

Skin

In the Introduction, I suggested that within histories of the asylum the physical body of the asylum patient has often been overlooked. This chapter introduces an archival source—an album of photographs—that graphically illustrates the value placed on the body as a site of information in the late nineteenth-century asylum. In its depiction of both the external body and its internal organs, the album highlights the converging research concerns—physiological and psychological—that increasingly characterised late-Victorian research-oriented British asylums like the West Riding. The chapter explores the place of medical photography in psychiatry before going on to discuss the outermost surface of the body that it captured: the skin.

The skin was credited with the ability to reveal something of the body's inner workings, and the developing field of dermatology used photographs and other illustrations to document skin conditions in great detail. This was a practice that extended to asylums, as doctors 'read' the skin for hints of their patient's medical history as well as for what it might say about their present mental condition. In the case of general paralysis, patients were often assumed to have a history of syphilis—evidenced by scarring, for example—but also suffered from phenomena such as anaesthesia of the skin, a condition that could put them at particular risk within the asylum. In documenting skin conditions, photographs reveal not only the importance of the surface of the body, which had the potential to reveal what was going on inside it, but also the working practices of the asylum—such as the testing of sensation in general paralysis. Thus, this chapter considers

how the information contained in photographs can illuminate the asylum's treatment of skin conditions, the surgical intervention employed, and the challenges of caring for the frail or destructive patient, one of whom was the general paralytic.

FRAGMENTS OF ASYLUM PRACTICE

Within the archival records of the West Riding Asylum, amidst volume upon volume of case records and annual reports, is a heavy book of photographs. The ageing, leather-bound volume is undated, and there are no indications of authorship or curatorship. The feelings evoked by the album's contents are reflected in its entry in the archival catalogue: though identified by a slip of paper between its pages as "Photographs of patients. Male & female patients. Undated. Path lab records," it is described in the catalogue as a collection of photographs of "various complaints, deformities etc."¹ The morphing of "Path lab records" into the rather more evocative "deformities" is a telling one, with a cataloguer presumably struck by some of the more visually arresting photographs within the book's pages.

There are 118 photographs in the album, most accompanied by a handwritten caption providing the patient's name. In one photograph, a nurse holds up a female patient's legs to display severe open sores on the back of her knees. In another a young, very thin, boy lies curled up on a neatly folded striped blanket. There are pictures of patients in the wards and Asylum grounds: two women seated in the garden in neat dresses and aprons, their hands resting in their laps; men sat in front of a greenhouse, the windows behind them filled with plants. Alongside these portraits of patients during life—indeed, often on the same page—are dead bodies and their constituent parts. In one photograph the Asylum mortuary wall and slab have been temporarily draped with black sheeting to provide a clear backdrop for photographing a deceased patient, her limbs painfully contorted. Brains are depicted in various states, some photographed in situ with the top of the skull removed and membranes pulled back to reveal a large clot of blood. Locum doctor Arthur Bodington poses for the camera during a postmortem, the patient's brain in the foreground and top of their skull resting on their knees. Several pages are occupied by photomicrographs of muscle tissue and nerves, some of them mounted carefully on thick card.

It is a startling source, and the lack of explanation regarding its content makes it possible to read it, at first glance, as nothing more than a somewhat fetishistic collecting of patients and their bodies—the “various deformities” of the archive catalogue as curiosities rather than conditions of scientific or medical interest. Large collections of photographs of institutionalised patients, and the exchange of such images between Victorian doctors, have led some historians to liken asylum photography to a hunt, which (like photographs of colonial expeditions) brought the ‘primitive’ elements of human nature into the hands of “the Victorian psychiatrist, a heroic explorer of the mind.”² Images drawn from the history of psychiatry evoke “a specific type of anxiety”³: it is very difficult to extricate them from concerns about power, labelling, incarceration, and unnecessary medical intervention. The image of the patient in an asylum uniform, photographed almost in the style of a mugshot, sometimes restrained by the hands of an attendant, seems to foreground those elements of psychiatric treatment—imposed uniformity, surveillance, and coercion—that raise the most concern. If such nineteenth-century images are those which indulge our romantic ideal of a simpler past we feel we have lost, the photographs collected at the West Riding perhaps speak of past realities that our modern sensibilities would much rather forget. The visceral nature of the photographs in the album “overpower[s] our critical faculties” and our initial reaction to the collection is that it is somehow wrong, sinister, or questionable.⁴

It is vital, though, to view such photographs with their broader contemporary social and medical context in mind. It is clear that the West Riding’s album was not intended for public perusal, but as a private and professional record of cases the Asylum staff deemed worthy of note. Whilst the taking of these photographs was made possible by a power differential between doctor, institution, and patient, recognising this fact does not invalidate the photographs as useful historical sources. Power has the ability to create knowledge, and I view these photographs as fragments of medico-psychiatric knowledge of the late nineteenth century, as windows onto contemporary concerns and practices in the Asylum.⁵ The album strongly suggests the importance of certain body parts and organs in late nineteenth-century asylum medicine. Why are there several photomicrographs of muscle tissue? Why take the time (and, as we shall see in Chapter “Brain”, significant technical effort) to photograph brains removed from the skull at postmortem? The care with which a brain or brain section was preserved and photographed speaks not only of the

medical or scientific value attached to it, but also of the scientific practices that made that preservation possible.

I do not wish to suggest that photographs alone are adequate sources for constructing a history of psychiatry in late nineteenth-century Britain. Though a photograph may perform multiple functions—evidential, didactic, aesthetic—it does not follow that it should be used in isolation without reference to other types of source. The photograph invites us to view it as a whole, but it is a fragment—framed, cropped, and incomplete. There are many aspects of the clinical or pathological encounter that photographs are unable to capture. Images omit the “sensual surround in which physician and patient interacted,” for example, including elements such as the smell of open wounds or skin conditions.⁶ Photographs are just one part, one trace, of a broader investigative enterprise. But neither should images be used simply for illustrative purposes, particularly when we consider that this was not the way that asylum doctors employed them. The contemporary motivations behind clinical photography were multiple, with varying aims of objectivity, cognition, and even aesthetic appreciation.⁷ The patient portraits produced by Hugh Welch Diamond at Surrey County Asylum, for example, posed and dressed patients to resemble well-known literary characters such as Shakespeare’s Ophelia. The nineteenth-century medical photograph is not something easily and uniformly readable—the result of an institutional, disciplinary gaze, for example—but an artefact dependent on many other processes and motivations.

