

**Self-Mutilation and Psychiatry: Impulse, Identity and the Unconscious
in British Explanations of Self-Inflicted Injury, c. 1864 – 1914**

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DECLARATION

I, Sarah Chaney, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Abstract

Modern accounts of “self-harm” commonly attribute self-inflicted wounds with emotional or other psychological “meaning”, while assuming that these acts are a product of twentieth-century concerns. While self-harm is certainly a modern concept, the attribution of meaning to self-inflicted injury – above and beyond the physical existence of the wounds themselves – is not new. This thesis explores the way in which medical writers in the later nineteenth century understood and explained what they called “self-mutilation”, situating this debate within the history of asylum psychiatry (where most discussion occurred). Self-mutilation as a concept, it is argued, could only exist within the context of a prior understanding of “the self” as a specific physical and psychological entity, and physiological, anthropological and psychological approaches to selfhood are closely associated with medical attention to self-injury.

While it might have been expected that writing on self-mutilation emerged from the bureaucratic nature of the contemporary asylum system, and psychiatric concern with the expansion of diagnostic nosologies, this was not necessarily the case. In fact, most of the alienists writing on this topic did not embrace “medical materialism” and hereditary models of illness wholeheartedly, but drew on a wide variety of fields – including anthropology, normal psychology, spiritualism and religious and literary allegory – in their efforts to understand self-injurious acts. This approach encouraged the idea that self-mutilation described more than just a physical wound, but was an act which could be analysed to uncover underlying mental or emotional meaning. In the writings and practices of these psychiatrists and, indeed, in cases of so-called “insane self-mutilation” reported more widely, I show that ideas and attitudes towards self-mutilation in this period can also inform the historian about ideas of the human condition, normal versus abnormal behaviour, and the very idea of selfhood.

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Introduction

The “Truth Hurts,” began a 2006 National Inquiry, going on to state that one in fifteen young people (aged 11 – 25) in the UK has practised self-harm.¹ The study, as is common in modern accounts, used the term self-harm to describe “a wide range of things that people do to themselves in a deliberate and usually hidden way”: in particular cutting, but also burning, scalding, hair pulling, bone-breaking and ingesting toxic substances. Around the same time this report was published, British newspapers also commented on a proposal to “allow ‘safe’ self-harming” in psychiatric hospitals, a topic of discussion at the Royal College of Nursing (RCN)’s annual congress.² This discussion (seemingly the only one of over twenty debates at the congress to be picked up by the mainstream press) considered the role of the nurse in facilitating such systems, reporting on a pilot scheme at St George’s psychiatric hospital in South Staffordshire, in which staff advised patients “to use ice cubes to freeze their skin or elastic bands to flick themselves with.”³ Such widespread interest indicates the high level of concern over the topic of self-harm in the modern media, as well as the breadth and variety of opinions on the subject. Nurses involved in the RCN debate claimed that psychiatric patients required support, rather than censure, while newspapers cited a clinical report from 2004, which had suggested that health service attitudes toward people who self-harm were “characterised by ignorance, negative attitudes and, sometimes, punitive behaviour by professionals.”⁴ Conversely, all newspaper reports agreed that “the controversial plans [for “safe” self-harm] will be resisted by those who argue that the duty of health-care professionals is to prevent harm, not to help cause it.”⁵

None of these reports, however, questioned the idea that self-harm can be considered a discrete and constant category. The physical reality of self-inflicted injuries appears to suggest to many writers today that the term is simply the description of a

¹ Camelot Foundation, *Truth Hurts: Report of the National Inquiry into Self-harm Among Young People*, (London: Mental Health Foundation, 2006).

² “Allow ‘Safe’ Self-harming, Nurses Urge” *Mail Online*, <http://www.dailymail.co.uk/health/article-384187/Allow-safe-self-harming-nurses-urge.html> [accessed 27 October 2010].

³ Polly Curtis, “‘Safe’ Self-harm for Patients” *Guardian.co.uk*, 22 March 2006, <http://www.guardian.co.uk/uk/2006/mar/22/politics.health> [accessed 27 October 2010].

⁴ Sarah-Kate Templeton, “Self-harmers to be Given Clean Blades” *Times Online*, 5 February 2006, <http://www.timesonline.co.uk/tol/news/uk/article727174.ece> [accessed 27 October 27 2010]. Also National Institute for Clinical Excellence, *Self-harm: The Short-term Physical and Psychological Management and Secondary Prevention of Self-harm in Primary and Secondary Care*, (Rushden, Northamptonshire: Stanley L. Hunt Ltd, 2004), p. 28.

⁵ Ben Leapman, “Self-harmers ‘Should Get Clean Blades’”, *Telegraph.co.uk*, 6 February 2006, <http://www.telegraph.co.uk/news/uknews/3336255/Self-harmers-should-get-clean-blades.html> [accessed 27 October 27 2010].

universal human tendency, with a meaning that can similarly be understood in universal terms. But what *is* self-harm? Can we view it as simply a new descriptive term for acts previously defined differently? In the mid nineteenth century, asylum psychiatrists certainly thought so. When they began to use the term “self-mutilation” to refer to self-injurious acts carried out by their patients, many assumed that they were describing an unchanging natural category, and incorporated into their definitions accounts going back to antiquity. These accounts were newly described as “self-mutilation”, a process that saw them acquire a variety of associated meanings they had not previously held. By the last two decades of the century, the term “self-mutilation” appeared in the indexes of psychiatric manuals, was the focus of journal articles, and received a five-page definition in Daniel Hack Tuke’s *Dictionary of Psychological Medicine* (1892).⁶ As in modern texts, alienists tended to incorporate a wide variety of acts under one headline term. In psychiatric and other medical literature one can find many descriptions of self-castration, eye enucleation, limb amputation, hair-plucking (the term trichotillomania, still in use today, was coined in 1889), knocking, burning and skin-picking, all of which were generally regarded to be distinct from suicidal acts. In contrast to the modern literature, in which self-cutting is usually emphasised,⁷ it is rare to find record in this period of injuries made using a sharp implement other than cut-throats, which were always considered suicidal. This is not to say that such acts of self-inflicted injury did not occur. Rather, they were not singled out as the paradigm for self-mutilation and, indeed, self-cutting was often not included in psychiatric definitions in this period. This reminds us that definitions of self-mutilation cannot exist separately from those doing the defining. Self-mutilation – like self-harm – is not a natural entity, but rather a collection of disparate acts carried out by equally diverse individuals. In various periods, patterns have been created by excluding certain individuals or acts in order to support particular generalisations or conclusions. But, while the meaning and parameters of the term have been questioned at various times, the central premise – that self-mutilation exists as an entity that can be labelled and understood – has not.

Such an approach continues to be the case in modern texts on self-harm, in which the assumption for grouping diverse acts under one heading is that they are all ways “of expressing very deep distress ... a means of communicating what can't be put into words or

⁶ Daniel Hack Tuke, *A Dictionary of Psychological Medicine*, 2 vols, (London: J. & A. Churchill, 1892).

⁷ See Steven Levenkron, *Cutting: Understanding and Overcoming Self-mutilation*, (New York; London: W.W. Norton, 1998); Barbara J. Brickman, "'Delicate' Cutters: Gendered Self-Mutilation and Attractive Flesh in Medical Discourse," *Body & Society*, 10, no. 4 (2004): 87-111; Adler and Adler, *The Tender Cut*, p. 6.

even into thoughts.”⁸ In a circular manner, this understanding serves to alter the population described by the term, encouraging the exclusion of any act not considered to have been carried out for such a purpose. Self-harm, it is strongly believed, is a *private* act that provides a physical vent for *inner* turmoil.⁹ Such an explanation is, as the nineteenth-century sources reveal, an idea that is by no means obvious. It thus becomes clear that self-harm (and self-mutilation) has multiple meanings, depending on whether it is considered within a physical, psychological, social or political context. The meanings may vary from person to person, behaviour to behaviour, culture to culture. By exploring the historical origins of psychiatric thought on self-inflicted injury in the late nineteenth century, this thesis challenges the assumption that self-harm – however labelled – can have any one distinct or obvious meaning. Self-mutilation cannot be considered a representational category. The very use of the term creates the category it describes, which cannot exist independently of the field in which it is created.¹⁰ By examining the attribution of meaning to self-inflicted injury from a historical perspective, it becomes clear that self-mutilation emerged from a variety of other contemporary concerns and frameworks for understanding human identity. Many of these are no longer current, making self-harm quite a different concept from self-mutilation. Nonetheless, understanding the *creation* of the category of self-mutilation encourages us to ask similar questions about self-harm today. What’s more, it enables us to highlight certain assumptions within today’s literature on self-harm that arose from nineteenth-century concerns but subsequently became taken for granted and often divorced from the issues that had given them meaning in the first place. Moreover, it was in the nineteenth century that it first appeared desirable to create a universal category of self-inflicted injury, incorporating multiple acts. Why this was so makes us reflect on the purposes the concept of self-harm serves for modern western society.

Historiography

Current researchers in the fields of psychiatry, clinical psychology and sociology tend to date investigation into self-inflicted injury as beginning with Karl Menninger’s landmark

⁸ Mind website, http://www.mind.org.uk/help/diagnoses_and_conditions/self-harm [accessed 21 August 2012]. Other popular websites often take this meaning of self-harm as un-contested, for example: en.wikipedia.org/wiki/Self-harm and selfinjury.org [last accessed 21 August 2012].

⁹ Adler and Adler, *The Tender Cut*, p. 24.

¹⁰ For similar claims about psychological categories, see Kurt Danziger, *Naming the Mind: How Psychology Found its Language*, 1st ed. (London: Sage Publications, 1997), p. 191; Ian Hacking, *Mad Travelers: Reflections on the Reality of Transient Mental Illnesses* (Charlottesville; London: University Press of Virginia, 1998).

study, *Man Against Himself*, in 1938, indicating that Menninger was “ahead of his time.”¹¹ The psychoanalytically-oriented Menninger regarded self-mutilation as an unconscious mechanism for avoiding suicide, by the concentration of a “suicidal impulse” on one part of the body as a substitute for the whole. Self-inflicted injuries – including “self-mutilation, malingering, compulsive polysurgery” and “certain unconsciously purposive accidents” – were thus gathered by Menninger under the banner of “focal suicide”.¹² Yet, although writers today often assume that Menninger introduced the very term “self-mutilation” to psychiatry, this was not the case.¹³ What’s more, Menninger’s work relied heavily on categories developed in the late nineteenth and early twentieth centuries, including concepts of “neurotic” and “religious” mutilation as well as the notion of “malingering”, all of which will be explored in this thesis.

So, how do modern authors explore the history of self-inflicted injury? Patricia and Peter Adler’s recent sociological study divides the background of the topic into three areas: a “pre-history” (from the ancient world to the 1990s!), burgeoning public awareness in the 1990s, followed by a seeming increase in self-harm in the “cyber era”, post-2001-2002. Within a psychiatric or psychological context, their assumption is that, prior to the 1990s, self-inflicted injury was *only* discussed in relation to psychiatric inpatient treatment. This view was also taken by medical writers in the early 1990s. Brenda and William Parry-Jones, for example, analysed 25 historical descriptions of patients between 1700 and 1900, whom they retrospectively diagnosed as bulimic, looking for evidence of self-injurious behaviour, in order to support the modern contention that eating disorders and self-mutilation are connected.¹⁴ While recognising that self-mutilation had been discussed in the nineteenth century, the authors made the entirely unsupported claim that “it seems likely that such behaviour was observed chiefly in psychotic or mentally retarded subjects.”¹⁵ Such a forthright conclusion was presumably drawn from twentieth century concerns, in conjunction with retrospective diagnosis of published nineteenth century cases, which are by no means representative of all instances regarded as self-mutilation by psychiatrists at

¹¹ Favazza, *Bodies Under Siege*, p. 232; Karl A. Menninger, *Man Against Himself* (San Diego; New York; London: Harcourt Brace Jovanovich, 1985). See also Barent W. Walsh and Paul M. Rosen, *Self-mutilation: Theory, Research, and Treatment* (New York; London: Guilford Press, 1988); Adler and Adler, *The Tender Cut*, p. 14.

¹² Menninger, *Man Against Himself*, pp. 201 – 308.

¹³ Adler and Adler, *The Tender Cut*, p. 14.

¹⁴ B. Parry-Jones and W. L. Parry-Jones, “Self-Mutilation in Four Historical Cases of Bulimia,” *British Journal of Psychiatry*, 163, (1993): 394-402.

¹⁵ Parry-Jones and Parry-Jones, “Self-Mutilation in Four Historical Cases of Bulimia”, p. 394.

the time.¹⁶ The assumption that psychiatric attention to self-inflicted injury in the nineteenth century was solely focused on either major mutilations (castration, enucleation and amputation) or certified inpatients will be strongly refuted in this thesis. This is particularly the case in chapters four and five, which explore “neurotic” and “hysterical” individuals who were rarely, if ever, institutionalised.

Another assumption often made by clinicians is that, until (and, in many instances, beyond) the publication of *Man Against Himself*, “in both popular and professional thought, self-mutilation was regarded generally as a type of suicidal behavior.”¹⁷ Surprisingly, despite this contention, the topic has not been picked up within the historiography of suicide, a field which will be further explored as a background to this thesis in chapter one. Invariably, these histories either bypass self-mutilation altogether or fail to acknowledge any distinction – either modern or historical – between suicide and other forms of self-inflicted injury, thus conveying the erroneous impression that none was made. For example, in purporting to discuss the “History of Suicide and Self Harm,” German Berrios focused entirely on published literature on suicide, suggesting that the two were one and the same.¹⁸ This thesis rejects the view that self-mutilation was not considered a separate field from suicide within late nineteenth-century psychiatry proposing that, unlike Victorian perspectives on suicide (which had emerged from the philosophical debates of the Enlightenment) interest in self-mutilation *per se* was a product of very nineteenth-century concerns. Whilst closely connected to the asylum system, with its opportunities for observation and classification, as well as neurological investigation into impulse and inhibition, the definition of self-mutilation nonetheless served much broader social and medical purposes, which will be drawn out in this study.

The major contribution to historical investigation of self-mutilation is the work of Armando Favazza, a psychiatrist working in the niche of “cultural psychiatry”, whose *Bodies Under Siege: Self-Mutilation and Body Modification in Culture and Psychiatry* was first

¹⁶ For similar assumptions in twentieth-century psychological literature, see Harold Merskey, *The Analysis of Hysteria* (London: Baillière Tindall, 1979), p. 69; M. M. Robertson, M. R. Trimble, and A. J. Lees, “Self-Injurious-Behavior and the Gilles-De-La-Tourette Syndrome - A Clinical-Study and Review of the Literature,” *Psychological Medicine*, 19, no. 3 (1989): 611-625, p. 618; Digby Tantam and Jane Whittaker, “Personality Disorder and Self-Wounding,” *British Journal of Psychiatry*, 161, (1992): 451-464, p. 453.

¹⁷ Favazza, *Bodies Under Siege*, p. 232. See also Michael G. Gelder, *Oxford Textbook of Psychiatry*, 3rd ed. (Oxford: Oxford University Press, 1996), p. 426.

¹⁸ G. E. Berrios, *The History of Mental Symptoms: Descriptive Psychopathology Since the Nineteenth Century* (Cambridge: Cambridge University Press, 1995), pp. 443 – 454. See also G. E. Berrios and M. Mohanna, “Suicide: Clinical Section,” in *A History of Clinical Psychiatry: the Origin and History of Psychiatric Disorders*, ed. G. E. Berrios and Roy Porter, (London, New Brunswick: Athlone Press, 1995), 612-624, p. 612.

published in 1987.¹⁹ Like Parry-Jones and Parry-Jones, Favazza aimed to shed light on modern clinical practice by exploring a particular behaviour historically, again suggesting that self-harm might prove to be a universal category. However, Favazza's detailed approach is much more subtle than that of the previous writers, for he makes it abundantly clear that the meaning of self-inflicted injury varies depending on the cultural context in which it is interpreted. Thus, Favazza includes both what he refers to as "culturally sanctioned", as well as "deviant", self-mutilation, across a century's worth of published material, indicating that, while people might carry out similar acts in different places or time periods, the meanings attributed to them are often diverse. Favazza's work has certainly been a valuable contribution to the literature, and held an important role in persuading clinicians and others to acknowledge the diversity of self-inflicted injury, as well as the difficulty of drawing a line between accepted and pathological behaviours. In the decades around the publication of Favazza's book, clinicians were engaged in a continual shaping and redefining of various types of self-destructive behaviour, with an accompanying alteration in terminology, from "self-mutilation" to "non-suicidal self-injury" and "deliberate self harm."²⁰ Despite their importance, however, clinical works like Favazza's cannot address many interesting historical questions, through his assumption that self-mutilation is, at root, an entity that can be defined. In this thesis, I ask: Why did self-mutilation become defined as a specific symptom of mental illness in the late nineteenth century? What forms of behaviour were so classified, and what new angles can these acts, and the ways in which they were understood, offer for understanding late nineteenth-century society? In what ways was self-mutilation pathologised (for example the creation of new terminology), and what new perspectives might this offer on the history of the psychiatric profession and patient care? In what ways did nineteenth century patients interpret their "self-mutilation," and did the creation of the category alter the ways in which they viewed themselves?

Similar questions have been explored in two historical works that directly focus on self-inflicted injury, exploring the emergent concept of "delicate self-cutting" in the 1960s. Both Barbara Brickman and Chris Millard have described the creation of a "psychiatric syndrome" in this period, with Millard in particular emphasising the way in which both the behaviour of cutting and a "cutter profile" were emphasised by the exclusion of all cases that did not meet agreed criteria. Cutters were assumed to be white, teenage, intelligent,

¹⁹ Favazza, *Bodies Under Siege*.

²⁰ Erwin Stengel and Nancy Cook, *Attempted Suicide: its Social Significance and Effects* (London: Oxford University Press, 1958); Erwin Stengel, *Suicide and Attempted Suicide*, (Harmondsworth: Penguin Books, 1967); H. G. Morgan, *Death wishes?: The Understanding and Management of Deliberate Self-harm* (Chichester: John Wiley, 1979).

attractive and female, and the very adoption of the epithet “delicate” served to perpetuate gender stereotypes. Male cutting, by contrast, was deemed to be “coarse”.²¹ As the amount of material published by these clinicians on their hospital patients increased, the “cutter profile” was subsequently disseminated by the media, and assumed to apply to all populations engaging in self-injurious behaviour.²² As with anorexia nervosa a decade earlier, by the 1990s self-harm was portrayed in clinical literature, newspapers, popular magazines and television programmes in both Britain and the United States as a modern “epidemic.”²³ The sudden appearance of this self-mutilation “phenomenon” has been little questioned: analysis of the emergence of self-mutilation as a medically-defined behaviour seems to be an important chapter missing from such debates.

This thesis argues that the creation of the category of “self-mutilation” in late nineteenth-century England provides an important context for understanding the emergence of other discourses on self-mutilation in the twentieth century. It also offers an opportunity to explore the boundaries of psychiatry in this period. Self-mutilation, for many nineteenth-century psychiatrists, was presented as a dramatic illustration of both scientific and popular concepts of abnormal behaviour, particularly those characterised by impulse. This encouraged reflection on normal psychology, by emphasising the importance of control and balance in the new science of the mind. Within a medical framework, the concept of self-mutilation was potentially viewable as “evidence” of either anatomical (brain) lesion, pathological instinct or functional disorder, externally visible in life rather than requiring post mortem dissection. The unarguable physical presence of external bodily damage situated self-mutilation as seemingly objective proof of several possible theories; choosing between these might require the input of the individual him or herself (for, unlike suicide, self-mutilation furnished the psychiatrist with a living subject for investigation), as well as the involvement of contemporary understandings of selfhood and belief in the existence of “hidden meanings” behind individual actions. While this approach meant that self-mutilation *could* be regarded as proof of almost any element of psychiatry, psychology or neurology, in practice those writing on the topic tended towards a view of the individual that emphasised a mental, rather than a physical, context to self-inflicted injury, even when they entered the

²¹ Brickman, "'Delicate' Cutters"; Chris Millard, "Self-mutilation and a Psychiatric Syndrome: Emergence, Exclusions & Contexts (1967-1976)" (unpublished MA thesis, University of York, 2007)

²² Brickman, "'Delicate' Cutters".

²³ P. M. Rosen and B. W. Walsh, "Patterns of Contagion in Self-Mutilation Epidemics," *American Journal of Psychiatry*, 146, no. 5 (1989): 656-658; Joan Jacobs Brumberg, "From Psychiatric Syndrome to 'Communicable' Disease: the Case of Anorexia Nervosa," in *Framing Disease: Studies in Cultural History*, ed. Charles Rosenberg and Janet Golden (New Brunswick: Rutgers University Press, 1992), 134-154.

topic from a physiological or neurological perspective. Throughout, I use the term “physiological” to refer to somatic concepts of self-inflicted injury, which were founded on the assumption that self-mutilation could be explained in terms of organic bodily processes. Where these are explicitly stated to be located in the brain or nervous system, I use the term “neurological” to refer to the framework within which such definitions were incorporated. More generally, I use the term “psychological” to apply to explicitly *mental* explanations for self-injury (in particular, but not limited to, the notion of “motive”): an impulse or idea that was *not* specified as located within the bodily functions.²⁴ Modern readers, who may assume that organic and psychological processes can be clearly distinguished, will no doubt be surprised by the extent of the overlap in nineteenth-century medical thought. Indeed, an absolute separation between the late nineteenth-century discipline of neurology, the earlier framework of “physiological psychology”, practical and legal attention to behaviour and explicit interest in mental processes can rarely be made. This study of self-mutilation thus illustrates the complexity of nineteenth-century concepts of psychological medicine, which cannot be understood from a simple dualist perspective in which mind and body are regarded as separate entities.

Context and Methodology

In the twenty-first century newspapers referenced previously, the headlines indicate an easy use of current psychiatric terminology, in particular the phrase “(deliberate) self-harm.” Used as both noun and verb, this diagnostic description is also utilised by the press to create a category of person: “the self-harmer”.²⁵ A century earlier, the *British Medical Journal* published an “Address on the Borderland of Insanity” delivered by George Savage, former Superintendent of Bethlem Royal Hospital and Consulting Physician for Mental Diseases at Guy’s Hospital. This “borderland” – the area perceived by late nineteenth-century psychiatrists to form a shadowy margin between insanity and sound mind – was described by Savage as inhabited by a variety of individuals who could not be certified as insane, but nonetheless presented social, legal and moral issues for those around them.²⁶ Among these was “the Self-Mutilator.” In both these instances, a hundred years apart, a particular type of individual was defined and set apart as a distinct group, outlined by a

²⁴ I recognise that these specific usages of the terms may not be shared by historical actors and I thus indicate instances where they apply these concepts in a significantly different manner.

²⁵ The term was added to the *Oxford English Dictionary Online* in 2006, with its earliest use dated back to 1980.

²⁶ George Savage, “An Address on the Borderland of Insanity,” *British Medical Journal*, 1, no. 2357 (1906): 489-492, p. 490.

common behaviour – the self-infliction of injury. In neither instance does the term convey to us anything about the individuals within that group, who undoubtedly exhibited more differences than they did commonalities. Nor does it tell us anything about the reasons for their inclusion within a psychiatric framework: in both instances, this is assumed to be self-evident. Both terms are used to describe an apparently specific population, depersonalising the individuals involved to create an object of scientific inquiry: speaking “in the species mode,” as Ian Hacking has termed it.²⁷

Yet, in both cases, we are also entering at the end of the story. As this study will show, the creation of such categories is in no way self-evident. The approaches of several other writers have proved particularly useful in informing my approach. In the first instance, Ian Hacking’s insightful model for “making up people” has aided my efforts to unpick a category without requiring the deconstruction of the behaviour – self-mutilation – itself, thus avoiding the necessity of searching for a false “reality” behind all the various discourses. After all, on the surface, self-mutilation appears to be a fairly clear descriptive term. Given the obvious physical reality of many such injuries, it would be ludicrous to suggest that, before late-nineteenth-century psychiatrists defined “self-mutilation”, self-inflicted injury did not exist. Instead, we can suggest that, before the late-nineteenth-century, people did not consider themselves to be self-mutilators, nor were they defined by others in this way: acts were considered quite separately from individuals.²⁸ Thus, while self-mutilation as a physical act may well have occurred throughout history and culture, self-mutilation as a specific category was created in the nineteenth century, by diverse methods and for a variety of purposes, and with particular consequences for those so defined. It is these methods, motives and effects that I explore in this thesis.

An additional concern I have faced throughout my research has been the potential of my work to exalt the very definitions I wish to deconstruct. The descriptive noun “self-mutilator” suggests that self-inflicted injury can define the very essence of someone who practices it. But even a person affected by profound physical consequences resulting from self-mutilation will have many daily experiences that do not involve, or even relate indirectly to, self-inflicted injury. Most of the sources I examine, however, describe the encounters of these people with the medical profession, whether in asylums, hospitals or general practice: other aspects of their lives are noticeably absent. By probing the topic of self-mutilation

²⁷ Ian Hacking, "Kinds of People: Moving Targets," *Proceedings of the British Academy*, 151, (2007): 285-318, p. 313.

²⁸ For more on this topic, see also Hacking, *Mad Travelers: Reflections on the Reality of Transient Mental Illnesses*; Ian Hacking, *Rewriting the Soul: Multiple Personality and the Sciences of Memory* (Princeton: Princeton University Press, 1998).

through such records, I run the risk of doing just what the medical practitioners I study do: classifying people by virtue of just one act or experience among many. I thus aim to retain this concern at the forefront of my research, regularly questioning the status of self-mutilation as a category within nineteenth-century medicine, taking my lead from other authors in the history of science who have sought to destabilise the very concepts that form their starting point for enquiry.²⁹ Accounts of self-inflicted injury, however, are understood as telling us more about the authors of these accounts, and their social and political context, than the individuals described therein. It should be remembered, however, that these latter were real people, whose own interpretations of their often troubled experiences may, or may not, have coalesced with those of their doctors. Exploring the psychiatric meanings attributed to self-mutilation is in no way intended to be dismissive of the genuine engagements that people, past and present, have had with self-inflicted injury, whether as practitioners or their carers. Indeed, I aim to offer the opposite perspective: by opening out the topic of self-mutilation I suggest that no one meaning should be claimed to be more “true” or genuine than any others or, indeed, that no one instance can be regarded as representative of the experiences of diverse individuals.

Historiographical concerns have also informed my choice of sources. As I did not wish to impose a modern understanding of self-harm onto nineteenth-century texts, I began with published definitions from this period. Almost all of these were written by alienists – asylum psychiatrists – and my research thus extended into the institutions of these practitioners. In particular, three of the writers on which I focus (George Henry Savage, Daniel Hack Tuke and Theophilus Bulkeley Hyslop) had long-running associations with one particular institution: the Bethlem Royal Hospital. Britain’s oldest asylum, Bethlem’s position fluctuated during the nineteenth century; it was at various times a focus of scandal and supposed maltreatment (particularly, but not only, during the investigations of 1814-15 and 1852-3)³⁰ and a beacon of hope, held up as a model institution with an exceptionally high cure rate.³¹ Unlike other psychiatric hospitals, Bethlem admitted only “curable” patients: those who had been ill for less than a year, and did not seem to be suffering from epilepsy or general paralysis of the insane. Patients usually received a year of free treatment (with possible extension if showing improvement) before discharge at which, throughout the

²⁹ For example: Steven Shapin, *The Scientific Revolution* (Chicago; London: University of Chicago Press, 1998); Danziger, *Naming the Mind*.

³⁰ For background, see Jonathan Andrews et al. *The History of Bethlem* (London: Routledge, 1997). A good overview of the scandals is also incorporated in the popular history: Paul Chambers, *Bedlam: London’s Hospital for the Mad* (Hersham: Ian Allen, 2009).

³¹ See “A Visit to the Royal Hospital of Bethlehem.” *Illustrated London News*. 24 Mar. 1860. Bethlem Royal Hospital Archives (BRHA), NEW-22. Series Box G0060.

century, around 50% of those admitted were regarded as cured. The Bethlem Archives hold a variety of sources, including Annual Reports, minutes of meetings, a hospital magazine, *Under the Dome* (from 1892) and patient case books throughout the period under investigation. Case records offer an interesting, but often problematic, source for the historian. Notes are sporadic, often vague and incomplete, and patient narratives are predominantly those transcribed and interpreted by doctors.³² Moreover, a large number of different individuals might be involved: case books in nineteenth century Bethlem were completed ad hoc by all of the Hospital's medical officers, from superintendents to clinical assistants (newly qualified medical practitioners who applied for a six month period of asylum experience, and thus changed regularly). Despite these issues, however, patient records can be revealing of psychiatric diagnosis and treatment. Akihito Suzuki, for example, used the mid-century Bethlem case books to suggest that the family was gradually disenfranchised from psychiatric discourse in the 1850s, although the patient often played an active role in influencing alienists' ideas of illness.³³ What's more, case materials were extremely important for alienists themselves: their work was based in practice (and often teaching) as much as publication.³⁴ They serve as a useful comparison to published material, in that they indicate the flexible and changing nature of psychiatric approaches. The conclusions alienists drew about self-mutilation in published material are *not* necessarily evident in their practices.

A number of Bethlem's medical officers during the late nineteenth century were conspicuous in the self-mutilation debate. George Savage, Resident Physician-Superintendent between 1878 and 1888, wrote on self-mutilation and moral insanity and, later, hysterical self-mutilation (and "the self-mutilator"). Theo Hyslop, at Bethlem from 1888 – 1910 (first as Assistant Physician, later Superintendent) regarded self-mutilation in sociological and psychological terms, which will provide the topic of discussion for chapter three, while the work of Maurice Craig, appointed as Junior Assistant Physician in 1894, on hysteria will be briefly discussed in chapter five. Alienist and asylum historian Daniel Hack

³² Although many cases in the Bethlem case books for this period include letters and other documents written by patients themselves. Again, however, these sources form material *selected* by doctors, perhaps from among many letters which might have been included. For more on the topic of case notes, see 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*, 11, no. 2 (1998): 255-281.

³³ Akihito Suzuki, "Framing Psychiatric Subjectivity: Doctor, Patient and Record-keeping at Bethlem in the Nineteenth Century," in *Insanity, Institutions and Society, 1800 - 1914*, ed. Joseph Melling and Bill Forsythe (London: Routledge, 1999), 115-135.

³⁴ As indicated in George Savage's annual report to the governors in 1885: BRHA, *Annual Report 1885*, BAR-22, p. 37.

Tuke was also a governor at Bethlem from 1872 until his death in 1897: it was he who decided to include self-mutilation in his *Dictionary of Psychological Medicine* (1892). Other alienists of particular interest are George Fielding Blandford, a physician in private practice, whose textbook on insanity incorporated one of the earliest attempts to define the term in the 1870s, and James Adam, author of the entry in Tuke's *Dictionary* and proprietor of private asylum, West Malling Place.

These alienists were elite practitioners, and their views should not be taken as reflecting the opinions of all alienists in this period. Their involvement in teaching and research (in most instances) set them a rank apart and may have contributed to their interest in a field of investigation that was not necessarily the focus of all – or even many – of their contemporaries. Meanwhile, their experiences with wealthy or educated patients (in private or middle class charitable institutions) may also have shaped the field of discussion, as did the fact that all were known to each other. Nonetheless, their ideas certainly emerged from their asylum practice, and many of these alienists were also highly regarded spokesmen for the asylum system. Their efforts to define and explain the topic of “self-mutilation” can thus provide an interesting window into theory and practice of the period. I thus examined every case record – at Bethlem and West Malling Place – over a twenty year period (1880 to 1900), creating a database of all instances of self-mutilation that fitted the definitions provided by practitioners in their published writings. This generated 592 records (all from the Bethlem archive: only one case was found at the tiny Malling Place, which will be discussed separately in chapter four). In addition, I maintained separate records of suicide attempts and food refusal for comparative purposes.

In addition to these records, I explore published textbooks and journal articles on the topic of self-mutilation, from periodicals including *The Journal of Mental Science*, *The Lancet* and the *British Medical Journal*. Published texts outside the field of psychiatry also proved important, and were often referenced by alienists. Of particular use were texts in the fields of psychology, anthropology, evolutionary biology and sexology, as well as fictional works and commentary in popular journals. Newspapers indicated some of the ways in which self-mutilation was presented and understood outside a medico-scientific context. My major sources were *The Times*, *The Guardian* and the *Illustrated London News*, as well as the British Library’s online database of seventy-one local and national newspapers. Later chapters also incorporate work from additional archives, examining the case notes of patients who were not certified as insane. In chapter three, I analyse the case records of patients diagnosed by physicians as “malingering” at the National Hospital for Neurology,

Queen Square. In chapter five, I examine patients admitted to the Royal London Hospital for the removal of “foreign bodies” and also the extensive folders on “hysterical malingering” compiled by dermatologist Frederick Parkes Weber and held in the Wellcome Library.

My research focuses on the years 1880 – 1900, a pivotal period in psychiatry and psychology. It was in this period that the first major definitions of self-mutilation were published, and interest in the topic expanded in Britain. It was also in these decades that alienists began to move outside the asylum, offering treatment for “borderland” cases, which encouraged extension of the concept of self-mutilation. Chapter one also incorporates early material on self-mutilation, from around 1860, while later chapters (particularly the last two, on sexology and hysteria) extend into the twentieth century. My examination of published sources suggests that alienists related particular “major” or “minor” mutilations to certain fields of inquiry: thus, each chapter focuses on a particular act, and a particular subset of the Bethlem case records. It should be remembered that these distinctions were by no means absolute and, although for the sake of coherency of structure I have limited the discussion of archival sources in each chapter to those relating to the specific behaviour under investigation, in published material there will be seen to be a great deal of crossover. My conclusions aim to take my own imposition of structure onto the nineteenth century sources into account.

Chapter Outlines

I begin with a broad overview of the topic, and the way in which it was categorised within the asylum, from the 1860s until the early 1890s. Chapter one offers a background to asylum psychiatry of the period, indicating how psychiatrists interpreted the individual mind as composed of intellect, emotion and volition, and how self-mutilation was regarded in terms of the breakdown of one of these mental faculties. In some instances, the emphasis on physiological concepts of the will promoted an understanding of self-mutilation as a physical phenomenon, revelatory of unseen bodily processes. Such accounts, which here focus on the so-called “major mutilations” of castration, enucleation and amputation, show little interest in the actual act of self-wounding, or professed motive, assuming the injuries themselves to be evidence of physical pathology. Beginning with a discussion of mid-nineteenth century British physiology, I indicate the ways in which the problematic relationship between impulse and “the will” in the work of W.B. Carpenter and Thomas Laycock was subsequently adopted by psychiatric theorists, and used to articulate concepts of self-mutilation. Much psychiatric literature in England relied on vaguely physiological notions of volition, inhibition and impulse, part of a common discourse shared by patients.

This view of self-inflicted injury was, however, rarely the only explanation proffered in British psychiatry: indeed, without additional interpretations, suggesting that self-mutilation was of psychological or social importance, the topic would not have received attention as a particular psychiatric symptom. I thus argue that we cannot understand late nineteenth-century self-mutilation solely as a physiological concept, or as a definition created and imposed theoretically. Definitions of self-mutilation stemmed from asylum practice, and were regarded to have intellectual and emotional content as much as they were perceived as physiological demonstrations of (the absence of) volition.

Chapter two explores the parallels drawn by evolutionary theorists between the so-called mutilations of “savages” and acts of self-inflicted injury carried out within and outside asylums in Britain. Here, self-mutilation was viewed as evidence of more than just a failure of bodily function, but indicative of a more general state of physical and moral degeneration, of both individual and race. This pessimistic perspective led to broad assumptions about the character (hereditary or acquired) of the individual, drawn from the self-infliction of a wound, and the direct association of certain traits (introspection, selfishness, excitability and a lack of emotional control) with the act of self-mutilation. I argue that the topic of self-mutilation was not located solely within the asylum, but constituted in relation to other practices. I relate this to the concept of the body as the physical “self,” with a focus on two particular forms of mutilation, skin (particularly face) picking and hair plucking. These two highly visible behaviours were incorporated into medical definitions of self-mutilation, even though they did not meet the legal meaning of “mutilation” as damage or loss of function to some significant part. Such actions, however, marked the most visible areas of the body, the head and face, and were thus often the most obvious “abnormal” acts to others. The understanding of face-picking and hair-plucking within an evolutionary context ensured that these acts were regarded as damaging not only to the bodies of individuals, but also to the race, civilization and the state. This suggests that, in addition to serving the scientific and professional aims of alienists themselves, the category of self-mutilation needs to be situated much more broadly in concerns over social cohesion.

Chapter three focuses on what Armando Favazza terms “stereotypic mutilation”: repetitive movements, in particular head-banging. While modern writers relate such behaviours to autism and learning disabilities, the nineteenth-century understanding of head-banging was markedly different.³⁵ Alongside the pessimistic, degenerationist model of psychiatry outlined in the previous chapter, another means of approaching psychiatry within

³⁵ Favazza, *Bodies Under Siege*, pp. 237-40.

the late Victorian period focused on the individual, and an individualist basis was still claimed to be the foundation for much asylum practice. This approach had its roots in moral treatment – incorporating humanitarian paternalism as well as the potential enforcement of social values – but also included new methods of understanding and interpreting the human mind within experimental psychology. Indeed, the vast majority of alienists who wrote on the topic of self-mutilation explicitly claimed that attention to mental motive was an essential element of understanding self-inflicted injury. They assumed that the ideas of the insane, like those of the sane, could be interpreted and analysed as part of a rational model of understanding, and suggested the view that self-mutilation held intellectual or emotional meaning for the individual (whether consciously understood by him or not) that could shed light on a broader understanding of normal and abnormal motivation. By incorporating notions of self-consciousness, dissociation and the subliminal self (from the writings of William James in North America, Frederic Myers in England and Pierre Janet in France) into their practices, certain alienists came to view self-mutilation as an *act*, rather than a wound, and thus a mental event quite separate from the physical wounds incurred.

Chapters four and five constitute a departure from the first half of the thesis, by exploring two specific ways in which late nineteenth-century self-mutilation was constituted: “sexual” and “hysterical” self-mutilation. Both labels were applied within and outside the asylum, and “hysterical malingering” in particular was in widespread use in general medical practice at the turn of the twentieth century. These two concepts of self-inflicted injury were interpreted and understood in relation to prior notions of gender-specific attributes, and received attention well beyond their actual reported occurrence in asylum and hospital records. It would be easy to assume that both concepts were entirely situated within the pessimistic doctrine of degeneration. However, a close look at contemporary medical practice indicates a much more nuanced picture, whereby psychiatrists might regard an act of self-mutilation as threatening society, but also – often simultaneously – as a reaction (conscious or ‘unconscious’) to the problematic demands of the social structure: sometimes even a form of legitimate social or political protest.

In male psychiatric patients, self-mutilation was frequently claimed to be associated with sexual pathology. While the concept of “sexual self-mutilation” discussed in chapter four might initially appear to be purely descriptive (in that it was usually applied to attempted or successful castration), in practice the definition had very distinct parameters. Sexual mutilation was perceived to be an exclusively male act (women who injured their genitalia did not receive the same attention), and was frequently related to broader

discussion of sexual pathology, in particular the two fields seen as of particular concern to masculine values in this period: masturbation and homosexuality. Castration was a major topic in published texts on the topic of self-mutilation, in psychiatry and beyond and yet, as an act, it was relatively uncommon. The interest in castration in this period thus needs to be seen in relation to specific medical and social concerns. Unlike in modern texts, it was not always assumed that self-castration was necessarily related to either severe mental disturbance or gender identity. Other assumptions were, however, made about an individual who had injured himself in such a way. The eunuch was claimed to be not only the opposite of masculine virility, but the very enemy of society: selfish and impulsive. Castration, it was claimed, changed the very personality of the individual.

The belief that self-mutilation might originate in a desire for the sympathy of others remains strong today.³⁶ In the last decade of the nineteenth century and the beginning of the twentieth, this so-called “senseless desire for sympathy” was positively linked to the diagnosis of hysteria.³⁷ Chapter five examines the position of women around the turn of the twentieth century through the way in which the “hysterical self-mutilator” was represented. American doctors George Gould and Walter Pyle retrospectively created the category of the “needle girl,” building on English surgical reports of “hysterical self-mutilation.” This chapter therefore concentrates on self-mutilation through the insertion of pins and needles into the skin, or the swallowing of similar foreign bodies. So-called “hysterical self-mutilation” emerged from a complex combination of influences. These included physiological interest in the hysterical symptom of cutaneous anaesthesia; an emphasis on individual character through the perceived manipulative tendencies of the hysterical female and the social and political problem of “malingering”, as well as a psychological interpretation: that hysterical mutilation had its origins in the unconscious mind. Generally assumed to be female, the “motiveless” hysterical malingerer was often contrasted with the pursuit of gain claimed to be evident in her male counterpart. Nonetheless, she was regarded as similarly deceptive, even when her emotional needs were perceived as being beyond the patient’s conscious control. Thus, it was within a hysterical context that self-mutilation became particularly associated with character, through the personification of the hysterical self-mutilator.

These outlines should give some idea of the complexity of the topic, and the vast number of elements which contributed to the emergence of the category self-mutilation in late nineteenth and early twentieth-century Britain. Were alienists who considered this

³⁶ Klonsky, "The Functions of Deliberate Self-Injury"; Camelot Foundation, *Truth Hurts*; Gratz, "Measurement of Deliberate Self-Harm", p. 254.

³⁷ Ernest Hart, "Hysteria: Wilful Self-Infliction of Injury," *The Lancet*, 79, no. 2014 (1862): 355.

category exploring behaviour or motivated action? The individual body or the social environment? Universal truths or individual cases? There were, and are, no clear answers to these questions, a situation of which many Victorian psychiatrists were surprisingly well aware. While this thesis concentrates predominantly on British sources, it should nonetheless be seen within a wider context (as indicated by the inclusion of texts from other countries, where referenced by British writers): part of a broad concern over degeneration, social unrest and gender roles within the western world at this time. Literature on self-mutilation appeared in French (*automutilation*), German (*selbstverstümmelung*) and North American texts within psychiatry, psychology and other fields of medicine, including dermatology. Just as the topic cannot be neatly incorporated into a scientific discipline, so nineteenth-century psychiatric debate can rarely be said to be wholly national, although it could certainly serve nationalistic policies. Thus, sources from other countries are often included in my discussion, whether as a comparison to English definitions of self-mutilation, or evidence of a broader context to concerns over national health and social unrest.

This comparative approach will, I hope, encourage reflection on the position of psychiatry in late Victorian England. Traditionally assumed to be something of an intellectual backwater, the topic of self-mutilation indicates that many alienists were very interested in developments in normal and abnormal psychology in other countries, as well as other fields of research.³⁸ Thirty years ago, Michael Clark identified late Victorian psychological medicine in Britain as having incorporated, for the first time, the efforts of psychiatrists to combine normal and abnormal psychology into a single, unified framework, as well as to integrate psychiatry into contemporary discussion of broader philosophical, scientific and social questions.³⁹ Clark's sensitive account of the period is persuasive, yet historians today continue to dismiss the period in sweeping statements about degeneration, eugenics and custodialism.⁴⁰ While recognising that all these concerns are certainly relevant, this thesis will indicate their inadequacy to do justice to late nineteenth-century psychiatric theory and practice, which also incorporated other frameworks, including the psychological and spiritual. While material and spiritual approaches to mental illness are often regarded as

³⁸ For this view, see W. F. Bynum, "Themes in British Psychiatry, J.C. Prichard (1786 - 1848) to Henry Maudsley (1835 - 1918)," in *Nature Animated*, ed. Michael Ruse (Dordrecht; Boston; London: D. Reidel Pub. Co, 1983), 225-242, p. 225; Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven: Yale University Press, 1993).

³⁹ Michael J. Clark, "'The Data of Alienism': Evolutionary Neurology, Physiological Psychology, and the Reconstruction of British Psychiatric Theory, c.1850 -c.1900" (unpublished PhD thesis, University of Oxford, 1982), esp. p. 29, 300 and all of chapter 7.

⁴⁰ For one recent example, see Barbara Taylor, "The Demise of the Asylum in Late Twentieth-Century Britain: A Personal History," *Transactions of the Royal Historical Society*, Sixth Series (21), (2011): 193-215, pp. 207-8

incompatible from a presentist perspective, this thesis shows that this was by no means the case in the late nineteenth century: thus, the various layers of explanation for self-inflicted injury offered by alienists in this period might often appear contradictory by modern standards. The sheer variety of explanations, and the manner in which certain elements were accepted or rejected across disciplines will, I hope, give the reader pause for thought in his or her conceptions of self-harm today. The “hysterical self-mutilator” bears many similarities to the “cutter profile” described by Brickman and Millard in the 1960s: yet this was just *one* of a number of late nineteenth century incarnations of self-mutilation, indicating the importance of examining the reasons for the adoption of particular models rather than accepting them as pre-existing entities. What, I ask, ever made it seem desirable to combine so many different elements into one general category in the first place?

Finally, while writing this thesis, the reactions I have encountered from those around me have often been surprising. While not quite so vehement as the “disgust” Armando Favazza reported while researching *Bodies Under Siege* in the early 1980s, it is evident that the topic invites much conjecture.⁴¹ Historians of medicine, often in a manner rather at odds with their own work, have regularly asked me “why” people in the nineteenth century mutilated themselves (as if there might be a universal explanation), whether they exhibited the “same” behaviours as today (suggesting that self-mutilation might be a natural entity), or asking whether more women “cut themselves” than men: never apparently stopping to consider that these very questions might perpetuate myths about self-mutilation. I have also frequently been questioned as to my own motives for pursuing the topic: one apparently so bizarre that only a “self-mutilator” would find it of interest. I choose not to address this question here. By so-choosing I aim to emphasise the way in which such classification is potentially disempowering and delegitimising. I thus highlight, once again, the problematic nature of defining a group of people as diverse as those who appear in this study purely by one arbitrary characteristic, which, as this thesis shows, may then lead to a host of associated (and frequently unfounded) assumptions. Rather than assuming interest only stems from self-involvement, I invite the reader to explore the way in which unpicking the category of self-mutilation can lead us to question the very nature of identity and the existence of a unified self.

⁴¹ Favazza, *Bodies Under Siege*, pp. xiii-xv.

Chapter One

From Self-Injury to Self-Mutilation: Medicine and the Somatic Self (1864 – 1894)

1.1 Introduction

In the second half of the nineteenth century, the term “self-mutilation” began to appear in asylum psychiatric literature: seemingly a new addition to the medical lexicon, endorsed by inclusion in Daniel Hack Tuke’s *Dictionary of Psychological Medicine* in 1892.⁴² Alienists (asylum psychiatrists) generated the majority of published discussion on the topic, and I, therefore, begin by outlining the context within which this debate emerged: nineteenth-century asylum psychiatry. What purpose did the creation of a new category of psychiatric symptoms serve for alienists and their patients? To what did it refer? Why was the category created in the second half of the nineteenth century in particular? What factors influenced the ways in which self-mutilation was described and presented by alienists? By examining the key theories behind literature on self-mutilation, I will outline the importance of the asylum context in early discussion of the topic, which subsequently moved beyond the asylum walls. It should be recognised from the start, however, that disciplinary boundaries were porous and often contested. In their efforts to describe the mental make-up of the individual as a balance between the so-called faculties of intellect, emotion and volition, alienists frequently incorporated material from other fields, including physiology, evolutionary biology, experimental psychology and anthropology. Throughout, I argue that self-mutilation cannot be regarded simply as a descriptive category of behaviours witnessed by alienists in their patients or, indeed, as an effort by alienists to gain “psychiatric power” through the classification of behaviour.⁴³ Instead, the concept was closely related to psychiatric theory and practice, in addition to social and political concerns outside the asylum.

Prior writing on asylum psychiatry provides a backdrop for this thesis. Following a short introduction on the emergence of terminology, I begin with an outline of the ways in which self-mutilation can be located within this historiography: in particular, through associations with suicide. I indicate the complexity of a debate which borrowed from, but nonetheless claimed to be distinct from, the suicide literature. The relation to suicide is used

⁴² James Adam, "Self-Mutilation," in *A Dictionary of Psychological Medicine*, ed. Daniel Hack Tuke. (London: J. & A. Churchill, 1892), 1147-1152.

⁴³ While Foucault’s ideas have certainly proved valuable to the history of psychiatry, rigid application of his approach by later writers has led to a historiography skewed towards power/knowledge relationships, and away from practice. Michel Foucault, *Psychiatric Power: Lectures at the Collège de France 1973-1974*, ed. Jacques Lagrange, trans. Graham Burchell, (Basingstoke; New York: Palgrave Macmillan, 2008)

to highlight the importance late nineteenth-century alienists placed on the idea of “motive”: insane behaviour, it was newly felt, could not be taken for granted as “irrational”, but had to be interpreted at the level of causation. Indeed, as the second section of the chapter argues, the belief that examination of self-mutilation might promote the discovery of some universal motivational force underpinned most psychiatric efforts to analyse the topic. This force, or “motive power” (as it was often termed) was, in itself, a complicated construct that can – and could – be interpreted in a variety of ways. Some alienists, inspired by German neurologist and psychiatrist Wilhelm Griesinger, adopted a somatic interpretation of this force, based on physiological descriptions of reflex action and inhibition, in addition to associations with the physical sciences, in particular thermodynamics. Nonetheless, analysis of early British publications on the topic indicates that many alienists viewed self-inflicted injury in relation to explicitly mental, as well as biological, categories – intellect, emotion and “the will” owed as much to faculty psychology as to a model based in the natural sciences.⁴⁴ In addition, an interest in the role of external factors – such as the environment or society – is often evident.

The notion of “motive” incorporated all three methods of interpreting behaviour: biological, psychological and socio-environmental. It also incorporated assumptions about the nature of mind, generally perceived by alienists in this period as divided into the three distinct faculties indicated above.⁴⁵ For late-century alienists, there were thus three ways of studying the development of mind: the biological evolution of its structure; its manifestations (in particular, the study of civilization), and the development of the individual.⁴⁶ All three of these perspectives will emerge in the study of self-mutilation outlined here. The final section of this chapter also investigates the ways in which these theories relied upon – but could also be contradicted by – asylum practice. Thus, the fundamental question underpinning many of these concerns did not, for Victorian alienists, necessarily centre on a distinction between biological and metaphysical concepts of mind: or, indeed, a divide between physical and emotional pain. Instead, alienists focused on the

⁴⁴ Lorraine J. Daston, "The Theory of Will versus the Science of Mind," in *The Problematic Science: Psychology in Nineteenth-century Thought*, ed. William Ray Woodward and Mitchell G. Ash (New York: Praeger, 1982), 88-115.

⁴⁵ Most alienists stated (albeit incorrectly, for the idea pre-existed Bain) that they were indebted to Bain's Association Psychology for this tri-partite division. Alexander Bain, *The Emotions and the Will* (London: John W. Parker, 1859); Alexander Bain, *The Senses and the Intellect* (London: Parker, 1855). For the increasing popularity of this model, endorsed by Kant and Schopenhauer, in the nineteenth century, see Thomas Dixon, *From Passions to Emotions: the Creation of a Secular Psychological Category* (Cambridge: Cambridge University Press, 2003), p. 70, p. 158; Kurt Danziger, *Naming the Mind: How Psychology Found its Language* (London: Sage Publications, 1997), p. 64.

⁴⁶ Theophilus Bulkeley Hyslop, *Mental Physiology: Especially in its Relations to Mental Disorders*, (London: J. & A. Churchill, 1895), p. 150.

differentiation of the individual from his environment. Was it, they wondered, a malfunction in the individual's biology or moral character (perhaps directly inherited) that made him or her present behaviours, like self-mutilation, which appeared to contradict the so-called "natural impulse" of self-preservation? Or was the "unnatural" state of civilization and society to blame, prompting human beings to damage their own bodies? The topic of self-mutilation within asylum psychiatry can thus be regarded as closely related to efforts to define the "self" as an individual with distinct mental and physical limits. Understanding the limits of the individual opened up ethical, social and political questions, which could not be solved simply by an appeal to naturalistic theories of development. Nonetheless, many alienists continued to hope that a physiological approach to behaviour – seemingly made externally visible by acts of self-mutilation – would shed light on both abnormal and normal psychology. A search for meaning behind acts of self-mutilation was thought to aid in the explanation of medical and moral concepts of the will and self-control, as well as efforts to integrate the nineteenth century "self" into wider society.

1.2 Terminology: The Creation of a Category of Self-Mutilation

The concept of "self-mutilation" appears to have emerged from a slightly earlier interest in "self-injury", and the two terms continued to be used interchangeably. Although there are linguistic differences, both purported to be a neutral description of an observed act or wound. From January 1844, standardised admission papers to the Bethlem Royal Hospital (which, until 1853, was not incorporated under the Lunacy Acts) enquired whether a patient was "disposed to suicide, or otherwise to self-injury," suggesting separate, albeit related, symptoms of mental disorder.⁴⁷ Self-injury, while ostensibly distinct from suicide, referred to a wide variety of acts, including refusal of food and attempted suicide: as indicated by the diversity of answers listed in the Bethlem admission papers. Many patients were listed merely as "Suicidal," often with no further detail appearing elsewhere. Other entries, however, provided information on suicide attempts or, alternatively, what might appear to a modern reader to be non-suicidal forms of self-injury. For example, in 1853, 23-year-old Henry Millbank "picks himself" and "has now several sore places on his head, face and legs from picking and scratching himself", while Sophia Warner has "a disposition to injure herself by knocking her head against the wall and biting herself".⁴⁸ Self-mutilation

⁴⁷ This question was not altered until Bethlem belatedly became incorporated under the Lunacy Acts in 1853, and the reception order required under the 1845 Act (which referred only to suicide) was adopted. See BRHA, *Patient Case books 1844 – 1852* (CB/030 to CB/059).

⁴⁸ BRHA *Male Patient Case book*, 1853 (CB/060 - 25) & *Female Patient Case book*, 1853 (CB/061 – 33).

seems to have represented a more discrete category, although it was often admitted that the distinction from suicide was “perhaps a somewhat artificial distinction”, although it was still emphasised that “there *is* a distinction”.⁴⁹ Unlike the medical term “injury”, however, the word “mutilation” implied active intention and dramatic consequence, with strong associations to punishment as well as to crime, issues that will recur throughout this thesis. The acts described as self-mutilation varied from disabling to relatively minor injuries. By the 1890s, the definition extended to flesh-picking, biting, hair-plucking, punching or knocking against objects, cutting or otherwise removing part of the body, swallowing or inserting foreign bodies such as needles, and eating rubbish.⁵⁰

In 1755, when Samuel Johnson first published his famous *Dictionary*, he indicated that the word “self” was “much used in composition” but did not provide separate definitions for any of the nearly 100 terms he gave – including “self-slaughter”, “self-harming” and “self-preservation” – illustrating them entirely by quotation.⁵¹ Johnson did not include “self-mutilation” or “self-injury” in his list: nor did John Ash in his *Dictionary* of 1775 (among 114 compounds of self).⁵² Nineteenth-century dictionaries, medical or otherwise (except Tuke’s), also did not include “self-mutilation”, despite a seemingly ever-increasing number of derivatives of “self” from the mere eight included in Bailey’s *Etymological Dictionary* (1730).⁵³ By the publication of what was later to be called the *Oxford English Dictionary*, these “self” compounds ran to several densely-printed pages.⁵⁴ While such an increase can be viewed as indicating the emphasis placed on individualism by many Victorians, terms like “self-mutilation” and “self-sacrifice” can equally be viewed as indicating the reverse: a dissolution of “self”.⁵⁵ These two approaches to selfhood will form the topics of chapters two and three respectively: on the one hand, concerted efforts to integrate disparate elements into the creation of an individual (a self, which might be

⁴⁹ P. Maury Deas, “The Uses and Limitations of Mechanical Restraint as a Means of Treatment of the Insane,” *Journal of Mental Science*, 42 (1896): 102-113, p. 104 [my emphasis]. See also James Shaw, *Epitome of Mental Diseases: For Practitioners and Students* (Bristol; London: John Wright, Simpkin, Marshall, Hamilton, Kent, 1892), p. 31.

⁵⁰ For the clearest definition, see Maury Deas, “The Uses and Limitations of Mechanical Restraint”.

⁵¹ Samuel Johnson, *Dictionary of the English Language* (London: W. Strahan, 1755).

⁵² John Ash, *The New and Complete Dictionary of the English Language* (London: Edward & Charles Dilly, R. Baldwin, 1775).

⁵³ N. Bailey, ed. *Dictionarium Britannicum: or a More Compleat Universal Etymological English Dictionary* (London: T. Cox, 1730). See also Walter W. Skeat, *An Etymological Dictionary of the English Language* (Oxford: Clarendon Press, 1882).

⁵⁴ J. Murray, ed., *A New English dictionary on Historical Principles*, vol. 8, part 2, (Oxford: Clarendon Press, 1914).

⁵⁵ For the former view, see Thomas Dixon, *The Invention of Altruism: Making Moral Meanings in Victorian Britain* (Oxford; New York: Oxford University Press, 2008), p. 6.

mutilated); on the other, the depiction of self-mutilation as a *breakdown* of self, revealing disintegration of mind and personality.

It was only in the *Supplement* to the *Oxford English Dictionary* (1933) that “self-mutilation” was first included, as an “obvious compound” of “self.”⁵⁶ However, the discarded slips sent in by volunteer readers for the first edition do, in fact, include a quotation for the term.⁵⁷ The quote, from Grote’s *History of Greece* (1862), reads “[i]t appears that Grecian reserve always stopped short of the irreparable self-mutilation of Atys.”⁵⁸ While not a psychiatric reference *per se*, this quotation comes closer to psychiatric use of the term than those in later editions of the dictionary. Following the myth of the castration of Attis, the ancient cult of Cybele reputedly practised self-castration, which was cited by Victorian alienists as an example of historical self-mutilation.⁵⁹ From the decision to exclude “self-mutilation” from the first edition but include it in the 1933 supplement, we might conjecture an increasing use of the term within the public domain, although not necessarily in a medical sense. The *OED*’s readers were all volunteers, from a variety of backgrounds: none of them were necessarily interested in or familiar with asylum psychiatry. While several of the books chosen by the editors to be scoured for references did fall within the field (including Maudsley’s *Pathology of Mind* and Tuke and Bucknill’s *Manual of Psychological Medicine*), the very lack of clarity within psychiatric definitions is often indicated in quotations chosen from medical works.

This can be seen in the term “self-destruction”, illustrated in the *Dictionary* by one of many quotations from Allbutt’s *System of Medicine* (1899), from alienist Henry Rayner’s piece on “Melancholia and Hypochondriasis”: “Very commonly attempts at self-destruction or self-injury are made.”⁶⁰ Five pages previously, Rayner had made a similar point, but with different wording: “Perversion of self-feeling may culminate in self-loathing or hatred ... resulting in neglect of health, or even in self-mutilation and self-destruction.”⁶¹ That neither quote was suggested as illustrative of either “self-injury” or “self-mutilation” indicates both the lack of agreement over terminology within psychiatry, as well as perceptions (lay and medical) that self-injurious behaviour was akin to suicide, and thus did not need separate

⁵⁶ J. A. H Murray, ed., *The Oxford English Dictionary* (Oxford: Clarendon Press, 1933).

⁵⁷ Many slips were prepared from important books, decided on by the editors and distributed to readers, while other quotations came from texts readers themselves had chosen. For background on the dictionary, see Simon Winchester, *The Meaning of Everything: the Story of the Oxford English Dictionary* (Oxford; New York: Oxford University Press, 2003).

⁵⁸ Oxford University Press Archive (OUPA), un-numbered (discarded) slips for “self” from first edition.

⁵⁹ Adam, "Self-Mutilation", p.1147.

⁶⁰ H. Rayner, "Melancholia and Hypochondriasis," in *A System of Medicine*, ed. T. Clifford Allbutt. (London: Macmillan, 1899), 361-381, p. 371.

⁶¹ Rayner, "Melancholia and Hypochondriasis", p. 366.

definition. Such a relation is, of course, highlighted in both quotes when viewed in isolation. However, in the same article, Rayner distinguished between suicide (intentional self-destruction) and “self-homicide” (when death occurred following self-mutilation *without* suicidal intent), emphasising an interest in motive to which I shall return.⁶²

Despite the lack of clear definition, the term “self-mutilation” was in regular use by the mid nineteenth century (before its adoption by alienists), as indicated by searches of both medical journals and newspapers. I carried out a keyword search in *The Times* and regional and national papers in the *19th Century British Library Newspapers* database: in every case, this dated the appearance of the word in the early to mid-1840s (see Figure 1, below). Use of the term quickly increased to reach – and subsequently overtake – the rate at which the newspapers themselves were expanding (as shown by the control searches using the term “word”, use of which one would not expect to alter significantly), between around 1860 and 1890.

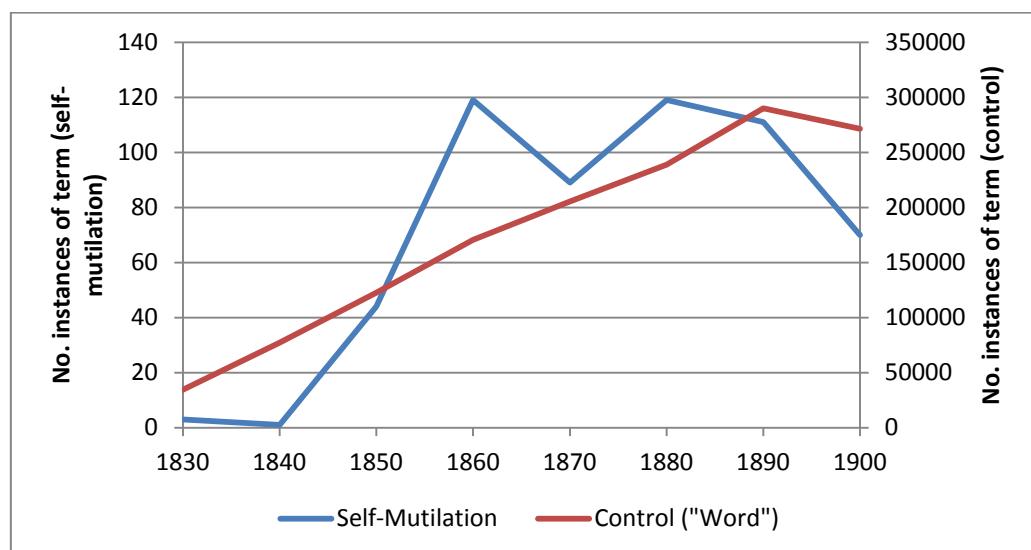


Figure 1: Graph showing references to “Self-Mutilation” in newspapers, 1830 - 1900

Press use of the term was varied. When physical acts were referred to, these were often in relation to military service, such as *The Morning Post*'s article on the “Self-Mutilation of a Deserter”.⁶³ This might suggest that, as with “malingering” (an idea explored in chapters three and five), the term “self-mutilation” was originally borrowed from military parlance,

⁶² Rayner, “Melancholia and Hypochondriasis”, p. 371 & 374.

⁶³ Woolwich Correspondent, “Self-Mutilation of a Deserter” *The Morning Post*, November 22 1843; Other early examples include: “Central Criminal Court: Singular Act of Self-Mutilation” *The Era*, November 6 1842; “Multiple News Items” *Berrow’s Worcester Journal* (Worcester, England), November 30, 1843.

although it does not appear to have been included in these dictionaries.⁶⁴ Newspapers were quick to apply the term to other acts of self-inflicted injury, however, most often in those regarded as insane. For example, *The Cornwall Royal Gazette* referred sympathetically in 1845 to the “distressing” self-mutilation of “a very handsome and accomplished young woman” who plucked out one of her eyes and was subsequently sent to Hanwell Asylum as a “confirmed maniac”.⁶⁵ Yet both “self-injury” and “self-mutilation” were also used figuratively, particularly to suggest injudiciousness or cruelty behind a political act. Thus, the *Liverpool Mercury*, referred to Sir Robert Peel’s emigration scheme as “selfishness and self-injury in one” while, a quarter-century later, a correspondent in *The Times* claimed “the Conservative party, since its self-mutilation in 1846, has been condemned for 20 years to political extinction.”⁶⁶

The complicated political and social meanings apparent in newspaper articles made “self-mutilation” a loaded concept well before alienists picked it up: the perceived threat of political upheaval and the military crime of malingering will form recurring themes in this thesis. Yet the press context also indicates why, when “self-mutilation” began to appear in medical journals, the term was used unproblematically, and felt to need little explanation.

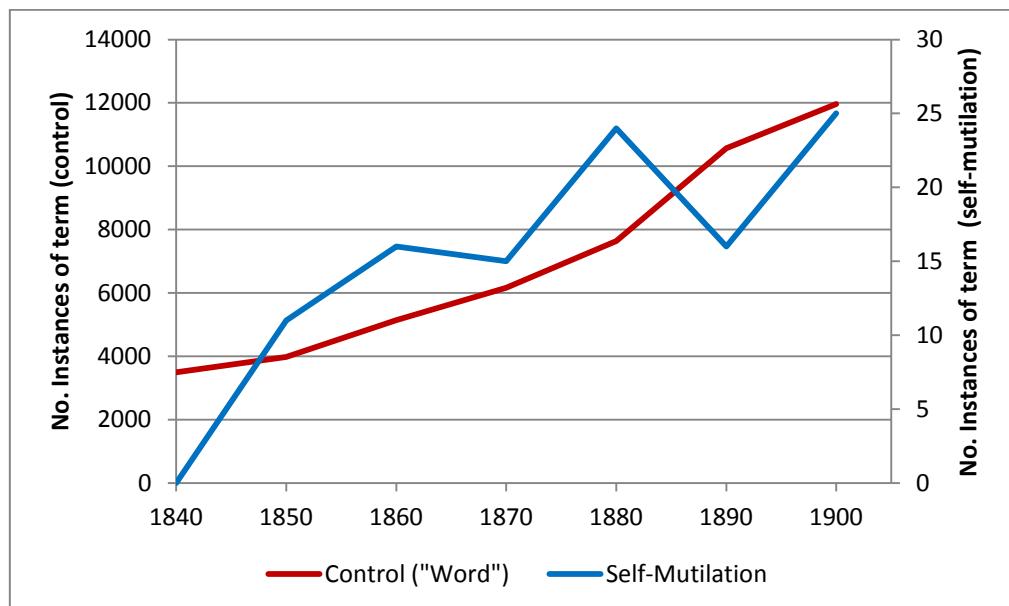


Figure 2: Graph showing references to “Self-Mutilation” in medical journals, 1840 - 1900

⁶⁴ See E. S. Norman Campbell, *A Dictionary of the Military Science* (London: Baldwin & Cradock & T. Egerton, 1830); Colonel H. L. Scott, *Military Dictionary: Comprising Technical Definitions; Information on Raising and Keeping Troops; Actual Service, etc.,* (New York; London: D. Van Nostrand; Trubner & Co., 1864).

⁶⁵ “Domestic News” *The Cornwall Royal Gazette, Falmouth Packet and Plymouth Journal*, Friday, January 10, 1845.

⁶⁶ ‘SIR ROBERT AND HIS STATISTICS.—THE EMIGRATION SCHEME’ *Liverpool Mercury* etc (Liverpool, England), Friday, November 26, 1841; “Shall We Pass a Reform Bill?” Letters to the Editor, *The Times*, Tuesday, Apr 10, 1866; pg. 10, col E.

In medical journals (*The Lancet*, *British Medical Journal* and the *Journal of Mental Science*), the term self-mutilation does not appear before the 1850s, and increases in use slightly later than in newspapers, with peak use of the term around 1890, as shown in Figure 2. What, though, did alienists mean by the term self-mutilation, and how did they explain it? Modern and historical sources indicate the close relation of self-injury to suicide. However, while suicide has received much attention in medical history, other forms of self-inflicted injury have not. Before exploring self-mutilation in more detail, it is thus important to situate it in relation to the existing literature on suicide, explaining the similarities – and, more importantly, the differences – between the two topics in late nineteenth-century psychiatry.

1.3 The Historiography of the Asylum: Self-Mutilation and Suicide

On 13 October 1900, Harriett Taylor was admitted to the Bethlem Royal Hospital after transfer from Holloway Prison where she had been held on remand since her “attempted suicide” on October 2. A fifty-year-old single woman, Taylor was described as of “fair height, well made & well nourished … [with] fairish hair which has lately been shaved on the top of her head, as she attempted suicide a short time ago by cutting her scalp.”⁶⁷ The “delusions of persecution” Harriett had apparently exhibited in prison had seen her very quickly transferred to Bethlem. However, the “suicidal” act that led to her arrest – a cut wound well away from any major blood vessels – was not something usually considered suicidal by alienists. Nonetheless, doctors at Bethlem attributed the wound to suicidal thoughts, just as the police, hospital and prison authorities had done. Cases like Taylor’s indicate the close relation of self-mutilation to the study of suicide. In another patient, a similar wound might have been interpreted as “self-mutilation”, leading to the important question: How does an act become defined as one or the other?

Much of the historiography of suicide has focused on the complementary practices of “medicalization” and “professionalization”: explanations offered by historians of psychiatry in the 1970s and 1980s to explain the growth of the asylum system.⁶⁸ Thus, histories of suicide have tended to focus on the expansion of asylums in the nineteenth

⁶⁷ BRHA *Female Patient Case book*, 1900 (CB/136 – 118).

⁶⁸ There is a large body of literature on suicide and the way in which the reinterpretation of suicide within a medical rubric supported professionalization. See in particular: Barbara T. Gates, "Suicide and the Victorian physicians," *Journal of the History of the Behavioral Sciences*, 16 (1980): 164-174; John C. Weaver and David Wright, *Histories of Suicide: International Perspectives on Self-destruction in the Modern World* (Toronto; London: University of Toronto Press, 2009); Olive Anderson, *Suicide in Victorian and Edwardian England*, (Oxford; New York: Clarendon Press; Oxford University Press, 1987); Michael MacDonald, "The Medicalization of Suicide in England: Laymen, Physicians, and Cultural Change, 1500-1870," in *Framing Disease: Studies in Cultural History*, ed. Charles Rosenberg and Janet Golden (New Brunswick: Rutgers University Press, 1992).

century, during which the total population rose from 11,272 in 1844 to over 80,000 by 1900.⁶⁹ This is usually thought to have been accompanied by the rise of the professional alienist: in 1841, these doctors set up a professional body – the Association of Medical Officers of Asylums and Hospitals for the Insane (from 1865 re-named the Medico-Psychological Association, henceforth referred to as the MPA) - and, in 1853, they started the *Journal of Mental Science*. By the end of the nineteenth century, the MPA had almost 600 members, something Edward Renouf has suggested provides evidence of alienists' efforts to cast themselves as specialists in "psychological medicine", defining their field through classification and publication.⁷⁰ Although early nineteenth-century therapies, particularly the concept of moral treatment, were introduced by lay practitioners, most historians have agreed that such treatment was subsequently "medicalized," showing the increasing emphasis laid on somatic explanations of insanity by a new generation of medically-trained alienists from the mid nineteenth century.⁷¹ These aetiologies could be interpreted in terms of biological heredity or vaguely defined "nervous impulses": both of these principles came into play in the classification of suicides and suicidal acts, which, to some alienists, seemed to be objective symptoms of mental illness. This notion was, however, complicated by the difficulty of determining the relationship between suicide and insanity, an on-going philosophical and medical debate from the eighteenth century until well beyond the period covered by this thesis.⁷²

Can we write a study of self-mutilation in similar terms, emphasising observation, classification, medicalization, professionalization and "social control" (the efforts by doctors and other authorities to impose a framework of values onto their patients)? It could, for instance, be suggested that the topic of self-mutilation was closely connected to concerns over mechanical restraint in asylums. Histories of suicide reveal a strong association between the classification of suicidal behaviour and the "non-restraint" movement of the 1840s and 1850s, as Anne Shepherd and David Wright suggested in their study of patients

⁶⁹ William Llywelyn Parry-Jones, *The Trade in Lunacy: a Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries* (London: Routledge and Kegan Paul, 1972).

⁷⁰ E. Renouf, "The Association of Medical Officers of Asylums and Hospitals for the Insane, the Medico-Psychological Association, and their Presidents," in *150 Years of British Psychiatry, 1841-1991*, ed. G. E. Berrios and Hugh L. Freeman (London: Gaskell, 1991), 29-78.

⁷¹ Andrew T. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven: Yale University Press, 1993); L. S. Jacyna, "Somatic Theories of Mind and the Interests of Medicine in Britain, 1850 - 1879," *Medical History*, 26 (1982): 233-258; Michael J. Clark, 'The Data of Alienism': Evolutionary Neurology, Physiological Psychology, and the Reconstruction of British Psychiatric Theory, c.1850 -c.1900 (unpublished PhD thesis, University of Oxford, 1982).

⁷² See, for example, Gates, "Suicide and the Victorian physicians".

admitted to two county asylums.⁷³ Mid-century asylum medical officers played on widespread anxiety about suicide rates by suggesting that an asylum might provide the only protection from self-homicide, in the absence of previously-used methods of mechanical coercion.⁷⁴ Conversely, as Shepherd and Wright correctly indicate, the Commissioners in Lunacy and the popular press perceived any instance of suicide in an asylum as tantamount to neglect.⁷⁵ Such a view is borne out by dialogue between the Lunacy Commissioners and Bethlem Hospital medical officers in the Annual Reports, where any suggestion of blame in the case of a suicide was vociferously refuted; in one instance, reported in 1893, this persuaded the Commissioners to alter their verdict.⁷⁶ Creating a distinction between self-mutilation and suicidal behaviour could provide another buffer against such accusations. In the Ipswich Asylum Annual Report for 1871, for example, the superintendent discussed a case in which a patient died several weeks after having torn out his eye, stating, “[t]he only remark I should wish to make upon this case is that I never considered it one of suicide, but simply one of self-mutilation”.⁷⁷ Self-mutilation, then, although essentially related to suicide, could be presented quite differently, more akin to accidental injury than an intentional act: in the same report from Ipswich, a list of “accidents” included “one patient [who] bit off the first joint of her little finger whilst in a state of epileptic delirium”.⁷⁸

Debate over self-mutilation was thus connected with some of the issues surrounding suicide. Some alienists felt that “it will be found as a rule on inquiry that the intention in their infliction [acts of self-injury] is suicidal in character – whereas instances of wilful self-mutilation, for its own sake, are much more rare”.⁷⁹ Thus, within the asylum, responses to self-mutilation were often similar to the treatment of suicidal patients, clearly outlined by Shepherd and Wright.⁸⁰ Disapproval of mechanical restraint in the mid nineteenth century

⁷³ Anne Shepherd and David Wright, "Madness, Suicide and the Victorian Asylum: Attempted Self-murder in the Age of Non-restraint," *Medical History*, 46 (2002): 175-196. On non-restraint, see also Robert Gardiner Hill, *A Concise History of the Entire Abolition of Mechanical Restraint in the Treatment of the Insane* (London: Longman, Brown, Green, and Longmans, 1857); Akihito Suzuki, "The Politics and Ideology of Non-Restraint: The Case of the Hanwell Asylum," *Medical History*, 39 (1995): 1-17.

⁷⁴ For example the bold claims in E. J. Seymour, "Thoughts on the Nature and Treatment of Several Severe Diseases of the Human Body," in *Three Hundred Years of Psychiatry, 1535-1860*, ed. Richard Alfred Hunter and Ida Macalpine (London; New York: Oxford University Press, 1963), 960-962, p. 961.

⁷⁵ Shepherd and Wright, "Madness, Suicide and the Victorian Asylum" p. 191.

⁷⁶ BRHA, *Bethlem Royal Hospital Annual Report 1893* (BAR – 31), p. 47 & p. 64; BRHA, Letter from Commissioners in Lunacy to R. Percy Smith, 19 Oct 1893, *Correspondence with Lunacy Commission 1887 - 1912* (ILB – 74a).

⁷⁷ Anon, "Asylum Reports for 1871," *Journal of Mental Science*, 18, no. 82 (1872): 262-276, p. 274.

⁷⁸ *ibid.*

⁷⁹ James Adam, "Cases of Self-Mutilation by the Insane," *Journal of Mental Science*, 29, no. 126 (1883): 213-219, p. 213.

⁸⁰ Shepherd and Wright, "Madness, Suicide and the Victorian Asylum".

encouraged many asylum officers to resort to so-called “chemical restraint” (the use of sedatives): most, however, preferred to stress the importance of vigilance.⁸¹ This need for “constant watching” (with a limited number of staff) demanded recognition of those patients likely to be suicidal. In addition, as Olive Anderson has recognised, the 1860s saw an increasing interest in exploring the pathology of suicide *attempts* (as opposed to completed suicides), which led to the perception of suicide as an individual, and not a social, problem.⁸² Such an attitude certainly informed understanding of self-mutilation, which was generally (though not always) presented as a deviant behaviour rooted in morbid changes in the individual’s brain or character.

Thus, it appears as no surprise that discussion of self-mutilation emerged within the asylum system, which offered (indeed, *required*) opportunities for the observation of behaviour, in addition to necessitating a response to self-damaging acts that might incur negative publicity for the institution. However, I would suggest that the case of Harriett Taylor indicates that a broader approach to the subject is required. It is important to acknowledge that Taylor’s own evidence played an important part in the decision to categorise her as suicidal (rather than self-mutilating). She told doctors she had been:

Hypnotized & subjected to X rays by some unknown person; this person told her she was a wicked woman, & must kill herself, hence she made her suicidal attempt, she was alone at the time but distinctly heard this person’s voice.⁸³

Exploring the motive behind the act was thus an important factor in determining the *difference* between suicide and self-mutilation and the legal necessity of deciding outside the asylum (for only suicide was a crime) might well have influenced debate over self-mutilation.⁸⁴ Indeed, alienists analysed the motives and “hidden meanings” behind self-mutilation in a way which was very different from how other behaviours in the asylum were discussed (refusal of food or persistent removal of clothes, for example, were often simply dismissed as troublesome, although the former could be just as dangerous to health as self-inflicted injury). As Taylor’s case indicates, attention to motive required input from both

⁸¹ George Savage, "Constant Watching of Suicidal Cases," *Journal of Mental Science*, 30, no. 129 (1884): 17-19. See also H. Hayes Newington, "What are the Tests of Fitness for Discharge from Asylums?" *Journal of Mental Science*, 32, no. 140 (1887): 491-500.

⁸² Anderson, *Suicide in Victorian and Edwardian England*, p. 207.

