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Response to reviews of *Diagnosing Madness*

I want to thank the reviewers profusely for engaging so deeply and thoughtfully with our book, and for offering both generous assessments and thorough, well informed critiques. It has been two years since the book was published and four since my mentor and co-author passed away; it is, perhaps, a good time to reflect on it and respond to those who in good faith have parsed its ideas and placed them in proper historical and theoretical context.

Before doing so, I would also like to provide the readers of the journal (who may not be familiar with the book) with some background. The project arose from my collaboration with Carol Berkenkotter on asylum archives, which resulted in several articles that made their way into the book (as a basis for Chapters 3 and 4). The project was also conceived as a follow-up to Carol's *Patient Tales: Case Histories and Uses of Narrative in Psychiatry* (Univ. of South Carolina Press, 2008). That book laid the ground for much of our collaboration, and we have obviously not repeated here much of the material, critiques, and cases that had already been covered. The Ticehurst Asylum archives, which had offered some of the material for *Patient Tales*, turned out to be a much richer reservoir of information, and so we returned to the Wellcome Institute that holds them to further explore cases of particular interest (especially Baldwin's, the basis of our fifth and final chapter). My attempt to explore a similar trove of archives in the U.S. was met with institutional and regulatory barriers (such as extended HIPAA laws, which protect sensitive patient information), and thus arose the need to rely on mostly public-facing accounts like those surrounding the Hinchman case (the basis for the first two chapters).

Archives are messy. They are a nearly opaque, or heavily tinged window into the past, and carry their own selective biases. In Derridean terms, archives both *commence* and *command*: they are the point of origin but also are kept by the "masters of the house," the keepers of the "law". The archives preserve institutional history, and as such encode the institution's ideology. This is particularly true of the Ticehurst archives: the reason they are so thorough, so rich in detail, and so well preserved is that the clientele Ticehurst catered to was rich, and the scrutiny and oversight expectations at Ticehurst were much more intense than in other, less posh places for the confinement of the mentally ill. (In fact, when we wanted to consult some of the remaining archives for contemporary British asylums kept at Wellcome, we could find

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almost no details of individual cases that could even partially reconstruct a case history; rather, the lower the social rung of the inmate, the sketchier the details; and for poorer or less endowed institutions, records were sparser or more poorly preserved.) But even case histories so detailed as those kept at Ticehurst at least until 1918 (after that, they became much more schematic until the close of the asylum in the late 1930s) do not bend to one narrative principle—narrative is the job of the researcher; and whenever a story can be extracted from them (as we have at times attempted to do), one must be wary of the implicit biases of the observer, and the particular lenses used to interpret them.

I am (and we were) cognizant of these limitations, which is why when trying to make sense of these fragile documents we employed mostly textual analysis tools, very broadly defined, that tried to honor these fragmentary memories, or that appeared to best explain what was going on. Hence, the heterogenous methodological apparatus that all the reviewers remarked upon. Popa is not a fan of this approach, remarking, "I am ready to accept that "the texts and their stories dictated [the authors'] approaches" (7), but I cannot accept the inevitability of this process". He is correct, of course: there is nothing inevitable about the process other than our own training as rhetoricians, and our own, necessarily idiosyncratic process of grappling with the messiness of the archives and adjacent documents. (By the same token, there is nothing inevitable about any rhetorical methodology.) It was our opinion that in order to take a closer look at how "madness" diagnoses were negotiated, we couldn't limit ourselves to one set of documents (e.g., case histories, which had been thoroughly addressed in *Patient Tales*), but bring into the fold a constellation of other genres—some of which we dubbed "occult" (having to do with the inner working of the institution of the asylum) and some of which were very public facing indeed (journalism, serialized novels). In a sense, the heterogeneity of our approaches mirrored the heterogeneity of our material; but our goal remained steadfast—and indeed, more descriptive than theoretical, as noted by the reviewers: what were the rhetorical processes at play as patients, doctors, legal institutions, and the public at large engage in when attempting to define madness? What can we learn from them? As we often pointed out, such rhetorical negotiations had drastic, often lifelong consequences for the patients, and public debate on the matter contributed to the rise and fall of the asylum as an institution; and they also serve as a historical precedent, and to an extent we have opened that space for our audience to draw their own inferences and parallels.