In the Introduction I suggested that Janelle S. Taylor’s notion of surfacing may be a useful way to think about investigations of the body in the nineteenth-century asylum. In line with Taylor’s multifaceted concept of surfacing, this chapter is concerned with two surfaces: the surface of the skin as a site of medical investigation, both in general paralysis and other conditions, and the surface of the photograph as a route into thinking about nineteenth-century practices of medical photography and the circulation of knowledge. Mechthild Fend notes that “certain terms became more prominent in medical discourse around 1800, among them the word ‘surface’.”⁸ Fend suggests this is due to greater attention being paid to the visual appearance of the body, as well as the growing specialism of dermatology and its conception of the skin as an indicator of other things. Nineteenth-century illustrations of skin conditions and their sufferers often portrayed these conditions with reference to the whole patient, carrying within them markers of social identity. Discussing the early

nineteenth-century dermatological watercolours of the pathologist Robert Carswell, Fend observes that although the purpose of the illustrations is to portray a disease, the disease “carrier,” “in the sense of both the body displaying a disease and the sheet of paper on which an image is printed or drawn, does not always remain indifferent.”⁹ In many dermatological photographs of the nineteenth century, much more of the patient—and of the doctor-patient interaction—is captured than simply the surface of their skin. I also wish to emphasise here the surface of the photograph itself—to view the photograph not only in terms of the image captured, but as an artefact of and testament to nineteenth-century asylum practice. As this chapter will show, photographs were (and are) dynamic objects: important for contemporary understandings of the relationship between bodily and mental disease, and capable of highlighting the varied practices of the late Victorian asylum.

PHOTOGRAPHS IN THE ASYLUM AND THE ARCHIVE

Photography was by no means confined to the medical arena in the nineteenth century. The 1851 census recorded a mere 12 photographers, but 10 years later that figure had leapt up to 2534.¹⁰ Alongside the growth of domestic photography (such as *cartes de visite* and family portraits), the photograph was employed by those working in science and medicine. Particularly following the Great Exhibition in 1851, which gave an important publicity platform to those using photography in their scientific work, photographs were increasingly used to record and document researcher’s observations, from astronomy to natural history.¹¹ Photographs could also provide a means of institutional surveillance. Gathering standardised knowledge about ‘types’ of people in the 1800s was an activity that took place in several arenas: the phrenology of Franz Joseph Gall and Johann Spurzheim, Alphonse Bertillon’s attempts to codify the criminal body, and various efforts by anthropologists to ‘catalogue’ the races of the world. Psychiatry was no exception. If the “body’s signs [were] a *text* to be read,”¹² where better to read them than in an institutional environment, where there might be several hundred examples of a broad ‘type’ (the insane, the criminal) collected together? The multiple functions of the photograph—surveyor, recorder, teacher—were well suited to the asylum and prison systems where a photograph could provide visual ‘proof’ of psychopathology, act as a legal identifier in case of escape, or, as Diamond claimed, even play a therapeutic role in forcing patients to

visually confront their condition.¹³ Collections like that of the West Riding pathology lab could be found throughout late nineteenth-century psychiatry as photography proliferated. The society photographer Henry Hering had taken photographs of Bethlem patients as early as the 1850s, but it was the period after 1870 that saw the use of photography in institutional and medical settings increase substantially. Photographs became an essential part of scientific discourse, exchanged between doctors in the mail and used to illustrate journal articles. The first textbook devoted to medical photography was published in 1893 (*La Photographie Médicale*), produced by Albert Londe who had worked with Jean-Martin Charcot at the Salpêtrière, but scientific photographs were also a vital part of publications for a broader readership such as atlases and popular periodicals.

Although it is unlikely that all asylums kept a ‘pathology lab album,’ in large asylums like the West Riding it was common to maintain basic photographic records as part of administrative practice. This was a task that represented a significant undertaking for asylum staff: at the West Riding the annual report for 1870 noted that a new photographic studio had been built on-site with a small pathological museum attached (this was a ‘museum’ in the sense of a collection of objects for teaching, rather than a dedicated building open to the public).¹⁴ Photographs were taken of patients and catalogued in large albums with a cross reference to the patient’s casebook; later, photos were stuck directly into the casebooks, a move partly encouraged by the Commissioners in Lunacy who advised that records would be enhanced by combining the two.¹⁵ By 1897 a complete set of photographs of all resident patients had been taken, indexed, and placed in the West Riding Asylum museum.¹⁶ Many of the patient photographs in the West Riding’s casebooks show a uniformity in their background that suggests the on-site studio was in regular use, though other photographs highlight that the camera was also introduced to other areas of the Asylum, depicting patients in the grounds or on the wards. This process of ‘cataloguing’ patients might involve several members of staff: at Londonderry Asylum, the superintendent took the photographs, the head attendant developed them, and a nurse printed the results.¹⁷ At other asylums, there might be an appointed or visiting photographer who was skilled in using photographic equipment, or an existing member of staff who took on the role. At the West Riding in the 1870s, for example, Dispenser George Bracey acted as photographer.¹⁸ The pathology lab’s album gives no hint of photographer identity, and the years spanned within it suggest that it was a combined effort of several staff members. By

comparing the patients depicted in the photographs—for the most part both living patients and pathological specimens are labelled with names—against casebook and postmortem records, it is possible to date the album to between c.1879–1901.

The format of the album and its contents plays an important part in its reading. Images of living patients pasted next to photographs of their brains after death offer an uncomfortably graphic representation of mortality as well as a useful illustration of the Asylum's multiple functions. The scrapbook acts as an anchor for the images. Viewed individually, without reference to other sources that provide contextual information about their subjects, it is less easy to see the photographs as part of a broader investigative and therapeutic enterprise.¹⁹ As the photographs are labelled only with names, with no notes about the conditions depicted, it is likely that the album was a companion source to casebook and postmortem records, with staff able to reference back and forth between them. Several of the images are reproduced or referenced in articles by staff members, suggesting the album was used by a number of doctors and that the images played an important part in the production of psychiatric knowledge. The brain of John R. was photographed and the photograph reproduced in sketch form (avoiding the costlier and sometimes difficult process of making copies of a photograph) in an 1891 article on spastic hemiplegia by Pathologist and Medical Officer Edwin Goodall; the case history and postmortem of a young patient in the album was related in detail by Medical Officer William Lloyd Andriezen in an 1897 article in the *British Medical Journal* (*BMJ*).²⁰ Fragments of patient bodies became part of a broader body of knowledge about mental and physical illness, with sketches of brains or written details of muscular anomalies allowing asylum doctors elsewhere to take part in a kind of “virtual witnessing.”²¹ The photographs are not simply illustrations, but an essential part of the clinical case, adding depth to the textual account, acting as a surrogate for real specimens, and in several cases conveying information difficult to put into words (such as the extent of degeneration of the brain substance).