⁸³ BRHA Female Patient Case book, 1900 (CB/136 – 118).

⁸⁴ See Olive Anderson on the “new crime” of attempted suicide in the mid nineteenth century. “Restraint” in Anderson, *Suicide in Victorian and Edwardian England*, from p. 263. Suicide remained a criminal offence in England and Wales until 1961.

alienist and patient, suggesting a two-way process of negotiation, which has been recognised in other psychiatric contexts.⁸⁵

In a paper published in *The Lancet* twenty years before Harriett was admitted to Bethlem, Thomas Brushfield, the Superintendent of Brookwood Asylum, divided “danger to self” into two kinds: that with and without a suicidal motive. As previously indicated, certain acts suggested to alienists at this time that the motive for self-injury was *not* a suicidal one, as in a case of castration described by Brushfield:

In the following example it was at first doubted whether the remarkable act of dismembering himself was or was not done with suicidal intent, but the patient subsequently admitted that it was done for the express purpose of making away with himself, otherwise the nature of the act led me at first to believe otherwise.⁸⁶

Despite his preconceptions, Brushfield claims to have accepted his patient’s professed motive for the purposes of defining his behaviour. Likewise, he re-categorised a female patient admitted as “suicidal”, asserting that “her motive for doing this [cutting off her hand] was a non-suicidal one”, which resulted from the “primary suggestion” of reading a Scriptural quotation, which prompted “auditory hallucinations” commanding the commission of the act. The doctor related these hallucinations to the patient’s life experiences (and a potential cause of her illness): long-term grief over the loss of a child.⁸⁷ In practice, then, alienists applied a variety of different criteria – medical, physiological, cultural and environmental – in determining the motives of their patients. It was not only Harriett Taylor’s assertion that she had attempted suicide which was deemed important, but also her circumstances that caused her case to be treated as suicidal rather than self-mutilating. The background given in the case notes suggests the lonely and difficult life of an aging spinster at the turn of the twentieth century. When Harriett’s sister-in-law was asked to provide a case history, she declared that “[n]one of the family have seen much of her for 14 years,” and was thus unable to answer. The sister-in-law’s testimony also indicated that Harriett’s belief that she was a “wicked woman” and had “committed some awful crime” might not simply be a delusion: her family had cut her off because she “[h]ad been kept by a gentleman who has given her a house” and was thought to be intemperate.

⁸⁵ Akihito Suzuki, "Framing Psychiatric Subjectivity: Doctor, Patient and Record-keeping at Bethlem in the Nineteenth Century," in *Insanity, Institutions and Society, 1800 - 1914*, ed. Joseph Melling and Bill Forsythe (London: Routledge, 1999), 115-135; Mikkel Borch-Jacobsen, *Making Minds and Madness: from Hysteria to Depression* (Cambridge, UK ; New York : Cambridge University Press, 2009).

⁸⁶ T. N. Brushfield, "On Medical Certificates of Insanity," *The Lancet*, 115, no. 2958 (1880): 711-713, p. 712.

⁸⁷ *ibid.*

The suggestion that Harriett Taylor had attempted suicide could, therefore, be interpreted by alienists as a rational response to a socially unacceptable lifestyle, the courage required for commission perhaps precipitated by intemperance. Although her wild behaviour and delusions might be judged to correlate with the “accidental” nature of the self-mutilations previously described, neither the patient’s own testimony, nor the preconceptions associated with her lifestyle did, and she was designated suicidal. The distinction between suicide and self-mutilation was thus not something that was simply waiting to be discovered, but instead had to be created. This was also the case with the description of an individual as “suicidal”, as Åsa Jansson has recently acknowledged. In a paper examining “suicidal propensities” in asylum literature, she refutes the implication in other histories that there might be a “real” number of suicidal persons, recognising that the term “suicidal” was not a descriptive category, but a concept requiring various layers of attribution.⁸⁸ Yet, while alienists like Brushfield emphatically and repeatedly claimed that it was important to distinguish between suicidal and non-suicidal motives, they rarely suggested *why* this might be the case.⁸⁹ Although, as previously noted, suicide was a criminal offence outside the asylum, once someone was incarcerated there would appear to be little practical or legal need for making a distinction: both suicide and self-mutilation could result in death, and, in both cases, intervention was often required. Thus, for a number of writers, it would appear that the motive behind self-mutilation was not explored solely in order to differentiate such acts from suicide, but could be regarded an end in itself.

Here, I would like to draw attention to one final connection between self-mutilation and suicide: the debate over “sane” and “insane” suicides. Although much secondary literature on suicide has concentrated on the way in which suicide was “medicalized” in the early nineteenth century, it has also been shown that this was never an absolute or even process and, indeed, proved controversial in the second half of the century in particular.⁹⁰ High profile murder-suicides, such as that of George Victor Townley in 1865, drew sceptical comments from medical professionals over the widespread belief that every suicide was a

⁸⁸ Åsa Jansson, “From Statistics to Diagnostics: Medical Certificates, Melancholia, and “Suicidal Propensities” in Victorian Medicine,” *Journal of Social History*, 46, no. 3 (2013): forthcoming.

⁸⁹ See also Rayner, “Melancholia and Hypochondriasis” 361-381, p. 371 & 374; Maury Deas, “The Uses and Limitations of Mechanical Restraint”, p. 102.

⁹⁰ See, for example, G. E. Berrios and M. Mohanna, “Suicide: Clinical Section,” in *A History of Clinical Psychiatry: the Origin and History of Psychiatric Disorders*, ed. G. E. Berrios and Roy Porter (London, New Brunswick, NJ: Athlone Press, 1995), 612-624; Gates, “Suicide and the Victorian physicians”.

sign of insanity.”⁹¹ However, even those alienists who insisted that many, if not most, suicides were committed by sane individuals continued to insist that the topic fell within their domain, discussing motive in “sane” as well as “insane” suicides.⁹² These analyses, such as French physician Brierre de Boismont’s examination of suicide notes (rarely left in “insane” suicides according to the author), offered a broad overlap between normal and abnormal psychology: alienists transferred explanations from one group to the other, explaining “insane” beliefs as “rational” (albeit argued from false premises) and using their understanding of the insane to predict or explain normal psychology.⁹³ Thus, some alienists came to view suicide attempts in asylum patients as a “natural and reasonable” response to mental illness: for example, to the extreme misery of melancholia.⁹⁴ Similar interest in normal psychology is also apparent in the topic of self-mutilation, through attention to human motivation in general, which will be explored in chapter three.

This background in the historiography of asylum psychiatry highlights the central question of this thesis: why *did* self-mutilation become a particular topic of debate in the last two decades of the nineteenth century? I have argued that neither an explanation located in concepts of professionalization and “social control” nor a practice-based approach emphasising “non-restraint” offers a complete answer to this question. Although both these elements were certainly relevant to late nineteenth-century efforts to define self-mutilation (the former explaining the drive to classify, and the latter the imposition of regulations and interventions, based on the practical consequences of injurious acts), neither can explain the interest alienists had in distinguishing between different types of self-injurious acts. A more satisfactory explanation requires attention to both psychiatric theory *and* practice, and the relation between these two approaches. Most of the alienists writing on self-mutilation explicitly rejected entirely determinist approaches to mental illness and its symptoms. Some, such as the eminent George Savage, even came to object to the use of classification at all.⁹⁵ All stressed the importance of connecting a patient’s illness to his or her life experiences,

⁹¹ Anonymous, “The Suicide of George Victor Townley,” *Journal of Mental Science*, 11, no. 53 (1865): 66–83. For the opposing view, agreeing with Winslow as to Townley’s state of mind, see Editorial, “Medical Annotations,” *The Lancet*, 85, no. 2165 (1865): 209–214.

⁹² In Tuke’s *Dictionary*, for example, there are two articles on suicide: one by Tuke himself on general statistics, the other by George Savage on suicide and insanity. Tuke, *A Dictionary of Psychological Medicine*, vol. 2, pp. 1217 – 1232.

⁹³ A. Brierre de Boismont, “The Last Sentiments of Suicide,” (anonymous translation) *Journal of Psychological Medicine and Mental Pathology*, 4, no. 14 (1851), 243–256. This approach is also recognised by Michael Clark. Clark, ‘*The Data of Alienism*’, p. 300.

⁹⁴ John Charles Bucknill and Daniel Hack Tuke, *A Manual of Psychological Medicine*, 2nd ed. (London: John Churchill, 1862), p. 216. See also Jansson, “From Statistics to Diagnostics”.

⁹⁵ George Savage, “Presidential Address, Delivered at the Annual Meeting of the Medico-Psychological Association,” *Journal of Mental Science*, 32, no. 139 (1886): 313–331, p. 317.

environment and inborn “character”, using both the subjective impressions of the patient and the alienist’s own inductive conclusions on the mental meaning behind physical acts of self-mutilation.⁹⁶ Within such a context, the topic of self-mutilation often became attributed with psychological, as well as physiological, meaning: indeed, it is often hard for a modern reader to decide whether to regard these practitioners as “materialists” or “spiritualists”, for they often took elements from both strands of argument. However, it is to somatic interpretations that we will turn first in order to explore *what* alienists termed as “self-mutilation”, and, indeed, who utilised such a concept.

1.4 Physiology and Morbid Instincts: Self-Mutilation as Perversion of the Will

The construction of a model of self-mutilation based in the perversion of “natural” instincts was first outlined by Wilhelm Griesinger. A translation of Griesinger’s lecture at the opening of the Psychiatric Clinic in Zurich includes the first mention of “self-mutilation” in the *Journal of Mental Science*. Griesinger (1817 – 68) was a German neurologist and psychiatrist, who explicitly rejected traditional psychological and metaphysical classifications of mental disorder. These took into account the way in which an insane person’s speech, manner or actions differed from those in normal life, but Griesinger instead preferred a division of symptoms into psychical depression, exaltation and debility.⁹⁷ This means of classification, he hoped, would assist in uncovering associated lesions of brain or nerves, and thus progress the medico-scientific side of psychology, by rooting diagnoses in physiological research. Although most psychiatrists, British and Continental, agreed that much investigation was needed before the physical nature of insanity could be firmly located, Griesinger suggested that, in the absence of hard evidence of pathological change, diagnoses must be made along the “entire collection of nervous symptoms”. He divided such irregularities into “anomalies of sensibility” and “disorder of the motor power”, indicating a number of sub-categories in each group. Self-mutilation, to Griesinger, rather than being a psychical symptom became associated with those insanities marked by “decreased sensibility, by anaesthesia or analgesia”. He cited as example a patient who “in part from wantonness, and in part to compel the attendant to send for the physician, had deliberately smashed the first phalanx of his thumb with a brick. This man told me he had not suffered

⁹⁶ For a clear example of such an approach, see George Savage, "The Influence of Surroundings on the Production of Insanity," *Journal of Mental Science*, 37, no. 159 (1891): 529-535.

⁹⁷ W. Griesinger, "German Psychiatrie; an Introductory Lecture, read at the opening of the Psychiatric Clinique, in Zürich," *Journal of Mental Science*, 9, no. 48 (1864): 531-547, p. 533. For more on Griesinger’s approach to neurology, see Edwin Clarke and L. S. Jacyna, *Nineteenth-Century Origins of Neuroscientific Concepts* (Berkeley: University of California Press, 1987), pp. 133-8.

the least pain".⁹⁸ For Griesinger, elevating the status of the physiological symptom meant that the direct motive for self-mutilation could be discarded: the lack of pain was the causatory factor, not the patient's desired result. Ten years later, forensic psychiatrist Richard von Krafft-Ebing also claimed that the "loss of the pain-sense is of great significance in insanity", clinically so because it "may lead to intentional self-injury, brutality in the manner of carrying out suicide ... [or] accidents."⁹⁹ Since a brutal suicide would presumably have the same result (biologically, legally *and* spiritually) as any more peaceful method, one might wonder why Krafft-Ebing should stress this particular issue. In addition, this quotation indicates the physiology of pain could, for some physicians, be regarded as a directly motivating factor in self-mutilation.

Although Krafft-Ebing (or his translators) did not use the term "self-mutilation", his concern over "brutality" also seems to be reflected in the increasing tendency in British texts to prefer the word "mutilation" to "injury". Many of the first alienists who touched on self-mutilation, including the naturalist William Lauder Lindsay, botanist William Carmichael McIntosh and the aforementioned James Adam were Scottish, a point which hardly seems coincidental for the word "mutilation" had entered the English language from Scottish criminal law.¹⁰⁰ Indeed, all three men may well have known one another. All studied medicine at Edinburgh University in the 1850s, and Lindsay and McIntosh were later colleagues at the Murray Royal Asylum in Perth (Adam's birthplace). On Lindsay's early death in 1880, Adam (who was, at that time, superintendent of the Crichton Royal Institution and Southern Counties Asylums in Dumfries) pasted an obituary of the older man into his diary.¹⁰¹ Adam referred directly to the Scottish legal tradition in his definition of self-mutilation, discussing a "quaint treatise": Alexander Seton's 1699 *Treatise of Mutilation and Demembra**n**n**a**t**ion and their Punishments*.¹⁰² Seton's text was not specifically about self-mutilation but described the crime (in Scotland) of mutilating another: demembra*n**n**a**t**ion* was the cutting off of a "member" (necessary part of the body), while mutilation meant the "privation of office", but not removal: a distinction not adopted in nineteenth-century psychiatry.

For Seton, unlike nineteenth-century alienists: "Mutilation and Demembra*n**n**a**t**ion* are Names of Crimes: and one who wants a Hand or other Members on other occasions, is not

⁹⁸ Griesinger, "German Psychiatrie", p. 539.

⁹⁹ R. von Krafft-Ebing, *Text-book of Insanity: Based on Clinical Observations for Practitioners and Students of Medicine*, trans. Charles Gilbert Chaddock (Philadelphia: F.A. Davis, 1904), p. 120 (first published in German, 1875).

¹⁰⁰ See the etymology of "mutilation" in the *Oxford English Dictionary*.

¹⁰¹ Wellcome Library London (WLL), *Adam Diaries*, MSS.5517 (1880).

¹⁰² James Adam, "Self-Mutilation," p. 1148.

properly call'd Mutilatus or Demembratus, fed Mancus."¹⁰³ Such a distinction was lost within psychiatry, where "self-mutilation" might refer to both injury and action, while the individual behaving in such a way could also be referred to as a "self-mutilator".¹⁰⁴ This ensured that many tensions were incorporated into the idea from an early date, further complicated by the tendency of alienists to refer to a variety of behaviours by the term. Seton, in contrast, had been careful to list which parts of the body should qualify as "members", distinguishing his treatise from those of nineteenth-century alienists who, unlike Seton, included damage to hair or skin in their definitions. Many of Seton's legal concerns were displaced into moral terminology in nineteenth century works. In particular, Seton declared that:

... it cannot be denied, but to cut off, mutilat, or disable a necessary Member of the Body, is one of the greatest injuries that can be done to it; for not only doth it deform the Body, but renders it unfit for Action; and in many places makes the injured person incapable of the Office of the *Priesthood*.¹⁰⁵

When nineteenth century doctors reflected on the "desperate injuries" – or, indeed, "brutality" – inflicted by patients upon themselves, they expressed a similar horror, suggesting that, in the words of Arthur Conan Doyle's fictional surgeon, "mutilations ... are worse than death."¹⁰⁶ Indeed, in moral terms self-mutilation remained viewed as akin to a crime (although, unlike attempted suicide, it was not): thus, alienists frequently related such acts to those diagnoses thought to be most connected with criminality: moral and impulsive insanity. Thus, Adam highlighted Seton's horror of *castratio viridium* as "one of the most atrocious demembrinations". Indeed, Seton's only reference to self-inflicted injury was that "when a man does it [i.e. castrates] himself he is *sui homicida*, and so punishable with death and confiscation of goods, and its equivalent if one suffered himself willingly to be castrated by another".¹⁰⁷ Although this was not the case in nineteenth-century British law, it did not prevent alienists and others reacting to self-castration as if it were a criminal offence, as we shall see in chapter four.

But what of the physiological context in which self-inflicted injuries might be understood? While Griesinger's classification of insanity was not adopted outright within British psychiatry, the view that self-inflicted injury was based on a combination of the absence of sensation and the influence of an "insane impulse" often appeared in texts

¹⁰³ Alexander Seton, *A Treatise of Mutilation and Demembraion* (Edinburgh: Symson, 1699), p. 3.

¹⁰⁴ George Savage, "An Address on the Borderland of Insanity," *British Medical Journal*, 1, no. 2357 (1906): 489-492, p. 490.

¹⁰⁵ Seton, *A Treatise of Mutilation and Demembraion*, p. 5.

¹⁰⁶ G. Fielding Blandford, *Insanity and its Treatment*, 3rd edition (Edinburgh; London: Oliver and Boyd; Simpkin, Marshall, 1884), p. 195; Arthur Conan Doyle, *Round the Red Lamp and Other Medical Writings*, ed. Robert Darby (Kansas City, Mo.: Valancourt Books, 2007), p. 200.

¹⁰⁷ Adam, "Self-Mutilation", p. 1148.

published in English in the second half of the century. These ideas were easily incorporated into the materialist and somatic approaches that many historians have claimed to be dominant in later nineteenth-century alienism.¹⁰⁸ The influence of phrenology in the earlier nineteenth century has been well-documented for its role in encouraging contemporary alienists to draw parallels between mind and brain, as well as inspiring efforts to localise brain function in health and illness (physiological psychology and neurology).¹⁰⁹ The “failure” of psychiatrists to uncover brain lesions that could be associated with diagnoses of mental illness has led to a particular historical representation of the late nineteenth century as a period characterised by pessimism and rigid determinist views of the heredity of mental illness. While all these concerns were certainly influential, closer examination of the field does indicate certain contradictions in such an approach. As Michael Clark has recognised, many alienists continued to hold faith in the search for brain lesions, or otherwise re-classified their ideas in terms of loose concepts such as “nerve force” or “nerve power” (associated with the “motive power” referred to previously).¹¹⁰ Others began to stress alternative approaches, based in pragmatism and attention to the unique combination of individual, social and environmental factors in every case.

In his 1886 presidential address to the MPA, George Savage speculated on the value of his early days working on the physiology of insanity. Savage is a recurring figure in this thesis, for he wrote on self-mutilation in a number of different contexts, and was superintendent of Bethlem for a full decade. Born in Brighton in 1842, he is most famous today for having been one of Virginia Woolf’s doctors, and the lengthiest analysis of his life and work remains that by Stephen Trombley, in a rather dated volume on Woolf that portrays Savage as an old-fashioned Victorian moralist, espousing outmoded and unscientific definitions of insanity.¹¹¹ Yet this is certainly not the view of Savage that we receive from his contemporaries; president of every psychiatric organisation at one time or another, and host (at Bethlem) of the majority of MPA meetings, Savage was a central figure in late Victorian psychiatry. Indeed, he was well-known outside medical circles, for he was knighted in 1912

¹⁰⁸ L. S. Jacyna, "Somatic Theories of Mind and the Interests of Medicine in Britain, 1850 - 1879," *Medical History*, 26, (1982): 233-258; L. S. Jacyna, "The Physiology of Mind, the Unity of Nature, and the Moral Order in Victorian Thought," *The British Journal for the History of Science*, 14, no. 2 (1981): 109-132; Anne Harrington, *Medicine, Mind, and the Double Brain: a Study in Nineteenth-century Thought* (Princeton: Princeton University Press, 1987).

¹⁰⁹ Robert M. Young, *Mind, Brain and Adaptation in the Nineteenth Century: Cerebral Localization and its Biological Context from Gall to Ferrier* (Oxford: Clarendon Press, 1970); Roger Cooter, "Phrenology and British Alienists, c. 1825 - 1845. Part I: Converts to a Doctrine," *Medical History*, 20, no. 1 (1976): 1-21.

¹¹⁰ Clark, 'The Data of Alienism', pp. 82-9.

¹¹¹ Stephen Trombley, "All that summer she was mad": *Virginia Woolf and her Doctors* (London: Junction Books, 1981).

(whereupon his portrait was included in *Vanity Fair's* "Men of the Day" series) and, on his death in 1921, his obituary appeared in the mainstream press, as well as medical journals.¹¹² Savage's main interest appears to have been in practical psychiatric education, rather than theory, and it is perhaps his lack of theoretical publications that has led to his relative neglect by historians, in preference to his associate (and occasional sparring partner) Henry Maudsley. Along with his close colleague, Daniel Hack Tuke (with whom he shared editorship of the *Journal of Mental Science* for sixteen years), Savage established (and examined) a test for doctors in the field of psychiatry in 1886.¹¹³ He also promoted the introduction of a certificate in mental nursing, lectured for many years at Guy's Hospital, and received classes of students within the wards at Bethlem. His own psychiatric practice was connected to his role as teacher, as he described it in 1885: "though, perhaps, very much has not been published to the world, yet the daily classes of students diffuse the results of their experience gained in Bethlem".¹¹⁴

Savage's approach to insanity reflected individualism: he kept personal notes of all his Bethlem cases, and encouraged his students to do the same.¹¹⁵ His early days in psychiatry had, he noted, been spent studying brain sections "by the thousand". Yet, in 1886, he concluded that "without learning very much from the sections, I think I have learnt a good deal while cutting them, and thinking over them, and the cases from which they were derived".¹¹⁶ Rather than situating insanity within the individual brain, divorced from any context, Savage here indicates the way in which a fruitless search for brain lesions might enable other ways of thinking about madness, emphasising reflection, introspection and socio-environmental concerns. Thus, Savage reminded his colleagues that flexibility, and not dogmatism, was essential to psychiatry, for "[t]he definition is after all but the summing up of the knowledge of to-day; it is not an absolute reflex of nature".¹¹⁷ Despite his words, Savage's textbook (like most of this period) was divided into sections by diagnosis, suggesting that these were discrete categories. However, the concerns he expressed in his lectures – in particular that, by naming a disease, "you erect an idol with special qualities" – reminds the historian that we cannot explore contemporary psychiatric practice through published definitions alone: textbooks were an entry-point for the student, not a summary

¹¹² "Sir George Savage: Authority on Insanity," *The Times*, July 7, 1921: 15, col. C.

¹¹³ BRHA, *Annual Report 1886*, p. 44.

¹¹⁴ BRHA, *Annual Report 1885*, p. 37.

¹¹⁵ R. Percy Smith, "Sir George Henry Savage, M.D., F.R.C.P." *Journal of Mental Science*, 67, no. 279 (1921): 393-404, p. 396.

¹¹⁶ George Savage, "Presidential Address, Delivered at the Annual Meeting of the Medico-Psychological Association," *Journal of Mental Science*, 32, no. 139 (1886): 313-331, p. 314.

¹¹⁷ *ibid.*, p. 317.

of all the ideas and experiences of a practitioner.¹¹⁸ For Savage and his colleagues, interest in self-mutilation was strongly connected to the observation and classification of individual cases within the asylum, which indicates one of the reasons as to why self-mutilation emerged in an asylum context. Thus, in 1880, Tuke noted that "the literature of self-mutilation appears to be rather scanty", stressing the importance of the publication of further individual case studies for analysis: this was certainly something which increased after this date.¹¹⁹

A number of historians have also explored the ways in which physiological and psychological frameworks were combined within so-called physiological psychology. Rather than assuming that physical science was the dominant category in such contexts, Lorraine Daston and Roger Smith have both indicated the importance of prior philosophical principles to neurological explanations of mental functioning.¹²⁰ Thus, where discussion of self-mutilation in the late nineteenth century was associated with physiological models of sensation these were, in turn, reliant on prior philosophies of human behaviour. In 1789, Jeremy Bentham had famously suggested that pleasure and pain were the over-riding principles of motivation in man: it is for these two "sovereign masters ... alone to point out what we ought to do, as well as to determine what we shall do."¹²¹ The pleasure/pain model was promoted in nineteenth century psychology in the work of Alexander Bain.¹²² Bain's emphasis on pain and pleasure as the "two great primary manifestations of our nature" frequently conflated physical experience and mental function (using the terms pleasure and pain to apply to both physical sensation and the subjective feelings of misery and happiness).¹²³ Bain has thus been well-recognised as playing an important part in the proliferation of parallels between physiological and psychological models of mental action, an important background for texts on self-mutilation.¹²⁴ Unlike Griesinger, Bain incorporated experimental physiological psychology and the old techniques of psychology by introspection into his work. British alienists, as we shall see, tended towards a similar

¹¹⁸ *ibid.*, p. 316.

¹¹⁹ Daniel Hack Tuke, "Psychological Retrospect: American Psychological Literature," *Journal of Mental Science* 26 (1880): 102-111, p. 105.

¹²⁰ Lorraine J. Daston, "The Theory of Will versus the Science of Mind," in *The Problematic Science: Psychology in Nineteenth-century Thought*, ed. William Ray Woodward and Mitchell G. Ash (New York: Praeger, 1982), 88-115; Roger Smith, "The Background of Physiological Psychology in Natural Philosophy," *History of Science*, 11, no. 2 (1973): 75-123.

¹²¹ Jeremy Bentham, *An Introduction to the Principles of Morals and Legislation*, ed. Benjamin Giles King (London: W. Pickering and E. Wilson, 1823), p. 1.

¹²² Alexander Bain, *The Emotions and the Will* (London: John W. Parker, 1859), pp. 31-5 and 336-50.

¹²³ Bain, *The Emotions and the Will*, pp. 31-2.

¹²⁴ Daston, "The Theory of Will versus the Science of Mind"; Young, *Mind, Brain and Adaptation*, pp. 101-133.

approach, connecting a perceived somatic basis for insane acts (in lesions of the brain or nerves) with the environmental and hereditary factors thought to influence moral and emotional insanity.

The first papers published in British psychiatric journals in the 1860s and '70s discussing self-mutilation thus referred the topic to so-called "natural laws". Lindsay explored the pathology of mind in animals, while McIntosh also incorporated his view of natural history in exploring the concept of "morbid impulse".¹²⁵ McIntosh's paper appeared first and, indeed, he had begun publishing on morbid instincts while he was Lindsay's subordinate in Perth, submitting two papers to the *Medical Critic and Psychological Journal* (edited by Forbes Winslow, author of the first psychiatric and forensic text on suicide).¹²⁶ An assumption that morbid instincts could be understood as the contravention of "natural laws" is clear in all McIntosh's papers, in which he sought a universal explanation for so-called "perverted impulses" (including self-mutilation) in damage to the faculties of volition and emotion. While utilising the language developed by a number of other alienists, McIntosh's explanations and extended classification relied predominantly on the physiological principles of Thomas Laycock (who had taught him at Edinburgh and remained a friend). Laycock was an important contributor to mid nineteenth-century physiological psychology, in particular for his application of reflex theory to the brain and mental processes.¹²⁷ McIntosh's concept of "morbid impulse" reflected the idea that human behaviour was regulated by the dual processes of impulse and inhibition. His own distinction between morbid impulse and "purely instinctive acts" also appears to incorporate the divisions of mental action formulated by W.B. Carpenter (Laycock's rival), who added a third dimension to the simple divide between conscious and unconscious behaviour.¹²⁸ For Carpenter, instinctive actions occurred in response to external sensation. Other automatic acts, however, might occur in response to an *idea*, located within the individual but of which

¹²⁵ W. C. McIntosh, "On some of the Varieties of Morbid Impulse and Perverted Instinct," *Journal of Mental Science*, 11, no. 56 (1866): 512-533; W. Lauder Lindsay, "The Pathology of Mind in the Lower Animals," *Journal of Mental Science*, 23, no. 82 (1877): 17-44.

¹²⁶ W. C. McIntosh, "On Morbid Impulse," *The Medical Critic and Psychological Journal*, 3, (1863): 1-29; W. C. McIntosh, "On the Diagnosis & Treatment of Morbid Impulse," *The Medical Critic and Psychological Journal*, 3, (1863): 1-20. For an account of McIntosh's life, see A. E. Gunther, *The Life of William Carmichael M'Intosh* (St Andrews: Scottish Academic Press for the University of St. Andrews, 1977), p. 58.

¹²⁷ See Kurt Danziger, "Mid-Nineteenth Century British Psycho-Physiology: A Neglected Chapter in the History of Psychology," in *The Problematic Science: Psychology in Nineteenth-Century Thought*, ed. William Ray Woodward and Mitchell G. Ash (New York: Praeger, 1982), 116-144; Clarke and Jacyna, *Nineteenth-Century Origins of Neuroscientific Concepts*; Tom Quick, *Techniques of Life: Zoology, Psychology and Technical Subjectivity (c. 1820 - 1890)* (Unpublished PhD thesis , UCL, 2011)

¹²⁸ McIntosh, "On Morbid Impulse", pp. 102-3.

he or she was nonetheless unaware. Such a process, Carpenter termed “unconscious cerebration” in the fourth edition of his textbook *Human Physiology* (1853).¹²⁹

Carpenter specified that many of the behavioural symptoms of insanity might be explained by unconscious cerebration, and McIntosh similarly referred the vast majority of insane acts to morbid impulse. The latter’s ideas most closely equated with Laycock, however, in that his explanations were associated with an emphasis on the “inherent purposefulness of the biological organization”.¹³⁰ This process is apparent in McIntosh’s understanding of natural instinct as holding a specific function: the morbid nature of an act was thus revealed by the instinct’s absence or a contravention of its purpose. Thus, McIntosh divided morbid instincts into four types in relation to the natural instinct they were assumed to contravene. In his earliest article, he took these from Unzer’s *Principles of Physiology*, where they were listed as self-preservation, self-maintenance, propagation of the species and love of offspring.¹³¹ Later, he shifted more closely to the categories described by Laycock, in which instincts were divided up by physiological process: first “alimentary” and then “sexual”, followed by less biologically explicit functions: the domestic, personal and social (self-mutilation came under personal).¹³² While stressing that wider factors than physiology played a part in the recognition and development of such “perversions” – for “their occurrence is found to be regulated by the degree of civilisation, mode of life ... and the prevailing tendencies of the age, which indelibly stamps them with its characteristic features” – he nonetheless related every morbid impulse to a corresponding natural process, indicating that both should be regarded in absolute terms.¹³³

We can thus view the emergence of definitions of self-mutilation as part of an ethos in which, on the one hand, volition and self-control and, on the other, brain biology, were emphasised within scientific and popular language. Roger Smith has noted that many physiologists used examples of insanity to support these theories, as the “simplest and most vivid evidence” of the existence of inhibition was thought to be what happened in its absence.¹³⁴ Self-mutilation, as in many of the reports already discussed, could thus be

¹²⁹ W. B. Carpenter, "The Physiology of the Will," *Contemporary Review*, 17, (1871): 192-217; Jenny Bourne Taylor and Sally Shuttleworth, *Embodied Selves: an Anthology of Psychological Texts, 1830-1890* (Oxford; New York: Clarendon Press; Oxford University Press, 1998), pp. 93-101; Danziger, "Mid-Nineteenth Century British Psycho-Physiology".

¹³⁰ Danziger argues that this was the main point of contention between Laycock and Carpenter (the latter extracting ideas of mental functioning from a purposive natural realm). Danziger, "Mid-Nineteenth Century British Psycho-Physiology", p. 130.

¹³¹ McIntosh, "On Morbid Impulse", p. 103.

¹³² McIntosh, "On some of the Varieties of Morbid Impulse and Perverted Instinct".

¹³³ *ibid.*, p. 512.

¹³⁴ Smith, *Inhibition*, p. 41.

characterised as a “morbid instinct” (representative of “delirium” or extreme intellectual disorder) or as an example of “uncontrollable impulse”. These descriptions appealed due to their apparent scientific respectability, as emphasised in McIntosh’s relation between morbid impulse and reflex functioning and his use of comparative examples from the animal world. Even those alienists who claimed to take an anti-materialist stance might use similar reasoning (often omitting any direct reference to physiological research). Bethlem’s Theo Hyslop claimed that loss of control in asylum patients provided direct evidence of the existence of the will in the normal self, illustrating this with two examples of self-injurious behaviour.

A patient was brought to Bethlem bound hand and foot, at his own request, in order to prevent self-mutilation, which proved an ungovernable impulse to him. Another patient begged and implored that mechanical restraint might be employed to prevent him injuring himself.¹³⁵

Such cases, Hyslop felt, indicated that impairments of the will could occur even when the patient understood his or her actions: understanding did not necessarily lead to self-control, demonstrating that the will was a separate process from intellect.

McIntosh himself did not discuss self-mutilation in his early papers on morbid instinct, and it was not until his publication in *The Journal of Mental Science* that this appeared as an example. Still holding firmly to Laycock’s emphasis on the teleology of nature, McIntosh asserted that self-mutilation was a natural process in certain animals. Referring to the “wonderful power of self-mutilation” in crustaceans (his own special study) he indicated that mutilations in nature often served a purpose: “Under ordinary circumstances ... such self-mutilations in the crustacea are intended for the safety of the animal, whereas in man, for the most part, they are essentially morbid.” In other words, in man, self-mutilation was proven to be unnatural (and thus connected with pathology), because it served no purpose.¹³⁶ He had previously referred similarly to suicide, claiming that:

Man in a state of nature seldom or never commits suicide, because his instincts and impulses are natural, even though they may be exaggerated, whereas in civilization nothing is more common.¹³⁷

Such statements indicate the complexity of notions of self-mutilation: it was not, as will be shown, necessarily an obvious conclusion that self-mutilation in man was “morbid”, either through description of acts or by analogy to the natural world: other factors influenced

¹³⁵ Hyslop, *Mental Physiology*, pp. 444-53.

¹³⁶ McIntosh, “On some of the Varieties of Morbid Impulse and Perverted Instinct”, p. 528.

¹³⁷ McIntosh, “On Morbid Impulse”, p. 103.

McIntosh's decision to draw a distinction here between human and animal life, attributing a use to self-mutilation within nature, while regarding it as indicative of disease in mankind.

Although McIntosh did not elaborate on the morbid nature of self-mutilation in man – simply listing various self-injurious acts without any attempt at explanation – later medical writers related self-mutilation in man directly to the *effects* of civilization: a response to a seemingly unnatural environment, which, it was supposed, caused a failure of natural selection. This idea became a strong theme in degenerationist literature in Britain following the publication of William Greg's "On the Failure of 'Natural Selection' in the Case of Man".¹³⁸ Many writers have commented on the increasing fear of racial and national decline across Europe in the final decades of the nineteenth century, as expressed within the fields of criminology, psychiatry and aesthetics.¹³⁹ This ethos shifted self-mutilation from a topic connected with a positivist progressive notion of purposeful evolution within nature (as it was, for the most part, in McIntosh's paper), to one instead associated with pessimistic theories of decline. This is particularly evident in a later comparison between human and animal behaviour, reported to the Irish Academy of Medicine in 1885, describing the "self-mutilation" of a lioness. The *Journal of Mental Science* chose to re-print the case appended to an asylum case study of a patient showing "persistent self-mutilation," emphasising the perceived relation between human and animal behaviour.¹⁴⁰ The former paper included a collection of cases of animal self-mutilation in captivity, beginning with the tale of a lioness in Dublin zoo who chewed off her tail followed by a paw. Similar habits, the author stated, were "not uncommon" among other animals in confinement despite being, as one listener claimed during the following discussion "so foreign to animal instinct".¹⁴¹ Thus, the unnatural environment of animals in captivity was here implied to have caused the development of morbid behaviour, something the author emphasised by extrapolating, in this instance, from human to animal, rather than (as in McIntosh's paper) the reverse. Unlike modern texts, alienists did not speculate as to whether confinement itself might exacerbate

¹³⁸ William R. Greg, "On the Failure of "Natural Selection" in the Case of Man," *Fraser's Magazine for Town and Country*, 78, no. 465 (1868): 353-362.

¹³⁹ Daniel Pick, *Faces of Degeneration: A European Disorder, c.1848-c.1918* (Cambridge; New York: Cambridge University Press, 1989); Richard A. Soloway, *Demography and Degeneration: Eugenics and the Declining Birthrate in Twentieth-century Britain* (Chapel Hill; London: University of North Carolina Press, 1990); William Greenslade, *Degeneration, Culture, and the Novel, 1880-1940* (Cambridge; New York: Cambridge University Press, 1994).

¹⁴⁰ Eric Sinclair, "Case of Persistent Self-Mutilation," *Journal of Mental Science*, 32, no. 137 (1886): 44-50; P. S. Abraham, "Self-Mutilation of a Lioness," *Medical Press and Circular*, i, (1885): 211-212; P. S. Abraham, "Self-Mutilation in a Lioness," *Journal of Mental Science*, 32, no. 137 (1886): 46-50.

¹⁴¹ Abraham, "Self-Mutilation of a Lioness", p. 212.

tendencies toward self-mutilation.¹⁴² Thus, it was certainly not suggested that increased levels of self-inflicted injury might occur in asylums due to incarceration. The asylum (unlike the zoo) was viewed as just as natural – if not more so – than the society beyond its walls.

The debate over the role of civilization in prompting self-mutilation also complicated the already uncertain relationship between self-mutilation and insanity, and alienists wondered whether the act itself proved insanity or could only do so in conjunction with other symptoms. McIntosh himself did not regard self-mutilation, even in extreme cases, as necessarily indicative of outright insanity. Alienists thus found it difficult to diagnose cases of self-mutilation, which rarely fitted neatly into prior categories of madness. James Shaw, for example, suggested an extremely broad definition of “self-injury apart from suicidal tendency”, which he characterised “as a result of excitement, terror, delusions, or unconsciousness” and hence occurring in “acute mania; pubescent insanity; agitated melancholia; puerperal insanity; monomania; epileptic insanity; [and] delirium tremens” – in other words, almost every psychiatric classification!¹⁴³

The extreme nature of certain acts meant that the involvement of alcohol was often assumed, as in Shaw’s final example. This offered a simple solution, such that the act itself was not required to hold any meaning. Thus, in 1863, the *British Medical Journal* printed a case from *The Express* detailing the “extraordinary self-mutilation” of barman’s wife, Jane Brickland, who had amputated her own left hand while intoxicated.¹⁴⁴ The suggestion that the patient had “for some time past … given way to drinking habits” meant that no further comment on the case was thought necessary. On other occasions, the involvement of alcohol added a moral to such reports. In 1885, *The Lancet* described a man who had fractured his leg while in a state of delirium tremens. Apparently annoyed by the pain of walking, he had subsequently cut off his own foot with a carving knife: an act that had apparently horrified the patient on recovering his senses. The writer concluded with the lesson that “during his recovery he will doubtless have time to reflect upon the senseless and idiotic act which his drink cravings gave rise to”.¹⁴⁵ This seeming senselessness might also be incorporated into certain psychiatric approaches. For example, when Lindsay

¹⁴² For this association post “care in the community”, see Favazza’s comparisons between humans and animals in captivity, Armando R. Favazza, *Bodies Under Siege: Self-Mutilation and Body Modification in Culture and Psychiatry* (Baltimore: Johns Hopkins University Press, 1996), chap. 4 pp. 68-81.

¹⁴³ James Shaw, *Epitome of Mental Diseases*, p. 31.

¹⁴⁴ “Extraordinary Self-Mutilation,” *British Medical Journal*, 1, (1863): 9.

¹⁴⁵ Birmingham Correspondent, “Extraordinary Self-Mutilation,” *The Lancet*, 126, no. 3243 (1885): 782-783. See also M. Demarquay, “A Case of Complete Self-Mutilation,” *The Lancet*, 100, no. 2554 (1872): 10; Mr. Francis and Mr. Grant, “Amputation of the Whole of the External Genitals During Delirium Tremens,” *British Medical Journal*, (1870): 130.

associated self-mutilation with the diagnosis of mania, he suggested that in animals it was “characterised by a morbid destructiveness that vents itself on the animal’s own person, if there be no opportunity for giving it an outlet on man or other enemies or prey.”¹⁴⁶ In addition to associating self-mutilation with a psychiatric diagnosis, this connection also implied that the so-called “maniac” was impulsive and animalistic, associating self-mutilation with aggression. However, in asylum practice, although self-mutilation might be linked with a general propensity for destructiveness (as in George Fielding Blandford’s description of suicide or self-mutilation in “acute insanity”), diagnosis was frequently more ambiguous.¹⁴⁷ Textbooks referencing self-mutilation tended to include it in descriptions of melancholia, due to the presumed link with suicide, although a connection with moral and emotional insanity added much uncertainty.¹⁴⁸

An analysis of cases of self-inflicted injury at the Bethlem Royal Hospital between 1880 and 1900 indicates a slightly greater tendency to associate self-mutilation with melancholia, as in figures 3 and 4 (although it would be hard to ascertain whether this was because self-mutilation occurred in cases exhibiting other symptoms associated with melancholia, like extreme mental depression, or whether alienists assumed that those who injured themselves were suffering from melancholia). At any rate, more than sixty per cent of patients who injured themselves were diagnosed with melancholia, while less than half of the total Bethlem patient population was. Nonetheless, a considerable number of patients with a variety of other psychiatric diagnoses were also considered to exhibit self-injuring behaviour, making it unclear with which mental disorder the symptom should be associated.

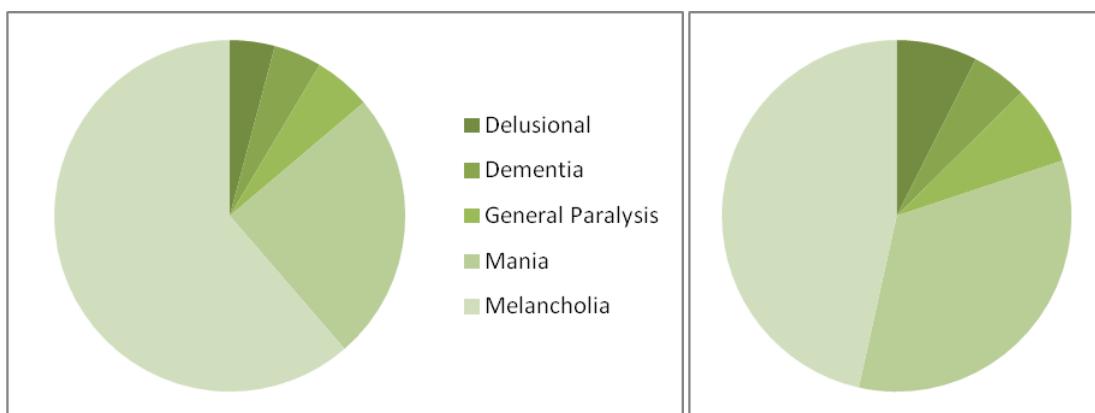


Figure 3: Chart showing diagnoses of "self-mutilating" patients at Bethlem, 1880 – 1900

Figure 4 (right): Chart showing total diagnoses at Bethlem, 1880 – 1900

¹⁴⁶ Lauder Lindsay, "The Pathology of Mind in the Lower Animals" p. 33.

¹⁴⁷ Blandford, *Insanity and its Treatment*, p. 167; George Savage "Mental Diseases" in T. Clifford Albutt and Various, *A System of Medicine*, ed. T. Clifford Albutt. vol. 8, London, 1899), p. 359.

¹⁴⁸ Blandford, *Insanity and its Treatment*; George Savage, *Insanity and Allied Neuroses: Practical and Clinical* (London; New York: Cassell, 1884); H. Rayner, "Melancholia and Hypochondriasis," p. 368.

The first case report specifically detailing self-mutilation in a patient in the *Journal of Mental Science* clearly highlights these diagnostic complications. In 1877, William Brown, Assistant Medical Officer at the Newcastle-upon-Tyne Borough Lunatic Asylum, described a case in which symptoms fluctuated, his patient (W.H.S) having many lucid intervals. He thus diagnosed the young man as suffering from "Monomania with Self-Mutilation and a Suicidal Tendency," implying that these symptoms formed the special focus of the illness.¹⁴⁹ Indeed, when W.H.S (a young boot-riveter), was admitted to the asylum, the outbreak of insanity was dated from the time of his self-mutilation (the removal of one of his testicles) just one day before. W.H.S was quiet, and even "rational", happily describing the infliction of his injury.

He answered questions rationally, and stated that he had mutilated himself with a table knife, and that, in consequence of it being blunt, he had made four or five cuts before effecting his purpose. He stated that he considered it proper to remove the organ, and asked reporter if he was going to remove the other testicle.¹⁵⁰

The impulse to self-mutilation (and, later, to acts regarded as explicitly suicidal) was thus viewed as the basis of W.H.S's illness, a "distinct and especial" monomaniacal delusion.¹⁵¹ This meant that the patient could not be trusted, and Brown referred regularly to his "taciturn" manner and "suspicious look", viewing both as indications of a suicidal or self-damaging propensity. This led to further enquiry into the patient's motives, and Brown recorded wide-ranging suggestions, gleaned from the patient, his family and previous doctors, in addition to the alienist's own interpretation of the patient as suicidal. Thus, as we shall see in the following section, the diagnosis of "impulse" was rarely regarded as self-evident in asylum practice, and usually required further levels of explanation rather than forming the basis for a diagnosis (such as impulsive insanity) in itself.

1.5 Exploring Intellect: Uncontrollable Impulse or Mental Motive

One of the earliest psychiatric textbooks to include the topic of self-mutilation was George Fielding Blandford's volume of lectures delivered at St. George's Hospital, first published in 1871. Lecture VII, *The Acts of the Insane*, contained a short section on self-mutilation.¹⁵² These lectures remained in print throughout the nineteenth century, the

¹⁴⁹ William J. Brown, "Notes of a Case of Monomania with Self-Mutilation and a Suicidal Tendency," *Journal of Mental Science*, 23, no. 102 (1877): 242-248.

¹⁵⁰ Brown, "Notes of a Case of Monomania", p. 243.

¹⁵¹ J. G. Davey, "Life Insurance Offices and Suicide," *Journal of Mental Science*, 7, no. 37 (1861): 107-120, p. 112.

¹⁵² The section on "self-mutilation" went unchanged in all four editions, issued in 1871, 1877, 1884 and 1891. Blandford, *Insanity and its Treatment*, pp. 169-70.

fourth edition being published in 1892, and Blandford's active membership of the Medico-Psychological Association may have promoted discussion of his ideas among members.¹⁵³ Like many of the second generation of alienists, Blandford was medically trained: indeed, his son later claimed that his specialisation was "accidental ... and I believe he would have found a less restricted line of practice congenial."¹⁵⁴ It is thus not surprising to find the physician exhibiting strong interest in somatic representations of insanity, such as pathological anatomy and neurology: two of the twenty lectures dealt with pathology, while another covered morbid appearances of the brain and other physical structures, including the so-called "insane ear". He also, however, had a well-documented interest in delusional beliefs and associated acts, something often seemingly coloured by his social background. Educated at Tonbridge School and then Rugby, Blandford was judged by his contemporaries as "exceptionally fitted to deal with the insane of the private class"¹⁵⁵, an elite background which undoubtedly encouraged his strong sense of social propriety. Many of his published writings cover the contested diagnoses of moral and impulsive insanity,¹⁵⁶ while his infamous certification of the young Edith Lanchester in 1895 (claiming that her co-habitation with a lover was a form of "social suicide") was mocked by journalists and even other members of his profession.¹⁵⁷

Later, Blandford's colleagues suggested that he had a particular interest in exploring symptoms and treatment in his work, rather than emphasising the classification of insanity.¹⁵⁸ It was perhaps this approach that focused his attention on self-mutilation, for it was certainly shared by all the other alienists who later picked up the topic. Blandford described self-mutilation in naturalistic terms, as a universal behaviour with no clear definition or categorisation. As McIntosh had also suggested, Blandford claimed that "morbid impulses", including self-mutilation, might indicate evidence of an intellectual defect: however, this alone could not prove insanity, and the patient's subjective motive and understanding of his act also required examination. While clearly influenced by physiological concepts of insanity, Blandford also showed a determination to differentiate psychiatry from

¹⁵³ Elected to membership in 1857, Blandford was President of the MPA in 1877.

¹⁵⁴ R. Percy Smith, "Obituary: George Fielding Blandford, M.D., F.R.C.P.," *British Medical Journal*, 2, no. 2644 (1911): 524-526, p. 524.

¹⁵⁵ Smith, "Obituary: George Fielding Blandford", p. 524.

¹⁵⁶ G. Fielding Blandford, "Insanity without Delusions," *Journal of Mental Science*, 15, no. 69 (1869): 23-48, p. 35. Blandford also wrote the entries on "moral insanity" and "impulsive insanity" in *Quain's Dictionary of Medicine ... Third edition*, ed. H. Montague Murray (London: Longmans, Green, 1902).

¹⁵⁷ Lanchester was released from the private asylum after just a few days, at the behest of the Commissioners in Lunacy. See "The Lanchester Case, of Insanity and the New "Morality"," *The Lancet*, 146, no. 3767 (1895): 1175-1176.

¹⁵⁸ Smith, "Obituary: George Fielding Blandford", p. 755.

physiology by examining in greater detail what lay *behind* any impulse. In impulsive insanity, the patient was “impelled, it is said *instinctively*” to commit an act – criminal or otherwise – he thus could not necessarily explain or understand why he had acted as he did, despite knowing the act was wrong.¹⁵⁹ Yet, nonetheless, Blandford emphasised that all such impulses sprang from an “idea or thought of some kind,” either “sudden” or “fixed,” which confirmed that the patient had an intellectual defect: thus, in the case of self-mutilation, he stressed that “[a]ll such acts are done from delusion, not from mere impulse, as the acts of suicide.”¹⁶⁰

Despite offering an early suggestion that self-mutilation might be distinct from suicide in terms of underlying emotional and intellectual factors, Blandford showed little interest in outlining the delusory ideas he mentioned. Perhaps this reflected his early move away from asylum practice: after just three years at the exclusive Blacklands House in Chelsea, the physician moved into private practice in 1863. Such a shift may have left him with fewer opportunities for exploring the background of his patients’ actions, as well as necessitating a higher degree of discretion: the absence of any archival records associated with his practice also makes his interest in self-mutilation far more difficult to explore. A key feature of Blandford’s interest in self-mutilation was, however, certainly shared by colleagues who took up the subject: an interest in “moral insanity”, in relation to a general emphasis on conduct as a means to judge the mental state of the individual. This approach can be seen in the definitions of self-mutilation produced in subsequent decades. The longest of these was written by James Adam for Tuke’s *Dictionary of Psychological Medicine*. Adam’s career trajectory was similar to Blandford’s, although from a less salubrious start. A medical graduate, he had chosen to specialise in psychiatry after an early career as an army medical officer, serving in the Indian Mutiny of 1857. He subsequently traced a path through several large English and Scottish pauper asylums before purchasing West Malling Place, a small private asylum in Kent, in 1883. Adam remained here, treating a small circle of upper class patients, until his death in 1908, after which one obituary remarked that his publications on self-mutilation evidenced his interest in the “scientific side of his life’s work”, represented by a systematic investigation of cases.¹⁶¹ Given that Adam published little else, it is entirely possible that the obituarist had struggled to find much else to say about him. However, for the historian, it remains interesting that Adam chose self-mutilation as a speciality for, unlike his colleagues, his writings on the topic were not incorporated into

¹⁵⁹ Blandford, “Insanity Without Delusions”, p. 45 [italics in original].

¹⁶⁰ Blandford, “Insanity Without Delusions”, p. 48.

¹⁶¹ Anonymous, “James Adam (Obituary),” *Journal of Mental Science*, 55, (1909): 208-209.

teaching lectures or textbooks, but intended to stand alone. In these papers, Adam sought to bring together a number of reported cases of self-inflicted injury; since, he said, the number recorded appeared to be small, it became still more important to bring these to the notice of the profession, in order that causation might be investigated.¹⁶²

Using similar techniques to Blandford and McIntosh, Adam began his definition of self-mutilation by legitimising the topic as an important area for scientific enquiry through retrospective diagnosis: providing an account of cases dating back to "the earliest ages" to indicate the "real" (i.e. universal) nature of the pathology described. These early acts were then compared and contrasted with those observed by the Victorian alienist. Adam claimed that the best way to throw "additional light ... upon the obscurity which surrounds the whole subject" was through "an endeavour to trace some of the motives which have prompted to the commission of the acts at various periods of history, and under various religious conditions."¹⁶³ Through such a method, he sought to shed light on normal psychology, as well as the relation of the individual to society under particular circumstances: cultural anthropology and psychology are thus considered as topics of some importance in the two following chapters. Indeed, self-mutilation did not for Adam (as for McIntosh and Blandford) necessarily indicate insanity; although the "borderland" between madness and sound mind formed a shady area, as reflected in his rather ambiguous claim that: "All the states of mind leading to self-mutilation, self-torture, &c., hitherto considered, are compatible with reputed sanity, although they are to insanity near akin, and generally indicate more or less mental derangement."¹⁶⁴ The widely agreed proximity between self-mutilation and sanity reinforces my argument that attitudes to self-mutilation are not necessarily fixed or obvious. For late nineteenth-century writers such as Adam, self-mutilation might indeed be carried out by sane individuals through religious conviction (although, like the "borderland", this term was difficult to define: religious delusion, for Adam, indicated outright insanity but nowhere did he suggest how the two might be differentiated), as a demonstration of endurance and strength of will, as attempted suicide or in order to manipulate others.¹⁶⁵ In insanity, these explanations might continue to play a part, as might the effect of hallucinations or delusions (which Adam illustrated by the example of a patient who plucked out her eyes to prevent disturbing hallucinations).

¹⁶² James Adam, "Self-Mutilation," p. 1149.

¹⁶³ *Ibid.*, p. 1147.

¹⁶⁴ *Ibid.*, p. 1148.

¹⁶⁵ Adam related this particularly to criminals, but the idea also became strongly connected with hysteria, as will be discussed in chapter five.

However, Adam concentrated particularly on one further explanation for insane self-mutilation, the “sexual self-mutilation”, which will be discussed in detail in chapter four.

But how did Adam reach his conclusions? Were they formed by “objective” description of his patients, or were other factors involved in the way in which he framed self-mutilation, and highlighted particular behaviours? It would appear misleading to view historical concepts of self-mutilation solely through published material. After all, the alienists who theorised on the topic were all in asylum practice, and their ideas were formed and shaped by the context in which they worked. Publications tended to concentrate on rare or unusual cases – particularly the dramatic examples of so-called “major” mutilations (castration, amputation and enucleation), while acknowledging the existence (as Adam did) of “minor” mutilations, including skin-picking and hair-plucking. While the small private asylums of Adam and Blandford provide little material for contextualisation, much more information can be gleaned from the medium-sized Bethlem Royal Hospital, whose superintendents almost all contributed to debate on the topic. We have already seen, from these cases, the difficulty alienists had in classifying and diagnosing cases of self-mutilation. In what other ways did they explore and interpret the ideas and actions of their patients?

Between 1880 and 1900, a total of 592 patients at Bethlem (or 11 per cent of the total patient population within this period) carried out some form of self-inflicted injury.¹⁶⁶ A slightly higher number of female patients were recorded as engaging in these behaviours than men, although the difference was not huge (63% of self-injuring patients were female, compared with 58% of the asylum population). The complicated relation with suicide is indicated in Figure 5, below.

¹⁶⁶ This total includes only behaviours not otherwise specified as suicidal by alienists (such as strangulation, cut-throat, suffocation or shooting), in addition to excluding individuals who refused food.

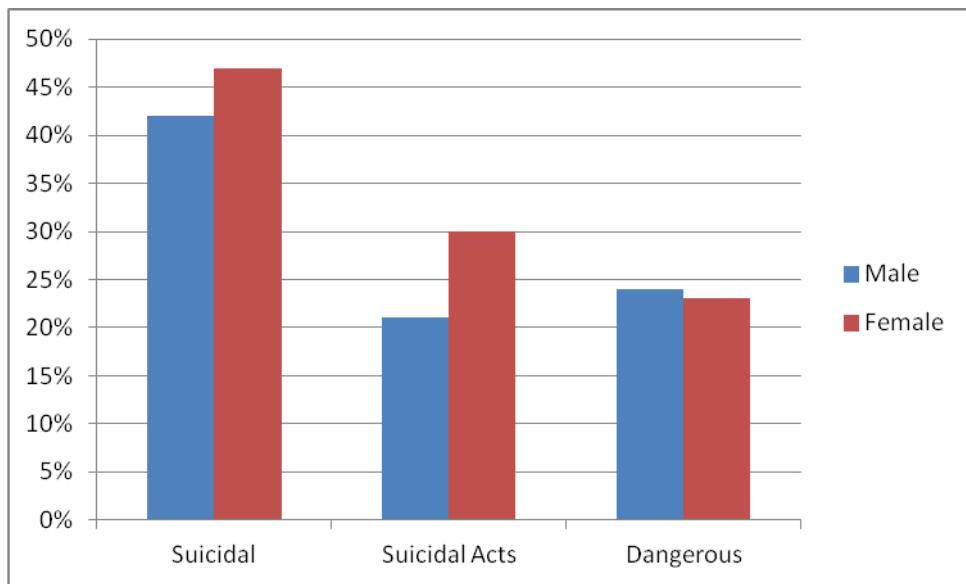


Figure 5: Graph showing the percentage of self-mutilating patients at Bethlem considered to be suicidal or dangerous, 1880 - 1900

Less than half of the patients who injured themselves in some way were reported to be suicidal, and only around a quarter carried out acts considered in the case book to *be* suicide attempts (in addition to exhibiting apparently non-suicidal forms of self-injury).¹⁶⁷ What's more, these two categories were not always connected: patients who were regarded as suicidal were not necessarily those who engaged in seemingly suicidal acts. However, it does appear that patients who injured themselves were more likely to be classed as suicidal than those who did not, for only 25-35% of total admissions were recorded to be suicidal. These patients were no more or less likely to be considered dangerous, despite the association of self-mutilation (by both Lindsay and Blandford) with wild and violent acts – between 20-25% of *all* patients were similarly thus classified.

Examining asylum case records can be instructive in two distinct ways. From a simple statistical standpoint, we can quickly judge whether or not alienists who wrote about self-mutilation were simply reporting the behaviours exhibited most frequently in their institutions. Figures 6 and 7 reveal the statistical disparity between acts occurring within the asylum, and the behaviours that alienists and other medical professionals focused on in their published works. Between 1840 and 1900, I found a total of 69 papers using the term “self-mutilation” published in the three major British medical journals previously examined. These papers referred to 89 instances of self-mutilation, with just over a quarter of these (24) being castration or genital injury. As shown by Figure 6, below, this made castration the dominant form of self-inflicted injury published in medical journals of the mid and late

¹⁶⁷ The decision as to whether or not a patient was suicidal was made by admitting doctors, but re-evaluated at Bethlem during the patient's stay. The figures given here reflect the latter decision.

nineteenth century. In addition, a number of cases also described amputation and enucleation, with a few articles (predominantly in the *Journal of Mental Science*) referencing the “minor mutilations” of skin-picking and hair-plucking. Figure 7, however, indicates the behaviours recorded in the Bethlem case records. While nearly half of the published papers relate to castration, amputation and enucleation, less than ten per cent of the Bethlem cases are of similar acts. Far more prevalent in this twenty-year period are the large number of individuals picking their skin or pulling out hair (particularly female patients) or knocking themselves against something (a behaviour seemingly dominant in male patients, or 43% of the total, compared to 28% of female patients).

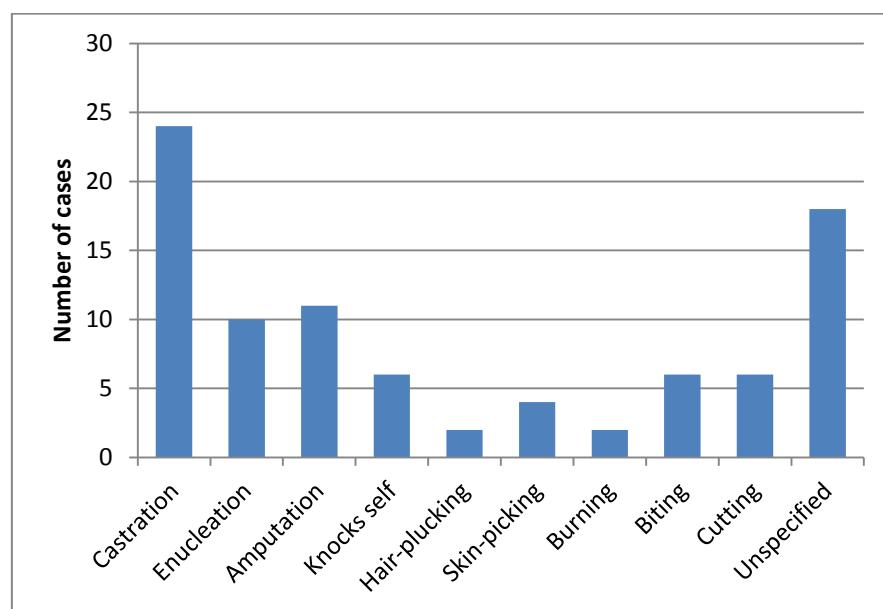


Figure 6: Graph showing types of self-mutilation in medical journals, 1840 – 1900

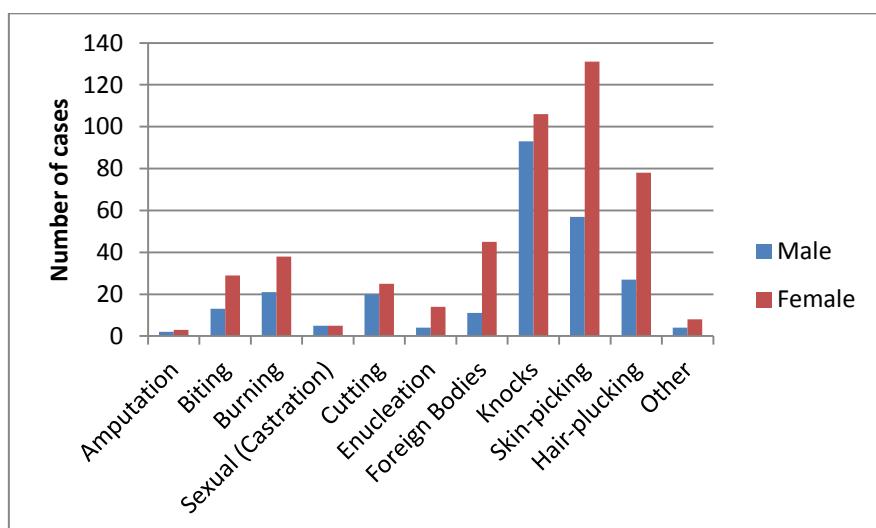


Figure 7: Graph showing types of self-mutilation in Bethlem patients, 1880 - 1900

The figures indicate that publications on self-inflicted injury did not simply describe what was observed within asylums. Publications concentrated on dramatic acts: writers and journal editors presumably assumed that extremes would be of most interest to readers. However, as has been previously indicated, this approach has misled historians into thinking that these behaviours *were* prevalent, and analysing them according to modern interpretations.¹⁶⁸ It could also, as we shall see in chapter four, mislead contemporaries into perceiving certain acts (castration) as far more frequent occurrences than practice suggested. Thus, understanding of self-inflicted injury was not constructed by statistical analysis, but through a complex interplay of factors within an institution: the practical maintenance of order and prevention of harm within the asylum, as well as interaction between doctors and patients in determining the focus of enquiry. Thus, while the volitional model of self-mutilation certainly held much currency in late nineteenth-century psychiatry, exploring the topic purely from this perspective runs the risk of privileging explanations couched in these terms. Attention to concepts of impulse and inhibition certainly did not prevent either patients or physicians from attributing additional meaning to self-injurious actions. The final section of this chapter will explore the interplay of the concerns outlined above in interactions between asylum physicians and their patients, through the medium of the case record.

1.6 Motive and Idea: Interpretation of Self-Injury at Bethlem

As has already been indicated, differentiation between self-mutilation and suicide usually required the patient's assertion that a certain act had been performed with suicidal intent. Indeed, the very definition of suicide was usually made, by physicians and patients' families, through acknowledgement of intent, rather than by judging whether an act was life-threatening. Thus, some patients were described as having attempted suicide when they had swallowed harmless substances, having "believed" them to be poison.¹⁶⁹ The motive explicitly attested to by the patient might thus be taken very seriously by the alienist in his attempts to categorise. Indeed, suicide usually required a further explanation on the part of the patient – *why* did he or she wish to die? It was here that the notion of "uncontrollable impulse" was often suggested by patients, a concept also invoked in many cases of self-mutilation that were *not* specified as suicidal. Concepts of impulse utilised a common discourse between patients and doctors around the physiological understandings of impulse

¹⁶⁸ Parry-Jones and Parry-Jones, "Self-Mutilation in Four Historical Cases of Bulimia", p. 394.

¹⁶⁹ For example Mary Ann Kate Skeats: BRHA, *Female Patient Case book 1898*, (CB/159 – 100).

and inhibition already outlined. Such somatic explanations, equated with damage to the nerves, served to absolve the patient from any suggestion of blame: moreover, it also appeared attractive to relatives and doctors by suggesting that no one could have prevented an injury, except perhaps through such controversial measures as mechanical restraint. Indeed, despite the disapproval of the Commissioners in Lunacy of *any* use of restraint, when an act of self-mutilation occurred they sometimes performed a dramatic U-turn. In 1889, Isabella Morant managed to remove one of her locked gloves (the “over-use” of which had been disapproved of at Bethlem in the *Times* controversy of the previous year)¹⁷⁰ and “very speedily enucleated her eyeball & threw it away from her.”¹⁷¹ The patient had regularly stated her determination to remove her right eye, indicating that it had offended her: these “religious delusions” (which had also led Mrs Morant to amputate her right hand prior to admission) ensured that the patient had been under restraint for several days. When informed of the occurrence, the Commissioners wrote to Bethlem to express their regret. Yet they also added that “[t]hey presume the glove worn by the patient was a strong one”,¹⁷² hinting that the physicians might have been lax in their application of restraint.

This contradictory position on restraint reflects the complexity of physiological debate, situated as it was between unconscious reflex action and a philosophical emphasis on free will.¹⁷³ At the Crichton Royal Institution, James Adam described a patient, admitted in 1875, who “about an hour and a half after admission gouged out her right eye, which now represents a horrible wreck. ... Restraint is employed to prevent her gouging out the other eye.”¹⁷⁴ Although he himself had not been at the institution at the time (indeed, most of Adam’s reports of major mutilations were second-hand: the case of “sexual self-mutilation” which will be explored in chapter four also occurred well before the alienist met the patient in question), Adam certainly paid much attention to the patient, Mrs Blacklock, after he became superintendent in January 1880. In October of that same year, he reported that he had abolished the locked bed from the institution, indicating that Mrs Blacklock had been

¹⁷⁰ This debate stemmed from a letter written to *The Times* by one of the Governors, J.C. Bucknill, complaining that restraint had reappeared at Bethlem. The heated discussion that followed was divided between those alienists that advocated absolute non-restraint, and those who declared that restraint might be the only manner of preventing impulsive self-mutilation or suicide. John Charles Bucknill, “Mechanical Restraint of the Insane: To the Editor of The Times,” *The Times*, August 22, 1888, 6, col. G and responses.

¹⁷¹ BRHA, *Bethlem Female Patient Case book, 1889*, (CB/137 – 76).

¹⁷² BRHA, “On extraction of eye”, Letter from Lunacy Commissioners to Dr Smith, 4th December 1889, *Correspondence with Lunacy Commission 1887 - 1912* (ILB – 16a).

¹⁷³ Roger Smith, “The Physiology of the Will: Mind, Body, and Psychology in the Periodical Literature, 1855-1875,” in *Science Serialized: Representation of the Sciences in Nineteenth-Century Periodicals*, ed. G. N. Cantor and Sally Shuttleworth (Cambridge; London: MIT Press, 2004), 81-110.

¹⁷⁴ Adam, “Self-Mutilation”, p. 1150.

under regular nightly restraint for five years. After visiting her during the following two nights, Adam declared that “careful nursing and nourishing with a generous diet and a moderate amount of stimulant” had been substituted for the use of restraint, indicating that they might similarly improve the patient’s self-control.¹⁷⁵ His conclusion in the case of Mrs Blacklock reflects the doctor’s general emphasis on the role of the social environment of the asylum in both care and cure.¹⁷⁶ When Adam left the Crichton Royal Institution in 1883, he reported that Mrs Blacklock:

Attends and enjoys the various amusements, and she enters with spirit and animation at times into the dances, she plays the piano, and altogether leads a life of as much composure and comfort as can be expected in a case of the kind, in which recovery cannot be hoped for.¹⁷⁷

Restraint, it seems, could only be regarded as beneficial if the impulse were truly neurological (and even this might be treated otherwise, by medication or diet, as Adam suggests). If, instead, idea preceded impulse, the patient must be helped to address this themselves, a suggestion that some patients reflected on, blaming their illness on their own lack of self-control. In 1900, for example, Mary Ellison made a promise to the doctors at Bethlem not to injure herself in her crochet work, writing that, however: “I find it impossible to pull myself together again as I have let myself go too far in every way mentally, morally & spiritually. ... I have wilfully & permanently lost my self-control & not through mania.”¹⁷⁸

Both Isabella Morant and Mrs Blacklock had claimed that their enucleations had been performed as punishment, under the influence of a higher power. The proximity of both amputation and enucleation to the Scriptural injunction that “if thy right eye offend thee, pluck it out...” was often remarked upon by alienists, even in instances where the patient themselves suggested no such relation.¹⁷⁹ This serves to remind us that religious motivations for action remained at the forefront for many late Victorians, despite what has widely been regarded by historians as an increasing secularisation of society. Thus, notions of divine punishment were made prominent in many published psychiatric explanations of self-mutilation which, moreover, ignored the frequent references to judicial punishment for

¹⁷⁵ October 2 1880 in WLL, *Adam Diaries*, MSS.5517. Adam, it seems, adhered strongly to the practice of non-restraint, as shown on 16 Dec 1880, when his subordinate, Dr Munro, requested the use of a strait-waistcoat for a patient who was attacking others and knocking his head against the wall. Adam refused, suggesting the padded cell instead.

¹⁷⁶ Adam’s greatest concern appears to have been for patients to dine in association. By the end of 1880 he had put *Table d’Hôte* dinners into practice on every ward, claiming that it gave “an increased tone of life & cheerfulness” to patients. December 3 1880 in WLL, *Adam Diaries*, MSS.5517.

¹⁷⁷ Adam, “Self-Mutilation”, p. 1150.

¹⁷⁸ BRHA, *Bethlem Female Patient Case book*, 1900, (CB/164 – 130).

¹⁷⁹ Matthew, 5:29-30, *King James Bible*.

supposed earthly crimes indicated by other patients in asylum case records. Despite his own regular church attendance, James Adam regarded religion as especially responsible for exacerbating an underlying human impetus to self-mutilation, suggesting that “many, perhaps most ... self-inflicted tortures have at all times had their origin in unduly exaggerated religious fervour, enthusiasm, or fanaticism.”¹⁸⁰ This was also the case for other writers. Alienist James Shaw regarded “self-mutilation” as occurring *solely* during religious monomania, as did the French writer Henri Dagonet in his 1894 *Traité des maladies mentales*.¹⁸¹ For Dagonet, it was during “la mélancolie religieuse ... que l’on a observé les exemples de mutilations les plus inconcevables.”¹⁸²

The emphasis of doctors on religious explanations was not necessarily shared by their patients. Just as doctors might regard a patient’s self-injury as physical evidence of mental illness, patients similarly suggested that the objective physical reality of their wounds was “evidence” of a particular fear, such as the claims of Eccles Aston that he was being vivisected, which the patient supported by showing doctors wounds that *they* claimed the patient himself had picked into his skin.¹⁸³ While such notions were often brushed off rather abruptly by alienists, who regarded such patients as scheming and manipulative, it is interesting to note that this dismissive attitude did not seem to promote reflection on their own use of self-mutilation as a form of “positive” external proof of internal “unsoundness of mind.” Other patient explanations received more serious attention, however, in particular the notion of endurance. Frederick Humphreys, for example, stated that he had burnt his arms because he had trained himself to bear pain.¹⁸⁴ Alienists similarly suggested that this “endurance” model of self-mutilation functioned in sane, as well as insane, subjects. James Adam suggested “American Indians” as an example of this, but other practitioners looked closer to home, focusing on the importance laid on duelling scars as exemplars of masculine endurance in contemporary German university culture.¹⁸⁵ The difficulty of classifying such acts as insane further suggests that notions of self-mutilation were not necessarily obvious for, when explanations were based on the notion of exhibiting *strength* of will (rather than

¹⁸⁰ Adam, “Self-Mutilation”, p. 1147.

¹⁸¹ Shaw did attribute “self-injury” to other forms of mental illness. Nowhere, however, did he elaborate on what he saw as the difference between the two terms. Shaw, *Epitome of Mental Diseases*, pp. 31;41.

¹⁸² Henri Dagonet, Jules Dagonet, and G. Duhamel, *Traité des maladies mentales* (Paris: J.-B. Baillière, 1894), p. 321.

¹⁸³ BRHA, *Bethlem Male Patient Case book, 1887*, (CB/132 – 82).

¹⁸⁴ BRHA, *Bethlem Male Patient Case book, 1897*, (CB/156 – 21).

¹⁸⁵ Adam, “Self-Mutilation”, p. 1148; Gould and Pyle, *Anomalies and Curiosities*, p. 745. For more on the latter topic, see Sander L. Gilman, *Making the Body Beautiful: A Cultural History of Aesthetic Surgery* (Princeton: Princeton University Press, 1999), p. 122.

its loss), they became viewed as rational, reflecting the importance laid on such notions within Victorian industrial society.¹⁸⁶

Exploring the words of patients, as reported by their doctors, can also remind us of some of the difficulties in interpreting nineteenth-century medical concerns. When the young Charles Hipwood was admitted to Bethlem in 1889, it was stated that the patient had told his mother that he "cut his cheek bec[ause] he ... wanted to see if he c[oul]d feel anything," but informed his keeper that "he liked to see the blood that followed." However, when he told the medical officers of "something dreadful that is going to happen & ... great suffering wh[ich] he will have to bear," they furnished an additional explanation: Hipwood was "apparently trying to prepare himself [for this suffering] by inflicting pain on himself now."¹⁸⁷ Although diagnosed with melancholia, Hipwood's actions were nonetheless interpreted as rational within the context of his illness. The patient's first reported explanation, however, also indicates another way in which self-mutilation was regarded as "evidence" by some patients: in this instance, evidence of existence. Hipwood's emphasis on "feeling" (implying both sensation and emotion) reminds the historian of the difficulty of distinguishing between physical and emotional pain in nineteenth-century texts, emphasising the proximity of physical and mental suffering in a system of medicine which assumed a close relation between bodily and mental states.¹⁸⁸ Charles had apparently told his mother that "he had been a humbug all his life & unfit to live", that he was "ungrateful" and "insensible to anything". Similarly, Charlotte Nash Young "said that she had no feeling & cut her arms, thinks that she has no blood in her body ... and bit herself on the wrist to see if it would bleed."¹⁸⁹ In this instance, all three aspects of proof of existence are combined: feeling might be interpreted either in sensational or emotional terms, while the existence of blood in the body was assumed to be physiological proof of the reality of being.

The physiological role played by blood could also be connected with notions of treatment or healing, indicating a further problem for historians in assuming that self-mutilation was seen as an unequivocally negative behaviour. Self-treatment was a widespread explanation for many forms of self-injury recorded in case books: self-castration

¹⁸⁶ For more on this topic, see the context offered in James Eli Adams, *Dandies and Desert Saints: Styles of Victorian Masculinity* (Ithaca: Cornell University Press, 1995); Andrew H. Miller and James Eli Adams, *Sexualities in Victorian Britain* (Bloomington: Indiana University Press, 1996).

¹⁸⁷ BRHA, *Bethlem Male Patient Case book, 1889*, (CB/136 – 18).

¹⁸⁸ Sarah Chaney, "Anaesthetic Bodies and the Absence of Feeling: Pain and Self-Mutilation in Later Nineteenth-Century Psychiatry," *19: Interdisciplinary Studies in the Long Nineteenth Century*, forthcoming, (2012).

¹⁸⁹ BRHA, *Bethlem Female Patient Case book 1892*, (CB/144 – 113).

was claimed as preventive of the supposedly deleterious effects of masturbation,¹⁹⁰ self-cutting cast as therapeutic bloodletting, while other forms of injury might be claimed an attempt at self-operation, for example to remove a perceived blockage to an organ (either medical or supernatural). Since the vast majority of these equated – often very directly – to contemporary medical practice, such explanations were particularly hard for alienists to recognise, threatening their own efforts to incorporate psychiatry and psychology into the practice of medicine. A particularly clear example is formed by self-cutting which, early in the definition of self-mutilation, did not seem to form part of a pathological model at all (it is possible that this may even help to account for the relative scarcity of such injuries in later case notes). In 1860, for example, Elizabeth Taylor was reported as having shown:

latterly some indications of a wish to injure herself, [...] to draw blood which she fancies would relieve her [.On one occasion...] without any obvious cause or previously speaking of it, she rushed into a chemist's shop & asked to be cupped immediately, as the only means to relieve the distress of her head. ... She states that she hears a supernatural voice "go & bathe" "go & be cupped", that she attempted in consequence of this command to draw blood from the temporal artery of [the] left hand - she has wounds on her right temple & left hand - she states that she tried to injure herself with scissors.¹⁹¹

The complicated dialogue here between self-injury and self-treatment is apparent: although a practice discarded by many physicians by the mid-nineteenth century, bloodletting was still widely available as a treatment for any type of illness, physical or mental, making it hard to define Taylor's actions as self-injurious. Throughout the nineteenth century, patients continued to claim that bleeding constituted self-treatment, whether to bring on menstruation,¹⁹² or, like Elizabeth Taylor, to relieve pressure in the head.¹⁹³ As late as 1900, 56-year-old Alexander McCulloch was said to have declared "that he had bled himself with a razor, because medical men were not now allowed to bleed & this relieved his head".¹⁹⁴ Given the proximity of these explanations to recent medical models of disease, it hardly seems surprising that patients like McCulloch refused to accept the word of their doctors that their acts were irrational or, indeed, that they were mad at all.

¹⁹⁰ This had been emphasised as medically dangerous by doctors since at least the eighteenth century. Thomas Walter Laqueur, *Solitary Sex: a Cultural History of Masturbation* (New York: Zone Books, 2003).

¹⁹¹ BRHA, *Bethlem Female Patient Case book 1860* (CB/77 – 39).

¹⁹² See Annie Melicent Prior, BRHA, *Bethlem Female Patient Case book 1899*, (CB/161 – 51). The same concern is also suggested in Louville Emerson's later psychoanalytic study. L. E. Emerson, "The Case of Miss A: A Preliminary Report of a Psychoanalytic Study and Treatment of a Case of Self-Mutilation," *Psychoanalytic Review*, 1, (1913): 41-54.