Could we have tightened this apparatus, and also—as Alex Cârlan points out in his review—relied more heavily on the "heuristic potential of pragma-dialectical argumentation theory"? I do not doubt it: one's methods can always stand improvement, and argumentation theory *could* have been pursued more assiduously to unify the book. I also welcome his suggestions for an alternative understanding of the Hinchman trial of wrongful confinement, which pitted individual liberty and madness (as norm-breaking): the trial, he writes, "might be indicative of the difficulty of winning a case which forces the audience to establish a hierarchy between freedom and property on the one hand, and any other contender of rhetorical invention, on the other"—to which I can only add that this was fabricated dichotomy that gained a peculiar valence in that particular American historical context (and it has only snowballed since). Nevertheless, we confess that we found the material—indeed, the lives and stories of these patients—dazzling enough to inspire reflection beyond our own interpretation. Thus I was very pleasantly surprised to see that this was the exact focus of George Tudorie's review; "the kaleidoscopic arrangement of the book," he writes, "is that it allows for a level of recon-

structive detail and learned contextualization which brings long dead people – and fictional characters in long dead genres – into vivid focus."

One particularly fascinating point raised by Tudorie is the treatment of patient texts: yes, he implies, it's ok—convenient, maybe! —to focus on ambiguous concepts like moral insanity, which lend themselves to obvious critique; or memoirs like Merivale's that appear to describe, at best, a borderline case of mental illness. But what about texts that exhibit "canonical madness," Tudorie wonders, such as Schreber's diatribes (1903) or Alexis-Vincent-Charles Berbiguier's treatise on the demons tormenting him—which describe decidedly bizarre ideation characteristic of psychosis: "These were not eccentric rhetors, even if they published readable material, and it would do little good to treat what they said simply as discourse, or their illness as a matter of "public negotiation", writes Tudorie. First, I would argue that "canonical madness" is a loaded concept that could easily fall apart under scrutiny, unless we reduce "madness" to, say, "psychosis"—which would be at best, problematic. Similarly, Popa makes a distinction between "a madness of behavior, not of ideas", suggesting that the patients we highlighted are *borderline* cases of insanity; but, indeed, what we wanted to question was precisely that borderline and when (and how, and why) it is crossed! (Besides, I am not sure what a "madness of ideas" is, or if one can pinpoint it precisely, as surely many thinkers, revolutionaries, and innovators have been accused of something similar throughout the ages. I am only half facetious here: madness is a slippery concept). But returning to the cases invoked by Tudorie: I would argue that even so, such texts cannot be denied their rhetoricity: they do enter into a sort of negotiation of madness, because they are public facing and as such subject to dialogue and critical reception, eliciting a consensus (or dissent!) on what sort of norms of sane (normal) discourse they break. Such texts in fact abound in the history of psychiatry and they could be subject of a separate study; Carol herself discussed in *Patient Tales* one such famous patient who produced relatively cogent or "readable" discourse which nevertheless was interpreted as clear proof of madness: James Tilly Matthews, he of the "air loom" invention (a contraption that allegedly extracted thoughts and caused extreme mental pain). His doctor, Haslam, famously wrote a whole treatise, *Illustrations of Madness* (1810), in which he meticulously set out to prove Matthews's madness (using, among others, the picture he drew of the Air Loom). But let's not forget that he wrote that book in the context in which the asylum was sued by Matthews's family, and as such needed to produce proof of insanity in order to justify his confinement (which, Matthews maintained, was on political grounds). The resulting negotiations are a clear instance of madness rhetoric at work; not everyone thought Matthews was mad (in fact two contemporary doctors consulting on the case found him sane); and Matthews continued to be confined not because there was agreement on his insanity, but rather because of orders from the Home Secretary.

Similarly, in 1868, Ebenezer Haskell, a famous patient of a famous Pennsylvania doctor, Thomas Kirkbride, sued in search for his freedom from the asylum, and published a loosely concocted memoir in support of his case; he won, despite his obvious and well documented psychotic symptoms. Merivale, whose memoir we examine in the book, was clearly suffering from mental illness—his symptoms align, possibly, with either depression or bipolar disorder (as Tudorie astutely observes); that does not make the text and its distant dialogue with the case notes less interesting or an "obvious" example of madness at work. Even if we are to consider psychosis as the benchmark for "true" mental illness (again, not something I would necessarily agree with), what to make of more recent memoirs and accounts of, for example, schizoaffective disorder, like Esmé Weijun Wang's *Collected Schizophrenias* (2019), which

grippingly describes her experience with the disorder? Granted, in that case, the psychotic delusions are not presented per se as reality, and the author, medicated and therapized, can reflect on and illuminate her disease much more cogently than any psychiatrist can. Overall, I agree that how we interpret the texts left by people in the grip of psychosis and to what extent we can deny their rhetoricity is a fascinating point to follow up on.

