female line of the family. In accordance, Oliphant's 'A Christmas Tale' explores tensions between medical authority and the pathologizing of place-specific beliefs and traditions. Furthermore, the character of Sherlock Holmes carves a space in which the symptoms of mania are celebrated, leading to questions about whether patients in intuitions could similarly be represented with brilliance. However, examining Doyle's texts alongside patient records shows that this could not be the case, because of the conception of both high and low mood states as impairing an ability to work based on either a lack of excess of energy. Holmes could only be culturally celebrated because his delusions are fulfilled and subsequently used to protect powerful members of society. This interdisciplinary approach is valuable because it seeks the conception of severe emotion as a type of illness, while additionally investigating how this concept was culturally interrogated.

This thesis's original methodological approach, based on flexibility between recognising shifts in current classifications for bipolar disorder while remaining historically grounded, was crucial to revealing the key finding in this research. Nineteenth-century mania

was not representative of solely high mood. Instead, it was characterised by severe high and low mood states, frequently recording solely low mood and alternating mood. Other histories have overlooked this classification of mania as an individual diagnosis because of viewing current bipolar disorder as a final, static form, and because of viewing nineteenth-century mania and melancholia according to present mania and depression: as opposite poles on the emotional spectrum. By doing this, these histories have attempted to trace a moment in the past where these two categories were combined into an emerging framework, basing their studies on categories like *folie à double forme* and *folie circulaire*. However, nineteenth-century mania already combined both high and low mood states in its classification. Despite flexibility in diagnostic classifications across institutions, each of the institutions of this study, which are representative of different places and stages in psychiatric provision, presented the same primary identifying patterns in mania of severe mood states across the mood spectrum with features of psychosis.

This conception of a manic-depressive illness, which focuses on severity of mood across the emotional spectrum instead of type of emotion, has important implications for both nineteenth-century mania and for current bipolar disorder. Through patient encounters, mania was identified as an illness consisting of severe emotional states, either high mood, low mood, or alternating mood, with features of psychosis that were traced according to emotional themes. Severity of emotion was identified by changes in habits and behaviours fuelled by either a lack or excess of energy, and new behaviours were considered at risk of becoming rooted without access to treatment. The development of mania's classification across the emotional spectrum points to a fluidity in movement between types of emotion in severe mood states, instead of a linear movement between two poles. Nineteenth-century patient cases reveal physicians attempting to trace patterns in the repetitions of episodes, in periods of remission, and in features of different emotional states. Their records, based on patient encounters, show a non-linear movement between emotional states. This imprecise pattern and non-linear movement between emotional states is also recognised in current bipolar disorder. However, criticism for the current term 'bipolar' has argued that it is ineffective because it suggests linear movement and total separation between high and low mood.<sup>1006</sup> The nature of this term also feeds into one of the main misconceptions of current bipolar disorder which mistakes this type of illness as continuous, rapid movements from one pole to another, instead of its reality as extended, severe

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<sup>1006</sup> See: Kay Redfield Jamison, *An Unquiet Mind* (London: Picador, 2015).

mood states which include both high and low mood features.<sup>1007</sup> This thesis's new finding about nineteenth-century mania as characterised by severe emotional states across the mood spectrum could be used to reflect on the current language used to frame this type of illness. Such work could research how the current term bipolar is culturally represented, or misrepresented. As pointed out by Cunningham and Muramoto, a diagnosis's primary purpose is operational.<sup>1008</sup> This includes directing a patient's psychiatric treatment, but another crucial component of this operational identity is to provide a framework for a patient, their relatives, and friends, to understand the nature of their illness and to be able to seek and access suitable support both inside and outside of a medical space. The cultural identity of diagnoses is therefore vital for patients and communities to be able to navigate a diagnosis.

Further research budding on this thesis could continue to trace the history of the term mania from the beginning of the twentieth century to seek the point at which mania became primarily associated with high mood, interrogating how and why this development happened, and investigating the representation of this change in both medical and literary writing. The key elements of this thesis's methodological approach could also be replicated to investigate the medical and cultural conception of other categories of mental illness. The approach of this thesis, including viewing current diagnostic frameworks as still in motion instead of final, focusing on how diagnosis happens and prioritising patient case records from working institutions, and remaining historically grounded with an interdisciplinary approach to medical and literary texts, has achieved a nuanced analysis of the medical and cultural conception of a manic-depressive illness while contributing to scholarship in both psychiatric history and literary criticism.

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<sup>1007</sup> APA, *DSM-5*, pp. 125-136.

<sup>1008</sup> Cunningham, 'Identifying Disease in the Past', p. 16; Muramoto, 'Retrospective diagnosis of a famous historical figure', p. 6.



## Appendix

The following work is appended to this thesis as supplementary material, not to be assessed. I created this artwork throughout the PhD and the pieces were exhibited at different stages of the research in Insole Court, Cardiff; The Gate Art Gallery, Cardiff; Plaza Gallery, Penarth; Hearth Gallery, Penarth; and Redhouse Cymru, Merthyr Tydfil. The purpose of creating and exhibiting the work throughout was so that these artworks would not be solely a final outcome of the project, but were instead research outputs in their own right that could ask different questions of the thesis whilst creating engagement with the public. In addition to the primary exhibitions, some of the artworks were included in group and touring exhibitions, published in journals and magazines, and selected for awards.<sup>1009</sup> Four of the pieces were created as a commission from the Royal College of Psychiatrists in Wales for their *Bipolar Education Project* which aimed to tackle current misconceptions about bipolarity. Further details about individual artworks will be provided in the image information.

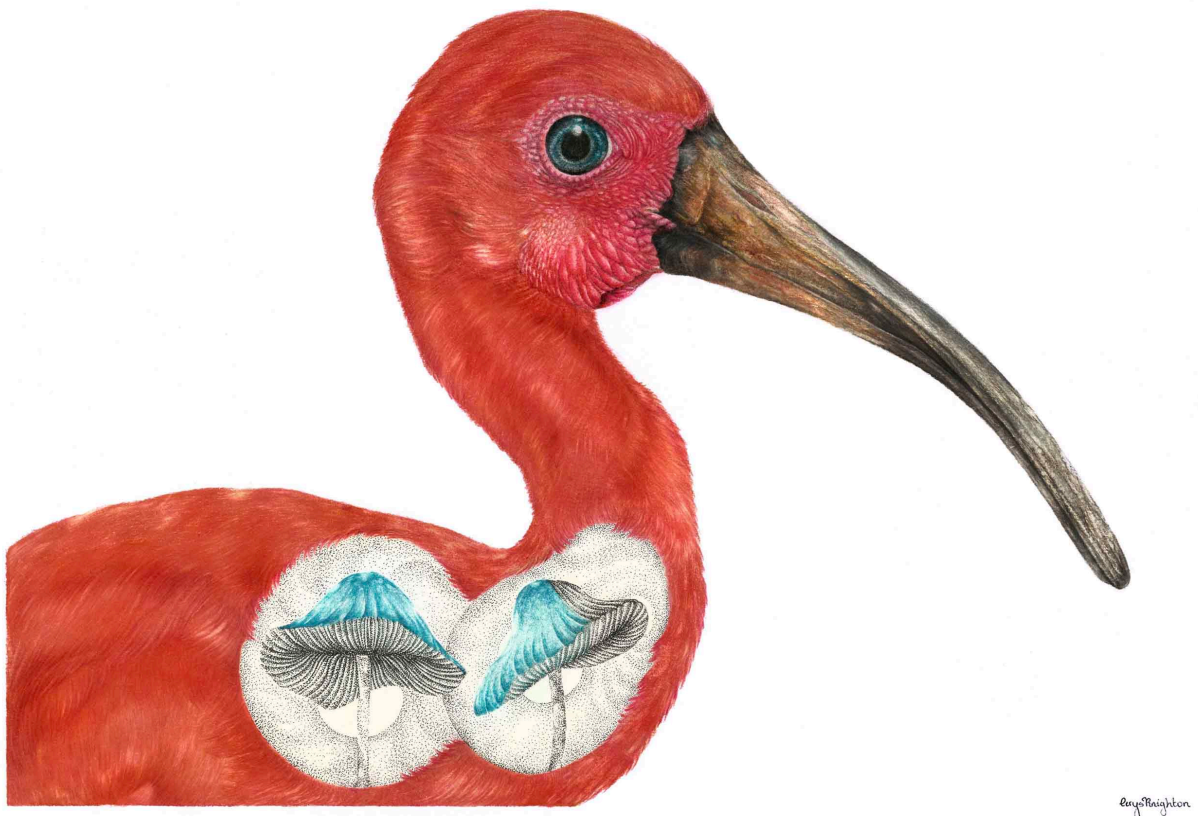


Figure 2.1: Cerys Knighton, *Two Bodies*, 2020, pencil and ink pointillism on paper.

<sup>1009</sup> Other exhibition venues included, for example: Mostyn, Llandudno; Pop Brixton, London; Oriel Cric, Crickhowell, Royal Cambrian Academy, Conwy. Journals and magazines included *Question Journal*, *Tabou Magazine*, *Lucent Dreaming*, and *Longitudinēs*. Awards included first place at the Doctoral Academy's *Images of Research* Exhibition, 2021, People's Choice Award at the Doctoral Academy's *Images of Research* Exhibition, 2019, and the 'Disability Art Award' from the Livery Company of Wales.