¹⁹³ For example George Joblin, BRHA, *Bethlem Male Patient Case book, 1880*, (CB/116 – 70).

¹⁹⁴ BRHA, *Bethlem Male Patient Case book, 1900*, (CB/163 – 50).

Thus, the variety of explanations given for self-mutilation in asylum case notes, some of which were perceived as beneficial (in particular the very prevalent notion of injury as healing and relief), indicates once more that the attitudes adopted by alienists were not necessarily obvious – or even widely accepted. Indeed, such differential models for self-inflicted injury continue to be posited today, with self-harm often classed as a “coping mechanism” rather than a pathological behaviour.¹⁹⁵ Perhaps surprisingly, this does not seem to have affected the assumption that self-mutilation is, nonetheless, a psychiatric issue, a belief which, if not created, was certainly exacerbated by the elevation of a pathological model of self-mutilation above any other type of explanation in the late nineteenth century. This understanding, however, was not always or solely couched in somatic terms. While the principle of “uncontrollable impulse” often appears in published papers, explanations for self-mutilation provided in case books indicate a much more nuanced approach, encompassing environmental, social and spiritual elements. In 1891, George Savage read a paper to the Psychology Section of the British Medical Association, pointing out that:

Insanity is a relative term after all. What is abnormal in one state of society may be quite sane in another, and what are reasonable acts at one age of the same individual may be symptoms of insanity at another.¹⁹⁶

Several years later, he presented another paper emphasising the use of conduct in order to define insanity, nonetheless noting that this “must be recognized as varying with the individual; what is abnormal in one being natural in another.”¹⁹⁷ Behind these two quotations, and much of the material presented in this chapter around efforts to define self-mutilation, is a transparent effort to uphold the importance of variation and individual freedom within a wider context of social progress. Thus, we can see this late nineteenth-century debate over the role of the individual (by his conduct and heredity) and wider society (through environment and culture) in the aetiology of mental illness as part of a far broader question, over the proper relation between self-knowledge and social fulfilment. Savage’s paper thus blames both “self-culture” and the “artificial relationships of society”

¹⁹⁵ See Favazza, *Bodies Under Siege*, pp. 243-53; J. Haines and C. L. Williams, “Coping and Problem Solving of Self-Mutilators,” *Journal of Clinical Psychology*, 53, (1997): 177-186; E. David Klonsky, “The Functions of Deliberate Self-Injury: A Review of the Evidence,” *Clinical Psychology Review*, 27, (2007): 226-239.

¹⁹⁶ George Savage, “The Influence of Surroundings on the Production of Insanity,” *Journal of Mental Science*, 37, no. 159 (1891): 529-535, p. 532.

¹⁹⁷ George Savage and Charles Arthur Mercier, “Insanity of Conduct,” *Journal of Mental Science*, 42, no. 176 (1896): 1-17, p. 2.

for producing insanity.¹⁹⁸ The tension between these two elements will be explored in the following chapter.

1.7 Conclusion

This chapter has provided an over-view of psychiatric writing on self-mutilation, indicating how psychiatrists interpreted self-mutilation in terms of a breakdown of volition and the faculties of intellect or emotion. In some instances, an emphasis on neurological and physiological concepts of impulse and inhibition advanced an understanding of self-mutilation as a physical phenomenon, revelatory of unseen physiological processes. Such accounts show little interest in the actual act of self-wounding, or professed motive, assuming the injuries themselves to be evidence of physical loss of will. This view of self-inflicted injury was, however, rarely the only explanation proffered in British psychiatry, despite its seeming popularity in Germany. Indeed, without additional interpretations, regarding self-inflicted injury as of psychological or social importance, the topic would not have received attention as a particular psychiatric symptom. While this certainly led to some conceptual confusion, wherein generalisations were drawn from biological, metaphysical and moral perspectives on self-mutilation, it should also remind us to hesitate before judging late nineteenth century psychiatry as explicitly somatic, environmental or psychological in approach. Indeed, most alienists utilised all three of these concepts, which they did not regard as contradictory. As this chapter has argued, it is more instructive to view the development of a category of self-mutilation within the context of efforts to explore and define what it was to be human, an idea which underwent a particular shift during the second half of the nineteenth century.¹⁹⁹

I have thus outlined the ways in which alienists developed an interest in self-injurious behaviour, encapsulated in the term “self-mutilation,” from the 1860s into the 1880s. While the application of this categorisation to the historiography of professionalization is recognised, this thesis takes a very different approach to the topic, instead exploring definitions of self-mutilation both within and outside the asylum in relation to understandings of the self. An investigation of asylum practice has indicated that those alienists who explored the topic of self-mutilation were not simply describing what they saw in their patients, but selecting particular material in relation to their other concerns: biological, social and environmental. In order to determine the various ways in

¹⁹⁸ Savage, "The Influence of Surroundings on the Production of Insanity", pp. 533-5.

¹⁹⁹ Roger Smith, *Being Human: Historical Knowledge and the Creation of Human Nature* (New York: Columbia University Press, 2007).

which definitions and theories intersected with asylum practice, historians of psychiatry need to make far greater use of the archival records of asylums, which have here been used to highlight the contradictions between theory and observation, as well as the willingness of alienists to adapt their ideas in relation to individual cases. We can, nonetheless, see certain general trends in nineteenth-century psychiatric explanations of self-mutilation. From the mid-nineteenth century in particular, explanations of human behaviour were increasingly cast in naturalistic terms, by analogy to animal behaviour and reliance on physiological and neurological concepts. Such a shift also caused a reformulation of concepts of pain, which was no longer seen as motivating human behaviour, following the Benthamite model, but rather as a medical concern.²⁰⁰ The concept of morbid instinct, however, required an understanding of motive, located in the universal model of natural science. Such a model assumed that behaviour throughout the natural world was purposive, a principle that was often applied to man and his surrounding environment. The major question, which will be explored in the following chapter, was whether mankind could truly continue to be regarded as natural, and thus bound by the same laws as the animal world, or whether acts like self-mutilation indicated the “unnatural” state of civilized man.

²⁰⁰ Roselyne Rey, *History of Pain*, trans. Louise Elliott Wallace, J.A. Cadden and S.W. Cadden (Paris: La Découverte, 1993); David B. Morris, *The Culture of Pain* (Berkeley: University of California Press, 1991).

Chapter Two
Anthropology and the Evolutionary Body: Mutilated Development (1870 – 1900)

2.1 Introduction

As the previous chapter has indicated, the category of self-mutilation incorporated a variety of diverse acts, with similarly varied explanations. What, it might be wondered, made it seem useful or desirable to combine these acts under one heading? What caused alienists to attempt to develop universal principles underlying self-mutilation, when much of the evidence from their patients pointed to the contrary? In this chapter, by setting self-mutilation within the context of contemporary ideas in anthropology and the natural sciences, I aim to indicate the importance of integration to late Victorian psychiatry. By this term, I imply two things. First, the efforts of alienists to incorporate their professional field into the frameworks of other contemporary disciplines, in particular those of evolutionary biology and anthropology. This was not simply an effort to improve the status of psychiatry by association with legitimate scientific practice. Rather, the centrality of evolutionary debate to later nineteenth-century science and medicine encouraged a widely held belief in the *unity* of nature. In appealing to developments in other disciplines, alienists sought to uncover universal ideas relating to mind and body, in order to better understand and treat their patients. As George Savage put it:

I feel yearly more and more convinced that unity is the one characteristic of natural working, in this planet at least, and that a law once discovered, whether it be discovered among the planets or the plants, has far-reaching powers which at first may not be seen.²⁰¹

The incorporation of various types of injury under the banner of self-mutilation fitted comfortably within this ethos. Further, the term integration is intended to denote something more specific to psychological medicine. The idea of unity had very definite connotations within psychiatry and psychology, for it implied not only harmony within nature as a whole, but also the importance of unity within the individual. Just as disparate acts and ideas were incorporated into a seemingly neat, objective category of self-mutilation, so nineteenth-century writers also saw the integration of various “faculties” in the make-up of the individual self, as outlined in the previous chapter. Attention to self-inflicted injury in the later nineteenth-century can, however, be used to show that the broader concept of integrated selfhood is similarly not a prior and unchanging category.

²⁰¹ George Savage, "Presidential Address, Delivered at the Annual Meeting of the Medico-Psychological Association," *Journal of Mental Science*, 32, no. 139 (1886): 313-331, p. 331.

This chapter focuses on the external physical nature of self-injurious wounds: the ways in which injuries were read as evidence of the biological structure of the individual, including the ways it was assumed this indicated the mental state, providing a broader perspective to the physiological approaches to volition examined in the previous chapter. In the next chapter, I will concentrate instead on “inwardness”: exploration of self-mutilation as revelatory of an internal psychological state through intent, motive or hidden meaning. While such approaches might appear to a modern scholar to be distinct, in both chapters I intend to make it clear that such concerns were combined in a complex – at times seemingly contradictory – manner in late nineteenth century psychiatric theories. We can nonetheless see, as the previous chapter has indicated, the extrapolation of claims about an individual’s biological nature from his or her self-mutilation as part of a broad shift from religious to natural explanations of self-inflicted injury and bodily denial (although, as we have seen already, religious explanations remained evident in many areas). In viewing self-mutilation as a bodily phenomenon, within the bounds of contemporary medicine, alienists combined a volitional model of neurology and physiological psychiatry with the environmental and developmental perspectives of sociocultural evolutionists, as will be outlined in the first section of this chapter. By placing self-mutilation on an evolutionary scale, alienists came to view it as a primitive behaviour. Motives behind self-injury were thus assumed to be similarly primitive, such as the love of “self-adornment” and vanity that Darwin claimed motivated body modification in so-called savage societies.

These explanations were complicated by the political implications of such a view of the relation of self-mutilation to the human body, whereby debates also entered into concern over what society – and the individual’s relation to it – could or should be. Nineteenth-century alienists were not unaware that an individual’s actions might be perceived in different ways depending on the social and cultural context in which his conduct was exhibited.²⁰² Indeed, this formed a large part of their interest in comparative anthropology. Nonetheless, anthropological explanations for religious asceticism, in addition to attention to the “mutilations” witnessed in other cultures, provided an attractive basis for the development of universal psychological truths about self-mutilation, either regarded as indicative of savage traits or, as the second part of this chapter emphasises, in relation to evolutionary concepts of habit and instinct. What assumptions did naturalistic definitions of self-mutilation lead to? The belief that self-mutilation was a pathological symptom within

²⁰² George Savage, "The Influence of Surroundings on the Production of Insanity," *Journal of Mental Science*, 37, no. 159 (1891): 529-535, p. 532; George Savage and Charles Arthur Mercier, "Insanity of Conduct," *Journal of Mental Science*, 42, no. 176 (1896): 1-17, p. 2.

psychiatry, based on an anthropological model which characterised impulsive behaviour as evolutionarily primitive, promoted a general tendency to explain mind in a developmental manner. Mental disorder was thus regarded as strongly linked to the physical development of the individual: asylum patients were viewed as impulsive children, with attempts to treat self-mutilation regarded as educative. Mechanical restraint was re-conceptualised within this context as encouraging the development of good “habits” and self-control, improving tasks such as reading and painting were encouraged, and physicians attempted to instil a sense of moral responsibility into their patients by forming mutual bonds of “trust.” Such methods, strikingly similar to the lay religious therapies developed by the Quaker York Retreat from the 1790s, remind us that conceptual change is not necessarily accompanied by therapeutic development.

Further, as the final section indicates, in suggesting a reversal of the process of evolution psychiatrists often adopted a more pessimistic outlook than the positive progress imagined by sociocultural anthropologists. Comparisons with the ritualistic behaviour of the “savage” appeared to indicate the failure of the self-mutilating patient to develop (physically and mentally), and thus became regarded as evidence of a regression to a primitive state. By extension, such a state appeared to hold implications for the future of civilization and even, if physical anthropologists like Francis Galton were to be believed, the biological degeneration of race. But why was self-mutilation seen as a concern even for those who did not regard heredity as of fundamental importance in discussion of insanity? And why were face-picking and hair-plucking (the two self-injurious acts on which this chapter will focus) censured as much in asylum case records as more extreme acts of physical violence to the body? Patients who injured themselves in this way were regularly suggested in case books to be “selfish”, a correlation that is by no means obvious from a modern perspective. This chapter will conclude that the questions raised by psychiatric attention to self-mutilation reflect a multitude of contemporary social and political issues, by association with sociological concerns over the need for “altruism” in modern society, which can be extended to political reflection on the relative merits of Liberal individualism and collectivist Socialism.

2.2 Adornment and Vanity: Self-Mutilation on the Evolutionary Scale

In 1897, American ophthalmologists George Gould and Walter Pyle included a section on self-mutilation in their *Anomalies and Curiosities of Medicine*. By far the largest part of this drew on anthropology to relate a wide variety of “peculiar custom[s] among savages,” including facial piercings, scarification or castration for religious or ceremonial purposes. All these cultural practices were of significant interest to the medical and popular

press in this period.²⁰³ The description of non-Western, culturally-sanctioned self-mutilation was frequently compared to apparently insane acts of self-injury in Western countries, implying the universal nature of such behaviour. These techniques were also adopted by British alienists, such as James Adam.²⁰⁴ More recently, Armando Favazza used a similar approach, although drawing very different conclusions. Favazza, recognising the way in which self-harm is often stigmatised in modern psychiatry, offered examples of what he regarded as culturally-sanctioned mutilations to suggest that self-inflicted injury is not necessarily an insane or criminal act and, indeed, is regarded as normal or pathological only by the external societal response.²⁰⁵ Gould and Pyle, meanwhile, offered non-Western examples of so-called self-mutilation to emphasise the pathological nature of such acts, drawing a link with "ignorance" and "barbarism." Self-mutilation was identified as signifying an absence of the features of civilised behaviour, and thus a lower stage of evolution, as in the writings of alienists like McIntosh and Lindsay discussed in chapter one. For the American doctors, it was the civilising influence of Christianity, "condemning as it did the barbarous customs of self-mutilation and self-murder, [which made] these practices seem to disappear gradually."²⁰⁶ While others certainly had a markedly different perspective on religion (as, for example, James Adam's equation of self-mutilation directly *with* religious observance), this association between civilization and the Christian religion was widespread. Even agnostic or atheistic writers in the field of anthropology tended to chart the development of civilization through religious and cultural observances, in particular a perceived progress from polytheistic to monotheistic religion.²⁰⁷ The importance of such ideas within psychiatry and psychology should not be underestimated, for the notion of progression from larger to smaller units (e.g. from tribe to family to individual) increased emphasis on a concept of selfhood located specifically within the individual. Henry Maudsley, for example, directly applied principles from natural development to human

²⁰³ George M. Gould and Walter L. Pyle, *Anomalies and Curiosities of Medicine* (London: Philadelphia: Rebman Publishing Co; W.B. Saunders, 1897), pp. 743-58. See also R. A. Jamieson, "Chinese Eunuchs," *The Lancet*, 110, no. 2813 (1877): 123-124; I Kopernicky and J. B. Davis, "On the Strange Peculiarities Observed by a Religious Sect of Moscovites Called Scoptsis," *Journal of the Anthropological Society of London*, 8, (1870): 121-135.

²⁰⁴ James Adam, "Self-Mutilation," in *A Dictionary of Psychological Medicine*, ed. Daniel Hack Tuke. (London: J. & A. Churchill, 1892), 1147-1152.

²⁰⁵ Armando R. Favazza, *Bodies Under Siege: Self-Mutilation and Body Modification in Culture and Psychiatry* (Baltimore, Md.: Johns Hopkins University Press, 1996).

²⁰⁶ Gould and Pyle, *Anomalies and Curiosities of Medicine*, p. 743.

²⁰⁷ Comte's system of "positive philosophy" was influential in this respect, in claiming a course of human development from "fetichism" to polytheism to monotheism and, finally, a hoped-for social reorganization under positivism. Auguste Comte, *The Positive Philosophy of Auguste Comte*, freely translated and condensed by Harriet Martineau, 2 vols. (London: Kegan Paul, Trench, Trübner & co, 1893).

intelligence, for “the analogy of nature rather prepares us to expect that the same progress from the general to the special, should be exhibited”.²⁰⁸

Anthropology as a formal discipline emerged in the late nineteenth century from debates within comparative ethnology over the origins of man: in particular, whether the human race was one species (the monogenist perspective) or many (polygenist). It was not until 1884 that the discipline was formalised with the first university post in anthropology created (for Edward Burnett Tylor), and a section for anthropology set up by the British Association for the Advancement of Science.²⁰⁹ It is interesting to note that the BAAS did not form a section for psychology until 1921: many early psychologists, such as W.H.R. Rivers, Charles Myers and William McDougall, situated themselves within the anthropology section.²¹⁰ However, as historian of anthropology George Stocking has indicated, formalisation is just one aspect of a larger picture, including the development of a general scientific framework of ethnology in the 1830s and ‘40s and its widespread replacement by “social evolutionism”, inspired by the publication of *On The Origin of Species* in 1859.²¹¹ Like the psychiatric debate over self-mutilation and selfhood, these notions were rooted in very broad questions over the state of civilization and social progress, in this instance extending from the belief that the evolution of mankind could be traced through a hierarchy of contemporary cultures, with Western civilization as its peak.²¹² Such progressive, West-centric notions of civilization shaped debate for several decades and, as many historians have noted, frequently formed the basis for the justification of colonialism: an important background to consider, despite falling outside the remit of this thesis.²¹³ In the later nineteenth century, however, an increasing number of writers began to question whether

²⁰⁸ Henry Maudsley, "The Genesis of Mind," *Journal of Mental Science*, 7, no. 40 (1862): 461-494, p. 468. For the broader implications of such attitudes, see L. S. Jacyna, "The Physiology of Mind, the Unity of Nature, and the Moral Order in Victorian Thought," *The British Journal for the History of Science*, 14, no. 2 (1981): 109-132, p. 118.

²⁰⁹ Henrika Kuklick, *The Savage Within: the Social History of British Anthropology, 1885-1945* (Cambridge: Cambridge University Press, 1991), p. 6. See also George W. Stocking, *Victorian Anthropology* (New York; London: Free Press; Collier Macmillan, 1987).

²¹⁰ For more on the association of psychology and anthropology at the turn of the twentieth century, see Adam Kuper, "Psychology and Anthropology: the British Experience," *History of the Human Sciences*, 3, no. 3 (1990): 397-413. Kuper, however, omits all reference to asylum psychiatry, including Rivers' early career, which included a period at Bethlem.

²¹¹ Stocking, *Victorian Anthropology*.

²¹² Edward B. Tylor, "Primitive Society (Part I)," *Contemporary Review*, 21, (1872): 701-718, p. 702. For more on the longevity of this view, see Adam Kuper, *The Invention of Primitive Society* (London; New York: Routledge, 1988).

²¹³ See Dinesh Bhugra and Roland Littlewood, ed. *Colonialism and Psychiatry* (Delhi; Oxford: Oxford University Press, 2001); Anna Cole and Anna Haebich, "Re-markable Bodies" in *A Cultural History of the Human Body: in the Modern Age*, ed. Ivan Crozier (Oxford: Berg, 2010), 147-164; Tony Ballantyne and Antoinette Burton, ed. *Bodies in Contact: Rethinking Colonial Encounters in World History* (Durham; London: Duke University Press, 2005).

the effects of civilization itself might be detrimental.²¹⁴ Within all these texts, however, the external body and visible behaviours were judged as measurable elements of the effects of natural selection in mankind, indicating the level of mental development in the individual.²¹⁵

From the importance laid on external characteristics, we can understand the evolutionist interest in expression (seen as the visible element of mind) but also the fascination of anthropologists with facial “mutilations” and cranial “deformities,” judged to be external evidence of a primitive state of mind.²¹⁶ These were listed among the characteristics to be recorded in the Anthropological Institute’s *Notes and Queries on Anthropology for the Use of Travellers and Residents in Uncivilised Lands*.²¹⁷ First issued in 1874, this short volume aimed to instruct travellers in the anthropological method, enabling them to collect data to be interpreted by “armchair anthropologists” in Britain.²¹⁸ Turn of the century medical texts are replete with images of similar “mutilations”, as shown below.

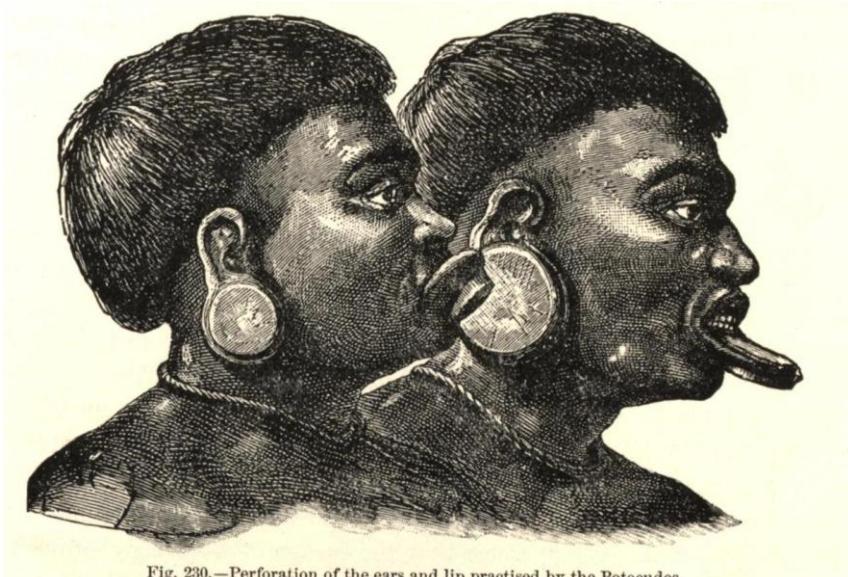


Fig. 230.—Perforation of the ears and lip practised by the Botoceudos.

Figure 8: From Gould and Pyle’s *Anomalies and Curiosities of Medicine* (1897), p. 749

In addition to the above, Gould and Pyle also included an engraving showing the bound feet of Chinese women: such illustrations were intended to indicate a dramatic difference from

²¹⁴ See Stocking, *Victorian Anthropology*, p. 45; William R. Greg, "On the Failure of "Natural Selection" in the Case of Man," *Fraser's Magazine for Town and Country*, 78, no. 465 (1868): 353-362; Kuklick, *The Savage Within*.

²¹⁵ For the first explanation of the widespread idea that natural selection in man acted on the mind, not the external body, see Alfred R. Wallace, "The Origin of Human Races and the Antiquity of Man Deduced from the Theory of "Natural Selection"," *Journal of the Anthropological Society of London*, 2, (1864): clviii-clxxxvii.

²¹⁶ Charles Darwin, *The Expression of the Emotions in Man and Animals*, ed. Konrad Lorenz (Chicago; London: University of Chicago, 1965); Thomas Dixon, *From Passions to Emotions: the Creation of a Secular Psychological Category* (Cambridge: Cambridge University Press, 2003), chapter 5.

²¹⁷ *Notes and Queries on Anthropology*, ed. John George Garson and Charles Hercules Read. 2nd ed. (London: The Anthropological Institute, 1892)

²¹⁸ See Kuklick, *The Savage Within*, p. 90.

Western cultural ideals. The adoption of similar approaches by alienists, who frequently used external signs, including self-mutilation, to measure the internal state of mind or brain, is hardly surprising given the absence of clear disciplinary boundaries in this period. One of the first figures examined by Stocking is James Cowles Prichard, whose *Researches into the Physical History of Man* (1813) was at the centre of British ethnology of the mid-nineteenth century.²¹⁹ Yet the medically-trained Prichard was also visiting physician to a lunatic asylum, and his treatise on insanity – in particular his controversial category of moral insanity – remained a popular text for alienists throughout the century.²²⁰ Towards the end of his career (Prichard died in 1848), the doctor expounded the concept of the “psychic unity of man”; a notion which, as indicated above, lay behind psychiatric efforts to use anthropological investigation of “mutilations” in other cultures to prove that self-inflicted injury was a universal human behaviour.²²¹ The underlying assumption that *motivation* was also universal was rarely questioned before the twentieth century: hence alienists used very diverse practices as examples of their theories, including the self-castration performed by the Russian religious cult (the Skoptsy) and the tradition of eunuchism in the Chinese Imperial Court.²²² Some of these examples will be explored in more detail in chapter four.

The widespread use of these analogies – particularly the conflation between physical characteristics and mental traits – ensured that certain behaviours within an asylum, including self-mutilation, tended to be judged as “primitive.” Such associations worked in a similar circular manner to anthropological assumptions: an uncivilized way of life was thought to explain differences in intellect or morals, just as a difference in mental characteristics between civilised man and savage explained different modes of living. One frequent correlation was that made between the “impulsive” and “emotional” state of savages and asylum patients. This relied upon a model of individual and racial development which assumed that the repression of instinct, including the control of reflexive emotional

²¹⁹ Stocking, *Victorian Anthropology*, p. 48; James Cowles Prichard, *Researches into the Physical History of Man*, ed. George W. Stocking (Chicago: University of Chicago Press, 1973). Prichard’s book was re-published, expanded into two volumes, in 1826, and then as five volumes in 1836-47.

²²⁰ James Cowles Prichard, *A Treatise on Insanity and Other Disorders Affecting the Mind* (London: Sherwood, Gilbert, and Piper, 1835); Daniel Hack Tuke, *Prichard and Symonds in Especial Relation to Mental Science: with Chapters on Moral Insanity* (London: J. & A. Churchill, 1891); Hannah Augstein, “J. C. Prichard’s Concept of Moral Insanity - a Medical Theory of the Corruption of Human Nature,” *Medical History*, 40, no. 3 (1996): 311-343.

²²¹ Stocking, *Victorian Anthropology*, p. 51. Henrika Kuklick sees psychic unity as the “common denominator” of the arguments of anthropologists in the later nineteenth century. Kuklick, *The Savage Within*, p. 82

²²² Laura Engelstein, *Castration and the Heavenly Kingdom: a Russian Folktale* (Ithaca; London: Cornell University Press, 1999); Melissa S. Dale, “Understanding Emasculation: Western Medical Perspectives on Chinese Eunuchs,” *Social History of Medicine*, 23, no. 1 (2010): 38-55.

responses, provided a marker of civilization. Such an emphasis is seen particularly clearly in the model of psychology developed by Herbert Spencer, who described a gradual developmental transition from instinctive to rational action.²²³ In a paper read to the Anthropological Institute in June 1875, Spencer suggested that anthropologists should pay the same attention to differences in human psychology as they paid to physical variation between races: Spencer himself laid particular emphasis on emotional divergence.²²⁴ Spencer judged that “[m]ental evolution, both intellectual and emotional, may be measured by the degree of remoteness from primitive reflex action.”²²⁵ Such a description added a reassuring element of control to the physiological model discussed in chapter one, which could seem to reject the notion of free will, by indicating that volition could be acquired.²²⁶ This notion of “self-control” loomed large in psychiatric and psychological texts, and provided a common language often adopted by patients.

“Impulsiveness” was thus often stressed in descriptions of self-mutilation, particularly in the so-called “minor” mutilations on which this chapter focuses: hair-plucking and skin-picking. As already indicated in chapter one (Figure 7), these behaviours were the most common types of self-mutilation in the late nineteenth-century asylum, accounting for 38% of male patients and 63% of female patients who engaged in some form of self-injurious act. They were often highly visible acts, as indicated in the photograph below. Such images were used to draw a variety of conclusions regarding the patient’s state of mind and associations between mind and behaviour.

²²³ Herbert Spencer, *The Principles of Psychology*, 2nd edn. (London: Williams and Norgate, 1870-2).

²²⁴ Herbert Spencer, “The Comparative Psychology of Man,” *Mind*, 1, no. 1 (1876): 7-20.

²²⁵ Spencer, *The Principles of Psychology*, p. 584.

²²⁶ For more on the “free will” debate, see Roger Smith, “The Physiology of the Will: Mind, Body, and Psychology in the Periodical Literature, 1855-1875,” in *Science Serialized: Representation of the Sciences in Nineteenth-Century Periodicals*, ed. G. N. Cantor and Sally Shuttleworth (Cambridge; London: MIT Press, 2004), 81-110.



Figure 9: Mary Stoate at Bethlem, 1895 (Bethlem Art & History Collections Trust)

The image shows a young woman admitted to Bethlem in February 1895.²²⁷ Her restless behaviour and frequent outbreaks of laughter on admission saw Mary Stoate diagnosed with hysterical mania. While in hospital, this diagnosis was corroborated by a description of Mary as impulsive, untidy and careless in dress and, when she began pulling out her hair in August this was seen as further evidence of such characteristics. Yet, despite her wildness, Mary Stoate was simultaneously considered to be solitary and reserved. The case book, completed by Clinical Assistant Dr Pring, reports that: "Patient keeps standing up in the position indicated in the photograph, continually picking her head. Remains by herself, doesn't talk". This suggested that Mary's behaviour was believed to indicate her preoccupation with her own troubles, evidenced by an unwillingness to socialise: the photograph was represented as visual evidence of this state of isolation. In the image, Mary's head is tilted downwards and sideways, looking away from the photographer as if she hasn't noticed he is there. One hand is folded across her chest, while the other is raised to her head, although she doesn't seem to be have been pulling out her hair when the photograph was taken (there is no blurring to suggest movement), but instead cradling her head with her fingers. It hardly

²²⁷ BRHA, *Female Patient Case Book, 1895*, (CB/152–14).

seems surprising that such an image might be used to emphasise a connection between mind and behaviour, for Stoate herself encourages this by both her pose and the exposure of her scalp. Mary was eventually discharged uncured, but visited the Hospital a year later, at which time she was considered entirely recovered.

How should we view this representation of psychiatric patients? Considering the acts of skin-picking and hair-plucking from a sociocultural evolutionary perspective helps to explain how, for the nineteenth century alienists writing on self-mutilation, these patients could be categorised with those who exhibited the more physically destructive behaviours of castration, amputation and enucleation. Just as evolutionary development was thought to progress along a gradual scale, alienists insisted on a progression of self-mutilation, from major injuries through to the “nervous, fidgety, restless habits” that “less perhaps in magnitude, are common among nervous people who are not insane.”²²⁸ Indeed, the extent of such behaviour at any given time was regarded as a “valuable criterion” of a patient’s nervous condition: an indication that the “excitable”, “emotional” or “reserved” (and thus particularly susceptible) patient had lost all self-control and was in danger of outright insanity.²²⁹ In effect, self-mutilation made the internal state of insanity externally visible to the physician, in the same way that the physical characteristics and modes of life in savage populations were correlated with their mental and moral make-up by anthropologists.²³⁰ Moreover, hair-plucking and skin-picking were behaviours that appeared quite directly comparable to savage behaviour. Many anthropologists in the late nineteenth and early twentieth centuries, as W.H.R. Rivers later observed, were particularly interested in the material culture that could be directly observed in savage communities, including “such obvious practices as tattooing, distension of the ear-lobe, circumcision, etc.”²³¹ In his controversial theory of “sexual selection,” Darwin similarly made heavy reference to anthropological accounts of body modification in other cultures when exploring the influence of beauty in determining the “marriages of mankind”. Although suggesting that “[h]ardly any part of the body, which can be unnaturally modified, has escaped,” he nonetheless concentrated on the face, which, “with us is chiefly admired for its beauty, so

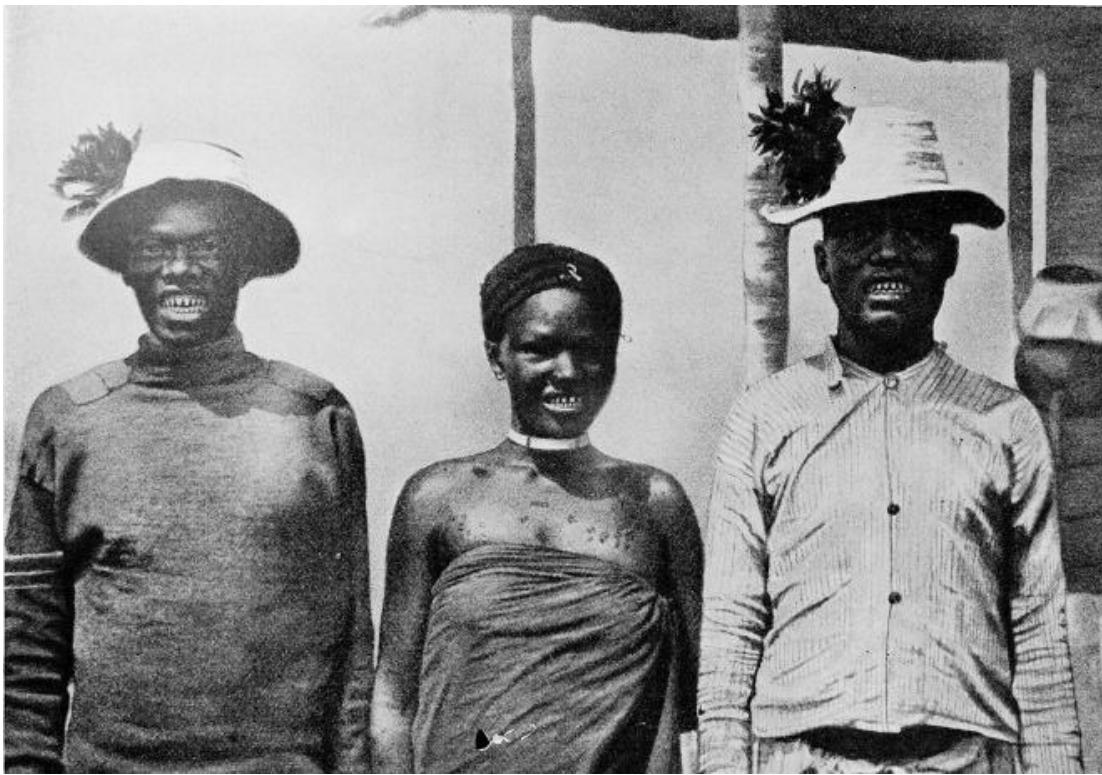
²²⁸ Adam, “Self-Mutilation”, p. 1151; G. Fielding Blandford, *Insanity and its Treatment: Lectures on the Treatment, Medical and Legal, of Insane Patients* (Edinburgh; London: Oliver & Boyd; Simpkin, Marshall, 1871), pp. 194–5.

²²⁹ Blandford, *Insanity and its Treatment*.

²³⁰ These ideas today tend to be associated with psychoanalysis, particularly Menninger’s claim that biting the fingernails was only “a degree short of biting the fingers”. These earlier examples indicate that Menninger was building on pre-existing assumptions and not, as he himself claimed, necessarily applying new techniques to old ideas. Menninger, *Man Against Himself*, p. 202.

²³¹ Quoted in Richard Slobodin, *W.H.R. Rivers: Pioneer Anthropologist, Psychiatrist of “The Ghost Road”* (Stroud: Sutton, 1997), p. 102.

with savages it is the chief seat of mutilation.”²³² The photographs taken by anthropologists invariably emphasised such “deformities”, as in the image below, taken at the Wellcome Tropical Research Labs in Cameroon in 1911.



**Figure 10: Photograph of a group of Nyam-nyam showing their sharpened teeth
(Wellcome Library, London)**

The group in this photograph have clearly been told to display their sharpened teeth, in order to emphasise this element of their appearance, although their clothing and stance would distinguish them far less clearly from the Western researchers who photographed them. The baring of the teeth also promotes animalistic associations, by requiring the people photographed to snarl, probably not their usual expression, but potentially interpreted in this way by viewers.

The second edition of *Notes and Queries on Anthropology* (1892) included a long section on “artificial deformities”, of which the vast majority related to the head and face (three out of four sections).²³³ This section was associated with that of “personal ornaments” by a note indicating that the practice of “tattooing and circumcision &c.” had been placed elsewhere, “although in one sense they may be regarded as kinds of artificial

²³² Charles Darwin, *The Descent of Man*, ed. H. James Birx (Amherst: Prometheus Books, 1998), pp. 596-7.

²³³ *Notes and Queries on Anthropology*, pp. 61-6. The corresponding section on “natural deformities” only amounted to one page.

deformation.”²³⁴ Just as alienists considered most forms of bodily damage under the heading of self-mutilation, the anthropological viewpoint also conflated “in one sense” every type of body modification, no matter how or why performed, including binding, amputation, castration, scarification, tattooing and piercing (and even though so-called artificial deformities were investigated under anthropography (physical anthropology) and piercing and tattooing under ethnography (social anthropology)). Such an approach highlights the interesting contradiction in Darwin’s account of sexual selection: by regarding facial alterations as unequivocally mutilating, they could be separated from the beautifying procedures of westerners, such as make-up, hairstyle or ear-piercing. Despite this, mutilations were deemed to stem from efforts to appear attractive, represented as an extreme or perverted version of the “natural” need of physical beauty for attracting a sexual partner. Degenerationists simply reversed this process, regarding decorative ear-piercing and tattooing in western societies as evidence of a reversion to savage tendencies, for example the assertion that “[t]he ludicrous custom of piercing the ears for the wearing of ornaments, typical of savagery and found in all indigenous African tribes, is universally prevalent among our own people.”²³⁵

Darwin’s concern with breeding led him to emphasise the relation of all mutilations in savages to sexual selection, thus insisting that the “lower” animal instincts were the main motivations for such behaviours: “self-adornment, vanity, and the admiration of others.” Meanwhile the observation that, in most tribes, men were more finely ornamented than women Darwin attributed to the “characteristic selfishness of man.”²³⁶ Never mind that he had previously suggested that a need for the admiration of others advanced the development of the “social instincts” responsible for the development of civilization: here vanity was held as demonstrative of the supposed selfishness of savages, a prior belief which also meant that those motivations for body modification which might have been considered related to higher feelings (such as religious sentiment), were relegated by Darwin to the status of lesser motives. The assumption that body modification was associated with vanity was also taken up in *Notes and Queries*, where no other possible motives were reported.²³⁷ If piercing, scarification, and other modifications were deemed evidence of vanity and selfishness in savages then it hardly seems surprising that self-mutilation became similarly regarded within an asylum context. By beginning with the individual case study, many

²³⁴ *Notes and Queries on Anthropology*, p. 62.

²³⁵ Gould and Pyle, *Anomalies and Curiosities of Medicine*, p. 749.

²³⁶ Darwin, *The Descent of Man*, p. 597.

²³⁷ *Notes and Queries on Anthropology*, p. 63.

alienists reversed the process explored by anthropologists, in which the biological evolution of the species was seen as metaphorically extendable to both the evolution of civilization and the education of the individual.²³⁸ Instead, in a case study, alienists might regard the individual as representative of a broader human state. Thus, a line could be drawn from patient to population at large, indicating the damaging effects that a lack of sociability in the individual might have for the progress of civilization, and the biological future of the race. Self-mutilation provided a distinctive focus, externally visible, and easily comparable to the traits of savages. There were, of course, dissenting voices. In his 1887 study on totemism, anthropologist James Frazer, for example, emphasised the relation of mutilations to religious practice.

In order, apparently, to put himself more fully under the protection of the totem, the clansman is in the habit of assimilating himself to the totem by dressing in the skin or other part of the totem animal, arranging his hair and mutilating his body so as to resemble the totem, and representing the totem on his body by cicatrices, tattooing or paint.²³⁹

Although introducing an apparent interest in cultural relativity, in that he attempts to explore closely the claimed value of certain physically damaging acts within non-western societies, Frazer's ideas nonetheless fitted into evolutionary arguments in other ways. As we have already seen, religious practices were also frequently judged on a progressive scale, and it would have been no surprise to many alienists that self-injurious practices might be connected with what they viewed as primitive superstition, an assumption that also accorded well with the assumption that religious delusions were frequently to blame for acts of self-mutilation within the asylum.

2.3 Civilization and Self-Control: the Re-Interpretation of Mechanical Restraint

Despite the widespread interest in evolutionary thought in Victorian psychiatry, there are a number of complications to the anthropological view of self-mutilation. While this perspective is certainly evident in many publications, it is also apparent that, in practice, not every individual who mutilated themselves within the asylum was considered impulsive, introspective or emotional. Skin-picking and hair-plucking were also not always regarded as analogous behaviours:²⁴⁰ for example, Figures 8 and 9 (below) show that the former was more closely associated with melancholia than the latter. This diagnosis accounted for 68% of patients who picked their skin, while only 20% were regarded as suffering from mania. In

²³⁸ Stocking, *Victorian Anthropology*, pp. 227-9.

²³⁹ J. G. Frazer, *Totemism* (Edinburgh: A. & C. Black, 1887), p. 26.

²⁴⁰ Although published texts did connect the two. For example, Richard L. Sutton, "Trichotillomania," *JAMA*, 63, no. 24 (1914), 2126-8.

patients who plucked their hair, the difference between melancholia and mania was much less marked: 53% of patients were diagnosed with melancholia and 37% with mania.

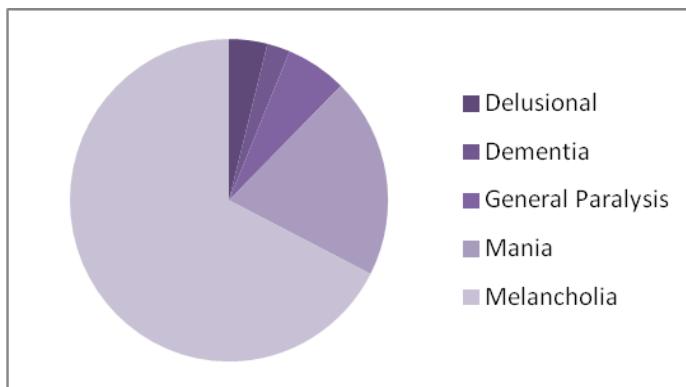


Figure 11: Chart showing skin-picking at Bethlem by diagnosis, 1880 - 1900

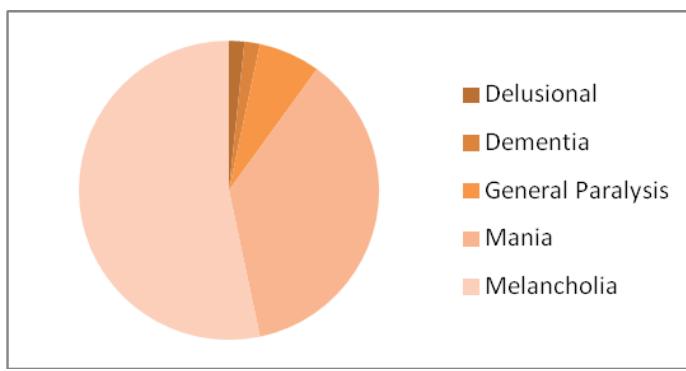


Figure 12: Chart showing hair-plucking at Bethlem by diagnosis, 1880 - 1900

Nonetheless, skin-picking and hair plucking were often regarded as closely related in asylums, in part because around 11% of patients exhibited both behaviours. One link between the two lay in the suggestion that both might be caused by skin irritation, although this was often discounted when patients failed to corroborate the theory. Still, most of the early texts discussing both behaviours were written by dermatologists seeking such a physiological cause, and it was a French dermatologist, Henri Hallopeau, who coined the term "trichotillomania" (still used to describe compulsive hair-plucking today), in 1889.²⁴¹ In addition, however, both behaviours, while not necessarily causing long-term damage, were highly visible, altering the appearance of the head and face. We might regard this emphasis as part of a more widespread medical interest in the head and face that lay within many theories related to psychiatry during the nineteenth century: phrenology, physiognomy, and the suggestions of Alfred Wallace that natural selection in mankind acted on the intellect

²⁴¹ Hallopeau's colleague, Ernest Besnier, simultaneously suggested the less popular "trichomania". H. Hallopeau and Ernest Besnier, "Alopecie par grattage (trichomanie ou trichotillomanie)," *Annales de Dermatologie et de Syphiligraphie*, 10, (1889): 440-441. The French context is outside the scope of this thesis, but would make for an interesting comparison.

and social emotions, with change made visible in the skull and face.²⁴² However, there is no evidence that alienists explicitly made this connection.

Although those evolutionists who saw progress as inevitable, such as Darwin, regarded mutilations in savages at the opposite end of the scale from decorative practices in western civilizations, it is not surprising to find that others considered new forms of aesthetic surgery in the West “cosmetic mutilations.” Gould and Pyle expressly stated that such mutilations were a reversion to primitive vanity: “It is quite possible that some of our modern operators have overstepped the bounds of necessity, and performed unjustifiable plastic operations to satisfy the vanity of their patients.”²⁴³ Sander Gilman offers an interesting explanation of such concerns around cosmetic surgery, arguing that facial alterations in the 1880s and ‘90s aimed to allow an individual to “pass” by disguising visible racial or moral attributes, such as “too-Jewish” features, or a “drunkard’s nose.”²⁴⁴ The face, after all, was strongly believed to indicate a person’s character; hence the importance attached to composite photographs in late nineteenth-century criminology, which aimed to illustrate a common facial “type” for any specific social element.²⁴⁵ Rooted in Enlightenment ideas of self-improvement, surgery allowed a person to “remake the self,” appearing happy and healthy and thus (deceptively) normal. Yet the deception provoked disapproval over the possibilities of cosmetic surgery. In contrast, the visibly disfiguring actions of face-picking and hair-plucking might be regarded as making *unhappiness* visible, marking the insane body as different (and thus socially dangerous): in effect, un-making, or destroying, the self.

Such social and political concerns can be viewed most explicitly in relation to gender. At Bethlem, far more women engaged in hair-plucking than men (73% of these patients were female). As with many other insane behaviours (for example undressing in public, the destruction of property or eating “ravenously”), such self-mutilations were interpreted as a rejection, consciously or otherwise, of social propriety. Long hair in women is “universally

²⁴² Wallace, "The Origin of Human Races". On phrenology see Roger Cooter, *The Cultural Meaning of Popular Science: Phrenology and the Organization of Consent in Nineteenth-Century Britain*, (Cambridge; New York: Cambridge University Press, 1984); Robert M. Young, *Mind, Brain and Adaptation in the Nineteenth Century: Cerebral Localization and its Biological Context from Gall to Ferrier* (Oxford : Clarendon Press, 1970).

²⁴³ Gould and Pyle, *Anomalies and Curiosities of Medicine*, p. 746.

²⁴⁴ Sander L. Gilman, *Making the Body Beautiful: A Cultural History of Aesthetic Surgery*, Princeton: Princeton University Press, 1999).

²⁴⁵ David G. Horn, *The Criminal Body: Lombroso and the Anatomy of Deviance* (New York; London: Routledge, 2003); Peter Becker and Richard F. Wetzell, eds. *Criminals and their Scientists: the History of Criminology in International Perspective* (New York: Cambridge University Press, 2006); Nicole Rafter, *The Criminal Brain: Understanding Biological Theories of Crime* (New York; London: New York University Press, 2008); Marie-Christine Leps, *Apprehending the Criminal: the Production of Deviance in Nineteenth-century Discourse* (Durham: Duke University Press, 1992).

admired”, claimed evolutionary anthropologist Winwood Reade, like many of his contemporaries connecting hair directly to femininity.²⁴⁶ Hair was not simply related to ideals of beauty, however, but also other elements of “proper” behaviour. In the Sherlock Holmes Adventure, *The Copper Beeches*, the detective is consulted by Violet Hunter, a governess who has just been offered a surprisingly lucrative position on the condition that she cuts off her hair. Miss Hunter is horrified by the suggestion: indeed, her prospective employer’s words sound almost obscene. “I could hardly believe my ears ... I could not dream of sacrificing [my hair] in this off-hand fashion.”²⁴⁷ Eventually, she decides she cannot afford such principles, and cuts off her hair to accept the situation. Although on the surface much of this tale, including Miss Hunter’s repeated use of the melodramatic term “sacrifice” might appear to be a misogynistic comment on the vanity of women, more is implied. Holmes repeatedly tells Watson that “no sister of his should ever have accepted such a situation”²⁴⁸ and the absence of any family members to advise and protect Miss Hunter is used to emphasise the governess’ vulnerability. In cutting her hair in return for payment, it is suggested that Violet Hunter has prostituted herself. Indeed, in female Bethlem patients, cutting the hair short was often viewed as self-mutilation. In 1893, 30-year-old Edith Blyth was described as having, under an impulse, “cut off all her hair, cut her hand, and her foot.”²⁴⁹ By grouping these three behaviours together, apparently compelled by the same impulse, it was indicated that cutting the hair was a similar act to wounding any other part of the body.

The rejection of feminine beauty through hair-plucking might make such women seem politically dangerous, like the “manly women” and “glorified spinsters” discussed in Judith Walkowitz’s *City of Dreadful Delight*, who cut their hair short and had other goals in life than marriage.²⁵⁰ 25-year-old Alice Gopp, for example, was described as “very boyish and untidy” with short hair.²⁵¹ The rejection of proscribed gender roles also made these women seem sexually dubious: in many cases, the act of hair cutting or plucking was explicitly linked to sexuality. The young Annie Brinckes “cut her hair short and shortened her dress,”²⁵² an act of both childish rebellion and provocative sexuality. Beginning to wear long dresses was a

²⁴⁶ William Winwood Reade, *The Martyrdom of Man*, 9th ed. (London: Trubner & Co, 1884). See also Darwin on sexual selection: Darwin, *The Descent of Man*.

²⁴⁷ Arthur Conan Doyle, *The Adventures of Sherlock Holmes* (London: Penguin, 1994), p. 281.

²⁴⁸ Doyle, *The Adventures of Sherlock Holmes*, p. 284.

²⁴⁹ BRHA, *Female Patient Case Book*, 1893, (CB/146 – 26).

²⁵⁰ Judith R. Walkowitz, *City of Dreadful Delight: Narratives of Sexual Danger in Late-Victorian London* (London : Virago, 1992).

²⁵¹ BRHA, *Female Patient Case Book*, 1896, (CB/154 – 88).

²⁵² BRHA, *Female Patient Case Book*, 1895, (CB/152 – 33).

sign of womanhood for the Victorian bourgeois girl, yet short dresses were also associated with the lower classes – Annie had expressed a desire to look like a servant. Judging by Annie's determination, the prospect of service might hold a tantalising prospect of independence (whatever the reality) for young middle-class women, some of whom welcomed admission to Bethlem as an escape from overbearing parents. Ada Smith was reported as describing her home life as "very quiet and irksome" because "her parents allow her to have very little company". Bethlem, however, offered Ada the opportunity to socialise, and "she greatly enjoys the music and the tennis she gets here."²⁵³

Judith Walkowitz has indicated that prostitutes were seen as "unsexed" through their claimed exhibition of "male lust".²⁵⁴ Walkowitz's analysis of the way in which late Victorian women identified with the prostitute victims of the Ripper murders is particularly interesting here.²⁵⁵ From September 1888, many patients admitted to Bethlem held delusions concerning the Whitechapel murders, yet there was a clear gender divide in these concerns. Male patients feared that they were suspected of being the murderer, while women openly identified with the victims. In some cases this promoted a link between self-mutilation and "deviant" sexuality. Annie Geake, a 25-year-old teacher, was admitted to Bethlem in early 1889. Geake's delusions centred on the idea, in the words of her brother-in-law, "that she was to be cut-up – unsexed – like the Whitechapel victims." Geake heard "gentlemen's voices", particularly those "of a person "lost" to her": hinted to be a former lover. Bethlem's medical officers thus made a direct link between Annie Geake and the prostitutes murdered by Jack the Ripper, suggesting that "with ideas of this nature there is a considerable admixture of the sexual element." Later, in the hospital, when the "erotic and troublesome" Geake attempted to injure herself, this was simply regarded as further evidence of her sexual state, with her "erotic" ideas thought to have predisposed her towards self-mutilation.²⁵⁶

The large number of excellent feminist histories of psychiatry in the late nineteenth century has tended to lead to the impression, by omission, that proscribed gender roles were only problematic for Victorian women.²⁵⁷ Yet the connection between the "unsexed" prostitute and self-mutilation reminds us that "sexual self-mutilation" was generally viewed

²⁵³ BRHA, *Female Patient Case Book 1891*, (CB/140 – 36).

²⁵⁴ Judith R. Walkowitz, *Prostitution and Victorian Society: Women, Class and the State* (Cambridge: Cambridge University Press, 1980).

²⁵⁵ Walkowitz, *City of Dreadful Delight*.

²⁵⁶ BRHA, *Female Patient Case Book 1889*, (CB/137 – 38).

²⁵⁷ Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (London: Virago, 1987); Walkowitz, *City of Dreadful Delight*. For the converse, see Lesley Hall, *Hidden Anxieties: Male Sexuality, 1900-1950* (Cambridge: Polity, 1991).

as a peculiarly *male* behaviour. The associations of self-mutilation with male sexuality will be discussed in greater depth in chapter four, but it is interesting to return here to the tendency in male patients to pluck facial, rather than head hair. Christopher Oldstone-Moore has suggested that, between 1850 and 1890, the beard was adopted by Englishmen "as a signifier of masculine identity," affirming authority politically and within the family to provide personal reassurance at a time in which both employment and family relations were markedly changing.²⁵⁸ In 1893, Bethlem patient Frederick Renwick explicitly related his facial hair to his sense of masculinity. Before admission to Bethlem, Renwick imagined that someone broke into his house, "took away his sense, cut off his beard & moustache & applied some lotion to prevent it growing again." He later imagined that the same individual cut his penis, and angrily told the doctors that he was "a man and not a man-woman."²⁵⁹ For Renwick, his beard and moustache were the visible indicators of his masculinity and hence his authority. Although in Renwick's case no actual mutilation occurred, for other patients the threat of injury might lead to it. In 1895, Francis Sheridan Chamberlain, unemployed and living with his sister, complained of ill-treatment when he thought his hair and moustache had been cut too short in the Hospital. Three months later he was regularly plucking out his beard, something which continued until his discharge at the end of 1896, by which time he "need[ed] a lot of looking after."²⁶⁰ The apparently impulsive nature of hair-plucking in both men and women, then, could be viewed by contemporaries as related to external as well as internal (biological and psychological) factors: an understandable, but nonetheless problematic, reaction to the self-control increasingly demanded by society.

We can see this most clearly by exploring the way in which self-injurious behaviours could be "sternly repressed" in the asylum, an approach George Fielding Blandford recommended to educate children away from "nervous habits".²⁶¹ From this, one might anticipate that the adoption of an anthropological model, which placed certain behaviours at particular stages of individual and social development, would lead to increasing use of physical methods of treatment, including mechanical restraint, within asylums (as, indeed, appears to have been the case in schools at this time).²⁶² Indeed, restraint did begin to make

²⁵⁸ Christopher Oldstone-Moore, "The Beard Movement in Victorian Britain," *Victorian Studies*, 48, no. 1 (2005): 7-34.

²⁵⁹ BRHA, *Male Patient Case Book 1893*, (CB/145 – 66).

²⁶⁰ BRHA, *Male Patient Case Book, 1895*, (CB/151 – 81).

²⁶¹ George Fielding Blandford "Imperative Ideas" in *Quain's Dictionary of Medicine, Third edition*, ed. H. Montague Murray, vol. 9, (London: Longmans, Green, 1902), p. 766.

²⁶² J.A. Mangan, "Social Darwinism and Upper-class Education in Late Victorian and Edwardian England" in J. A. Mangan and James Walvin, ed. *Manliness and Morality: Middle-class Masculinity in Britain and America, 1800-1940* (Manchester: Manchester University Press, 1987), 135-159.

a reappearance in many asylums, most publicly at Bethlem (as described in chapter one), in the later decades of the nineteenth century. These restraints differed from those used in asylums prior to the non-restraint movement of the mid-century, and were closely monitored by the Commissioners in Lunacy, who required every use to be recorded and justified. Nonetheless, in practice, justifications were extremely vague: for example, "for medical reasons" might include stopping a patient removing a dressing after an operation or the prevention of self-mutilation, suicidal impulses or masturbation, while the methods used also carried vague and euphemistic names, such as "soft gloves" and "strong dresses".²⁶³

At the centre of the debate over mechanical restraint, however, was the question as to whether restraint was used as a matter of convenience, or constituted a form of treatment. In the 1890 Lunacy Act, mechanical restraint was explicitly "legalised" for the first time, through an attempt to define which items could (as well as could *not*) be used. Although the Commissioners declared that they did not want this "to be construed as implying greater countenance by them of this mode of treatment," they also commented that, at times, "mechanical restraint is beneficial to the patient."²⁶⁴ This implied that certain patients might be incapable of controlling themselves, and thus need mechanical assistance. This had, of course, long been a legal argument for the incarceration of the mad. Indeed, the beneficial nature of mechanical coercion was frequently emphasised in medical arguments against the introduction of non-restraint in the 1830s and '40s.²⁶⁵ What was new in the late nineteenth century was the notion that a patient could somehow be trained by the process of restraint so that, when restraint was removed, he or she would no longer engage in destructive practices. The same was occasionally claimed for medication, such as the regular use of sedatives, although pharmaceutical measures received far less attention.²⁶⁶ This view required the acceptance of a developmental understanding of behaviour, as described above, and also found in contemporary descriptions of the formation of "habits".

The importance of habit in physiology had been emphasised by W.B. Carpenter, who laid increasing importance on the notion in his textbooks, beginning with the role of habit in reflex action in *Principles of Human Physiology* (first published 1842), and later incorporating

²⁶³ "Soft gloves" were padded to the thickness of about an inch, while "strong dresses" restrained patients by placing the hands in padded extremities. George Savage, "The Mechanical Restraint of the Insane," *The Lancet*, 132, no. 3398 (1888): 738-739, p. 738.

²⁶⁴ Editorial, "Mechanical Restraint (Occasional Notes of the Quarter)," *Journal of Mental Science*, 36, no. 154 (1890): 381-382, p. 382. This article complained that the "legalization" of restraint was retrogressive.

²⁶⁵ For example, Metropolitan Commissioners in Lunacy. *Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor* (London: Bradbury and Evans, 1844), pp. 140-1

²⁶⁶ George Savage, "Hyoscyamine and its Uses," *Journal of Mental Science*, 25 (1879): 177-84, p. 183.

an entire chapter on the topic in *Principles of Mental Physiology* (first published 1874).²⁶⁷ For Carpenter and, later, Darwin, habits differed from instincts in that they were learned, rather than innate.²⁶⁸ These habits were strengthened by regular use and, eventually, might become almost as strong as instincts, thus allowing for their inheritance: something in which Carpenter strongly believed.²⁶⁹ Although, as Robert Richards has noted, Darwin increasingly relied on the mechanism of natural selection, rather than habit, to explain animal behaviour, he nonetheless retained the idea of habit even in his later works, in particular to the development of social and moral traits in mankind, an emphasis he gained from Carpenter.²⁷⁰ From this approach, impulse could explain the development of "higher" powers of mind, rather than being solely a force that the civilised individual needed to overcome.²⁷¹ This positive notion of habit was certainly accepted by some alienists,²⁷² although the evolutionary context also meant that self-mutilation could come to be regarded as directly hereditary, something that was also argued in the case of suicide.²⁷³ The mental state perceived to be connected with such behaviour could be construed in somatic terms, and thus viewed as presenting evidence of *direct* (biological) heredity. Thus, "nervous habits" in a parent might be felt to cause the development of self-mutilation in a child: as in one case reported to show a "singular family tendency to excessive constipation and self-mutilation!"²⁷⁴ Here, the physical symptom of constipation was connected with a variety of other attributes seen in the same family, including, as we shall see, the physical change of

²⁶⁷ W.B. Carpenter, *Principles of Human Physiology*, 6th edition (London: J. Churchill, 1855), esp. pp. 569-71 and 627-31; W.B. Carpenter, *Principles of Mental Physiology*, reprint of 1876 edition (London: Routledge; Thoemmes Press, 1993), pp. 337-375.

²⁶⁸ Dixon, *From Passions to Emotions*, p. 162.

²⁶⁹ Charles Darwin, *The Descent of Man, and Selection in Relation to Sex* (London: John Murray, 1871), p. 100; Carpenter, *Principles of Mental Physiology*, pp. 367-75. See also Robert J. Richards, "Instinct and Intelligence in British Natural Theology: Some Contributions to Darwin's Theory of the Evolution of Behavior," *Journal of the History of Biology*, 14, (1981): 193-230.

²⁷⁰ Richards, "Instinct and Intelligence in British Natural Theology".

²⁷¹ See Thomas Dixon, *The Invention of Altruism: Making Moral Meanings in Victorian Britain* (Oxford; New York: Oxford University Press, 2008), p. 150; Darwin, *The Descent of Man* (1871), pp. 71-80. For concern over the contagious nature of "bad habits", see Daniel Hack Tuke, *Illustrations of the Influence of the Mind Upon the Body in Health and Disease*, vol. 2 (Philadelphia: H.C. Lea's Son & Co, 1884), pp. 40-1.

²⁷² Tuke, *Illustrations of the Influence of the Mind Upon the Body*, vol. 1, p. 249; Theophilus Bulkeley Hyslop, *Mental Physiology: Especially in its Relations to Mental Disorders*, (London: J. & A. Churchill, 1895), p. 396. Indeed, the title of Hyslop's text meant that parallels with Carpenter were frequently made.

²⁷³ Prichard, *A Treatise on Insanity*, p. 400; J. H. Blount, "Review of *Du Suicide et de la Folie Suicide* by A. Brierre de Boismont," *Journal of Mental Science*, 2, no. 17 (1856): 302-320, p. 307; John Charles Bucknill and Daniel Hack Tuke, *A Manual of Psychological Medicine*, 2nd ed. (London: John Churchill, 1862), p. 221.

²⁷⁴ James C. Howden, "Notes of a Case - Mania followed by Hyperesthesia and Osteomalacia. Singular Family Tendency to Excessive Constipation and Self-Mutilation," *Journal of Mental Science*, 28, no. 121 (1882): 49-53.

organs after death, and acts of self-inflicted injury, as if all came from the same cause, which had been directly inherited.

This case was published by James Howden, of the Montrose Royal Asylum: another Scottish alienist, educated at the University of Edinburgh. Howden had previously read his report at the Edinburgh Quarterly Meeting of the MPA in November 1881, where he may have come into contact with James Adam (at that time based in Dumfries, from whence he made regular journeys to Edinburgh), whose first article on self-mutilation was published not long afterwards. Howden described three members of the same family: 26-year-old mason's wife, J.C., admitted in 1855, her brother A.C., admitted at the age of 22 in 1854, and a sister, M.C., 24 years old when she was admitted in September 1874. Two factors appear to have encouraged Howden to speak, and then publish, on the case. One was J.C.'s death, in February 1877, following which a post-mortem examination uncovered significant degeneration of her bones and fatty tissue, but little or no cerebral change. This suggested to Howden that the mental symptoms from which she had suffered (including mania and self-mutilation) might have been connected to osteomalacia, rather than structural lesions of the brain. The second point emphasised was the repetition of an act of self-mutilation: in 1868, J.C. had attempted to gouge out her eyes, much injuring them in the process. Fourteen years earlier, younger brother A.C. had also gouged out one of his eyes, although Howden gave little detail. Presumably, it was the second enucleation (which, as indicated in chapter one, appears to have been a fairly uncommon act) that sparked his interest in the family. The post mortem on J.C. led him to relate all her mental and physical symptoms to structural change, suggesting that this might also be apparent in her siblings, who had suffered similar digestive problems.

The tendency to constipation was always marked during the maniacal attacks. The same condition existed in the brother's case, and he died from ulceration of the stomach. A younger sister [M.C.]... had it to a still more marked degree.²⁷⁵

Rather than seeing the self-mutilation as a response to a physical condition, the similar acts in two members of the same family meant that Howden considered this, too, as an inherited behaviour. This was despite the existence of a wide variety of different self-injurious acts on the part of J.C., who, over a period of thirteen years, had also bitten off part of her tongue, made various wounds and bruises on her arms, and severely lacerated her vagina. It was the enucleation, however, that most impressed Howden, who anticipated the appearance of this trait in the younger sister as well.

²⁷⁵ Howden, "Notes of a Case - Mania followed by Hyperesthesia and Osteomalacia", p. 52.

The tendency to self-mutilation has not yet shown itself in M.C., but it is remarkable that when J.C. gouged out her eyes in 1868 she was not aware that her brother A.C. did the same thing in 1854.²⁷⁶

The use of the qualifying “yet” in the first sentence indicates that Howden thought that, as she already suffered from the constipation he assumed was inherited, M.C. might well exhibit a tendency to self-mutilation at some point. He does not, however, make clear why this should be an inherited trait rather than imitative behaviour. Why should J.C. have been unaware of her brother’s act, which occurred when she was herself an adult and not certified as insane? Was the enucleation concealed from the entire family, given that the brother died less than a year afterwards? Did the brother, about whom we are told little, have similar delusions to J.C., who “imagined that God had ordered her to mutilate herself”?²⁷⁷ It seems that Howden’s prior assumptions as to the hereditary nature of insanity caused him to view self-mutilation as inherited in this case: others might just as easily have attributed the acts of the C. family to habit or imitation.

Indeed, it is in relation to the concept of habit that we should view the discussion of restraint in self-mutilation: a belief in the beneficial nature of habit formation, associated with the idea that impulses might be difficult or impossible to control (due to their physiological nature). George Savage, for example, declared that restraint was indispensable for patients “given to determined attempts at self-mutilation … and some have even expressed a hope that similar treatment should be followed in case of a relapse.”²⁷⁸ Such an attitude was articulated still more clearly in an article presented by Peter Maury Deas, superintendant of Wonford House (a private asylum in Exeter), to the South Western Division of the MPA in October 1895. Deas described a variety of cases “classed under the head of self-mutilation” in which, after mechanical restraint had been used for a period of days, weeks, or even months, patients no longer attempted to injure themselves. While, no doubt, a variety of explanations for this apparent “cure” could be suggested, Deas specifically alluded to the topic in one case of face-picking where, after two weeks of wearing gloves, Deas declared that “the habit was completely broken.”²⁷⁹ This statement presents a more negative portrayal of Darwin’s model of the acquisition of traits by a process of use-inheritance (in that habits required to be overcome, not developed), but nonetheless suggests an evolutionary approach to impulse, in which self-control might be

²⁷⁶ *ibid.*

²⁷⁷ *ibid.*, p. 49.

²⁷⁸ Savage, “The Mechanical Restraint of the Insane”, p. 738.

²⁷⁹ P Maury Deas, “The Uses and Limitations of Mechanical Restraint as a Means of Treatment of the Insane,” *Journal of Mental Science*, 42, (1896): 102-113, p. 107.

acquired. In the discussion following the paper, most other alienists were in agreement with Deas that “gradual improvement” would take place until the restraints could be safely removed: in effect, the aim was to restore the self-control that had apparently been lost by altering the physiological response of the body. Restraints prevented “primitive reflex action,” forcibly ensuring the patient exhibited (and then, apparently, acquired) the civilised state of self-control. Photographs in asylum case books seemingly reflect this view. The photograph below shows a young male patient at Bethlem in the early 1880s, whose padded gloves were intended to prevent him rubbing away hair from the top of his head.

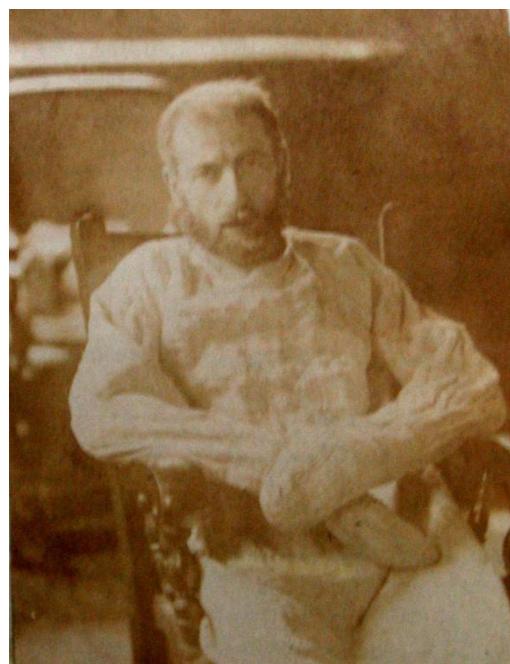


Figure 13: Robert Haussmann wearing padded gloves at Bethlem, 1884 (Bethlem Art & History Collections Trust)

Robert Haussmann, a 34-year-old Clerk, was admitted to Bethlem in April 1884, and frequently described as “vacant” and “wet and dirty” (i.e. incontinent). He did, it seems, have periods of lucidity, in which he “talked rationally in English to the attendants, played a game of cards & smoked a cigarette.” However, following such periods, he was soon back in restraints. The photograph, however, does not seem to reflect descriptions of Robert’s vacant attitude. He is pictured staring directly at the camera, seated in what appears to be a relaxed pose, despite his clothing. Here, Robert appears engaged and alert, rather than vacant and speechless: the intention may have been to indicate that the restraints themselves have made the patient calm and tractable. Despite this “therapeutic” use of restraint, Robert did not recover from his illness, and died at Hanwell Asylum in May 1889, apparently from General Paralysis of the Insane.

Restraint was certainly a recurrent issue at Bethlem, particularly in relation to the common behaviours of hair-plucking and face-picking. The impulsive nature of these behaviours was frequently highlighted by emphasising the cases of patients who, we are told, *requested* mechanical restraint, being unable to otherwise control themselves. In March 1891, Annie Bourne, who had “always [been] excitable and hysterical” began picking the skin on her head and “at her own request wore gloves to prevent it”²⁸⁰ while, in 1898, Reginald Gleadow, who “became wild at Cambridge … wears gloves voluntarily to prevent picking of fingers.”²⁸¹ Both of these patients had been considered neurotic before their admission, and their self-mutilation was regarded as indicating a breakdown of self-control that was already defective. What is more interesting, however, is that this rather simplistic explanation of self-mutilation as an external representation of physiological impulse is not indicated by the majority of case records: of the 174 patients who began or continued to pluck their hair or pick their skin while in hospital, only 48 were put into any form of restraint, usually in the form of padded gloves. Thus, around three quarters of the patients who picked their skin or pulled out their hair were *not* restrained in any way, as seen in figure 14, below.

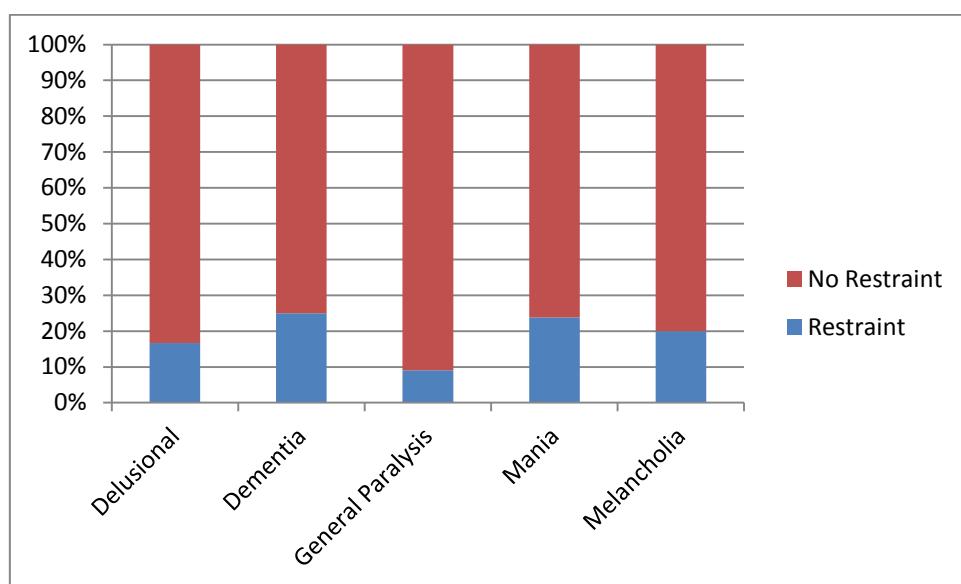


Figure 14: Graph showing restraint by psychiatric diagnosis in skin-picking and hair-plucking patients at Bethlem

Surprisingly, in the above graph, the diagnosis that was regarded as having the most severe neurological consequences (for it was the only one with which lesions of the brain could be correlated post-mortem), General Paralysis of the Insane, led to the lowest level of

²⁸⁰ BRHA, *Female Patient Case Book, 1890*, (CB/139 – 94).

²⁸¹ BRHA, *Male Patient Case Book, 1898*, (CB/158 – 60).

mechanical restraint. Even in the case of Mania and Dementia, also regarded to have poor prognoses, only around a quarter of patients were restrained.

But what other conclusions can we draw concerning the relative levels of restraint? Did they differ for male and female patients? Figure 15 indicates the levels of restraint at Bethlem by gender.

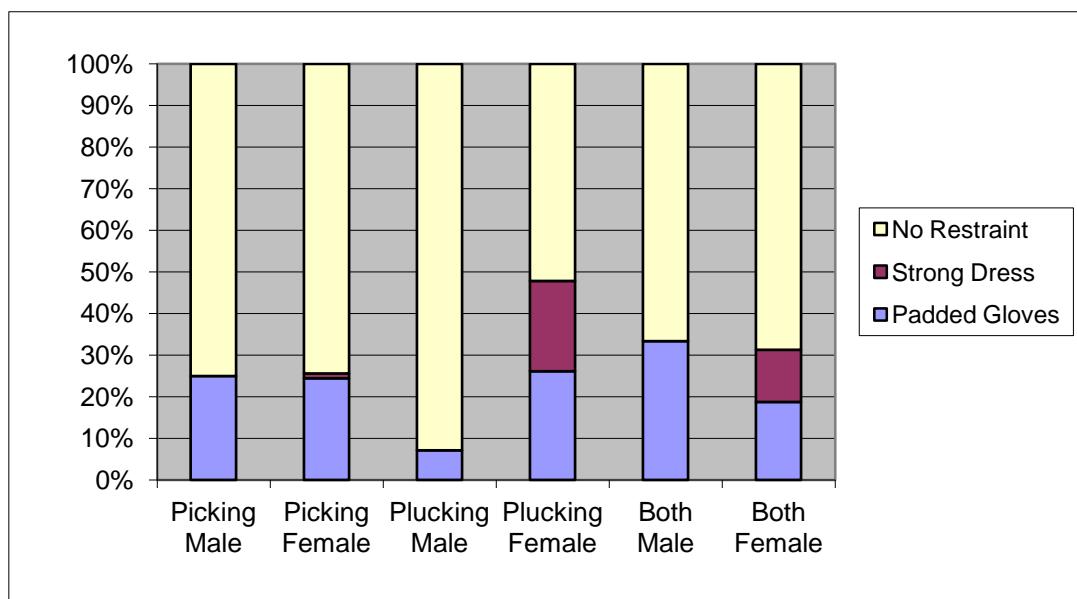


Figure 15: Graph showing restraint by gender in skin-picking and hair-plucking patients

Two main points of difference are indicated. First, it appears that the “strong dress” was used far more frequently on female patients who injured themselves than men, for whom padded gloves were thought to suffice. In addition, we can see that the level of restraint for hair-plucking was considerably higher in female patients than in male patients – a total of 48% of the former, but only 8% of the latter were restrained. Such might well reflect the associations between hair and femininity indicated previously: hair-plucking was considered a much more injurious practice in women than in men. Of course, there is no reason for considering hair-plucking more physically dangerous in women: the increased concern thus seems to reflect social fears. Overall, however, the level of restraint for *both* male and female patients was low: just over 20% wore padded gloves, while use of the strong dress in female patients means that a higher number (30%) of women were restrained.

However, the fact that nearly 70% of women engaging in these behaviours were *not* restrained contradicts the view put forward by many evolutionists that women were much more impulsive than men, and thus required a greater level of behaviour-regulating intervention.²⁸² In some cases, specific reasons were given for the absence of mechanical restraint. At times, this allows us to reflect on doctor-patient relations, as in the case of 35-

²⁸² See Stocking, *Victorian Anthropology*, p. 230.

year-old teacher Jessie FitzGerald, admitted in 1898 suffering from Recurrent Mania. According to her brother, Jessie had recently set fire to herself. The patient herself was said to have insisted that, rather than being self-inflicted, her burns were proof of the annoyances to which she had been subjected in Paris. In January 1899, Jessie began to re-open some of her wounds by rubbing, stating that her Parisian persecutors still troubled her. She also exhibited frequent outbursts of violence, usually attributed to impulse within the asylum. Yet, when Jessie began “biting pieces out of her arms” in June 1899 and gloves were ordered, it was subsequently noted that “[a]s she has promised not to do it again, the gloves have not been used.”²⁸³ Despite her seemingly deluded state, Jessie FitzGerald was not treated as if she had no rational control over her actions, as it was assumed that her promise would be kept (as, indeed, seems to have been the case). Like Jessie, other patients were encouraged to keep their word, and thus presumably deemed to have some measure of self-control.²⁸⁴ The emphasis doctors laid on verbal contracts with their patients seems surprising if, as many historians have argued, late nineteenth-century psychiatry was guided predominantly by somatic principles. Here, it reminds us that the concept of moral treatment remained, alongside more explicitly physiological theorisations of insanity.

Directly medical reasons were, however, also given to explain the absence of restraint. Physiologically speaking, picking could be regarded as potentially curative. Five months after Eveline Burton was admitted to Bethlem in November 1894, Assistant Physician Theo Hyslop reported that: “The patient has taken to picking her forehead and left temple. She is allowed to do so in the hope that the counter irritation may act beneficially.”²⁸⁵ Counter-irritation, a phrase employed by physicians to describe the supposed medical benefits of blistering and similar corrosive remedies applied to the skin for the treatment of internal conditions, had proved a controversial topic in nineteenth-century medicine. Yet it doesn’t seem surprising, given the obvious physical barrier to accessing the brains of their patients, and their interest in finding a connection between insanity and physical change, that alienists would retain interest in such theories. Bethlem physicians frequently remarked on the strange lucidity of certain patients during an attack of fever or other bodily disease: George Savage claimed that this sometimes resulted in complete cure if the experience raised the body temperature or caused the patient pain, going on to declare that “[w]e have seen the like result follow severe inflammation of the hand due to

²⁸³ BRHA, *Female Patient Case Book, 1898*, (CB/159–126).

²⁸⁴ For example Henry Breton, BRHA, *Male Patient Case Book 1895*, (CB/151 – 97); Marian Louise Birch, BRHA, *Female Patient Case Book 1899*, (CB/161 – 94).