I appreciate Dietz's nuanced reading of the text as well; he has a few more specific, targeted questions, such as the extent of moral treatment in asylums in the U.S., and their transformation into custodial care in the post-Civil War era. To my knowledge, that understanding is correct: the ostensible success of the campaign to build more asylums (for moral treatment) together with the rise of psychiatry as a medical field colluded with demographic and industrialization forces to drive the asylum population up and severely diminish the standard of care. As for Dietz's point that we chose to highlight the 1850-1918 era in the title, as opposed to 1849 (the year of the Hinchman trial) or earlier: we considered 1850 a mid-century point that lent itself to a more elegant rounding of the period we covered and truthfully reflected where things stood at one point in American psychiatry. In regard to the question about power hierarchies and administrative scrum between states and municipalities over asylums: this issue has not featured prominently in our research, although it does come up in some later legislative sessions; this is an interesting point to raise, especially as who controls/administers the "mad" inmates became a matter of state control (I would defer to the work of Gerald Grob or Nancy Tomes, among others, in that regard).

Regarding the choice of Ticehurst: a large part of that choice was the breadth and excellent preservation of the records. As I discussed earlier, such data was not possible to procure in the U.S. at the date we were working, although I do hope it will become so again in the future; we also had to limit ourselves to records in a language we could reliably analyze, in an area we could have access to. Also as discussed, Ticehurst was the exception rather than the norm in that it preserved exceptionally lengthy descriptions and notes, due to the exclusive nature of the institution. No matter how much Merivale, for example, complained to be brutalized during his stay, we suspect Ticehurst did not employ very harsh restriction methods and had decent living conditions compared to asylums for the poor; thus, in that regard at least, it is difficult to determine whether we can generalize. However, the struggles to diagnose and treat mental illness that we captured are, I think, universal and generalizable, even though they may not be as well documented elsewhere as at they are at Ticehurst.

I must thank Laura Russell for her generous—and generative—reading of the book, and for the provocative and thoughtful questions she asks, mostly about how this foray into psychiatry's past may echo into its present and future. Although I do not have the time or space to fully engage with all the questions and issues raised by her review (less this turns into a book-length opus), I will attempt to engage some of the crucial points she raises.

Russell urges me to reflect on how past views of mental illness as something intrinsic to the individual may still inform present practices. I think we should, at all times during a clinical encounter, consider "the dynamic nexus—between persons and their environments—that constitutes mental health", as Russell puts it; and we are seeing that happening, however imperfectly, as the right to confine persons is currently strictly limited and with court oversight, and multidisciplinary teams of doctors, nurses, social workers, and so on usually attend to the needs of individuals in the grips of a mental health crisis. However, echoes of that traditional, stigmatizing understanding of mental health are everywhere and built into our (American) health care system, which values an individual approach over community care and interven-

tions. As we show in the book, even when people have the best of intentions—say, Morgan Hinchman's relatives, his Quaker doctors, or the Newington medical dynasty in charge of Ticehurst; even when patients have a wealth of resources (Hinchman and the Ticehurst patients were well off); and even when there is public consensus on what asylums should or shouldn't do, systemic inertia, shifting views of norms and normality, patriarchal expectations of gender roles and rules of conduct, and fluid or evolving scientific consensus on medical diagnoses can all contribute to harm individuals who would otherwise, with the proper care or support system, would continue to live their lives unencumbered by institutional or medicolegal pressures. Mental illness is idiosyncratic and manageable, a symptom of the individual's relation with the world rather than of an individual's worth; nevertheless, our collective anxieties related to mental illness render it disruptive, unmanageable, alienating. Esmé Weijun Wang writes in *The Collected Schizophrenias* that "Craziness scares us because we are creatures who long for structure; we divide the interminable days into years, months, and weeks. We hope for ways to corral and control bad fortune, illness, unhappiness, discomfort, and death — all inevitable outcomes that we pretend are anything but". The fits and starts that we witnessed and documented in our book as the (Anglo-Saxon) psychiatric system settled in the second half of the 19th century are, at least in part, reverberations of that fundamental fear of madness, attempts to regulate and tame that which would keep disorder (bad fortune, unhappiness, discomfort) at bay.