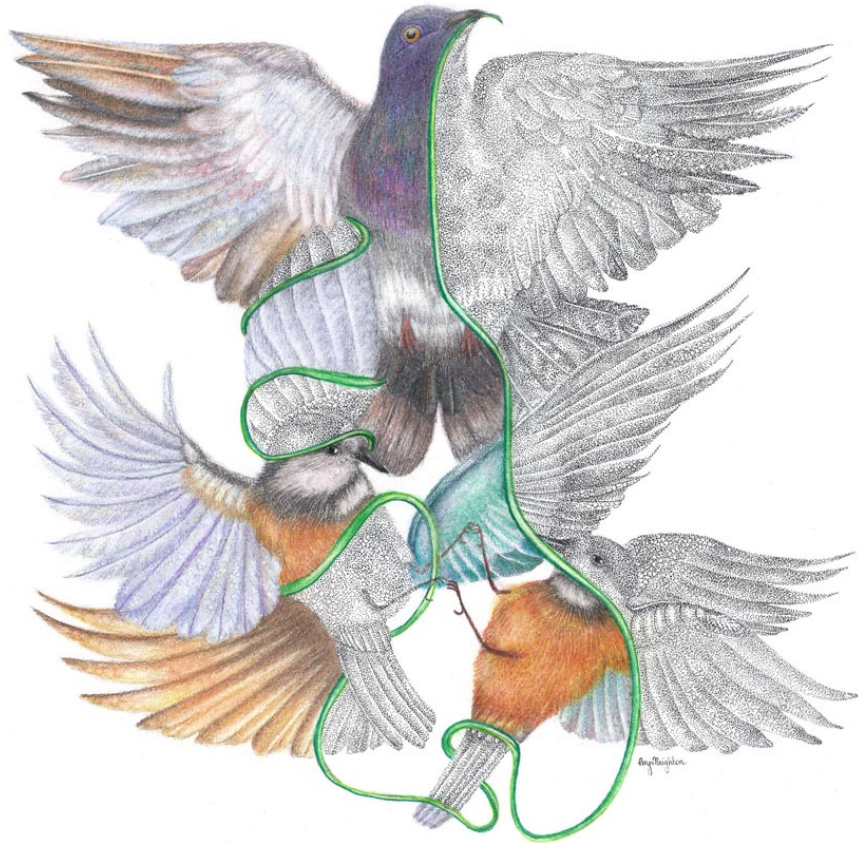


Figure 2.2: Cerys Knighton, *Polarisation*, 2019, ink pointillism and pencil on paper.

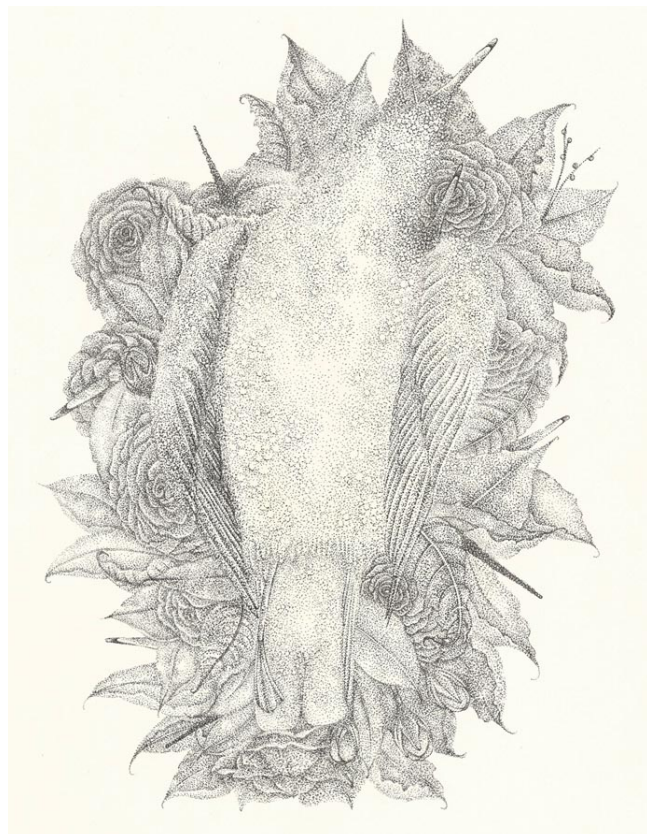


Figure 2.3: Cerys Knighton, *Loss*, 2019, ink pointillism on paper.





Figure 2.4: Cerys Knighton, *Growth*, 2018, ink pointillism on paper.

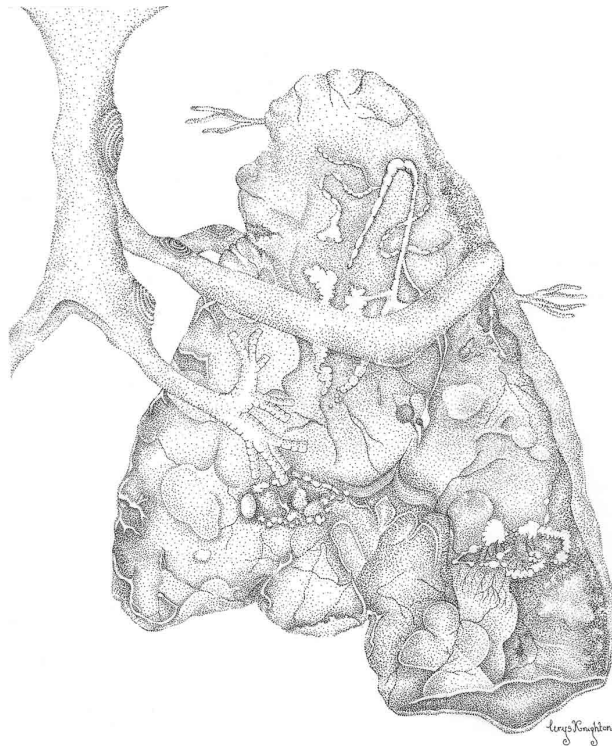


Figure 2.5: Cerys Knighton, *Lung*, 2019, ink pointillism on paper.

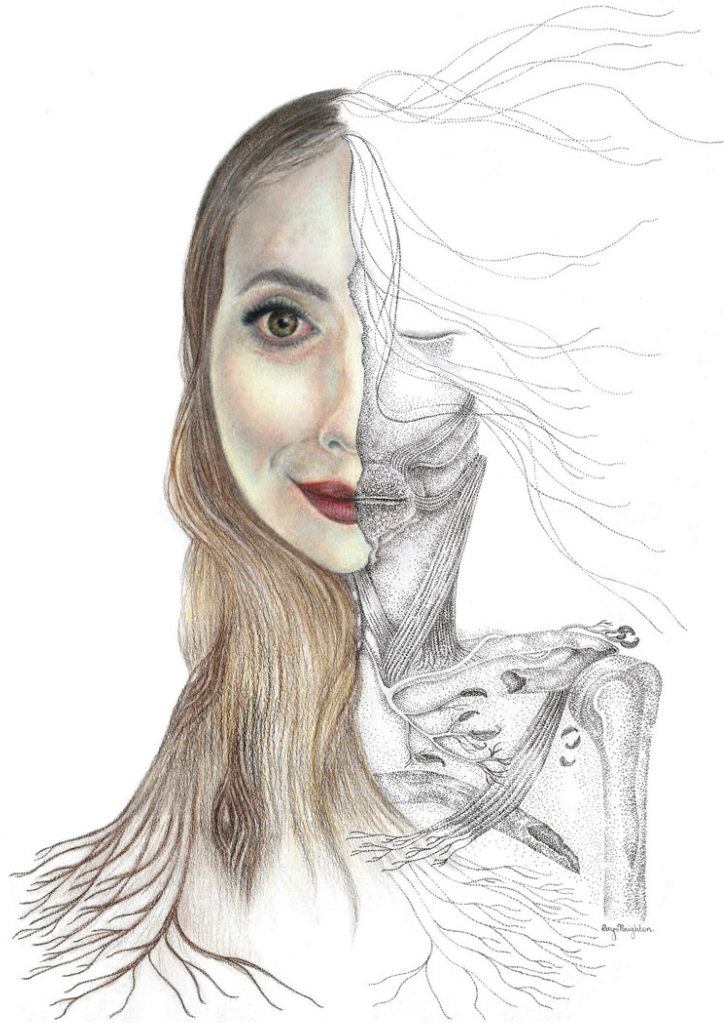


Figure 2.6: Cerys Knighton, *Gaia: Bipolar, Psychosis, and the Rotting Body*, 2019, ink pointillism and pencil on paper.

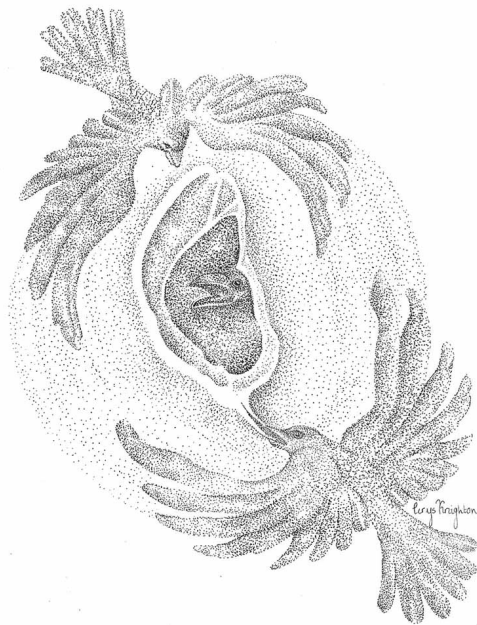


Figure 2.7, Cerys Knighton, *Sensory Overload: Sound*, 2018, ink pointillism on paper.