²⁸⁵ BRHA, *Female Patient Case Book, 1894*, (CB/150–142).

self-inflicted injury.”²⁸⁶ Indeed, “fever cure” was a growing area of research in the late nineteenth century, particularly in the work of German experimental physicians like Julius Wagner-Jauregg.²⁸⁷ While a cure was not realised for Eveline, who was still picking her arms and neck in June 1895 and was subsequently discharged uncured, it nonetheless indicates that the potentially curative – and thus beneficial – nature of self-inflicted injuries remained a matter of consideration for alienists, as well as their patients. However, explicit reasons for the lack of mechanical restraint were not given at all for many patients who picked their skin or pulled out their hair, even though some of these were reported as having requested it. The “hypochondriacal” Samuel Starky, who had “a habit of picking the fundament”, asked in 1889 “to be allowed to restrain the hands by means of a chain which he formerly used for the purpose and which his brother brought for him.” Starky’s requests were repeatedly refused.²⁸⁸ The contemporary psychiatric characterisation of mechanical restraint as curative does not, therefore, explain why the vast majority of self-mutilating patients were not restrained, indicating that a developmental model of self-mutilation, incorporating notions of impulse and habit, was only one of a number of explanatory frameworks employed by alienists. By further investigating this topic, we can also explore the broader context of attention paid to “minor” mutilations, regularly suggested to be “disfiguring” or “marring appearance.”²⁸⁹

2.4 Moral Insanity: Self-Mutilation and Selfishness

In 1874, *The Lancet* reported a relation between religious fervour and self-mutilation, claiming that stigmatisation (in other words, the artificial creation of the wounds attributed to Jesus) had become a “trade” among the “Ultramonte girls of the Continent”. Such self-wounding was described as a taking of “hideous liberties … with their persons.”²⁹⁰ The description of wounds as “hideous” indicates both the importance placed on what was considered attractive or aesthetically pleasing, as well as the censure which might greet a departure from what was conventionally deemed to be appropriate appearance. In addition,

²⁸⁶ George Savage, “Alternation of Neuroses,” in *A Dictionary of Psychological Medicine*, ed. Daniel Hack Tuke (London: J. & A. Churchill, 1892), 79-83, pp. 79-80; see also Savage, “Presidential Address” (1886), p. 326 on the effect of counter-irritation in removing delusions and hallucinations.

²⁸⁷ See Magda Whitrow, “Wagner-Jauregg and fever therapy,” *Medical History*, 34 (1990): 294-310. In Britain, see S. Rutherford and Lewis C. Bruce, “The Effect of Thyroid Feeding on Some Types of Insanity,” *The Lancet*, 144:3711 (1894): 846-848; Carlisle Howard, “The Systematic Estimation of the Leucocytosis in Certain Cases of Insanity: with Special Reference to the Toxoemic Theory,” *Journal of Mental Science*, 56 (1910): 63-86. With thanks to Carole Reeves for pointing out this context.

²⁸⁸ BRHA, *Male Patient Case Book*, 1889, (CB/136 – 13).

²⁸⁹ See Francis Ambridge, BRHA, *Male Patient Case Book* 1893 (CB/145 – 77) or Ethelreda Sophie Dickson, BRHA, *Female Patient Case Book* 1898, (CB/159 – 60).

²⁹⁰ “Louise Lateau,” *The Lancet*, 104, no. 2669 (1874): 604.

the suggestion that the girls were taking liberties indicates a complicated connection between self-mutilation and social and political freedom. If these girls were not free to injure their bodies, to whom did their bodies belong? Moreover, in what might this taking of hideous liberties result? The writer pointed to the potential threat of the Catholic Church, concluding that “this latest development of Ultramonte fanaticism” provided the best possible justification for “the policy by which Prince Bismarck is attempting to complete the reformation in Germany.” This, it should be recognised, was not a rejection of religion *per se*, but rather the suggestion that a particular form of religion might be the reverse of national solidarity and political progress. In an article addressing the new concept of altruism in the second half of the nineteenth century, Thomas Dixon has suggested that, although debates often focused on the apparent divide between science and religion, at the root of such issues were, instead, “fundamentally political questions about what constituted the ideal society, about who was a member of one’s moral community, and about how that community should be organised.”²⁹¹ Within the cultural concerns made apparent by discussions over skin-picking, hair-plucking and appearance lie similar political issues.

Many of these concerns were associated with the belief that evolution might not be a straightforward, linear process, but something that could be halted or even reversed. Such a doctrine appeared likely to many alienists. As many of their charges had previously fulfilled an active role in society, the onset of mental illness seemed to suggest regression to an earlier stage of development. Such debates were often closely related to efforts to explain the acquisition of moral traits through a process of natural selection. Particularly influential was Greg’s pessimistic article referred to in chapter one, in which the author suggested that, in “our complicated modern communities … artificial and conventional have taken the place of natural advantages as the ruling and deciding force.”²⁹² Greg pitted “natural” against “artificial”, suggesting that modern civilization was an *unnatural* environment, in which survival would not necessarily be of the fittest. Alienists, who, as the previous chapter has indicated, recognised the effects of social and environmental pressures on their patients, seem to have been particularly inclined to accept such ideas. Greg listed three problems that he viewed as running counter to natural selection in western civilization: individual freedom; lack of self-control and the results of charitable aid.²⁹³ Although Greg’s negative and conservative approach was not shared by Darwin and other evolutionary anthropologists,

²⁹¹ Thomas Dixon, “The Invention of Altruism: Auguste Comte’s Positive Polity and Respectable Unbelief in Victorian Britain,” in *Science and Beliefs: From Natural Philosophy to Natural Science, 1700-1900*, ed. David M. Knight and Matthew Eddy (Aldershot; Ashgate: 2005), 195-211, p. 208.

²⁹² Greg, “On the Failure of ‘Natural Selection’”, pp. 358; 363.

²⁹³ Greg, “On the Failure of ‘Natural Selection’”, p. 362.

many of the concerns he raised were acknowledged by them. Darwin, for example, built on the texts of Alfred Russel Wallace and evolutionary anthropologists such as Sir John Lubbock and Edward Burnett Tylor to address Greg's concerns, focusing on the beneficial elements of the moral and intellectual faculties, which he saw as vital to the development of civilization. In particular, Darwin described the evolution of the "social instincts," contrasting these with "selfishness" in an image of linear, purposeful progress.²⁹⁴

For Darwin, the sentiment of "sympathy" became the most important element of the development of civilization.²⁹⁵ Such an idea built on the Enlightenment concern with sympathy as a physical force, acting between organs *and* individual bodies to produce organic change, implying a biological context for what was now cast as an emotional connection.²⁹⁶ Many of Darwin's contemporaries were in agreement with such a conclusion. Tylor, for example, asserted that:

A general survey of the lower races shows that their selfish and malevolent tendencies are stronger in proportion to their unselfish and benevolent tendencies, than in higher grades of culture. It would be a wonder were it not so, and our talk of progress and civilization would be indeed a mockery.²⁹⁷

Of course, there were many late nineteenth-century commentators who very much feared that progress might be a "mockery". Few, however, questioned the attribution of selfishness to savages. This required a particular construction of the concept of selfishness, that did not suggest merely that the individual pursued personal gain, or even that he attended his own needs in opposition to the requirements of those around him, but that he (and his family or group) did not engage in the concerns of humanity at large. The broadly humanistic arguments given by writers like Tylor were designed to uphold contemporary western political and social virtues: a liberal utilitarianism, in which individual ownership of property could be represented as beneficial, for "every millionaire enriches the community."²⁹⁸ Such a theory could ignore any individual acts of kindness between "savage" and westerner, instead insisting on this broader view, almost impossible to attain outside a western context that provided commercial, press and political links between cultures.

²⁹⁴ For more on Darwin's view of social instincts, see Dixon, *The Invention of Altruism*, chapter 4.

²⁹⁵ Darwin, *The Descent of Man* (1988), p. 139.

²⁹⁶ For more on concepts of sympathy, see Jonathan Lamb, *The Evolution of Sympathy in the Long Eighteenth Century*, (London: Pickering & Chatto, 2009); Paul White, "Sympathy Under the Knife: Experimentation and Emotion in Late Victorian Medicine" in *Medicine, Emotion and Disease, 1700-1950*, ed. Fay Bound Alberti (Basingstoke; New York: Palgrave Macmillan, 2006): 100-124; Paul White "Darwin Wept: Science and the Sentimental Subject", *Journal of Victorian Culture*, 16, no. 2 (2011): 195-213, p. 200.

²⁹⁷ Tylor, "Primitive Society (Part I)", p. 708. See also Reade, *The Martyrdom of Man*, p. 445.

²⁹⁸ Reade, *The Martyrdom of Man*, p. 508.

Social theories of “instinct” complemented physiological explanations of impulse by adding to the former the “‘connective tissue’ of civilization”, enabling the “evolution” of political and legal systems to be represented from a perspective which required the development of intellect, volition and, additionally, the social emotions, in every individual.²⁹⁹ The term most commonly associated with this philosophical idealism was that of altruism, coined by French positivist philosopher Auguste Comte in 1851 and introduced into English by his translators in 1852.³⁰⁰ The new term was rapidly diffused, and included in the first edition of the Oxford English Dictionary, compiled in the early 1880s. For Comte, all human actions were divided into egoistic and altruistic instincts, with the latter being higher in quality but inferior in force. As George Henry Lewes explained in 1853: “dispositions influenced by the purely egotistic [sic] impulses we call popularly ‘bad,’ and apply the term ‘good’ to those in which altruism predominates”.³⁰¹ The positivist hope for evolution, then, was that the altruistic instincts would steadily gain in dominance, with social organization becoming the most important principle of mankind.³⁰² Central to the dissemination of Comte’s theories in England was evolutionary philosopher Herbert Spencer, who adopted the idea in the second edition of *Principles of Psychology* (1870-2).³⁰³ Although Spencer included an intermediary – the “ego-altruistic sentiments” – a stark divide between selfish and altruistic behaviour began to dominate later nineteenth century thinking. It was Spencer’s work in particular that was picked up by alienists, who quickly adopted the phrase “altruistic sentiments”.³⁰⁴ Yet Spencer also fostered a confusion between action and intention that remained an issue in debates over altruism well into the twentieth century.³⁰⁵ Such uncertainty between behaviour and motivation formed a large part of the psychiatric discussion over self-mutilation: did the term describe a wound, an act, or the idea behind

²⁹⁹ Walter Bagehot, "Physics and Politics, I: The Pre-Economic Age," *Fortnightly Review*, 2, no. 11 (1867): 518-538, p. 521.

³⁰⁰ Auguste Comte, *Catéchisme positiviste*, (Paris: Imprimerie Larousse, 1890), p.49 (first edition published in 1851). English and French dictionaries all attribute the term to Comte.

³⁰¹ George Henry Lewes, *Comte's Philosophy of the Sciences: Being an Exposition of the Principles of the 'Cours de philosophie positive' of Auguste Comte* (London: H.G. Bohn, 1853), p. 224.

³⁰² Comte had already outlined this idea, without using the term “altruism”. Comte, *The Positive Philosophy*, vol. 1, pp. 12-13.

³⁰³ Spencer, *The Principles of Psychology*, vol. 2, pp. 578-627. Henry Maudsley also appears to have taken up the issue at an early date. Henry Maudsley, "The Genesis of Mind (II)," *Journal of Mental Science*, 8, (1862): 61-102, p. 67.

³⁰⁴ Daniel Hack Tuke, "Moral or Emotional Insanity," *Journal of Mental Science*, 31, no. 134 (1885): 174-190.

³⁰⁵ Dixon, *The Invention of Altruism*, chapter 5; Stefan Collini, *Public Moralists: Political Thought and Intellectual Life in Britain 1850-1930* (Oxford: Clarendon Press, 1991). In sociology, Durkheim’s adoption of these two categories in suicidal motivation makes for an interesting continuation of these ideas within Comte’s own field. Emile Durkheim, *Suicide: A Study in Sociology*, trans. John A. Spaulding and George Simpson (London; New York: Routledge, 2002).

the act? It was also closely associated with another psychiatric notion often applied to cases of self-mutilation: the diagnosis of moral insanity.

Moral insanity was introduced by James Cowles Prichard in 1833, and incorporated into his 1835 *Treatise on Insanity*. The diagnosis referred to a defect in moral or emotional capacity in an individual who otherwise showed no sign of intellectual impairment. Hannah Augstein has provided a detailed analysis of Prichard's adoption of the term, indicating that the diagnosis reflected his dismay at what he saw as the increasing materialism of the age, related to a decline in religious observation.³⁰⁶ Prichard wished to retain the doctrine of man's soul as an essence distinct from his physical form: thus, moral insanity was indicated by the individual's behaviour, rather than a physical lesion of the brain. Nonetheless, Prichard applied these ideas within a natural framework, suggesting that moral insanity was evidenced by a perversion of natural faculties, including affection for the family and self-preservation. The very existence of the diagnosis was much contested: John Charles Bucknill recalled that the topic was one of the few on which he and Daniel Hack Tuke disagreed when compiling their *Manual* (Bucknill, presumably, refuted the diagnosis, for Tuke certainly did not).³⁰⁷ It is particularly interesting here, however, to examine the religious background of moral insanity, which is important in two respects. First, while Augstein suggests that the diagnosis lost its metaphysical content in subsequent generations (who instead interpreted moral insanity from a physicalist perspective), all of the alienists writing on self-mutilation tended towards a theistic outlook on life (while rejecting religious – and, indeed, scientific – dogmatism).³⁰⁸ They also held to the importance of judging insanity by conduct from a moral, as well as practical, perspective. In addition, Prichard's adoption of the concept of self-centredness as a feature of insanity appears, to some extent, to be reflected (albeit from a secular perspective) in the very idea of altruism as a key element of human progress, for the notion was created by Comte as part of a new humanist religion.³⁰⁹ Later nineteenth-century scientists and philosophers shared great concern for the future of humanity, equating morality with physical and mental evolution.³¹⁰ By claiming the self-sacrifice of religious teaching to be the biological trait of altruism, these writers re-packaged ideals of social order within a natural scientific ethos to become the "great fundamental law alike of

³⁰⁶ Augstein, "J. C. Prichard's Concept of Moral Insanity".

³⁰⁷ W. W. Ireland, "Daniel Hack Tuke, M.R.C.S., M.D., LL.D.", *Journal of Mental Science*, 41, no. 174 (1895): 377-386, p. 382.

³⁰⁸ Augstein, "J. C. Prichard's Concept of Moral Insanity", p. 342.

³⁰⁹ Prichard apparently adopted the idea of "selfishness" in insanity from the Nasse school of thought. Augstein, "J. C. Prichard's Concept of Moral Insanity ", p. 332.

³¹⁰ George Savage, "Moral Insanity," *Journal of Mental Science*, 27, no. 118 (1881): 147-155, p. 147; Maudsley, "The Genesis of Mind (II)", p. 90.

Nature and Christian morals".³¹¹ The attention to the "social instincts" in the late nineteenth century thus represented a re-evaluation of the qualities considered necessary for the civilised self.

Such a re-evaluation is evident in the psychiatric approach to moral insanity, which acquired an evolutionary bent through the assumption that it resulted from the loss of the highest emotions, as defined by Spencer. In his paper on the comparative psychology of man, Spencer discussed the various degrees of mental evolution, claiming that the altruistic sentiments, "coming last ... are also the highest" (i.e. above intellect).³¹² Such an evolutionary ethos was incorporated into neurology, in the work of John Hughlings Jackson.³¹³ For Daniel Hack Tuke, used to the rationalist idea that intellect formed the highest development of mind, this caused some conceptual confusion. In attempting to incorporate moral insanity into the new doctrine, he queried:

If intellect or thought is of later growth than feeling, and if, as evolutionists suppose, the most recently evolved – the least organised therefore – is the first to go, how is it possible that Feeling can be disordered without the Intellect being involved? In other words, how can the deeper down Feeling go before the higher up Intellect?³¹⁴

Tuke's solution was to combine the evolutionary psychology of Spencer with Jackson's concept of the higher faculties, concluding, like Darwin and Spencer, that "the highest feelings of all – the altruistic – are of later growth" than either simple feeling or intellect.³¹⁵ Thus, in his *Dictionary* a decade later, Tuke included a definition of altruism (attributed to Comte):

It is exemplified in the sentiments of friendship, veneration, and goodness. It is the source also of domesticity and sociability; sentiments recognisable in animals as well as in man. A departure from altruism and a leaning towards egoism, mark some of the early phases of mental affections.³¹⁶

From such a standpoint it was selfishness – a trait already identified by Prichard – that was central to moral insanity: the attribution of the evolutionary context additionally suggested that such a condition might be dangerous for more than just the individual. This view was

³¹¹ Thomas Laycock, "Contributions to a New Chapter in the Physiology and Pathology of the Nervous System: V. On the Nervous Disorders in General Caused by Excessive or Unnatural Sexual Excitation," *British Medical Journal*, 1, no. 389 (1868): 577-579, p. 577.

³¹² Spencer, "The Comparative Psychology of Man", p. 19.

³¹³ George Savage, "Dr. Hughlings Jackson on Mental Disorders," *Journal of Mental Science*, 63, no. 262 (1917): 315-328.

³¹⁴ Tuke, "Moral or Emotional Insanity", p. 186.

³¹⁵ Tuke, "Moral or Emotional Insanity", pp. 186-7.

³¹⁶ Daniel Hack Tuke "Altruism" in *A Dictionary of Psychological Medicine*, ed. Daniel Hack Tuke. vol. 1, (London: J. & A. Churchill, 1892), p. 83. For the same view, see Robert Jones, "A Lecture on Mental Unsoundness Amounting to Certifiable Insanity and its Diagnosis," *The Lancet*, 161, no. 4162 (1903): 1572-1576, p. 1575.

also offered by other writers, including Henry Maudsley, who associated a development from egoistic to altruistic sentiments with a shift in the individual's attitude from "self-consciousness" to "world-consciousness".³¹⁷ Similarly, George Savage saw moral insanity as the form of mental disorder that was "most dangerous socially" for such patients had "no sense of truth or honesty, and no altruism".³¹⁸

The topic of moral insanity was an important theme in alienist discussions of self-mutilation. Despite its contested status, *all* of the alienists writing on self-mutilation recognised and discussed moral insanity as a diagnosis, and frequently attributed it in cases of self-mutilation, within and outside the asylum.³¹⁹ The concept of impulsive ideas was central to this doctrine. If impulse was activated by both intellect and emotion, which directed the outcome of voluntary activity, then, according to Blandford "*volitional* insanity must imply an insane reason and judgment, and an insane emotional condition, not only an insane will We cannot consider intellect as having a separate existence apart from emotions."³²⁰ For Blandford, intellect, volition and emotion were intrinsically linked and, moreover, these aspects of the individual also associated body and mind, as evidenced by particular actions, including self-inflicted injury. Thus impulsive actions were "plainly the outcome of some idea present for the moment in the mind, but present, possibly, only for the moment, and then so obliterated that the individual afterwards has lost all trace of it."³²¹ This explanation also supported Blandford's conviction that intellectual defect always existed in moral or impulsive insanity, despite the absence of clear delusions: from this model, delusory thinking could be evidenced by an act, even if the patient could not remember his or her motivation. Like his understanding of self-mutilation, Blandford's concepts of impulse fitted into a developmental model: despite his rejection of the will as the major civilizing force, his notions of the development of emotion and intellect were distinctly Spencerian. The child thus exhibited "lower" forms of intellect and emotion, responding directly to feelings, both mental and physical.

For Blandford, physical structure could alter only very slowly through generations as a result of evolutionary progress, and thus the individual savage could never be educated to the level of a European. From this idea of slow progress – but sudden regression – within evolution, came the anxiety of alienists over impulsive acts like self-mutilation, for moral

³¹⁷ Maudsley, "The Genesis of Mind (II)", p. 67, 87. See also Savage, "Moral Insanity", p. 147.

³¹⁸ George Savage "Mental Diseases" in *A System of Medicine*, ed. Albutt, p. 181

³¹⁹ Savage, "Moral Insanity"; Tuke, "Moral or Emotional Insanity"; Tuke, *Prichard and Symonds*.

³²⁰ G. Fielding Blandford, *Insanity and its Treatment*, 3rd ed. (Edinburgh; London: Oliver and Boyd; Simpkin, Marshall, 1884), p. 36.

³²¹ Blandford, *Insanity and its Treatment* (1884), pp. 350-1.

insanity could represent a “reversion to an old savage type”.³²² This model incorporated the concept of congenital heredity, but *also* the creation (and potential transmission) of acquired “habits”. For Blandford, impulsive acts of violence against self or others were:

[A]kin to the imperative ideas or obsessions which beset some people. Such tricks in the neurotic may develop till the *obsession* becomes a *possession* and rules the whole life. Thus may these persons advance to insanity, their higher centres losing control more and more...³²³

For this reason, all such “tricks” (as Blandford called also habits like nail-biting and hair-pulling) should be “sternly repressed” in children, “and no pains should be spared to repair their degenerated constitution”,³²⁴ a task also associated with the suppression of the nervous child’s “selfishness and egoism”.³²⁵ George Savage shared this notion, indicating that it was necessary to rein in eccentricity otherwise “a habit is in process of development which may influence for evil the whole life of the individual.”³²⁶ From this, the fall from grace could be rapid: the child born to such a “retrograded” individual would inherit an “imperfect brain” and, “[l]ike the savage child ... will be incapable of attaining the perfection of intellectual and emotional life ... destitute of the sense of duty and of right possessed by others of his country and social status.”³²⁷ From such a perspective, the behaviour of the individual was explicitly connected with his or her moral feeling and social position.

This forms an important background to instances in which moral insanity was directly attributed to acts of self-mutilation in the psychiatric literature. In a paper on “Insanity of Conduct”, published in the late 1890s, George Savage and Charles Mercier confirmed their continued belief in the existence of moral insanity, aiming to show “that breaches of the conventional as well as the moral laws of society may be but symptoms of disorder or disease of the higher nervous system.”³²⁸ Savage’s examples in this paper concentrated on the “malingering and mischief-making” he connected with hysteria and hypochondriasis. In particular, he remarked that: “it is not at all uncommon to meet with hysterical young women who put themselves to great personal torture without any

³²² Daniel Hack Tuke, "Case of Moral Insanity or Congenital Moral Defect, with Commentary," *Journal of Mental Science*, 31, no. 135 (1885): 360-366, p. 365.

³²³ George Fielding Blandford “Impulsive Insanity” in *Quain's Dictionary of Medicine*, p. 766 (italics in original)

³²⁴ *ibid.*

³²⁵ G. Fielding Blandford, "Prevention of Insanity (Prophylaxis)," in Tuke, *A Dictionary of Psychological Medicine*, vol. 1, pp. 996-1002, p. 998.

³²⁶ George Savage, *Insanity and Allied Neuroses: Practical and Clinical* (London, New York: Cassell, 1884), p. 4.

³²⁷ Blandford, *Insanity and its Treatment* (1884), p. 32. See also the two cases of moral insanity reported by Bethlem’s Percy Smith. R. Percy Smith, "Cases Contributed by Dr. Percy Smith," *Journal of Mental Science*, 31, no. 135 (1885): 366-371, p. 365.

³²⁸ Savage and Mercier, "Insanity of Conduct", p. 2.

apparent object.”³²⁹ Yet, in the cases cited, Savage had already hinted at possible explanation for this “torture” by explicitly linking self-mutilation (including burning and skin-picking or rubbing) to the otherwise deceitful nature of the patient. Miss M, for example, a “bright, pretty and accomplished” girl, had been sending threatening anonymous letters to relatives, “saying many things which were not true. ... Beside all this, some time before, she had had a peculiar skin affection, which was proved to have been produced by herself by burning with hair-curlers.” Thus, Miss M’s self-mutilation was connected, via the diagnosis of moral insanity, to a presumed deceitful nature and “most supreme self-confidence”: the inference being that her selfish instincts had won out.³³⁰

A tendency to describe particular behaviours as selfish, and the relation made between what, on the surface, might appear to be un-connected traits, such as an act of self-mutilation and an unwillingness to socialise, formed a platform from which the alienist could, by extension from an individual, comment on society. Indeed, the analogy from the human body to the social body was a commonplace for many writers.³³¹ While such references are vague and sporadic within case books, in published texts we often see them more clearly. George Savage was one of a number of alienists who frequently insisted that the majority of cases of insanity depended on the influence of surroundings more than heredity and biology.³³² Simultaneously, although insisting that sanity and insanity were “relative terms” and “varying with the individual,” Savage, nonetheless, pointed out that alienists (as well as patients’ families), often judged their charges by conduct, rather than any clear evidence of cerebral disease.³³³ Thus, although insanity might be a disorder of self, it was closely related to social concerns, which simultaneously caused and were threatened by it. In what way, however, could an act of injury to the patient’s own body be regarded as socially dangerous? One explanation was to view behaviour in evolutionary terms. The Lamarckian perspective that acquired characteristics might be hereditary continued to hold much weight in the later nineteenth century (even for other evolutionists, including Darwin), suggesting that parents might pass an acquired tendency to self-mutilation on to their

³²⁹ *ibid.*, p. 4.

³³⁰ *ibid.*, p. 3

³³¹ Haeckel’s “biogenetic law”, was a particularly influential articulation of this idea. Daniel Pick, *Faces of Degeneration: a European Disorder* (Cambridge; New York: Cambridge University Press, 1989), p. 28. See also Young, *Mind, Brain and Adaptation*, p. 153.

³³² Savage, “The Influence of Surroundings”; George Savage, “The Lumleian Lectures on the Increase of Insanity,” *The Lancet*, 169, no. 4362 (1907): 933–936.

³³³ Savage “Mental Diseases”, p. 180; Savage, “The Influence of Surroundings”, p. 532; Savage and Mercier, “Insanity of Conduct”.

offspring.³³⁴ In psychological terms, this was usually described in relation to “self-adjustment” (the ability of the individual to adapt psychologically to the environment).³³⁵ Thus, while Savage had a fairly optimistic view of the potential outcome of mental disease overall (he maintained that the only patients who were definitely incurable were those suffering from general paralysis),³³⁶ he had a less positive view of civilization, regarding much insanity as produced by “the artificial relationships of society”.³³⁷ George Fielding Blandford addressed these concerns still more explicitly in an entry on “Prevention of Insanity” in Tuke’s *Dictionary*, in which he blamed contemporary systems of education (especially competition for scholarships) and individualist religious groupings for a “self-culture”, which might lead to failure in adjustment or integration.³³⁸

Outside the strictly medical arena, the extrapolation from individual character to social and political commentary was often still more explicit. We can see this clearly in accounts of the life and death of farmer Isaac Brooks, whose attempts at self-castration will be discussed in detail in chapter four. The young farmer had apparently injured his own genitals twice, before accusing others of having done so. Alienists quickly diagnosed Brooks (who had never been in an asylum or, according to his friends, exhibited any unsoundness of mind during his life), for the combination of self-mutilation and false accusation appeared to be “a definite plan of lying and mischief-making [which] seems to be the symptom of moral insanity.”³³⁹ The anonymous author of a commentary on Brooks in the *Journal of Mental Science* (perhaps one of the editors, George Savage or Daniel Hack Tuke, both of whom, as we have seen, were interested in the topic) cited a number of examples from his own asylum experience, where patients had injured themselves, apparently in order to accuse others. He went on to describe other instances of self-inflicted injury, implying a similar background of moral insanity and manipulation in all instances. The Brooks case thus drew together evolutionary thoughts about moral insanity. As Blandford, Savage and Tuke had all suggested in other instances, Brooks’ insanity was judged solely by his actions – in this instance an attempt at self-castration and the false accusation of others. Indeed, given that the farmer had already died, there were no other criteria available on which his state of mind might be judged! It was his acts that led to a diagnosis of moral insanity, the new evolutionary interpretation of which indicated that the very first trait lost by Brooks must

³³⁴ Maudsley, "The Genesis of Mind (II)", p. 65.

³³⁵ George Savage, "Heredity and Neurosis," *BRAIN*, 20, no. 1-2 (1897): 1-21, p. 6.

³³⁶ Savage, *Insanity and Allied Neuroses*, p. 14.

³³⁷ Savage, "The Influence of Surroundings ", p. 535.

³³⁸ Blandford, "Prevention of Insanity (Prophylaxis)", pp. 996-1002; Savage, "The Influence of Surroundings ", p. 533.

³³⁹ F. W. Warrington, "The Case of Isaac Brooks," *Journal of Mental Science*, 28, (1882): 69-74, p. 73.

have been altruistic sentiments. If, as many writers held, individual development reached its peak in social feeling, then those, like Brooks, who were thought to have failed to develop such characteristics posed a national threat. As Henry Maudsley put it:

A child ... begins with feeling, like the animal, entirely for itself; but, rightly developing, it goes on to feel for two or three persons, then for the family, then for the country, and perhaps in time for the whole human race.³⁴⁰

If an act was characterised as “selfish”, it was thus implied that it must be antagonistic, not only to a person’s immediate contacts, but to national and social feeling as well.

2.5 Conclusion

As this chapter has indicated, nineteenth-century naturalist concepts of mind were developed within an evolutionary context. Within such concerns, self-mutilation could be regarded as a bodily phenomenon by placing either somatic or metaphysical approaches to mind within evolutionary accounts of development. Such a model equated impulsive, emotional and reflexive behaviours with the lower or animal instincts and thus emphasised a view of self-mutilation as a primitive behaviour. These ideas were supported by analogy to other mutilations deemed primitive: for example, bodily modification in savage societies or, on occasion, self-inflicted injury in animals.³⁴¹ Within such a model, self-mutilation could easily be incorporated into a pessimistic, hereditarian view of insanity, as seen in George Fielding Blandford’s description of moral insanity. The motivation behind self-mutilation was similarly perceived to be related to lower levels of mental development. The assumption was that, just as voluntary control of nervous impulses would develop through a process of evolution, so too would the moral and intellectual state of mankind. From such a perspective, it was easy to draw the conclusion that selfishness was the “natural and unfortunate birthright” of man, which could be transcended by the development of civilization and humanitarian influences.³⁴² Thus, whether approached from a physiological or a sociological perspective, self-mutilation became cast as a reversion to this “natural” state of primitive selfishness, made analogous to body modification for the process of “self-adornment” in other cultures. As the first section of this chapter has shown, this meant that vanity (in some instances loosely related to Darwin’s concept of sexual selection) became frequently viewed as a prime motive behind certain forms of self-inflicted injury.

An alternative explanation was, however, also offered, through attention to the development of impulse, particularly in relation to the notion of “habits”. From such a

³⁴⁰ Maudsley, “The Genesis of Mind (I)”, p. 493.

³⁴¹ P. S. Abraham, “Self-Mutilation in a Lioness,” *Journal of Mental Science*, 32, no. 137 (1886): 46–50.

³⁴² Darwin, *The Descent of Man* (1998), p. 584.

perspective, self-mutilation might be held to indicate a response to the *unnatural* state of civilization: perhaps part of a morbid attention to self. Reflecting this, I have indicated the way in which mechanical restraint was re-interpreted in later nineteenth-century asylums as directly curative, by its perceived role in encouraging the development of individual self-control. From an investigation of skin-picking and hair-plucking in the asylum, however, I have shown that while it was claimed that such acts could develop as unconscious habits, and should thus be sternly repressed, this approach was not always put into practice. The large proportion of patients who were *not* restrained, despite injuring themselves, reminds us that, while attempting to uncover universal explanations for self-mutilation and other symptoms, alienists did not necessarily apply these in practice. In some cases, self-mutilation was even suggested to be beneficial to the individual, through the relief of mental disorder by physical harm: George Savage went so far as to claim that he was “inclined to think that the scourging of the lunatic in times past might have occasionally been a help to recovery”.³⁴³ What’s more, many alienists rejected a hereditarian model, which assumed that self-mutilation was evidence of degeneration of both individual and race, and instead sought other meanings, psychological and sociological, in their patients’ acts.

Nonetheless, even those who promoted the exploration of meaning within self-injurious acts rarely rejected the evolutionary model outright and, particularly within the context of the diagnosis of moral insanity, viewed an act of self-mutilation as evidence of a failure to develop the higher sentiments, like altruism. Self-mutilation was thus – directly and indirectly – associated with selfishness, despite the fact that many behaviours could equally easily have been regarded as the reverse. Patients, for example, often attributed altruistic motivation to their acts through reference to religion, suggesting that they had injured themselves in order to “save” others. Self-injury could, then, easily have been viewed as a sympathetic, social, or even self-sacrificing act. It is only within the particular context of contemporary anthropological and evolutionary thought that we can understand how late nineteenth-century alienists associated self-mutilation unequivocally with selfishness. Self-mutilation, within this context, becomes part of a much broader contemporary debate over the self: the relation of body to behaviour and body to mind, the external representation of mental phenomena and, most importantly, an indicator of the relation of the individual towards society. The tendency to view selfishness as an early symptom of insanity gave rise to the converse view: that the insane were necessarily selfish, and their acts therefore motivated by egoism. From such a perspective, in which conclusions

³⁴³ Savage, "The Presidential Address delivered at the Opening Meeting of the Section of Psychiatry of the RSM", p. 20.

about an individual's character might be made simply by their residence in an asylum, self-mutilation *had* to be viewed as selfish for notions of progress in evolutionary development to remain valid. This explains why acts of "minor" self-mutilation, which were seen as little different from "nervous habits", might be considered selfish, for if these acts were considered to be the first indication of insanity in an individual, it implied that they *must* be selfishly motivated.³⁴⁴ Indeed, this even meant that minor self-inflicted injuries could be regarded as *more* problematic than major injuries, for the proximity to nervous habits suggested that the individual was closer to health, presumably possessed some degree of self-control, and thus had a responsibility to refrain from self-inflicted injury.

But why *was* "selfishness" regarded as such a threat by late Victorians, and thus became the dominant explanation for self-injurious acts? As has been indicated, the debate around altruism and the higher sentiments in mankind had both religious and political implications. Many authors worried that a perceived secularisation of society might lead to a decline in moral values: Comte's humanitarian religion thus became part of a new tradition of what Thomas Dixon calls "moralistic unbelief".³⁴⁵ Concerns over the importance of altruism in modern society were prominent, and evolutionists stressed the need for the cultivation of humanitarian ideals in the name of progress. Rejecting Enlightenment philosophies, which were increasingly regarded as selfish and individualist, authors in a wide variety of fields insisted on the necessity of the "social instincts" for the functioning of late nineteenth-century society. Darwin, for example, made the political implications of his account of natural selection in mankind clear by stressing the inspiration of Walter Bagehot's "Physics and Politics", which, he stated, had shown that "[s]elfish and contentious people will not cohere, and without coherence nothing can be effected".³⁴⁶ Finally, if altruism was the source of "domesticity and sociability", then it fell that the reverse threatened the stability of home and society.³⁴⁷ Thus, the concept of self-mutilation as a selfish behaviour must be set within the context of debate over the proper relation between self-knowledge – held by Enlightenment thinkers as the highest aim of the individual – and social progress.

³⁴⁴ Blandford, *Insanity and its Treatment*, pp. 194–5.

³⁴⁵ Dixon, *The Invention of Altruism*, p. 95.

³⁴⁶ Darwin, *The Descent of Man* (1998), p. 134.

³⁴⁷ Tuke "Altruism", p. 83.

Chapter Three

The Normal Self: Psychology and ‘Motive Power’ in Self and Society (1880 – 1910)

3.1 Introduction

As indicated in the previous chapter, viewing self-inflicted injuries on an evolutionary scale did not offer the only perspective on self-mutilation. Alongside the progressive and pessimistic models equating the development of the individual to the development of mankind, there was also another means of approaching psychiatry within the late Victorian period, focused on the individual. Despite the widespread nature of theoretical texts adopting evolutionary and degenerationist perspectives, an individualist basis remained the foundation for much late nineteenth-century asylum practice, as indicated in hospital archives. This approach had its roots in moral treatment – incorporating humanitarian paternalism and the re-enforcement of social values – but was also related to new ideas within experimental psychology that aimed to understand and interpret the human mind. The vast majority of alienists who wrote on the topic of self-mutilation explicitly claimed that mental and physical processes could not be regarded as identical (as materialists claimed), and that attention to motive as something separate from physical process was an essential element of understanding self-inflicted injury.

This chapter will outline the ways in which late nineteenth-century alienists suggested that the subjective ideas of their patients could aid in the exploration of abnormal *and* normal psychology. In the 1890s, James Adam indicated that analysis of the motives for self-mutilation throughout history was the most important factor in understanding the behaviour.³⁴⁸ Other alienists also emphasised such an approach.³⁴⁹ The concerns of these writers reflects a growing interest in late nineteenth-century asylum psychiatry in the suggestion that impulse might be prompted by an idea, and so emphasising introspection as an important approach to mind.³⁵⁰ While investigation of brain biology continued to be regarded important, a number of alienists insisted that psychiatric questions could not be answered through a purely somatic approach that correlated mind and brain. As George Savage put it, “neurologists and physiologists are only the engineers who are studying the

³⁴⁸ James Adam, "Self-Mutilation," in *A Dictionary of Psychological Medicine*, ed. Daniel Hack Tuke. (London: J. & A. Churchill, 1892), 1147-1152, p. 1147.

³⁴⁹ George Savage, "Presidential Address, Delivered at the Annual Meeting of the Medico-Psychological Association," *Journal of Mental Science*, 32, no. 139 (1886): 313-331; Daniel Hack Tuke, *Illustrations of the Influence of the Mind Upon the Body in Health and Disease* (Philadelphia: H.C. Lea's Son & Co., 1884).

³⁵⁰ George Savage, "The Harveian Oration on Experimental Psychology and Hypnotism," *British Medical Journal*, 2, no. 2547 (1909): 1205-1212, p. 1208.

machinery, while we in asylums have the much more difficult problem of studying the motive power.”³⁵¹ Later in life, Savage conceptualised this “motive power” as a universal force which, he admitted, was closely related to other metaphysical and theological beliefs and could only be revealed through its relation to action, making the behaviour of asylum patients, including self-mutilation, a worthy topic of study. Modern studies suggest that self-harm “cannot be discussed without consideration of intent”.³⁵² That such is not necessarily the case has been made evident in many aspects of the previous two chapters. However, an association between injury and motive was increasingly assumed in the later nineteenth century. Here, I focus on the way in which self-mutilation was thought to aid the alienist to conceptualise hidden mental processes within the individual. Could exploring self-mutilation help the physician to “look within” the individual? Was such a means of examination beneficial for treatment or theoretical knowledge? How could self-mutilation reveal the “self”, and its seeming breakdown or dissolution? Such questions were often rooted in religious, as well as secular, thought, for psychological considerations left space for addressing not only body and mind, but also an immaterial soul.

I will begin this chapter by providing a context for these concerns in the shifting language of selfhood in the middle and later nineteenth century. Looking particularly at the philosophies of John Stuart Mill, I examine the changing meaning of “self-consciousness”, whereby acts of self-mutilation were interpreted psychologically. In the mid-nineteenth century the term “self-conscious” first acquired negative connotations. While Enlightenment philosophers had regarded self-knowledge as intrinsically positive, introspection in the later nineteenth century seemed increasingly suspect, not least due to the potential links with the egoistic motivation discussed in the previous chapter. This furthered a tendency to see self-mutilation as one of the dangers of introspection, and thus indicative of an unhealthy focus on the self, as exemplified in the psychiatric diagnosis of hypochondriasis, which a number of physicians specifically associated with self-inflicted injury. In a seemingly paradoxical manner, such introspection could nonetheless be deemed to result in a *loss*, or disintegration of self. Through such interpretations, we can see an increasing tendency among asylum practitioners to view their patients in a psychological, as well as a physiological, context, searching for and interpreting the “motive” behind self-injurious acts. Sometimes this search for motivation began with the subjective descriptions of the patient; sometimes physicians used their own inductive reasoning to supplement these. On still

³⁵¹ Savage, “Presidential Address, Delivered at the Annual Meeting of the Medico-Psychological Association”, p. 315.

³⁵² Karen Skegg, “Self-Harm,” *The Lancet*, 366 (2005), 1471-83, p. 1472.

other occasions, the lack of explanation invited broader conclusions over the nature of selfhood; a seeming disconnect between act and idea could be used to explore new models of consciousness, in particular that of dissociation, related to the fields of psychical research and French experimental psychology. It is important to note, however, that these psychological concerns did not prevent alienists from drawing broader conclusions about the individual's character and the social implications of his or her acts. Indeed, if anything, the symbolic nature of many psychological approaches encouraged this, while the notion of "inwardness", like that of biological determinism, served to locate social problems within the individual, despite admitting the relevance of external social and political circumstances. I conclude by reiterating the impossibility of seeing late nineteenth-century approaches to self-mutilation in either explicitly psychological or somatic terms, while recognising that these approaches tended towards certain similar conclusions. The psychological approach, just like the somatic, hereditarian attitude discussed in the previous chapter, located the impetus towards self-mutilation within the individual, and therefore supported the notion that self-injurious acts were indicative of selfishness, leading to disintegration of personality or selfhood and, by analogy, the breakdown of social order.

3.2 Self-Consciousness and Introspection: The Shifting Philosophical Language of Selfhood

In recent years, the history of selfhood has become something of a preoccupation for historians, philosophers, sociologists and anthropologists alike. Accounts have tended to emphasise the way in which concepts of self vary across culture and history. The human self thus becomes, as the titles of many of these volumes stress, an idea, an invention, a cultural construct.³⁵³ Of course, issues of human identity have long been a theme of various discourses, and many contemporary accounts draw on such sources: Stoic philosophy, religious texts on the soul, the much-debated Cartesian divide between mind and body and Romantic self-expression, as well as modern psychology. For many modern writers, psychology in the nineteenth and early twentieth centuries is presented as especially prominent due to its promise to connect the "inwardness" of the individual with the needs and values of society. Sociologists David Armstrong and Nikolas Rose have represented such efforts through a Foucauldian perspective, viewing them as negative, restrictive and related

³⁵³ John O. Lyons, *The Invention of the Self: the Hinge of Consciousness in the Eighteenth Century* (Carbondale: Southern Illinois University Press, 1978); Jerrold E. Seigel, *The Idea of the Self: Thought and Experience in Western Europe Since the Seventeenth Century* (Cambridge: Cambridge University Press, 2004); Rhodri Hayward, *Resisting History: Religious Transcendence and the Invention of the Unconscious* (Manchester; New York: Manchester University Press, 2007).

to the imposition of power.³⁵⁴ Conversely, the historical approach of Mathew Thomson, Rhodri Hayward and Roger Smith provides a perspective that attempts to incorporate the *desire* of many individuals to attain a promised cohesion, and the fear, individual and collective, that this might not be achieved.³⁵⁵

How, then, do these histories of selfhood relate to the belief that the self that has been created might be subsequently mutilated? Figurative language around self-mutilation remains prominent in modern texts. Philosopher Charles Taylor, for example, suggested that a “stripped-down secular outlook” on the self emerged through a process of “mutilation”, and paralleled such an attitude with “self-inflicted wounds.”³⁵⁶ Here, Taylor rejects the late twentieth-century tendency to deny human personality a spiritual side. Like nineteenth-century alienists, however, he paints a direct relation between a potentially self-damaging *attitude* and self-inflicted *bodily injury*. Indeed, a look at the *Oxford English Dictionary* indicates that it is this figurative (rather than the medico-psychiatric) use of the term “self-mutilation” that has been predominantly upheld linguistically. The most recent (1980) of the two quotations for self-mutilation included today reads “[i]t represents self-mutilation, it can only lead to genocide and biocide.”³⁵⁷ Such a quote does not refer to an act of bodily injury, but instead uses self-mutilation figuratively to describe the effects of an unspecified (presumably political) act. Illustrative quotations relating to individual acts of bodily harm were even removed from later editions, such as a reference from Haldane and Huxley’s *Animal Biology*, on the lizard’s “power of self-mutilation (or autonomy as it is often called).”³⁵⁸ This use of the term appears to have more in common with psychiatric definitions of self-mutilation: not least in the suggestion through “autonomy” that the lizard’s behaviour is not simply biological, but also related to metaphysical concepts of will and self-government. The relation between self and self-mutilation, then, requires us to look in more detail at late nineteenth-century notions of selfhood.

³⁵⁴ David Armstrong, *A New History of Identity: a Sociology of Medical Knowledge*, (Basingstoke: Palgrave, 2002); Nikolas Rose, *Inventing our Selves: Psychology, Power and Personhood* (Cambridge, New York: Cambridge University Press, 1996).

³⁵⁵ A concern previously addressed by post-structuralist philosophers, such as Gilles Deleuze and Felix Guattari, *Anti-Oedipus: Capitalism and Schizophrenia* (London: Athlone, 1984). See also Mathew Thomson, *Psychological Subjects: Identity, Culture, and Health in Twentieth-century Britain* (Oxford; New York: Oxford University Press, 2006); Hayward, *Resisting History*; Roger Smith, *Being Human: Historical Knowledge and the Creation of Human Nature* (New York: Columbia University Press, 2007)

³⁵⁶ Charles Taylor, *Sources of the Self: Making of the Modern Identity* (Cambridge: Cambridge University Press, 1992), p. 520.

³⁵⁷ *OED Online* (<http://www.oed.com/view/Entry/175092?redirectedFrom=self-mutilation#eid120793899>) [accessed 9 September 2011]

³⁵⁸ OUPA, *OED 1933 Supplement slips*, no. 737.

The definitions of self prominent in this period emerged from the Enlightenment quest for self-knowledge, which itself followed on the rationalist discourse of seventeenth-century New Science (the so-called “Scientific Revolution”).³⁵⁹ Yet, in the mid nineteenth century, belief in the relative merits of self-knowledge and introspection appear to have shifted, giving rise to psychiatric concepts like “morbid introspection” and related concerns over the dangers of “self-consciousness” and the “self-culture” of civilization.³⁶⁰ By the late nineteenth century, patients (as well as practitioners) were blaming introspection and self-consciousness for the onset of illness, often suggesting that such traits were inherited.³⁶¹ Young Arthur Browne, for example, was reported to have told the Bethlem medical officers that his delusions were “probably due to self-consciousness & that he inherits that” while Nesta Luke was claimed to have attributed her illness directly to “morbid introspection”.³⁶² While the term self-conscious (as descriptive of an act of cognition and inward sense of reflection) dates from at least the seventeenth century, it is unsurprising that the earliest quotation given in the *OED* for the “morbid” sense of the term is from 1834, in the letters of John Stuart Mill. Indeed, it would be difficult to outline nineteenth-century psychological approaches to selfhood without paying attention to Mill’s writings; his work on liberty, in particular, will be identified as offering a strong connection between self-injurious and socially dangerous acts.

Born in 1806, Mill was a child of the Enlightenment (son of political writer James Mill, himself part of a close circle of Benthamite radicals). He was, nonetheless, a product of the nineteenth century, establishing himself as a well-known outspoken political thinker. Mill’s ideological works can be situated at the centre of mid-century debate over the relation of the individual to society, forming a bridge between individualist Benthamite utilitarianism, and late nineteenth-century interest in collectivist ideals, epitomised in the socialist and feminist movements.³⁶³ Moreover, his work was of much significance to

³⁵⁹ Steven Shapin, *The Scientific Revolution* (Chicago; London: University of Chicago Press, 1996).

³⁶⁰ Michael J. Clark, “Morbid Introspection”, Unsoundness of Mind, and British Psychological Medicine,” in *The Anatomy of Madness: Essays in the History of Psychiatry*, ed. W. F. Bynum, Roy Porter, and Michael Shepherd. Vol.3 (London: Routledge, 1988), 71-101.

³⁶¹ Edgar Sheppard, “On Some of the Modern Teachings of Insanity,” *Journal of Mental Science*, 17:80 (1872): 499-514, p. 502.

³⁶² BRHA, *Male Patient Case book 1893*, (CB/145 – 26); BRHA, *Female Patient Case book 1900*, (CB/164 – 124). See also George Savage, “Hypochondriasis and Insanity,” in *A Dictionary of Psychological Medicine*, ed. Daniel Hack Tuke (London: J. & A. Churchill, 1892), 610-618; H. Rayner, “Melancholia and Hypochondriasis,” in *A System of Medicine*, ed. T. Clifford Albutt. (London: Macmillan, 1899), 361-381; Henry Maudsley, *Responsibility in Mental Disease*, (London: Henry S. King, 1874), p. 298.

³⁶³ For more on political change in the period, see Stefan Collini, *Public Moralists: Political Thought and Intellectual Life in Britain 1850-1930* (Oxford: Clarendon Press, 1991); Eric M. Sigsworth, *In Search*

psychological medicine. In *On the Logic of the Moral Sciences* (the sixth book of the weighty series, *A System of Logic*, 1843), Mill followed up on the ideas of his father to outline a Psychology based on “scientific principles.” Although his division between psychology (science of the mind) and ethology (science of the formation of character) was not widely taken up, both features were certainly embraced in much psychological writing in the later nineteenth century, especially in concepts of “the neuroses”. Until 1884, in the admission interview at Bethlem, relatives were questioned on the “habits” and “temperament” of each patient. When these two categories were removed from the pre-printed record in 1884, the same information continued to be recorded, but now in the field for “Neuroses” (which, previously, had included only information on physical conditions, such as neuralgia and headaches). José Piñero has similarly noted that the term neurosis disappeared from British literature in the mid-nineteenth century, reappearing as a psychological concept in the 1880s and 1890s.³⁶⁴ Such a connection makes it unsurprising that alienists often made associations between psychological motive and character in cases of so-called hysterical self-mutilation, for the notion of neurosis conflated the two. Indeed, with “moral treatment” remaining prevalent, one might argue that the very functioning of the asylum was bound up in the perceived relation between motive and character.³⁶⁵

One of the important ways in which Mill differed from his predecessors was in his rejection of Bentham’s theory of motivation through the pleasure/pain principle.³⁶⁶ As indicated in chapter one, Bentham had claimed that pleasure and pain were over-riding principles of motivation in man. Self-mutilation in such a context appeared to be in opposition to “natural laws”. Thus, the motive behind such an act would not require attention (being similarly irrational). In order for the motives behind self-mutilation to become of interest, a new model of mental functioning in mankind was required and Mill, in conjunction with the evolutionary thinkers described in the previous chapter, provided the foundation for the belief that sane and insane motives were both more complex and in

of Victorian Values: Aspects of Nineteenth-Century Thought and Society (Manchester: Manchester University Press, 1988); H. S. Jones, *Victorian Political Thought* (Basingstoke: Macmillan Press, 2000).

³⁶⁴ José M. López Piñero and D. Berrios, *Historical Origins of the Concept of Neurosis*, (Cambridge: Cambridge University Press, 1983).

³⁶⁵ This is similar to the arguments of sociologist Erving Goffman in the 1950s, who concluded that asylums functioned in a manner fundamentally at odds with the claims of psychiatry as a discipline. For Goffman, the contradiction was in the claims of psychiatrists that illness, rather than the individual, was responsible for the behaviour of the mentally ill. Yet an asylum could only function on a day-to-day basis by assuming that the individual was responsible for his actions, and thus that these formed part of his character. Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Harmondsworth; New York: Penguin, 1975).

³⁶⁶ John Stuart Mill, *On The Logic of the Moral Sciences*, ed. Henry M. Magid. (Indianapolis; New York; Kansas City: The Bobbs-Merrill Company, Inc, 1965), p. 16.

closer proximity than Bentham's model allowed. Such a re-evaluation required each action to be examined in the context of character and environment. This understanding of the individual as part of his wider social relations led to a shift in the meaning of self-consciousness to the morbid sense of the term most often used today. Inwardness in the seventeenth and eighteenth centuries had been regarded as an attribute setting man apart from animals, making self-consciousness part of a positive quest for self-knowledge. Although such connotations did continue to be associated with the term in the nineteenth century, the boundaries of this self-knowledge, and the extent to which reflexivity was viewed as beneficial, became regarded as increasingly complex. Indeed, in certain situations, it was suggested that self-consciousness might *discourage* the individual from performing particular social functions.

A close relation between self-mutilation and morbid attention to oneself is found in the diagnosis of hypochondriasis. Hysteria (or "Fits of the Mother") and "Hypochondriack distempers" had both been reclaimed by medical writers in the early 1600s (from the concept of demonic possession), and soon became explicitly linked to melancholy and madness.³⁶⁷ A flurry of works relating these "passions" (the "Spleen and Vapours" as they popularly became known) to irregularities of the nervous system followed in the late seventeenth and early eighteenth centuries.³⁶⁸ By the late nineteenth century, hypochondriasis (like hysteria), was generally regarded as a functional disorder (rather than resulting from a structural lesion of the nerves, as the previous century's writers had suggested), on the borderline between sanity and outright madness.³⁶⁹ Despite this shift in characterisation from nervous lesion to functional illness, many writers still regarded hypochondriasis as the male equivalent of hysteria, as had been the case since at least the seventeenth century.³⁷⁰ The exact location of the illness on the spectrum of mental health continued to be much debated. In Albutt's *System of Medicine*, Henry Rayner (former superintendent of Hanwell Asylum and co-editor of the *Journal of Mental Science* from 1895 to 1911) saw hypochondriasis as "but a sub-variety of melancholia", and thus treated both

³⁶⁷ This is generally dated from Edward Jorden's *Briefe Discourse of a Disease Called the Suffocation of the Mother* (1603), in Edward Jorden, *Witchcraft and Hysteria in Elizabethan England: Edward Jorden and the Mary Glover Case*, ed. Michael MacDonald (London; New York: Routledge, 1990).

³⁶⁸ Bernard Mandeville, *A Treatise of the Hypochondriack and Hysterick Passions*, (London: J. Tonson, 1711); Richard Blackmore, *A Treatise of the Spleen and Vapours: or, Hypocondriacal and Hysterical Affections*, (London: Printed for J. Pemberton, 1725); Nicholas Robinson, *A New System of the Spleen, Vapours, and Hypochondriack Melancholy* (London: A. Bettesworth, W. Innys, and C. Rivington, 1729)

³⁶⁹ For more background, see Russell Noyes Jnr, "The Transformation of Hypochondriasis in British Medicine, 1680 - 1830," *Social History of Medicine*, 24, no. 2 (2011): 281-298 and Janet Oppenheim, "*Shattered Nerves*": Doctors, Patients, and Depression in Victorian England, (New York: Oxford University Press, 1991), chapter 5.

³⁷⁰ Savage, "Hypochondriasis and Insanity" 610-618, p. 611.

as depressed emotional states of varying intensity.³⁷¹ George Savage, meanwhile, treated hypochondriasis and hysteria together (as “functional disorders”), differentiating both from the severe mental diseases of melancholia and mania. An increasing tendency to associate “the neuroses” with psychological concerns rather than structural changes in the brain or nerves, led physicians to separate them from other categories of mental illness, moving away from the eighteenth century view that hypochondriasis, melancholia and mania were “but the several steps or stages of the same Distemper”.³⁷² Thus, Savage claimed that not every neurotic individual became insane, for “hypochondriasis … rarely pass[es] beyond the border line of sanity.”³⁷³ The characterisation of mental illness as a series of stages did not entirely disappear – after all, some physicians, like Rayner, still regarded hypochondriasis and melancholia as different severities of the same illness. However, the growing divide between the neuroses and outright insanity caused increased attention to the meaning of the neurotic’s actions.

Indeed, Rayner and Savage agreed on two important points. Both connected hypochondriasis with a morbid focus on the self, and both claimed this might result in self-inflicted injury. One of three causes of illness listed by Rayner was “the mere habit of self-attention” while, even where the cause was rooted in “actual bodily disease”, illness was perpetuated by the fixing of attention on local sensations.³⁷⁴ Such definitions were rooted in judgments concerning the moral character of the patient. The active terms in which illness was described suggests a level of intent on the part of the patient in both the onset and continuation of illness: the “fixing” of attention appeared to require active volition. Savage’s definition, while stemming from different principles, ultimately reached the same conclusion. His description of the onset of disease was cast in both physiological and evolutionary terms. Thus, hypochondriasis was either a “form of imperfect evolution” (reversion to a primitive state, or atavism) or “nervous dissolution” (degeneration). In such cases, for Savage, the individual had either never learned to perform bodily functions without thinking, or had reverted to a lower level of consciousness as a result of illness. Thus, “[t]he constant conscious repetition of sensations, which in the individual or in the race ought to be unconscious, leads to morbid introspection and hypochondriasis; such is

³⁷¹ Rayner, “Melancholia and Hypochondriasis” 361-381, p. 369.

³⁷² George Cheyne, *The English Malady: or, a Treatise of Nervous Diseases of all Kinds* (London: G. Strahan, 1735), p. xviii. See also Robinson, *A New System of the Spleen*, p. 234; Blackmore, *A Treatise of the Spleen and Vapours*, p. 154.

³⁷³ George Savage, “Heredity and Neurosis,” *BRAIN*, 20, no. 1-2 (1897): 1-21, p. 16.

³⁷⁴ Rayner, “Melancholia and Hypochondriasis” 361-381, p. 369.

our contention.”³⁷⁵ This is an interesting reversal of the Spencerian idea outlined in the previous chapter, in which reflex actions were regarded to be primitive, with consciousness leading to self-control. It also indicates something that was, for later nineteenth-century alienists, a concern of primary importance: the *integration* of self, which might be threatened by excessive attention to individual elements of consciousness. Such complications can explain why, despite his seemingly biological explanation, Savage had more to say about the character of the hypochondriac than Rayner had. While the onset of illness might be unavoidable, it was “increased and aggravated by attention,” bringing the patient’s supposedly morbid focus on himself to the fore once again. Indeed, Savage felt that, in most cases, nervous dissolution was itself caused by “an unhealthy solitude or want of object in life, so that an unhealthy subjective life has been led.” What’s more, he claimed that such self-attention could change the patient’s entire disposition, “so that the kindly and un-selfish man becomes selfish and egotistical.”³⁷⁶ Rather than *losing* self-control, then, the hypochondriac was instead represented as giving *too much* attention to his own state. His failure to integrate was the fundamental problem: internally and, by extension, externally with society.

This correlation between the patient’s attention to himself and his supposedly selfish character was played out in concerns over self-mutilation which, in hypochondriacal patients, was usually thought to be an attempt at self-operation. Rayner declared that “[s]elf-homicide may result ... from attempts by operation to relieve some imaginary condition of the bowels or bladder.”³⁷⁷ Similarly, Savage thought that: “Patients ... will cut open their abdomens to give vent to the collections which they believe to be there, they will suggest the most ingenious operations so that the defects may be repaired.”³⁷⁸ Unlike earlier writers, who had characterised such acts as suicidal, both Savage and Rayner differentiated “self-homicide” from suicide due to the difference in intent: death might be self-inflicted but *not* through a desire to commit suicide.³⁷⁹ In particular, for Savage, “Hypochondriasis of the Digestive Tract” was closely connected with both self-mutilation and emotional disorder, due to the “natural association” (according to Savage) between emotions and the pit of the stomach. Such a connection reminds us once again of the proximity between emotion and sensation in nineteenth century medical descriptions, made most famous in psychology by

³⁷⁵ Savage, “Hypochondriasis and Insanity” 610-618, p. 611.

³⁷⁶ Savage, “Hypochondriasis and Insanity” 610-618, pp. 611-2.

³⁷⁷ Rayner, “Melancholia and Hypochondriasis” 361-381, p. 369.

³⁷⁸ Savage, “Hypochondriasis and Insanity” 610-618, p. 616.

³⁷⁹ For cases of self-operation and castration judged to be suicidal, see William W. Gull, *A Collection of the Published Writings of William Withey Gull*, ed. Theodore Dyke Acland, vol. 2, (London: New Sydenham Society, 1894), pp. 297-8 (originally published 1868).

William James' suggestion that our subjective evaluation of an emotion *follows*, rather than creates, the physiological elements of feeling.³⁸⁰ Thus, cases of hypochondriacal self-mutilation were often attributed to the emotional state of the patient. Samuel Starky, for example, was admitted to Bethlem in February 1889, and diagnosed with Hypochondriacal Melancholia. Although not considered suicidal, it was noted that he had a "tendency to injure self."³⁸¹ Ill for eight or nine months prior to admission, Starky's brother declared that his sibling had complained of irritation of the rectum which, after his mother died of cancer of the uterus, he attributed to cancer. He: "[s]aid that the bowel was choked up, that 'someone' told him to cut out the rectum. Got a razor for purpose. Tore part with fingers. Got chain & padlocks to restrain self from this." On admission to the hospital, Starky was no longer allowed to use these restraints. Treatment, instead, followed the pattern recommended by Savage. As the self-mutilation in hypochondriacs was regarded as representative of an excessive self-attention –evident in Starky's "irritable" and "morose" disposition and his "lack of interest in the ordinary daily pursuits" – "we give tonics, baths, and aperients and try to persuade the patient to take up some definite occupation or amusement, so that he may be taken out of himself and his narrowing feelings."³⁸² If self-mutilation was linked with morbid introspection and excessive attention to self, then it followed that it could be combated with social and environmental therapies, encouraging the individual to adopt wider interests. Such an ethos continued to be adopted well into the twentieth century; one of the main forms of treatment suggested by Horatio Adamson for skin-picking in 1915 was "occupation which will help to withdraw attention from the patient's self".³⁸³

The diagnosis of hypochondriasis in the later nineteenth century thus indicates the close attention paid by alienists to the relation of the individual to society, and the way in which this might be articulated through notions of self-mutilation. The understanding that hypochondriasis and other nervous disorders were close to sanity meant that the motives for the self-inflicted injuries of such patients were seen to require particular attention. Yet, as we have seen, these motives could not be explored outside their social context, and were

³⁸⁰ The notion was widespread in British texts, despite the tendency of most alienists to disagree with James. For more on the subject, see: William James, "What is an Emotion?" *Mind*, 9, no. 34 (1884): 188-205; Charles Arthur Mercier, "A Classification of Feelings," *Mind*, 9, no. 35 (1884): 325-348; Thomas Dixon, "The Psychology of the Emotions in Britain and America in the Nineteenth Century," *Osiris*, 16 (2001): 288-320.

³⁸¹ BRHA, *Male Patient Case book, 1889*, (CB/136 – 13).

³⁸² Savage, "Hypochondriasis and Insanity" 610-618, p. 615.

³⁸³ H. G. Adamson, "Acne Urticata and Other Forms of 'Neurotic Excoriations,'" *The British Journal of Dermatology*, 27, no. 1 (1915): 1-12, p. 11.

perceived to relate directly to the individual's relationship with society. Comte had challenged the old psychology as well as religion, claiming that it portrayed all actions as motivated by selfishness (i.e. the "pleasure-pain" principle). And, as we saw earlier, attention to concepts such as altruism caused alienists to attempt to explore the actions and behaviour of their patients in greater depth, and place far more emphasis on motive in insanity than they had done previously.

3.3 Unconscious Mutilation: Spiritualism and the Disintegration of the Self

In the summer of 1912, while considering his forthcoming presidential address to the new Section of Psychiatry of the Royal Society of Medicine, George Savage allowed "some wild imaginations" to take possession of him. While "lying on mountain slopes", Savage:

contemplated a universal force, call it vital ether, as yet unrecognised and possibly beyond human powers to recognise, which, like the astronomers' ether, is universal and prevalent, this acting on what are called living bodies according to their structure. ... The consideration of this theory caused me much pleasure, but I admit it has no ground of fact, though it represents, perhaps, in a crude way, all we know of life.³⁸⁴

The idea of a vital, universal life force had been of much interest to writers on the human condition in the seventeenth and eighteenth centuries.³⁸⁵ Often dismissed by modern writers as pertaining to the retrogressive influence of religious thought in scientific practice, such concerns nonetheless experienced a resurgence in the late nineteenth and early twentieth centuries, as part of an increasing interest in spiritualist modes of thought. Spiritualist schools of philosophy and psychology (as distinct from, although related to, the "religion" of Modern Spiritualism, which emerged in the United States in the late 1840s) held that consciousness was an essence apart from, and superior to, matter, and "is the cause rather than the effect of certain changes in the brain."³⁸⁶ While, as Roger Smith has noted, the concerns explored by many spiritualist and metaphysical psychologists were often complicated by their adoption of terminology from the natural sciences (such as "force" or Savage's "motive power", a term from thermodynamics), most of their

³⁸⁴ George Savage, "The Presidential Address delivered at the Opening Meeting of the Section of Psychiatry of the Royal Society of Medicine on October 22nd, 1912," *Journal of Mental Science*, 59, no. 244 (1913): 14-27, pp. 17-18.

³⁸⁵ See Gary Hatfield, "Remaking the Science of Mind: Psychology as Natural Science," in *Inventing Human Science*, ed. Christopher Fox, Roy Porter, and Robert Wokler (Berkeley: University of California Press, 1995), 184-231.

³⁸⁶ Professor Balfour Stewart, "Chairman's Address: Proceedings of the General Meeting on June 30, 1884," *Proceedings of the Society for Psychical Research*, 2, (1884): 187-188, p. 187.

explanations emphasised that thought might precede organic change in the brain (the domain of the materialists).³⁸⁷ Most importantly, for those alienists, like Savage, who wished to set themselves apart from physiologists and neurologists, motive power was characterised as a *living force*, not confined to "this deadening belief in the all-powerfulness of the organ".³⁸⁸ In order to explore motive, psychiatrists had to pay close attention to individual patients, in order to follow the interplay of "feelings as well as coarser environing conditions".³⁸⁹

These alienists tended to reject materialism, and shared an interest in exploring consciousness and contemporary theories of unconscious phenomena, from W.B. Carpenter's "unconscious cerebration" to psychological interpretations of multiple consciousness in the late nineteenth century, including Janet and Bernheim in France, Myers and Gurney in England and Freud and Breuer in Germany.³⁹⁰ While the later influence of psychoanalysis persuaded a number of historians to chart such theories in terms of the "discovery" of the unconscious (as if this was a fixed, natural entity), far less attention has been paid to the discovery (or, rather, the re-framing) of *consciousness*.³⁹¹ Like the unconscious, consciousness cannot be regarded as a universal given entity, although it certainly incorporates seemingly fundamental elements; one can hardly ignore, for example, the difference between a dead and living being. However, this difference can be explained in a variety of ways, one of which is the concept of consciousness. Consciousness was a significant problem for evolutionary psychology, for it was hotly debated at what point in the development of individual or species it appeared. This could make it a fundamental problem

³⁸⁷ Roger Smith, "The Background of Physiological Psychology in Natural Philosophy," *History of Science*, 11, no. 2 (1973): 75-123, p. 97; Savage, "Presidential Address, Delivered at the Annual Meeting of the Medico-Psychological Association", p. 315. For more on motive power see Anson Rabinbach, *The Human Motor: Energy, Fatigue, and the Origins of Modernity* (Berkeley: University of California Press, 1992), esp. p. 46.

³⁸⁸ Savage, "Presidential Address, Delivered at the Annual Meeting of the Medico-Psychological Association", p. 315.

³⁸⁹ *ibid.*

³⁹⁰ W. B. Carpenter, "The Physiology of the Will," *Contemporary Review*, 17, (1871): 192-217; Pierre Janet, *L'automatisme psychologique*, (Paris: Felix Alcan, 1889); F. W. H. Myers, "Automatic Writing II," *Proceedings of the Society for Psychical Research*, 3, (1885): 1, p. 27; Sigmund Freud and Josef Breuer, *Studies on Hysteria*, trans. Angela Richards and James Strachey (Harmondsworth: Penguin Books, 1991). For the context of the debate, see Henri F. Ellenberger, *The Discovery of the Unconscious: the History and Evolution of Dynamic Psychiatry*, (New York: Basic Books, 1970).

³⁹¹ For more on "the unconscious", see Henri F. Ellenberger, *Beyond the Unconscious: Essays of Henri F. Ellenberger in the History of Psychiatry*, ed. Mark Micale (Princeton: Princeton University Press, 1993); Nicholas T. Rand, "The Hidden Soul: The Growth of the Unconscious in Philosophy, Psychology, Medicine, and Literature, 1750-1900," *American Imago*, 61, no. 3 (2004): 257-289; Hayward, *Resisting History: Religious Transcendence and the Invention of the Unconscious*; Jill L. Matus, "Victorian Framings of the Mind: Recent Work on Mid-Nineteenth Century Theories of the Unconscious, Memory, and Emotion," *Literature Compass*, 4, no. 4 (2007): 1257-1276.

for evolutionary principles. Alfred Russel Wallace, whose work on natural selection inspired and supported Darwin, felt strongly that the origin of consciousness could *not* be explained by evolution through natural selection. Much has been written about Wallace's connections with spiritualism, and the way in which his scientific principles were shaped by a humanitarian, socialist ideology that required a teleological approach to the natural world.³⁹² Wallace's corresponding interests in vitalist accounts of biology, and the potential existence of unseen and unclassified forces within the natural world (such as telepathy and spirit communication), however, indicates that attention to diverse phenomena was by no means limited to the fringes of late nineteenth-century science.

Discussion of consciousness encouraged interest in associated fields, in particular that of motive, as previously indicated. But what *was* motive? In Jonathan Andrews' recent discussion of pyromania, there is a clear legal context for such concerns, and interest in motive within psychiatry should certainly be understood in relation to criminal proceedings: understanding the background to a crime had a clear bearing on punishment.³⁹³ Yet the topic also held broader implications within psychological approaches to madness. In 1884, on the publication of the much expanded second edition of his *Illustrations of the Influence of the Mind Upon the Body in Health and Disease*, Daniel Hack Tuke drew attention to the "remarkable increase in the amount of intelligent interest felt in the more subtle relations existing between Mind and Body" since he had first published on the topic a decade earlier.³⁹⁴ This attention marks a departure from the physiological psychiatry of the mid-century (in which the acts of the insane were often explained through reference to nervous impulse), and even from evolutionary explanations of the will. For these alienists, insanity was part of "...wider laws or a larger circle of phenomena ... [which] may exist, and may still be discovered."³⁹⁵ Writers on self-mutilation viewed the topic as providing a direct link between idea or mental process and physical action, and this informed their understanding of the self-injurious acts of their patients.

We cannot draw a clear and direct link between interest in self-inflicted injury and interest in psychological investigation of the mind: the psychologists listed above (with the

³⁹² Alfred R. Wallace, "The Origin of Human Races and the Antiquity of Man Deduced from the Theory of "Natural Selection"," *Journal of the Anthropological Society of London*, 2, (1864): clvii-clxxxvii; Roger Smith, "Alfred Russel Wallace: Philosophy of Nature and Man," *The British Journal for the History of Science*, 6, no. 2 (1972): 177-199; Malcolm Jay Kottler, "Alfred Russel Wallace, the Origin of Man, and Spiritualism," *Isis*, 65, no. 2 (1974): 144-192.

³⁹³ Jonathan Andrews, "From Stack-firing to Pyromania: Medico-legal Concepts of Insane Arson in British, US and European Contexts, c. 1800-1913. Part 1," *History of Psychiatry*, 21, no. 3 (2010): 243-260.

³⁹⁴ Tuke, *Illustrations*, p. vii

³⁹⁵ Tuke, *Illustrations*, p. viii

notable exception of Pierre Janet) apparently had no interest in the topic of self-mutilation. Meanwhile, Savage, Tuke and Hyslop at Bethlem were all also influenced by physiological explanations of brain function, the belief that mind was situated within the brain (and, at times, might be analogous with brain functioning) and evolutionary concepts of development. However, this did not preclude a broader approach to mental functioning that placed consciousness outside the domain of biological science.³⁹⁶ All three of these alienists derided “scientific snobs” and “self-satisfied science”, referring to those doctors who, in the words of William James, identified science with a fixed belief in mechanical origins, even though “in its essence science only stands for a method”.³⁹⁷ For Savage, science simply meant “organised inquisitiveness”, which allowed for the acceptance of a wide variety of methods of investigation within psychiatry, including experimental psychology, “psychic analysis”, psychical research and hypnosis.³⁹⁸ Thus, although it may not have sparked their interest in the topic, the receptiveness of this particular set of alienists to psychological approaches to mind certainly shaped the way in which they understood self-mutilation. In addition to interpreting some self-inflicted injury as revelatory of brain lesions or functional nervous disorder, a background in psychical concepts of mind suggested another interpretation, in which self-inflicted injury appeared to be evidence of a disordered psychical state, including (but not limited to) altered or secondary consciousness. In the 1880s and 1890s, all three Bethlem superintendents (George Savage, R. Percy Smith and Theo Hyslop) experimented with hypnotism, apparently influenced by Daniel Hack Tuke’s efforts to give the topic serious consideration at meetings of the MPA.³⁹⁹ Hyslop, to whose interest I shall shortly return, appears to have been the most influenced by psychological approaches to mind: in 1895, he was elected an Associate of the Society for Psychical Research, and remained as such until at least 1901.⁴⁰⁰

These physicians regarded hypnotism as a potential therapy for mental disorder. In what ways was this related to efforts to alter behaviour, including preventing acts of self-

³⁹⁶ Savage, "The Presidential Address delivered at the Opening Meeting of the Section of Psychiatry of the RSM", p. 15.

³⁹⁷ Tuke, *Illustrations*, p. viii; Savage, "The Presidential Address delivered at the Opening Meeting of the Section of Psychiatry of the RSM", p. 17; William James, *William James on Psychical Research*, ed. Gardner Murphy (London: Chatto & Windus, 1961), p. 44.

³⁹⁸ Savage, "The Presidential Address delivered at the Opening Meeting of the Section of Psychiatry of the RSM", pp. 16-17.

³⁹⁹ R. Percy Smith and A. T. Myers, "On the Treatment of Insanity by Hypnotism," *Journal of Mental Science*, 36, no. 153 (1890): 191-213, p. 191; Savage, "The Harveian Oration on Experimental Psychology and Hypnotism", p. 1209; Daniel Hack Tuke, "On the Mental Condition in Hypnotism," *Journal of Mental Science*, 29, no. 125 (1883): 55-80.

⁴⁰⁰ "List of Members and Associates", *Proceedings of the Society for Psychical Research*, 10 (1895), p. 625.

inflicted injury? In order to explore this, we need to look more closely at some of these experiments. Not all were published, and it is often through the asylum records that we glean information on the way hypnosis was employed and directed.⁴⁰¹ In early 1883, Tuke and Savage invited Carl Hansen, a Danish hypnotist, to experiment at Bethlem, and Tuke's paper on the topic was presented to the next meeting of the MPA.⁴⁰² Tuke concluded that the mental condition in hypnotism was strongly related to that in insanity and, moreover, that suggestion might be used to cure both physical and mental disease, absorbing the topic into his earlier work on the imagination.⁴⁰³ While the introduction of dynamic psychotherapy has generally been attributed to French (Janet and Bernheim), German (Freud) and Swiss (Jung) thinkers, Tuke may, in fact, have been one of the earliest advocates of "psycho-therapeutics".⁴⁰⁴ This term, for Tuke, incorporated a wide variety of techniques of therapeutics, ranging from the use of medication known to be inert to hypnotism and, finally, the influence a doctor might have due to the patient's faith and trust in him. This concept, Tuke hoped, would bind psychiatry more closely to general medicine, by indicating the close relationship between body and mind.⁴⁰⁵ Tuke also invoked a universal force – Imagination – to explain psycho-therapeutics, complaining that, while other doctors had dismissed this concept, it deserved further investigation.

When a person on swallowing a bread-pill, in the belief that it possesses aperient properties, is purged, it is said to be Imagination ... That she is relieved is no Imagination. What cured her? Merely to say it was the Imagination is no solution of the problem.⁴⁰⁶

The imagination, Tuke felt, deserved greater credit for its curative powers, as well as investigation of its therapeutic role: as Sonu Shamdasani has recognised, this emphasis on the imagination meant that Tuke did not seem to connect his own approach with continental work on suggestion, despite being aware of the latter.⁴⁰⁷ For Tuke, the power of cure lay in the *patient*, not the doctor, whose duty was simply to "excite" the patient's

⁴⁰¹ This is also the case elsewhere. For example, Joseph Melling has indicated the use of hypnosis in the treatment of patients at Wonford House in Exeter around 1900: again, this can only be found in the archive records. Joseph Melling, "'Buried alive by her friends': Asylum Narratives and the English Governess," in *Mental Illness and Learning Disability Since 1850*, ed. Pamela Dale and Joseph Melling (London; New York: Routledge, 2006), 65-90, p. 80.

⁴⁰² Tuke, "On the Mental Condition in Hypnotism".

⁴⁰³ Tuke, "On the Mental Condition in Hypnotism"; Tuke, *Illustrations*.

⁴⁰⁴ Sonu Shamdasani, "Psychotherapy: The Invention of a Word," *History of the Human Sciences*, 18, no. 1 (2005): 1-22.

⁴⁰⁵ Michael J. Clark, "The Rejection of Psychological Approaches to Mental Disorder in Late Nineteenth-Century British Psychiatry," in *Madhouses, Mad-doctors, and Madmen: the Social History of Psychiatry in the Victorian Era*, ed. Andrew T. Scull. (London: Athlone Press, 1981), 271-312, p. 281.

⁴⁰⁶ Tuke, *Illustrations*, p. 181.

⁴⁰⁷ Shamdasani, "Psychotherapy", p. 4.

naturally occurring sentiments in order to aid cure: the same sentiments that, in diseases such as hypochondriasis, might cause the symptoms in the first place.⁴⁰⁸ Tuke cited a number of cases, predominantly using hypnotism, which claimed to achieve cure by changing the patient's mental state. Savage, although sceptical at the time, claimed thirty years later to have reached a "stage of hope" over the possibilities offered by hypnotism as a treatment for nervous and functional disorders, as well as for investigation of the mind.⁴⁰⁹ Smith, meanwhile, indicated that hypnotism might be interpreted as a continuation of moral treatment, for "[t]he dominance of one human being over another, which is, for the moment at least, gained by its [hypnotism's] influence, seems in some ways more appropriate to the guidance and help of the insane by the sane."⁴¹⁰

Smith's experiments in the late 1880s offer the first direct connection between therapeutics at Bethlem and the recently founded Society for Psychical Research (SPR), set up in 1882 to investigate spiritual, mesmeric and other psychical phenomena using a scientific methodology.⁴¹¹ In 1890, Smith published the results of experiments (made with A.T. Myers) into therapeutic hypnotism in twenty-one female Bethlem patients. Much of this hypnosis was carried out by the SPR's Mr G. A. Smith, a former stage hypnotist: however, Myers, Percy Smith and Dr Goodall (a clinical assistant at Bethlem) also made attempts to induce hypnotic states.⁴¹² Arthur Myers was the younger brother of Frederic W.H. Myers (one of the founders of the SPR) and had a keen interest in hypnotism, having visited Charcot in Paris and Bernheim in Nancy in the 1880s.⁴¹³ A physician by training, Arthur provided a link between the medical establishment and psychical research, paying more attention than his brother to the use of hypnotism in medical therapeutics.⁴¹⁴ He also maintained connections with asylum psychiatry, contributing an article to Tuke's *Dictionary*

⁴⁰⁸ Tuke, *Illustrations*, p. 187.