Apart from its directly illustrative function, it is also necessary to emphasise the photograph as a demonstration of professional skill and as a tool in museological practice. Since the earliest days of medical photography, photographs were recognised as a useful way of charting the improvement of a disease under treatment. The *BMJ* noted in 1895: “In many cases no verbal description can surpass a good photograph of the patient.”²² Photography was used for the before and after documentation

of orthopaedic cases by Hermann Wolff Behrend as early as 1852, and continued to be employed across a variety of medical specialities. William Withey Gull's pictures of anorexic patients were presented in such a way as to testify to the recovery of the patient even without any accompanying textual commentary, becoming standalone descriptors of 'health' and 'illness.' They were also, however, problematic in their depiction of the naked and emaciated female body versus the clothed and therefore 'civilised' patient.²³ The before and after photograph thus provided powerful visual proof of medicine's imagined civilising, as well as curative, capacity and thus broader societal benefit at a time when medicine—and particularly psychiatry—was becoming more conscious of its professional status. The photograph was eagerly embraced by the medical profession—both in Britain and elsewhere—to define itself and its interests in a visual discourse that was generally private rather than intended for public consumption.²⁴ Some portraits might depict doctors apart from the rest of the hospital: a photograph in the West Riding collections depicts Superintendent William Bevan Lewis surrounded by his senior Medical Officers, while another of the pathology lab (see Fig. 2, Chapter "Bone") depicts several of the same Medical Officers working at their bench.²⁵ Photographs were thus important records of professional practice as well as clinical phenomena. American neurosurgeon Harvey Cushing's photographs portrayed blood-spattered surgeons displaying the marks of their trade, and the dissection photograph was something of a rite of passage for medical students in the United States.²⁶ In the latter, students typically assembled in groups around their allotted cadaver, sometimes manipulating the body into comedic positions or tableaux. British dissection photography is rarer, and the portrait of Arthur Bodington in the course of a postmortem in the West Riding album is self-consciously serious. He is carefully posed to display himself within his working environment of the mortuary, behind the corpse and in front of a shelf of glass jars, underneath which hang white aprons. His hands are raised, giving the impression of a brief moment of rest from his endeavours as well as the delicacy of the task he is engaged in.

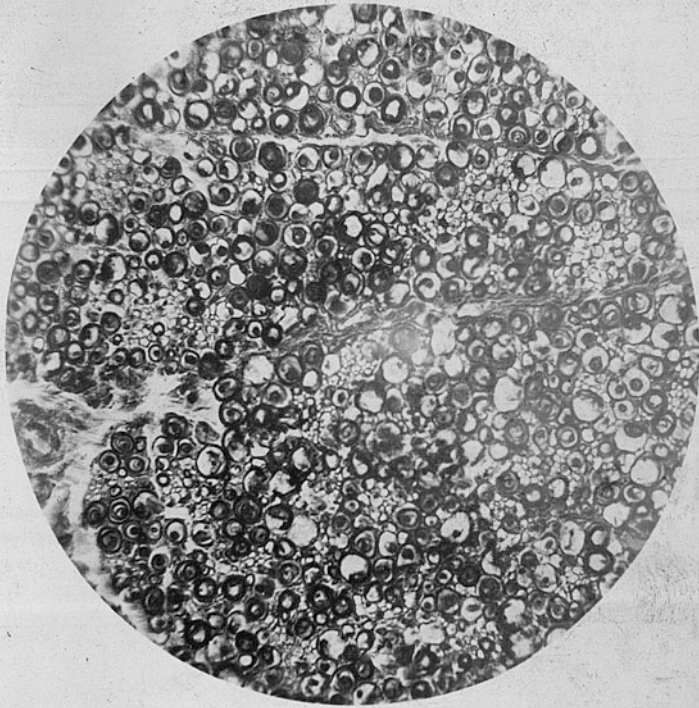
The display of medical skill and postmortem practices evident in the portrait of Bodington can also be seen in photographs of pathological specimens, many of which were photographed prior to their inclusion in the West Riding Asylum museum. This concern for pathological fragments as well as whole bodies can be seen in other collections of psychiatric photography—for instance, a photograph album kept by Colney Hatch Asylum staff in the 1890s and 1910s, and sets of photographs taken by

Alexander Johnston Macfarlan and William Carmichael M'Intosh in Edinburgh in the 1860s.²⁷ Both the West Riding and Colney Hatch albums are collage-like in appearance, without necessarily seeming to compile any taxonomies of disease, “challeng[ing] the viewer to make sense of the layout and individual photographs.”²⁸ The Edinburgh photographs betray a similar preoccupation with pathological specimens, but engage particularly closely with the practical work of staff, testifying to practices such as the casting of death masks. This visual record documented the pathologist’s contribution to a professional discourse as well as his practical skills in dissection and technical endeavours. On-site museums thus became sites that catalogued the work of staff as well as the bodily fragments of patients. Robert Cook, visiting the West Riding from New York’s St Lawrence State Hospital, marked his trip by adding a preservation of his own to the Asylum’s collection.²⁹

The visual demonstration of practical, professional skill also extended to published work. An 1898 article in the *Edinburgh Medical Journal* contained a photograph of a woman’s head before and after dissection, the skull sawn and photographed in a way that highlighted the thickness of the skull bones.³⁰ The pairing of image and text in the article made clear that such examination and display served an instructive purpose, acting as a two-dimensional mortuary for the reader unable to see the dissection first-hand. Several images in the West Riding scrapbook evidently served as teaching or demonstrative aids. Some of the photomicrographs are explicitly concerned with the correct production and use of images, annotated with guidance for their viewing. Notes such as “Look at it with a magnifying glass. The details are very clear” (Fig. 1), or “Peripheral neuritis. To show masses of fibrous tissue,” have clear didactic purpose, describing not only what is depicted, but how it is to be viewed. An X-ray image of a hand notes that it is an “Exposure of one minute,” suggesting the testing of new technology (the asylum had acquired a “6-inch induction coil, accumulator, vacuum tube, fluorescent screen and dark slides for radiography” in 1896).³¹

The photographs in the album thus provide a window onto asylum practices—X-rays, dissection, the preservation of museum specimens—that aimed to shed light on the links between mental health and bodily disease. These photographs are fragments, if you will, of that practice, just as the things depicted in the photographs themselves are also fragments, either literally or in their presentation. Body parts are sectioned off from the rest of the body using a clever arrangement of cloth (to highlight the degenerative condition known as ‘Charcot’s joint’ in the knees) or sectioned

Oates. Orange acid Ulnai in arm
Anophy of myelone etc etc



Look at it with a magnifying glass
The details are very clear }

◀ **Fig. 1** The didactic role of the photomicrograph at the West Riding Asylum, late nineteenth century: “Look at it with a magnifying glass.” Reproduced with permission of West Yorkshire Archive Service: Wakefield and the South West Yorkshire Partnership NHS Trust. WYAS C85/1111

quite literally using the scalpel (brain sections, muscle tissue). Both within medical history and more generally there is a degree of unease in dealing with this division of the body into pieces. At the same time, it is a division that fascinates us. It is a reminder that “[t]he corpse is always approaching from within.”³² In *The Body in Pieces* (1994) Linda Nochlin argues that the bodily fragment was utilised in art during the French Revolution to denote the destruction of one civilisation and the construction of a new one, a process mirrored in histories of anatomy.³³