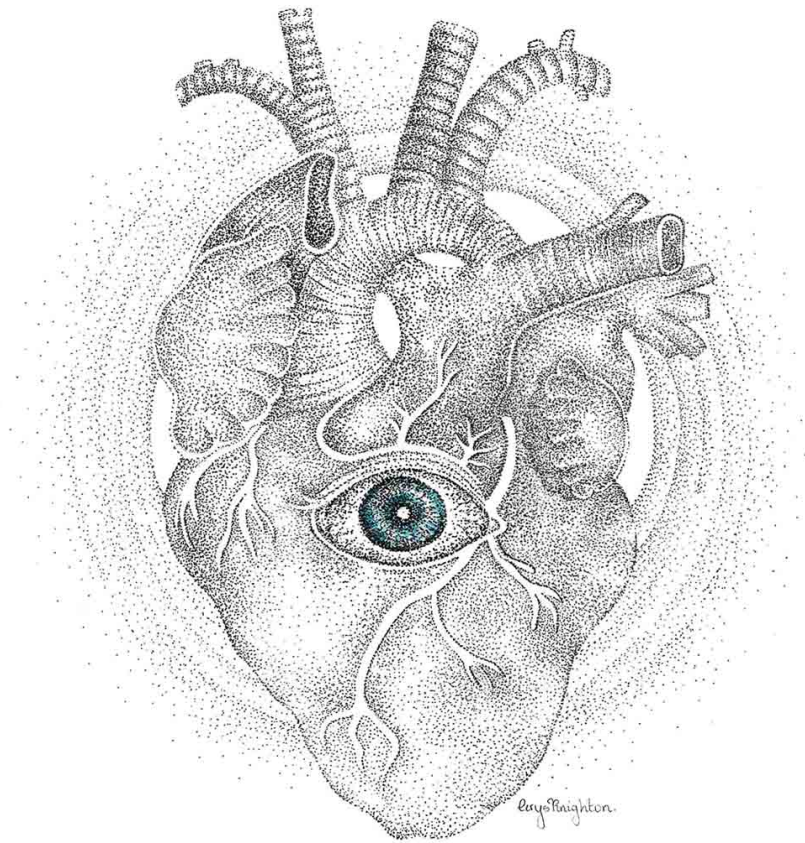


Figure 2.8: Cerys Knighton, *The Tell-Tale Heart*, 2018, ink pointillism and pencil on paper.

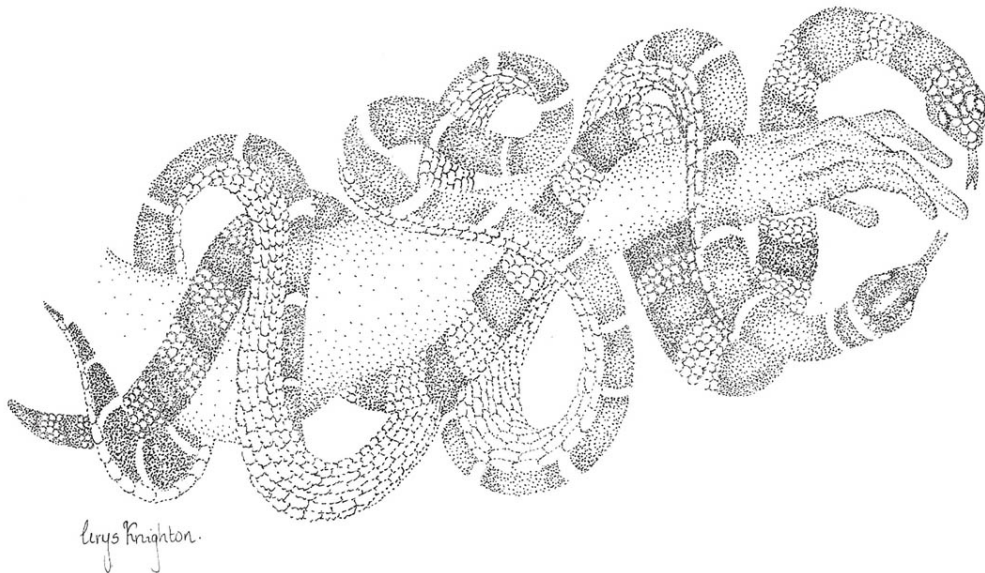


Figure 2.9: Cerys Knighton, *Sensory Overload: Touch*, 2018, ink pointillism on paper.

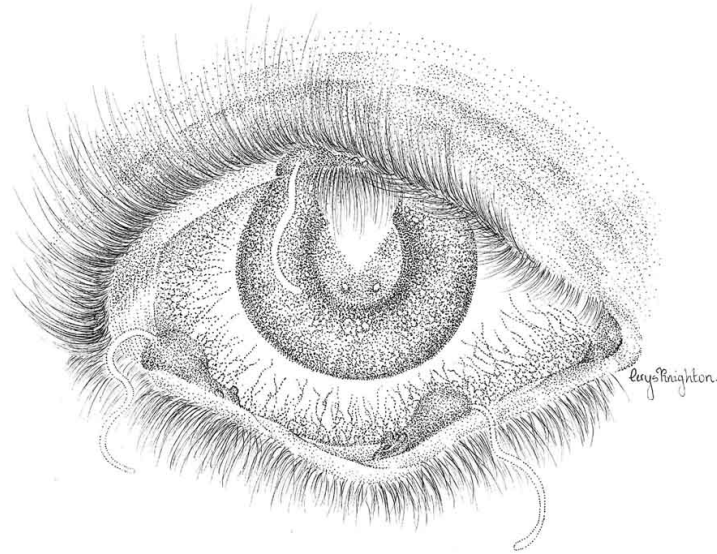


Figure 2.10, Cerys Knighton, *Sensory Overload: Sight*, 2018, ink pointillism on paper.



Figure 2.11: Cerys Knighton, *F(l)ight*, 2020, acrylic painting on clay, driftwood, and dried flowers. One of the pieces made for the Royal College of Psychiatrists Wales's *Bipolar Education Project*.



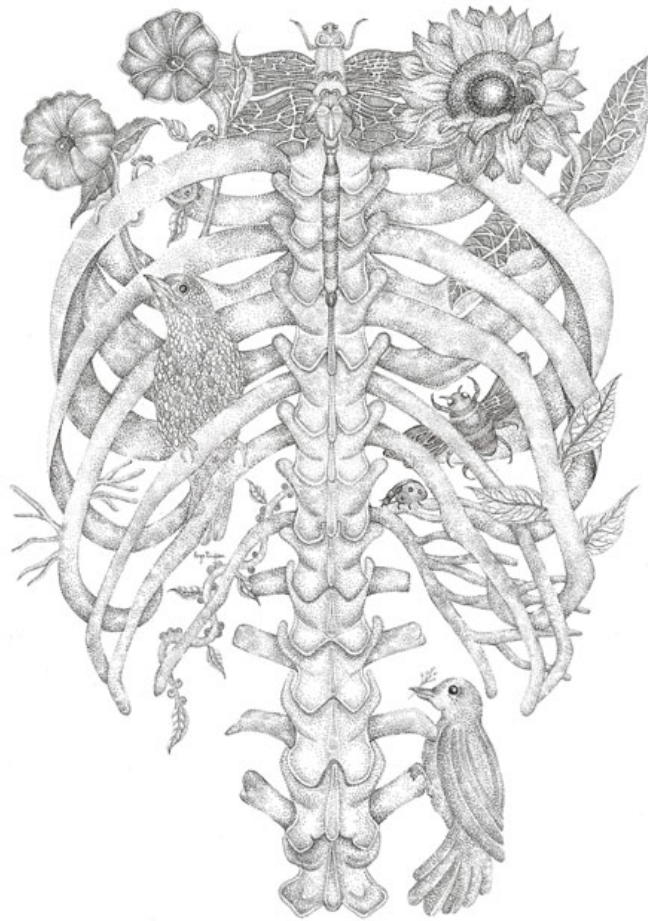


Figure 2.12: Cerys Knighton, *On the Edge of Restoration*, 2019, ink pointillism and pencil on paper.