⁴⁰⁹ Savage, "The Harveian Oration on Experimental Psychology and Hypnotism"; Savage, "The Presidential Address delivered at the Opening Meeting of the Section of Psychiatry of the RSM", p. 17.

⁴¹⁰ Smith and Myers, "On the Treatment of Insanity by Hypnotism", p. 191. Other alienists agreed. See: "Note and News: The Medico-Psychological Association." *Journal of Mental Science* 29.125 (1883): 124-128.

⁴¹¹ For more on the Society, see J. P. Williams, "Psychical Research and Psychiatry in late Victorian Britain: Trance as Ecstasy or Trance as Insanity" in *The Anatomy of Madness: Essays in the History of Psychiatry*, vol. 1, ed. W. F. Bynum, Roy Porter, and Michael Shepherd (London: 1985), 233-254; Janet Oppenheim, *The Other World: Spiritualism and Psychical Research in England, 1850-1914*, (Cambridge: Cambridge University Press, 1985); Alan Gauld, *A History of Hypnotism* (Cambridge; New York: Cambridge University Press, 1992).

⁴¹² On Smith, see Gauld, *A History of Hypnotism*, p. 291.

⁴¹³ For more on A.T. Myers, see Gauld, *A History of Hypnotism*, p. 390.

⁴¹⁴ A. T. Myers and F. W. H. Myers, "Mind-Cure, Faith-Cure, and the Miracles of Lourdes," *Proceedings of the Society for Psychical Research*, 9, (1893): 160-209.

on the history of hypnotism, in which he referred to the Bethlem experiments as a rare study among “very little done in therapeutics” in England.⁴¹⁵

What, then, did Smith and Myers attempt with these patients, and how did they select the individuals on whom they experimented? All of the patients hypnotised were female. Was this because they were deemed easier to hypnotise or because their symptoms related to those Smith and Myers wanted to study? The article gives no reason for the choice. It is possible that these were milder cases of illness. In one instance, (Case VI) it was commented that the patient was chosen for her “considerable intelligence” which, it was felt, would make it “easy to gain her attention”.⁴¹⁶ Attention was a new focus in late nineteenth century psychology, particularly following the work of Théodule Ribot, and increasingly formed a chapter heading in textbooks.⁴¹⁷ This faculty, alienists often claimed, was frequently lacking in the insane, making them harder to hypnotise.⁴¹⁸ It is also possible that a larger number of female patients exhibited the types of symptom Myers and Smith wished to investigate. The hypnotic suggestions concentrated on efforts to remove or minimise troubling behaviour or symptoms: wild and destructive acts, “dirty habits” (incontinence), hallucinations and delusions and, in particular, refusal of food. Half of the patients experimented on (10 out of 21) had refusal of food – a self-injurious (but not mutilating) behaviour – listed as one of their most prominent symptoms, and the suggestions made to these patients generally focused on encouraging them to eat. While there were certainly a high number of patients in Bethlem who refused food for short or prolonged spells, this was well under half the female population (in 1889, for example, the year in which the experiments were carried out, 51 out of the 160 women admitted refused food at some point – with only a third of these refusals occurring during the hospital stay). Refusal of food was also associated with other self-injurious acts, with around 25% of male patients and 45% of female patients who otherwise injured themselves also refusing food at some stage in their treatment.

Hypnotic suggestion certainly constituted a very different manner of treatment from the standard technique of force-feeding, which often occurred as soon as one meal was

⁴¹⁵ Myers, A.T. “Hypnotism, History of” in Daniel Hack Tuke, *A Dictionary of Psychological Medicine*, ed. Daniel Hack Tuke. vol. 2 (London: J. & A. Churchill, 1892), 603-6, p. 606.

⁴¹⁶ Smith and Myers, “On the Treatment of Insanity by Hypnotism”, p. 206.

⁴¹⁷ Théodule Ribot, *The Psychology of Attention* (Chicago: Open Court, 1890).

⁴¹⁸ Dr Yellowlees complained that his efforts at therapeutic hypnotism at the Glasgow Royal Asylum had been hampered by this. J. Milne Bramwell, “The British Medical Association and Hypnotism,” *Proceedings of the Society for Psychical Research*, 14, (1898): 98-110, p. 109. On attention, see the relevant sections in William James, *The Principles of Psychology*, Vol.1. (New York: London: Dover Publications; Constable & Co., 1950); Theophilus Bulkeley Hyslop, *Mental Physiology: Especially in its Relations to Mental Disorders* (London: J. & A. Churchill, 1895).

refused. Indeed, some success in persuading patients to eat seems to have been the result that Smith and Myers found most encouraging. Although many attempts at hypnotism failed, “[c]ases I, VIII, and XVII. were very similar in symptoms, in all three refusal of food being the greatest difficulty to combat, and in all there certainly was some improvement in this respect after the attempts at hypnotism.” All three patients were in their teens and it was concluded that “the results gained would appear to have been due much more to the large amount of personal attention devoted to each case than to any hypnotic influence.”⁴¹⁹ Smith does not appear to have drawn any conclusions from this as to the general benefit of personal attention in psychiatry, although all three patients were discharged cured. At Sussex House Asylum, Dr Huggard was far more enthusiastic, suggesting that hypnotism not only compelled patients to eat, but that this was achieved by “reaching and exciting to action long disused nervous channels”, thus directly aiding relief of illness, as well as symptoms like food refusal.⁴²⁰

Smith, however, was less-than convinced by the results of therapeutic hypnotism, noting that “so far the results have been extremely limited.”⁴²¹ Despite this, he and Myers carried out further experiments in 1892 (this time unpublished)⁴²² and Smith’s junior colleague, Theo Hyslop, investigated therapeutic hypnotism with John Milne Bramwell later that decade.⁴²³ In 1895, the year he joined the Society for Psychical Research, Hyslop made the bold claim that:

Among the insane, it [hypnotism] has been employed as a sleep producer, as a sedative in excitement, to dispel fleeting delusional states and the minor psychoses, to overcome morbid resistance of patients, and as a substitute for mechanical restraint.⁴²⁴

Attempting to dispel then-prevalent concerns around the potential use of hypnotism for criminal purposes, Bramwell claimed that his experiments with Hyslop revealed “the fact that there has been neither loss of consciousness nor of volition”. He also suggested that the effect of hypnotism in the insane proved that it worked by *increasing* the individual’s ability to exercise his or her natural volition over apparently morbid (often self-injurious) tendencies.⁴²⁵ Refusal of food remained a dominant issue in therapeutic hypnotism within psychiatry, and George Savage later connected the method with the cure of “nervous

⁴¹⁹ Smith and Myers, “On the Treatment of Insanity by Hypnotism”, p. 213.

⁴²⁰ Tuke, *Illustrations*, vol. 2, p. 280.

⁴²¹ BRHA, *Bethlem Royal Hospital Annual Report 1889* (BAR-27), p. 40.

⁴²² This is reported only in the case books, e.g. BRHA *Female Patient Case book 1892*, (CB/144).

⁴²³ J. Milne Bramwell, “Hypnotism: A Reply to Recent Criticisms,” *BRAIN*, 22, no. 1 (1899): 141-156, p. 145.

⁴²⁴ Hyslop, *Mental Physiology*, p. 534.

⁴²⁵ Bramwell, “Hypnotism: A Reply to Recent Criticisms”, p. 145; Hyslop, *Mental Physiology*, pp. 423-4.

anorexia".⁴²⁶ This was similarly explained by the ability of hypnotism to restore "natural instincts", including that of self-preservation. Hence we can understand Hyslop's claim that hypnotism might replace mechanical restraint by, in his view, restoring the instinct of self-preservation in individuals exhibiting self-injurious or suicidal tendencies.

In recent years, historians have become interested in the connections between psychical research and psychology in the late nineteenth century, and the overlap between the two fields is certainly indicated by the interest in hypnotism and altered states at Bethlem.⁴²⁷ It was not only in order to prevent troublesome behaviour that alienists explored hypnotism, but also as part of efforts to understand and explore the human mind. Indeed, Tuke, who had witness Charcot's experiments in 1878, came to believe that the procedure was most useful for this purpose.⁴²⁸ This approach drew on the representation of insanity, and associated acts such as self-mutilation, as characterised by a loss of "self-feeling", encouraging parallels with investigation into other "abnormal" states of consciousness.⁴²⁹ Cases of purportedly psychical phenomena, such as the state of mediumship, furthered the view that insanity and mental health were proximate, such "that it is possible to interpolate an innumerable series of gradations between them [abnormal cases] and health."⁴³⁰ In exploring these concerns, alienists increasingly drew on mental, rather than somatic, philosophies, focusing on identity through such concepts as "double consciousness", which they saw as particularly relevant to insanity.⁴³¹ In the case of hysteria in particular, and the "dermatitis artefacta" that will be discussed in chapter five, self-mutilation was directly related to these altered states. As Myers put it:

Both in hypnosis and hysteria there is a disaggregation of the personality. Instead of the continuous personality of commonlife, with its one familiar alternation of sleep and waking, there are minor changes of phase, interruptions of memory, irregularities of will, inhibitions of faculty, something capricious and mutilated in the manifestation of the self.⁴³²

⁴²⁶ Savage, "The Harveian Oration on Experimental Psychology and Hypnotism", p. 1211.

⁴²⁷ See the recent special issue "Relations between Psychical Research and Academic Psychology in Europe, the USA and Japan", Elizabeth R. Valentine ed. *History of the Human Sciences*, (25: 2, April 2012). Also Heather Wolffram, *The Stepchildren of Science: Psychical Research and Parapsychology in Germany, c. 1870-1939* (Amsterdam; New York: Rodopi, 2009); Thomson, *Psychological Subjects*.

⁴²⁸ Daniel Hack Tuke et al. "A Discussion on Hypnotism in Therapeutics," *British Medical Journal*, 2, no. 1547 (1890): 442-449, p. 443; Daniel Hack Tuke, *Sleep-Walking and Hypnotism* (London: J. & A. Churchill, 1884), p. vi. See also Savage, "The Presidential Address delivered at the Opening Meeting of the Section of Psychiatry of the RSM", p. 17.

⁴²⁹ Hyslop, *Mental Physiology*, p. 443; Theo Hyslop, "On 'Double Consciousness,'" *British Medical Journal*, 2, no. 2021 (1899): 782-786.

⁴³⁰ Hyslop, "On 'Double Consciousness'", p. 782.

⁴³¹ Tuke, "On the Mental Condition in Hypnotism", pp. 67-8.

⁴³² J. Milne Bramwell et al, "The British Medical Association and Hypnotism," *Proceedings of the Society for Psychical Research*, 14 (1898), 98-110, p. 101.

There was thus more crossover between British asylum psychiatry and psychical research than has been recognised. Hyslop approvingly mentioned the “large number of keen investigators” in England and America exploring mediumship “scientifically.”⁴³³ In turn, psychical researchers took psychological medicine seriously. The Society for Psychical Research added Tuke’s *Illustrations of the Influence of the Mind upon the Body* to their Library as soon as it was published (1884), while his *Sleep Walking and Hypnotism* (1884) was added the following year.⁴³⁴ When Frederic Myers included a helpful glossary of terms used in psychical research in the Society’s *Proceedings* of 1896, he took the definitions for most words “in common philosophical or medical use” from Tuke’s *Dictionary* (another volume in the Society’s Library), deeming it “the most authoritative – almost the only – English work of its kind.”⁴³⁵ The Glossary included “Psycho-therapeutics”, as defined by Tuke, with Myers confident that “all *suggestion* of course comes under this head.”⁴³⁶ While many writers dismissed psychical phenomena as evidence of fraud or disease others, who, like Tuke and Hyslop, stressed the importance of imagination and sympathy to human life, regarded them as revelatory of positive truths about humanity and selfhood.

Other than refusal of food, however, what forms of self-injury were most often related to altered consciousness? The wild movements and spasms of mediums and other hypnotised persons meant that the most frequent parallel drawn with so-called insane self-mutilation was that of knocking the head or other part of the body. Alongside skin-picking and hair-plucking, such knocking was one of the most frequently recorded acts of self-mutilation in Bethlem during this period (see figure 7). Associating such acts with an altered form of consciousness was not, however, the only or obvious explanation. Several decades earlier, in February 1850, 29-year-old nailmaker Samuel Day was admitted to Bethlem as a potentially “dangerous” (but not suicidal) patient. Due to his violent behaviour, Day was often secluded in a padded room (although mechanical restraint was not abolished at Bethlem until 1851, it was a rare occurrence in preceding years).⁴³⁷ On 4th July, all the padded rooms being full, Day was locked in an ordinary bedroom but soon after found “kneeling in the corner of the room, himself and the floor covered with blood which had

⁴³³ Hyslop, “On ‘Double Consciousness’”, p. 785.

⁴³⁴ *Proceedings of the Society for Psychical Research*, vols. 2 and 3 (1883 -5).

⁴³⁵ F. W. H. Myers, “Glossary of Terms used in Psychical Research,” *Proceedings of the Society for Psychical Research*, 12, (1897): 166-174, p. 166. Much of this (including Tuke’s definition of psycho-therapeutics) was reproduced in the posthumous publication F. W. H. Myers, *Human Personality and its Survival of Bodily Death*, (London: Longmans, Green and Co., 1903), p. xx

⁴³⁶ Myers, “Glossary of Terms”, p. 173. Discussion of psycho-therapeutics is also incorporated into Myers’ paper on faith cure. Myers and Myers, “Mind-Cure”.

⁴³⁷ BRHA, *Bethlem Royal Hospital Annual Report 1850* (BAR-06), p. 52.

flowed very profusely from a severely lacerated wound of the scalp". The patient later claimed that he had "intentionally beaten his head against the projecting edge of the brick wall." Nonetheless, his death (a short period later) was not listed as suicide.⁴³⁸ Suicide could thus be categorised in particular ways in order to avoid negative publicity for the asylum. The classification also, however, brings to mind the association of certain forms of self-injury with wild, but essentially unintentional, acts, made by George Fielding Blandford and in the Ipswich asylum reports discussed in chapter one.⁴³⁹ In French neurology, head-banging continued to be associated with uncontrollable behaviour, such as the "Maladie des Tics" described by Gilles de la Tourette in 1885.⁴⁴⁰ By providing psychological explanations for certain cases of head-banging, however, Theo Hyslop offered an entirely different view of self-inflicted injury.

In 1899, the year in which Milne Bramwell rather boldly claimed that "the principle upon which the subliminal consciousness theory depends is now largely admitted by science", Hyslop expanded his own work into this field by presenting a paper on "Double Consciousness" at the Annual Meeting of the British Medical Association Section of Psychology.⁴⁴¹ While Bramwell's claim is arguable, it does indeed seem that many writers in medical and popular literature had become impressed with the idea that the "self" was formed from a combination of elements (some conscious and some not), rather than being one unitary personality.⁴⁴² In his short paper, Hyslop sought to expand the field of research on consciousness through a discussion of cases he felt might "help to bridge the apparently impassable gap between double consciousness and more ordinary experiences",⁴⁴³ thus showing his belief in the proximity of sane and insane states. Hyslop's interest in the field may well have increased following correspondence with Pierre Janet, who has widely been perceived as influential in the field of psychodynamic psychiatry in the later nineteenth

⁴³⁸ BRHA, *Male Patient Case book (Morison) 1850*, (CB-048 - 10).

⁴³⁹ Anon, "Asylum Reports for 1871," *Journal of Mental Science*, 18, no. 82 (1872): 262-276 p. 274.

⁴⁴⁰ Georges Gilles de la Tourette, "Study of a Nervous Disorder Characterized by Motor Incoordination with Echolalia and Coprolalia," trans Graeme Yorston and Nick Hindley, *History of Psychiatry* 9, No. 33, (1998): 97-101; Favazza, *Bodies Under Siege*, p. 239. Favazza associates head-banging and other "stereotypic" forms of self-mutilation with institutionalisation.

⁴⁴¹ Bramwell, "Hypnotism: A Reply to Recent Criticisms", p. 152; Hyslop, "On 'Double Consciousness'". The term "subliminal consciousness" was coined by Myers. F. W. H. Myers, "The Subliminal Consciousness VI: The Mechanism of Hysteria," *Proceedings of the Society for Psychical Research*, 9, (1894): 3-128 (and articles 1-5 in previous volumes).

⁴⁴² See, for example, Théodule Ribot, *The Diseases of Personality* (Chicago: Open Court, 1895); F. W. H. Myers, "Human Personality in the Light of Hypnotic Suggestion," *Proceedings of the Society for Psychical Research*, 4, (1887): 1; "The Consciousness of Self" in William James, *The Principles of Psychology*, (New York: Henry Holt, 1890), pp. 291-401.

⁴⁴³ Hyslop, "On 'Double Consciousness'", p. 782.

century.⁴⁴⁴ The two presumably met, for Janet's calling card is pasted into Hyslop's copy of *Mental Physiology* along with later correspondence.⁴⁴⁵ In "Double Consciousness", Hyslop related Janet's work on the "anaesthetic hysterical types" of multiple personality as one example of altered states of consciousness, citing particularly his well-known work with the subject Léonie.⁴⁴⁶ Here, however, I wish to focus particularly on a case in Hyslop's paper featuring self-mutilation: that of "A.M."

Twenty-five-year-old teacher Alice Rose Morison was admitted to Bethlem as a Voluntary Boarder in March 1895. Alice only remained in the Hospital for sixteen days before "her friends took her away as they thought that the other people in the gallery would be bad for her", yet there are more case notes recorded about her than for many patients who remained a full year or more at the Hospital, indicating the high level of interest in her case.⁴⁴⁷ Alice, "an intellectual and highly cultivated lady" of "restless, nervous disposition", had begun sleepwalking in 1891.⁴⁴⁸ "She used to make a great deal of noise at night, banging at the door, hitting her head on the floor & such like." Two years later, mesmerism (carried out by "a friend") apparently eased her condition, stopping Alice from "bang[ing] herself about so much", but in the summer of that year (1893) "she again started sleeplessness & sleepwalking only she threw herself about more." Knocking the head or body, as already indicated, came under contemporary definitions of self-mutilation, and it is interesting to note the way in which changes in Alice's condition seem to have been measured by those around her through her level of self-injurious behaviour. In Christmas 1893, Miss Morison began "clairvoyance" and writing letters in her sleep, although for a long time she reportedly refused to believe anything she was told she had done in a trance. Having been advised the rather un-somatic (but not unusual) treatment of "rest and marriage" by neurologist Victor Horsley, Alice (who refused to follow this advice) had subsequently developed three separate personalities:

Her second person she calls "Nocturna" & herself she calls "Morison" ... a little later on she seems to have acquired a "3rd state" who used to do all manner of mischief... Perhaps one of the most important things to be grasped is that Nocturna knows what Morison is doing but Morison does not know what Nocturna is doing and neither of them know what the 3rd state is doing. This has been picked out of 2 hours

⁴⁴⁴ For more on Janet see Ruth Harris, "The 'Unconscious' and Catholicism in France," *The Historical Journal* 47, no. 2 (2004): 331-354; Henri F. Ellenberger, *The Discovery of the Unconscious: the History and Evolution of Dynamic Psychiatry* (New York: Basic Books, 1970).

⁴⁴⁵ Letter Pierre Janet to Theo Hyslop, 28 April (no year given), pasted into WLL copy of Hyslop, *Mental Physiology*.

⁴⁴⁶ Hyslop, "On 'Double Consciousness'", pp. 784-5; see also Janet, *L'automatisme psychologique*; Ellenberger, *The Discovery of the Unconscious*.

⁴⁴⁷ BRHA, *Voluntary Boarder Book*, 1893 - 6, (CB/147 – 26).

⁴⁴⁸ Hyslop, "On 'Double Consciousness'", p. 782.

conversation [with Alice and her friend Miss Kennedy] so that necessarily there are many details wanting.⁴⁴⁹

Despite the absence of detail, and the short duration of Alice's stay at Bethlem, Hyslop nonetheless concluded in his publication that the case was:

In favour of the hypothesis that dual consciousness is only complete somnambulism. The successive awakening of the senses constitutes a gradation from ordinary sleep to complete somnambulism, which gives to the person studied the appearance of leading a dual life.

From this, he indicated that insanity might be comparable to "some dream states", with acts like self-mutilation thus committed "unconsciously".⁴⁵⁰ Such a notion also suggested that there might be a motive behind the self-inflicted injury that was beneath the level of consciousness, even if this were as confused or irrational as in a dream.

Another explanation was that the patient's "second self" (or underlying consciousness) was, in fact, *more* rational than the primary self (which was subject to insanity or other nervous disorder) in that it protected him or her against injury: Alice Morison, as Hyslop remarked, "never really hurt herself".⁴⁵¹ The ability of hysterics to protect themselves from injury despite loss of sensation was similarly remarked upon by many writers, who noted that such was not the case in other conditions of anaesthesia, such as damage to the spinal cord.⁴⁵² Thus, Frederic Myers declared that "[t]here is normally, in fact, a supervision – a *subliminal* supervision – exercised over the hysteric's limbs. Part of her personality is still alive to the danger, and modifies her movements, unknown to her supraliminal self."⁴⁵³ Indeed, even when the patient's conscious self was insane, the "second self might protect against self-mutilation, which appeared as a "remarkable feature" in the case of Anna Winsor, sent to the American Society for Psychical Research. Here, the patient's right arm "became, as it were, the primary possession of the secondary personality" with "beneficent control" over the subject's attempts to tear out her hair.⁴⁵⁴ Myers' conclusions about human personality in this case resulted from the prior assumption that the act of tearing the hair was a perversion of the natural instinct of self-preservation: a similar perspective to that of the asylum psychiatrists discussed in chapter one. Nonetheless, for Myers, this instinct could be maintained by the subliminal self.

⁴⁴⁹ BRHA, *Voluntary Boarder Book*, 1893 - 6, (CB/147 – 26).

⁴⁵⁰ Hyslop, "On 'Double Consciousness'", p. 786.

⁴⁵¹ Hyslop, "On 'Double Consciousness'", p. 782.

⁴⁵² J. Russell Reynolds and John Charles Bucknill, *The Diagnosis of Diseases of the Brain, Spinal Cord, Nerves, and their Appendages*, (London: J. Churchill, 1855).

⁴⁵³ Myers, *Human Personality*, pp. 43-4.

⁴⁵⁴ Myers, *Human Personality*, p. 355.

In keeping with his usual method of working, Hyslop divided his conclusions on double consciousness into what he referred to as psychological and physiological considerations (depending on the authorities to whom he referred: in the latter instance, physicians, and in the former experimental psychologists). In physiological terms, he found it difficult to make any generalisations for, as he stated, within physiology there was no clear conception of what constituted the physical basis of consciousness, let alone any multiplicity of this phenomenon.⁴⁵⁵ While noting Hughlings Jackson's suggestion that the left hemisphere of the brain, being more "highly evolved" might be able to inhibit the right hemisphere, this could not, he felt, explain cases of multiple personality. Indeed, the very existence of such cases suggested "the diffusion of the elements of consciousness everywhere throughout the brain substratum" with "no supreme centre anywhere."⁴⁵⁶ Psychologically, however, Hyslop felt able to draw four conclusions, primarily based on Wundt's suggestion that ego (or selfhood) was founded in bodily sensations and images. Thus, for Hyslop, abnormal states of consciousness were characterised by "the disjoining of these bodily feelings and images which ... removes the background of the awareness of self."⁴⁵⁷ Hyslop's descriptions remained associated with the physiological psychology of Carpenter and Laycock, through his characterisation of such states as entailing a loss of volition. However, these concepts were modified by new interpretations of self, in which, as Myers described it, the "old-fashioned view of a single unitary personality" (as in associationist psychology), was replaced by the "modern view that the self is a co-ordination."⁴⁵⁸ Hyslop's article thus reflected the work of Théodule Ribot, whose *Diseases of the Personality* (1885) suggested that the self was a complex of memories and bodily sensations: indeed, Hyslop referenced the French writer in the article and his psychiatric textbook.⁴⁵⁹ The "disjoining" of these would, then, appear to make the self disappear, or otherwise disintegrate. Such concepts of self were attractive to many alienists, whose asylum experiences (in particular the continuing environmental and educational approach of moral treatment) persuaded them to claim a model of insanity based on heredity,

⁴⁵⁵ See Arthur H. Pierce, "Subliminal Self or Unconscious Cerebration? (I)," *Proceedings of the Society for Psychical Research*, 11, (1895): 317-325; Frank Podmore, "Subliminal Self or Unconscious Cerebration? (II)," *Proceedings of the Society for Psychical Research*, 11, (1895): 325-332.

⁴⁵⁶ Hyslop, "On 'Double Consciousness'", p. 786.

⁴⁵⁷ Hyslop, "On 'Double Consciousness'", p. 785.

⁴⁵⁸ Myers, *Human Personality*, p. xxiv & pp. 9-12. Myers, "Human Personality in the Light of Hypnotic Suggestion".

⁴⁵⁹ Ribot, *The Diseases of Personality*.

physiology, environment *and* sociology, in which selfhood “cannot be treated as if it were a constant quantity.”⁴⁶⁰

In addition, however, the regular parallels made between the integration of the individual into his surroundings, and the integration of the personality (or self) in the individual, meant that acts (like self-mutilation) which were seen as indicative of such a disintegration of self - “the old and oft-repeated statement that insanity is a perversion of the ego”⁴⁶¹- might be deemed similarly representative of a loss of social function. Indeed, despite their divergences, psychological and physiological approaches stemmed from, and resulted in, similar judgments about the individual. Whether self-mutilation was seen to represent a psychological alteration of identity (revealing the hidden recesses of mind) or a biological reversion to a “primitive” state, it was nonetheless regarded as the opposite of the “instinct” of healthy self-preservation and, as such, antagonistic to the “social instincts” required for the future of civilization. Psychological approaches to character, like physiological ones, incorporated philosophical and economic concerns for national well-being: in particular, the increasing discussion of “malingering.”

3.4 Liberty, Malingering and Responsibility: Self-Help or Self-Sacrifice

In order to set malingering in a wider context, I will first explore the seeming opposites of “self-help” and “self-sacrifice”, concerns which formed the focus of much political and intellectual discussion in the later nineteenth century. The former notion is most commonly associated with the popular book by Samuel Smiles, published in the same year as John Stuart Mill’s *On Liberty* and Darwin’s *On the Origin of Species*.⁴⁶² Like Darwin, with whom he corresponded, Smiles saw the values he promoted in *Self-Help* as “natural” and, like Mill, he was deeply concerned with the relationship of the individual to society.⁴⁶³ *Self-Help* effectively begins where *On Liberty* ends: with the notion that the “worth of a

⁴⁶⁰ George Savage, “The Influence of Surroundings on the Production of Insanity,” *Journal of Mental Science*, 37, no. 159 (1891): 529-535, pp. 531-2.

⁴⁶¹ George Savage, *Insanity and Allied Neuroses: Practical and Clinical* (London, New York: Cassell, 1884), p. 2.

⁴⁶² It was only retrospectively that this term became associated with Smiles. Samuel Smiles, *Self-Help: with Illustrations of Conduct and Perseverance*, ed. Ralph Harris (London: IEA Health and Welfare Unit, 1997). For background, see Adrian Jarvis, *Samuel Smiles and the Construction of Victorian Values*, (Thrupp: Sutton Pub., 1997); Timothy Travers, *Samuel Smiles and the Victorian Work Ethic*, (New York; London: Garland, 1987).

⁴⁶³ On the relationship between Smiles and Darwin, see Thomas Dixon, *The Invention of Altruism: Making Moral Meanings in Victorian Britain* (Oxford; New York: Published for the British Academy by Oxford University Press, 2008), p. 156.

State, in the long run, is the worth of the individuals composing it.”⁴⁶⁴ Mill himself had attempted to discern the proper balance between individualism and state control (in general, he felt the former under-valued). Influenced in his early writings by the approach of Auguste Comte, some of whose texts were explored in the previous chapter, Mill’s concerns over Comte’s development of a “humanitarian religion” in the *Catèchisme Positiviste* caused him to distance himself from Positivist thought.⁴⁶⁵ Yet the distinction made in *On Liberty* between acts considered self-regarding and those felt to be other-regarding appears remarkably similar to Comte’s division of motivation into egoistic and altruistic. Traditional criticisms of *On Liberty* have portrayed Mill as championing individualism and diversity over state control, suggesting that the only limits – legal or social – which might be legitimately enforced on an individual were in order to prevent his or her behaviour being harmful to others.⁴⁶⁶ In the last ten years, however, Mill scholarship has been subject to much revisionism. Joseph Hamburger, for example, has indicated that Mill does not explicitly denounce all social constraints over the individual, and any analysis of his ideas must take into account the shifting meaning of what might be deemed “harmful”.⁴⁶⁷ Every individual who receives the protection of society, according to Mill, owes a return. This responsibility is not merely defined by active harm to others, but also “in each person’s bearing his share ... These conditions society is justified in enforcing at all costs to those who endeavour to withhold fulfilment.”⁴⁶⁸ From such a perspective, self-mutilation (an intentional damaging of the body’s function) might be considered economically “selfish”, preventing an individual from working or fulfilling other social responsibilities.

Self-mutilation certainly did become bound up in contemporary debate around the concept of malingering, or feigning illness, which, by the turn of the twentieth-century, it was claimed, had “reached a high level of perfection”.⁴⁶⁹ Medical commentators often emphasised the importance of the medical “detective” to uncover those individuals deemed

⁴⁶⁴ John Stuart Mill, *On Liberty and Other Essays*, ed. John Gray (Oxford: Oxford University Press, 1998), p. 128. Smiles quoted this section from the last page of *On Liberty* at the head of the first chapter of *Self-Help*.

⁴⁶⁵ Various references to Comte were removed from later editions of Mill’s *On the Logic of the Moral Sciences*, although many do remain. See John Stuart Mill, *On The Logic of the Moral Sciences*, ed. Henry M. Magid (Indianapolis; New York; Kansas City: The Bobbs-Merrill Company, Inc, 1965), pp. 154-6. Also the chapters on Mill in Dixon, *The Invention of Altruism*; Stefan Collini, *Public Moralists: Political Thought and Intellectual Life in Britain 1850-1930*, (Oxford: Clarendon Press, 1991).

⁴⁶⁶ William Stafford, “John Stuart Mill: Critic of Victorian Values?” in *In Search of Victorian Values: Aspects of Nineteenth-Century Thought and Society*, ed. Eric M. Sigsworth. (Manchester: Manchester University Press, 1988), 88-101.

⁴⁶⁷ Mill, *On Liberty*, p. 91; Joseph Hamburger, *John Stuart Mill on Liberty and Control*, (Princeton: Princeton University Press, 1999), p. 10; p. 59.

⁴⁶⁸ Mill, *On Liberty*, p. 83.

⁴⁶⁹ Editorial, “Malingery,” *The Lancet*, 165, no. 4245 (1905): 45-46.

to constitute a social evil.⁴⁷⁰ While this was certainly not a new approach for doctors, the late nineteenth century saw a rapidly increasing interest in both the concept of malingering, and use of the term itself, as indicated by figure 16, below. This graph shows the results of my search for the terms “malingering” and “feigned disease” between 1851 and 1910. “Medical” incorporates my data from the *Journal of Mental Science*, *British Medical Journal* and *The Lancet*. “Press” includes a search of the British Library Victorian Newspapers database and *The Times* Digital Archive, while “Books” was a search of British texts on Google books. While the limitations of the databases used means that this graph cannot be regarded as definitive, it nonetheless illustrates a general trend: increasing discussion of malingering in the later decades of the nineteenth century, particularly after 1870.

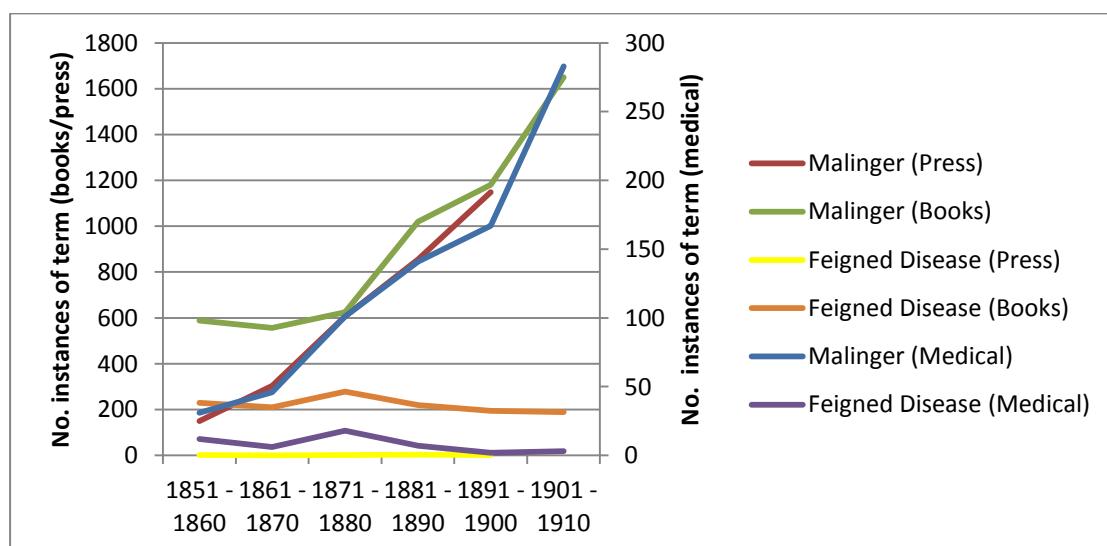


Figure 16: Graph showing the increase in discussion of malingering, 1850 – 1910

But where did the term come from? One medical correspondent to the *Oxford English Dictionary* – William Sykes M.D. – claimed to have “traced this word down to almost the case of the Great French War.”⁴⁷¹ Like other writers, Sykes was certain that malingering had entered the English language from the French verb *malingre* (to be sickly or weak), and that it had gained its association with military conduct during the Napoleonic Wars.⁴⁷² This connection was made despite the fact that neither he, nor anyone else, could find any French quotation using “malingre” in such a sense and, indeed, the term “malingerer” in

⁴⁷⁰ This “detective” work is well described in Joanna Bourke, *Dismembering the Male: Men’s Bodies, Britain and the Great War*, London: Reaktion Books, 1996), chapter 2 and Roger Cooter, “Malingering in Modernity: Psychological Scripts and Adversarial Encounters During the First World War,” in *War, Medicine and Modernity*, ed. Roger Cooter, Mark Harrison, and Steve Sturdy (Stroud: Sutton, 1999), 125-148.

⁴⁷¹ W. Sykes, Un-numbered discarded slip for “Malingering. Malingering”, OUPA.

⁴⁷² F. Chance, “To Malingering,” *Notes and Queries*, (1888): 326-327; Herbert A. Strong, “Malingering,” *Notes and Queries*, (1896): 252-253.

British texts pre-dates this period.⁴⁷³ The idea thus rested on prior assumptions that military self-mutilation had a French history, based on the fact that France was the first country to legally threaten punishment for it in a law of 1832.⁴⁷⁴ This ruling subsequently became incorporated into military law in other nations.⁴⁷⁵ Indeed, some of the earliest references to self-mutilation in journals and newspapers tended to be in the context of malingering. When Forbes Winslow's *Psychological Journal* reported on "Moral and Criminal Epidemics" in 1856, the article included self-mutilation among a list of social problems, giving as example a claimed epidemic of "voluntary mutilations" in the French Foreign Legion in 1844.⁴⁷⁶ Throughout the late nineteenth and early twentieth centuries, commentators in French and English regularly referred to the origins of the concept of "malingering" (however phrased) and self-mutilation in the Napoleonic Wars.⁴⁷⁷

Yet military parlance alone does not explain the surge in interest in malingering, as shown in figure 16. Indeed, it was the increasing application of the concept to civilian populations that accounted for a large proportion of this use. While the description of civilians as malingering had certainly occurred prior to the Napoleonic Wars, the retrospective attempt to locate the origins of *all* malingering in wartime experiences suggested that civilians must be trying to gain something – as, it was claimed, soldiers were – by inflicting injuries on themselves or otherwise feigning disease. The relation to self-mutilation was further emphasised by claims that the term malingering indicated the physical nature of a deceit: as one correspondent in *Notes and Queries* explained, the British War Office distinguished between feigning (pretending to be ill) and malingering (the production of the physical appearance of disease by drugs or mechanical means).⁴⁷⁸ The increasing interest in civilian "malingering" has been convincingly associated by historians with the rise of health insurance systems across Europe: the introduction of accident

⁴⁷³ Francis Grose, *A Classical Dictionary of the Vulgar Tongue* (London: S. Hooper, 1788). Skeat, however, considered the word to be a modern term, and notes that it is not found in Johnson's Dictionary. See Walter W. Skeat, *An Etymological Dictionary of the English Language*, (Oxford: Clarendon Press, 1882), also E. S. Norman Campbell, *A Dictionary of the Military Science*, (London: Baldwin & Cradock & T. Egerton, 1830), p. 136.

⁴⁷⁴ Roger Cooter also dates the bulk of material on malingering from this time, although recognising earlier usage of the term. Roger Cooter, "Malingering in Modernity", p. 128.

⁴⁷⁵ For background in France, see Julien Varet, "Les automutilations de l'adolescence: Approche psychopathologique individuelle et lien social" (unpublished M.D., Université Paris Val-de-Marne, 2007), p. 51; for Britain, see *Manual of Military Law* (War Office, 1894), pp. 358-9.

⁴⁷⁶ Anon, "On Moral and Criminal Epidemics," *The Journal of Psychological Medicine and Mental Pathology*, 9, no. 2 (1856): 240-281. With thanks to Åsa Jansson for referring me to this article.

⁴⁷⁷ For example, Charles Blondel's thesis was based in concerns stemming from the military crime of self-inflicted wounds. Charles Blondel, *Les auto-mutilateurs: étude psycho-pathologique et médico-légale*, (Paris: J. Rousset, 1906).

⁴⁷⁸ Strong, "Malingering".

insurance in Germany in 1871 and the Employer's Liability Act of 1880 and subsequent Workmen's Compensation Acts in England.⁴⁷⁹ Many of those discussing self-mutilation in the later nineteenth century also assumed such a context. The collections of physician Frederick Parkes Weber on the topic of self-mutilation, for example, were closely associated with his files on *Workmen's Insurance* and *Life Assurance Claims*: Weber also claimed to have been the first person in England to publish on the German system.⁴⁸⁰ Historical accounts of the emergence of these worker insurance schemes have portrayed them as indicating a broad shift from a model of obligation (in which responsibility for accident and compensation lay with the employer, unless employee negligence could be proved) to one of collective responsibility, in which accidents would be assessed by the seemingly neutral measure of statistical probability. Yet the costs of such a system, and the means of assessing the worker's right to a claim, made debates around malingering class-oriented from the outset. The malingerer was invariably the worker, not the employer, and he (and not his employer) would be the person accused of attempting to cheat the system. Thus physicians like Weber often became involved in such a system by policing it, whatever their personal political ideals.⁴⁸¹

These concerns seemed to legitimate a distinction between deserving and undeserving recipients of relief, and can be (and have been) used to attack the concept of a welfare state as well as to support it.⁴⁸² The apparent simplicity of the insurance model of healthcare was complicated at an early stage by the difficulty of judging whether or not a person was entitled to compensation. A number of writers have indicated the importance of the traumatic neuroses in such concerns, which led to a re-definition of "accident" in insurance circles. So-called traumatic neurosis emerged from medical interest in "railway spine" in the mid-nineteenth century (early manifestations appeared in the context of new rail networks spreading across Europe). It was characterised as an illness that might emerge

⁴⁷⁹ Wolfgang Schaffner, "Event, series, trauma : the probabilistic revolution of the mind in the late nineteenth and early twentieth centuries," in *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870-1930*, ed. Mark S. Micale and Paul Frederick Lerner (Cambridge; New York: Cambridge University Press, 2001), 81-91; Greg A. Egihan, "German welfare state as a discourse of trauma," in *Traumatic Pasts*, 92-114, pp. 87-90.

⁴⁸⁰ Frederick Parkes Weber, "Remarks on the Medical Aspect of a System of Compulsory Instance of the Working Classes," *British Medical Journal*, 1, (1897): 388-389. See also Weber Collection, WLL, folders PP/FPW/B186 (Life Assurance Claims, especially Early Claims) and PP/FPW/B360/1 (Workmen's Insurance: Legislation and General Measures against Tuberculosis and all Preventable Diseases). Both of these are referenced in Weber's collection on "Self-Mutilations".

⁴⁸¹ Weber appears to have held left-wing views. After attending a lecture at the Fabian Society on "Socialism and the Medical Profession", he corresponded approvingly with the speaker. Weber to F. Lawson Dodd, 13 Feb 1897 in PP/FPW/B360/1.

⁴⁸² For a modern example of this, see Jack Kitaeff, *Malingering, Lies, and Junk Science in the Courtroom* (Youngstown: Cambria Press, 2007), p. 37.

long after an accident, which itself had caused little or no physical damage.⁴⁸³ The physical and emotional shock of the accident, it was suggested, caused damage to the nervous system, which later resulted in a wide variety of symptoms, including aches, pains, exhaustion, trembling, and mental depression. Such cases often became the subject of legal battles between insurance companies – who refused to recognise the diagnosis – and claimants, who asserted the veracity of their illness.⁴⁸⁴ The neuroses – including hysteria, hypochondriasis and the popular turn-of-the-century diagnosis neurasthenia – thus held an uneasy relationship with malingering, a proximity which continued into the First World War via the concept of “shell-shock”.⁴⁸⁵

Indeed, the label of malingering appears to have been more frequently applied to cases of neurosis than to acts of self-mutilation. This can be seen within the records of two hospitals: the National Hospital for Nervous Diseases in London’s Queen Square and the Royal London Hospital. The former was founded in 1860 as a private philanthropical enterprise with just ten beds, the hospital had expanded to hold 100 in-patients by 1871 and 200 by 1900. Between 1878 and 1905, a total of seventeen patients were suspected of malingering, with the term forming either all or part of their diagnosis (with or without a question mark). The low number of “malingering” in the Hospital, quite in contrast to articles stressing the prevalence of this type of act, is also evident in patients admitted to the Royal London. Founded in 1740, the Royal London Hospital was a charitable institution in East London, which had rapidly expanded in size following the opening of a purpose-built hospital in Whitechapel in 1757. Most of the patients were drawn from the surrounding communities and, by the late 1800s, some paid a small fee for their treatment, while others were cared for free of charge. By the 1880s, the Hospital housed around 800 in-patients at any one time: enormous in comparison to Queen Square. Yet, between 1893 and 1910, 171 male and 76 female patients were categorised as “Nil or Malingering” (just 0.002% of over 120,000 admissions in this period). The amalgamation of “Nil” and “Malingering” into one category meant that many of these patients were not considered to be feigning disease at all: the total included babies admitted with their mothers and administrative errors, in addition to individuals viewed as deceptive. Unlike several Royal London cases, which will be discussed shortly, not one of the Queen Square “malingering” was suggested to have self-

⁴⁸³ Micale and Lerner, *Traumatic Pasts*. See also Mark S. Micale, "Charcot and *les névroses traumatiques*: scientific and historical reflections," *Journal of the History of the Neurosciences*, 4, (1995): 101-119; Mikkel Borch-Jacobsen, "How to predict the past: from trauma to repression," *History of Psychiatry*, 11, (1995): 15-35.

⁴⁸⁴ Egighan, "German welfare state as a discourse of trauma" 92-114.

⁴⁸⁵ Bourke, *Dismembering the Male*, pp. 107-23; Cooter, "Malingering in Modernity," 125-148; Ben Shephard, *A War of Nerves* (London: Jonathan Cape, 2000).

inflicted injuries: instead, reflecting the neurological focus of the Hospital, these were patients who complained of pain, numbness, paralyses and fits, which appeared to have no organic foundation and, for one or other reason, did not result in the “functional” diagnosis of neurasthenia, hysteria or hypochondriasis.

Although we might imagine a diagnosis of malingering would bring into question whether *any* medical treatment should be given, only two of the patients at Queen Square classed as malingers were treated for less than ten days (the average length of stay was 31 days), while many were discharged with ongoing medication. Indeed, the reason for any suspicion of malingering is often hard to pinpoint, and rarely seems to have been confirmed. Only in one case did a patient confess to feigning illness, 17-year-old apprentice James Carter. Admitted in April 1878 suffering from hyperesthesia and paralysis of the right leg, the suspicions of doctors appear to have been raised early for, rather than referring to the general conditions of the patient’s life, James’ previous history stated simply: “Apprentice to Brush maker. Doesn’t like his work.” This, it was implied, might explain the patient’s efforts to gain admission to Hospital, where he was pejoratively described as a “stupid-looking boy”. Punishment, it seems, was felt to be the most apt form of treatment after James was suspected of copying the symptoms of other patients and, two days after admission, “Faradization [was] this morning painfully applied to buttocks, dropped his stick & literally ran away from it.” The following day, when James would not sit “properly”, he was given the cold douche and sit bath, after which he was described as “very much better. Sits now.” A week after admission, having been Faradized on two more occasions, “[n]ow he walks as well as anyone. Jumps well & sits down. In fact has nothing whatever the matter with him according to his own account.” Responsibility was passed on to James’ mother, who was “advised as to treatment in case of relapse.” In spite of the boy’s confession that he had “put it on because his mother wanted him to go to sea”, it is interesting to note the retention of medical language here, via the terms “treatment” and “relapse”. James’ malingering, although seemingly intentional, nonetheless remained within a medical remit.⁴⁸⁶ The proximity of medical treatment and investigation into malingering was further complicated by the use of the same techniques as both treatment and punishment. Such is evident in the above case, where Faradization and the cold douche were used to shock the patient into confessing or otherwise abandoning his feigned symptoms. The wire brush, used in cases of numbness or paralysis to re-invigorate the nerves, could also be applied in such a way. William Symonds, whose paraplegia appeared to the doctors to be “voluntary”, “[r]ecovered

⁴⁸⁶ Queen Square Archives (QSA), *Case Notes: Radcliffe 1878*, p. 69.

completely after a few applications of wire brush very strongly", implying that he had dropped feigned symptoms following intentionally painful treatment.⁴⁸⁷

Although Queen Square was a charitable hospital, a number of the malingering patients were educated and from formerly wealthy backgrounds. Such patients complicated a situation which, in other instances, was read through class and economic concerns, with the decision as to whether a patient was hysterical or malingering often made on such grounds.⁴⁸⁸ From an insurance perspective, malingeringers were working class, while their middle class counterparts (who did not benefit financially) were hysterical, and thus sought emotional, rather than financial, gratification. In some circumstances, doctors were forthright in dismissing working class patients as deceptive. In 1889, George Thorpe, a general practitioner in Walthamstow, commented indignantly on the case of a seventeen-year-old servant he had treated. This "healthy-looking country girl" had visited Thorpe on several occasions with an inflamed hand. The surgeon seems to have been suspicious from the outset, for "[h]er mistress informed me that the girl was not at all fond of work, and that she had a deal of trouble to get her to do it." When Thorpe examined the hand he discovered a needle, which he removed – a procedure which recurred several times over the next week. Eventually, Thorpe "felt so disgusted with her that I advised her mistress to get rid of her at once, which was done, and the girl returned to the country." He concluded that "[i]t seems hardly credible that a person of her age could be so cunning, and would inflict so much pain upon herself to avoid work."⁴⁸⁹ Yet this explanation nonetheless appeared to Thorpe to be the only possible one, given the girl's station in life, although his decision to remove a number of needles before coming to this conclusion indicates that even doctors who were outspoken on this subject were wary of accusing their patients directly. Nonetheless, class-oriented definitions of malingering continued to appear in physician's reports on working class women who injured themselves in the early twentieth century.⁴⁹⁰ Accusations of deception were not necessarily the only interpretations of working class injury made by doctors: a liberal political bent might suggest a socio-environmental explanation. Scottish laryngologist, Sir James Dundas-Grant, for example, referred sympathetically (if patronisingly) to a "poor lodging-house drudge" who had continued to return for hospital treatment following an operation, as scraps of bone were regularly found

⁴⁸⁷ QSA, *Case Notes: Jackson 1889*.

⁴⁸⁸ Richard A. A. Kanaan and Simon C. Wessely, "The Origins of Factitious Disorder," *History of the Human Sciences*, 23, no. 2 (2010): 68-85, p. 79.

⁴⁸⁹ George Thorpe, "A Strange Case of Malingering," *The Lancet*, 134, no. 3455 (1889): 1001.

⁴⁹⁰ See also Letter to BMJ from J. Charsley Mackwood (Dorset) regarding Dr. Gardiner's case. *BMJ*, 29 March 1930, p. 619; F. Parkes Weber, "Artificial Skin Eruption" *Proceedings of the Royal Society of Medicine*, VI (March 1913), p. 115.

in the wound. Later, it was discovered that she was inserting the bone herself, an act Dundas-Grant judged a “pitiful endeavour to obtain respite from the drudgery of her everyday existence [which] made her an object for commiseration rather than for blame.”⁴⁹¹

Nonetheless, the hypothesis of fraud remained commonly judged by class, sex (with men deemed more likely to be fraudulent than women), and personality. The connection of self-inflicted injury with malpractice was supported by newspaper articles. In 1906, *Weekly Dispatches* published a case of “self-torture as fraud”, citing one Mary Brown, a 35-year-old woman who had been convicted of impersonating nurses in order to make fraudulent financial transactions. Mary, it was claimed “gained her knowledge of the nurses’ names by obtaining admission to the various hospitals as a patient, one of the means to that end being the sticking of hairpins in her body.”⁴⁹² Anthropological examples also appeared to support such contentions. When the case of a Chinese beggar who had amputated his own feet “in order to make “himself as attractive as possible to the charitably disposed” was reported in the *BMJ* in 1882, it was suggested that such acts were frequent in China. This, the author concluded, enabled Western readers to “throw a light on that singular mixture of courage, deceit, and sacrifice of almost anything to advance low enterprise, which characterise the lower orders in that country.”⁴⁹³ The assumption that a rational motive lay behind self-inflicted injury promoted a tendency to rule self-injurious acts as suspicious: whether for financial, moral or other reasons. By the mid twentieth century, these concerns were so fixed in common opinion that doctors claimed “malingering is best classified by motives rather than by techniques”.⁴⁹⁴ This increasingly coloured attitudes to psychiatric patients in the later years of the nineteenth century. A physiological explanation of self-injurious acts, as caused by a nervous impulse difficult or impossible to resist, had prompted a view of injuries as beyond a patient’s control. The later nineteenth-century attention to individual psychology and patient responsibility encouraged self-mutilation to be viewed in the context of malingering and associated diagnoses, such as hysteria (which will be discussed in more detail in chapter five). That such a perspective is not necessarily self-evident, but rooted in many other judgments concerning the relation of the individual to society, is made clear by the association with another contemporary concern used by patients (but not, generally, psychiatrists) to explain acts of injury: self-sacrifice.

⁴⁹¹ “Discussion on Functional and Simulated Affections of the Auditory Apparatus,” *Proceedings of the Royal Society of Medicine (Otological Section)*, 6, (1913): 73-86, pp. 82-3.

⁴⁹² “Self-Torture as Fraud”, *Weekly Dispatches*, 26 Aug 1906.

⁴⁹³ R. A. Jamieson, “Self-Mutilation in China,” *British Medical Journal*, (1882): 397-398, p. 398.

⁴⁹⁴ Richard Asher, “Malingering,” in *Health and Disease: A Reader*, ed. Clive Seale, Basiro Davey, and Alastair Gray (Buckingham; Philadelphia: Open University Press, 2002), 99-102, p. 99. Asher was responsible for naming Munchausen’s Syndrome in the early 1950s.

Although often associated with altruism in the later nineteenth century, the concept of self-sacrifice had a longer history, directly tied to Roman Catholicism and High Church Anglicanism. Despite the long-running existence of such a notion, the topic appears to have received little scholarly attention.⁴⁹⁵ Victorian texts, however, are littered with references to self-sacrificing women, seen to epitomise the domestic ideal.⁴⁹⁶ For alienists, this trait was particularly important, for it was evidence of the way in which the “position and ... profession of the individual will colour the nature of the insanity: ... a man is more egotistical, a woman more altruistic in her bent.”⁴⁹⁷ In late-nineteenth-century Christian texts, the notion that self-sacrifice was a female trait meant that it was embodied by female characters, such as the heroine of the Reverend William Des Brisay’s epic poem *Ethelena or Self-Sacrifice*, who learnt devotion and self-sacrifice from reading texts on the holy martyrs.⁴⁹⁸ Such tracts often reinforced traditional gender roles. In 1882, the London Society for Promoting Christian Knowledge published a pamphlet entitled *Lizzie Blake, or Self-Sacrifice*.⁴⁹⁹ The short story was presumably aimed at girls around Lizzie’s age (twelve at the start of the story); in a period of increasing feminist agitation, and reforms to women’s education, the text reminds children on the verge of puberty to attend to daughterly (and, later, wifely) duties *before* pursuing personal goals, concluding that:

I hope the girls who read this will try and be like Lizzie, who in all she did was so unselfish and kind. There is no doubt, if all tried to give up their own will, and to think of other’s before their own pleasure, the homes of a great many would be the happier for it.⁵⁰⁰

It is clear from the text that the “all” supposed to give up their will were, specifically, women, represented by the only two characters in the story given actual names: Lizzie and her elder sister Martha, who “selfishly” abandons her family to gain “independence” as a servant. When alienists described the women around them as self-sacrificing, they perpetuated such myths of femininity.⁵⁰¹

⁴⁹⁵ One exception is Ida Magli, *Women and Self-sacrifice in the Christian Church: A Cultural History from the First to the Nineteenth Century* (Jefferson; London: McFarland & Co., 2003).

⁴⁹⁶ For example George Savage apparently described his mother as “the most self-sacrificing and best woman I ever met.” R. Percy Smith, “Sir George Henry Savage, M.D., F.R.C.P,” *Journal of Mental Science*, 67, no. 279 (1921): 393-404, p. 394; see also James Eli Adams, *Dandies and Desert Saints: Styles of Victorian Masculinity* (Ithaca: Cornell University Press, 1995), p. 8; John Tosh, *A Man’s Place: Masculinity and the Middle-class Home in Victorian England* (New Haven; London: Yale University Press, 1999), p. 45 & 155.

⁴⁹⁷ George Savage “Mental Diseases” in *A System of Medicine*, ed. T. Clifford Albutt, vol. 8 (London, 1899), p. 186.

⁴⁹⁸ Rev. William A. Des Brisay, *Ethelena; or, Self-Sacrifice: A Poem*, (Connecticut: 1871).

⁴⁹⁹ *Lizzie Blake, or, Self-sacrifice* (London; Brighton: Society for Promoting Christian Knowledge, 1882)

⁵⁰⁰ *Lizzie Blake, or, Self-sacrifice*, p. 16.

⁵⁰¹ Smith, “Sir George Henry Savage”, p. 394.

Yet these notions were accompanied in the late nineteenth century by the idea of a more secular, heroic, masculine self-sacrifice, epitomised in artist G. F. Watts' "Memorial to Heroic Self-Sacrifice", unveiled in London's Postman's Park in 1900, as seen in figure 17, below.

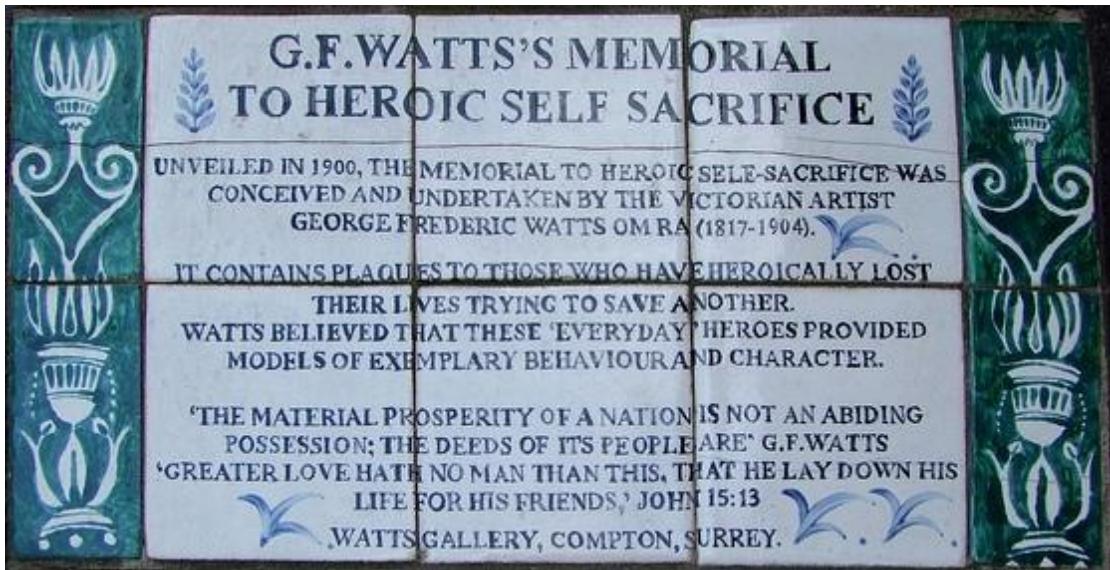


Figure 87: Photograph of the Watts Memorial, Postman's Park, London. This plaque was added to explain the display by the Watts Gallery in June 2009

The Watts Memorial was designed to commemorate ordinary people who had died saving the lives of others, and would otherwise have been forgotten. Its very existence indicates the extent to which notions of "self-sacrifice" were idealised in this period: in many of the tablets, both attempted rescuer and helpless victim are revealed to have perished, making the sacrifice futile to modern eyes. Yet the memorial itself is revelatory of the extreme late nineteenth-century perspective, steeped in notions of altruism, in which multiple deaths are portrayed as having become socially beneficial through the sacrifice of selfhood, such as the aptly-named David Selves, a twelve year old boy who died in 1886, while supporting "his drowning playfellow and sank with him clasped in his arms."⁵⁰² Selves' "heroic" self-sacrifice appears to consist of simply sharing the death of his companion. The medical profession might also be characterised as self-sacrificing, as indicated in reactions to the "heroic" death of Middlesex Hospital medical officer, William Freer Lucas, who died of diphtheria caught while administering medicine to a child.

We cannot afford to let such deeds drop into silence. Here in the Jabez Balfour end of the nineteenth century is a great white fact! A man lays down his life for another! ... Deeds like that of William Freer Lucas help to make belief in God and humanity a possibility and a fact.⁵⁰³

⁵⁰² G.F. Watts, *Memorial to Heroic Self-Sacrifice* (Postman's Park, London: 1900).

⁵⁰³ H.F.H. (Henry Francis Harding) "Notes Apropos" *Under the Dome*, Vol. 2. No. 8, (1893), pp. 114-5.

Jabez Balfour was a businessman who, in 1892, fled the country after swindling investors in his Building Society by using funds to purchase his own properties at inflated prices: the contrast here sets the potential for selfish individualism within self-help squarely against self-sacrifice as a humanitarian goal. Watts esteemed Lucas similarly highly, and a commemorative plaque to his death was incorporated into the Memorial. Yet Samuel Smiles' concern with progress meant that he cast self-help as opposed to selfishness for, "it will also be found ... that the duty of helping one's self in the highest sense involves the helping of one's neighbours."⁵⁰⁴ Thus, Smiles boldly declared: "National progress is the sum of individual industry, energy, and uprightness, as national decay is of individual idleness, selfishness, and vice."⁵⁰⁵

However, the notion of heroic self-sacrifice could just as easily be appropriated as justification for capitalist gain. Smiles himself declared that "some of the finest qualities of human nature are intimately related to the right use of money; such as generosity, honesty, justice, and self-sacrifice",⁵⁰⁶ implying that these virtues could only be achieved by the wealthy or prudent. Other writers took this train of thought still further. Anthropologist William Winwood Reade declared the "love of money ... the root of all industry, and ... therefore ... the root of all good."⁵⁰⁷ Reade, like Smiles and some of the evolutionists discussed in the previous chapter, saw capitalist, industrial society as natural: free trade promoted individuality, and individual gain led to social progress. Reade declared that: "Wealth, like health, is in the air; if a man makes a fortune he draws money from Nature and gives it to the general stock."⁵⁰⁸ Such an economic perspective on self-help and self-sacrifice supports the hypothesis that self-mutilation might be considered damaging to the community by making the individual economically worthless, and thus unable to repay those debts to society outlined by Mill. Such concerns were not, however, explicitly addressed in relation to self-inflicted injury beyond the concept of malingering, which, although part of medical debate around hysteria, did not become directly connected to medico-political concerns until the 1910s, following the introduction of national insurance.⁵⁰⁹ That this was

⁵⁰⁴ Samuel Smiles, *Self-Help: with Illustrations of Conduct and Perseverance*, ed. Ralph Harris Baron (London: IEA Health and Welfare Unit, 1997), p. xii.

⁵⁰⁵ Smiles, *Self-Help*, p. 2.

⁵⁰⁶ Smiles, *Self-Help*, p. 177.

⁵⁰⁷ William Winwood Reade, *The Martyrdom of Man*, 9th edition, (London: Trubner & Co, 1884), p. 507.

⁵⁰⁸ Reade, *The Martyrdom of Man*, pp. 506-7.

⁵⁰⁹ Archibald McKendrick, *Malingering and its Detection under the Workmen's Compensation and Other Acts*, (Edinburgh: E. & S. Livingstone, 1912); John Collie, *Malingering and Feigned Sickness: with Notes on the Workmen's Compensation Act, 1906* (London: E. Arnold, 1917).

the case becomes more understandable when one recognises the way in which the practical and spiritual ideals outlined above were intertwined in notions of both self-help *and* self-sacrifice.

In 1894, Francis Herbert Bradley (a leading member of the idealist movement in philosophy) published a paper in the *International Journal of Ethics* on "The Limits of Individual and National Self-Sacrifice."⁵¹⁰ Bradley began from the assumption "that self-sacrifice can exist and also may be right," before covering various approaches to it in an attempt to determine on what principle self-sacrifice might be right, and whether there was a limit beyond which it became wrong.⁵¹¹ He concluded that "self-sacrifice is right if the loss is sustained with a view to a greater gain, and otherwise it is wrong."⁵¹² It should be noted, once more, that Bradley does not suggest that the gain must be achieved, it must only be *expected*. This is an important distinction, which is not necessarily in accordance with the sense in which the term might be used today. This may well relate to the religious history: from a Christian perspective, the gain *will* be achieved in the after-life. It also provides an important background from which to view the Watts memorial, in which many of those who sacrificed themselves failed in their efforts to save others. Evolutionary writers in the same period equated this sacrifice with the notion of progress. Winwood Reade titled his history of Africa *The Martyrdom of Man* in order to describe, as he saw it, "universal history."

In each generation the human race has been tortured that their children might profit by their woes. Our own prosperity is founded on the agonies of the past. Is it therefore unjust that we also should suffer for the benefit of those who are to come?⁵¹³

Such a belief could be pitted against social reformers, by casting poverty and inequality as an important element of the overall improvement of the race. Reade himself, who had originally planned to call his book *The Origin of Mind*, claimed that the sacrifice for western Victorian society was predominantly "a season of mental anguish", suggesting that mental disorder itself was an essential aspect of progress.⁵¹⁴ Thus, the acts of those, inside or outside asylums, who castrated themselves, plucked out an eye or amputated a hand in order to, as they saw it, benefit society could in theory be viewed as self-sacrificing, whether any actual benefit accrued or not. What is most surprising, then, is that such motivations

⁵¹⁰ F. H. Bradley, "The Limits of Individual and National Self-Sacrifice," *International Journal of Ethics*, 5, no. 1 (1894): 17-28.

⁵¹¹ Bradley, "The Limits of Individual and National Self-Sacrifice", p. 17.

⁵¹² *ibid.*

⁵¹³ Reade, *The Martyrdom of Man*, p. 543. Alienists might also claim such sacrifice as necessary: see the very similar quote in Henry Maudsley, "The Genesis of Mind (II)," *Journal of Mental Science*, 8, (1862): 61-102, p. 82.

⁵¹⁴ *ibid.*, p. 544.

were *not* generally acknowledged by alienists. At Bethlem, Annie Hockley claimed that she wanted to become a martyr in order to save the world, while Ada Rider thought burning herself would save everyone from ruin.⁵¹⁵ Such patients were simply considered delusional, without any recognition of the way their ideas fitted into contemporary concerns. For those who saw altruism as solely associated with progress, it was impossible to see self-injurious behaviour as stemming from similar impulses. Indeed, only those writers who appear to have been quite negative about both biological progress and religious faith appear to have made this connection, such as Charles Mercier, who darkly claimed that the "spirit of self-sacrifice ... is but self-injury on a higher level than that of actual physical mutilation. The principle on which it depends is precisely the same, although the manifestation takes a different form."⁵¹⁶ Mercier's words form part of a broader criticism of the concept of altruism, which, some writers argued, could not be portrayed as the "motive power" necessary for life.⁵¹⁷ However, these dissenting voices were few and far between, at least in the field of asylum psychiatry, where the impact of evolutionary and anthropological concerns furthered the depiction of self-mutilation as selfish, rather than self-sacrificing.

3.7 Conclusion

As previous chapters have indicated, there continued to be much debate around the role of impulse and volition in late nineteenth-century discourses on insanity, in particular a tendency to regard many acts of self-mutilation in asylums as indicative of loss of self-control. Nonetheless, in the 1880s and 1890s, this debate was part of a much broader picture. Many late nineteenth-century alienists no longer regarded the will as a pure element of mind, as had previously been claimed. Daniel Hack Tuke, for example, came to view will as constituted by intellect and emotion, a circumstance which emphasised the ideational, rather than the neurological-inhibitory, elements of the concept.⁵¹⁸ Thus, although sane and insane acts might still be viewed from a physiological perspective (in that they were perceived to result from neurological impulse), many suggested that emotion or idea preceded such an impulse, with the "inward" experiences of intellect and emotion increasingly forming the province of the late nineteenth-century alienist. These new explorations of motive depended not just on the influence of contemporary psychological

⁵¹⁵ BRHA, *Female Patient Case book 1885*, (CB/127 – 136); BRHA, *Female Patient Case book 1890*, (CB/139 – 28). See also Agnes Pringle, BRHA, *Female Patient Case book 1899*, (CB/161 – 106).

⁵¹⁶ Charles Arthur Mercier, *Sanity and Insanity*, (London: Walter Scott, 1890), p. 354.

⁵¹⁷ Anon, "The Failure of Altruism," *Fraser's Magazine*, 100, (1879): 494-503, p. 501.

⁵¹⁸ Daniel Hack Tuke, *Illustrations* (Philadelphia: H.C. Lea's Son & Co, 1884), p. 138. See also Charles Arthur Mercier, "A Classification of Feelings (part 2)," *Mind*, 9, no. 36 (1884): 509-530, p. 522.

theories of consciousness, but also on the social and political implications of new concepts of self, by which the individual was regarded as a combination of elements, conscious and unconscious, rather than one unitary personality. The integration of these factors in the individual, often represented in evolutionary terms as adaptation to environment, was seen to be vital to mental health. Paradoxically, such self-knowledge could also be potentially dangerous, and needed to be viewed in the context of the individual's integration in society. We can see these concerns clearly in the ways alienists paid increasing attention to the subjective motives of their patients and the part these played in prompting self-injurious acts. While by no means all alienists adopted this approach, it is interesting that those who considered self-mutilation to be a definite topic were often those – like the physicians at Bethlem – who also tended towards an anti-materialist stance, their concepts of selfhood incorporating physiological, psychological, sociological, metaphysical and even theological concerns.

The re-evaluation of the seemingly disparate concepts of self-help and self-sacrifice should thus be viewed as illustrative of a shift in concepts of selfhood in the later nineteenth century, which provided the impetus for interest in self-mutilation, as well as shaping a number of features of the psychiatric debate. From being characterised as either rational or irrational (based on the old psychology), the psychological model of motivation in mankind in the second half of the nineteenth century began to follow a Comtian model, separating acts into egoistic and altruistic: those for and against society. This shift has been highlighted by an exploration of morbid self-consciousness in hypochondriasis, which provides an important backdrop for the characterisation of self-injurious acts as selfish, indicating that debate over self-mutilation formed part of a much wider discussion over the nature of the individual, and his or her relationship to society. Thus, although self-mutilation continued to be characterised by a perceived absence of will, new approaches to volition caused alienists to see some self-inflicted injuries as the opposite, the result of "those active operations of the mind which involve movements and active concentration of the attention upon an object or idea, with the addition of a resolve."⁵¹⁹ The topic thus sat uncomfortably at both ends of the spectrum of ideas: regarded as both internal and external, evidence of self-knowledge or morbid self-consciousness, self-help or self-sacrifice, atavism or degeneration.

Late nineteenth-century concerns about the self can be regarded as rooted in the political visions offered by two seemingly opposing views. In defining purpose in purely individual terms, rationalism appeared to undermine the cohesion of society, while

⁵¹⁹ Hyslop, *Mental Physiology*, p. 409

Romantic expression offered a means of maintaining a free, participatory society, supported by an ethos of nationalism.⁵²⁰ In this chapter I have argued for the existence of a still more complex political and social background to late nineteenth-century concepts of self-mutilation, in which there was no clear divide between physical and spiritualist or evolutionary and degenerationist concepts of motivation. Self-mutilation was sometimes, as in the case of Isaac Brooks, held up as indicative of excessive individualism: an act performed against society, as much as an act of inwardness, and thus representative of the effects of the self-culture of modern civilisation.⁵²¹ Yet, as we have seen in the previous chapter, self-mutilation might equally be regarded as *irrational*, an improper (and un-civilised) means of intellectual or emotional expression, which required regulation and control. The efforts of alienists to deal with this disjunction, which appeared to simultaneously require the engagement and detachment of the doctor, also led them to comment on the issues they considered to be facing society. If self-mutilation might be caused by factors both internal and external to the individual, then both of these fields became the psychiatrist's concern. That these concerns could be supported, as in the case of self-mutilation, by biological, psychological, metaphysical, moral *and* spiritual arguments indicates the importance of recognising that we can see none of these fields as essentially any more or less restrictive or liberating than any other: indeed, that we often cannot regard them as separate fields at all.

⁵²⁰ Charles Taylor, *Sources of the Self*, p. 414.

⁵²¹ George Savage, "The Influence of Surroundings on the Production of Insanity," p. 36; F. W. Warrington, "The Case of Isaac Brooks," *Journal of Mental Science*, 28, (1882): 69-74.

Chapter 4

Sexual Self-Mutilation: Masturbation, Masculinity and Self-Control (c. 1880 – 1900)

4. 1 Introduction

On the rare occasion medical histories have discussed self-mutilation, many have noted the interest in castration during the late nineteenth century. Armando Favazza has suggested that such reports played an important role in the development of psychiatric theories, as well as positing a link between case studies of self-castration and the “castration complex” of psychoanalysis.⁵²² Yet a focus on the role of Freud is misleading, for psychiatric attention to the meaning of castration (biologically, psychologically and symbolically) certainly pre-dates his work. By the 1890s castration seemed, for some, to be the paradigm for self-mutilation. In his *Dictionary* entry, James Adam specifically isolated “sexual self-mutilation” as a particular category, setting such acts in the context of contemporary work by French and German authors, in particular the new field of sexual pathology. In American texts, the prominence of case studies of castration in European publications led to bold claims in the same decade that “self-mutilation in man is almost invariably the result of meditation over the generative function.”⁵²³ Thus, by the time the issues for “S” in the Surgeon-General’s Index-Catalogue were published in 1910, the entry for “self-mutilation” pointed readers to the entries for “Sexual instinct (perversion of)” and “Skoptzy”, suggesting a link between the three.⁵²⁴ The articles listed included a large number focusing on other forms of self-inflicted injury, including amputation and enucleation, which might be regarded equally dramatic. So why was there such medical interest in genital self-injury in the later nineteenth century? And in what ways did alienists explain and interpret self-castration?

It might seem obvious to us today, following psychoanalytic tradition and the introduction of gender reassignment surgery, that the removal of the male sex organs should be regarded as a process of gender inversion. However, we cannot assume that

⁵²² See Armando R. Favazza, *Bodies Under Siege: Self-Mutilation and Body Modification in Culture and Psychiatry*, 2nd ed. (Baltimore: Johns Hopkins University Press, 1996), p. 176. The latter claim was removed from the most recent edition of the book (2012), suggesting the declining emphasis on psychoanalysis in American psychiatry.

⁵²³ George M. Gould and Walter L. Pyle, *Anomalies and Curiosities of Medicine* (London; Philadelphia: Rebman Publishing Co; W.B. Saunders, 1897), p. 732.

⁵²⁴ *Index-Catalogue of the Library of the Surgeon-General's Office*, U.S. Army, Second Series, Vol. 15 (pp. 394-5). The final term refers to the contemporary Russian religious cult who advocated self-castration (Skoptsy translates as ‘the castrated’).

masculinity has always been perceived as directly related to sexual identity (and organs).⁵²⁵ Nonetheless, examining the ways in which psychiatrists related self-mutilation to male sexuality does illuminate certain aspects of masculinity in late nineteenth-century culture, a period which has been regarded by many writers as one of intense male self-doubt.⁵²⁶ This chapter thus explores the ways in which male identity in the late nineteenth century was associated with sexual function. The widespread assumption within this period that masculinity was synonymous with self-control (and sexual restraint) offers a far more complex picture than the assumption that castration is intrinsically emasculating. I argue that attention to castration may well be seen to reflect contemporary masculine ideals, but not necessarily in the ways that twenty-first century readers would expect. I begin by describing the psychiatric category, and the way in which this was shaped by two particular cases. Outside the asylum, the widely-reported mutilation of farmer Isaac Brooks encouraged growing psychiatric interest in the topic: in particular, a tendency to relate castration to changes in character, as well as physical form. This case was certainly one of the factors that led James Adam to the topic, and medical and lay ideas from the Brooks case permeate his work. Adam chose to apply certain of these to one of his own patients, formulating sexual self-mutilation as a psychological category.

In order to understand why Adam and others drew certain conclusions about individual character and mental state from the act of castration, we need to understand the context within which they were working. I thus explore the relation of self-castration to what might be considered as surgical genital mutilation, in particular the remedies adopted to counter the supposedly harmful effects of masturbation. Both within and outside asylums, practitioners experimented with potentially harmful genital therapies for the dreaded disease of spermatorrhoea, including cauterisation and “wiring”. While it is arguable as to whether castration ever formed part of the medical arsenal for this disease, late nineteenth-century writers certainly believed that it *had* done, and often viewed castration in such a light. In the context of intense concern with sexual health, from venereal

⁵²⁵ A point also made by Tim O'Neill in his thoughtful analysis of “male” medicine in the later nineteenth and early twentieth centuries. Timothy H. O'Neill, *The Invisible Man?: Problematising Gender and Male Medicine in Britain and America, 1800-1950* (Unpublished PhD Thesis, University of Manchester, 2003).

⁵²⁶ On masculinity (and, particularly, the relation to self-control in this period), see John Tosh, *A Man's place: Masculinity and the Middle-class Home in Victorian England* (New Haven, Conn; London: Yale University Press, 1999); J. A. Mangan and James Walvin, ed. *Manliness and Morality: Middle-class Masculinity in Britain and America, 1800-1940* (Manchester: Manchester University Press, 1987); James Eli Adams, *Dandies and Desert Saints: Styles of Victorian Masculinity* (Ithaca: Cornell University Press, 1995); Elaine Showalter, *Sexual Anarchy: Gender and Culture at the Fin de Siècle*, (London: Virago, 1992), pp. 8-9; Judith R. Walkowitz, *City of Dreadful Delight: Narratives of Sexual Danger in Late-Victorian London* (London: Virago, 1992), p. 17.

disease to masturbation, castration could thus easily be regarded as a very masculine act: the ultimate form of self-control. Indeed, religious sects – most prominently in this period the Skoptsy (“the castrated”) – presented castration as part of a controlled, civilised lifestyle, in which they also abstained from meat, tobacco and alcohol.

Yet declarations of castration as self-cure were complicated by changing views of sexuality, with a general shift from sexual anatomy to a psychological understanding of sexual desire.⁵²⁷ For alienists, an increasing emphasis on a developmental view of individual psychology encouraged the view that the acquisition of sexual desire was part of a more general psychological change in puberty. Certain writers even claimed the sexual impulse to be the basis for social advancement, a view promoted by writers on sexual pathology, who had an interest in viewing their chosen field as fundamental to human progress. These discourses shifted models of masculinity away from a focus on control or restraint, as well as revealing “new” pathologies which seemed to deviate from a two gender model, such as the invert (homosexual) or eonist (transvestite). Both of these practices, particularly the former, were explicitly linked by some writers to self-castration.⁵²⁸ By viewing a (heterosexual) interest in sex as the basis for individual growth and social cohesion sexologists and psychiatrists began to depict castration as a social threat. Genital mutilation was considered most worrying in men, not only because the sex organs were external, and thus easier to damage, but also because men were assumed to be “naturally” selfish, and thus required a stronger physiological impetus (associated with the development of sexual characteristics during puberty) to acquire altruistic traits than did women. This view of castration as anti-social is emphasised by exploring British attitudes toward the Skoptsy, and the way in which their supposed bad character (considered to result from castration) was regarded by many as a social and political threat. Thus, we can see a shift (though by no means universal or straightforward) from a mid-century focus on a biological and neurological understanding of castration to the later nineteenth-century view whereby sexual self-mutilation was viewed through a psychological and sociological lens. Through such a shift, self-castration came to be viewed as a highly symbolic act; later, the symbolism would come to receive more attention, especially in psychoanalysis, than the act itself.

⁵²⁷ Harry Oosterhuis, *Stepchildren of Nature: Krafft-Ebing, Psychiatry, and the Making of Sexual Identity* (Chicago; London: University of Chicago Press, 2000), p. 40.

⁵²⁸ This chapter predominantly explores the former as most prominent in late nineteenth century texts, although Havelock Ellis’ later writings suggest a growing link between transvestism and “sex change” in the early twentieth century. For example the case study of R.M., which provoked Ellis to remark that “Eonism has sometimes actually led to self-castration.” Havelock Ellis, *Studies in the Psychology of Sex, vol. 7, Eonism and Other Supplementary Studies* (Philadelphia: F. A. Davis, 1928), p. 94, fn. 1.