As ideas about disease became more informed by the visible bodily lesion in the nineteenth century, the splitting open of bodies was central to the development of the medical profession. The body became a “repository of knowledge” to decipher.³⁴ Medical men viewed fragments as a way of conceptualising the whole; that the photographic fragment appears flat and disconnected from the body does not mean that doctors were not, at the same time, able to conceive of patients as whole bodies and beings, using these smaller pieces of knowledge to inform the treatment of the whole. Just as Nochlin emphasises the creation evolving with and out of destruction, Jonathan Sawday says of anatomisation: “in lieu of a formerly complete ‘body’, a new ‘body’ of knowledge and understanding can be created. ... As the physical body is fragmented so the body of understanding is held to be shaped and formed.”³⁵ For both Nochlin and Sawday fragmentation is a distinctly modern enterprise, in which order is achieved by division and subsequent classification. It is an impulse to completeness rather than reduction as the scalpel “creates new surfaces as it cuts.”³⁶

Maria Angel, writing in *Images of the Corpse* (2004), notes the linguistic relationship between corpse (body) and corpus (text). She describes “the dead body and [the] book as a series of laminated surfaces that are unfolded, refolded, and discovered in acts of research.”³⁷ The West Riding album acts rather like an encyclopaedia of the patient’s body, cataloguing its characteristics inside and out. Whilst much of the content of the album is striking, it would be difficult to say with certainty what the book’s origins were with no knowledge of its background. Few of the photographs are the images of madness we are accustomed to: the staged ‘religious melancholy’ of Diamond, or the spectacular bodies of the Salpêtrière analysed so eloquently by Georges Didi-Huberman.³⁸ Rather, they attempt to dissect madness in the most literal sense by examining the minute fabric of insane bodies.

In examining the bodily fabric, few of the album photographs reveal more of their subject than is necessary—the image of a patient suffering from Charcot’s joints is concerned only with their legs, and there are several close-ups of patient’s hands to show the extreme contortion and flexion of wrist and finger joints. This focus is a consequence of the doctor’s interest in certain parts of the body, but it also raises the question of increasing awareness of the ethical issues surrounding clinical photography. Not all members of the medical profession were convinced that photography was a harmless or neutral exercise. Clinical photography prompted serious considerations of doctor’s ethical responsibilities towards patients in the late nineteenth century, a point in time when notions of privacy were changing and evolving.³⁹ A letter to the *New York Medical Journal* in 1894, for example, was critical of the “craze” for medical photography which, the correspondent said, led to indecent images being produced as patient’s bodies were exposed to a degree that was unnecessary.⁴⁰ In Britain in 1901, at the meeting of the Northern and Midland Division of the Medico-Psychological Association, one Dr. Powell (likely Evan Powell of Nottingham Asylum) suggested that the practice of photographing patients “was done somewhat indiscriminately, and done too much as a routine without considering whether it gave pain to the patients or not.”⁴¹ In replying to his remarks, Dr. C.K. Hitchcock of York’s Bootham Asylum said that he “did not think that anyone had a right to photograph insane patients, and he had felt very strongly on the subject since some years ago he was shown in the collection of an amateur photographer photographs of patients suffering from acute mania.”⁴² A few years earlier, a resolution was put forward from a London infirmary that medical officers should not photograph any “persons thought to be of weak intellect” without first obtaining the permission of the local guardians. The resolution was not passed, but *The Lancet*—commenting on the suggestion—noted that certainly no photographs ought to be *published* without the consent of the patient or their representative.⁴³ This increased concern for patient anonymity in the 1890s manifested itself in various ways, such as the addition to photographs of black squares across the patient’s eyes or the use of plain, unidentifiable, backgrounds. Whilst this was certainly no guarantee of anonymity, it signalled recognition that patients had lives beyond their condition and a right not to be defined by it.

What are the implications, then, when we choose to reproduce—as I have in this chapter—images of patients? Although nineteenth-century asylum doctors imagined photographs as items of future as well as contemporary use, they likely did not anticipate the uses to which such

photographs would be put by historians of medicine and psychiatry. The medical image is “an ethical borderland in which legal definitions of privacy, personhood, and human rights compete with the contemporary politics of witnessing, memory and memorialisation.”⁴⁴ Because the photograph is both past and present—thus, capable of being constantly re-read—it enables a series of processes and interactions between subject and viewer such that a degree of emotional engagement seems unavoidable. The historian does not stand outside these processes: in analysing and re-purposing images we enter into (and alter) the present and future readings of those images. Our analysis may also be informed by our own personal experiences of illness, our past research, or the context in which we view the image. To use the present-day example of MRI scans, some people “who view an MRI in an art gallery may be swept up in its beauty, whereas those who view such an image in the examination room might find the image horrifying.”⁴⁵ Similarly, whether a photograph of a nineteenth-century patient appears, alone, in a digital collection as an example of a particular disease, or alongside their contextualising case notes, can affect our interpretation of it. We might argue that, with time, the patients who are represented in such photographs are “liberated from typology” as their conditions are re-assessed in light of changing medical knowledge, and the circumstances surrounding their photograph interrogated and historicised.⁴⁶ During that interrogation and historicisation, though, and particularly in using images in publications, we produce new visual artefacts in our re-contextualisation. Caroline Bressey, working with patient records from the City of London Asylum, is one of few historians who has openly discussed this issue in relation to her own research: “in pulling out these particular photographic stories from the archive books, they become dislocated from their supportive text and context. ... By digitally copying the records, cropping the images, and representing the portraits in this [new] format, I have created among them a new form of unity.”⁴⁷ Bressey reminds us of our own role as historians in the reproduction of images, and the responsibility that brings. In reproducing several images from the West Riding records in this book, I have deliberately chosen those that are important to my study of the body in the asylum, and which have in fact guided it. The album kept by the West Riding pathology lab has been crucial in informing my study of the body in nineteenth-century psychiatry, with its clear focus on certain parts of the body raising questions and inspiring further research—the images highlight, for example, asylum practices as well as the preoccupations of doctors.