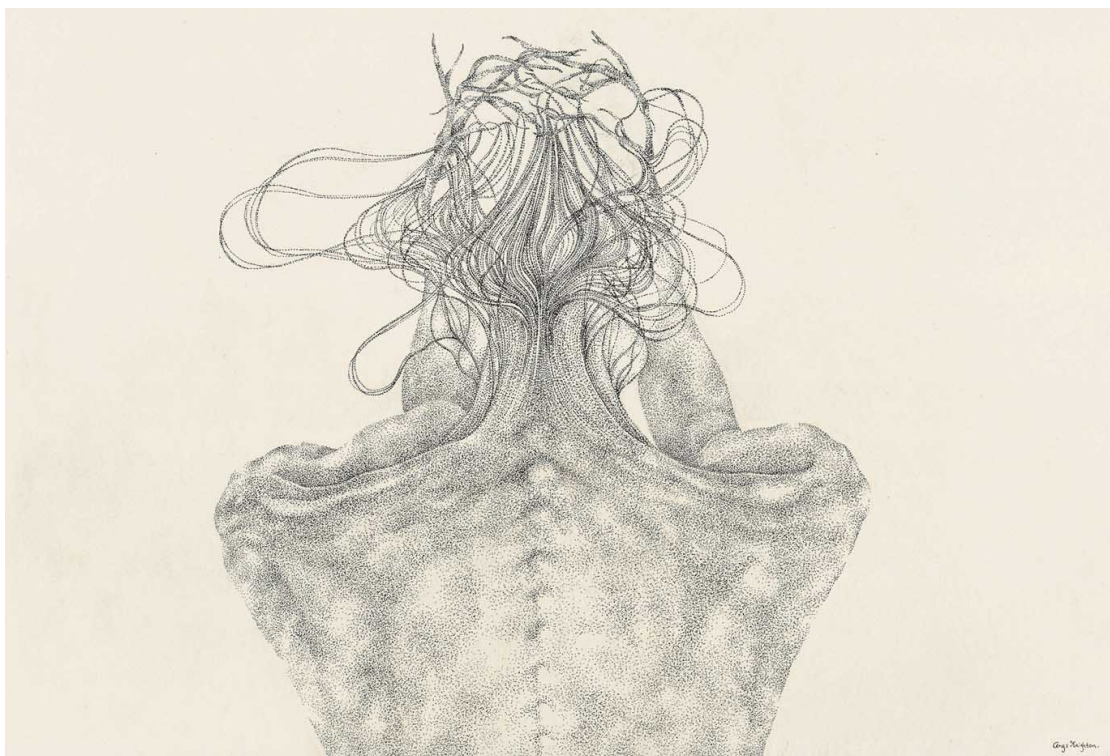


Figure 2.13: Cerys Knighton, *In the Seam*, 2021, ink pointillism on paper.

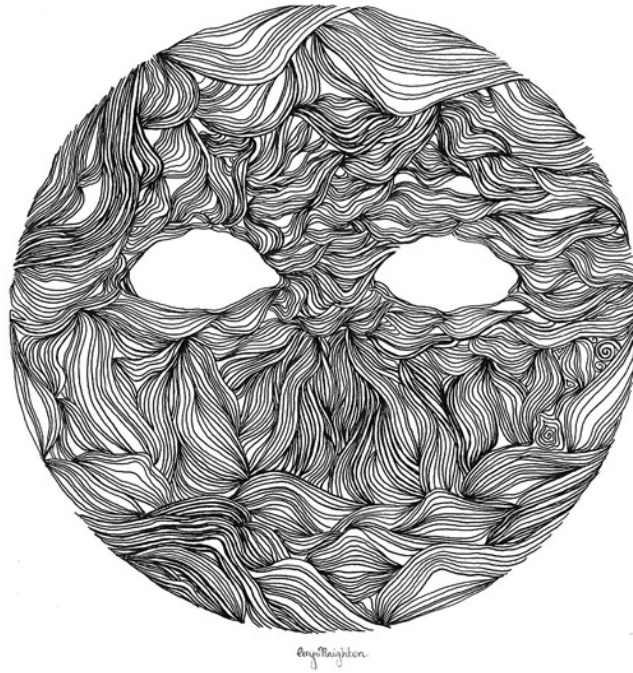


Figure 2.14: Cerys Knighton, "*On the Treatment of Mania*", 2018, ink on paper.

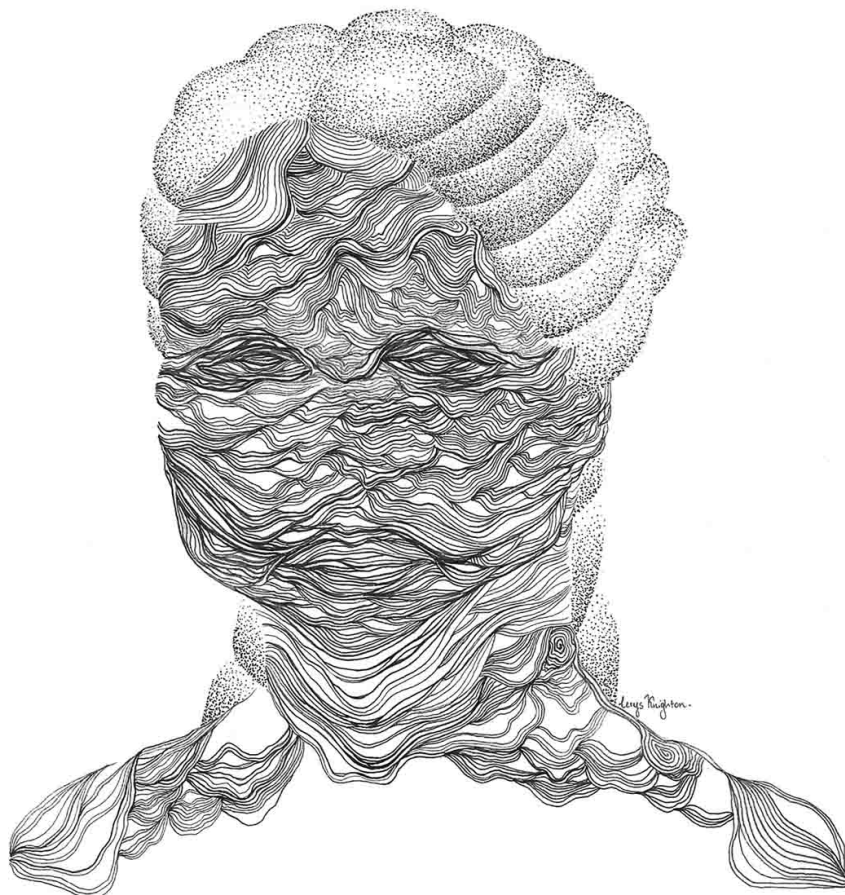


Figure 2.15: Cerys Knighton, "*Bodily Restraint is Imperative*", 2018, ink on paper. Winner of the People's Choice Award at the Doctoral Academy's *Images of Research* Exhibition, 2019.





Figure 2.16: Cerys Knighton, *Visibility*, 2021, ink on paper.

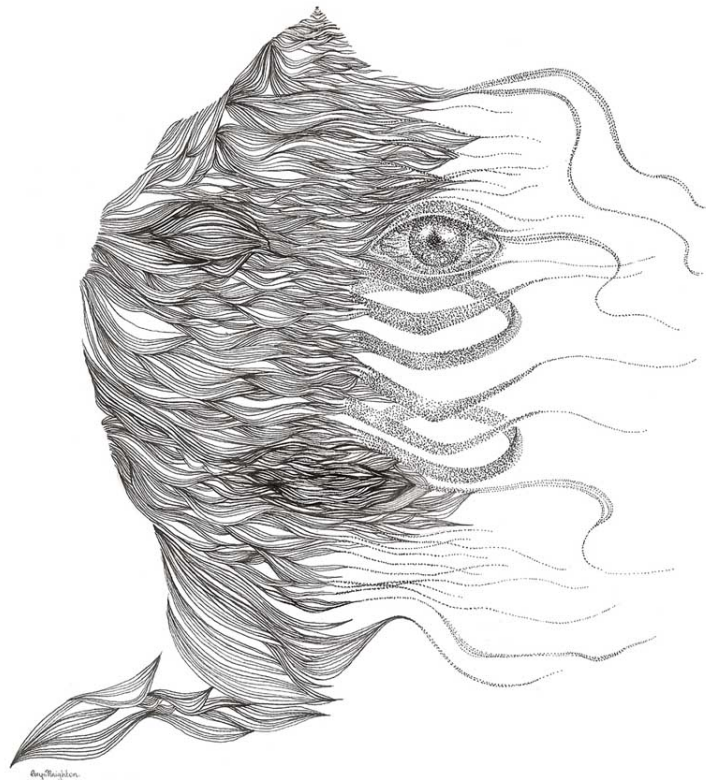


Figure 2.17: Cerys Knighton, *Frontiers of Medical Treatment*, 2019, ink on paper.



Figure 2.18: Cerys Knighton, *Dancing Mania*, 2019, ink and pencil on paper.