4.2 Sexual Self-Mutilation: A Psychological Category

Before exploring early psychiatric attempts to explain self-castration, we might wonder what the term actually means. The *Oxford English Dictionary* gives the primary meaning of castration as “the removing of the testicles”. Such an explanation seems so obvious that other historians have assumed this is what castration always means.⁵²⁹ Yet, in nineteenth-century texts, the term castration was applied to operations carried out on women (in particular, ovariectomy)⁵³⁰ and was also used interchangeably to mean removal of the testicles *and* amputation of the penis. Literary scholar Gary Taylor has claimed that this was part of a general shift in the meaning of castration during the nineteenth century, which laid increasing emphasis on the penis. However, both he and urologist Mels Van Driel place a mistaken emphasis on the instrumental role played by Freud in redefining castration, biologically and culturally.⁵³¹ In late nineteenth-century psychiatric texts on self-mutilation, both removal of the testicles and of the penis are referred to as castration, and there is rarely any interest in differentiating between these two acts. While this might seem surprising today, following a century of endocrinological research into “sex hormones”, there was no obvious reason to distinguish between acts that impaired sexual function in the late nineteenth century. The sex organs were generally believed to exert an influence on the body through the central nervous system, not by means of chemical secretion.⁵³² If this was so, then damage to any part of the genitals might affect this process.

Another element of Victorian writing on castration that seems surprising to modern readers is that there is often little interest in whether or not the operation has been “successful” in preventing sexual function, suggesting that this may not have been the

⁵²⁹ For example, O'Neill, *The Invisible Man?* (who does, however, recognise that there was some ambiguity as to whether the term referred to the removal of one or both testicles); Thomas Laqueur, *Making Sex: Body and Gender from the Greeks to Freud* (Cambridge; London: Harvard University Press, 1990), p. 126.

⁵³⁰ There has been much interest in “female castration” in the later nineteenth century. See Andrew T. Scull, “A Chance to Cut is a Chance to Cure”: Sexual Surgery for Psychosis in Three Nineteenth-Century Societies,” in Scull, *The Insanity of Place: The Place of Insanity*, (London; New York: Routledge, 2006), 151-171; Ornella Moscucci, “Clitoridectomy, Circumcision and the Politics of Sexual Pleasure in Mid-Victorian Britain,” in *Sexualities in Victorian Britain*, ed. Andrew H. Miller and James Eli Adams (Bloomington: Indiana University Press, 1996), 60-78. The ovaries are also emphasised in Chandak Sengoopta, *The Most Secret Quintessence of Life: Sex, Glands, and Hormones, 1850-1950*, (Chicago: University of Chicago Press, 2006).

⁵³¹ Gary Taylor, *Castration: An Abbreviated History of Western Manhood* (New York; London: Routledge, 2000), p. 61; Mels van Driel and Paul Vincent, *Manhood: the Rise and Fall of the Penis* (London: Reaktion Books, 2009), p. 8.

⁵³² Sengoopta, *The Most Secret Quintessence of Life*, p. 39. This work also contains a useful overview of research into sex hormones, setting this well outside the period covered by this thesis.

fundamental importance of castration to contemporaries. Today, we often assume that castration causes impotence and a related loss of secondary sex characteristics. Histories of other periods, however, show that the procedure does not have to be interpreted in this way. Peter Brown's work on early Christianity, for example, offers a variety of very different models for castration. For some, the practice was considered to *enhance* masculinity, for the tying of the testicles ensured that a man would not waste the "vital force" essential to his male status.⁵³³ By the time of Origen's probable castration in the third century AD, Brown suggests that it was a routine operation. Origen viewed the sexual aspect of human life as a mere passing phase. As humans were only sexually active during a certain period of life, sexual impulse could not be considered essential to the human spirit and was, therefore, dispensable. This view differs even from the previous, in that it depicts castration as having *no effect* on masculinity (or femininity), for it cannot alter the essence of the individual.⁵³⁴ In later periods, Gary Taylor has questioned the work of modern scholars looking at castration in early modern drama, in particular Thomas Middleton's *A Game at Chess* (1624). Taylor suggests that Freud's later definition of castration as symbolising loss and impotence has caused modern historians to find such meanings where they are *not*, in fact, evident.⁵³⁵

Castration, then, does not necessarily mean what we think it means. This is particularly evident in a case that I describe here as the paradigm for sexual self-mutilation (the term used by James Adam to refer specifically to male genital self-injury): the story of Staffordshire farmer Isaac Brooks, briefly outlined in chapter two. Brooks was by no means a "typical" case (if, indeed, there can be any such thing): the medico-legal context of his story and its wide publication made it distinctly unusual. Nonetheless, medical writers adopted many conclusions drawn from the Brooks case as a model for other acts of self-mutilation, in particular male genital injury. The case assumes particular significance when we note that a third of the articles on self-castration published in medical journals in the later nineteenth century referred to it. The story was followed by all three medical journals examined in this thesis (as well as large numbers of local and national newspapers), and in all three writers used the term "self-mutilation" to refer to Brooks' actions (although it was nowhere definitively proved that Brooks' wounds *had* been self-inflicted, and his doctor certainly claimed they were not). Favazza, meanwhile, referred to the Brooks case as "the first case of male genital self-mutilation in the medical literature" and, although this is not strictly the

⁵³³ Peter Brown, *The Body and Society: Men, Women and Sexual Renunciation in Early Christianity*, (New York: Columbia University Press, 2008) p. 19.

⁵³⁴ Brown, *The Body and Society*, pp. 168-9.

⁵³⁵ Taylor, *Castration*, pp. 43-7.

case, this claim recognises the contemporary prominence given to the incident across medical specialities, as well as in the wider public arena; something that did not occur in other reported case studies of self-mutilation.⁵³⁶

Isaac Brooks was a stonemason and small farmer from Leek, Staffordshire. Single, he lived with other family members, including his own illegitimate son. In 1879, then aged twenty-nine, Brooks called the local doctor to attend to a cut wound to his scrotum, from which one of his testicles protruded. When pushed for an explanation, the young man claimed he had been attacked and wounded by three others, whom he later named as local farmers. Two of these men were subsequently arrested, and sentenced to ten years imprisonment for the crime. The whole story (including treatment for a second, identical, injury eighteen months later) only appeared after Brooks' death in December 1881. On his deathbed, the farmer signed a full confession stating that the two men were innocent and, according to initial (mistaken) reports, that his injuries were self-inflicted (this, it later transpired, Brooks had never explicitly stated). The newly-formed Press Association ensured the wide distribution of the story and, from 5th January 1882, it appeared in, among others, newspapers in London, Birmingham, Glasgow, Leeds, Sheffield and Liverpool. Many newspapers quickly followed up with further details as they became available, so that it was small wonder that, by the time *The Lancet* came to publish on Brooks, their reporter called it "the case of mutilation which is now exciting so much public interest."⁵³⁷ From an initial focus on an alleged miscarriage of justice, most reports quickly moved to speculation over the life, character and habits of Isaac Brooks himself, and how these related to what was widely agreed to be an act of self-mutilation, suggesting that it was not only within psychiatry that self-inflicted injury became connected to wider social and political issues.

On 14th January (the same day that the Home Secretary ordered the release of Brooks' supposed attackers from prison), the account of Brooks' doctor, Francis Warrington, was published in both the *British Medical Journal* and *The Lancet*.⁵³⁸ Both letters, although slightly different, described the nature of the wound and treatment and confirmed that a second injury had taken place in February 1881. Warrington paid most attention, however, to providing detail on Brooks' character: supposedly a defence against certain reports which

⁵³⁶ Favazza, *Bodies Under Siege*, p. 198. At least six case studies of self-inflicted castration pre-date the Brooks story in the journals I examined, including the report of William Brown discussed in chapter one. There are certainly further cases in which the term "self-mutilation" is not used.

⁵³⁷ F. W. Warrington, "The "Strange Confession" in Staffordshire," *The Lancet*, 119, no. 3046 (1882): 81-82, p. 81.

⁵³⁸ The Brooks case appears to be Warrington's single claim to fame. His obituary in the *BMJ* in 1901 is a brief anecdote of the life of a provincial practitioner. "Francis William Warrington, M.D., J.P," *British Medical Journal*, 1, no. 2113 (1901): 1655.

attempted to explain the incident through the suggestion that “Brooks was a man of bad character with a malignant disposition.”⁵³⁹ Warrington’s statement, however, was frequently contradictory, not least in his continued insistence that the injuries could not have been self-inflicted, which conflicted with his efforts to protect both his own and Brooks’ reputation against the possibility that they *had* been. Defending his medical reputation from accusations of aiding the miscarriage of justice, he stated: “Neither before the magistrates nor at the assizes were any questions asked me, as to whether it was possible the injury could have been self-inflicted” (at no point suggesting what his verdict would have been had he been consulted), while he played down any suspicion of malice on Brooks’ part by suggesting the man was pressured by the police into naming his attackers.⁵⁴⁰ Local papers were sceptical of Warrington’s statement, “his evidence at the trial that Brooks could not have injured himself being well remembered”.⁵⁴¹ The doctor’s evaluation of Brooks’ mental state was similarly ambiguous: despite attributing him with many qualities (“exceptional” among the “rough unmannered hill-country farmers”),⁵⁴² he nonetheless described the young man as “of eccentric habits, close, and reserved”.⁵⁴³ This encouraged medical reporters to cast just as much doubt on Warrington’s conclusions as the lay audience had done, although Warrington had attributed the lay belief that the injuries were self-inflicted to a lack of medical knowledge.⁵⁴⁴ Both medical journals immediately declared that it was *entirely* possible that such wounds could have been self-inflicted, with *The Lancet* asserting most stridently that “there cannot be the slightest doubt in the mind of any one reading Dr. Warrington’s statement that the case was throughout one of self-mutilation from insanity.”⁵⁴⁵ After all, as both journals were quick to note, Warrington’s description of Brooks’ temperament implied unsoundness of mind, something that can hardly have escaped the doctor’s own notice.

The Brooks case became a focal point for medical thought on self-castration, which fed into Adam’s later description of this topic as a distinct field of self-injury. First, it sparked widespread interest in the frequency of such acts. A writer in *The Lancet* declared that the

⁵³⁹ Reporter, “The Extraordinary Confession,” *The Huddersfield Daily Chronicle* (January 10, 1882): 3. Similar comments, usually comparing Brooks unfavourably to the two men imprisoned, appeared in many other newspapers.

⁵⁴⁰ F. W. Warrington, “The Case of Isaac Brooks,” *British Medical Journal*, 1, no. 1098 (1882): 72.

⁵⁴¹ Reporter, “The Extraordinary Confession,” *The York Herald* (January 14, 1882): 5.

⁵⁴² Warrington, “The Case of Isaac Brooks,” *BMJ*, p. 72.

⁵⁴³ F.W. Warrington, “The “Strange Confession” in Staffordshire,” *The Lancet*, 119.3046 (1882): 81-82.; Warrington, “The Case of Isaac Brooks,” *BMJ*, p. 72.

⁵⁴⁴ Warrington, “The Case of Isaac Brooks,” *BMJ*, p. 72.

⁵⁴⁵ Editorial. “The Case of the Farmer Brooks,” *The Lancet*, 119.3046 (1882): 73. This statement was re-printed verbatim in *The Times*.

Brooks case was “no isolated one. There are many well-authenticated cases of youths and men of all ages who have sometimes successfully, at others unsuccessfully, performed this painful operation upon themselves.”⁵⁴⁶ None of these cases were detailed: instead, the belief that Brooks’ injuries had been attempts at self-castration was seen as confirmation that such acts occurred. The writer in the *Journal of Mental Science* similarly used the Brooks case to support the statement that “it is not very uncommon to meet insane persons who have injured themselves, and in these the injuries are often of the sexual organs.”⁵⁴⁷ Again, no other evidence was given for this claim which, while supported by some published cases of the period, is certainly *not* indicated by a close examination of asylum records. Indeed, on examining the prevalence of such acts at Bethlem between 1880 and 1900, castration hardly even registers – just four male patients (out of a total of over 2,000 admitted in this period) attempted self-castration, and two more threatened it. In contrast, twenty patients attempted (and sometimes managed) to pluck out their eyes, while every year more than six patients picked their faces, pulled out their hair or knocked themselves against the wall or floor. Thus, while the Brooks case was used by medical writers to draw together and evaluate medical cases to create a category of self-mutilation, its prominence also helped to *create* a focus on self-castration as the major form of this behaviour.

What, then, made the Brooks case appear so important to contemporaries? Apart from the mysterious nature of the story, the medico-legal implications were drawn out for professional reasons. *The Lancet* felt that the wound itself should have been medically investigated, asserting that the case formed “a typical and striking example of a class of cases which must always be liable to misconception, to the lasting discredit of justice, so long as lawyers think they can appraise the real value of medical evidence.”⁵⁴⁸ However, it was the proposed connection between self-mutilation and insanity that formed the topic of most discussion and the “psychological interest” of the case was stressed by many.⁵⁴⁹ The *British Medical Journal*, for example, suggested that psychological examination was important in evaluating character as well as state of mind.

The case is one of considerable psychological complication, for no doubt Dr. Warrington is justified in assuming that it is highly improbable that the man would

⁵⁴⁶ Editorial, “Self-Mutilation,” *The Lancet*, 119, no. 3047 (1882).

⁵⁴⁷ F. W. Warrington (with anonymous commentary), “The Case of Isaac Brooks,” *Journal of Mental Science*, 28, (1882): 69-74, p. 72.

⁵⁴⁸ For example: Reporter, “Wrong Verdicts and False Charges,” *Newcastle Courant* (January 20, 1882); Reporter, “The Latest Failure of Justice,” *Leicester Chronicle & Leicestershire Mercury* (January 21, 1882): 8. *The Times* reiterated the medico-legal case in *The Lancet*. “The Strange Confession in Staffordshire,” *The Times*, 30403 (January 13, 1882): 10, col. F-10.

⁵⁴⁹ For example “The Strange Confession in Staffordshire,” *The Times*, p. 10; “The Extraordinary Confession” *The Sheffield & Rotherham Independent*, Saturday, January 14, 1882, p. 3.

inflict the first injury on himself; but, on the other hand, anyone accustomed to deal with peculiarities of erratic and temporary forms of mental disease, will probably say that it is just possible that, a man of such eccentric, solitary, and reserved habits, under a morbid impulse, may have inflicted such injuries on himself.⁵⁵⁰

The claim here suggests that both mental disease *and* the character of an individual were relevant in forming a judgment about self-mutilation. Indeed, Warrington had attempted to use the latter as the most important means of *defending* the farmer against accusations of self-injury: "The possibility of the injuries being self-inflicted has been made a strong point in the case, therefore I have been the more particular in describing the man himself."⁵⁵¹ Warrington thus suggested that Brooks' "pleasing manners", fondness for music and reading and "pride in using long words" were evidence against the possibility of his having injured himself.⁵⁵²

An anonymous commentator – presumably an alienist – in the *Journal of Mental Science* unsurprisingly stressed the value of psychiatric evidence in the courtroom. As with debate over the insanity defence, the Brooks case was explicitly connected here with what many alienists saw as the strongest point of "forensic contest": the diagnosis of moral insanity.⁵⁵³ The Brooks case was valuable to psychiatrists in that, rather than being an instance in which they were required to prove to sceptical lawyers the existence of such an illness, the widespread publicity given to the concept of "insane self-mutilation" meant that Brooks' alleged acts were seen as *proof* of the existence of this slippery diagnosis, for no one had regarded the farmer insane in life. Thus, it was claimed, the author's asylum experience suggested that many patients who injured themselves "to a slight extent, and have accused others" were either weak-minded or morally insane.⁵⁵⁴ Despite the fact that Brooks was dead, and had never actually admitted attempting to castrate himself anyway, the location of his wound became viewed as evidence of his motivation. Perhaps surprisingly, no one suggested that Brooks had been unmanned by twice injuring his testicles. Instead, the injury was related to masculinity through the assumption that certain traits perceived to be masculine had led to it. This included sexual indiscretion: masturbation was suggested, as

⁵⁵⁰ Editorial, "The Staffordshire Mutilation Case and Confession," *British Medical Journal*, 1, no. 1098 (1882): 60.

⁵⁵¹ Warrington, "The "Strange Confession" in Staffordshire", p. 82.

⁵⁵² Warrington, "The "Strange Confession" in Staffordshire", p. 81.

⁵⁵³ G. Fielding Blandford, "Insanity Without Delusions," *Journal of Mental Science*, 15, no. 69 (1869): 23-48. See also Joel Peter Eigen, *Witnessing Insanity: Madness and Mad-doctors in the English Court*, (New Haven: Yale University Press, 1995); Roger Smith, *Trial by Medicine: Insanity and Responsibility in Victorian Trials* (Edinburgh: Edinburgh University Press, 1981).

⁵⁵⁴ Warrington and Anon, "The Case of Isaac Brooks", p. 72.

was other sexual activity, represented by the illegitimate son (which even led one newspaper to call the farmer “a rustic Don Juan”!).⁵⁵⁵

The sexual, individual, and social elements of the Brooks case are evident in many later descriptions of self-castration and, by the end of the nineteenth century, it was widely assumed that, in cases of self-mutilation, “not uncommonly the organs of generation, one or all, are removed because they have ‘offended,’ and incited the patient to lust or masturbation”.⁵⁵⁶ Before the Brooks case came to light, however, this conclusion was by no means obvious, indicating that “sexual self-mutilation” had to be created, rather than simply discovered. James Adam referred to the Brooks story as one of the influences informing his first article on self-mutilation.⁵⁵⁷ In his later texts, he referred to sexual self-mutilation as a specific type of male self-injury. But how did the alienist move from this one case to a category of “sexual self-mutilation”? What did the idea mean? And how were his theories informed by his own practice? Adam referred specifically to two cases he had himself treated.⁵⁵⁸ Both had resulted in asylum admission immediately after self-castration, which in one case had been removal of the testicles and in the other the penis. The latter case, a young farm servant Adam had encountered many years before, will be discussed in the following section. The former, however, provides some interesting background to the way in which “sexual self-mutilation” was understood by Adam and others in the late nineteenth century, as the alienist would have met this patient around the time he began writing on the subject.

The case has been bookmarked by Adam in the patient case book for West Malling Place: “Captain H.H. self-mutilation.” Captain Henry Puge Halhed had been admitted to West Malling Place in April 1871, over a decade before Adam arrived there. At this time he was 65 years old, but had first been regarded as showing signs of mania thirty years previously, when he was sent to Brook House in Clapton. Prior to his asylum admission, Halhed had been a Captain in the Bengal Army: perhaps their shared military background in India contributed to Adam’s interest in both patient and topic. About five years before his admission to West Malling Place, Halhed had “removed the testes & part of the scrotum ... having the impression he must become a Eunuch to preach to a tribe in the North of

⁵⁵⁵ “The Extraordinary Confession in Staffordshire,” *Daily News*, January 9, 1882. For the connection to masturbation, see Warrington and Anon, “The Case of Isaac Brooks”, p. 72.

⁵⁵⁶ G. Fielding Blandford, *Insanity*, (New York: William Wood, 1897), p. 101.

⁵⁵⁷ James Adam, “Cases of Self-Mutilation by the Insane,” *Journal of Mental Science*, 29:126 (1883): 213-219, p. 214.

⁵⁵⁸ Adam, “Cases of Self-Mutilation by the Insane”.

India.”⁵⁵⁹ Halhed’s explanations were interpreted as religious and sexual delusions by both Adam and his predecessor, Thomas Lowry. The case notes state that Halhed claimed that:

Although a Eunuch in this country he would not be thought so in India for they would say “he might have connection with their Wifes & Daughters to amuse them.” Such scandal as this would be ignominious to a Missionary. This appears one objection to his returning to India and he thinks now he might meet with a Lady who would live with him without being desirous of cohabitation – “A kind of Spiritual Wife.” There he thinks he could live happily.⁵⁶⁰

When Adam classified Halhed as a case of “sexual self-mutilation,” he implied that his sexual drive somehow accompanied or inspired the “fit of religious enthusiasm and excitement” which the doctor regarded as prompting the act itself. In mutilating himself, Halhed had prevented proper reproductive function and his desire for a “Spiritual Wife” was judged a related delusion. This term may well refer to historian and traveller William Hepworth Dixon’s 1868 book, *Spiritual Wives*, which compared “celibate love” to polygamy, *both* being regarded as misguided and low on the evolutionary scale.⁵⁶¹ Yet the investigation of motive, which Adam regarded as fundamental to understanding self-mutilation, was further complicated by Halhed’s connections with India. In the *Dictionary*, Adam began by noting that the Captain “had been many years resident in the East, and had come to acquire many Eastern languages and ways,” suggesting that exposure to Eastern culture had influenced the patient’s act.⁵⁶² Indeed, Halhed’s own apparent recognition of the cultural specificity of concepts of eunuchism, as indicated in the above quote, is interesting in this relation. As histories of castration describe, many cultures removed the testicles from certain males in order to create reliable guardians for harems, for the eunuch would not be able to impregnate the inhabitants. Gary Taylor’s analysis of Elizabethan drama finds that references to eunuchs in such a light were common in England at this time. Eunuchs, in these dramas, were invariably portrayed in Eastern, rather than Western, contexts, and tended to be associated with absolutist governments and slavery.⁵⁶³ Yet, as Halhed notes,

⁵⁵⁹ Kent County Archives (KCA), *West Malling Place Case Histories (Visitors)*, 1877 - 1893 (Ch84 / Mc3), p. 200.

⁵⁶⁰ *ibid.*

⁵⁶¹ William Hepworth Dixon, *Spiritual Wives*, (London: Hurst and Blackett, 1868).

⁵⁶² Adam, “Self-Mutilation”, p. 1150. This was emphasised by the omission of any detail on Halhed’s family background: many of his brothers and uncles were also in the Bengal Army or had worked for the East India Company without suffering any similar ill effects. See the Halhed family tree on <http://www.halhed.com> genealogy site [accessed 03 February 2012].

⁵⁶³ Taylor, *Castration*, pp. 76-7.

the eunuch is still able to “have connection”: he is generally capable of erection, but not of procreation.⁵⁶⁴

In the same year that Halhed was admitted to West Malling Place, the British Governor-General enforced the Criminal Tribes Act in Northern India, which effectively criminalised certain individuals purely due to their membership of particular groups. Among those included in the act were the *hijda*, often translated as the “third gender”, a tribe of “natural eunuchs” (perhaps one of those Halhed was “so anxious” to convert),⁵⁶⁵ who dressed in women’s clothing.⁵⁶⁶ Such activity blurred the distinction between the physical creation of a eunuch by castration and his social creation through the adoption of a female role: the *hijda* were not necessarily castrated, or congenitally deformed. It is possible that both Adam and Halhed had come across this tribe, and Adam certainly created a role for “Eastern” religions and culture in the origins of the impulse toward self-mutilation in mankind.⁵⁶⁷ Thus, he used Halhed’s case to suggest the dangerous nature of savage tendencies to those exposed to them: the Christian missionary could be altered by the very culture he wished to convert. Yet this association with Eastern influences is striking in its absence from the notes on Henry Halhed’s behaviour in the privileged West Malling Place environment (where he apparently believed he was the proprietor). He was permitted to walk off the premises unattended, and slept alone in a single room – suggesting that his status over-ruled any possible risk of further self-inflicted injury. Instead, the notes indicate the relative freedom a wealthy, elderly gentleman in a country asylum might have: despite suggesting that the Captain’s health would be affected by his insistence on taking daily walks, even in cold weather, the asylum officers seemed unable to enforce any control, for “he is so perverse you cannot get him to remain indoors or take anything except what he feels inclined.”⁵⁶⁸ Rather than implying the Eastern ways Halhed had supposedly acquired, or even his status as a certified lunatic, Halhed instead appears as certain of his domain as any wealthy imperial officer. Thus, although he may have assumed that he was uncovering a hidden truth behind Halhed’s case, it was Adam’s own belief in the relevance of Eastern religion, within a context of evolutionary anthropology, which led him to relate Halhed’s

⁵⁶⁴ This was well-known by the late nineteenth century, as Gary Taylor explores at length. Taylor, *Castration*, introduction.

⁵⁶⁵ KCA, *West Malling Place Case Histories (Visitors)*, 1877 - 1893 (Ch84 / Mc3), p. 200.

⁵⁶⁶ See John Shortt, “The Kojahs of Southern India,” *The Journal of the Anthropological Institute of Great Britain and Ireland*, 2, (1873): 402-407 (which also discusses the “Higras”); Laurence W. Preston, “A Right to Exist: Eunuchs and the State in Nineteenth-Century India,” *Modern Asian Studies*, 21, no. 2 (1987): 371-387.

⁵⁶⁷ Adam, “Self-Mutilation”, p. 1147.

⁵⁶⁸ Case Histories (Visitors), 1877 - 1893 (Ch84 / Mc3), p. 201.

self-mutilation to Eastern influences. In actual fact, the castration had not been carried out until the age of sixty – some twenty-five years after Halhed had been invalidated out of the army (and India) due to his mental state!

From the examination of published cases *and* asylum patient records, it has emerged that acts of self-castration were not as numerous as alienists and other medical writers made out. We cannot find the explanation for the prevalence of this belief within psychiatric practice. Instead, we must look at other concerns, both within and outside contemporary medicine, in order to understand how alienists understood sexual self-mutilation. In the case of Halhed, certain religious, sexual and social concerns highlighted by alienists do make an appearance, in particular the connection with “the East”, which Adam claimed to be the basis of all human impulse toward self-mutilation.⁵⁶⁹ Yet Halhed’s life and behaviour in the asylum complicates this story, as did his continued insistence that his actions had been perfectly justified. Indeed, it is just as easy to find examples in asylum records in which the expectations of alienists are *not* confirmed as those in which they are. In 1875, for example, the previous superintendent of West Malling Place appeared quite mystified by the “very gay and joyous” manner of Clayton Barnett, who “has been married five years and has never been capable of cohabitation”. Barnett’s manner was deemed “unusual in a person who is impotent for generally they are low and depressed and humiliated when in this condition.”⁵⁷⁰ This association of impotence with depression and humiliation bears a strong similarity to the connections Taylor regards Freud as having created around the concept of castration and, indeed, sexual self-mutilation appears to be an important aspect of this story. Why, though, did sexual self-mutilation strike a particular chord at this time? And what can such interest suggest to us about the way in which contemporaries related sexual function to masculinity?

4.4 “He has tried to kill himself with masturbation”: Castration and Self-Cure

In his popular study of the correspondence between two men involved in the writing of what was later the *Oxford English Dictionary* – Editor James Murray and American army surgeon William Chester Minor – Simon Winchester describes the latter’s castration in a straightforward manner. Minor had been confined to Broadmoor Asylum for the Criminally Insane in April 1872, after shooting a man he wrongly believed to have been in his bedroom: all his contributions to the *Dictionary* were made from his rooms at Broadmoor, and he was one of the most prolific contributors. In December 1902, after thirty years in the asylum,

⁵⁶⁹ Adam, “Self-Mutilation”, p. 1147.

⁵⁷⁰ Case Histories (Visitors), 1877 - 1893 (Ch84 / Mc3).

Minor cut off his penis with a penknife he had been given to cut the pages of first edition books. Winchester begins this chapter, as he does every other, with a definition from the completed *Dictionary*: in this instance, the entry for "masturbate". Minor's act is presented as a "bizarre" accompaniment to his re-conversion to Christianity, and a belief that God would not forgive him for his prior sexual misdemeanours and persistent masturbation. But would his contemporaries have perceived his act as equally bizarre?⁵⁷¹ Victorian attitudes to sex and sexuality have long been a prominent field of historical debate. In the early historiography, the "Victorian period" was often regarded as an era of sexual repression, contrasted with the supposed licentiousness of the eighteenth century. In such histories, the study of sex and sexuality at the turn of the twentieth century appeared to show a progressive advance to modern "enlightened" notions of sex.⁵⁷² These assumptions were questioned by Steven Marcus, in an influential study of nineteenth-century pornography and other sexual literature.⁵⁷³ Michel Foucault further suggested that the existence of this literature refuted the "repression" hypothesis, although this has been questioned by more recent scholars.⁵⁷⁴ However, many historians continue to apply several elements of Foucault's work: the idea that the decades around 1900 were a "turning point" in the history of sexuality, and that the concept of sexuality itself cannot be considered a natural given from which our analyses depart, but rather is created and shaped by the discourse itself.⁵⁷⁵ Until the publication of Lesley Hall's *Hidden Anxieties*, much historiography concentrated on the categorisation of "sexual deviance" within this period, with particular focus on homosexuality and the subjection of women.⁵⁷⁶ As Hall notes, this focus misleads us into perceiving the "normal" male as "monolithic, unchanging [and] unproblematic", masking the

⁵⁷¹ Simon Winchester, *The Surgeon of Crowthorne: A Tale of Murder, Madness and the Love of Words*, (London: Viking, 1998), pp. 165-76.

⁵⁷² Paul A. Robinson, *The Modernization of Sex: Havelock Ellis, Alfred Kinsey, William Masters, and Virginia Johnson* (Ithaca, N.Y: Cornell University Press, 1989).

⁵⁷³ Steven Marcus, *The Other Victorians: A Study of Sexuality and Pornography in Mid-Nineteenth-Century England* (London: Weidenfeld and Nicolson, 1966).

⁵⁷⁴ Michel Foucault, *The History of Sexuality I: The Will to Knowledge* (London: Penguin Books, 1998). For arguments against the non-repressive hypothesis, see Taylor, *Castration*, pp. 96-100; Michael Mason, *The Making of Victorian Sexual Attitudes* (Oxford; New York: Oxford University Press, 1994).

⁵⁷⁵ For recent examples, see Howard H. Chiang, "Liberating Sex, Knowing Desire: Scientia Sexualis and Epistemic Turning Points in the History of Sexuality," *History of the Human Sciences*, 23, no. 5 (2010): 42-69; Paolo Savoia, "Sexual Science and Self-Narrative: Epistemology and Narrative Technologies of the Self Between Krafft-Ebing and Freud," *History of the Human Sciences*, 23, no. 5 (2010): 17-41; Taylor, *Castration*.

⁵⁷⁶ See Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980*, (London: Virago, 1987); Ivan Crozier, "Nineteenth-Century British Psychiatric Writing About Homosexuality Before Havelock Ellis: The Missing Story," *Journal of the History of Medicine and Allied Sciences*, 63, no. 1 (2008): 65-102; Oosterhuis, *Stepchildren of Nature*; Ivan Crozier, "The Medical Construction of Homosexuality and its Relation to the Law in Nineteenth-Century England," *Medical History*, 45, no. 1 (2001): 61-82.

existence of numerous concerns about male sexuality – and, indeed, male health in general – in the late nineteenth and early twentieth centuries.⁵⁷⁷ Fear over widespread venereal disease, concerns about the effects of masturbation and need for sex education, and political agitation (both male and female) around the sexual “double standard” (in particular the Contagious Diseases Acts of 1864 and 1866) indicate that “normal” sexuality could be a fraught and contentious topic.⁵⁷⁸ Of particular relevance to sexual self-mutilation, as we have already seen in the Brooks case, was masturbation.

Many histories of sexuality have commented on the intense concern around masturbation during the nineteenth century. As Michael Mason notes, modern readers tend to assume anyone doubting the ill effects of masturbation must be “progressive”, ignoring the complexity of Victorian attitudes to sex, whereby doctors might doubt certain elements of the doctrine, but unquestioningly accept others.⁵⁷⁹ What’s more, masturbation pathology faded in the twentieth century without any direct medical recantation of the theory.⁵⁸⁰ Historian Thomas Laqueur has suggested that ways of thinking about masturbation changed dramatically during the eighteenth century. Previously regarded as a vice (albeit an unhealthy one), “solitary sex” subsequently became conceptualised as a *disease* following the anonymous publication of John Marten’s *Onania: or, the Heinous Sin of Self Pollution* in 1712,⁵⁸¹ which went through numerous editions. Masturbation, it suggested, resulted in physical wasting, lethargy, impotence, and even death. The term “spermatorrhoea” emerged to refer to a physical illness largely regarded as caused by masturbation, a condition characterised by exhaustion, wasting, mental depression, nocturnal emissions and impotence.⁵⁸² Prior to this period, Laqueur suggests, although masturbation had been of physical and moral concern to many, it had not been singled out as *the* sexual vice, rather it had been regarded as one of a number of ways, including excessive sexual intercourse, in which essential fluids (and thus energy) might be lost.⁵⁸³ Treating the topic within the context of other contemporary concerns – political, social and cultural – Laqueur regards the increased emphasis on masturbation as part of a new philosophical understanding of the relation between individual and society, which encouraged greater attention to self-imposed

⁵⁷⁷ “Introduction” in Lesley Hall, *Hidden Anxieties: Male Sexuality, 1900-1950* (Cambridge: Polity, 1991). See also O’Neill, *The Invisible Man*?

⁵⁷⁸ Hall, *Hidden Anxieties*, pp. 26-36.

⁵⁷⁹ Mason, *The Making of Victorian Sexual Attitudes*, pp. 178-9.

⁵⁸⁰ *ibid.*, p 194.

⁵⁸¹ John Marten, *Onania, or the Heinous Sin of Self-pollution, and all its Frightful Consequences in Both Sexes, Considered* (London: P. Varenne, 1716).

⁵⁸² Mason, *The Making of Victorian Sexual Attitudes*, pp. 294-8.

⁵⁸³ Thomas Laqueur, *Solitary Sex: A Cultural History of Masturbation* (New York: Zone Books, 2003).

restraint. Masturbation, in this context, became viewed as evidence of the individual who had *lost* self-control, and was thus also unable to contribute to society.⁵⁸⁴

Despite a strong argument, Laqueur pays little attention to the relation of masturbation to *mental* pathology in the later nineteenth century, although he does note that the term “masturbatory insanity” was coined by Henry Maudsley in 1868. For Laqueur, this forms a confusing sidestep in what he sees as a shift within psychiatry from interest in behaviour to a focus on neurology and organic lesions.⁵⁸⁵ Yet, as this thesis has argued throughout, an interest in neurological approaches to the mind was certainly not incompatible with attention to behaviour and individual psychology. Indeed, even the most materialist of psychiatrists continued to look for moral, as well as physical, causes for insanity.⁵⁸⁶ However, there was much confusion over the exact role that masturbation played in mental illness: was it a cause or a symptom? Many physicians in the later nineteenth century tended towards the latter suggestion although this certainly did not stop them considering masturbation to be dangerous: something to be safeguarded against by a variety of physical means including the use of restraining garments.⁵⁸⁷ However, it seems that the strongest concerns around masturbation were related to a mid-nineteenth-century neurological and materialist perspective (focused on the conservation of “nervous force”). In the late nineteenth century, an increasing interest in psychological approaches to mind caused a simultaneous shift in understandings of the effects of masturbation from physical to psychological, making self-castration appear far less acceptable as a solution.

In one of the first articles to reference self-mutilation in *The Lancet* in 1861, alienist Robert Ritchie, superintendent of Bethnal House Asylum, carried out “An Inquiry into a Frequent Cause of Insanity in Young Men.”⁵⁸⁸ Ritchie offered a link between masturbation and self-inflicted injury (presumably genital), drawing attention to this connection three times in a short four-part article. He declared, in a similar decided manner to the medical commentators in the Brooks case twenty years later, that “[s]elf-mutilation is also not an

⁵⁸⁴ Laqueur, *Solitary Sex*. Arthur Gilbert had previously suggested this view in the work of Henry Maudsley. Arthur N. Gilbert, “Masturbation and Insanity: Henry Maudsley and the Ideology of Sexual Repression,” *Albion: A Quarterly Journal Concerned with British Studies*, 12, no. 3 (1980): 268-282, p. 278.

⁵⁸⁵ Laqueur, *Solitary Sex*, p. 363.

⁵⁸⁶ As Janet Oppenheim has also pointed out. Janet Oppenheim, “*Shattered Nerves*: Doctors, Patients, and Depression in Victorian England, (New York: Oxford University Press, 1991), p. 42.

⁵⁸⁷ Lesley Hall, “‘It Was Affecting the Medical Profession’: The History of Masturbatory Insanity Revisited,” *Paedagogica Historica*, 39, no. 6 (2003): 685-699, p. 694.

⁵⁸⁸ Robert Ritchie, “An Inquiry Into a Frequent Cause of Insanity in Young Men (part 2),” *The Lancet*, 77, (1861): 185-7, p. 185.

infrequent accompaniment; but correct statistics on this point I am unable to obtain.”⁵⁸⁹ Despite his lack of supporting evidence, he later reiterated “the tendency frequently exhibited to self-mutilation” in acute cases, which, “as reports show, … are not unfrequently successful.” Ritchie further hinted at the form such injury might take by concluding that it indicates “an unsound reasoning power, the visiting on the supposed offending organs the faults of the ill-regulated mind.”⁵⁹⁰ Presumably, then, the alienist referred to castration, of either the penis or testicles. But where did these many cases he failed to describe come from? While it is entirely possible that a larger number of cases occurred than were published in medical journals, any form of self-inflicted injury is invariably described in asylum case books, for the purpose of protecting medical officers and attendants from accusations of abuse. Bethnal House during this period was roughly twice the size of Bethlem: nonetheless, it seems unlikely that Ritchie encountered a considerably higher number of castrations (and, if he had, he would presumably have had *some* statistics to refer to). Of the four attempts at Bethlem in the twenty year period previously alluded to, only two actually resulted in injury, neither of which caused permanent damage. So, where did Ritchie’s idea that self-mutilation was so common come from? And did the link he made between masturbation and self-mutilation influence the description of sexual self-mutilation in the later nineteenth century?

The eighteenth and nineteenth centuries saw a proliferation of medicines and other devices aimed at preventing masturbation and curing its supposedly deleterious effects.⁵⁹¹ While some historians, most notably Laqueur, have downplayed the role of sexual surgery within this context, others have claimed it was more common.⁵⁹² Robert Darby, in particular, has fiercely argued that fear of masturbation advanced the practice of routine circumcision well into the twentieth century.⁵⁹³ Timothy O’Neill, while more cautious about these claims, notes that the procedure was performed with increasing frequency from the 1860s to the 1880s.⁵⁹⁴ While we cannot assume that *all* circumcisions were designed to combat masturbation, sexual surgery was certainly regarded as one of the weapons with which the

⁵⁸⁹ Ritchie, “An Inquiry Into a Frequent Cause of Insanity in Young Men (part 2)”, p. 186.

⁵⁹⁰ Robert Ritchie, “An Inquiry Into a Frequent Cause of Insanity in Young Men (part 3),” *The Lancet*, 77, (1861): 234-5, p. 235.

⁵⁹¹ Hall, “It Was Affecting the Medical Profession”; Laqueur, *Solitary Sex*, p. 46.

⁵⁹² Laqueur, *Making Sex*, p. 176. For the claim that vasectomy and castration were both practised, see Vern L. Bullough, *Science in the Bedroom: A History of Sex Research*, (New York: Basic Books, 1994), pp. 26-7; Moscucci, “Clitoridectomy, Circumcision and the Politics of Sexual Pleasure”, p. 64.

⁵⁹³ Robert Darby, *A Surgical Temptation: the Demonization of the Foreskin and the Rise of Circumcision in Britain* (Chicago: University of Chicago Press, 2005); Robert Darby, “The Masturbation Taboo and the Rise of Routine Male Circumcision: A Review of the Historiography,” *Journal of Social History*, 36, no. 3 (2003): 737-757.

⁵⁹⁴ O’Neill, *The Invisible Man?*, chapter two.

late nineteenth-century practitioner might combat the solitary vice: physical remedies included cauterisation, circumcision and, in some asylums, so-called “wiring”. In 1876, David Yellowlees, superintendent of the Glasgow Royal Asylum, described the insertion of a wire or safety pin through the foreskin of masturbating male patients, with the intention of preventing erection by causing a “painful dragging on the pins” when the foreskin retracted.⁵⁹⁵ It is unclear whether Yellowlees and his colleagues began this practice due to a belief that masturbation exacerbated mental and physical ill-health or repugnance at witnessing such acts carried out in open galleries (the latter certainly receives more frequent mention). The procedure was trialled at Bethlem in the mid-1880s, although it appears to have been quickly abandoned – perhaps because the results were not as striking as those claimed by Yellowlees. In the case of one young clerk, for example, judged to be suffering from “partial weak-mindedness with impulsiveness” (and thus presumably regarded incapable of self-control) the “safety pin fixed in position in hopes of stopping masturbation” on 4 August 1887 had been removed a month later – perhaps, it was suggested, by another patient.⁵⁹⁶

It seems likely, from the rarity with which this practice is mentioned, that it was only employed on occasions where the level of masturbation was considered particularly high or, as in the case above, the patient was deemed impulsive, and thus could not be led by moral means to control himself. There are no references to “wiring” at Bethlem after 1887, although Yellowlees was still recommending the procedure, “[w]hen honest efforts fail”, in 1893.⁵⁹⁷ Permanent forms of surgery do not appear to have been considered at Bethlem, although they certainly occurred on occasion elsewhere, on men as well as women. Thomas Laycock suggested that castration as cure for mental disorder had a long heritage, citing an “old Scotch popular work on medicine” from 1775, in which it was suggested to “geld the patient, and his madness will cease”.⁵⁹⁸ While the citation did not apparently make a connection with masturbation as the cause of insanity, Laycock himself certainly assumed such a context. Yellowlees, meanwhile, felt the need to refer simultaneously to clitoridectomy, ovariotomy and castration in his 1893 piece for Tuke’s *Dictionary*, suggesting all three ideas (if not necessarily the procedures) were still in common currency. The alienist

⁵⁹⁵ David Yellowlees “Masturbation,” *Journal of Mental Science*, July 1876, pp. 336-7; David Yellowlees, “Masturbation” in *A Dictionary of Psychological Medicine*, ed. Daniel Hack Tuke, vol. 2, (London: J. & A. Churchill, 1892), p. 785.

⁵⁹⁶ Samuel Henry Joseph, *Bethlem Male Patient Case Book 1886*, CB/128 – 106.

⁵⁹⁷ Yellowlees, “Masturbation” in *A Dictionary of Psychological Medicine*, p. 785.

⁵⁹⁸ Thomas Laycock, “Contributions to a New Chapter in the Physiology and Pathology of the Nervous System: V. On the Nervous Disorders in General Caused by Excessive or Unnatural Sexual Excitation,” *British Medical Journal*, 1, no. 389 (1868): 577-579, p. 578.

dismissed all three, claiming that sexual desires were not destroyed, and “the operation is generally deemed ineffectual and unsatisfactory.”⁵⁹⁹ Such an explanation suggests an increasing tendency, for some, to divorce sexual desire from physiological processes: desire was no longer deemed to be created by the sex organs themselves, but instead was a mental process. This meant that radical cures, like castration, no longer seemed reasonable to many writers, although they may have done previously. As Ritchie had suggested, for many it became the *mind* that required regulation, and not the genitals.

The on-going concern over the dangers of masturbation, and the advocacy of radical cures for a disease that it was widely believed could result in death, sets the concerns of many asylum patients of this period in a very different context. John Tilston Evans, admitted to Bethlem with “Partial Dementia” in October 1886, complained of “frequent nocturnal emissions” and thus “[e]xpresses a wish to be castrated as the only means of cure.”⁶⁰⁰ While certainly expressed in melodramatic terms, it was quite possible for young Frederick Bethell to interpret his actions as suicidal, and his doctors recorded that he says “[h]e has tried to kill himself by masturbation.”⁶⁰¹ The physicians did not interpret their patient’s behaviour in the same way, for he was not classed as suicidal in the case book. Instead, it was claimed that his “[g]eneral mental condition seems to be that of brooding over the state of his sexual organs with hypochondriasis.” Such a comment is suggestive of the changing psychiatric position on masturbation, which slowly shifted from viewing masturbation as a physical to a mental cause of insanity.⁶⁰² Other physicians also associated masturbation with sexual hypochondriasis, offering accounts in which the place of the sex organs shifted from being the physical site of disease (which might require castration for cure to be affected) to a psychological fixation of the patient (with castration similarly indicative of the patient’s state of mind).⁶⁰³

In his textbook, *Insanity and Allied Neuroses*, first published in 1884, George Savage listed “self-abuse (sexual)” under the *physical* causes of insanity, regarding masturbation as “a cause of insanity ... fully recognised by the profession and the world at large.” In common with many other writers of the period, Savage felt that masturbation “produces insanity chiefly, if not solely, in those who are highly nervous” and regarded it as more often a

⁵⁹⁹ Yellowlees, “Masturbation” in *A Dictionary of Psychological Medicine*, p. 786.

⁶⁰⁰ *Bethlem Male Patient Case Book 1886*, CB/128 – 103.

⁶⁰¹ *Bethlem Male Patient Case Book 1886*, CB/128 – 112.

⁶⁰² Hall, “It Was Affecting the Medical Profession”.

⁶⁰³ Sir James Paget 1879, quoted in Laqueur, *Solitary Sex*, p. 17.

symptom of insanity than a cause.⁶⁰⁴ Nonetheless, he certainly felt that masturbation produced “nervous” symptoms, as well as general mental weakness, providing a neurological justification for medical interest in the topic. Although Savage did not alter this section in later editions of the textbook, his views in Allbutt’s *System of Medicine* (published in 1899) show a definite shift toward viewing masturbation as a *mental* rather than physical cause of insanity:

Self-abuse is one of the most commonly cited causes of adolescent insanity; it certainly is an accompaniment, and occasionally the cause of such disorder. It occurs very frequently in both sexes, and the more sensitive the person the greater the danger of the practice; not so much from the physical harm of it as from the notion of its being debasing and unnatural. The indulgence itself is of less moment, except in the very young or very weak; the thoughts about it are more harmful.⁶⁰⁵

Despite maintaining that masturbation could, for some (the young or weak), be physically harmful, here Savage emphasised the effect on the individual’s psychological state, with worry about masturbation highlighted as more dangerous than the act itself. The way in which sexual self-mutilation was described shifted in a similar manner. In early accounts (such as the *Journal of Mental Science* description of Isaac Brooks), it was perceived as the result of a nervous impulse resulting from physical weakness. Later, self-castration was re-interpreted as a considered response to a problematic situation, itself viewed as delusory or otherwise wrongly interpreted by the patient. Adam’s second patient who castrated himself, an eighteen-year-old farmer, “admitted that he had masturbated” and thus removed his penis to prevent temptation. Adam further noted, laying the blame for the patient’s actions in external suggestion rather than the masturbation itself, that “[h]e had been reading some quack publications on nervous debility, and also Salvation Army publications, which roused within him strong convictions of his wickedness.” This claim received greater emphasis in Adam’s second report, in 1893, than it had ten years previously.⁶⁰⁶ Such re-interpretation supported the claim that thoughts about masturbation might be more harmful than the act. Similarly, it indicates a shift in understanding of self-castration, from having been viewed as caused by masturbation, to being seen as a pathological act in itself. Thus, when Dr Campbell Black reported a case of self-ablation of the testicle in the *Medical Press* of 1889, he regarded this as “the act … of a maniac”, although the young man in question clearly stated

⁶⁰⁴ George Savage, *Insanity and Allied Neuroses: Practical and Clinical* (London, New York: Cassell, 1884), pp. 63-4. This was part of a wider shift in views on masturbation from cause to symptom. See Hall, “It Was Affecting the Medical Profession”, p. 689.

⁶⁰⁵ George Savage, “Mental Diseases” in *A System of Medicine*, ed. T. Clifford Allbutt. vol. 8, (London, 1899), pp. 190-1.

⁶⁰⁶ Adam, “Self-Mutilation”, p. 1151; Adam, “Cases of Self-Mutilation by the Insane”, p. 218.

that he had mutilated himself to prevent the nocturnal emissions he perceived as a result of too-frequent masturbation, and seemed mentally sound following his physical recovery.⁶⁰⁷

4.5 The Basis for Social Advancement: Sexology and Self-Mutilation

We should take particular note of the way in which descriptions of sexual and mental health relied on a developmental model: Savage stated that masturbation occurred “very frequently” during adolescence but, if precocious, could interfere with “normal mental growth.”⁶⁰⁸ Similar ideas were also adopted in psychological circles, and have been particularly noted as influencing Freud’s theories of the aetiology of hysteria, after he abandoned the seduction theory in 1897.⁶⁰⁹ Influenced by socio-evolutionary approaches to mind, physicians in the later nineteenth-century were paying greater attention to adolescence, with sexual and mental change regarded as closely connected. Savage frequently reiterated that youth was “a period of nervous instability”, for “the whole of a new side to the life is being developed, and the hitherto chiefly egoistic is now growing out of itself, and becoming more altruistic.”⁶¹⁰ This was one area where he was in support of his long-term associate, Henry Maudsley, who similarly connected the emerging “sexual feelings” of puberty with “sympathetic ideas”, judging this to be the time of life when “the highest feelings of mankind” were developed.⁶¹¹ Herbert Spencer, meanwhile, had incorporated propagation of the species into the acts generally regarded as altruistic in 1879, regardless of the motivation in each individual case, while Charles Mercier claimed “the spirit of self-sacrifice” to be “intimately connected with the sexual function”.⁶¹² However, sexual feelings needed to be directed towards the opposite sex in order to be viewed as healthy: masturbation, within such a context, became a developmental concern. By directing attention toward the self, it was thought that masturbation could prevent the development of “higher feelings” for others.

⁶⁰⁷ Campbell Black, "Case of Self-Ablation of the Testicle," *Medical Press and Circular*, ii, (1889): 32.

⁶⁰⁸ Savage, “Mental Diseases”, pp. 190-1.

⁶⁰⁹ George J. Makari, "Between Seduction and Libido: Sigmund Freud's Masturbation Hypotheses and the Realignment of his Etiologic Thinking, 1897-1905," *Bulletin of the History of Medicine*, 72, no. 4 (1998): 638-662, pp. 660-1.

⁶¹⁰ Savage, *Insanity and Allied Neuroses*, p. 63.

⁶¹¹ Henry Maudsley, *Body and Mind: An Inquiry into their Connection and Mutual Influence* (London: Macmillan, 1873), p. 34. That Savage and Maudsley could nonetheless differ in their views on the importance of heredity indicates that a developmental view of sexuality could lead alienists down the route of either a pessimistic determinism or a positive view of evolution as progress.

⁶¹² Thomas Dixon, *The Invention of Altruism: Making Moral Meanings in Victorian Britain*, (Oxford; New York: Oxford University Press, 2008), p. 200; Charles Arthur Mercier, *Sanity and Insanity*, (London: Walter Scott, 1890), p. 354.

Thus, male-female marital relations might be claimed to be directly related to altruism. Savage was particularly concerned with this topic and regularly upheld the importance of marriage for maintaining mental health. Marriage in "neurotic subjects" (who were not insane) could often, for Savage, be beneficial. Although he stressed that there might be an increased risk of insanity in the children of such parents, these same children could have a beneficial influence.

Thus, as one is in the habit of seeing, the sexual function is the function which develops altruism, so without children the parents become egotistical, and egotism and insanity are not far apart.⁶¹³

This connection of marriage with healthy social relations relied on pre-existing religious models of society (Savage was certainly a practicing Christian), as well as the suggestion of evolutionary biologists that man had evolved as a "social" animal, with sexual selection forming an important element of progress.⁶¹⁴ Michael Mason has emphasised, in contrast to other historians who assume that all religions promoted an Augustinian interpretation of sex which emphasised celibacy, that for much of the nineteenth century celibacy was regarded as *more* problematic within Protestant religions than sex for purposes other than procreation.⁶¹⁵ Despite the increasing interest in eugenic concerns around the turn of the twentieth century, this continued to be the case. Indeed, the particular focus in England on *positive* rather than negative eugenics (the promotion of reproduction among the "fit") emphasised this equation between celibacy and selfishness, particularly in the middle classes, where the postponement of marriage and children was regarded as the pursuit of personal gain above social progress.⁶¹⁶ In later decades, similar concerns encouraged Freud to associate a shift of sexual desire from the self to another as part of childhood development with the emergence of altruism.⁶¹⁷

It is within this context that we should see English psychiatric interest in the emerging continental field of sexology. While it has long been assumed that British

⁶¹³ George Savage, "Marriage in Neurotic Subjects," *Journal of Mental Science*, 29, (1883): 49-54, p. 53.

⁶¹⁴ Charles Darwin, *The Descent of Man and Selection in Relation to Sex* (New York: D. Appleton and Company, 1897).

⁶¹⁵ Mason, *The Making of Victorian Sexual Attitudes*, p. 17. For the opposite viewpoint, see Bullough, *Science in the Bedroom*, p. 3.

⁶¹⁶ For more on eugenics see Daniel J. Kevles, *In the Name of Eugenics: Genetics and the Uses of Human Heredity* Cambridge, Mass: Harvard University Press, 1995); Richard A. Soloway, *Demography and Degeneration: Eugenics and the Declining Birthrate in Twentieth-century Britain* (Chapel Hill: London: University of North Carolina Press, 1990).

⁶¹⁷ Sigmund Freud, "Three Essays on the Theory of Sexuality (1905)," in *Standard Edition of the Complete Psychological Works of Sigmund Freud*, ed. James Strachey. vol. 7, (London: Hogarth Press, 1974), 123-254, pp. 207-8; Makari, "Between Seduction and Libido," 638-662.

psychiatrists avoided much of this debate, Ivan Crozier has recently recognised otherwise.⁶¹⁸ Thus, when Adam referred readers on sexual self-mutilation to further examples in the texts of Richard von Krafft-Ebing and Albert Moll, he addressed a field that many of his contemporaries could be expected to have encountered, even if they were not actively writing in it themselves.⁶¹⁹ One of the elements of sexological research that has often been emphasised by historians is the way in which psychiatrists were able to create new ways of "being" in the late nineteenth century, in which the individual was defined by his or her sexual preferences, shifting attention "from practices to psyches", with the emergence of "the homosexual", "the fetishist" and so on.⁶²⁰ Adam's grouping of cases of sexual self-mutilation, supported by reference to continental studies in sexual pathology, served a similar purpose: in particular, the case study method of description emphasised the notion that every element of the narrative was related in some way to the individual's "perversion" (in this case castration). Further, this method of reporting ensured that castration itself, rather than being viewed as a reaction to another form of sexual misdemeanour (such as a form of self-treatment), was depicted as the primary perversion.

To what, then, did Adam refer when he cited sexological literature? The work of Krafft-Ebing in particular fitted neatly within the contemporary British commitment to altruism, emotion and social feeling as the primary factors in progress, as discussed in chapter two. Using the theories of British alienists to justify his work (he specifically cites Maudsley's view that sexual feeling formed the basis for social advancement),⁶²¹ Krafft-Ebing claimed the relevance of sexual life to more or less every aspect – individual and social – of existence.

Sexual life is no doubt the one mighty factor in the individual and social relations of man that discloses his powers of activity, of acquiring property, of establishing a home, and of awakening altruistic sentiments toward a person of the opposite sex, toward his own issue, as well as toward the whole human race.⁶²²

⁶¹⁸ Crozier, "Nineteenth-Century British Psychiatric Writing About Homosexuality".

⁶¹⁹ Adam, "Self-Mutilation", p. 1150.

⁶²⁰ "Introduction" in Roy Porter and Mikulas Teich, *Sexual Knowledge, Sexual Science: the History of Attitudes to Sexuality* (Cambridge; New York: Cambridge University Press, 1994), p. 15; Arnold I. Davidson, *The Emergence of Sexuality: Historical Epistemology and the Formation of Concepts*, (Cambridge, Mass.; London: Harvard University Press, 2001). There has been some interesting attention in recent years to the ways in which doctors and "perverts" were able to mutually constitute such definitions, as well as challenge received opinion. See in particular Oosterhuis, *Stepchildren of Nature*; Ivan Crozier, "Havelock Ellis, Eonism and the Patient's Discourse; or, Writing a Book About Sex," *History of Psychiatry*, 11, (2000): 125-154.

⁶²¹ Henry Maudsley in Krafft-Ebing, *Psychopathia Sexualis* (1899), p. 1.

⁶²² Krafft-Ebing, *Psychopathia Sexualis* (1899), p. 1.

When broken down, such a statement can appear mystifying to a twenty-first century reader in some areas (what can sex have to do with acquiring property?) and exaggerated in others. Yet many of these claims are closely connected to broader contemporary ideals. While most of us, today, regard sex as an important aspect of romantic relationships, it seems unlikely that many would assume that a person was required to be sexually active in order to develop feelings towards humanity. Yet this is just what Krafft-Ebing claimed, a suggestion that only makes sense within the anthropological and evolutionary context set out in chapter two, by which civilization was regarded as progressing from smaller to larger units. In the anthropological model, intimate personal relationships were regarded as progressing inexorably towards family relationships, which in turn enabled an individual to appreciate a wider human sphere: from village or tribe to humanity as a whole.⁶²³ From such a perspective, the two major drives in human life described by Krafft-Ebing – the sexual and self-preservation – appeared to be intimately connected, suggesting that disorder of the latter (evidenced by self-mutilation) might indicate a perversion of the former.⁶²⁴

From this starting point, in a shared view of civilization and social progress, we can begin to examine in what way Krafft-Ebing's cases of sexual self-mutilation related to those described by Adam. What broader context might Adam assume by referring to the Austrian writer? One of Krafft-Ebing's earliest published cases detailed attempted self-mutilation: he re-printed this case in later classificatory studies and, finally, in *Psychopathia Sexualis*.⁶²⁵ E., a thirty-year-old journeyman painter, was reported to suffer "sexual anaesthesia". Krafft-Ebing was called as a medical witness after E. was arrested:

while trying to cut off the scrotum of a boy he had caught in the woods. He gave as a motive for this act that he wished to cut into it in order that the world should not multiply. Often in his youth, with like purpose, he had cut into his own genitals.⁶²⁶

Voicing the Malthusian belief that population growth would inevitably outstrip natural resources, E.'s concerns acted out the fears of many others, for he "declared that it would be better to castrate all children than to allow others to come into the world that could only be fated to endure poverty and misery."⁶²⁷ On Krafft-Ebing's testimony, however, E. was judged insane, and sent to an asylum rather than prison. This judgment meant that E.'s

⁶²³ Edward B. Tylor, "Primitive Society (Part I)," *Contemporary Review*, 21, (1872): 701-718; Edward B. Tylor, "Primitive Society (Part II)," *Contemporary Review*, 22, (1873): 53-72.

⁶²⁴ R. von Krafft-Ebing, *Text-book of Insanity: Based on Clinical Observations for Practitioners and Students of Medicine*, trans. Charles Gilbert Chaddock (Philadelphia: F.A. Davis, 1904), p. 79.

⁶²⁵ For earlier examples, see Oosterhuis, *Stepchildren of Nature*, p. 133, p. 136. E is case 9 in both the 7th and 10th edition of *Psychopathia Sexualis*.

⁶²⁶ Krafft-Ebing, *Psychopathia Sexualis* (1899), p. 45.

⁶²⁷ Krafft-Ebing, *Psychopathia Sexualis* (1899), p. 45.

concerns about procreation and his own childhood poverty were dismissed as irrational. Instead, Krafft-Ebing's emphasis lay in an association between E.'s violent acts (to himself and others), his lack of desire for "normal" sexual intercourse, and his personality. Given the writer's strong belief in the altruistic potential of sexual activity, it is hardly surprising that he found E. "selfish and weak-minded" and a lover of solitude. Conclusively, Krafft-Ebing declared that "[s]ocial feelings are absolutely foreign to him."⁶²⁸ E. certainly did possess physical feeling: Krafft-Ebing noted that his attempts at "self-emasculation" had not been carried out because of pain. Thus, for Krafft-Ebing, absence of sexual feeling was not entirely a physical phenomenon: his cases of sexual anaesthesia were not impotent, but "the corresponding emotions of sexual life are absolutely wanting."⁶²⁹ While this is often interpreted as indicating a shift towards an internal and subjective reading of sexuality,⁶³⁰ the heading of anaesthesia (which remained unchanged in later editions of *Psychopathia Sexualis*) suggests a more nuanced reading, whereby these psychological categories remained bound up with physiological understanding of sensation. Imposing a modern division between somatic and psychological can thus lead to an anachronistic reading of nineteenth-century ideas.

Krafft-Ebing's judgement was opposite to that voiced by E. For E., his act of violence was socially motivated, aiming to benefit humanity in its entirety. Rather than being pathological, his attempts at self-castration were efforts at cure, not necessarily of his own condition, but of the human race. A number of Krafft-Ebing's other cases explicitly focused on castration as *self*-cure. Harry Oosterhuis, following a historical analysis of all Krafft-Ebing's writings, states that two homosexuals and one fetishist reported that they had considered castration in order to cure what these patients (but not necessarily others) thought to be an unhappy condition.⁶³¹ In 1899, Krafft-Ebing published a case in which such a castration was carried out: a seventeen-year-old student decided that his neurasthenia was caused by masturbation. When hypnosis failed to help, the student told Krafft-Ebing he wished to be castrated. Although the psychiatrist advised against such a procedure, the patient had his testicles removed by a willing surgeon. When his symptoms continued, he visited Krafft-Ebing again, this time considering amputation of the penis. According to Oosterhuis, the psychiatrist successfully persuaded the boy against such a course, although

⁶²⁸ Krafft-Ebing, *Psychopathia Sexualis* (1899), p. 46.

⁶²⁹ Krafft-Ebing, *Psychopathia Sexualis* (1899), p. 42.

⁶³⁰ Renate Irene Hauser, *Sexuality, Neurasthenia and the Law: Richard von Krafft-Ebing (1840-1902)* (Unpublished PhD Thesis, UCL, 1992), pp. 241-2

⁶³¹ Oosterhuis, *Stepchildren of Nature*, p. 155. These are presumably cases 96, 129 and 145 in the 12th edition.

whether this advice was ultimately taken is, of course, impossible to know.⁶³² What these cases *do* indicate, however, is that castration was certainly considered – and even sometimes carried out – by men for a variety of perceived medical problems, up until the end of the nineteenth century, and quite possibly beyond. The suggestion that sexual surgery might be *self*-performed in seemingly mentally healthy subjects is also apparent in a letter received by Marie Stopes in 1923, discussing the possibility of the admittedly less drastic option of circumcision to prevent masturbation. “Would you advise me to be circumcised?” Her correspondent enquired. “If you advise circumcision could I do it myself as I don’t wish to approach a doctor on the subject as I am thoroughly ashamed of myself.”⁶³³ In such a light, the “self-mutilations” of psychiatric patients who blamed masturbation or sexual activity for their mental condition appears rather differently. Indeed, it may well have been the psychological interests of alienists like Krafft-Ebing that led them to cast self-mutilation as pathological: by rejecting surgery as a potential cure for sexual disorders judged by them to be explicitly *mental*, the rationale behind self-damaging treatments also had to be rejected.⁶³⁴ Certainly, this was the perspective that psychoanalytic practitioners in the early twentieth century chose to emphasise, when reporting that castration had “even recently” been reported as a cure for “neuroses, perversion, sexual crimes, sexual abnormalities, mental diseases, and even tuberculosis”.⁶³⁵

In addition to the relation made between self-inflicted genital injury, the sexual instinct and the “selfish” personality, did Krafft-Ebing make any specific connection with the pathologies he famously outlined? Today, we might expect some reference to sadomasochism: indeed, certain psychoanalysts later invoked this concept to explain self-mutilation.⁶³⁶ Yet the connection is strikingly absent in Krafft-Ebing’s work, and was certainly not picked up by British alienists, although both masochism and sadism were introduced into *Psychopathia Sexualis* in 1890, several years before Adam’s definition of self-mutilation was

⁶³² Richard von Krafft-Ebing, “Zur Castratio virorum,” *Arbeiten aus dem Gesammtgebiet der Psychiatrie und Neuropathologie*, vol. IV, pp. 189–92 in Oosterhuis, *Stepchildren of Nature*, p. 155.

⁶³³ Quoted in Darby, “The Masturbation Taboo”, p. 746.

⁶³⁴ For Krafft-Ebing’s views on castration, see Richard von Krafft-Ebing, *Psychopathia Sexualis: with Especial Reference to Contrary Sexual Instinct: a Clinical-Forensic Study*, 12th edition. (Burbank: Bloat, 1999), p. 380. It is here implied that others consider castration as a treatment for “antipathic sexuality”.

⁶³⁵ Karl A. Menninger, *Man Against Himself*, (San Diego; New York; London: Harcourt Brace Jovanovich, 1985), p. 270.

⁶³⁶ The earliest instance is probably L. E. Emerson, “The Case of Miss A: A Preliminary Report of a Psychoanalytic Study and Treatment of a Case of Self-Mutilation,” *Psychoanalytic Review*, 1, (1913): 41–54. See also Wilhelm Stekel, *Sadism and Masochism: the Psychology of Hatred and Cruelty*, (London: Vision, 1953), vol. 2, pp. 161–213; Menninger, *Man Against Himself*.

published.⁶³⁷ Masochism was thus readily available as a model for self-inflicted injury, but was not adopted. Instead, relying on prior understanding of the characteristics of the castrated male, castration seems most frequently to have been discussed in relation to cases of “antipathic sexuality” (known in England as “sexual inversion”), i.e. homosexuality. It was here that Krafft-Ebing adamantly rejected castration as cure, and it was also in such circumstances that castration gained a very specific meaning, forming a reflection on the physical and mental state, and the “inverted” character of the individual. By association with a “third sex”, castration became seen as a very particular form of emasculation.

In his introduction to early editions of *Psychopathia Sexualis*, Krafft-Ebing referred at some length to the work of physician Victor von Gyurkovechky on impotence. Gyurkovechky compared a loss of virility in men as they aged to castration and, subsequently, to “effemimation”.

...the man bereft of his virility is morose and spiteful, egotistic, jealous, contrary, listless, has but little self-respect or sense of honor, and is cowardly. Analogies are seen in the Skopzems, who, after their castration, change for the worse. The loss of virility is still more noticeable in certain weakly constituted individuals, where it expresses itself in formal effemimation.⁶³⁸

Such a generalisation clearly related castration to both gender inversion and a broader change in character, and claimed that anthropological investigation of the Skoptsy proved such a connection. The particular role of the Skoptsy will be discussed in the final part of this chapter. Here, however, it is important to note the regular use of such correlations in psychiatric discussion of homosexuality, through the suggestion that “gender inversion” might be evidenced physically (by changes in the genitals) as well as through a perceived “feminine” character. Yet we encounter a paradox here. Women, as was shown in the previous chapter, were frequently associated with altruistic traits (Darwin, for example, saw men as “naturally” more selfish than women), especially in their extreme form, the maternal ideal of “self-sacrifice”.⁶³⁹ Krafft-Ebing, too, saw women as “naturally” passive – and, therefore, presumably not “egotistic” in the aforementioned sense.⁶⁴⁰ In the characterisation of eunuchs (and homosexuals) as feminised *and* aggressive, effeminate *and* egotistic, we have a combination of several theories. The eunuch is regarded as feminised, and therefore cannot show a masculine “self-respect” or drive. However, he is unable to perform the reproductive sexual functions of the male *or* the female, and thus cannot

⁶³⁷ Hauser, *Sexuality, Neurasthenia and the Law*, p. 240.

⁶³⁸ Victor Gyurkovechky, *Pathologie und Therapie der Männlichen Impotenz*, (Vienna: Urban & Schwarzenberg, 1889) in Krafft-Ebing, *Psychopathia Sexualis* (1999), pp. 12-13.

⁶³⁹ Charles Darwin, *The Descent of Man*, ed. H. James Birx (Amherst: Prometheus Books, 1998), p. 597.

⁶⁴⁰ Krafft-Ebing, *Psychopathia Sexualis* (1899), p. 187.

acquire the civilising altruism associated with the reproductive sexual act by contemporaries. Castration in such a context would appear to result in far more than simply a loss of masculine status: perhaps also a complete loss of humanity

Assumptions about the connection between castration, passivity and homosexuality were supported in medical texts by reference to anthropological literature. These texts were often created within a naturalist framework, intended to indicate the universality of homosexual behaviour, thus framing it as biologically, as well as culturally, natural. This approach emphasised associations between act and character, for this formed the “proof” of universality. Thus, while claims for universality supported legal sanction for abnormal sexual behaviour, it also served to increase the association of certain character traits with homosexuals and eunuchs, as well as suggesting a relation between the two. Krafft-Ebing took one such example from the work of American doctor William Alexander Hammond. A formerly disgraced army-surgeon, Hammond later became a specialist on mental disease and published on a variety of fringe topics, including spiritualism, hypnosis and “fasting girls”.⁶⁴¹ His several volumes on *Sexual Impotence* included anthropological material gathered during his days in the army, and Krafft-Ebing was particularly interested in reports of the creation of *mujerados* among the Pueblo Indians of New Mexico. The *mujerado* formed a ceremonial function among the Indians, being the “chief passive agent in the pederastic ceremonies ... which take place in the spring of every year”.⁶⁴² According well with western medical thought, the *mujerado*’s state of impotence was claimed to be achieved by repeated masturbation and continuous horseback riding. Physically, his penis and testicles were supposed to atrophy: Hammond had personally examined two such *mujerados*, and confirmed this change. However, both Hammond and Krafft-Ebing concentrated on a claimed alteration in the instincts and desires of the subject. In addition to losing his social place as a male (his family, if he had one, passing from his control), the *mujerado* apparently became timid and lost his taste “for those sports and occupations in which he formerly indulged.”⁶⁴³ In essence, then, both writers presented the *mujerado* as having become physically, socially and sexually passive – and thus female. While Hammond was most concerned with the way in which impotence might affect a man in the broadest sense, Krafft-Ebing related Hammond’s discussion directly to his own research on antipathic sexual instinct. The example of the *mujerados* followed on from the case of Sch., a thirty-

⁶⁴¹ For more on Hammond, see Joan Jacobs Brumberg, *Fasting Girls: the Emergence of Anorexia Nervosa as a Modern Disease*, (Cambridge, Mass: Harvard University Press, 1988), pp. 76-89.

⁶⁴² William Hammond, *Sexual Impotence in the Male and Female*, (Detroit, 1887), pp. 167-8; Krafft-Ebing, *Psychopathia Sexualis* (1999), pp. 253-4.

⁶⁴³ Hammond, *Sexual Impotence*, p. 168.

year-old physician whose autobiographic account of his physical and sexual development, and homosexual experiences, was similarly followed by a description of his character. Sch. described himself as “effeminate, sensitive, easily moved, easily injured and nervous.” Further, “[m]asculine pursuits do not interest me.” Krafft-Ebing concluded that Sch. had acquired his antipathic sexual instinct through early sexual experiences, which in turn, having “induced a desire for the passive role”, ensured that “[t]he character became feminine.” The example of the *mujerados* was thus claimed to form an “interesting confirmation” of Krafft-Ebing’s own theories.⁶⁴⁴

In using ethnological data to support theories about western sexual practices, both Hammond and Krafft-Ebing assumed the universality of behaviour and character, ignoring elements specific to any particular instance, such as the religious and ceremonial function of castration in New Mexico. Other anthropological studies of the period regarded castration in other cultures in a similar manner, including the eunuchs of Imperial China, the *hijda* and the *kojahs* of India and, of course, the *Skoptsy*.⁶⁴⁵ Many of these accounts, despite acknowledging the multiple historical purposes of castration, nonetheless equated modern day eunuchs with homosexual prostitution, through assumptions about their “passive” nature. Thus, in his report to the Anthropological Society of London, Dr Shortt referred to the “debauchery and low practices” of the “Higras” (*hijdas*) who hired themselves out “to a dissipated set of Moslems” at night.⁶⁴⁶ In Western psychiatric texts, analogies were frequently made between castration and an assumed feminine character: Gould and Pyle, for example, noted that one Italian law student who castrated himself was “of delicate complexion”.⁶⁴⁷ Another army-surgeon pseudonymously published a volume about his travels, *Untrodden Fields*, making a similar link between castration and male prostitution.⁶⁴⁸ In this instance, rather than claiming his anthropological examples to be natural (and hence not punishable by law), the author suggested the opposite view to Krafft-Ebing, playing on contemporary fears of national and racial decline. This indicates that it was perfectly possible to use ethnological examples to support whichever argument the author preferred. Unlike Krafft-Ebing, the author of *Untrodden Fields* appeared to support castration for some

⁶⁴⁴ Krafft-Ebing, *Psychopathia Sexualis* (1999), p. 252.

⁶⁴⁵ See also R. A. Jamieson, “Chinese Eunuchs,” *The Lancet*, 110, no. 2813 (1877): 123-124; Melissa S. Dale, “Understanding Emasculation: Western Medical Perspectives on Chinese Eunuchs,” *Social History of Medicine*, 23, no. 1 (2010): 38-55.

⁶⁴⁶ Shortt, “The Kojahs of Southern India”, p. 406.

⁶⁴⁷ Gould and Pyle, *Anomalies and Curiosities of Medicine*, p. 732.

⁶⁴⁸ Dr Jacobus, *Untrodden Fields of Anthropology: Observations on the Esoteric Manners and Customs of Semi-Civilized Peoples*, trans. Charles Carrington (Paris: Librairie de Medecine, Folklore et Anthropologie, 1898), p. 117.

individuals assumed to be deviant, including “sexual perverts”.⁶⁴⁹ Such concerns indicate a continued interest in castration as a cure for homosexuality. Indeed, Krafft-Ebing’s associates apparently recommended this treatment. Moritz Benedikt, his colleague in Vienna, saw three possibilities for homosexuals: abstinence, imprisonment or castration.⁶⁵⁰ Similarly, some doctors continued to advocate surgical intervention for preventing masturbation into the twentieth century.⁶⁵¹

Further indicating that castration could still be interpreted by some as a cure for sexual pathology, Havelock Ellis added a section on the topic to the 1915 edition of *Sexual Inversion* (first published in 1897), noting that “the treatment of homosexuality must be approached with discrimination, caution and scepticism.”⁶⁵² Ellis gave firm reasons for his rejection of this “seemingly very radical method” of treatment, which was “sometimes believed to have been successful by those who carried it out.” His contention was that castration *could not* be successful, because it acted only on the body and not “the whole psychic state.” Since sexual inversion was “firmly imprinted”, “[c]astration of the body in adult age cannot be expected to produce castration of the mind.” Such an argument supported the now widespread view that sexual inversion did not refer solely to an act, but an entire way of being. It avoided, however, the contention of other authors – like Hammond and Krafft-Ebing – that castration might *alter* the entire way of being, and not merely the physical state of the genitals. Indeed, the cases Ellis quoted (from other authors) did refer to mental as well as physical change. These mental changes, however, were not claimed to affect the “inverted” character. Instead, the cases reported the “aggravation” of neurasthenic symptoms, in particular the inability to resist impulse, relying on earlier correlations between castration and selfishness. Ellis highlighted this dangerous effect of castration by referring back to a case history reported earlier in the volume, that of Guy Olmstead.⁶⁵³

Olmstead was not one of the cases collected by Ellis and his co-writer, John Addington Symonds, but had already been reported in American newspapers as a medico-

⁶⁴⁹ Jacobus, *Untrodden Fields of Anthropology*, pp. 250-1, fn. 1 (it is unclear whether this is written by the author, or the footnote was added by the editor).

⁶⁵⁰ Oosterhuis, *Stepchildren of Nature*, p. 186.

⁶⁵¹ Archibald Campbell Clark and Henry E. Clarke, “Neurectomy A Preventive of Masturbation,” *The Lancet*, 154, no. 3969 (1899): 838. Carole Reeves notes that blistering the penis was a weekly ritual in Colney Hatch Asylum around the turn of the twentieth century, and castration was even sometimes suggested. Carole Anne Reeves, *Insanity and Nervous Diseases Amongst Jewish Immigrants to the East End of London, 1880 - 1920* (Unpublished PhD thesis, University of London, 2001), pp. 166-7.

⁶⁵² Havelock Ellis, *Studies in the Psychology of Sex, Vol II: Sexual Inversion* (Philadelphia: F.A. Davis, 1915), p. 327.

⁶⁵³ Havelock Ellis and John Addington Symonds, *Sexual Inversion: A Critical Edition*, ed. Ivan Crozier, (Basingstoke: Palgrave Macmillan, 2008), pp. 151-5.

legal case when Ellis and Eugene Talbot (Olmstead's physician), collaborated in a report in the *Journal of Mental Science* in 1896. Talbot, a medical doctor with an interest in degeneration, provided the data; Ellis was responsible for the commentary.⁶⁵⁴ Olmstead had shot a fellow letter-carrier in the street, apparently fatally wounding him. Subsequently, many details about Olmstead's history, in particular his homosexual involvement with the victim, William Clifford, came to light. Olmstead, it was said, had "never been considered perfectly sane", and had been previously treated in various asylums. Following an affair, Clifford had apparently rejected Olmstead, and later gave incriminating letters to their employer, resulting in Olmstead's dismissal. Subsequently, "on the advice of friends", Olmstead had his testicles removed. Both Talbot and Ellis drew their strongest conclusions about the case in connection with Olmstead's castration. Both seemed to regard castration as having provoked the onset of hysterical melancholia, and Ellis concluded adamantly that:

The removal of the testicles, the apparently depressing effect of the operation, and the speedy occurrence of the crime after it, should suggest caution to the surgical psychiatrists who advocate the castration of inverts and sexual perverts generally. Such persons are frequently of unstable mental balance, so that the mutilation produces a depressing effect, while it does not remove the perverted tendency.⁶⁵⁵

Ellis thus emphasised that castration was dangerous, rather than curative: his aim was to suggest that it was, in fact, *more* socially problematic than inversion might be. Given the social functions doctors as diverse as Krafft-Ebing and George Savage attributed to the sexual instinct, this would certainly seem to have been a persuasive line of argument, and fitted amongst other contemporary depictions of castration as leading to violence and sudden emotional changes in the individual.⁶⁵⁶

The case of Guy Olmstead highlights the emphasis placed on restraint as a key element of masculinity in the later nineteenth century, associated with contemporary interest in Stoicism and neo-Spartanism.⁶⁵⁷ Thus, sexuality, gender and character were all bound up in the same ideals, judged important for both individual and race.⁶⁵⁸ From the several perspectives outlined above, castration thus shifted from a potential cure for a sexual or other biological problem (an imposition of control), to a pathological act in itself,

⁶⁵⁴ Havelock Ellis and Eugene Talbot, "A Case of Developmental Degenerative Insanity, with Sexual Inversion, Melancholia following Removal of Testicles, Attempted Murder and Suicide," *Journal of Mental Science*, 42, no. 177 (1896): 340-346, p. 340.

⁶⁵⁵ Ellis and Talbot, "A Case of Developmental Degenerative Insanity", p. 346.