Throughout this book, patients (and their bodily fragments) are referred to by first name and surname initial. There is little to be gained from using patient's full names, yet there is something particularly dehumanising about taking away the patient's real first name and replacing it with a pseudonym. Contemporary doctors, when publishing clinical cases, tended to use initials only. In any case, the patient's name is not the end of the story—images may compromise privacy even as they remove identifying information.⁴⁸ By presenting the face and body of a patient to public view we also run the risk of reducing the patient to an abstract representation of a disease. Is it any less ethically problematic to present the photograph of William T., as I do in this chapter, because his surname has been truncated? Does it, in fact, further pathologise William by making him less identifiable, rather like Patient One or Patient Two? I have struggled with these issues in writing this book, and in presenting material from it to both academic and nonacademic audiences. But I have decided to include pictures like William's because I think that without them we run the risk of being too distant from the topic at hand, of forgetting that the medical and scientific practices of the asylum were done out of a need to care for very real people, and not simply introduced at the whim of needlessly interfering doctors. Where possible, I have included biographical information about patients that recognises their lives before they entered the Asylum. There is a power in these images that holds significant potential for engaging readers more fully with histories of the body, histories of psychiatry, and the ways in which we have interpreted mental (and physical) illness through time. As Elizabeth Edwards puts it in her discussion of anthropological photography, “[t]he rawness of photographs ... hold[s] the seeds for recognition.”⁴⁹ My concern with ways of seeing or knowing the body in nineteenth-century asylum practice makes images an integral part of this book. It would be disingenuous to imply that those various ways of seeing did not include photographic records of interactions between very real, human, doctors and very real, human, patients. Photographs were one part of those interactions, and captured elements of the clinical encounter not always recorded in written documentation, as this chapter will discuss shortly.

THE GROWTH OF DERMATOLOGY

One of the most arresting and interesting images in the West Riding photograph album is the portrait of William T. (Fig. 2), who had come to the Asylum as a criminal lunatic after apparently interfering with points on

the Great Western Railway and constructing a fire on the line. William's own account of this was that he had made a fire not with any malicious intent, but merely to keep himself warm. Sentenced to three years servitude, he was judged to be not of sound mind and subsequently admitted to the Asylum where he was diagnosed with general paralysis. Throughout his stay he was plagued by recurrent attacks of psoriasis. Psoriasis could be treated locally—by removing the scales of the skin with soap—and with specifics, the most common of which was the oral ingestion of small quantities of arsenic. In the Asylum William was treated with liquid arsenic, thyroid extract, and ointments.⁵⁰ A casebook entry tells us, unusually, the exact date when his photograph was taken, his “Very marked case of psoriasis” being photographed on 17 October 1895.⁵¹ The photograph is a hybrid, using the conventions of portrait photography yet at the same time meeting the criteria of a clinical photograph. Many asylum photographs “borrow from, but also unsettle, three different genres: the family memento, the studio portrait and the institutional record.”⁵² Similarly, the asylum photography of Diamond, intended for public exhibition as well as private use, blurred the boundaries between medical and nonmedical imagery, with the medical portrait a “special performance” as well as an attempt at capturing reality.⁵³ Certainly, the portrait of William constitutes a notable event: a backdrop is put in place, William is carefully placed in front of this in a manner that points to his body as a spectacle, and the event is noted down in the casebook. William is photographed unclothed, side on, in order to capture the many raised, irritated patches of skin that cover his torso and legs. He crosses his arms and stares directly at the camera—his casebook photograph depicts a similarly direct engagement⁵⁴—and it is difficult not to read a degree of defiance in his stance. It is the surface of William's skin, however—the stated reason for his photograph being taken—that jumps out most clearly to the viewer. The painted studio backdrop of a woodland scene further draws attention to his condition, the banks of a stream serving to frame his body in the centre and the dark blotches of the trees mirroring the mottled surface of his skin.

The nineteenth century witnessed a growing interest in ‘markings’ of the skin—psoriasis and other skin conditions, scars, tattoos—and their depiction in medical literature. As “the body's face,” the skin was seen as having profound significance regarding inner mental, moral, and physical health: its “involuntary expressiveness” could reveal details of an individual's social life, wealth, and intimate contacts without the patient saying a word.⁵⁵ At the same time, the skin could be deceptive: it concealed what lay beneath



Fig. 2 William T., photographed while suffering from severe psoriasis (1895). Reproduced with permission of West Yorkshire Archive Service: Wakefield and the South West Yorkshire Partnership NHS Trust. WYAS C85/1111

the body's surface and tested the doctor's medical skill with its many manifestations. Throughout the nineteenth century, the specialism of dermatology developed significantly, building on its late eighteenth-century origins. Between 1819 and 1899, 30 hospitals dedicated to skin diseases were founded in Britain.⁵⁶ There was greater professional organisation of dermatologists both in Britain and elsewhere: The Dermatological Society of London was founded in 1882 and the American Dermatological Association in 1877. From its inception, dermatology was an intensely visual specialism: Robert Willan's 1798–1808 volume, *Description and Treatment of Cutaneous Diseases*, was richly illustrated and dermatologists enthusiastically employed new technologies like photography in their work throughout the century. Jean Louis Alibert, a French physician particularly interested in diseases of the skin, was explicit in his comparison of the hospital to the theatre—though he also recognised that the audience's affective reaction to what they saw was an important element of medical practice.⁵⁷ Similarly, the Dermatological Society of London saw the illustration of skin disease—via the exhibition of living patients or models and illustrations—as one of its main objects.⁵⁸ Portable visual depictions of disease like the photograph proved vital in exchanging information with other specialists across geographic, language, and even class, barriers. For American dermatologist George Henry Fox, studying skin diseases without individual cases and illustrations was “like the study of osteology without bones, or the study of geography without maps.”⁵⁹

Dermatology went hand in hand with another expanding specialism at this time: venereology. The close connection between the two was exemplified in journals such as the *American Journal of Syphilology and Dermatology*, founded in 1870. In the link between dermatological affections and venereal disease, syphilis was central. The dermal manifestations of early syphilitic infection—small ulcers or sores, usually around the genitals, and later a blotchy rash and warty growths—had long been recognised, but it was only in the 1840s with the work of Austrian dermatologist Ferdinand Ritter von Hebra that it came to be clearly separated and recognised as different from leprosy.⁶⁰ Awareness was growing in the second half of the century of the possible causes and modes of transmission of skin conditions. The skin was increasingly imagined as a mediating surface, providing drainage for the body but also vulnerable to attack from external sources.⁶¹ This sense of the skin as a porous barrier could be seen

in dermatologist Erasmus Wilson's 1845 book *Healthy Skin*, a volume for the lay reader that emphasised the importance of personal hygiene. Wilson was a prolific writer on dermatology, penning a series for *The Lancet* in 1850 on the cutaneous manifestations of syphilis within which he emphasised the various affections of the skin that syphilis could not only give rise to, but also imitate.⁶² Syphilis had long been recognised as “capable of producing almost every form of eruption” and for this reason it posed challenges to doctors seeking to make a sure diagnosis.⁶³ Psoriasis like that suffered by William T. was said by some to be frequently mistaken for syphilis,⁶⁴ but it was explicitly aligned with that disease by others. Jonathan Hutchinson—well versed in the study of both dermatology and venereology—suggested that psoriasis was “a frequent result of a remote taint of syphilis”; George Henry Fox thought that in most cases of psoriasis there was an underlying “morbid condition of the economy, an ill-defined something, deeper than the scaly patches.”⁶⁵ This sense that the skin could provide clues to past infection, but also point to deeper-rooted hereditary taint, was not unusual in dermatological circles at this time.