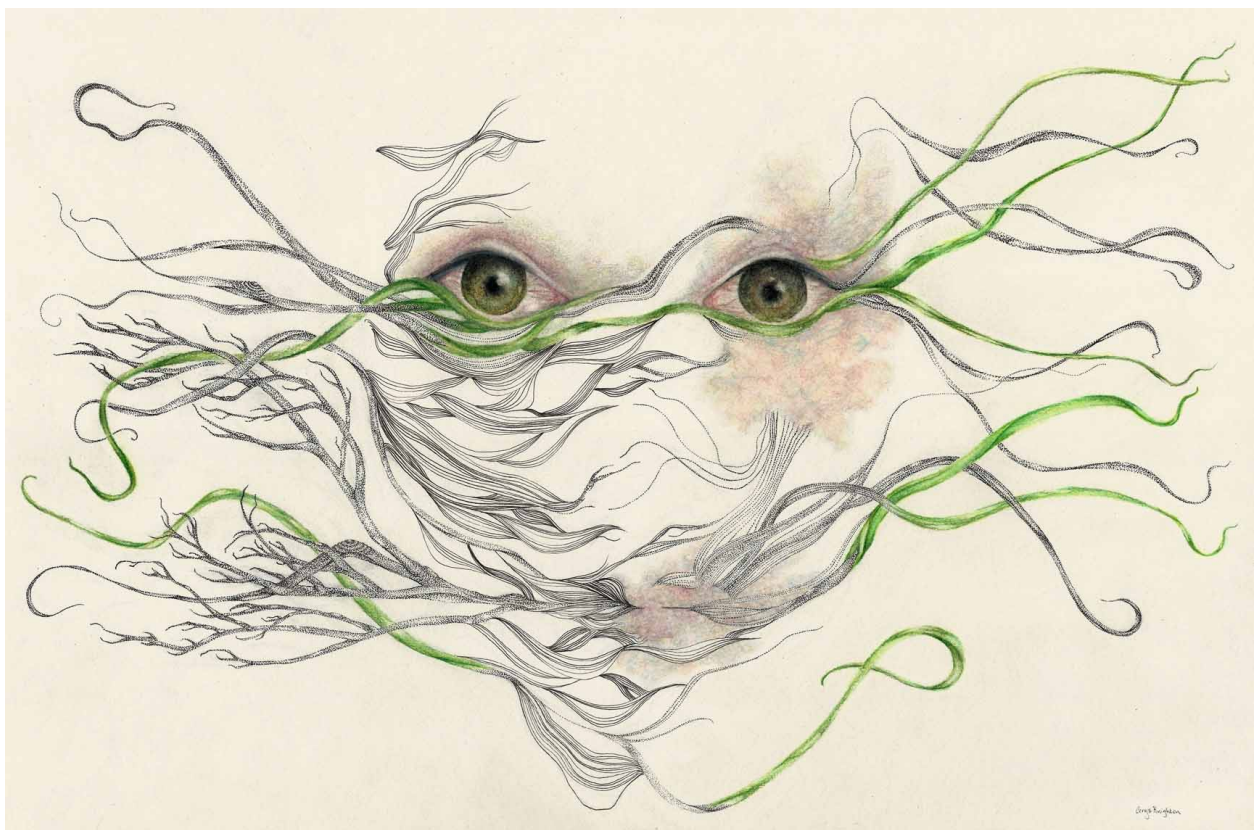


Figure 2.19: Cerys Knighton, *Cymorth [Support]*, 2020, ink and pencil on paper.



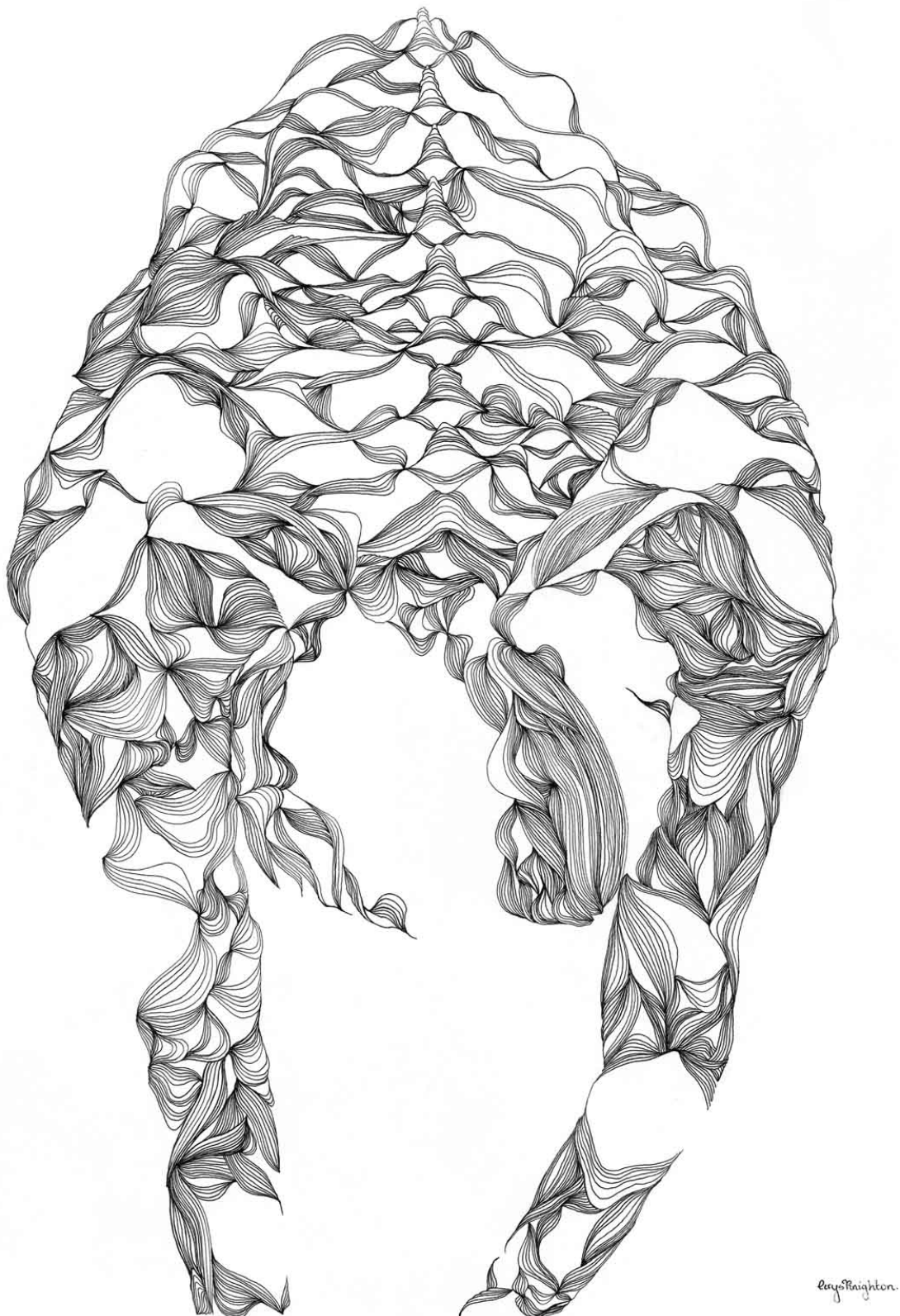


Figure 2.20, Cerys Knighton, *Pressed into Place*, 2021, ink on paper.

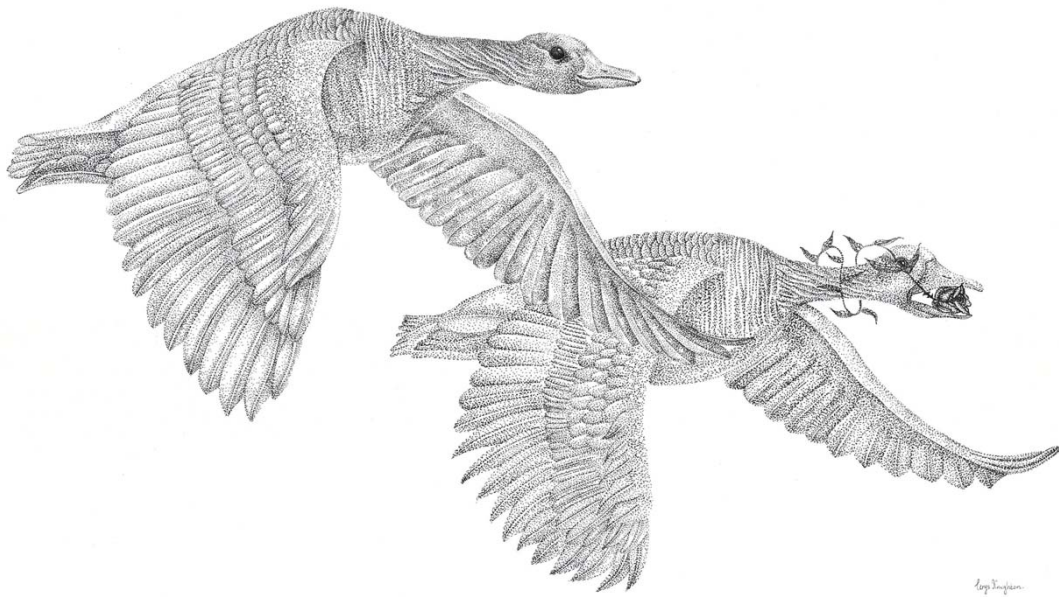


Figure 2.21: Cerys Knighton, *Iaith [Language]*, 2019, ink pointillism on paper.



Figure 2.22: Cerys Knighton, *Serpent*, acrylic painting on clay, driftwood, and dried flowers.





Figure 2.23: Cerys Knighton, *Coil*, 2021, ink pointillism and pencil on paper.