⁶⁵⁶ Dale, "Understanding Emasculation," p. 48.

⁶⁵⁷ J.A. Mangan, "Social Darwinism and Upper-class Education in Late Victorian and Edwardian England" in Mangan and Walvin, *Manliness and Morality*, p. 139.

⁶⁵⁸ Adams, *Dandies and Desert Saints*, introduction. For more on masculinity and self-control, see Mangan and Walvin, *Manliness and Morality*.

regarded as resulting in an impulsive *loss* of control (and hence loss of masculinity) in the patient. For some, such as John Addington Symonds, who had his penis cauterised by William Action in 1864, castration had to be represented as pathological to highlight the legitimacy of what Symonds saw as an inborn condition (homosexuality).⁶⁵⁹ Conversely, as in the case of the author of *Untrodden Fields*, castration could be viewed as evidence of degeneration and sexual perversion, turning the eunuch into the passive recipient of anal intercourse while, as in the examples of Krafft-Ebing and Hammond, simultaneously feminising his character. Finally, the association between the physical act of castration, the mental state and the individual character became viewed as especially problematic in relation to the emphasis put on sexual restraint and self-control in Victorian culture. Sexual restraint was perceived as a vital element of masculinity, shaping the individual's response to other social situations. Castration was thought to *weaken* the will, removing the need for the individual to learn control of himself. If he were not making a concerted effort to restrain himself sexually, the Victorian male might be expected to fail to restrain himself in other ways: thus, it was implied, Guy Olmstead would not have shot his former lover had he not been castrated. For some critics, this was associated with much wider concerns about respectability and social convention. As James Eli Adams has noted, writers as varied as Oscar Wilde, John Stuart Mill and Matthew Arnold represented Victorian moral conventions as a type of "mutilation" of the body.⁶⁶⁰ Within a medical context, concerns about the relation between self-control, sexual restraint, character and social convention can be viewed most explicitly in texts on the Skoptsy, the Russian religious cult who practised ritual castration.

4.6 "Indifferent to his Environment": Religion, Self-Restraint and the Eunuch

As outlined in chapter one, a number of writers linked self-mutilation specifically to religious fervour, and English alienists frequently noted an association with Matthew 5:29 - "If thy right hand offend thee, cut it off" - whether or not their patients cited this scriptural injunction.⁶⁶¹ James Adam regarded Christianity as having *caused* the spread of self-mutilation in Europe and, although there were certainly many who disagreed with this viewpoint, one particular example was often used to support the connection between

⁶⁵⁹ Darby, *A Surgical Temptation*, p. 304.

⁶⁶⁰ James Eli Adams, "The Banality of Transgression?: Recent Works on Masculinity," *Victorian Studies*, 36, no. 2 (1993): 207-213, p. 209.

⁶⁶¹ For example Adam, "Self-Mutilation", p. 1147.

religion and castration: the Russian Skoptsy.⁶⁶² As already indicated, the Skoptsy were one of the most oft-cited instances of castration outside the psychiatric realm, receiving a separate category in the *Surgeon-General's Index Catalogue*, and providing much of the material for later medical investigation of the consequences of "Eunuchism".⁶⁶³ Although castration was not literally self-performed, their acts were nonetheless considered under the remit of "self-mutilation".⁶⁶⁴ Thus, an article in the *Medical Press* of 1888 compared cases of self-mutilation in western asylums with contemporary "religious fanaticism in Russia", even though the British cases described were of enucleation rather than castration.⁶⁶⁵

The Skoptsy emerged in the late eighteenth century, and their history has been ably traced by Laura Engelstein, through religious texts as well as legal and medical documents.⁶⁶⁶ One of a number of sects that broke away from the Russian Orthodox Church, the Skoptsy appear to have been persecuted particularly severely following the discovery of their practice of castration in 1772. As Engelstein notes, the Russian state struggled to pin down their problem with the Skoptsy's practice: was it religious heresy or social harm?⁶⁶⁷ Commentators claimed that the Skoptsy's practice of castration stemmed from a "misinterpretation" of the Bible and a "mystical madness".⁶⁶⁸ Engelstein suggests that three passages of the Bible were emphasised in the sect's religious teachings: Matthew 19:12 ("there be eunuchs which have made themselves eunuchs for the kingdom of heaven's sake"), Matthew 5:29 (as above) and Luke 23:29 ("blessed are the barren").⁶⁶⁹ When a paper on the topic was read to the Anthropological Society of London in 1870, one member complained that "according to the best commentators, the assertion that some eunuchs made themselves such referred to the living a life of celibacy and not to mutilating the

⁶⁶² For the suggestion that Christianity prevented rather than caused the spread of self-mutilation, see Gould and Pyle, *Anomalies and Curiosities of Medicine*, p. 744.

⁶⁶³ A. P. Cawadias, "Male Eunuchism Considered in the Light of the Historical Method," *Proceedings of the Royal Society of Medicine*, 39, (1946): 23-28.

⁶⁶⁴ This connection was also adopted by Karl Menninger, who regarded mutilation "willingly submitted to" for religious reasons as equivalent to that self-inflicted. Menninger, *Man Against Himself*, p. 220.

⁶⁶⁵ Anon, "Self-Mutilation by the Insane," *Medical Press and Circular*, ii, (1888): 260-261, p. 260.

⁶⁶⁶ Laura Engelstein, "From Heresy to Harm: Self-Castrators in the Civic Discourse of Late Tsarist Russia," in *Empire and Society: New Approaches to Russian History*, ed. Teruyuki Hara and Kimitaka Matsuzato. (Sapporo: Slavic Research Centre, 1997), 1-22; Engelstein, *Castration and the Heavenly Kingdom*.

⁶⁶⁷ Engelstein, *Castration and the Heavenly Kingdom*, p. 51.

⁶⁶⁸ This claim continued well into the twentieth century. For example, the repeated use of the term "mystical madness" (which hardly explains why self-castration became the central ritual of Skoptsy practice) in Cawadias, "Male Eunuchism Considered in the Light of the Historical Method", p. 24.

⁶⁶⁹ Engelstein, *Castration and the Heavenly Kingdom*, p. 19.

body.”⁶⁷⁰ This was, in itself, a deliberate but unnecessary reading of this passage of the Bible as allegory: indeed, a footnote in the same journal noted that the Vulgate used the verb “castraverunt” in this same passage, suggesting a literal interpretation. As Gary Taylor notes, it is perfectly possible to interpret the passage literally, and many of the early Christian teachers, such as Augustine and Clement of Alexandria, who *did* claim this passage to be allegorical, attacked similar readings of other parts of the Bible as heretical. Taylor concludes that this interpretation was necessary to resolve a conflict in the Bible that might cause problems with missionary conversion, as well as to explicitly reject pagan cults in which castration had been practised.⁶⁷¹

Whatever the explanation, it is certainly true that this passage was usually taught as allegorical well before the nineteenth century. Explanations as to why the Skoptsy reversed this interpretation were many and varied. Anthropologists attributed the existence of the sect to “the psychological peculiarity of the race of Moscovites, in which it prevails”.⁶⁷² Psychiatrists, and some lay writers, related acts to a “morbid condition”, while general newspapers and journals gave particular weight to cultural influences, such as the “want of intellectual nourishment” in Russia.⁶⁷³

Although the Skoptsy had existed for a hundred years previously, it was not until the late nineteenth century that the sect came to the attention of Western Europe, following a series of open trials in the late 1860s and early 1870s. These reports indicate the close relation made by Western commentators between castration and character. The trial of a wealthy gentleman named Plotitzine, reported in *The Times*, appeared in a number of local newspapers. As with the later case of Isaac Brooks (which some newspapers even compared to the Skoptsy),⁶⁷⁴ journalists shaped these stories into a mystery format, based on contemporary interest in – and suspicion of – secret societies.⁶⁷⁵ Thus, three papers titled the story “Russian Self-Mutilators and their Treasure”, claiming that the Skoptsy escaped persecution due to their great wealth and that it was “common practice to induce

⁶⁷⁰ I Kopernicky and J. B. Davis, "On the Strange Peculiarities Observed by a Religious Sect of Moscovites Called Scoptsis," *Journal of the Anthropological Society of London*, 8, (1870): 121-135, p. 134.

⁶⁷¹ Taylor, *Castration*, pp. 68-70.

⁶⁷² Kopernicky and Davis, "On the Strange Peculiarities Observed by a Religious Sect of Moscovites", p. 132.

⁶⁷³ Reporter, "London, Saturday 14 January 1882," *The Morning Post* (January 14, 1882): 4.; Berlin Correspondent, "A Russian Sect," *The Times*, April 8, 1869, 10, col D-10, col E.

⁶⁷⁴ Reporter, "London, Saturday 14 January 1882," *The Morning Post* (January 14, 1882): 4.

⁶⁷⁵ For more on the interest in secret societies, see Adams, *Dandies and Desert Saints*, chapter 2.

conversion by cash.”⁶⁷⁶ Such views of the Skoptsy were often based on anti-Semitic rhetoric. Engelstein notes that:

the Skoptsy suffered from comparison with the Jews, not the reverse. ... Portraying the Skoptsy as ferociously money-loving became a cliché of antisectarian writing. Having deprived themselves of human love and renounced all family ties, it was said, they devoted their energies to acquiring wealth.⁶⁷⁷

This was not by any means a foregone conclusion: after all, Krafft-Ebing regarded the sexual instinct as a requirement for the drive to acquiring wealth.⁶⁷⁸ It did, however, fit into western discourses that associated the sexual instinct with altruism and love for humanity, and the reverse with selfishness. In general, the Skoptsy came to be associated – socially, financially, and psychologically, as well as sexually – with a selfish way of life.

What's more, it was invariably the physical act of castration itself that was regarded to have changed the Skoptsy's character, as indicated in the above quote from Gyurkovichky, that the sect “changed for the worse” following castration.⁶⁷⁹ This was a common assumption about eunuchism in British evolutionary psychology. Darwin thought that eunuchs were inferior to other males,⁶⁸⁰ while Henry Maudsley declared with characteristic forthrightness that:

The physical degeneration of a sexual impotency is surely reflected in a corresponding moral degradation ... The perfect moral man must be of perfect physical development. Eunuchs are said to be the vilest creatures of the human race, cowards, deceitful, envious and vicious.⁶⁸¹

Thus, descriptions of the Skoptsy invariably vilified them for their secrecy and love of gain, without wondering whether this was true or, even if it was, it might have been created by their life of exile, rather than castration itself.⁶⁸² Moreover, this view also insisted that even an allegorical reading of the biblical injunction was “unnatural” in modern society, and that “enforced celibacy” was a social problem. Russian writer Evgeny Pelikan was particularly influential in such portrayals of the Skoptsy in the West. Pelikan (1824 – 1884) was a professor of forensic medicine at St Petersburg, and his use of case studies emerged from

⁶⁷⁶ *Sheffield & Rotherham Independent*, Friday, April 09, 1869; pg. 4; Issue 4910; *Glasgow Herald*, Monday, April 12, 1869; Issue 9134; *The Dundee Courier & Argus*, Thursday, April 15, 1869; Issue 4895. Berlin Correspondent, "A Russian Sect".

⁶⁷⁷ Engelstein, *Castration and the Heavenly Kingdom*, p. 69.

⁶⁷⁸ Krafft-Ebing, *Psychopathia Sexualis* (1999), p. 5.

⁶⁷⁹ Krafft-Ebing, *Psychopathia Sexualis* (1999), pp. 12-13.

⁶⁸⁰ Darwin, *The Descent of Man*, p. 585.

⁶⁸¹ Henry Maudsley, "The Genesis of Mind (II)," *Journal of Mental Science*, 8, (1862): 61-102, p. 90.

⁶⁸² This was just the suggestion made by Gavriil Prokopievich Men'shenin (1862 – 1930), a Skopets castrated before puberty and exiled to Siberia at the age of thirteen. Men'shenin prepared his own manuscript on Skoptsy life in 1900, “to counter the defamations of “researchers, past and present”. Engelstein, *Castration and the Heavenly Kingdom*, p. 143.

this medico-legal context. As many Skoptsy claimed at trial that they had been castrated "accidentally", Pelikan's writings focused on medical evidence which contradicted this, as well as providing details of other ways of physically identifying Skoptsy, whether castrated before or after puberty.⁶⁸³ The two forms of castration practised were thus detailed in his work. The "minor seal" involved removal of testicles and scrotum, while the major, or "royal", seal included amputation of the penis. Female Skoptsy also underwent a physical indoctrination: the breasts were scarred, and sometimes removed, as was the labia and, occasionally, the clitoris.⁶⁸⁴ Interest in the physical appearance of the Skoptsy was a major feature of attention in Western Europe. At the Anthropological Society, Barnard Davis showed an anatomical preparation "which exhibits the radical excision of the sexual organs of a male Scopts" in conjunction with "photographs ... of rich individual Scopts at Bucharest."⁶⁸⁵ Photographs were thought to evidence physiognomic change rather than the physiological effects of castration: thus showing the way castration altered character. Thus, Davis noted the "peculiar mildness and want of force in their countenances".⁶⁸⁶

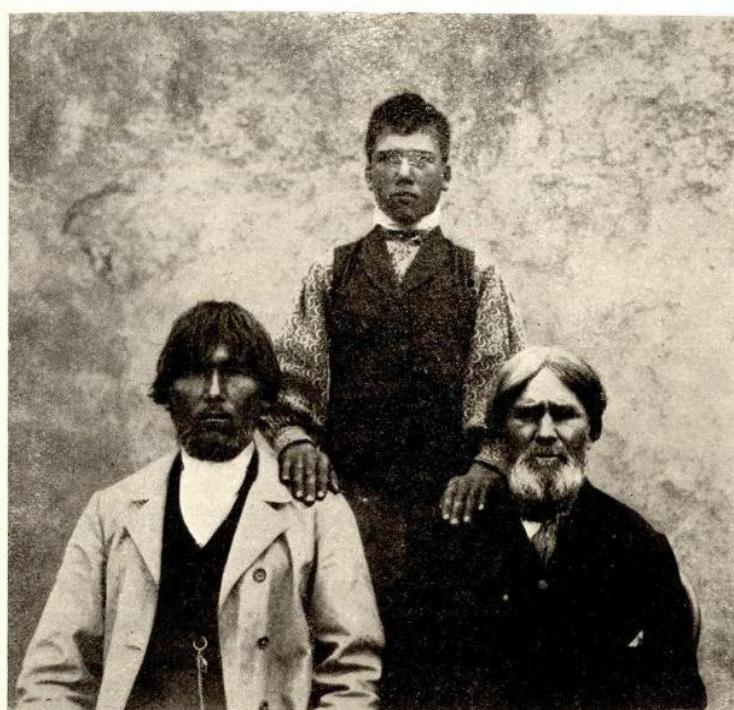


Figure 18: Photograph of three male Skoptsy in the early 1900s. The beards of the seated gentlemen indicate that they were castrated after puberty. Western photographs often depicted several generations, drawing attention to the differences in time of castration.
 (from Eugéne Pittard, *La castration chez l'homme*, (Paris: Masson, 1934), fig. 68)

⁶⁸³ For more on Pelikan, see Engelstein, *Castration and the Heavenly Kingdom*, pp. 60-8.

⁶⁸⁴ E. Pelikan, *Les Skoptzy*, trans. E. Teinturier, (Paris, 1877)

⁶⁸⁵ Kopernicky and Davis, "On the Strange Peculiarities Observed by a Religious Sect of Moscovites Called Scoptsis", p. 122; p. 124.

⁶⁸⁶ *Ibid.*, p. 124.

The examination of specimens, and the connections between physical, facial and behavioural change, tended to concentrate on the male Skoptsy. Although many of the trials analysed by Engelstein revealed as many mutilated female as male Skoptsy, and the two sexes were treated the same in Russian legal proceedings, it was the castration of the male that formed the topic of most discussion in the West.⁶⁸⁷ This was very similar to accounts of sexual self-mutilation in asylums. There were just as many instances of female genital self-injury as male in Bethlem during the last two decades of the nineteenth century, yet the only published article (discussed earlier) which referenced the topic in women was suggested to be unusual, and compared directly to the Brooks case to prove this.⁶⁸⁸ Sexual self-mutilation, it seems, spoke particularly to western commentators about the regulation of masculine sexual desire, and the role of sexuality in the creation of masculinity. This can be associated with the interest in same-sex relations, as outlined above (which also concentrated on men), in addition to concerns around masturbation. The male was more closely associated with his sex drive (not to be confused with reproductive capacity, which was seen as a greater physiological factor in women) than the female, and thus the social consequences of the loss of sexual function were deemed far greater in men than in women. Indeed, the element of Pelikan's text which particularly resounded with western commentators was his suggestion that the loss of sexual ability in the Skoptsy might be a source of social danger, for the regulation of sexual desire also controlled other elements of male behaviour.

Once he becomes sexually active, the normal man starts to find the opposite sex attractive: the first instinctive call of love also inspires him with the urge to noble action and great deeds and with devotion to the fatherland. The young man castrated before puberty knows none of this: he remains indifferent to his environment, lacking the smallest germ of noble aspiration, sense of duty, or civic obligation.⁶⁸⁹

This description certainly resonated in Western Europe, for it was not the religious or political context that English commentators reflected on, but rather the threat to society. "These fanatics," James Adam declared of all the "old religions of the East" were most

⁶⁸⁷ Although Gould and Pyle were so surprised by Pelikan's diagram of the "major seal" that they mistakenly classified it as showing the sex organs of a female Skoptsy. Gould and Pyle, *Anomalies and Curiosities of Medicine*, p. 758.

⁶⁸⁸ James C. Howden, "Notes of a Case - Mania followed by Hyperesthesia and Osteomalacia. Singular Family Tendency to Excessive Constipation and Self-Mutilation," *Journal of Mental Science*, 28, no. 121 (1882): 49-53. For the comparison to Brooks, see Warrington and Anon, "The Case of Isaac Brooks", p. 74.

⁶⁸⁹ Pelikan, quoted in Engelstein, "From Heresy to Harm", p. 12. Engelstein further notes that a number of other Russian writers of the period made the same connection. Engelstein, *Castration and the Heavenly Kingdom*, p. 156.

dangerous in having “withdrawn from the society of man”,⁶⁹⁰ while Charles Mercier claimed that the “orphan celibate” could not experience the “social emotions” of ethical and patriotic duty.⁶⁹¹ Such a description indicates once again why the supposed character of the Skoptsy was frequently associated with the physical act of castration. In addition to being perceived as evidence of “an intimate and natural bond between the psychological character of a race and its religious ideas and propensities”, the assumption that sexual desire was connected to altruistic behaviour made the reverse a foregone conclusion.⁶⁹² Thus, the Skoptsy “are in general very greedy, avaricious, but peaceful and sober.”⁶⁹³ Even when “eunuchism” had been re-classified as an “endocrine disease”, attention to the psychological profile continued to emphasise such traits. Although cast in post-psychoanalytic language, the psychological picture described by Cawadias in 1946 was nonetheless rooted in late-nineteenth-century assumptions about selfishness. Eunuchs, Cawadias claimed, usually show: “tendency to introversion with infantilistic traits and abnormalities of behaviour of ‘limelight’ nature due to over-compensation of inferiority complex.”⁶⁹⁴ In nineteenth-century terms, they had failed to develop the altruism associated with the acquisition of the normal sexual function during puberty. In such a context, the castrated man could not fail to be selfish, turning castration itself into an egotistical act.

4.7 Conclusion

While this chapter has drawn together a number of examples of self-castration and other forms of ritual mutilation, it should in no way be assumed that castration was a widespread procedure in late nineteenth-century Britain. Rather, I have sought here to account for what appears to be a much higher level of *discussion* of castration – particularly self-performed – than is evident in practice. Many of the writers cited in the fields of sexology and anthropology were not discussing castration *per se*, but using cases as examples to build entirely different arguments. Nonetheless, the way in which they framed the cases they *did* discuss provides an important context for understanding the definitions of self-mutilation created by alienists. In the first place, I have recognised the importance of case studies (in particular those of Isaac Brooks and Henry Halhed), within and outside the

⁶⁹⁰ Adam, "Self-Mutilation", p. 1147. Adam was not alone in this declaration. See also Anon, "On Moral and Criminal Epidemics," *The Journal of Psychological Medicine and Mental Pathology*, 9, no. 2 (1856): 240-281, p. 249.

⁶⁹¹ Charles Arthur Mercier, "A Classification of Feelings (part 3)," *Mind*, 10, no. 37 (1885): 1-26, p. 3.

⁶⁹² Kopernicky and Davis, "On the Strange Peculiarities Observed by a Religious Sect of Moscovites Called Scoptsis", p. 131.

⁶⁹³ *Ibid.*, p. 124.

⁶⁹⁴ Cawadias, "Male Eunuchism Considered in the Light of the Historical Method", p. 26.

asylum, in creating a concept of "sexual self-mutilation". The existence of such cases does not, however, indicate why castration was emphasised over other forms of self-mutilation, or why it acquired associations with a selfish, passive and introverted character. Neither can this be explained by the assumption that castration is "necessarily" about loss of masculinity. Indeed, the Victorian concern over masturbation challenges this notion, for castration – even where self-performed – could certainly be regarded as preferable to the slow death or decline into insanity often attributed to masturbation. A few physicians do appear to have suggested (or carried out at the behest of their patients) this radical cure, along with the lesser surgery of circumcision, well into the twentieth century. Within psychiatry, however, I have placed more emphasis on the increasing interest in psychological and sociological aetiologies of mental illness – particularly among those alienists most interested in self-mutilation. This perspective meant that physical therapies – such as castration and other forms of sexual surgery – no longer seemed therapeutically appropriate. Sexuality began to be considered a mental state, and thus more deeply embedded in the individual character than could be altered by surgical intervention. From this, it fell that the act of self-castration became viewed as pathological in and of itself.

Yet, in order to understand how the character of the eunuch could arouse such censure, the broader context of socio-evolutionary approaches to civilisation need to be taken into account. Like other male disorders, including hypochondriasis, masturbation and sexual perversion, castration in the late nineteenth century was claimed to alter the character of the individual, encouraging a selfish self-obsession, at times related to insanity. These concerns were strongly rooted in contemporary ideals of masculinity, of which self-control was an essential element. In the later nineteenth century, the acquisition of this control became increasingly connected with sexual health. As the individual developed sexually so, it was assumed, did he develop socially, so that the natural selfishness of the male sex would blossom into altruism. Self-castration, in this context, was presented as the ultimate act of selfish preoccupation: a refusal to perform a useful social function. Anthropological and sexological examples appeared to support this contention, claiming to provide evidence that castration altered the behaviour, leaving the eunuch passive, inert, disinterested in society and focused instead on personal gain. Thus, Isaac Brooks was claimed to be "just the type of man in whom all the evils of civilization seem to accumulate ... A solitary man, thinking himself misunderstood and neglected, building castles in the air, finding the times out of joint".⁶⁹⁵ Yet can we find it surprising if some individuals *did* end up

⁶⁹⁵ Warrington, "The Case of Isaac Brooks", *The Lancet*, p. 73.

exhibiting the very traits they were accused of? The words of one of the Skoptsy's most articulate spokesmen offer a poignant conclusion. Nikifor Petrovich Latyshev (1863 – c. 1939), a self-appointed chronicler of the sect, speculated in later life on the cause of hostility toward the Skoptsy.

Judging by my life, my proper life, I'm a great guy! My exemplary decent behaviour admits me everywhere. What qualities are missing for me to be accepted as human. Better be a drunk, a hooligan, roué, drifter, loafer or malingerer – but not castrated! Nothing is more shameful among humankind. I've felt this on my own hide for 75 years.⁶⁹⁶

That castration has not always been perceived to make a man less than human – or even less masculine – suggests that the topic of sexual self-mutilation in late nineteenth and early twentieth century England was related to concerns in a large number of other fields – psychiatric, psychological, anthropological and sexological. In the early twentieth century, it was still claimed that castration was a common self-operation in “psychotics and sexual perverts”, while psychoanalytic writers viewed castration as the fundamental form of self-mutilation.⁶⁹⁷ Today, self-harm in men is still often characterised as a feminine disorder, supported by ongoing attention to castration, which is now framed around the concept of gender identity disorder.⁶⁹⁸ The creation of this very diagnosis required certain other shifts in thought, in particular that outlined here: the re-framing of the “sexual instinct” from something that ought to be repressed and controlled to a vital force seen to uphold social, as well as individual and moral, life.

⁶⁹⁶ Letter from Latyshev to Stalin (December 22, 1938) translated in Engelstein, *Castration and the Heavenly Kingdom*, p. 229.

⁶⁹⁷ W. J. Bishop, "Some Historical Cases of Auto-Surgery," *Proceedings of the Scottish Society of the History of Medicine*, 1960-70, (1961): 23-32, p. 23; Menninger, *Man Against Himself*, p. 248.

⁶⁹⁸ Barbara J. Brickman, "'Delicate' Cutters: Gendered Self-Mutilation and Attractive Flesh in Medical Discourse," *Body & Society*, 10, no. 4 (2004): 87-111, p. 93.

Chapter Five

The Hysterical Maligner: Attention-Seeking and the Unconscious

At the Turn of the Twentieth Century

5.1 Introduction

Modern texts on self-harm often refer to a level of seeming manipulative intent within self-inflicted injury, generally from the viewpoint of clinicians and relatives.⁶⁹⁹ Such a view, it is suggested, may deny those who self-harm access to many treatment opportunities, stigmatising acts as inherently selfish, encapsulated in the negative concept of “attention seeking”. But how did the suggestion that inflicting damage on one’s own body might be manipulative of others arise? As this thesis has already indicated, the correlation of self-inflicted injury with selfishness was a complicated construct within late nineteenth-century psychiatry, entangled in a variety of other concerns. At the turn of the twentieth century, this ethos was most commonly articulated as a craving for sympathy, strongly associated with the medical diagnosis of hysteria. This concept was founded on preconceived notions of the traits exhibited by hysterical individuals, subsumed within late-nineteenth-century attention to the topic of malingering, which, as we have seen in chapter three, was increasingly extended from military to civilian populations across Europe in this period. This model assumed that the malingerer inflicted injury on him or herself in the pursuit of gain, an association that was extended to so-called “hysterical self-mutilation” through prior (masculine) notions of the emotional needs of women. In the early twentieth century, medical texts often differentiated between male and female self-mutilation. The former was portrayed as outright deception (for the purpose of avoiding duty or economic gain) and the latter as “unconscious malingering”.⁷⁰⁰ Nonetheless, as this chapter will show, such a distinction does not appear to have led to significant differences in treatment (in civilian populations at least), and the “maligner” and the “self-mutilator” were viewed as equally problematic.

In addition, I here explore the tensions between so-called somatic and psychological views of hysteria. While historians have generally viewed concepts of hysteria as “progressing” from the former to the latter, I question this process by indicating that mental

⁶⁹⁹ E. David Klonsky, "The Functions of Deliberate Self-Injury: A Review of the Evidence," *Clinical Psychology Review*, 27, (2007): 226-239; Kim L. Gratz, "Measurement of Deliberate Self-Harm: Preliminary Data on the Deliberate Self-Harm Inventory," *Journal of Psychopathology and Behavioral Assessment*, 23, no. 4 (2001): 253-263, p. 254.

⁷⁰⁰ Henry MacCormac, "Autophytic Dermatitis," *British Medical Journal*, 2, no. 4014 (1937): 1153-1155; Judson Bury, "The Physical Element in the Psycho-neuroses," *The Lancet*, 196, no. 5054 (1920): 66-68.

and bodily symptoms were frequently bound up together in nineteenth and early twentieth-century accounts of illness.⁷⁰¹ The distinction between mental and physical is often retrospectively imposed by historians, in particular through attention to certain elements of psychological medicine in isolation from other fields, ignoring the connections between psychiatry and other areas of medical practice. In this chapter, then, I approach concepts of the mind/body relation more generally, through a perhaps unexpected field: that of dermatology. Dermatologists were often interested in exploring possible mental elements to skin conditions, and many seem to have promoted links between their own field and psychological medicine. The distinction between mental and physical illness, however, was by no means an easy or obvious one to make. By exploring dermatological records, I indicate just how much might be missed by the historian specialising on too-narrow concepts of psychiatry or psychological medicine in earlier periods.

This chapter begins by exploring the creation of a link between the diagnosis of hysteria and self-inflicted injury, and the way in which this connection built on, but also shaped, understandings of the hysterical individual. The notion of hysterical self-injury appears to have emerged from attention to the “fasting girls” of the mid-Victorian period, where abstinence, lesions (such as religious stigmata) and associated mental states were increasingly explained in physiological and behavioural, rather than spiritual, terms. These often contradictory explanations stemmed from a prior understanding that such cases must (and therefore *could*) be explained as “natural”. In reports of so-called “needle girls” in the later decades of the nineteenth century, it will be shown that these concerns promoted an increasingly gendered view of self-inflicted injury as an essentially female act. A physiological understanding of self-mutilation often minimised any claims made by the patient as to the meaning of his or her acts, portraying behaviour as resulting from nervous impulses beyond the patient’s control. The association of self-mutilation at the turn of the twentieth century with “unconscious” or “subconscious” impulses, however, did appear to advance exploration of the psyche by some practitioners. Yet, despite the explicit rejection by these practitioners of a somatic model of self-injury, the mental model they adopted showed many similarities to the neurological one. Unconscious motive, like nervous impulse, could be understood only by the doctor, and not the patient, from whom it was claimed to be hidden. However, those doctors who adopted a mental model of hysterical self-injury also related it to their

⁷⁰¹ For the “progressive” view, see Mark S. Micale, *Approaching Hysteria: Disease and its Interpretations*, (Princeton, N.J.: Princeton University Press, 1995); Mark S. Micale, *The Mind of Modernism: Medicine, Psychology, and the Cultural Arts in Europe and America, 1880-1940* (Stanford: Stanford University Press, 2004).

own efforts to change medical practice more generally. In rejecting materialism, doctors who emphasised the “psychical” nature of self-inflicted injuries also explicitly rejected *physical* treatment for hysteria, correlating the self-inflicted injuries of their patients with the “mutilating” operations supposedly carried out by surgeons. This attitude had certain points of contact with the asylum cases previously cited: in particular, the shifting position of self-mutilation from surgical “puzzle” (whereby detective-work in uncovering “deception” was equated with cure), to something deemed to hold emotional and social relevance above and beyond any physical damage to the body. By the 1920s and ‘30s, for writers in a variety of medical fields, self-mutilation was perceived as directly expressive of the inner life of the individual: “a reflection upon the skin of a disordered condition of the mind.”⁷⁰²

5.2 Self-Mutilation and Hysteria: From Sacred to Pathological Symptom

The connection between self-inflicted injury and the diagnosis of hysteria emerged in the mid nineteenth century, from medical re-evaluation of certain individuals whose behaviour might previously have been interpreted in spiritual terms. This section will explore the investigation of two cases of supposed religious phenomena, and the way in which these were claimed by doctors to indicate medical pathology. By rooting their explanations in the disorder of hysteria, doctors commenting on the cases of “Welsh Fasting Girl” Sarah Jacob, and Belgian stigmatic Louise Lateau emphasised a correlation between self-injury and nervous disorder. Their explanations, nonetheless, incorporated a wide variety of ideas, including efforts to explain this connection physiologically (in relation to the nerves) or psychologically (via the character of the individual). As has been repeatedly emphasised in this thesis, these ideas were not mutually exclusive and, in fact, can often be found side by side in texts. What’s more, treatment tended to emphasise a social and pastoral approach which continued to incorporate elements of the religious interpretation of behaviour, which thus remained bound up in medical understanding of so-called hysterical self-injury. Indeed, rather than necessarily indicating a conflict between science and religion, the adoption of a medical approach to phenomena previously regarded as spiritual might equally suggest a broader change in religious practice, whereby the belief that mortification of the flesh might purify the soul was discarded for the view that, instead, it damaged the inner self of the individual.⁷⁰³

⁷⁰² Henry MacCormac, "Autophytic Dermatitis," *British Medical Journal*, 2, no. 4014 (1937): 1153-1155, p. 1153.

⁷⁰³ For the background to this idea, see John O. Lyons, *The Invention of the Self: the Hinge of Consciousness in the Eighteenth Century*, (Carbondale: Southern Illinois University Press, 1978), p. 13.

The concept of hysteria has a lengthy history, which some historians have dated back to the oldest surviving documents in medical history, circa. 1900 B.C.⁷⁰⁴ It is also argued, however, that the concept of hysteria as a constant disease entity is problematic for, throughout the centuries, models of hysteria, and the symptoms presented by patients, have shifted. Indeed, the very *term* hysteria may be questionable. Helen King has noted that the attribution of the word to ancient texts was often added in nineteenth-century translations, reflecting the keen interest in both hysteria and the use of retrospective diagnosis in this period.⁷⁰⁵ In Ancient Greek medicine, according to King, there was no concept of hysteria, although later writers assumed that the Greek term had long been applied to a disorder thought to reside within the female reproductive anatomy. By the seventeenth century, however, doctors certainly regarded hysteria as a disease entity, and began to explore a neurological aetiology, setting hysteria as the female counterpart to male hypochondriasis (which was discussed in chapter two). Hysteria thus became a "neurosis": a disease of the nerves, rather than the womb. By the nineteenth century, this "nervous" model was well-established, and hysteria was regarded by many as a distinct and unchanging disease. Nonetheless, the medical concept of hysteria remained extremely broad: general practitioners, alienists, neurologists and surgeons were all involved in the treatment of hysterical patients, whose symptoms might vary from mild malaise or weakness to complaints of paralysis or cutaneous anaesthesia and the grand fits made famous by Charcot at the Salpêtrière in late nineteenth-century Paris.⁷⁰⁶ In practice, hysteria was often used as a means of explaining any phenomenon that did not fit neatly within an organic model of disease, and competing models of the disorder were often used in combination, so that practitioners might suggest a mix of neurological, behavioural and psychological interpretations of their patients' symptoms.

On science and religion, see Tess Cosslett, *Science and Religion in the Nineteenth Century* (Cambridge: Cambridge University Press, 1984); Ruth Harris, "The 'Unconscious' and Catholicism in France," *The Historical Journal*, 47, no. 2 (2004): 331-354.

⁷⁰⁴ Mark S. Micale, *Approaching Hysteria: Disease and its Interpretations* (Princeton: Princeton University Press, 1995), p. 19; see also Mark S. Micale, "Hysteria and Its Historiography - A Review of Past and Present Writings (I)," *History of Science*, 27, no. 77 (1989): 223-261; Mark S. Micale, "Hysteria and Its Historiography - A Review of Past and Present Writings (II)," *History of Science*, 27, no. 78 (1989): 319-351.

⁷⁰⁵ Helen King, "Once upon a Text: Hysteria from Hippocrates," in *Hysteria Beyond Freud*, ed. Sander L. Gilman et al. (Berkeley; Los Angeles; London: University of California Press, 1993), 3-90, p. 7.

⁷⁰⁶ For several different approaches, see Janet Oppenheim, *"Shattered Nerves": Doctors, Patients, and Depression in Victorian England* (New York: Oxford University Press, 1991); Micale, *Approaching Hysteria*; Edward Shorter, "Paralysis: The Rise and Fall of a "Hysterical" Symptom," *Journal of Social History*, 19, no. 4 (1986): 549-582.

Many of these explanations have been deemed essentially secular, a notion promoted by Charcot's famous retrospective diagnosis of hysteria in cases of magic and witchcraft in past centuries.⁷⁰⁷ It is instructive, therefore, to examine in greater depth the efforts of nineteenth century medical men to provide naturalistic explanations for certain phenomena, which subsequently became assumed to be self-inflicted injuries. An interest in explaining human behaviour as natural (rather than supernatural) has been viewed by many historians as central to scientific ideals of the mid and late nineteenth century, from evolutionary theory to anthropology.⁷⁰⁸ While it has been previously noted that such a shift should not be over-emphasised, it should also not be assumed that, where it did occur, these new frameworks were necessarily progressive. The teleological way in which historical accounts are often framed has tended to cast religious theories as unenlightened and repressive, while scientific ideas constitute a new "truth." Yet such a shift can equally cause the reverse, whereby an act that previously might have had positive spiritual meaning becomes viewed as pathological, and thus something to be prevented. After all, outside the medical realm, self-imposed abstinence did continue to receive a certain level of acceptance, as in the case of "fasting girls", although it is the medical diagnosis of "anorexia nervosa" that will be explored here.⁷⁰⁹ Named in 1873 by William Withey Gull in England and Charles Lèsegue in France, anorexia nervosa was viewed by physicians as somewhere between hysteria and outright insanity, although not conforming exactly to either state.⁷¹⁰ Although noting the patient's desire to refuse food, diagnosis of anorexia nervosa concentrated predominantly on physiological symptoms. Thus, in addition to a loss of appetite and emaciation, patients were described as suffering from absence of menstruation (amenorrhoea), low body temperature and hyperactivity.⁷¹¹ As Joan Jacobs Brumberg has noted, the emphasis on female symptoms (such as failure to menstruate), and the uncertain relationship with hysteria, meant that anorexia nervosa was frequently presented as a female disease. The best known "fasting girl" in Britain was Sarah Jacob, who became nationally famous in December 1868, having reportedly taken no food since October the

⁷⁰⁷ Jean-Martin Charcot and Paul Marie Louis Pierre Richer, *Les démoniaques dans l'art*, (Paris: Delahaye et Lecrosnier, 1887). This approach was also adopted in Britain. See, for example, Sydney Coupland, "Hysterical Anaesthesia," *The Lancet*, 110, no. 2827 (1877): 644-645.

⁷⁰⁸ See George W. Stocking, *Victorian Anthropology* (New York; London: Free Press; Collier Macmillan, 1987); Thomas Dixon, *From Passions to Emotions: the Creation of a Secular Psychological Category*, (Cambridge: Cambridge University Press, 2003).

⁷⁰⁹ Joan Jacobs Brumberg, *Fasting Girls: the Emergence of Anorexia Nervosa as a Modern Disease*, (Cambridge, Mass: Harvard University Press, 1988); Walter Vandereycken and Ron van Deth, *From Fasting Saints to Anorexic Girls: the History of Self-Starvation*, (London: Athlone, 1994).

⁷¹⁰ William W. Gull, "Anorexia Nervosa," *The Lancet*, 131, no. 3368 (1888): 516-517; Dr. Laségue, "On Hysterical Anorexia," *Medical Times and Gazette*, II, (1873): 265.

⁷¹¹ Brumberg, *Fasting Girls*, pp. 139-40.

previous year. Her case was frequently outlined in the medical press as an incidence of fraud, and investigated by a team from Guy's Hospital. During the investigation Sarah Jacob died, and a widespread refusal to accept the spiritual explanations put forward by Sarah's parents and other believers was legally endorsed when the parents were found guilty of manslaughter.⁷¹²

The case of the Welsh Fasting Girl was effectively concluded by Sarah Jacob's death, regarded by many as incontrovertible proof that she was, indeed, bound by natural laws, even if no one had been able to discover the means by which Sarah had been kept alive prior to the investigation. The *British Medical Journal* went so far as to uphold Sarah as a martyr of science, suggesting that her death was "almost necessary" in order to dispel the convictions of the "ignorant and unreasoning multitude."⁷¹³ This indicates a ready acceptance within the medical profession to transport religious concerns wholesale into the medical arena. Thus, self-imposed abstinence or other forms of "martyrdom" were cast as pathological, encouraging emphasis on physiology rather than motive. This can be seen still more clearly in the investigation of religious stigmata, which caused more explicit associations between self-inflicted injury and religious phenomena. In the year Sarah Jacob died, the Belgian medical profession began to investigate a strange case of supposedly miraculous bodily transformation: the stigmata of a young seamstress, Louise Lateau. Born in January 1850 to a "humble" family in the village of Bois d'Haine, Louise had grown up in poverty after the early death of her father: all medical accounts described the privations the family had faced, as well as the hard work Louise in particular had undertaken, from caring for a crippled neighbour at the age of eight, to entering service at eleven.⁷¹⁴ This, it was widely believed, had caused the "low" state of Louise's nervous system, such that remarkable physiological changes could occur. Louise was sixteen when she began to exhibit stigmata, first bleeding from the side, then the feet and, in a few weeks, the hands as well; soon, this was accompanied by ecstatic trances.⁷¹⁵ As in many similar investigations of the period, including that of Sarah Jacob, the investigation here was prompted by the Church, apparently concerned by the excitement provoked by a "miracle" in an uneducated peasant girl. The investigator appointed was an alienist from Louvain, Dr Lefebvre, suggesting the

⁷¹² Robert Fowler, *A Complete History of the Case of the Welsh Fasting-Girl, Sarah Jacob*, (London: Henry Renshaw, 1871).

⁷¹³ "Ecstasy and Stigmatism," *British Medical Journal*, 1, no. 540 (1871): 479-480, p. 479.

⁷¹⁴ George E. Day, "Louise Lateau: a Biological Study," *Macmillan's Magazine*, 23, no. 138 (1871): 488-498; "Ecstasy and Stigmatism"; "Louise Lateau," *The Lancet*, 97, no. 2486 (1871): 543-544.

⁷¹⁵ Day, "Louise Lateau: a Biological Study", p.489.

existence of the preconceived idea that the symptoms were associated with mental or nervous illness.

The assumption, as in the Sarah Jacob case, was that Louise's stigmata were evidence of fraud, and such challenges continued to be made throughout the debate; Lefebvre stated that his own initial hypothesis had been one of deceit.⁷¹⁶ Yet the physician quickly changed his mind, through a combination of intuition and experiment. He regarded Lateau as reliable and hardworking, and therefore unlikely to resort to deliberate deception; what's more, her lack of education (she could barely read or write) suggested to the doctor that Louise would be incapable of deceiving an intelligent, scientific physician: a conclusion accepted by many medical commentators in England.⁷¹⁷ Lefebvre also found great difficulty in reproducing the phenomena Louise exhibited. In a series of what *The Lancet* thought "rather cruel and very unnecessary tests", Lefebvre applied various caustics to Lateau's skin, yet was unable to create a wound similar to those from which she bled.⁷¹⁸ The suggestion implicit in these tests was, of course, that the wounds were self-inflicted, and much of the medical profession refused to accept Lefebvre's conclusion that they were not.

The case provoked much interest, in Belgium and France, but also across the channel in Britain. In France, a pervading anti-clericalism frequently encouraged parallels with hysteria. Désiré Bourneville, a supporter of the famous neurologist Jean-Martin Charcot, compared Louise to one of Charcot's hysterical patients who suffered from a similar form of bleeding.⁷¹⁹ Other writers in the next few decades similarly dismissed the religious context of mortification by comparing ancient Saints to modern criminal cases of self-mutilation.⁷²⁰ In British responses to the Lateau case, the suggestion of self-inflicted injury was frequently explicit. The *British Medical Journal*, for example, criticised one of Lefebvre's tests – that of securing Louise's hands in thick leather gloves before the stigmata appeared – by reference to a case of self-mutilation treated by Henry Lee, a surgeon at St. George's Hospital. Lee's patient was an unmarried teenage seamstress, admitted with a discoloured bleeding patch on the right leg. Observing "fresh red spots and effusion of blood" each time he saw his patient, Lee ordered a sheet of lead to be secured over the skin. He reported:

⁷¹⁶ *ibid.* See also J.M. Ferdinand, Lefebvre et al. *Louise Lateau of Bois d'Haine, her Life, her Ecstasies, and her Stigmata: A Medical Study*, trans. Charles J. Bowen and E. MacKey, ed. James Spencer Northcote (London: London, 1873), p.35.

⁷¹⁷ Day, "Louise Lateau: a Biological Study", pp. 494-5.

⁷¹⁸ "Louise Lateau", p. 543.

⁷¹⁹ Désiré Magloire Bourneville, *Science et miracle: Louise Lateau, ou la stigmatisée belge*, (Paris, 1875).

⁷²⁰ Ward A. Holden, "Self-Mutilation of the Eyes by an Ancient Saint and a Modern Sinner," *Proceedings of the Charaka Club*, 2, (1906): 55-57.

On the next visit, when the dressings were removed, there were few spots and little blood, but the sheet of lead was found to be pierced with holes large enough to admit a needle. When asked how this had happened, she was silent, and she was discharged as a convicted imposter.⁷²¹

That a needle could, similarly, have been used by Louise Lateau to perforate her leather gloves and injure her hands was the writer's obvious claim: thus, he remarked, the minute points of blood on the girl's forehead were "probably needle-points" (although he had no evidence to prove this). Thus Lee used comparison with proven cases of self-mutilation to cast doubt on Lefebvre's conclusion that, when Louise's gloves were removed and found to be filled with blood, this proved that the stigmata were not self-induced.⁷²²

Writers in this journal seemingly remained wedded to the thesis of hysterical imposture: four years after the initial case was reported, a further suggestion was printed (with no reference as to the source) that Lateau "frequently rubs and scratches with her nails and with a rough cloth ... and keeps up on these spots, even mechanically during sleep."⁷²³ Moreover, a full two decades later, a review of Gould and Pyle's *Anomalies and Curiosities of Medicine* complained that: "In speaking of "stigmata," the case of Louise Lateau is quoted, but nothing is said of the scientific controversies which make the case celebrated in the records of hysterical imposture."⁷²⁴ Such a firm declaration was made despite the fact that, neither in the *British Medical Journal* nor anywhere else, was it ever determined how Louise might be (if indeed she was) inflicting wounds upon herself. This certainty that the stigmata were the result of fraud was not, however, shared by writers in *The Lancet*, and publications within psychological medicine also tended to the latter view. Although the *BMJ* was at pains to admit "the great influence of the nervous system upon the circulation",⁷²⁵ their writers insisted that stigmata could not be produced by this effect alone. In this respect, they took issue with the explanation posited in *The Lancet*, which ascribed all of Louise Lateau's symptoms to the effects of the imagination upon the human body:

The general law is quite clear, that the direction of attention upon any part or parts of the body may be followed by all manner of nervous and vascular changes; that this attention, in order to be effectual, must be automatic and complete; and that it most readily becomes so in uneducated persons, who have never gained from mental training the power to control the operations of the mind.⁷²⁶

⁷²¹ "Ecstasy and Stigmatism", p. 479.

⁷²² Day, "Louise Lateau: a Biological Study", p. 496.

⁷²³ "News of Louise Lateau," *British Medical Journal*, 2, no. 773 (1875): 533.

⁷²⁴ "Review: Anomalies and Curiosities of Medicine," *British Medical Journal*, 1, no. 1940 (1898): 629-630, p. 630.

⁷²⁵ "Ecstasy and Stigmatism", p. 479.

⁷²⁶ "Louise Lateau", p. 543.

This approach was heavily indebted to the mid nineteenth-century physiology explored in chapter one, and the article cited W.B. Carpenter as an influence. Thus, we can view the emergence of definitions of hysterical self-mutilation as part of an ethos in which, on the one hand, volition and self-control and, on the other, brain biology, were emphasised within both scientific and popular language. Towards the end of the century, many of these concerns were incorporated into the concept of hypnotic blistering: various writers in Continental Europe claimed to have produced blisters on the skin of their patients by making the suggestion that a burn had been received during hypnosis, an approach that emerged from the “self-suggestion” of well-known hysterics like Louis Vivé, who had caused his own stigmata.⁷²⁷ These experiments, as we shall see, formed an important backdrop to later interest in feigned skin disease, the so-called *dermatitis artefacta*.

Yet physiological and neurological explanations of the connection between mind and body held an uneasy status, for critics claimed they failed to allow for the existence of free will.⁷²⁸ Evolutionary explanations, such as those described in chapter two, offered a new perspective, which allowed volition (characterised as the ability to control the operations of the mind) to form one of the “higher” functions, thus lacking in the uneducated, like Louise Lateau. This view was emphasised in *The Lancet*’s physiological explanation while, in the one *BMJ* article that gave the role of imagination a greater emphasis, Louise was described as “accustomed from her earliest infancy to the more than frugal regimen of the Hindoos.”⁷²⁹ Thus, despite the fact that those who had met Lateau invariably described her as “unemotional and unimaginative”,⁷³⁰ English and American doctors repeatedly endowed her with the impulsive and emotional tendencies attributed to savages. These traits, it was believed, were exacerbated by religious teaching. American specialist in mental diseases Meredith Clymer insisted that such afflictions were most common in persons “of warm imagination, of delicate frame, and of excitable temperament, and who have prepared distempered and willing nervous centres by persistent medication of religious matter,

⁷²⁷ Alan Gauld, *A History of Hypnotism*, (Cambridge; New York: Cambridge University Press, 1992), pp. 459-464; Léon Chertok, *Sense and Nonsense in Psychotherapy: the Challenge of Hypnosis*, (Oxford: Pergamon, 1981); F. W. H. Myers, “On Telepathic Hypnotism and its Relation to Other Forms of Hypnotic Suggestion,” *Proceedings of the Society for Psychical Research*, 4, (1887): 127-188, p. 166.

⁷²⁸ Smith, *Inhibition*, p. 18; Roger Smith, “The Physiology of the Will: Mind, Body, and Psychology in the Periodical Literature, 1855-1875,” in *Science Serialized: Representation of the Sciences in Nineteenth-Century Periodicals*, ed. G. N. Cantor and Sally Shuttleworth (Cambridge, Mass.; London: MIT Press, 2004), 81-110.

⁷²⁹ Nestor Charbonnier, “Louise Lateau and the Disease of the Mystics,” *British Medical Journal*, 2, no. 708 (1874): 116-117.

⁷³⁰ Lefebvre, *Louise Lateau of Bois d'Haine*; Day, “Louise Lateau: a Biological Study”, p. 490.

together with the discipline of long fastings and general mortification of the flesh.”⁷³¹ Thus, religious belief was, for many doctors, the *cause* of the strange physiological changes in Lateau’s body, just as church commentators might have argued. The major difference between the two explanations was that, rather than having been created by a deity (and therefore being of mystical significance), for doctors the stigmata were evidence of internally-produced *pathological* change, and thus undesirable.

This led some doctors to the conclusion that religious belief itself contradicted the laws of health. While some physicians, like Clymer, emphasised the relation of stigmata to Catholicism, others suggested that religion might cause self-mutilation in Catholic countries (through an emphasis on mortification) and Protestant ones (via the introspective nature of religious observance, which led to an excessive focus on the self).⁷³² The Protestant perspective was reflected in claims by *The Lancet* that Lateau’s “reserved temperament” had led her to fix her mind so strongly on her religious devotions that stigmata had been the result, for, “in her little world, ... [religious devotion had] nothing else to contend [with].”⁷³³ The extreme effect of religious observance upon the body was again asserted in an article three years later, when a Dr Richardson reported to the Medical Society of London “that in certain ... cases [of stigmata] the influence of the mind upon the heart was quite sufficient to excite such an over-action of the circulation as would cause a temporary exudation of blood.”⁷³⁴ There were, of course, dissenting voices to this pathologisation of religion. Certain alienists, for example, continued to regard religious pursuits as an important element of human life. For such writers, religious observance was portrayed as an intellectual, rather than an emotional, exercise. In the second edition of *Illustrations of the Influence of the Mind Upon the Body*, Daniel Hack Tuke added the Lateau case to his examples of the influence of the intellect on the involuntary muscles (and not, as might have been expected, in his far larger section on “the emotions”). Rather than viewing Louise’s uneducated and emotional state as responsible for her stigmata, Tuke saw them as evidence of her deep devotion and faith. Although he, nonetheless, interpreted the physical change as pathological, his report indicates that even among the medical profession, religious faith in this period was not always viewed as emotional and irrational, but could instead be

⁷³¹ Meredith Clymer, “Notes of Ecstasy and other Dramatic Disorders of the Nervous System,” *Journal of Psychological Medicine*, 4, no. 4 (1870): 657-688, p. 660.

⁷³² G. Fielding Blandford, “Prevention of Insanity (Prophylaxis),” in *A Dictionary of Psychological Medicine*, ed. Daniel Hack Tuke (London: J. & A. Churchill, 1892), 996-1002.

⁷³³ “Louise Lateau”, p. 544.

⁷³⁴ Dr. Richardson, “Pathological Explanation of Louise Lateau’s Case,” *The Lancet*, 104, no. 2674 (1874): 778.

regarded as an intellectual exercise, closely associated with the imagination which “stirs, through the operation of Sympathy, the whole being to its depths.”⁷³⁵

Although differing interpretations of the Louise Lateau case were thus possible, even within a medical context, the suggestion that Lateau might have inflicted injuries upon herself caused many doctors to form a direct link between cases of stigmata and self-mutilation, albeit one that was complicated by physiological explanations: even Tuke separated “genuine” stigmata from those “caused by mechanical irritation”.⁷³⁶ It was from this background that a distinction between intentional and nervous self-injury emerged: a physiological model that later became transported into the psychological distinction between conscious and unconscious injury. In 1873, a case in California was reported by several newspapers, which declared – in a rather tongue-in-cheek manner – that it had been discovered that a certain Miss Collins was “herself the author of the stigmata, which she produced by a free use of her nails.”⁷³⁷ In the same year, another article in *The Lancet* cemented the link between stigmata and self-mutilation in a report claiming that stigmatising had become “a trade”.⁷³⁸ These links were made even by those who regarded Louise’s stigmata as the physiological manifestation of hysterical disease, for *Lancet* writers retained their emphasis on the imagination in Louise Lateau’s case. The assumption was that only certain types of individuals were susceptible to the direct manifestation of mental phenomena on the surface of the body, whether produced consciously or not. These traits were often attributed to a hysterical temperament, which increasingly became an accepted explanation for self-inflicted injury, in cases regarded as intentional and otherwise.⁷³⁹ Thus, while historical accounts of “malingering” have emphasised the importance of intentional deception, this tended to be less of an issue in concepts of hysterical self-mutilation.

5.3 Needle Girls: The Foreign Body and the Motiveless Maligner

The highly publicised cases of Sarah Jacob and Louise Lateau encouraged attention to self-mutilation in the medical records. The emergence of this interest from the re-interpretation of religious concerns, as well as contemporary physiological debate over the relationship between body and mind, is an important factor often lost in historical discussions of malingering, which tend to over-emphasise the role of economic and military

⁷³⁵ Daniel Hack Tuke, *Illustrations of the Influence of the Mind Upon the Body in Health and Disease*, (Philadelphia: H.C. Lea's Son & Co., 1884), pp. 115-120; p. 98.

⁷³⁶ Tuke, *Illustrations of the Influence of the Mind Upon the Body*, p. 115.

⁷³⁷ “An Authenticated Miracle”, *The Times*, Jan 21, 1874, p. 10.

⁷³⁸ “Louise Lateau,” *The Lancet*, 104, no. 2669 (1874): 604.

⁷³⁹ Brumberg, *Fasting Girls*, p. 140.

concerns. While the concept of malingering was certainly associated with both these contexts, as outlined in chapter three, it was also part of medical debate over the way in which body and mind functioned, and the relation of volition to health. In 1870, inspired by the death of the Welsh Fasting Girl the previous year, the *British Medical Journal* published a series of articles by practitioners on the topic of feigned disease and malingering. An editorial remarked that investigation of this topic had hitherto been confined to the simulation of disease in order to escape military service. Although this was not strictly the case,⁷⁴⁰ these articles certainly pre-dated *any* of the economic legislation outlined in chapter three. The majority of writers in the 1870s and beyond regarded "motiveless malingering" (as the *BMJ* termed it) as an entirely new topic of medical enquiry. The very terminology used here indicates an important element of the debate. Motiveless malingers were to be distinguished from those in whom the reason for self-inflicted injury was deemed obvious: evasion of duty or financial gain. By analogy to such contexts, however, the assumption was made that the hysterical patient *must* have an underlying motive for his or her injury. The term "motiveless malingering" was thus adopted for distinction's sake, while:

by no means intending to imply that the will ever really acts without motive, but merely that in these cases the motive cannot be quoted beforehand as explaining the act, but has to be sought after the fact has been established by other means.⁷⁴¹

Uncovering this motive, however, was a more complicated task than physical treatment of the wounds.

Prior to the Lateau and Jacob cases, surgical authors had given little thought to the reasons behind their patients' actions, as indicated in many of the cases collated in Gould and Pyle's *Anomalies and Curiosities of Medicine*. Within a short section on "self-mutilation", the American doctors drew attention to the practice of so-called "needle girls". This name was, it seems, coined by the authors to play on widespread interest in the afore-mentioned "fasting girls" (on whom they also included a section): medical and popular editions were published in close proximity. Needle girls, Gould and Pyle stated, exhibited a "peculiar type of self-mutilation ... sometimes seen in hysterical persons" of "piercing their flesh with numerous needles or pins."⁷⁴² The descriptions included focused on the work of the surgical

⁷⁴⁰ Historians have indicated a number of occasions prior to the 1870s when civilian "malingering" had come to the fore (whether or not the term itself was used). See examples in Roger Cooter, "Malingering in Modernity: Psychological Scripts and Adversarial Encounters During the First World War," in *War, Medicine and Modernity*, ed. Roger Cooter, Mark Harrison, and Steve Sturdy. (Stroud: Sutton, 1999), 125-148.

⁷⁴¹ "Motiveless Malingers," *British Medical Journal*, 1, no. 470 (1870): 15-16, p. 15.

⁷⁴² George M. Gould and Walter L. Pyle, *Anomalies and Curiosities of Medicine* (London; Philadelphia: Rebman Publishing Co; W.B. Saunders, 1897), p. 735.

detective, rather than the patient, and any motives deemed to underlie self-inflicted injury were incorporated under the broad banner of hysteria, in itself regarded as sufficient explanation. In 1862, for example, Ernest Hart, surgeon to the West London Hospital reported a case under the telling title "Hysteria: Wilful Self-Infliction of Injury". Hart described a "young girl of good appearance and superior education", who entered the hospital with an abscess of the forefinger. From this abscess, the surgeon removed several pieces of needle and, although "no suspicion was then excited as to her peculiar habit ... there is little doubt that the needles were wilfully introduced and broken into the flesh." The end of the finger was eventually amputated; however, the patient continued to return regularly to the hospital, presenting damage to the stump. As evidence of her fickle, manipulative nature, Hart complained that: "At the same time she managed to have several of her teeth extracted, and was taking medicine as a physician's out-patient." Although his patient "energetically" denied producing the symptoms herself, Hart was convinced, and solved the problem by sealing the bandages.⁷⁴³

In Hart's analysis, as in other "needle girl" reports, the manipulative patient is clearly presented as controlling her situation. Even when she could be regarded as the passive recipient of damage inflicted by another – as in the surgical extraction of her teeth – Hart describes her as the active subject, "managing" the situation, until she is eventually outwitted by the surgeon's ingenious technical ability and forced to submit to medical cure, whereupon her moral management is off-loaded onto her relatives. Other surgeons continued to describe patients as "highly neurotic, sly, and deceitful,"⁷⁴⁴ and some concluded that any such case was evidence of "hysterical deception",⁷⁴⁵ making self-inflicted injury synonymous with deceit. This approach stemmed from the nineteenth century concept of the hysterical temperament, defined by such negative character traits.⁷⁴⁶ Ultimately, it was the ingenious nature of the protective surgical treatment – or the skill in removing foreign bodies – that was of more interest than the patient herself. Meanwhile,

⁷⁴³ Ernest Hart, "Hysteria: Wilful Self-Infliction of Injury," *The Lancet*, 79, no. 2014 (1862): 355, p. 355.

⁷⁴⁴ F. Bowreman Jessett, "A Case of Faecal Fistula due to Self-Mutilation Occurring Twice in the Same Patient," *The Lancet*, 148, no. 3818 (1896): 1213-1215, p. 1214.

⁷⁴⁵ Mr. Callender and Morrant Baker, "St Bartholomew's Hospital (Hysteria)," *The Lancet*, 100, no. 2551 (1872): 78-79, p. 78.

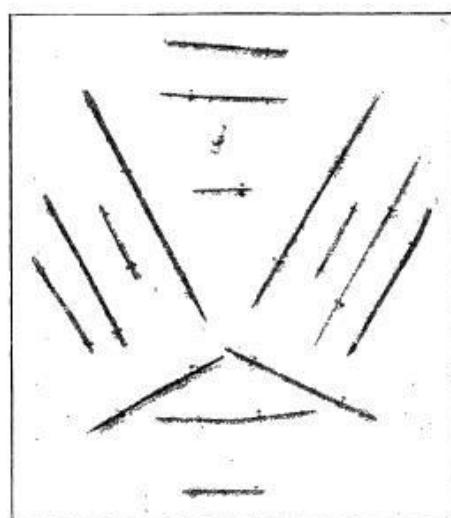
⁷⁴⁶ Micale, *Approaching Hysteria*, p. 24; Michael J. Clark, "'Morbid Introspection', Unsoundness of Mind, and British Psychological Medicine," in *The Anatomy of Madness*, ed. W. F. Bynum, Roy Porter, and Michael Shepherd, Vol.3 (London: Routledge, 1988), 71-101, p. 82; Carroll Smith-Rosenberg, *Disorderly Conduct: Visions of Gender in Victorian America*, (New York ; Oxford: Oxford University Press, 1986), pp. 205-7; Roy Porter, "Body and Mind, the Doctor and the Patient: Negotiating Hysteria," in *Hysteria Beyond Freud*, ed. Sander L. Gilman et al. (Berkeley; Los Angeles; London: University of California Press, 1993), 225-285, pp. 261-5.

any explanations for such acts tended to be rooted in character and situation, and did not necessarily offer a diagnosis of nervous illness.

[M]otiveless malingeringers ... are almost invariably of the class of those known as "hysterical". In other words, they are of the female sex, arrived at the age of puberty and unmarried. Hysterical in any more definite sense they seldom are; on the contrary, those guilty of these tricks have often been previously considered by their friends to be of remarkably calm and well-balanced temperament.⁷⁴⁷

The absence of nervous symptoms or a disposition to deceit caused problems for the physician in detecting such forms of malingering. Unlike the male malingeringer, who might give himself away with his suspicious manner or expression, the only way of uncovering the hysterical malingeringer was often in the wounds themselves: hence images, like figure 19 (below), focused on the objects removed, rather than the patient.

FIG. 1.



Needles removed at first operation. The reproduction of the photograph shows well the extent to which they were corroded.

Figure 19: Image from Nicoll's 'A Remarkable Case of Persistent Ingestion of Needles'⁷⁴⁸

It is thus in the records of general hospitals and specialist nervous institutions, rather than asylums, that we find early discussion of hysterical self-mutilation. Surgeons, not alienists, wrote most of the papers on the topic of foreign bodies, within which "needle girl" texts were subsumed, and it was surgeons who avidly added foreign body specimens to the collections of pathology museums.⁷⁴⁹ Although most surgeons, as has been seen, showed

⁷⁴⁷ "Motiveless Malingeringers", p. 16.

⁷⁴⁸ Reprinted from *The Lancet*, Vol. 171, no. 4411. Nicoll, Alexander, "A Remarkable Case of Persistent Ingestion of Needles," 772-778. Copyright (1908), with permission from Elsevier.

⁷⁴⁹ All pathology museums appear to have a number of specimens of this kind, collected mostly in the late nineteenth and early twentieth centuries. See Ian Fraser, "Foreign Bodies," *British Medical*

little interest in understanding the behaviour of their patients, the cases were later picked up in psychological medicine, and incorporated into the literature on self-mutilation. Moreover, a small number of elite practitioners *did* show some interest in attempting to explain the existence of foreign bodies in their publications. I thus explored the surgical case notes of the Royal London Hospital, from 1893 (when registers were first introduced, allowing “foreign bodies” cases to be easily isolated) until 1910, giving a total of 775 cases. This investigation quickly pointed to one discrepancy with the published reports, which assumed “needle girls” to be almost invariably female: in fact, more *male* than female patients were admitted to this hospital with foreign bodies (409 compared to 366). Unlike the cases treated by Chevalier Jackson in early twentieth century Philadelphia and described in Mary Cappello’s fascinating work of literary non-fiction, *Swallow*, the majority of foreign bodies cases admitted to the Royal London Hospital were teenagers or adults, even though the Hospital claimed to treat more children annually than “at the largest Children’s Hospital in London”.⁷⁵⁰ This meant that patients certainly could be considered *capable* of providing an explanation of the way in which the foreign body had been ingested or otherwise entered the body. Yet patient accounts appear to have been of little interest to most surgeons at the Royal London, who rarely took detailed case histories before attempting to remove the foreign body. These surgeons, it seems, almost never regarded the swallowing of foreign bodies as explicit evidence of “malingering”, and very rarely as a sign of insanity, nervous disorder, or other mental disturbance.

This makes it difficult to pick out cases that a modern reader might interpret as self-inflicted injury. Nonetheless, 46 instances most likely to be self-inflicted were extracted from the records by including cases in which multiple foreign bodies were removed from the same adult; repeat visits by a patient; reference in the notes to mental state; and all objects removed from urethra, vagina or rectum. Some of these latter cases were claimed to be – and perhaps were – accidental. In others, such as when a tallow candle was removed from the bladder of Elizabeth Waller in 1898, it is unclear whether the insertion of the object was carried out by the patient or someone else (with Elizabeth’s consent or not), and surgeons do not appear to have enquired. While recognising such issues, closer examination of these case notes does provide a useful comparison to published material. Fourteen of the cases (30%) were male, and most were relatively young (half were under 30, and ninety per cent under 40), and predominantly single (72%). This does appear to support the contentions of

Journal, 1, no. 4088 (1939): 967-971; Mary Cappello, *Swallow: Foreign Bodies, their Ingestion, Inspiration, and the Curious Doctor who Extracted Them*, (New York; London: New Press, 2011).

⁷⁵⁰ Cappello, *Swallow*; Royal London Hospital Annual Report, 1904, p. 16.

Gould and Pyle and others that “needle girls” (and, by extension, “hysterics”) were more likely to be young, unmarried, and female – although it should nonetheless remind us that there were certainly those who injured themselves while fitting none of those criteria.⁷⁵¹ Moreover, the overall numbers are very low, lending little support to the idea that “needle girl” phenomena were widespread. Indeed, it was rare for surgeons to draw explicit connections between the ingestion and insertion of foreign bodies and insanity, hysteria or other nervous disorders. Just *one* of all 775 foreign bodies cases in this period was referred to the Hospital’s physicians as a possible case of hysteria. This was a 66-year-old woman who had tried to relieve constipation by inserting a pen-holder into her rectum, which she claimed she had been doing for ten years – hardly conforming to the “needle girl” stereotype.⁷⁵² One other patient was suggested to be insane in 1898, a diagnosis that – as we shall shortly see – was queried on later admissions.⁷⁵³

Overall, surgeons showed little interest in the causes of their patients’ foreign bodies. “Foreign Body” was a diagnosis, not an exploration of the patient’s state of mind. When Rachel Taylor was admitted in 1900 – after swallowing a pin and a tin tack – and again in 1906 having swallowed two nails “the night before last”, it was not even noted whether either instance was accidental or intentional.⁷⁵⁴ Despite published concern over the abuse of charitable treatment by malingering, in practice this does not seem to have been a significant issue for either surgeons or physicians at the Royal London Hospital; for the latter, cases of “artefact injury” were treated without question whether or not the patient was receiving free treatment.⁷⁵⁵ Diagnosis appears to have been the topic of most interest to surgeons. Many of the foreign bodies case histories in the London Hospital (after 1896, when the X-ray was introduced) concentrate on the use of the “Röntgen Rays” or “skiagraph” to locate the object in question. In 1898, for example, little interest was shown in the fact that the X-ray images of 38-year-old domestic servant Elizabeth Quaife did not tally in the slightest with the history she gave.⁷⁵⁶ Elizabeth claimed that she had suffered pain in the knee joint ever since a long hat pin had run into her leg while she was sweeping under a bed: in hospital, however, five separate needles were discovered in the joint. Unlike published cases, the surgeon made no reference to the potential use of X-ray imagery to

⁷⁵¹ Gould and Pyle, *Anomalies and Curiosities of Medicine*, p. 735.

⁷⁵² Susan Trayte, Royal London Hospital Archives (RLHA), *Microfilm Case Records (Surgical)*, EVE F(emale)1906, pt. no. 876.

⁷⁵³ Beatrice Alliston, RLHA *Microfilm Case Records (Surgical)*, TREVES F1898, pt. no. 901.

⁷⁵⁴ Rachel Taylor, RLHA *Microfilm Case Records (Surgical)*, TAY F1900, pt. no. 2326 & FENWICK 1906, pt. no. 906.

⁷⁵⁵ Rose Liddiard, RLHA *Microfilm Case Records (Medical)*, F1907, pt. no. 2354.

⁷⁵⁶ Elizabeth Quaife, RLHA *Microfilm Case Records (Surgical)*, DEAN F1898, pt. no. 29 & 511.

detect fraud, but instead used the case to evaluate the usefulness of the technique itself.⁷⁵⁷ This, it was deemed, had been successful in locating and removing four needles but “the fifth needle shewed by the skiagraph was ... not found. It is probable that the figure shewed in the skiagraph was due to a shadow of the other needles. This, once more, shews that the skiagraph may be deceptive.”

There were, however, a minority of surgeons who were interested in explaining the presence of foreign bodies. In 1844, elite surgeon Sir Benjamin Collins Brodie published a paper on the topic, which included a great deal of discussion of subcutaneous needles, again suggesting this to be common. Brodie stated that there were two important points to be deciphered in such cases. Although he concentrated primarily on the first of these – the techniques for removal – he laid only a little less weight on his second: “how the needles got there.”⁷⁵⁸ Brodie’s interest in psychology (broadly defined by him as the “mutual relations of the physical organization and the mental faculties”) appears to have been an unusual one in surgery.⁷⁵⁹ Moreover, his efforts at explaining motives were not particularly subtle: most foreign body cases, he remarked disparagingly, occurred through carelessness or foolishness, and he dismissed one patient as a “monstrous blockhead”!⁷⁶⁰ As in the cases discussed by Mary Cappello, this emphasis on stupidity and accidental injury is not always borne out by the records, where a much wider variety of interpretations appear (including self-inflicted wounds and intentional violence by others).⁷⁶¹ However, the existence of such assumptions led many surgeons to ignore the issue of causation entirely. Even the writer of the *British Medical Journal* article on “motiveless malingerers” did not, it seems, expect to find the answer as to why patients “assume their maladies without any ostensible object in sight, and often to the destruction, apparently, of their social happiness”.⁷⁶²

There are, however, two case histories in the Royal London Hospital Archives in which we gain a fuller description of the background to the patient’s injuries: simply because both patients returned to the Hospital on a number of occasions. Daniel Prendergast⁷⁶³ was

⁷⁵⁷ Compare with an article of the following year: "Self-Inflicted Injuries Diagnosed by the Roentgen Rays," *The Lancet*, 153, no. 3955 (1899): 1668.

⁷⁵⁸ Benjamin Collins Brodie, "Extraction of Foreign Bodies," *The Lancet*, 1, no. 1063 (1844): 497-502, p. 500.

⁷⁵⁹ For evidence of Brodie’s broader interests, see: Benjamin Collins Brodie, *Psychological Inquiries* (London: Longman, Brown, Green and Longmans, 1855); Benjamin Collins Brodie, *Psychological inquiries, the 2nd part* (London: Longman, Green, Longman, 1862),

⁷⁶⁰ Brodie, "Extraction of Foreign Bodies", p.499.

⁷⁶¹ Cappello, *Swallow*, pp. 62-3; 105-10.

⁷⁶² "Motiveless Malingeringers," p. 15.

⁷⁶³ Or Pendegast – both are found in different volumes. On one occasion, the patient’s first name is recorded as “Anthony” in the admission register but “Daniel” in case notes and index. This might suggest the careless nature of record keeping or an intentional use of aliases by the patient. RLHA

first admitted to the Royal London in November 1906, and returned for further treatment in 1909 and 1910. Thirty-five years old when first admitted, Daniel claimed a history of fits, which had begun in 1900 while he was in South Africa, serving in the Boer War. Invalided home in 1901, it appears that the former soldier struggled to make ends meet: his prescriptions were stamped "no means" on every visit to the Hospital and, by 1909, he was recorded to be homeless. Perhaps this provoked scepticism over his shifting story: his reports to have "fallen among needles" are invariably reproduced in inverted commas. In 1906, Daniel claimed that he had had a fit while holding a packet of needles and "got some needles into himself", an explanation Brodie, at least, would have dismissed, for "[i]t is ridiculous to suppose that a paper of needles could run in by themselves".⁷⁶⁴ Two needles were discovered in the patient's thigh via a radiograph, although an operation failed to locate and remove them. Initially claiming the needles had entered only his hand and leg, when he returned to the Hospital in 1909, Daniel reportedly said that he had "[g]ot some into back, got some into legs, got some into left arm." Since his first visit to the Royal London, the patient had had needles removed at Birmingham, Guy's, Fleetwood and Pipton Hospitals.⁷⁶⁵

Had he been female, it seems possible that Daniel would have been regarded as hysterical. However, although male hysteria was a topic of some discussion during the nineteenth century, it was rarely emphasised in medical reports.⁷⁶⁶ This is apparent in the varying way in which patients were diagnosed at the Royal London Hospital, depending on gender. Figures 20 and 21 show the differing diagnoses of male and female patients. We can see that far higher numbers of male patients were deemed to be suffering from "mental diseases" (i.e. insanity) than from so-called "nervous diseases" (hysteria and hypochondriasis): this pattern is reversed in female patients.⁷⁶⁷ What's more, the higher number of male "malingeringers" *includes* some patients diagnosed with nervous symptoms. In

Microfilm Case Records (Surgical), RIGBY M1906, pt. no. 4223; OPENSHAW M1909, pt. no. 1347; DEAN M1910, pt. no. 1916. See also indexes and admission books for the same years (RLHLH/M/2/12, 15 & 16).

⁷⁶⁴ Brodie, "Extraction of Foreign Bodies", p. 500; Prendergast 1906 (as above).

⁷⁶⁵ Prendergast 1909 (as above).

⁷⁶⁶ Micale, for example, notes that while many of Charcot's patients were male, these were never emphasised in his published records. Mark S. Micale, "Charcot and the Idea of Hysteria in the Male: Gender, Mental Science, and Medical Diagnosis in Late Nineteenth-Century France," *Medical History*, 34, (1990): 363-411.

⁷⁶⁷ The sudden rise in nervous illnesses for both sexes in 1910 is due to the absorption into this category of cases of "neurasthenia", which had previously been included with "debility and marasmus". This indicates a shift in explanations of neurasthenia from organic to nervous causes, which is interesting in itself. On this topic, see also Ruth Taylor, "Death of Neurasthenia and its Psychological Reincarnation," *British Journal of Psychiatry*, 179, (2001): 550-557.

1904, for example, of the 11 male "malingeringers" at the Royal London Hospital, two were cases of "hysterical vomiting" and one had "hypochondriasis": both of which could have been incorporated under nervous disorders (as they always were in women).

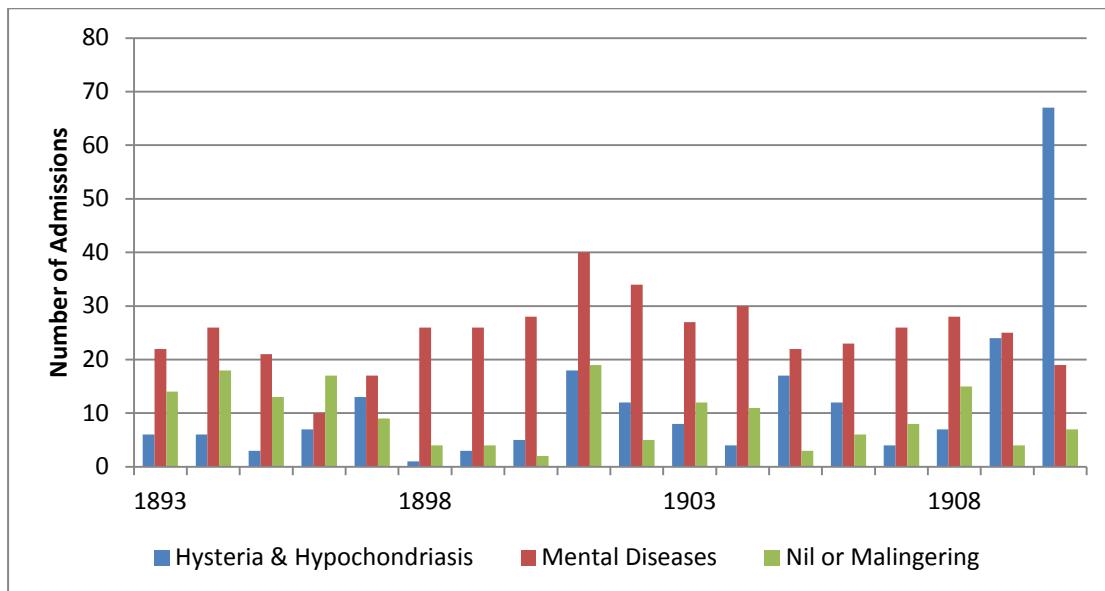


Figure 20: Graph showing diagnoses of male medical patients at the Royal London Hospital, 1893 - 1910

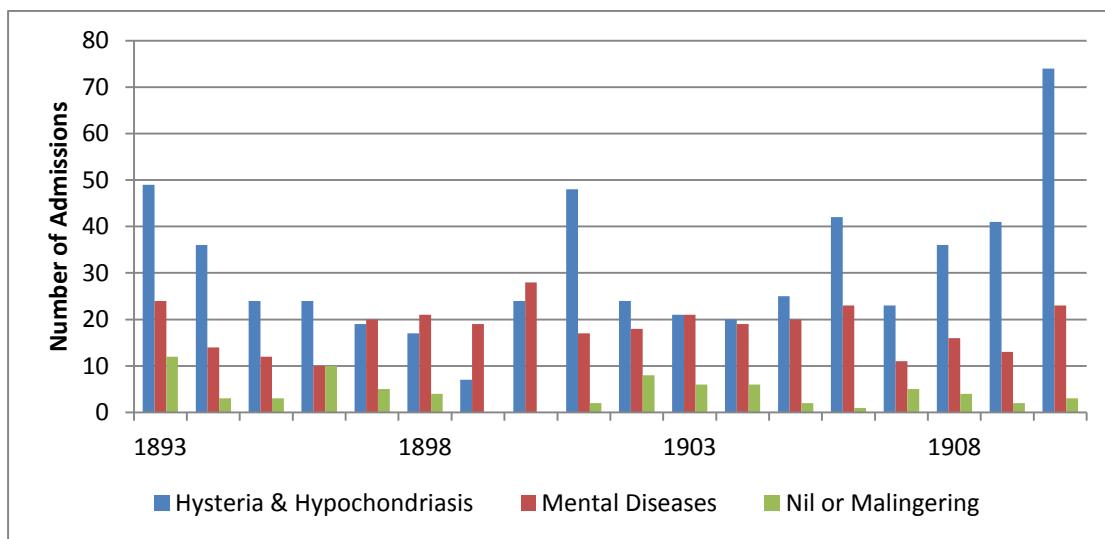


Figure 21: Graph showing diagnoses of female medical patients at the Royal London Hospital, 1893 - 1910

Thus, it may well have been because he did not fit the "needle girl" profile that it was never explicitly suggested that Daniel Prendergast was intentionally inserting needles into his body. Either way, his story is a tragic one. Over the years, Daniel suffered repeated operations to remove twenty-seven needles. In 1905, his front teeth and a portion of his tongue were removed after he had bitten it during a fit while in 1909, the extent of his operations (which had several times required skin grafts) led to the amputation of his left

arm. Small wonder that the doctors regularly found the “thin and haggard” man “in very poor spirits.”⁷⁶⁸ We will never know whether Daniel Prendergast’s experiences were a tragic consequence of epilepsy, a desperate effort by a homeless and friendless ex-soldier to put a roof over his head, or the result of mental imbalance. Either way, his case indicates the importance of the charitable hospital system to many impoverished individuals in a pre-welfare state, as well as the potentially devastating consequences of repeated medical intervention.