Alongside the increasingly meticulous classification of skin diseases was a recognition that not all conditions were caused by infection or trauma to the skin. Psoriasis, for example, was suggested to be dependent on a degree of predisposition by Heinrich Koebner in 1872.⁶⁶ This co-existence of predisposition and external influence in disease aetiology was a recurring theme in late nineteenth-century psychiatry. Many diagnoses at the West Riding betrayed this: William S., a 34-year-old labourer admitted in 1885, was diagnosed with general paralysis attributed to a “predisposing cause” of “hereditary influence” and an “exciting cause” of “alcoholic excess.”⁶⁷ Assigning multiple causations to a disease may also have been partly due to the difficulty of obtaining reliable patient histories upon admission. The physical and mental condition of many general paralytic patients—confused, incoherent, and sometimes physically unable to speak—made it difficult to obtain clear information from them. In such cases the body could be a valuable source of information for the doctor.

THE SKIN IN GENERAL PARALYSIS

That the skin could tell of latent vulnerabilities and past lives was encapsulated in Woods Hutchinson's statement in his 1901 *Studies in Human and Comparative Pathology*, that “[t]he skin has suffered many things ...

and has been seriously misunderstood clinically, simply from the fact that it is the most external and superficial of our organs.”⁶⁸ Hutchinson’s recognition that the skin “suffered many things” is of particular relevance to the skin of patients with general paralysis and syphilis. In the asylum, as this section will discuss, the skin could tell stories: of past occupations and accidents, of previous infection, and of the state of the body’s interior.

The search for markings on the body’s surface began upon admission to the asylum, with patients bathed before being assigned to a ward. Bathing served an important hygienic function in large asylums, removing dirt and lice. James F., a colliery deputy, was said to be “very dirty on admission ... [and was] warm-bathed & put to bed in the sickroom.”⁶⁹ James W., a general paralytic patient, was admitted to the Asylum in 1899 “in an extremely neglected, filthy & verminous condition, the skin yellowish brown colour shewing numerous spots & scratches resulting from pediculi [lice].”⁷⁰ Bathing served a double purpose, as the cleaning of the patient’s body also revealed any scars, tattoos, injuries, or bruises. The West Riding’s Regulations for Officers of 1909 reveals bathing to be a methodical and meticulous exercise: the patient was to be “carefully undressed, and any bruises, marks, injuries, or eruptions on his person, are to be looked for and noted.”⁷¹ Tattoos were viewed as useful identifying marks and were often recorded in some detail in casebooks. James Thomas N., a 28-year-old scavenger, was noted to have a ship on his chest, a “shield & spray” on his right upper arm, “bracelets,” and a “tombstone & spray” on his right leg.⁷² The noting of the marks of injury served, as I will discuss in more detail in Chapter “[Bone](#)”, to absolve medical attendants of blame in cases of accident in the asylum, but it could also serve a clinical function in revealing the signs of past infections.

Early syphilis treatment, such as that offered by the London Lock hospitals, may have healed or lessened the severity of the initial sores and eruptions of the disease, but it did not eliminate them entirely just as it did not cure the disease. The scars that often remained after topical treatment with mercury were regularly searched for by asylum doctors to determine past syphilitic infection. Those patients who had not sought treatment could also exhibit significant scarring. In many cases, despite the patient’s denial of the fact, a history of syphilis could be read by the asylum practitioner in “the crescentic outline, the dusky margin, the depressed circular scar” on the patient’s body.⁷³ Standing the patient in a brightly lit room, or using a mirror to reflect light accordingly, examination of the mouth, tongue, and throat could reveal old scars that were “silent witnesses of the

greatest value.”⁷⁴ The body spoke of what the patient would or could not: although George S. “denie[d] syphilis ... he [had] a well marked scar on the penis.”⁷⁵ Fred H., whose initial diagnosis of imbecility was replaced with “dementia of GP” not long after his admission, was noted to have a “distinct history of syphilis—old scars present on edge of tongue & penis.”⁷⁶ Thirty-two year old George W., suffering from a syphilitic rash, was carefully photographed—a full body shot, as well as close-ups of his torso and back—with the photographs (from life) making their way into the post-mortem records after his death just over two years later.⁷⁷ The skin of patients could also reveal something of their personal history and working life. George C., a 52-year-old labourer admitted to the West Riding Asylum in 1895 was observed to have “Numerous coal pigmented scars about [his] face & body ... got in the pit.”⁷⁸ Albert Walter S.’s skin was roughened, a condition linked by the doctor to Albert’s occupation of blending coloured yarns.⁷⁹ The face of Joseph S., a fisherman, was marked by smallpox, and he was also noted to have “linear scars from flogging on [his] back.”⁸⁰

As well as external conditions experienced by the patient, the skin was viewed by dermatologists (and other doctors) at this time as a means of understanding much deeper goings-on inside the body. There was increasing recognition in the late nineteenth century that skin conditions might be aligned with mental or neurological disorder: the Dermatological Society of Great Britain and Ireland attracted a wide variety of doctors into its membership, including the neurologist John Hughlings Jackson as well as several venereologists. With skin identified as an organ with a complex nervous arrangement, asylum doctors began to turn their attention towards it. A number of ‘dermato-neuroses’—skin conditions linked to emotional states—were identified by doctors specialising in dermatology, including the suggestion of a relationship between grief or fear and impetigo.⁸¹ At Sussex County Asylum Patrick Nicol made a number of observations of patients with the assistance of Head Attendant Miss Buckle, compiling a list of the affections suffered. Most of the conditions that he found were minor temporary afflictions, such as eczema, though he also drew attention to some more unusual conditions, including the “sanguineous heel of the insane” (a build-up of blood in the foot).⁸²

In general paralysis the surface of the body had long been recognised to indicate something gone awry, with the facial expression offering one of the earliest indications of the disease. West Riding patient Adolph K. “at times ... smile[d] or laugh[ed] in a beaming jovial manner, strongly suggestive of

General Paralysis”; Thomas H. had “a pleased beaming expression of countenance & well marked G.P. Physiognomy.”⁸³ This concern for the facial features of general paralytic patients drew upon older ideas about physiognomy and mental disease—the idea that insanity betrayed itself in an individual’s facial features—but also genuine changes to muscle tone that altered the skin’s appearance. As general paralysis progressed, the features of the face became flabby, the skin took on a greasy sheen, and the lines of expression became both erased (around the mouth) and enhanced (on the forehead), leading to a distorted facial balance and a strange mask-like appearance that many doctors commented on in the disease. As well as these changes to the skin and muscle tone, general paralytic patients were said to be prone to a whole host of unusual skin conditions. The *Journal of Mental Science* (*JMS*) recounted the case of one patient who had been observed to have darkening skin of the eyelids, which increased until “a narrow, black band crossed the upper part of the nose”—this remained for seven days before fading.⁸⁴ “Pemphigus blebs” (blisters) were described in several cases of late-stage general paralysis—claimed by one investigator to be the result of nerve atrophy.⁸⁵