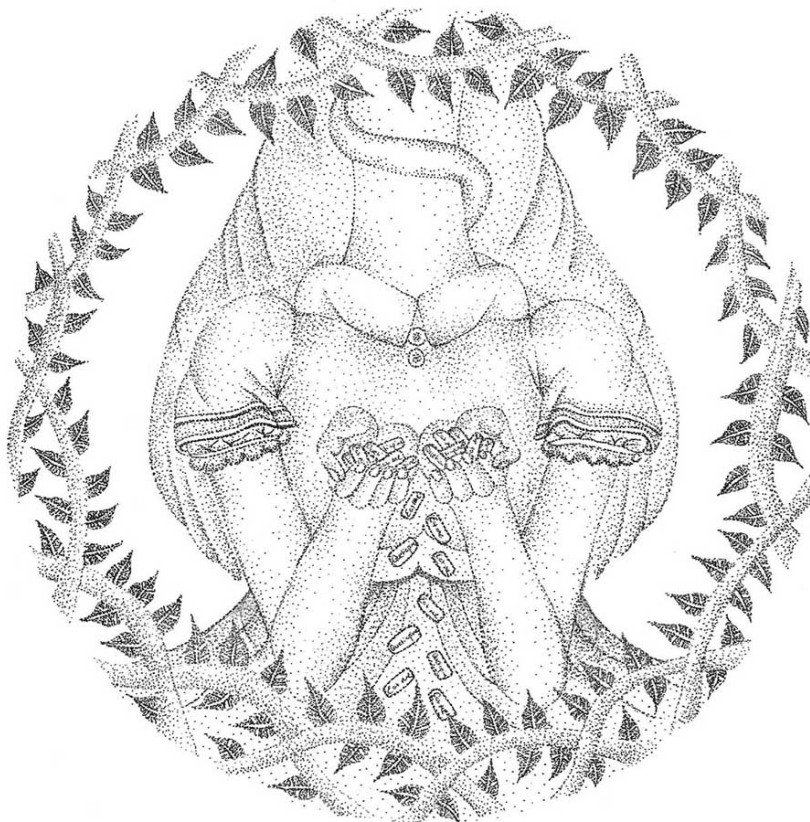


Figure 2.24: Cerys Knighton, *Alice and Serpent*, 2018, ink pointillism on paper.



Figure 2.25: Cerys Knighton, *Sensory Overload*, 2020, acrylic painting on clay, driftwood, and dried flowers. One of the pieces made for the Royal College of Psychiatrists Wales's *Bipolar Education Project*.



Figure 2.26: Cerys Knighton, *Bodies*, 2021, driftwood and dried flowers.





Figure 2.27: Cerys Knighton, *Peel*, 2021, pencil and ink pointillism on paper.



Figure 2.28: Cerys Knighton, *Bodies*, 2020, clay.

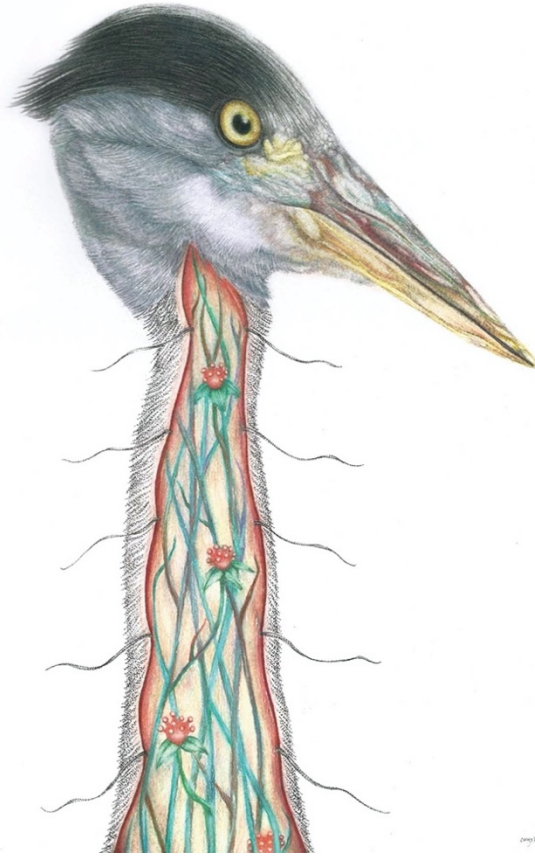


Figure 2.29: Cerys Knighton, *Heron, Apple Blossoms, Virions*, 2020, pencil and ink pointillism on paper.



Figure 2.30: Cerys Knighton, *Grebe, Daffodils*, 2021, pencil and ink pointillism on paper.





Figure 2.31: Cerys Knighton, *Sleep Well*, 2019, pencil and ink pointillism on paper.



Figure 2.32 Cerys Knighton, *Hold*, 2021, acrylic painting on clay and dried flowers.



Figure 2.33: Cerys Knighton, *Disordered*, 2019, ink pointillism and pencil on paper.

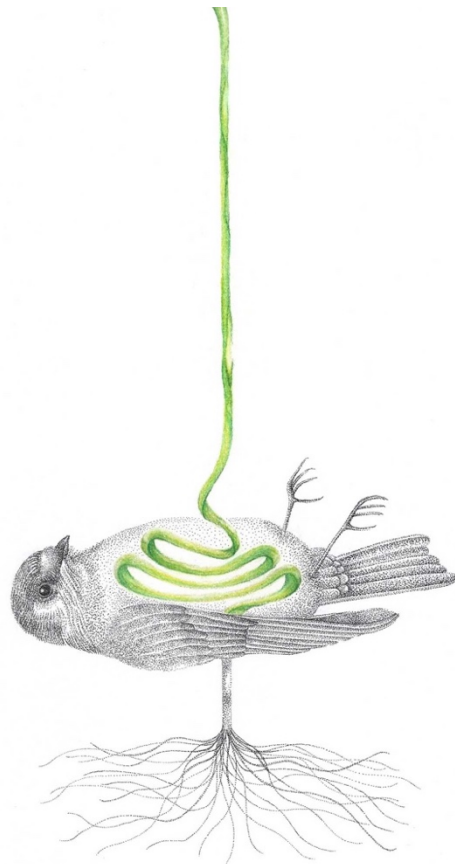


Figure 2.34: Cerys Knighton, *At the Root*, 2019, ink pointillism and pencil on paper.



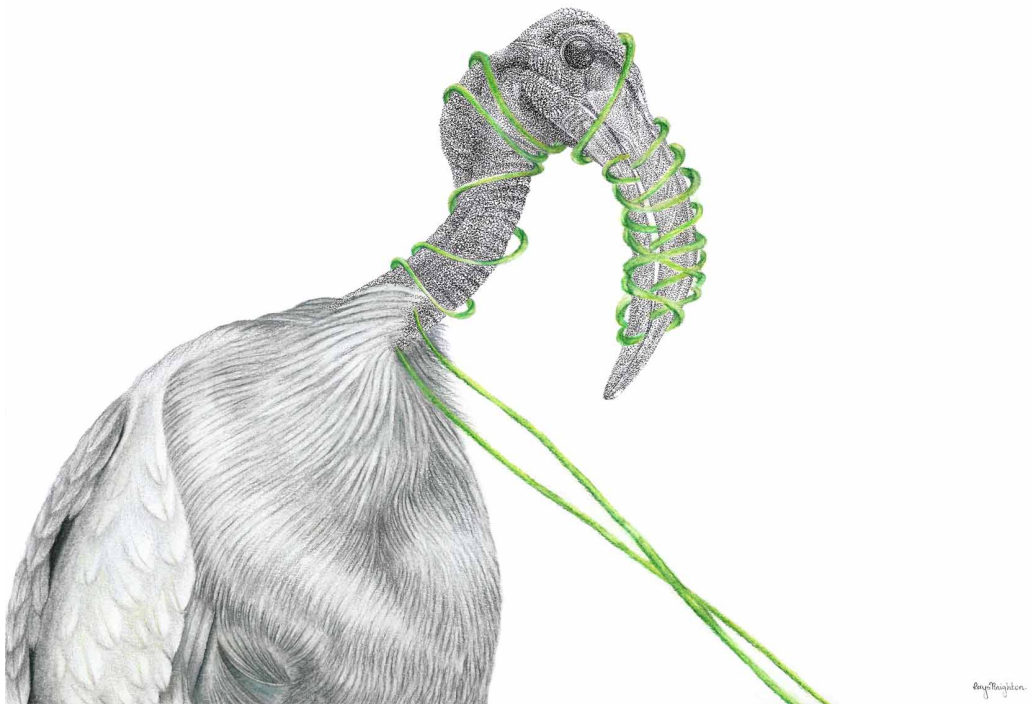


Figure 2.35: Cerys Knighton, *Ibis*, 2018, ink pointillism and pencil on paper.