Like Daniel, Beatrice Alliston had a number of foreign bodies removed at the Royal London and other hospitals. Beatrice, however, readily admitted that she had intentionally inserted hairpins into her bladder. Between 1898 and 1909, Beatrice was admitted into the Hospital on four occasions, and it was noted on her first admission, then aged 24, that she “[h]as had foreign bodies removed thrice before.”⁷⁶⁹ Initially a waitress and later a milliner by trade, Beatrice appears to have been fairly educated: her letters, it was claimed, are “very skilfully done”.⁷⁷⁰ In 1898, the motive for the patient’s injury was regarded as obvious. Beatrice was the patient previously alluded to as insane: she is as “[m]ad as a hatter (Sister Mary says so)!”.⁷⁷¹ This diagnosis was presumably made on the basis that she admitted intentionally inserting a curling pin and doubled-up hairpin into her bladder. Nonetheless, Beatrice was discharged cured without being referred to a hospital physician or an asylum and, when readmitted in 1906, absolutely no reference was made to her mental state. Again, the hairpin was extracted and she was discharged: the rapid solution of a surgical puzzle evident in museum specimens, where more interest is often shown in the way in which the foreign body has been transformed by its journey than the patient’s experience of it. The below photograph, of a specimen from St Bartholomew’s Hospital Pathology Museum, shows a hairpin retained after its removal in 1882, because a calculus had formed around it while it had been in the bladder of a seventeen-year-old girl.

⁷⁶⁸ Prendergast 1909 (as above).

⁷⁶⁹ Beatrice Alliston, *RLHA Microfilm Case Records (Surgical)*, TREVES F1898, pt. no. 901.

⁷⁷⁰ Beatrice Alliston, *RLHA Microfilm Case Records (Surgical)*, HUTCHINSON F1909, pt. no. 1154.

⁷⁷¹ Alliston 1898 (as above).

Figure 22: Photograph of hairpin, removed from a patient's bladder in 1882, in the St Bartholomew's Hospital Pathology Collection

In 1909, Beatrice's case was described more extensively. Hinting in moralistic tones at malingering, following the statement that no symptoms of insanity had been observed, it was noted that “[t]his patient writes letters describing her case & purposely to be seen by a medical man. Once admitted & the hair pin is removed she will make full confession & solemn promises not to do it again.” Since it had already been indicated that she returned repeatedly, this note suggests the patient to be deceitful. Yet the description does not end here, for Beatrice was candid now that she was being asked about her behaviour. She informed the surgeons:

that she formerly suffered from an impulse to throw herself out [of] windows & once did it. Many years ago however she gave this up for the now harmless amusement of putting hairpins into her bladder. She was quite willing to discuss her mental state, says she has no other peculiarities and that the introduction of the hairpin has no relation to sexual feelings.⁷⁷²

This slightly odd explanation appears to have perturbed Beatrice Alliston's surgeons, located as it was somewhere between the rational and the irrational (inserting hairpins did indeed seem less dangerous than falling from a height: but why might she need to do *either*?). The

⁷⁷² See also *RLHA Microfilm Case Records (Surgical)*, FENWICK F1906, pt. no. 1695; OPENSHAW F1908, pt. no. 1814.

next time Beatrice appeared in the Receiving Room (about a month later), she was told she would not be admitted, and an offer was made (seemingly punitively) to remove the pin immediately, without anaesthetic. The patient refused and was sent away, seemingly lost to the medical record.

Again, it is impossible to draw any conclusions as to the psychological factors underlying Beatrice Alliston's peculiar "harmless amusement". What we *can* state, however, is that this record serves as a rare occurrence of surgical interest into the reasons behind self-inflicted injuries. In later decades, such cases led surgeons to suggest that the story of the foreign body offered "a wide field for the study of human nature".⁷⁷³ In 1909, however, the association of exploration of Beatrice's mental state with complaints about her failure to keep her word suggests that interest in her psychology was bound up in notions that the behaviour of the female (hysterical) patient was rooted in a "peculiar perversion of mind" for, as Brodie explained of needle girls, "[w]e know that hysterical women cheat in all manner of ways".⁷⁷⁴ Such concerns coloured much of the debate around hysterical mutilation, and were further complicated by the difficulty of drawing a line between hysteria and feigned illness, even in psychological texts. In the index of his 1905 textbook, Bethlem physician Maurice Craig linked self-mutilation directly with hysteria.⁷⁷⁵ Yet his remarks were off-hand and vague:

Suicide is often threatened, but rarely attempted On the other hand, hysterical individuals not uncommonly inflict injuries upon themselves, probably from a desire to obtain the sympathy of others.⁷⁷⁶

Craig, like his colleagues at Bethlem, was a lecturer in psychological medicine and, soon after the publication of his textbook, left the hospital to go into private practice. Like George Savage and Theo Hyslop, Craig was consulted by Virginia and Leonard Woolf, and was widely known as an elite practitioner specialising in the treatment of nervous diseases, including hysteria.⁷⁷⁷ Yet, even though his textbook began with a chapter on normal psychology, and a declaration that "sanity and insanity are both relative terms", Craig's comments on hysterical self-mutilation paid little attention to explaining or understanding the behaviour.⁷⁷⁸ He simply declared that it existed, and gave a "probable" explanation, couched, like those above, in preconceptions about the nature of the hysterical patient.

⁷⁷³ Fraser, "Foreign Bodies", p. 970.

⁷⁷⁴ Brodie, "Extraction of Foreign Bodies", p. 500.

⁷⁷⁵ Maurice Craig, *Psychological Medicine: A Manual on Mental Diseases for Practitioners and Students*, (London: J. & A. Churchill, 1905), p.449.

⁷⁷⁶ Craig, *Psychological Medicine*, pp. 267-8.

⁷⁷⁷ Craig was knighted in 1921 for his services to psychological medicine.

⁷⁷⁸ Craig, *Psychological Medicine*, p. 19.

In retrospect, we might well find the absence of much interest in *why* patients presented with swallowed or otherwise inserted foreign bodies surprising: particularly given the keen attention to the relation of mind and body within purported religious phenomena. Yet, although attention to Lateau and Jacob appears to have encouraged speculation about so-called needle girls, the latter cases were generally presented in a purely surgical context. For the surgeon, dealing with the immediate bodily problem was the concern, after which the patient could be discharged as cured. The separation between medical and surgical cases in the Royal London Hospital exacerbated this divide, and it was relatively rare for patients to pass from surgeon to physician and vice versa. For many of these surgeons, claims that their patients were hysterical seem to have been used simply to explain the difficulty in curing the immediate problem. Indeed, such an approach might also be taken by alienists, like Maurice Craig, who regarded the injuries themselves as outside their field of practice. Nonetheless, there are certain hints at a wider puzzle in some of the cases discussed. The example of Beatrice Alliston in particular indicates a growing belief that the question as to "why?" could not necessarily be answered by the patient, and solutions instead needed to be sought elsewhere. For certain physicians and alienists, if not necessarily surgeons, the concept of the unconscious became an increasingly popular response to this problem. This is most apparent in the treatment of so-called dermatitis artefacta.

5.4 The Psyche on the Skin: From Motiveless to Unconscious Malingering

In 1937, London dermatologist Henry MacCormac reviewed approaches to self-inflicted skin damage over the previous four decades. He suggested that "autophytic dermatitis" (more commonly called *dermatitis artefacta* or *dermatitis factitia*) was "by no means a modern phenomenon" although he nonetheless felt that "the strain and increasing effort which characterize present conditions have very clearly increased its incidence" - a frequent claim about self-inflicted injury throughout the twentieth century.⁷⁷⁹ MacCormac divided patients into four groups: Hysterical, Malingering, Mischief (predominantly attributed to children) and "Phantom Dermatoses" (this last was a patient's belief that a complaint was more extensive than the doctor perceived it to be). However, he spent far longer exploring the first class than the other three, in which, he claimed, investigation was

⁷⁷⁹ MacCormac, "Autophytic Dermatitis," p. 1153. For more recent claims about a rapid increase in self-harm, see Patricia A. Adler and Peter Adler, *The Tender Cut: Inside the Hidden World of Self-injury*, (New York; London: New York University Press, 2011).

relatively easy. “Hysterics” – whom he regarded as exhibiting both intentional and unintentional (“unconscious”) injuries – were a far more complicated issue.

Recognition and disclosure of the true state of affairs, far from bringing the matter to an end, in most cases only raises new and perplexing problems ... for these eruptive processes are not skin diseases as ordinarily understood, except in the malingering class, but rather a reflection upon the skin of a disordered condition of the mind.⁷⁸⁰

Unlike the surgeons of the late nineteenth and early twentieth-century Royal London Hospital, who regarded a case as closed once physical damage to a patient had been repaired, this opened up an entirely new realm, whereby physical and mental cure were no longer one and the same thing. Such a claim about the nature of self-inflicted lesions was by no means the only or most obvious one. Indeed, even within the context of asylum psychiatry, self-inflicted injury was not necessarily regarded as indicative of a patient’s state of mind. Nonetheless, this suggestion formed an increasingly popular means of understanding self-inflicted skin lesions in hysterical patients in the early twentieth century.

Many cases of *dermatitis artefacta* were collected by Frederick Parkes Weber, whose extensive papers are held in the Wellcome Library. Born in 1863, Frederick was the son of Sir Hermann Weber, a German who had moved to London and trained in medicine. Frederick followed his father into medical practice, training at St Bartholomew’s Hospital and, in 1894, gaining a post his father had also previously held as physician to the German Hospital in Dalston. Rather than separating material written by himself and others, much of Weber’s collection is organised by subject. These topics grew up around his own writings and interests, each bundle headed by a lengthy description, which often appears to have been added to over the years.⁷⁸¹ The collections thus span much of Weber’s career: his folder on self-mutilation includes newspaper and journal cuttings, case histories and other handwritten notes spanning the period 1894 – 1956. Self-mutilation did not form Weber’s only or main interest: the folder is just one of 360 “subject collections” in his papers. What’s more, like much of the nineteenth-century literature on self-mutilation already discussed, the collection was extremely broad. Weber’s full title incorporates:

Self-Mutilations for various purposes, Needle-swallowing &c. Hysterical Malingering, and Simulation or Aggravation of Symptoms without Hysteria. Psychasthenia and Morbid Impulsions, “Relief” or “Release” Phenomena of various classes, Dipsomania, Sitomania, Geophagia, Trichotillomania &c. Supposed Hysterical Skin-Eruptions, Hysterical Skin-Gangrene, &c. Skin eruptions and physical (bodily) changes of psychic

⁷⁸⁰ MacCormac, "Autophytic Dermatitis", p. 1155.

⁷⁸¹ For more biographical detail on Weber, his methods of compiling his collection, and its contents, see Lesley Hall, "Illustrations from the Wellcome Library: A "Remarkable Collection": The Papers of Frederick Parkes Weber FRCP (1863 - 1962)," *Medical History*, 45, (2001): 523-532.

origin. Also the subject of “foreign bodies” (for comparison). Rejuvenation operations and the question of the illegality of self-mutilation (Italy). Symptoms in skin, subcutaneous tissue, lungs &c. from mineral oils – “Siphoid pneumonia” from mineral and other oils. Male and female infibulation, “circumcision” &c. (for comparison).⁷⁸²

This broad array of references to self-inflicted injury and comparative cases (in which physical damage was either caused by others or thought due to the influence of the mind upon the body) indicates a far wider field than that covered by self-harm today.

Unlike the published material by alienists, which, as we have seen, tended to concentrate on major mutilations (however rarely such acts were, in fact, witnessed in asylums), the Weber archive includes a greater proportion of “minor” mutilations, in both dermatological publications and his own notes. When cases “for comparison” in which no self-inflicted injury occurred are removed from the list, we can see in Figure 23 (below) that the bulk of Weber’s notes deal with foreign bodies, trichotillomania,⁷⁸³ and – most prominently and dating back earliest – dermatitis artefacta.⁷⁸⁴

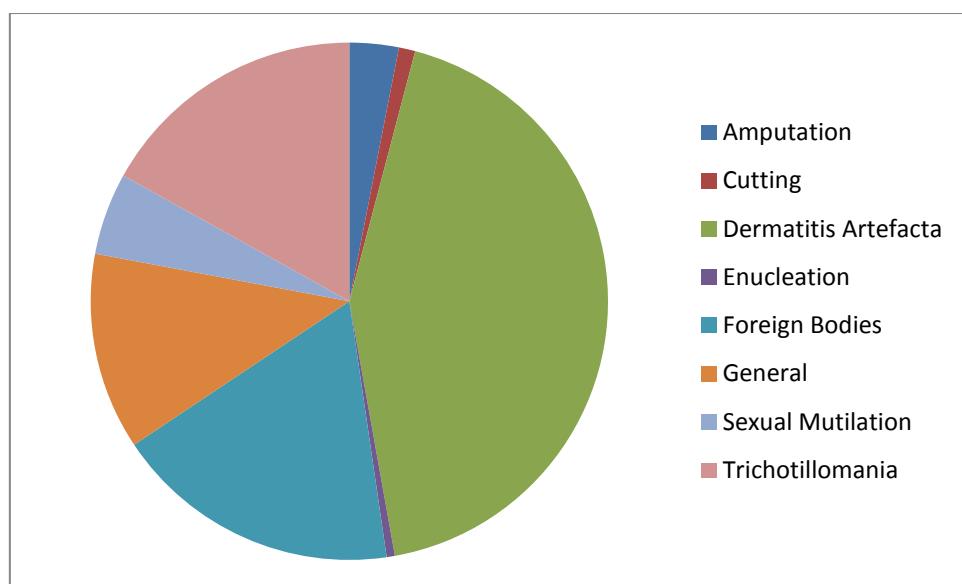


Figure 23: Graph showing the relative occurrence of different types of self-mutilation in the Parkes Weber Collection, c. 1894 – 1956

So, what was dermatitis artefacta, and why do these cases dominate Weber’s collection? The diagnosis appears to have emerged from the same debate that saw the collation of

⁷⁸² Wellcome Library London (WLL), *The Papers of Frederick Parkes Weber*, PP/FPW/B163/1.

⁷⁸³ This term appears to have been new to Weber in 1913, for he annotated several papers with its etymology.

⁷⁸⁴ Of these 84 cases, it should be noted that not all use this particular term, some preferring “neurotic gangrene”, “neurotic excoriation”, “dermatitis factitia” or the French term “pathomimie”. For ease of analysis, these have all been incorporated into the most frequently used term (and that adopted by Weber in his annotations), “dermatitis artefacta”.

needle girl cases. Of the papers on “motiveless malingering” published in the *British Medical Journal* in 1870, three dealt with “feigned or hysterical diseases of the skin”.⁷⁸⁵ Similar examples appear in dermatology textbooks and, at the end of the century, this form of self-inflicted injury was the only one to receive a special entry in Allbutt’s *System of Medicine*.⁷⁸⁶ Some physicians claimed that cases “were nearly always of the nature of mechanical or chemical irritation of the skin”, although others considered that lesions might appear spontaneously through a condition of mental distress: the effect of a peculiarly delicate state of both skin and imagination in neurotics.⁷⁸⁷

Indeed, even in 1936, the spontaneous emergence of skin lesions remained a consideration, as Holger Haxthausen noted in an article on “The Pathogenesis of Hysterical Skin-Affections”:

Even if the possibility be conceded that cutaneous affections of such “endogenous” causation may occur in hysteria, there is, however, no doubt that by far the majority of hysterical lesions of the skin are of external traumatic origin and belong to the group appropriately labelled *pathomimia*.⁷⁸⁸

Haxthausen’s emphasis here indicates that self-inflicted injury was strongly regarded as the most likely cause of unusual skin lesions by the 1930s. In tests similar to those *The Lancet* had called cruel in the Lateau case some 65 years earlier, Haxthausen tried six different irritants on the skin of his patients, claiming that in no instance was a different result obtained from that which would have occurred in the skin of normal persons (although he does not record how he verified this). In conclusion, he drew attention to a suggestion that had been regularly made throughout the literature on hysteria since the mid nineteenth century: “The intensity however with which the traumatization is conducted may be dependent perhaps upon the hyp- or analgesia so frequently to be noted in these patients.”⁷⁸⁹ This association of self-inflicted injury with cutaneous anaesthesia was a common assertion, although it had been discarded by many by the early twentieth century,

⁷⁸⁵ James Startin, "Remarks on Feigned or Hysterical Diseases of the Skin," *British Medical Journal*, 1, no. 471 (1870): 25-27; C. Hilton Fagge, "Notes on Some Feigned Cutaneous Affections," *British Medical Journal*, 1, no. 476 (1870): 151-152; Thomas Flower, "Feigned or Hysterical Disease of Skin," *British Medical Journal*, 1, no. 482 (1870): 307-308.

⁷⁸⁶ Erasmus Wilson, *Lectures on Dermatology* (London: J. & A. Churchill, 1875); Henry Radcliffe Crocker, *Diseases of the Skin: Their Description, Pathology, Diagnosis and Treatment*, (London, 1893), p. 288; Galloway, J. “Feigned Diseases of the Skin” in *A System of Medicine*, ed. T. Clifford Allbutt. vol. 8, London, 1899), pp. 937-9.

⁷⁸⁷ Galloway, “Feigned Diseases of the Skin”, p. 937; Wilson, *Lectures on Dermatology*.

⁷⁸⁸ H. Haxthausen, "The Pathogenesis of Hysterical Skin-Affections," *British Journal of Dermatology and Syphilography*, 48, (1936): 563-567, p. 563.

⁷⁸⁹ *ibid*, p. 566.

who claimed that anaesthesia was not as frequent a symptom of hysteria as had been previously claimed.⁷⁹⁰

The diagnosis of dermatitis artefacta produced two major topics of discussion among dermatologists. As with surgeons, the first issue was how to discover that lesions had been self-inflicted. Doctors pointed to the need for discovering the agent used, or surprising the patient in the act. However, the methods employed might be more ingenious. James Galloway claimed that lesions could be “interpreted readily”, preventing the need for relying on the character, mental condition and articulacy of the patient. Thus, lesions inflicted by a right-handed individual would be commonly found on the left side and in areas readily accessible. Sometimes they might display a pattern “as if the irritant had been applied by a bandage, or, conversely, had been used where the skin was left uncovered”; they might show the marks of nails or other instruments used. A fluid irritant might evidence spots or streaks where the liquid had dripped during application, as suggested in the diagram below, published by John Collie in 1916.⁷⁹¹



Figure 25: Diagram showing the pattern of a self-inflicted chemical burn⁷⁹²

This image, Collie claimed, showed the “typical trickle tail” pattern produced in self-inflicted chemical burns, where the caustic substance had run after being deliberately placed on the flesh. Collie himself had little interest in the many “physiological and psychological reasons ... why reasonable sane girls are found wilfully to produce troublesome, irritating diseases”, although he was sure that reasons existed.⁷⁹³ The very tone of this statement indicates his overall concern: putting a stop to the trouble and irritation caused by such patients, generally by proving that a wound had been self-inflicted. Unlike more general texts on

⁷⁹⁰ Sarah Chaney, "Anaesthetic Bodies and the Absence of Feeling: Pain and Self-Mutilation in Later Nineteenth-Century Psychiatry," *19: Interdisciplinary Studies in the Long Nineteenth Century*, forthcoming, (2012).

⁷⁹¹ Galloway, “Feigned Diseases of the Skin”, p. 937; John Collie, “Fraud and Skin Eruptions,” *The Lancet*, 188, no. 4868 (1916): 1008-1010, p. 1009.

⁷⁹² Reprinted from *The Lancet*, Vol. 188, no. 4868. ; John Collie, “Fraud and Skin Eruptions,” p. 1009. Copyright (1916), with permission from Elsevier.

⁷⁹³ Collie, “Fraud and Skin Eruptions”, p. 1009.

malingering, Collie laid little emphasis on examining the patient's manner and expression to uncover deception. This was likely due to the belief that the hysterical was capable of manipulating everyone around her, including her doctors, and thus the only clue as to the "real" nature of the injury was in the wound itself.⁷⁹⁴ Others claimed that even the patient might be unaware that the injuries were self-inflicted, meaning that attention to her wounds might be the only way of uncovering the artefact.

Indeed, "artefact" injuries were often treated in a very similar manner to other medical cases. Physicians concentrated on healing the wounds and, even when they instituted measures to prevent the patient from continuing to injure herself, this rarely seemed to involve confronting the patient directly. In 1905, twenty-nine-year-old dressmaker Esther Harwood was admitted to the Royal London Hospital under Dr F.J. Smith for possible "Congenital Aphasia of Aorta". Her case was quickly re-evaluated as "Factitious ulcers of leg & Hys etc". The order of the diagnosis indicates that while hysteria was considered to be an accompaniment of the factitious wounds, the ulcers themselves were the main focus of treatment. It seems to have been the number of times Esther had been admitted to the Hospital that aroused suspicion, as well as the shape of the ulcers themselves – oval, with "edges sharply punched out".⁷⁹⁵ Following her previous discharge in June 1904, Esther had been under more or less continual medical treatment, having spent four months at St Thomas' Hospital, followed by a period in a convalescent home. This time, her leg was put into plaster, a common technique to prevent a patient interfering with an injury, and it quickly healed. Esther was discharged on 11th May, after exactly a month in the Hospital: at no point in the case notes is it indicated that Smith or his deputies confronted her with the suspicion that her wounds were self-inflicted, and it seems entirely possible that this was never mentioned.⁷⁹⁶

Even patients suspected of malingering were often, as at Queen Square, treated as medical cases. When fifteen-year-old servant Rose Liddiard was admitted in September 1907, it was noted that "Dr Linnell of Poplar says that she is a fraud as she is able to dance & sing in the wards. When leaving Poplar she is said to have been heard to affirm 'Well it doesn't matter they will take me at the London.'" Indeed they did and, although a querying

⁷⁹⁴ S. E. Dore, "Report on a Case of Dermatitis Artefacta," *Proceedings of the Royal Society of Medicine (Dermatological Section)*, 19, (1926): 47-48, p. 48.

⁷⁹⁵ See RLHA, *Medical Index 1908*, LH/M/2/56, (Diseases of the Nervous System – Hysteria and Hypochondriasis); RLHA *Admission Register 1908*, LH/M/1/46, (female pt. no. 1983).

⁷⁹⁶ RLHA *Microfilm Case Records (Surgical)*, FJS F1905, pt. no. 766. For other cases in which physicians advise against accusing hysterical patients of malingering, see Craig, *Psychological Medicine*, p. 272; H. Haldin Davis, "Dermatitis Artefacta," *Clinical Journal*, 53, (1924): 211-216, p. 216; Letter Weber to Milligan, 11 Dec 1929, in WLL, *The Papers of Frederick Parkes Weber*, PP/FPW/B163/3.

note on her case file suggests “?Maligner” and that the “oedema of legs” might be “?artificial”, Rose was nonetheless diagnosed with Hysteria and remained at the Royal London for seventeen days. Her treatment was similar to other cases: diet, rest, and various medications (including Bromide, Strychnine and Magnesium Sulphate), as well as the application of the battery to her legs, a method commonly used at Queen Square.⁷⁹⁷ Rose’s case, stamped “free – no means”, also indicates that although malingering in published reports frequently held a class dimension, this is less obvious in practice. Published reports by those concerned about insurance fraud often judged working class patients more harshly than middle class hysterics as the former were regarded to have something more obvious to gain (charitable aid). Although we cannot judge how many patients who presented at the Royal London with injuries thought to be feigned were *not* admitted (or treated as outpatients, records for which do not survive), the fact that some were – and were treated even after their deception was uncovered – suggests that, in practice, working class patients with artefact injuries often received medical treatment.

In neither of these cases were attempts made to provide a psychological explanation for the “deceitful” actions or nature of the maligner. However, new psychological theories emerging on the continent appear to have been attractive to many dermatologists. There appear to be several reasons for the existence of this interest. First, the profession at this time was small but well-organised, particularly in London. A regular group, including Parkes Weber and MacCormac, among others mentioned, attended meetings of the Royal Society of Medicine Dermatology Section, where they discussed puzzling cases, including those of artificial dermatitis. In addition, these specialists frequently had difficult cases referred to them, which had been unsuccessfully treated by a variety of general and other practitioners: a number of these patients were subsequently diagnosed with *dermatitis artefacta*. Finally, there was a large body of literature on the connection between mind and body in skin diseases, frequently considered to be caused or exacerbated by mental conditions. Indeed, the interest in *dermatitis artefacta* seems to have arisen from this field, for many of the early writings focused on the topic discussed by Haxthausen, above, that neurotic patients might suffer a peculiarly sensitive skin that was easily damaged. Thus, dermatologists were often particularly interested in new psychological theories of hysteria.

While interest in the physical symptoms of dermatitis certainly continued, two important (and inter-connected) ideas which emerged from this approach to hysteria came

⁷⁹⁷ RLHA Microfilm Case Records (Surgical), DAWSON F190, pt. no. 2354.

to be associated with self-inflicted injury in Britain. First was the suggestion that self-mutilation might be performed “unconsciously”, so that the patient himself was not actually aware that he had done it. As we have seen in chapter three, these notions were firmly rooted in new psychological explanations for behaviour that attributed an important role to mental stimuli and contexts of which the patient was unaware. Today, this is most frequently attributed to Freudian psychoanalysis: however, it was in the psychotherapeutic approach of Pierre Janet that the connection of unconscious states to self-inflicted injury as explicitly made by British practitioners.⁷⁹⁸ Debate increased in the early twentieth century in relation to malingering, when it became assumed that this involved “conscious” simulation of illness, while the feigned element in hysteria was its counterpart in the “unconscious”. These concerns later became bound up in discussion of war neuroses during the First World War, a topic which has been extensively covered by Joanna Bourke, so will not be further explored here.⁷⁹⁹ I would like, however, to make the important point that psychological approaches to hysteria and self-inflicted injury in England certainly pre-dated the First World War, destabilising the position of the war as a watershed in British psychiatry and psychology.⁸⁰⁰ I will concentrate, however, on the second, closely related, implication of the use of Janet’s model of psychasthenia (obsessional behaviour) in hysterical self-injury: the concept of double personality.

This notion (variously called “double consciousness” or “multiple personality”) was explored within British psychiatry in chapter three. The idea that dermatitis artefacta was associated with “double personality” was promoted in England by dermatologist George Pernet. Born in London, Pernet was educated in Bonn, Edinburgh and Paris, and received his M.D. from the University of Paris in 1908, where he was no doubt exposed to French teaching on hysteria: he had certainly read Janet’s dissertation, *L’automatisme psychologique*.⁸⁰¹ An early member of the Dermatological Society of London, Pernet showed a number of cases of “dermatitis factitia”, and assisted others in the diagnoses of such cases.⁸⁰² By 1909, he claimed to have been interested in “the psychological aspect of dermatitis factitia” for “a good many years.” Invited to speak at a meeting of the American

⁷⁹⁸ Pierre Janet, "On the Pathogenesis of Some Impulsions," *The Journal of Abnormal Psychology*, (1906): 1-17. Indeed, the lack of material on the topic in a Freudian context is striking.

⁷⁹⁹ Bourke, *Dismembering the Male*.

⁸⁰⁰ Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980*, (London: Virago, 1987); Ben Shephard, *A War of Nerves*, (London: Jonathan Cape, 2000).

⁸⁰¹ "Obituary: George Pernet," *British Medical Journal*, 1, (1940): 113; George Pernet, "The Psychological Aspect of Dermatitis Factitia," *Transactions of the American Dermatological Association*, 30, (1909): 20-26, p. 21.

⁸⁰² Stanley Green, "Gastrostaxis, with Gangrene of Two Fingers of the Right Hand," *Proceedings of the Royal Society of Medicine (Dermatological Section)*, ii, no. 1 (1908): 8.

Dermatological Association, Pernet indicated the difficulty of untangling the underlying motive in such cases. His solution was to look to contemporary research on hysteria and unconscious acts, citing, in particular, Janet on multiple personality and the related concept of dissociation as taken up by Morton Prince and others.⁸⁰³ While a number of the physicians in the discussion following disagreed with such an interpretation, preferring to view their patients as manipulative, others accepted it whole-heartedly. The attribution of multiple personality in such cases accounted for the failure of many physicians to secure confessions from their patients, and the hostility of patients and their families to a diagnosis of artefact. A hysterical patient, it was suggested, might not be aware that her wounds were self-inflicted and "should be looked upon as mentally rather than physically ill. They mutilated themselves because they could not help it."⁸⁰⁴ Rather than being "motiveless", such cases of malingering were now deemed to be *unconscious*: it was assumed that a motive existed, but was hidden from both patient *and* doctor.

Thus, when Pernet presented several cases of dermatitis artefacta to the Dermatological Section of the Royal Society of Medicine in 1915, much debate focused on the "mysterious mental element in these cases."⁸⁰⁵ A Mr Samuel suggested a Freudian interpretation, based on the view that self-mutilation provided evidence of mental repression. From such a perspective, self-inflicted skin lesions could be regarded as a conversion hysteria: the alteration of an idea into physical stigmata. Samuel recommended treatment with psycho-analysis or hypnosis: if the acts themselves were unconscious, treatment needed to access the patient's unconscious mind.⁸⁰⁶ Pernet himself was in broad agreement with this psychological interpretation, although he (like many dermatologists and alienists) preferred a Janetian explanation to "Freudism". He again suggested "that in some of these cases there was perhaps an alternation of personality", a contention that appears to have been more attractive to many of his colleagues than the Freudian interpretation put forward by Samuel. Frederick Parkes Weber agreed, suggesting that:

of all diseases related to disorders of the psychical system, artificial eruptions in young women most deserve ... study from the psychical point of view, and it would have been a great advantage if the followers of Freud's teaching had concentrated upon this subject much of their psycho-analytic investigations.⁸⁰⁷

⁸⁰³ Pernet, "The Psychological Aspect of Dermatitis Factitia", p. 21. For further interest in Janet in Britain at this time, see chapter three.

⁸⁰⁴ Pernet, "The Psychological Aspect of Dermatitis Factitia", p. 25.

⁸⁰⁵ George Pernet, "Two Cases of Dermatitis Factitia," *Proceedings of the Royal Society of Medicine (Dermatological Section)*, 8, (1915): 89-91, p. 91.

⁸⁰⁶ For other instances of the use of hypnosis to cure dermatitis artefacta, see Ludwig von Szoellesey, "Multiple Neurotic Skin Gangrene," *Munchener Medizinische Wochenschrift*, (1907).

⁸⁰⁷ Pernet, "Two Cases of Dermatitis Factitia", p. 89.

Ten years later, Weber was still grappling with the notion of double personality when a case was reported to the Royal Society of Medicine by S.E. Dore. Dore's patient, a 19-year-old girl with linear excoriations on her arms, had been under his treatment for five months. Confused by the case, Dore sent the girl to Dr Stoddart at St Thomas's Hospital. Stoddart, a former medical officer at Bethlem:

said that the case was one of dual personality, and that the patient was unaware that she produced the lesions herself. Dr. Pernet had mentioned the association of dual personality and artefact, but this is the first case which I have seen in which the diagnosis had been definitely made by an alienist.⁸⁰⁸

Many of Dore's audience seemed struck by this diagnosis, as well as the prospect of collaborating with psychiatrists. The president, Dr J.H. Sequeira, "said that many cases of the kind showed mental stigmata, and ... [he] frequently raised the question in his department as to whether such cases should not be sent to the mental specialist rather than to the dermatologist".⁸⁰⁹ Pernet, Weber, Sequeira, Dore and MacCormac (some of the most active contributors to the Dermatology section of the RSM during this period) all strongly supported this connection between double personality and self-inflicted skin lesions, indicating that patients were "unconscious" of the lesions they produced. But what implications *did* this model have for the treatment of patients? Or, indeed, more broadly for medical theories in England? These questions can be answered through a close analysis of the changing views of Frederick Parkes Weber himself.

5.5 Self-Mutilation and Mutilating Operations: Psychological Views of Hysteria

In 1943, Weber and his colleague Dr Schwarz discussed what they considered to be hysterical symptoms in women due to an unhappy marriage. Schwarz had related the story of a consultation he had in 1910, with a young woman whose puzzling abdominal symptoms had been operated on three times without any obvious benefit. Weber transcribed the story:

Suddenly the patient disappeared from England – she had run away with a man, deserting her husband and children. Twenty-two years afterwards Dr. Schwarz met her in a London hotel, and she asked him whether he thought badly of her. He answered that he did so 22 years ago, but later experience had modified his views and now he thought otherwise than he did then. This critical incident in the patient's

⁸⁰⁸ S. E. Dore, "Report on a Case of Dermatitis Artefacta," *Proceedings of the Royal Society of Medicine (Dermatological Section)*, 19, (1926): 47-48.

⁸⁰⁹ Henry MacCormac, "Self-Inflicted Lesions in Twins," *British Journal of Dermatology and Syphilography*, 60, no. 3 (1948): 106.

life had apparently completely cured her of her abdominal complaint! – and Dr. Schwarz [and I] think the case a typical one.⁸¹⁰

What had changed in the intervening period, to shift Schwarz's view of the patient's actions from unjustified (a moral condemnation of her abandoning her family) to justified (having directly cured her illness)? We have already seen some signs of the emergence, in the late nineteenth century, of a perceived connection between organic conditions – including self-inflicted injury – and the inner life of the individual. This became still more apparent in the early twentieth century, when the topic of "dermatitis artefacta" became the centre of debate.

In such examples, mental and physical symptoms are hard to distinguish, the mind and body being regarded as part of an inter-connected system. This difficulty is particularly evident in Janet's main work on self-mutilation. "On the Pathogenesis of Some Impulsions", published in 1906, recorded observations of patients exhibiting "certain useless, bizarre and even dangerous acts", which they found extremely difficult to resist. Janet was a pupil of Jean-Martin Charcot, and his efforts to find "a psychological unity in these diverse phenomena" may well have stemmed from the influence of his tutor.⁸¹¹ Charcot himself, however, does not appear to have had any particular interest in self-injury, a topic absent from his clinical lectures. Like the British surgeons referred to earlier, the French neurologist instead emphasised the simulation and "desire to deceive" in hysterical cases, and it is probable that he saw self-mutilation as evidence of this trait.⁸¹² Janet certainly regarded himself as departing from the thoughts of his teacher who, he felt, had laid far too much emphasis on the role of anaesthesia in hysteria. Anaesthesia, Janet declared, was not causational but only held diagnostic relevance, a shift in view that was important for regarding self-inflicted injury as holding meaning other than a response to a lack of physical sensation.⁸¹³ Rather than a physical basis for the acts, Janet's explanations for self-inflicted injury increasingly focused on mental phenomena: what's more, those that were outside the conscious control of the individual.⁸¹⁴

In his earlier works, Janet had described two cases of self-inflicted injury as "tics". In 1898, he reported the case of a ten-year-old girl who was dominated by an *idée fixe*, under which she tore at her skin, despite showing every sign of intelligence and possessing a

⁸¹⁰ Frederick Parkes Weber, "Multiple abdominal operations (Handwritten Note)" WLL, *The Papers of Frederick Parkes Weber*, PP/FPW/B163/4.

⁸¹¹ Janet, "On the Pathogenesis of Some Impulsions," p. 8

⁸¹² J. M. Charcot, *Clinical Lectures on Diseases of the Nervous System*, ed. Ruth Harris. (London; New York: Routledge, 1991), p. 14, p. 42, p. 94.

⁸¹³ Pierre Janet, *The Major Symptoms of Hysteria* (New York; London: Macmillan, 1907), p. 273.

⁸¹⁴ Janet, "On the Pathogenesis of Some Impulsions", pp. 1-2.

normal degree of cutaneous sensation.⁸¹⁵ Five years later, he connected such *tics* with psychasthenia, through the example of a young girl who pulled out her hair to such an extent that she was required to wear a wig, suggesting that a state of nervous malaise prevented patients from resisting ideas of self-injury.⁸¹⁶ By 1906, self-inflicted injury appears to have achieved greater prominence in Janet's framework for understanding imperative ideas: the former examples are simply two among hundreds of case studies judged to suffer psychasthenic symptoms. In 1906, however, he described a young girl of twenty, Ne., who "cannot stop herself from burning her hands and feet; her pleasure, when she is alone, consists in taking a kettle of boiling water, and pouring it, drop by drop, on the skin of her extremities." The gratification of impulse here, for Janet, produced pleasure for the patient, even when it also caused pain, thus requiring the rejection of a simplistic physical model of self-inflicted injury. This Janet made explicit by directly refuting the explanation he thought likely to be made by his contemporaries:

We have here, you will say, an insane person who has a mystical delirium and who is anaesthetic. By no means; she is a young girl, intelligent and instructed, who is not at all delirious, at least when she is being examined, and who has preserved all her sensibilities.

Ne., then, could not be regarded as insane – or even necessarily hysterical – and the physical symptoms of hysteria (including cutaneous anaesthesia) could not be used to explain her injuries.

Janet regarded the physical pain felt by the patient as a secondary result of her injuries: the gratification of impulse was the primary reason for Ne.'s self-mutilation. But from whence did the impulse spring? The French doctor associated various forms of impulse – including obsessions with food, walking, alcohol and self-mutilation – with mental depression, which, he claimed, produced a feeling of incompleteness for the patient and could only be broken by exciting acts. He illustrated this with several lengthy accounts from Ne.'s letters, seemingly impressed with her insight which, nonetheless, had not cured her condition. Ne. apparently declared that her state of depression made mental effort difficult for her, and thus she could only obtain pleasure from the impact of physical change on her body, which she described as "awakening" her and giving her a sensation of control and independence. Finally, she was reported as having written:

Why do you speak of my desire for mortification? It is my parents who believe that, but it is absurd. It would be a mortification if it brought only suffering, but I enjoy

⁸¹⁵ Pierre Janet, *Névroses et idées fixes*, (Paris: Félix Alcan, 1898), pp. 388-90.

⁸¹⁶ Pierre Janet, *Les obsessions et la psychasthénie* (Paris: Félix Alcan, 1903), pp. 232-3.

this suffering; it gives me back my mind; it prevents my thoughts from stopping; what would not one do to attain such happiness?⁸¹⁷

For Ne, it seems, self-mutilation was both a physical *and* a mental therapy for her unpleasant state. Janet himself laid greater emphasis on the mental aspect of her symptoms. Since he regarded her self-inflicted wounds as pathological, and her underlying illness as mental, this supported the contention that *any* physical intervention into her condition must constitute improper treatment.

Indeed, artefact injury *did* often result in serious surgical intervention, as we have already seen in the case of Daniel Prendergast. In 1908, Georges Dieulafoy, professor of pathology at the Hôtel-Dieu de Paris, gave a lengthy report of an unusual case.⁸¹⁸ Dieulafoy's patient was "un garçon" of thirty, who had suffered from a gangrenous affection of the skin for two and a half years. He had consulted numerous doctors and surgeons before ending up at the Hôtel-Dieu. On one occasion, the patient had even agreed to have most of his arm amputated, and had contemplated further operations. Despite this drastic treatment, Dieulafoy came to the conclusion that the man's injuries were self-inflicted. In order to prove this diagnosis, he had portions of the skin tested for the presence of corrosive substances and, when these tests proved positive, arranged a confrontation with the patient with the assistance of his employer. The patient's confession was, it claimed, eventually secured when Dieulafoy assured him that he would not be regarded as responsible for his actions, which were the result of a morbid mental state, but that if he persisted in the deception now that it had been discovered he would *become* a dishonest man. This call to honour – whereby patients were considered deceitful only once an "unconscious" process had been revealed – appears to have been common in this period. Even in those diagnosed as mentally ill, doctors often expected patients to give – and keep – their word that they would not injure themselves.⁸¹⁹ Apparently shocked, Dieulafoy's patient readily agreed, stating that he had been compelled to create the wounds just as a morphinomaniac was compelled to inject morphine.

I was, he said, dominated by a fixed idea, of which I could not rid myself. I allowed my arm to be amputated, and I well believe that one day would come when, in order to continue the deception, I would have allowed the amputation of my leg.⁸²⁰

⁸¹⁷ Janet, "On the Pathogenesis of Some Impulsions", p. 13.

⁸¹⁸ Georges Dieulafoy, "Escarres multiples et récidivantes depuis deux ans deux bras et au pied. - Amputation du bras gauche. Discussion sur la nature de ces escarres. - Pathomimie," *La Presse Médicale*, (1908): 369-373.

⁸¹⁹ These promises appear in case records. For example, Emily Kate Townsend, BRHA, *Female Patient Casebook 1888* (CB/135 – 347); Henry Breton, BRHA *Male Patient Casebook 1895* (CB/151 – 97).

⁸²⁰ Dieulafoy, "Pathomimie", p. 371 (my translation).

Unlike Janet's cases, Dieulafoy claimed his patient easily cured: all that was needed was for the doctor to reveal the true nature of the wounds, and the patient recovered. Thus, the *Standard's* correspondent in Paris regarded the case as "A Medical Puzzle Solved".⁸²¹

Other doctors, however, were beginning to doubt that cure was so easy, and suggesting that lengthy psychotherapy was instead required, to reveal the unconscious roots of the patient's need to injure him or herself. By the 1920s, Weber began to refer many such patients for psychotherapeutic treatment. This allowed the general practitioner to absolve himself of responsibility for his patient, who instead, became "a psychological problem".⁸²² Although there were few places in early twentieth-century Britain where such treatment might occur, this did not prevent some doctors looking for other sources of emotional support for their patients: sympathetic family members and nurses were both thought to be well placed to discuss "troubles" with a patient.⁸²³ What's more, physicians began to show an increased interest in the *outcome* of hospital treatment. In 1925, Henry MacCormac found himself embarrassed by a student's innocent question as to what ultimately happened to patients presenting with self-inflicted lesions. Accordingly, he set about a follow-up study. The dermatologist wrote to all patients treated for artificial dermatitis during the years 1913 – 25. The small number of patients (just ten cases in twelve years) once again reminds us that it was not self-evident that dermatitis artefacta should be a topic of interest to physicians. MacCormac's patients were all unmarried women, the majority between the ages of 17 and 26, and half showed signs of hysteria "such as anaesthesia of the palate and patchy anaesthesia and numbness of the skin."⁸²⁴ Of course, as indicated previously, the extraction of "genuine hysterical eruptions" (which MacCormac claimed had been his criteria for this study) from those patients deemed to have self-inflicted injuries was frequently made along lines of gender and age; a male patient was more likely to be viewed as either a malingeringer or suffering a "true" dermatitis. The division of malingering into hysterical and unconscious on the one hand, and conscious and manipulative on the other was thus very often made along gender lines.⁸²⁵

⁸²¹ "A Medical Puzzle Solved: Self-Inflicted Injuries", *Standard*, 11 June 1908.

⁸²² Frederick Parkes Weber, "Artificial "erythrodoema" of finger tips" (Case notes), 28 Nov 1936, in WLL, *The Papers of Frederick Parkes Weber*, PP/FPW/B163/1.

⁸²³ Henry MacCormac, "Autophytic Dermatitis," *Proceedings of the Royal Society of Medicine (Dermatological Section)*, 28, (1935): 734; Haldin Davis, "Dermatitis Artefacta," p. 216.

⁸²⁴ Henry MacCormac, "Self-Inflicted Hysterical Lesions of the Skin, with Special Reference to the After-History," *The British Journal of Dermatology and Syphilis*, 38, (1926): 371-375, p. 372.

⁸²⁵ This distinction is made very clearly in H. G. Adamson, "Acne Urticata and Other Forms of "Neurotic Excoriations.," " *The British Journal of Dermatology*, 27, no. 1 (1915): 1-12, p. 11.

MacCormac received replies from just half his patients, while one more had been readmitted since her first visit. Many, MacCormac claimed, seemed to have mis-remembered or even entirely forgotten their hospital experiences. One young kitchen maid, who had married since her admission aged 17, asked:

if you would inform me if being a married woman as I now am will it affect my leg or will I ever have any trouble with it later on in life? ... I should also like to know if it will have any effect on my future children.⁸²⁶

Deciding that the patient's query was genuine, MacCormac suggested that this could only be explained either by double personality or "the habit of burying the memory of unpleasant events in the subconscious mind.". Several decades earlier, this would not have been a foregone conclusion, for the notion of "habit" explored in chapter two suggests that it would have been perfectly possible, in the late nineteenth century, to view the young patient's *moral* affliction as potentially inheritable. Another patient insisted that she had *never* been in the Middlesex Hospital, although her "name is an uncommon one." The mysterious mental aspect of these cases, MacCormac concluded, meant that, although all the patients from whom he had received news "appear to have recovered, or at least discontinued damaging the skin ... it is hardly likely that they will eventually become normal individuals".⁸²⁷ If the patient's issues were unconscious, this meant they could re-emerge at any point.

Indeed, physicians who viewed self-inflicted injury in psychological terms were often more inclined to focus on the gendered nature of self-inflicted injury in relation to "hysterical temperament". When Frederick Parkes Weber published an article on the relation of hysteria to malingering in 1911, he claimed hysteria to be a disorder of the "tertiary sex characters", by which he meant the psychological characteristics thought to be common to men or women. From this, he provided an evolutionary explanation for the existence of hysterical self-mutilation.

In past ages ... simulation or deception of various kinds must often have been serviceable to the weaker female in protecting herself from the stronger (and sometimes cruel) male, as well as in enabling her sometimes to get her own way ... therefore, at the present time the facility (instinct) for deception is probably greater in the average female than in the average male.⁸²⁸

⁸²⁶ MacCormac, "Self-Inflicted Hysterical Lesions of the Skin", p. 373.

⁸²⁷ *Ibid.*, p. 375.

⁸²⁸ Frederick Parkes Weber, "The Association of Hysteria with Malingering," *The Lancet*, 178, no. 4605 (1911): 1542-1543, p. 1542. For a similar suggestion some years earlier, see "Motiveless Malingeringers", p. 16.

Weber's interest in the psychological nature of self-inflicted injury led him to view it as a female behaviour, rooted in the morally dubious context of deception, even when he thought that social and environmental factors enhanced this manipulative tendency.⁸²⁹ This belief that women were naturally deceptive was widespread in this period, and is particularly evident in the attitudes of many medical men to rape: as George Savage put it, "I have come to the conclusion that though there are evil men there are more evilly-minded hysterical women".⁸³⁰ The concept of hysterical deception thus relied on preconceptions about the nature, not just of hysteria as an illness, but of women in general. This caused physicians to minimise the possibility of sexual or physical abuse; emphasising the "self" in self-inflicted injury ensured that a third party was rarely considered. This attitude has been highlighted by feminist historians, in particular Lisa Cardyn's association of self-mutilation with the construction of female sexual trauma in turn-of-the-century America. Although Cardyn's article is problematic, in that she invariably reads late nineteenth-century cases of self-injury in the light of modern claims about the relation of self-harm to sexual abuse (whether there is any evidence of the latter in the texts or not), she is right to draw attention to the complete absence of such explanations in the writing of contemporaries.⁸³¹ When patients referred to "family troubles", or even detailed their experiences of rape or assault, practitioners nonetheless divorced any self-inflicted injuries from this external origin instead locating self-mutilation in the medical diagnosis of hysteria, and female psychology more generally.⁸³²

The emphasis on the mental element of cases of dermatitis artefacta, however, had other effects in terms of treatment. In particular, it made physicians move away from surgical treatment in cases diagnosed as hysterical. MacCormac wondered about one patient who had, seemingly arbitrarily, had her appendix removed shortly after discharge from the Middlesex, while another – an "intelligent and highly educated" protozoologist –

⁸²⁹ For more on the complex interplay between traits regarded as female, and those thought to be hysterical, see Smith-Rosenberg, *Disorderly Conduct*, pp. 207-9.

⁸³⁰ George Savage, "An Address on the Borderland of Insanity," *British Medical Journal*, 1, no. 2357 (1906): 489-492, pp. 489-90; Cardyn, "Construction of female sexual trauma," 172-204. For more on the history of rape, see Joanna Bourke, *Rape: A History from 1860 to the Present*, (London: Virago, 2007).

⁸³¹ Cardyn, "Construction of female sexual trauma" 172-204, p. 176 & p. 185. For a similar suggestion, see Carole Anne Reeves, *Insanity and Nervous Diseases Amongst Jewish Immigrants to the East End of London, 1880 – 1920* (Unpublished PhD thesis, University of London, 2001), p. 213 (case of Leah G).

⁸³² See Judson B. Andrews, "Case of Excessive Hypodermic Use of Morphia. Three Hundred Needles Removed from the Body of an Insane Woman," *American Journal of Insanity*, 29, (1872): 13-20; Alexander Nicoll, "A Remarkable Case of Persistent Ingestion of Needles," *The Lancet*, 171, no. 4411 (1908): 772-778; L. E. Emerson, "The Case of Miss A: A Preliminary Report of a Psychoanalytic Study and Treatment of a Case of Self-Mutilation," *Psychoanalytic Review*, 1, (1913): 41-54.

had been “mutilated” by a surgeon “who found it necessary to perform an amputation of a finger”.⁸³³ A psychological view of hysteria and surgical intervention were, it seems, incompatible, especially for those who followed a Janetian approach. In his Harvard lectures on the major symptoms of hysteria, Janet had warned his students:

Do not count the number of arms cut off, of muscles of the neck incised for cricks, of bones broken for mere cramps, of bellies cut open for phantom tumours, and especially of women made barren for pretended ovarian tumours.⁸³⁴

Cases such as this would later be classified as “factitious disorder” or “Munchausen’s syndrome”, placing the blame for unnecessary operations on the patient, rather than the physician.⁸³⁵ In the early twentieth century, however, the indistinct divide between hysteria and malingering might lead to different conclusions.

Dieulafoy’s case of pathomimie, which drew explicit attention to the extent of unnecessary surgery in self-mutilation, appears to have been influential to Frederick Parkes Weber in interpreting his own collection. It still came to mind as an example some twenty years after publication, when Weber entered into correspondence with Dr Peter Milligan of the Swansea General Hospital over a difficult case. Milligan’s patient was a girl of twenty, who for two years had suffered “frequent recurrences of a skin eruption on the right arm, r[igh]t leg or right side of the face. ... The attacks have no obvious cause.”⁸³⁶ Weber regarded the case as, most likely, one of “hysterical simulation – in fact, the evidence on paper is overwhelming”, and he provided a range of suggestions for proving and treating such a diagnosis. However, his attention to the patient’s state of mind went well beyond the standard attribution of a manipulative hysterical character. He suggested:

The patient is perhaps more or less confused about it herself. One might suppose her to be thinking:- “She is doing no harm in puzzling doctors – it is their own fault if they are deceived – they ought to know – certainly it is no crime to humbug them – moreover, it is rather nice to become the centre of interest.”

Such a description, stemming from the attribution of “unconscious” thought to hysterical self-mutilation, assumed that the physician understood his patient’s motivation better than she did herself. This encouraged a paternalistic view, and at the end of his letter, Weber reiterated that:

⁸³³ MacCormac, "Self-Inflicted Hysterical Lesions of the Skin", p. 375.

⁸³⁴ Janet, *The Major Symptoms of Hysteria*, p. 12.

⁸³⁵ Richard Asher, "Munchausen's Syndrome," *The Lancet*, 257, no. 6650 (1951): 339-341. For more on this topic see Richard A. A. Kanaan and Simon C. Wessely, "The Origins of Factitious Disorder," *History of the Human Sciences*, 23, no. 2 (2010): 68-85.

⁸³⁶ Letter Milligan to Weber, Dec 9 1929, in WLL, *The Papers of Frederick Parkes Weber*, PP/FPW/B163/3.

If my suggestion, however, turns out to be right, she may be much to be pitied. More than one patient has permitted amputation (for resulting gangrene, &c.) before the secret was detected. I remember reading of Dieulafoy's "Mythomania" case (in a man!).⁸³⁷

Leaving aside Weber's evident surprise at the existence of male cases (another indication of the strong association made between female hysteria and self-inflicted injury by British doctors), his return to the Dieulafoy case is an interesting one. His suggestion that the patient was to be "pitied" turned her into a passive object of surgical attention – quite unlike the manipulative, deceptive hysteric described by mid-nineteenth-century surgeons, such as Ernest Hart.⁸³⁸ For Weber, it was the surgeon's responsibility – and not the patient's – to determine whether an operation was justifiable. In hysteria, it seems, he felt that surgery was often precluded by the nature of the case: for Weber (although not for all physicians in the early twentieth century) hysteria was a *psychological* and not a somatic condition, and thus could not be cured by surgical intervention.

Such a contention explains the presence of a number of cases "for comparison" in Weber's "self-mutilations" collection. These do not include *self*-mutilation, but instead imply *surgical* mutilation, similar to the warnings offered by Janet. Following the letters to Milligan is a lengthy set of private patient case notes, headed "Recurrent abdominal pain and vomiting (1925 – 9)". Weber has indicated that "[t]hese notes are for comparison re cases of 'hysterical simulation & multiple operations'". The patient, a young Russian widow (Mme T.), had been treated for recurrent vomiting, for which, at various times, she had had her appendix removed, uterus sutured and adhesions between her gall bladder, duodenum and omentum removed. Weber noted rather wryly that the "[p]atient thinks the English like operations". None of these interventions cured the symptoms, and Weber appeared deeply sceptical about their validity: particularly on the uterus. Indeed, he commented on the effect of the multiple operations on Mme T's quality of life: "Patient used to gain money in America by Russian popular dances, but since the operations she cannot dance."⁸³⁹ Indeed, Weber was a strong advocate of a combined psychological and *sociological* approach to hysteria, which may well have been associated with his political views, grounded in socialism. In his paper on hysteria and malingering, he concluded that:

When a woman is depressed and altogether discontented with the life she has to lead, she is more likely than a man would be to try to attract attention or pity by

⁸³⁷ Letter Weber to Milligan, 11 Dec 1929, in WLL, *The Papers of Frederick Parkes Weber*, PP/FPW/B163/3

⁸³⁸ Ernest Hart, "Hysteria: Wilful Self-Infliction of Injury," *The Lancet*, 79, no. 2014 (1862): 355.

⁸³⁹ Frederick Parkes Weber "Recurrent abdominal pain and vomiting" (Case notes), 1925-9 in WLL, *The Papers of Frederick Parkes Weber*, PP/FPW/B163/3.

simulating disease or injury. A man usually has much more open to him; he can seek a new country or (if he does not endeavour to obtain relief by drink or gambling) he can take part in dangerous ventures of various kinds which bring excitement and temporary relief.⁸⁴⁰

Weber's assumptions about the psychological nature of women were thus situated within his understanding that, in contemporary society, women had few options open to them. Their injuries thus became evidence of wider social problems, and the attention of surgeons to female bodies represented the subjection of women to male brutality.

Several years later, Weber angrily annotated an off-print of David Forsyth's "The Place of Psychology in the Medical Curriculum" with the note: "See page 6 in regard to multiple operations wrongly performed in cases of psycho-neurosis ("conversion – hysteria", &c.)".⁸⁴¹ By the 1940s, his belief that operations continued to be wrongly performed in cases that ought to be regarded as psychological caused the handwritten reflections which began this section, titled:

Multiple abdominal operations (nothing pathological found, unless adhesions – probably from a previous exploratory operation – or one for supposed "chronic appendicitis" &c., at which possibly a normal appendix was removed) – in women, notably Jewish women, whose married life is unsatisfying or unhappy or who cannot get married.⁸⁴²

The assumption in this title is that the illness of these women resulted from their unhappy social circumstances, relating to unfulfilled sexual and emotional needs (Weber explained his emphasis on Jewish women through his perception that early marriage was expected of them). These needs were thought to explain self-inflicted injury, as well as what we might regard as psychosomatic symptoms, for which "mutilating surgery" had been carried out. Thus we can see a close relation, for Weber and others, between the topic of self-inflicted injury and the treatment of hysteria. Just as he came, in the early decades of the twentieth century, to regard hysteria as a psychological state, so too he regarded the physical infliction of injury by the patient on herself to be evidence of a traumatic state of mind. As Dr Ingram noted in a dermatological discussion in 1935, no "patient should be bullied out of an artefact dermatitis; the artefact might be cured in that way, but some other psychological disturbance would follow".⁸⁴³ This explicit association of self-mutilation with psychological turmoil appears to be new to the twentieth century.

⁸⁴⁰ Weber, "The Association of Hysteria with Malingering", p. 1543.

⁸⁴¹ Forsyth, D. "The Place of Psychology in the Medical Curriculum". *Reprinted from Proceedings of the RSM*, Vol. XXV (Section of Psychiatry, 1932), pp. 30-42 (PP/FPW/B163/3).

⁸⁴² Weber, "Multiple Abdominal Operations", PP/FPW/B163/4.

⁸⁴³ MacCormac, "Autophytic Dermatitis".

5.6 Conclusion

This chapter has explored the emergence of “hysterical self-mutilation” at the end of the nineteenth century and the beginning of the twentieth. There are aspects of this topic that may seem more familiar to us today than other elements of nineteenth-century texts on self-mutilation. A presentist perspective can mislead us into seeing hysterical self-mutilation as familiar, and thus failing to acknowledge the many ways in which it was not. We tend to assume that a psychological approach must be “progressive”, because it aligns more neatly with modern understandings of self-harm. However, the particular context within dermatology might equally indicate a rejection of other methods of treatment: in particular, widespread concern over a perceived increase in surgical intervention for a variety of illnesses, associated with advances in technique and equipment in the nineteenth century. What’s more, a comparison with the previous chapter indicates clearly the way in which such a psychologisation of self-mutilation was perceived in gendered terms. In men, as in the debate around self-castration, self-inflicted injury was considered to be evidence of a more general national decline, economic unrest and social change. In women, as in the cases of so-called hysterical self-mutilation outlined above, self-mutilation was generally rooted in individual pathology, rather than environmental causes, explicitly connected to the perceived emotional needs of women.⁸⁴⁴

As this chapter has shown, the apparent psychologisation of self-injury meant that wounds were thought to say something specific about an individual: perhaps proving the pathological nature of symptoms previously judged to be spiritual; indicating a manipulative and deceitful temperament; or showing the troubled state of the inner psyche. In the mid-Victorian period, I have shown that a connection between self-mutilation and hysteria emerged through the creation of naturalistic explanations for supernatural phenomena. These concerns indicate the complex relation of mind and body for writers at this time, for whom physiological and behavioural explanations existed side by side. Such concerns are indicated in the contemporaneous surgical records on “needle girls”, which emerged from the same complex interplay of assumptions around the emotional context of physiological change and intentional fraud. The latter concept promoted a relation between hysterical self-mutilation and malingering in the later nineteenth century, which increased attention to the motive behind an injury. The widespread assumption emerging from this idea – that self-

⁸⁴⁴ Although there are certainly complications to this view in the Weber material. Howard Kushner sees a similar gender divide in the literature on suicide. Howard Kushner, “Suicide, Gender and the Fear of Modernity” in Weaver and Wright, *Histories of Suicide*, p. 29.

mutilation *must* have a motive – caused a circular method of reasoning. Physicians found a “gain” (whether financial or emotional) for their patients because they assumed there must be one, while the assumption of a benefit might lead to the “discovery” of artefact in the first place. Nonetheless, malingering continued to be treated, in practice, as an illness.

All of these factors, however, played a part in the creation of the early twentieth-century model, whereby the physical nature of injuries became regarded as less important than their context. Hysterical self-mutilation shifted from being “motiveless” to “unconscious”: in other words, even when the patient was unaware of the motive, it was assumed to exist. Such an understanding complicated the notion of cure: physical intervention was rejected, but physicians had great difficulty in accessing the presumed psychological content of their patients’ injuries. Moreover, concerns over the association of self-mutilation with manipulative behaviour continued through the perception that self-inflicted injury necessarily resulted in a gain for the individual and the continued acceptance of the concept of hysterical temperament. It was in an early twentieth century address given to the British Medical Association, that George Savage referred to “the Self-Mutilator” as a particular category related to the hysterical. By using a proper noun, Savage suggested that self-mutilation was the result of both a temporary state of illness *and* an innate constitution.⁸⁴⁵ Attention to the mixture of hereditary constitution and acquired psychological turmoil in the individual case in fact emphasised the notion that the “self-mutilator” was not only a particular type of hysteric but a particular class of person.

⁸⁴⁵ Savage, "An Address on the Borderland of Insanity", p. 489.

Conclusion: Reflections on the Modern Meaning of Self-Harm

Modern psychiatric textbooks tend to refer to self-harm as if it were a natural, stable category, which has, however, only relatively recently been recognised as such by clinicians. Yet assumptions about the meaning of self-harm are often incorporated into the initial definition of the behaviour. Although the 2012 NICE (National Institute for Clinical Excellence) guidelines use the term self-harm “to refer to any act of self-poisoning or self-injury carried out by an individual irrespective of motivation”, most definitions pay close attention to motive.⁸⁴⁶ The section on self-harm in Bird and Faulkner’s *Suicide and Self-Harm*, for example, begins with the statement that:

A great many people, both men and women, hurt themselves in various ways (such as cutting, burning, scratching or bruising) as an expression of distress and often as a means of coping with that distress.⁸⁴⁷

Such a claim assumes that not only the occurrence of the acts described, but also a particular motive for carrying out these behaviours is required in order to define an act as self-harm. Similarly, the National Self Harm Network website, despite quoting the NICE definition above, goes on to state that self-harm “is primarily a coping strategy and can provide a release from emotional distress and enable an individual to regain feelings of control.”⁸⁴⁸ This idea is common across various fields of research. In one particularly revealing example, the remit of Adler and Adler’s recent sociological study of self-injury was shaped by these assumptions. Having defined self-injury as a private expression of inner turmoil, the authors thus excluded from their survey those people who carried out acts which seemed to them to have alternative goals, such as body decoration or what they call “deceptive” efforts to “garner medical attention”.⁸⁴⁹

As I noted in the introduction, none of these studies questions the notion that self-harm is, in itself, a category that can be measured, even though all of the texts cited above differ slightly in what acts they include. The NICE guidelines explicitly exclude anorexia

⁸⁴⁶ National Institute for Clinical Excellence, *Self-harm: The Short-term Physical and Psychological Management and Secondary Prevention of Self-harm in Primary and Secondary Care*, (Rushden, Northamptonshire: Stanley L. Hunt Ltd, 2004), p. 12.

⁸⁴⁷ Lisa Bird and Alison Faulkner, *Suicide & Self-harm* (London: Mental Health Foundation, 2000), p. 16.

⁸⁴⁸ National Self Harm Network website: <http://www.nshn.co.uk/whatis.html> [accessed 19 September 2012]. The NSHM is a UK charity that focuses on supporting people to seek alternatives to self harm (the idea of the “coping strategy” is thus built into their very reason for existence).

⁸⁴⁹ Patricia A. Adler and Peter Adler, *The Tender Cut: Inside the Hidden World of Self-injury*, (New York; London: New York University Press, 2011), p. 24. See also J. L. Whitlock, W. Lader, and K. Contario, “The Internet and Self-injury: What Psychotherapists Should Know,” *Journal of Clinical Psychology*, 63, (2007): 1135-1143, p. 1136.

nervosa, but the National Self Harm Network, by deeming eating disorders to constitute a “coping strategy”, include them within their remit. Both of the latter organisations, however, claim self-poisoning to be a means of self-harm, while Adler and Adler and Bird and Faulkner do not. This should lead to questioning of the category itself, and yet it does not, in part because all of these definitions do have several important similarities. First, as already stated, there is a preconceived notion that self-harm exists and can be defined. In addition, however, all these writers assume that self-harm is an intentional act carried out by an individual and all assume, from this, that self-injurious behaviour must therefore have some *meaning* for the individual. As we have seen, neither of these assumptions are implicit in the *term* self-harm, and we cannot necessarily take either for granted. Indeed, both assumptions rely on the prior existence of another seemingly stable category: that of the self. The terms self-harm, self-injury and self-mutilation gain a large portion of their meaning from the assumption that a self exists, and that it may be mutilated. To refer to a *wound* as a “self-injury” does not necessarily imply that the wound has any psychological meaning or, indeed, that the infliction of the injury was even intentional. However, all three terms are most often used to refer to an *act*, and it is this application that appears to be new in the late nineteenth century, as outlined in this thesis. While people had certainly intentionally injured themselves in a variety of ways prior to this period, the late nineteenth century was the first time these diverse acts became regarded as equivalent behaviours. To combine all these acts under the umbrella of self-mutilation prompted the idea that some form of universal meaning might also be discoverable. The recognition of self-mutilation as an act assumed the existence of a self carrying out that act, and thus a meaning behind the act for that self. From this, various other assumptions about the nature of self-mutilation easily followed. It became viewed as an act that might have meaning beyond the physical nature of any wounds inflicted or the immediate sensations they might cause; an act that revealed something of the character of an individual; and, in addition, an act that might help to explain the relation between individual and environment.

In this thesis, I have argued that all of these assumptions can be undermined by a historical perspective on self-inflicted injury. In chapter one, I explored the way in which the concept of self-mutilation was created within a psychiatric context in the second half of the nineteenth century. I showed that modern clinical and historical approaches which assume that it was only in the twentieth century that self-inflicted injury became considered

separately from suicide are deeply flawed.⁸⁵⁰ Psychiatrists in the nineteenth century frequently argued that self-mutilation was not carried out for suicidal motives, although they differed in their method of applying alternative meaning to such acts. For many, definitions in this period relied on a somatic model of mental illness, whereby self-mutilation might be explained by a disorder of the nervous structure of the body and resultant impulses of which the individual was unaware. However, within British psychiatry, I have shown that this somatic model of self-injury was rarely the only or even main explanation offered. Indeed, without additional interpretations, suggesting that self-inflicted injury was of individual psychological or general social importance, the topic would not have received attention as a particular psychiatric symptom.⁸⁵¹ Historians of this period have often been misled by their tendency to over-emphasise the role of brain biology and heredity in accounts of late nineteenth-century psychiatry. While these concerns are certainly evident in published texts, close attention to asylum archives indicates that, in practice, such accounts might be of little relevance to the way in which the asylum functioned and symptoms were managed and treated. While neither archival sources nor published works can give a "true" picture of how asylums functioned in this period, the contradictions between the two provide an interesting opportunity for analysis. From this, I argued that the definition of self-mutilation did not emerge from a top-down model (in other words, one created by alienists in published material and then disseminated to their staff, patients and a wider public). All the psychiatrists writing on the topic were in asylum practice and their beliefs were formulated in the asylum – and often shaped as much by their patients' words as their acts. Overall, this chapter argued that we cannot see the historical creation of self-mutilation in purely physiological terms *or* as a definition created and imposed theoretically. Instead, it was located firmly within the practicalities of asylum functioning.

In chapter two, I built on these ideas to move beyond the asylum context, showing how anthropological and evolutionary concerns encouraged a tendency to draw parallels between acts of self-inflicted injury in psychiatric patients and the so-called mutilations of savages. This had even broader consequences for the understanding of self-mutilation in psychiatry, in that the use of an evolutionary model of mind suggested that self-inflicted injuries might be interpreted as the physical evidence of an individual's mental state. This

⁸⁵⁰ Armando R. Favazza, *Bodies Under Siege: Self-Mutilation and Body Modification in Culture and Psychiatry* (Baltimore, Md.: Johns Hopkins University Press, 1996), p. 232. See also Michael G. Gelder, *Oxford Textbook of Psychiatry*, 3rd edition (Oxford: Oxford University Press, 1996), p. 426; G. E. Berrios, *The History of Mental Symptoms: Descriptive Psychopathology Since the Nineteenth Century*, (Cambridge: Cambridge University Press, 1995), pp. 443 – 454.

⁸⁵¹ Just as little attention was paid to other acts reported in asylums, including destruction of clothes or property, or refusal of food.

perspective was often interpreted through a pessimistic, degenerationist idiom, which caused broad assumptions to be made about the character and heredity of an individual, drawn directly from the self-infliction of a wound. In addition, this led to the direct association of certain traits (introspection, selfishness, excitability and a lack of emotional control) with the act of self-mutilation. Even more broadly, the evolutionary model of self-mutilation furthered the view that an act of self-harm said something not just about the individual, but about his or her relationship to the external social environment. From such a perspective, self-mutilation was viewed as evidence of more than just a failure of physiological function, but indicated a general state of physical and moral degeneration, in both individual and race. This chapter indicated that arguments from *outside* the asylum were regularly incorporated into asylum practice and vice versa. These broader concerns were largely responsible for encouraging the view that self-mutilation could not be dismissed as an insane act, but also held a relation to the evolution of the individual mind, and his or her relation to society: in short, self-mutilation became represented as a social problem.

Chapter three explored an alternative mental model of self-mutilation, in that, as well as being viewed as representative of the individual's relationship to society, self-inflicted injuries were considered by some to say something about the psychology of the individual. I explored the relation of late nineteenth-century British asylum psychiatry with normal psychology, a perspective much neglected in the historiography of the field.⁸⁵² While it certainly cannot be argued that all alienists took such a perspective, it is notable that many of those writing on self-mutilation did so, viewing self-inflicted wounds in many cases as direct evidence of the inner nature of the individual. Almost all of the late nineteenth-century British alienists writing on self-mutilation explicitly rejected the medical materialist perspective that viewed mental illness as a bodily condition (situated in lesions of the brain): instead, they tended to view physical acts as representative of mental events, while viewing selfhood as a notion situated somewhere between the two. Such an approach prompted the assumption that the ideas of the insane, like those of the sane, could be interpreted and analysed and, from this, that self-mutilation held intellectual or emotional meaning that could shed light on a broader understanding of normal and abnormal motivation. This

⁸⁵² A few exceptions to this include: Michael J. Clark, '*The data of alienism': Evolutionary Neurology, Physiological Psychology, and the Reconstruction of British Psychiatric Theory, c.1850 -c.1900* (Unpublished PhD Thesis, University of Oxford, 1982); Akihito Suzuki, *Madness at Home: the Psychiatrist, the Patient, and the Family in England, 1820-1860* (Berkeley: University of California Press, 2006); Elizabeth Lunbeck, *The Psychiatric Persuasion: Knowledge, Gender, and Power in Modern America*, (Princeton: Princeton University Press, 1994).

psychological approach to self-mutilation emphasised the behaviour as an *act*, and therefore a mental event quite distinct from the physical wounds created. While psychological approaches to mind are often considered by historians to be progressive, this notion is counterpointed here by the reminder that such assumptions could nonetheless lead to a pessimistic view of the individual as morally (rather than biologically) inferior, a notion clearly indicated in the concept of malingering, which ensured that psychological approaches to self-mutilation remained closely bound up with social concerns.

In the second part of my thesis, I explored two specific instances in which the ideas and theories discussed in part one were applied in medical practice of the period, indicating the complex manner in which these concerns were associated in practice. My focus lay on the concepts of “sexual self-mutilation” and “hysterical malingering”. Both diagnoses were applied within and outside the asylum, and hysterical malingering in particular was in widespread use within general medical practice at the turn of the twentieth century. These two concepts of self-inflicted injury received attention well beyond their actual reported occurrence in asylum and hospital records, something I argue needs to be understood through the way both concepts were interpreted and understood in relation to prior notions of gender-specific attributes: how men and women could and should behave. Castration was a major concern in published texts on the topic of self-mutilation, in the medical field and beyond. Yet, as I showed in chapter four, attempted or successful self-castration was uncommon in medical records, in comparison to other forms of injury. The emphasis on castration thus needs to be seen in relation to specific medical and social concerns. It is easy to assume that castration is “about” masculinity, but is this necessarily the case? I argued that it *is*, but perhaps not in the ways twenty-first century readers would expect. In psychiatry and psychology, this period saw an increasing emphasis on the role of the sexual instinct in individual and racial development, particularly in the case of men who were regarded as naturally less altruistic than women. Attention to self-castration in later nineteenth-century psychiatry can be read in relation to heightened concern over the physical state of British men, alongside the difficulty of reconciling contemporary models of masculinity with the elevation of the concept of altruism.

So-called hysterical self-mutilation seems far more familiar to us today than does sexual self-mutilation. The majority of modern studies emphasise that self-harm occurs far more frequently among women than men and, in particular, among young, middle class,

educated women.⁸⁵³ This was often the profile assumed by psychiatrists and general practitioners treating so-called hysterical women for self-inflicted injuries in the early twentieth century which, I argued, indicates that self-mutilation was not solely understood in relation to psychiatric in-patients in this period. However, I also argued that this apparent proximity to modern views should not blind us to the differences between hysterical "malingering" and twenty-first-century self-harm. First, the relation to the social and political problem of malingering sets hysterical self-mutilation in a completely different context. Turn-of-the-century (male) practitioners also shaped their explanations in relation to their understanding of gendered attributes, through the assumption that hysterics – and, by extension, all women – were inherently manipulative. I used these prior assumptions to show that even the apparent psychological attention to the "unconscious" in notions of hysterical self-mutilation can be misleading. The "motiveless" hysterical malingerer was often contrasted with the "obvious" pursuit of gain evident in her male counterpart. Nonetheless, she was similarly regarded to be deceptive, even when her acts were perceived to have been prompted by emotional needs characterised as outside the patient's conscious control. I thus intend the chapters on sexual self-mutilation and hysterical malingering to be contemplated together. The latter appears familiar to us today, the former confusing and distant, rooted in old-fashioned notions of the perils of masturbation and proper sexual conduct. The way in which both notions existed side by side at the turn of the twentieth century explodes the idea that self-mutilation has any kind of universal meaning that can be discovered, that it necessarily says anything in particular about a person, or that it can ever be understood outside the historical and cultural context in which the term is used.

By undermining the assumption that self-inflicted injury necessarily says something about a person I intend, by extension, to question the very notion of an integrated and stable selfhood. As I have shown, in nineteenth-century psychiatry and psychology these two concepts were often bound up together. It was in this period that a new view of selfhood emerged that regarded the individual as the sum of his or her mental processes and feelings, rather than one clear entity that existed from birth. However, this new concept of integrated selfhood promoted the assumption that mental illness resulted from either a failure to achieve this integration or the disintegration of a self that had previously been

⁸⁵³ Adler and Adler, *The Tender Cut*, p. 35; Bird and Faulkner, *Suicide & Self-harm*, p. 16; Gelder, *Oxford Textbook of Psychiatry*, p. 428. For the way in which studies in the 1960s encouraged this tendency to view self-harm in relation to gender, see Chris Millard, *Self-mutilation and a Psychiatric Syndrome: Emergence, Exclusions & Contexts (1967-1976)* (Unpublished MA Thesis, University of York, 2007); Barbara J. Brickman, "'Delicate' Cutters: Gendered Self-Mutilation and Attractive Flesh in Medical Discourse," *Body & Society*, 10, no. 4 (2004): 87-111.

ordered. Self-mutilation could thus be interpreted as representing this disintegration, and hence saying something very specific about the nature of selfhood. However, as I have shown throughout this thesis, these claims were entangled in cultural depictions of the individual, including notions of proper physiological functioning, as well as his or her relation to wider society. Indeed, one might even suggest that the central conflict of psychiatric practice, in the nineteenth century and beyond, lies in the divide between individual and collective: psychiatry claims to treat the individual, but only as part of a larger social group.⁸⁵⁴

In exploring notions of selfhood in late nineteenth and early twentieth-century British psychiatry, I have aimed to rescue this period of asylum medicine from historical obscurity, indicating that it is a much more complex topic than is often realised. Alienists were not all obsessed with degeneration on the one hand and bureaucracy on the other: rather, many of them were well aware of the potential held within their specialty for commenting much more widely on mind and behaviour, individual and society. Further, however, I aim to question the views of self-inflicted injury that are seen to be common wisdom in the western world today. Generalisations about the behaviour abound: that it is mostly practised by young, educated, white women; that it is associated with certain cultural pursuits (most notably genres of music); that it is connected to sexual deviance; that it is manipulative and deceitful. Some of these stereotypes are informed by modern concerns about self and society; others may linger from nineteenth-century explanations that became attributed with an independent truth and thus remained in psychiatric and other reports long after the context in which they emerged had disappeared. Rather than perpetuating these assumptions, psychiatrists should aim to challenge them, recognising the normative nature of the assumption that self-inflicted injury is inherently “abnormal”. To class self-harm as pathological is, as Georges Canguilhem has pointed out in other contexts, to depict it as “a manifestation of an attachment to some value”.⁸⁵⁵ In the preceding work, I have indicated some of the values incorporated into Victorian definitions of self-mutilation, by which I intend to shed doubt on the suggestion that self-harm has any kind of “true” or “real” meaning. While in no way intending to negate the experiences of those who feel that conceptualising self-harm as an emotional release offers a convincing explanation of their own feelings, or to suggest that their experiences are not, somehow, genuine (which is in no way my intention), I do suggest that this manner of experiencing self-inflicted injury is

⁸⁵⁴ See Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, (Harmondsworth; New York: Penguin, 1975), p. 306.

⁸⁵⁵ Georges Canguilhem, *The Normal and the Pathological*, (New York: Zone Books, 1989), p. 57.

certainly not universal or essential. Self-harm, like self-mutilation, is not a given entity but a concept that is created by its very categorisation, with certain consequences for those so classified. While these might be beneficial (for both individual and society) in some instances, in others these consequences may be damaging in themselves: and, what's more, perpetuate the problem they intend to solve by imbuing it with an essential nature. Recognition of the way in which the concept of self-harm was brought into being within psychiatry is an important step in beginning this debate.

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