Refocusing on today: emphasis in our current system (in the U.S.) is placed on psychopharmacology and (occasionally) individual therapy to correct the individual's adjustment to what is essentially a psychopathogenic environment that fosters stress, anxiety, depression, addiction, loneliness, or economic precarity; stigmatizes those with mental illness; and cultivates alienation of the self from the most deeply human values we yearn for—love, human connections, compassion—in favor of accumulation of capital, success, individual uniqueness, ambition, and so forth. A (perhaps unlikely) parallel that can serve by way of an explanation to what I am trying to get at is the discourse surrounding food and food-related pathologies, from eating disorders to obesity, which usually places the onus on individual recovery and adjustment. At least in the U.S., it is clear that we live in an obesogenic environment that is replete with unhealthful, hyperpalatable, addictive foods, heavily advertised and heavily subsidized, forming a formidable systemic apparatus with which an individual's self-control and will must wage constant battle to emerge unscathed (free of food-related pathologies). This is to say nothing of the profoundly unbalanced systems of food production which exploit marginalized populations, animals, and the land alike, further contributing to pollution, climate change, environmental destruction, and health issues. Disorders of restriction (anorexia) and especially of excess (binge eating, bulimia, obesity) occur often precisely when we are trying to control our interactions with such an environment.

To go back to Russell's questions: indeed, what point do the reflections on the past serve if not to open up a meditative space for what would be possible in the future? We can, and should, reimagine psychiatric encounters as diffuse and local (not the exclusive purview of the psychiatrist's office or hospital crisis team, but open to wide variety of community-based practitioners), warm, affirming, and mindful of the whole person and their environment; but at the same time, more systemic changes need to happen in our society that would diminish psychopathogenesis factors before we can reinvent psychiatric care (and medical care in general).

All of this is, of course, aligned with Russell's commentary. She further wonders, "How do we probe our rhetorical imaginations to initiate a wellness lens, one of appreciative inquiry

into discursive negotiations about health"? The intervention of the rhetorician can take multiple forms but left me highlight for now three possible paths. One is exposing the fear of the "mad" as a psychosocial and rhetorical construct that is maintained by multiple institutional mechanisms; looking at the textual basis of those mechanisms allows for their deconstruction and demystification. Another is the interrogation of categories: drawing attention to the blurry boundaries between normality and madness, or rather the continuum between the two as something to be embraced, accepted, and understood rather than the domain of multiple harsh delineations and more or less metaphorical policing (in that regard, disability advocates have made great strides and should be a model for what is possible in mental health advocacy). When we look at the linguistic negotiations that make clear-cut distinctions possible (one is mad, therefore confined, one is not, therefore is free) we see how difficult they are to maintain and justify. Third, examining the rhetorical ecology shaping the discourses of mental illness allows us to identify and, eventually, target those factors that are most influential in defining and treating it—from public zeitgeist to legislation. Placing it all in historical context should serve as a reminder that we need to transcend certain attitudes of the past that led psychiatry into aporetic conundrums that it could never fully shake (a certain anti-psychiatry undercurrent runs through most of the 20th century and beyond, peaking in the actual antipsychiatry movement of the 1960s, but otherwise ebbing and flowing).

If there is one main area that I wish we had incorporated into the manuscript it would be a deeper reflection on archives and methodology, of the difficulties of selection. In the Ticehurst archive, there are close to a hundred of large-format, thick and heavy casebooks covered in faded longhand, not all of which constitutes riveting or even illustrative material. Early in the project we abandoned the idea of including a chapter on "mad art"—art produced by the patients, samples of which are preserved, pressed within the massive tomes, mostly as exhibits of madness supporting the doctor's notes. Our considerations were rather pragmatic—such an addition required even more diversification of our already eclectic methods to incorporate visual rhetoric tools, and at the time seemed like a detour that would have added many months of work to our project or that deserved its own separate piece. We looked at many more cases than we have settled on in the final iteration of the manuscript. We also wondered how many patient memoirs we should include; this became eventually another abandoned chapter due to the fact that the topic is more frequently addressed in the literature, but also due to lack of time and resources, as well as, eventually, Carol's premature passing. In all these decisions, we exercised our own ideological biases, inevitably informed by Foucauldian analyses of psychiatric power as well as by more recent critiques of psychiatry and psychopharmacology in particular. Since Ticehurst has already been the subject of macroanalyses in the monographs by Charlotte Mackenzie (1985) and Trevor Turner (1989), we chose a closer, deeper reading of a small number of illustrative cases, rather than a comprehensive look at the workings of the asylum as a whole. Such an act, we felt, both honored the individual lives of the confined and allowed the material to breathe, unfold, and reveal the inner workings of the delicate art of psychiatric diagnosis together with the practical consequences brought about by the diagnosis. But I admit that both our selection of texts and of hermeneutical tools could be—and should be—subject to fair critique. The project, as the reviews have revealed, is far from being complete; but I trust that it provides enough openings for future scholars to continue the work.

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