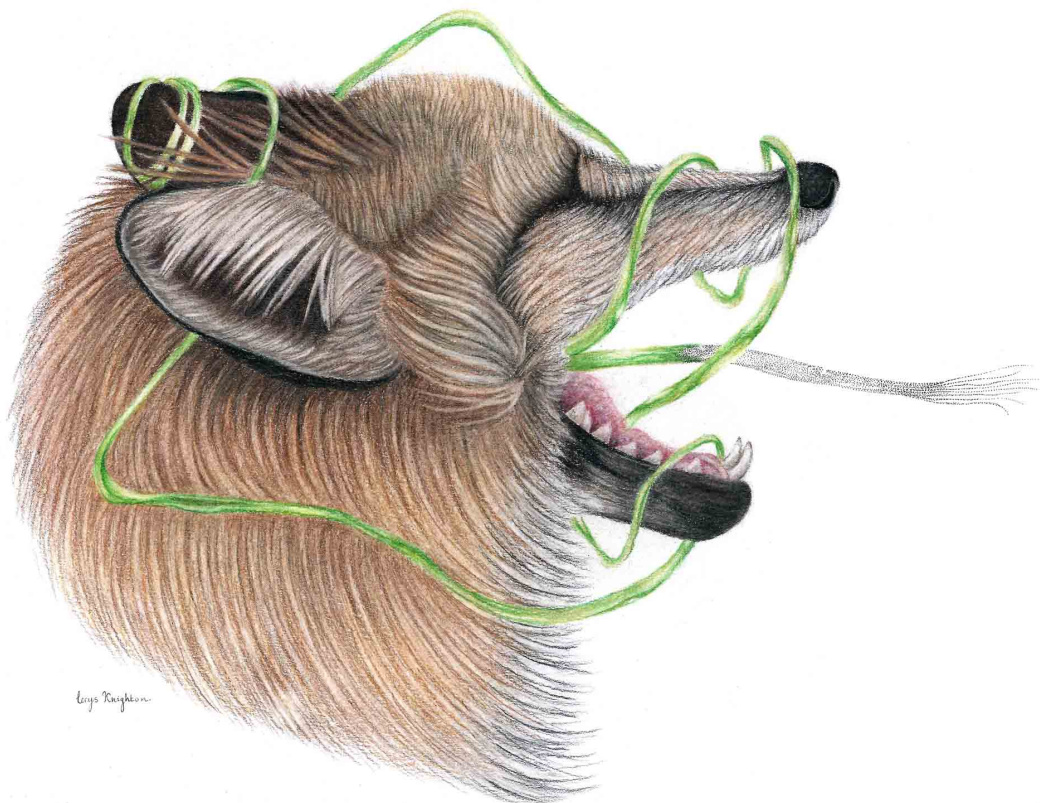


Figure 2.36: Cerys Knighton, *A Foregone Conclusion*, 2019, pencil and ink pointillism on paper.

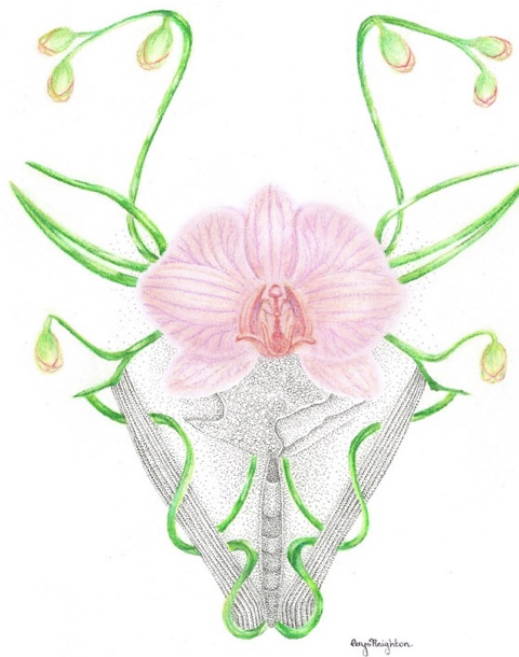


Figure 2.37: Cerys Knighton, *Voice*, 2019, ink pointillism and pencil on paper.



Figure 2.38: Cerys Knighton, *Throat*, 2018, pencil on paper.

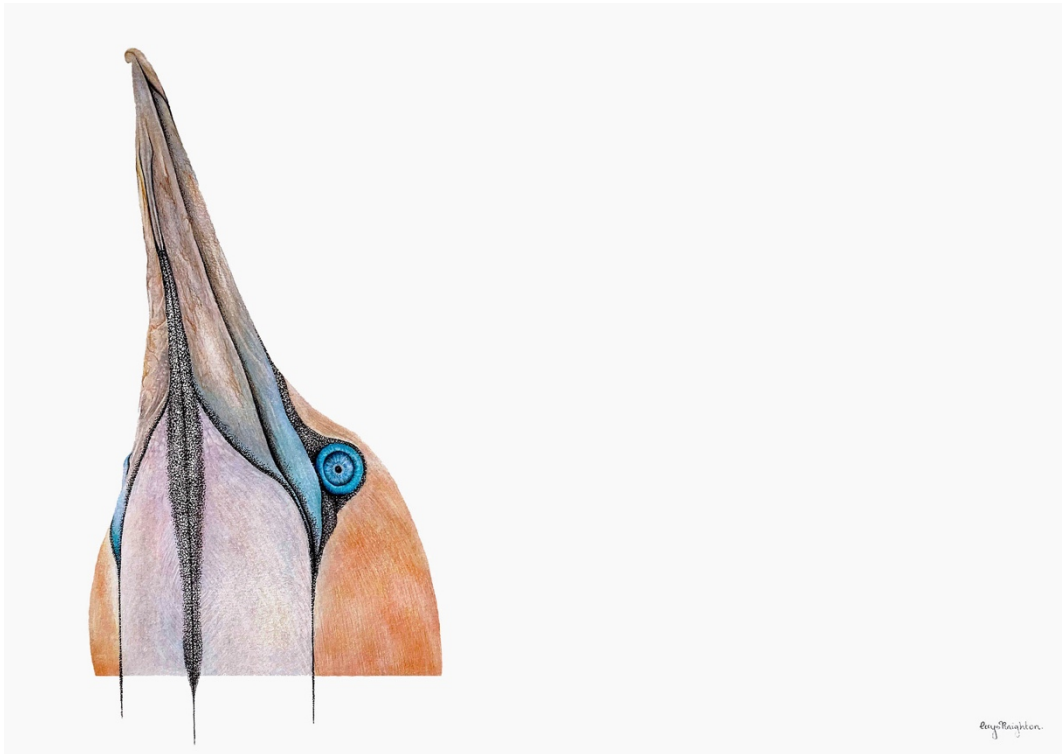


Figure 2.39: Cerys Knighton, *Drain*, 2021, pencil and ink pointillism on paper.



Figure 2.40: Cerys Knighton, *Stag*, 2021, acrylic painting on clay, driftwood, and dried flowers.



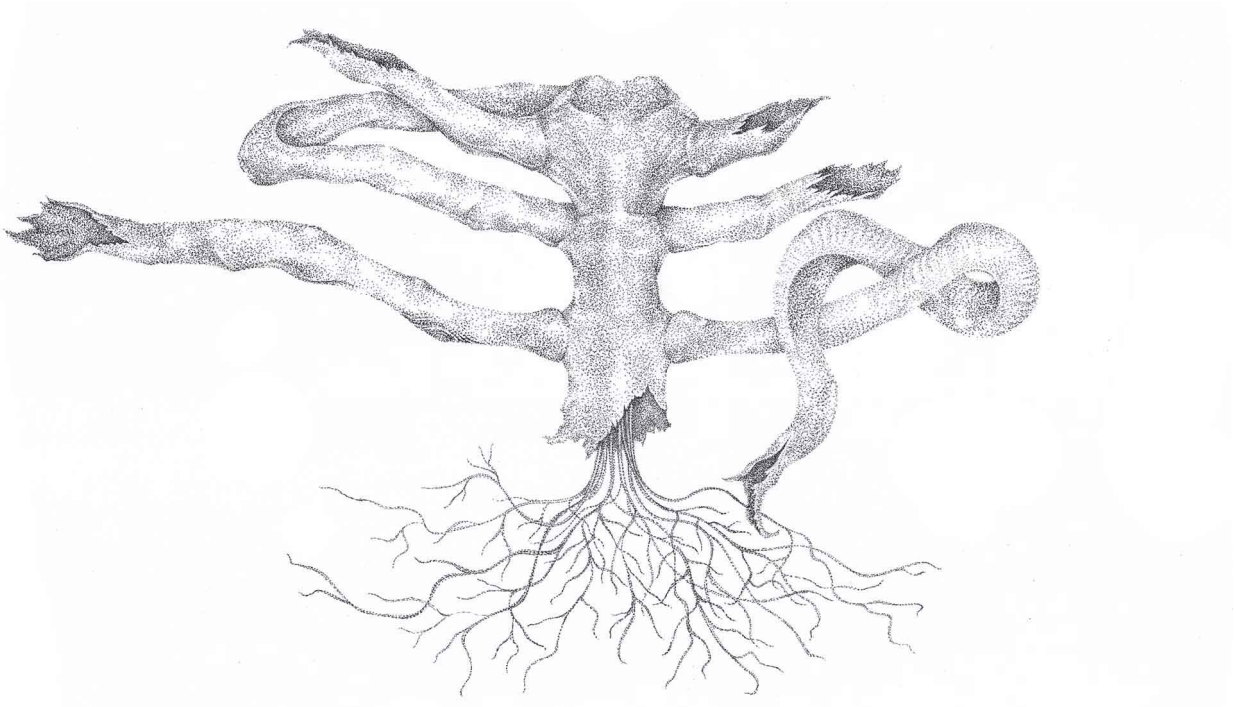


Figure 2.41: Cerys Knighton, *Sternum*, 2021, ink pointillism on paper.



Figure 2.42: Cerys Knighton, *Hypersensitivity*, 2020, acrylic painting on clay, driftwood, and dried flowers.  
One of the pieces made for the Royal College of Psychiatrists Wales's *Bipolar Education Project*.



Figure 2.43: Cerys Knighton, *Cormorant, Eel*, 2021, ink pointillism and pencil on paper.

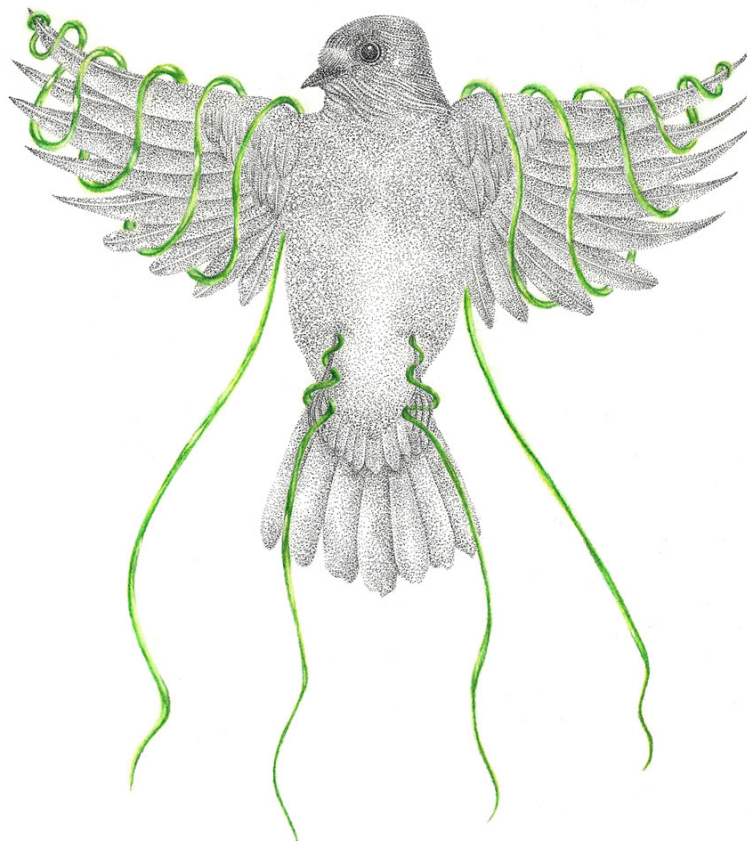


Figure 2.44: Cerys Knighton, *Trust Yourself to Tear Out the Weeds*, 2019, ink pointillism and pencil on paper.



Figure 2.45: Cerys Knighton, *Snare*, 2021, acrylic painting on clay, driftwood, and dried flowers.

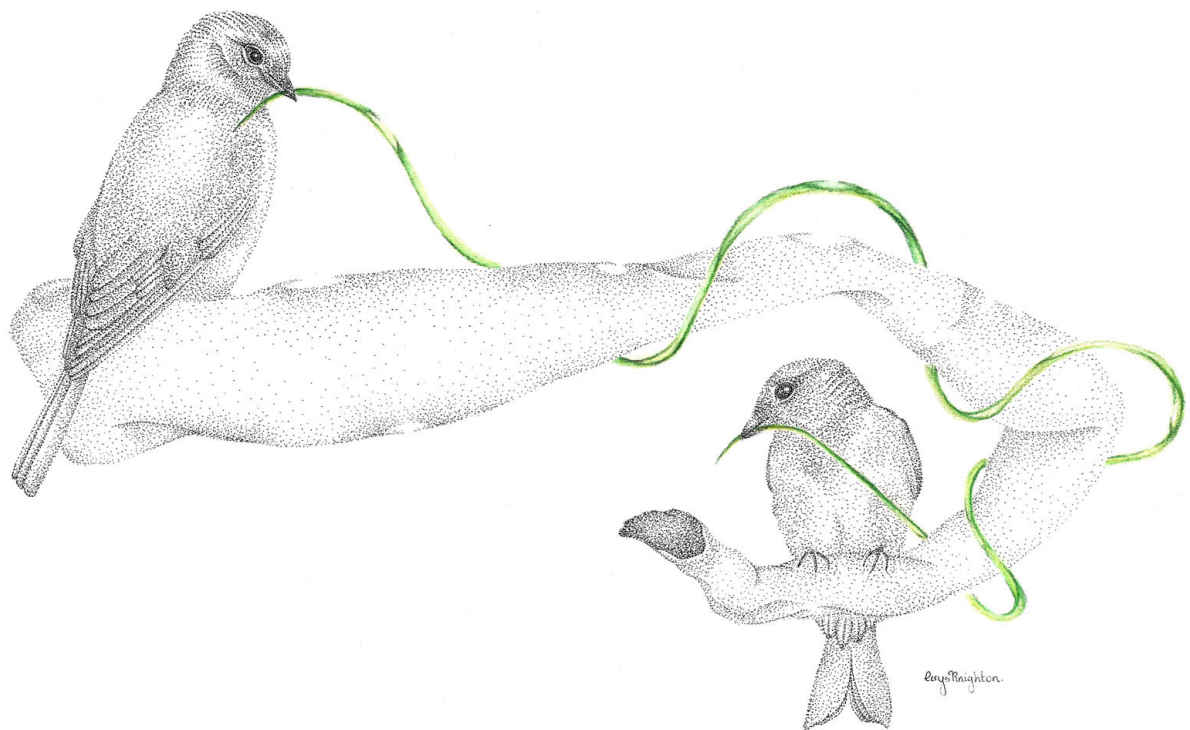


Figure 2.26: Cerys Knighton, *Clavicle*, 2019, ink pointillism and pencil on paper.



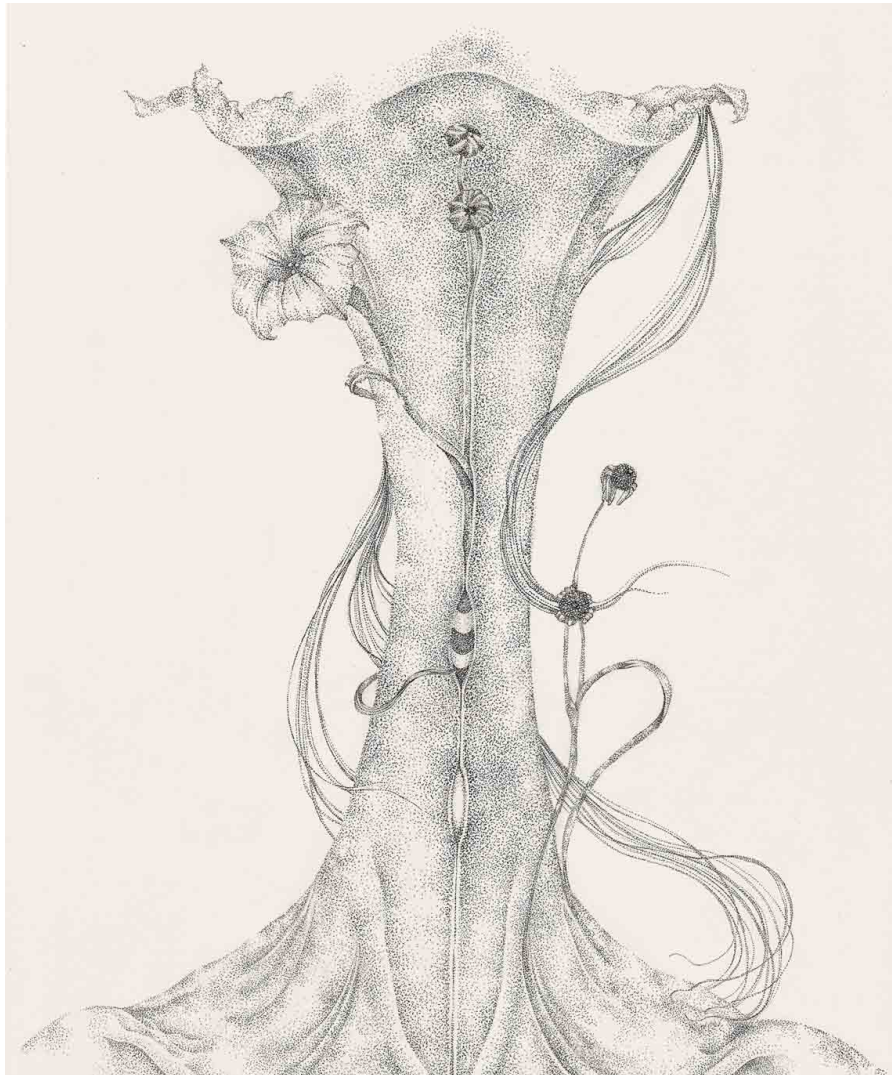


Figure 2.47: Cerys Knight, *Recoil*, 2020, ink pointillism on paper. One of the pieces made for the Royal College of Psychiatrists Wales's *Bipolar Education Project*.



Figure 2.48 Cerys Knighton, *Perception*, 2019, pencil and ink pointillism on paper.



Figure 2.49: Cerys Knighton, *Taken Root*, 2022, acrylic painting on clay, driftwood, and dried flowers.



Figure 2.50: Cerys Knighton, *Unroot*, 2022, acrylic painting on clay, driftwood, and dried flowers.





Figure 2.51: Cerys Knighton, *Perhaps it was Only the Pepper*, 2022, ink pointillism and pencil on paper.

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