Besides visual anomalies, some doctors held that the skin of insane patients emitted unusual odours, described by one observer as a “mousy smell.”⁸⁶ Prussian psychiatrist Heinrich Laehr suggested this odour was due to a greater secretion of sweat, and indeed strange patterns of perspiration were also noted.⁸⁷ William Julius Mickle, Superintendent of London’s Grove Hall Asylum, reported a case in which a general paralytic patient of his had experienced significant perspiration limited to the right side of his face.⁸⁸ The skin was credited, then, with the potential to reveal deep disturbances within the body, with the insane imagined more prone to specific affections than the general population (a 1904 study of inmates at the Manhattan State Hospital in America claimed that “malignant growths” were twice as frequent among insane, as opposed to sane, populations⁸⁹). Relating a case of postepileptic hysteria in 1898, F. Graham Crookshank of the Northampton County Asylum noted that the chief interest of the patient’s case was “due rather to his cutaneous than his mental eccentricities”: his skin was covered with warts and growths, and he had patches of psoriasis on his knees and elbows. Crookshank used the “correlation of the insane diathesis with cutaneous abnormalities” to suggest that such skin affections might be an indication of abnormal mental states.⁹⁰ Indeed, phenomena such as the unilateral sweating witnessed by Mickle suggested—as research on localisation of the brain developed—

something awry in the brain substance, with the sweating side of the body indicative of a brain lesion or nervous anomaly. An experiment on a horse by physiologist Claude Bernard in 1851, for example, had shown “that division of the cervical branch of the sympathetic [nervous system] ... caused increased perspiration on the corresponding side.”⁹¹ Neurologist Charles-Édouard Brown-Séquard, in a series of lectures in 1876, suggested that simple lesions of the brain substance could cause marked changes in distant parts of the body. He cited the findings of Jean-Martin Charcot, who had noticed that bedsores developed on the opposite side of the body to the side of the brain found (at postmortem) to be affected by organic disease.⁹² Alongside localisation studies, by the end of the century skin specialists were also identifying a number of ‘dermato-neuroses’: skin conditions of nervous origin.⁹³ These ranged from relatively minor stress-induced eczema to the marked symmetrical skin lesions seen in hysterics at the Salpêtrière; such conditions were often assimilated into contemporary discussions about self-inflicted injury that continued into the twentieth century, as doctors struggled to distinguish between dermato-neuroses and self-harm.⁹⁴

As well as the visual evidence of the skin, its receptivity to external stimuli was also recognised as a useful marker of the progress of disease by asylum doctors. Many patients with general paralysis suffered from diminished, heightened, or otherwise distorted bodily sensations. In the early stages of the disease, patients might experience hyperaesthesia—a state in which “Ordinary, painless, impressions [became] painful; and painful ones agonizing.”⁹⁵ Later, physical sensations tended to be deadened, making it difficult for patients to walk normally or carry out basic physical tasks that required holding on to an object such as a pen or a button. Upon admission, many general paralytic patients were tested both in regard to their sensibility to pain and general sensation. Aesthesiometers, caliper-like tools that measured the distance between which two points on the skin could be distinguished, aimed to quantify a patient’s tactile sense. Benjamin U., admitted to the West Riding in 1891, had the sensation in his upper and lower limbs and face tested with this instrument. The examination was carried out the day following his entrance to the Asylum because, immediately upon admission, he “appear[ed] to be in considerable suffering” after providing a vivid and emotional account of his visual hallucinations.⁹⁶ Instruments like the aesthesiometer were just one way of assessing patient’s sensations, and the Asylum often employed simpler tests that did not require specialist equipment. Joseph K. was unable to feel the

floor with his right foot, and had anaesthesia of the skin on the right leg, “tested by pinching or pricking”; the skin of his right forearm was also completely insensitive.⁹⁷ Another patient had “to reflect some time before deciding that two contiguous toes [were] being touched” by the doctor; one had a test tube placed against their skin and was asked to determine if it was filled with hot or cold water; another was asked if he was aware “whether he [stood] on board or carpets.”⁹⁸ When employed in cases of general paralysis, these tests usually found significantly diminished and sometimes wholly absent sensation on the surface of the skin. This lack of sensation could easily lead to accidents, as general paralytic patients burned themselves on hot water bottles or radiators, or injured themselves in other ways. A lack of pain seemed to be a factor in 44-year-old Rawnsley A.’s perpetual gnawing at his finger to the point of producing an open wound that the doctor feared would become gangrenous.⁹⁹ This was a habit noted by Mickle to have resulted in several amputations among the general paralytic patients he had seen. Most startlingly, he claimed that some of these amputations were performed without anaesthetic due to the complete lack of sensation experienced by the patient, demonstrating just how far diminished sensation could advance in cases of general paralysis.¹⁰⁰

The sense of alienation from one’s body in general paralysis is frequently suggested in the supposed delusions of patients recorded by doctors in the casebooks. Although such delusions were not exclusive to general paralytic patients, many doctors recognised that delusions relating to the body were especially frequent among this group. Bryan H. declared that he had “no throat heart or liver” and that “his bones have been taken out to build other people his ribs have been taken out to build the children they make in [the] asylum and gutta percha has been put in their place.” Referring to two other patients on the ward, Bryan told the doctor that “both those bodies belong to me.”¹⁰¹ George Savage explained cases like this with the analogy of the miller who could not sleep when the incessant noise of his mill was stopped, reasoning that “the general paralytic becomes conscious of his visceral sensations when these are cut off.”¹⁰² General paralytic patients could experience specific and often startling sensations alongside a more general anaesthesia: pricking of the skin, a sensation of electric shock to the head, and an unusual bodily heaviness or buoyancy were typical complaints. Many of these sensations were described in admission interviews in a way that could complicate the boundary between reality and imagination, as patients searched for ways to articulate their bodily experiences. As historian Brendan Kelly has noted, apparent delusions might—despite their ‘false’ nature

—“reflect truths, unspeakable truths, in disguised or metaphorical form.”¹⁰³ James T., a suspected general paralytic admitted to the West Riding in 1875, was said by the doctor filling in his reception order to be subject to delusions, one of which was that “the flesh was dropping off his bones.” Upon admission, however, James explained to the Asylum staff that this statement was an analogy that he had used in attempting to describe numbness in his toes, illustrating the gap that could exist between lay and professional language in a medical context.¹⁰⁴ The role of such sensations in the production of hallucinations and delusions—whether actual or merely interpreted as such by doctors—was recognised by Mickle:

Here is a fertile field for the generation of hypochondriacal and melancholic delirious conceptions. The sensory perversions might conveniently be spoken of as hypochondriacal illusions. Under that head, and under the hypochondria of g.p., have they been described; particularly as, owing to the mental state of the patients, these perverted sensations are difficult to examine.¹⁰⁵

On seeing patients suddenly shriek or declare that they had been attacked, doctors and attendants had to keep in mind that such outbursts might be due not to hallucination, but to painfully tangible physical and mental events. In some cases changes to the body—particularly visible skin affections—were interpreted by patients in light of existing persecutory delusions. Edward L. was noted to have a small sore on his leg, telling the doctor that it was caused by men blowing darts at him at night that had perforated the skin.¹⁰⁶ Similarly, a case of ecchymosis (bleeding beneath the skin causing a bruise-like appearance) reported in the *JMS* related that the “small purpuric spots” that had appeared on a patient’s skin following an episode of excitement were “promptly fixed on [by her] as evidence of poisoning.”¹⁰⁷ Pellagrous insanity (the mental disturbance resulting from vitamin B deficiency), in which the sufferer’s skin may burn or itch as well as presenting severe lesions, could also lead to delusions of “being burned, of sorcery, and of persecution.”¹⁰⁸ The skin was a surface, then, through which patients made sense of their contact with, and place in, their immediate surroundings. In general paralysis, the changing sensitivity of the skin limited the sufferer’s interaction with and understanding of these surroundings, causing pain or a dangerous loss of sensation. At the same time, this altered sensation was investigated by asylum doctors in the hope of glimpsing the inner workings of the body and the disease that lay beneath the surface of the skin.

THE SKIN AS SITE OF SURGERY AND THERAPY

Just as the surface of the skin could conceal as well as reveal the body's inner workings, the surface of the photograph represents both the significant and the insignificant, unwittingly preserving facts considered too mundane to be recorded in written documents. In addition to saying something of the photographic practices of the asylum and of patient's conditions, the photograph reveals something else: the presence of asylum staff. In the West Riding album, there are four instances in which we can see the hand (and in two instances face) of an attendant or doctor encroaching into the frame. An elderly patient, Mary L., is touched on one shoulder by someone out of shot as her picture is taken on the Asylum grounds; it looks like a gentle touch, a momentary encouragement to remain seated for the duration of the photograph, and the fact that I feel compelled to read such a small fragment of the image in this way speaks of the significance of the seemingly insignificant. Today, we tend to judge the presence of anything besides the object of the photograph as a technical failure, yet the limited editing ability of early photography means that these unwitting glimpses beyond the photographic frame are often retained, offering the historian extra information.¹⁰⁹ In attempting to frame a subject, and to omit those people or things around them, the photograph often succeeds in drawing attention to those intended omissions. Rory du Plessis, discussing the photographic records of South Africa's Grahamstown Lunatic Asylum, has described how photographs may capture—despite their clinically oriented aims—acts of resistance by subjects. In the Grahamstown pictures, patients look away, close their eyes, or are depicted actively straining against the hands of attendants. The photographic details that “strike and pierce” du Plessis are “how the postures, gestures and facial expression of the patients reveal resistance,” highlighting that the act of taking a photograph can never be completely neutral.¹¹⁰

Even as we recognise the agency of those patients who display resistance to being photographed, it is also important to recognise that the presence of ‘others’ (attendants’ hands, for example) in asylum photography is not always straightforwardly readable as coercive or restraining. Illustrating a 1900 *JMS* paper on skin diseases in the insane was a photograph of a woman with unusual skin pigmentation. Looking into the camera, she clutches the hand of someone next to her with both hands; she appears to be experiencing some trepidation about the photograph being taken, and holds on to someone out of shot for reassurance.¹¹¹ Of the four

photographs in the West Riding album that depict the presence of attendants, three illustrate cases that were of especial interest to doctors on account of the conditions suffered by patients and their subsequent treatment. All involve the surface of the skin and, in following the stories behind these photographs in the final part of this chapter, it is possible to elucidate three further elements of asylum practice: the challenges of caring for bed-bound and frail patients, the carrying out of surgical procedures, and the introduction of phototherapy for the treatment of skin conditions.

Two of the four photographs depict Elizabeth B., a long-term resident of the asylum who had been admitted in 1871. The two photographs seem to have been taken at the same time and depict the severe bedsores on the back of Elizabeth's knees. With Elizabeth lying in bed, and clearly frail, displaying these sores to the camera necessitates the assistance of a nurse and another attendant or doctor, both of whom can be seen in shot as they lift Elizabeth's legs up from the bed. The presence of these staff in the photograph testifies to the challenges involved in caring for patients like Elizabeth, described in her records as restless and destructive, as well as the potentially harmful consequences of patients remaining bed-bound for long periods of time. Elizabeth's bedsores were a long-standing issue. In the Asylum's Register of Mechanical Restraint—a legal requirement under the 1890 Lunacy Act—she accounts for a large number of the entries, being regularly placed in either leather gloves or long sleeves to prevent her interfering with the dressings applied to her bedsores and, it was implied, to check her general “destructive” tendency.¹¹² A casebook entry in January 1895 recorded that she had “two sores on [the] front of [her] left knee which [were] being dressed daily” and some “very unhealthy looking” sores behind both knees. A month later one of these had extended to “nearly 2in. long, [the] subjacent tendons being exposed & the sores covered with a nasty slough.” Elizabeth was placed in long sleeve restraints and by June the sores were said to be “quite healed.”¹¹³ The photograph was likely taken before this period of restraint commenced, offering vivid visual proof of its necessity. In Elizabeth's case, however, her relief was not to be permanent: upon her death the following year she was noted to again have extensive bedsores across her body.¹¹⁴

While Elizabeth was not suffering from general paralysis, bedsores were a widespread problem in the asylum, in many cases as a consequence of the asylum environment itself. Bedsores caused by long periods spent in bed posed serious problems, with the most severe instances leading to the destruction of ligaments, thrombosis of the limbs, joints, and internal

organs, and septicaemia. Bedsores were said to be an important contributory factor in the death of Adolph K., a death “hastened by suppuration at the seat of [a] fracture, and by large bed-sores.”¹¹⁵ General paralytic patients were especially vulnerable to bedsores as the disease progressed, partly because of their lack of mobility and partly, some suggested, as a result of an innate degenerative tendency. Mickle listed bedsores alongside boils, zoster crops, haematoma of the ear, and carbuncles as common features of the condition.¹¹⁶ In some cases water beds were used in order to prevent or alleviate bedsores, or the patient swaddled in layers of cotton wool and flannelling. Bedsores could also increase the possibility of patients contracting erysipelas, a streptococcal infection occurring when bacteria enter the body via cuts or broken skin. Erysipelas was usually treated by painting the skin with a solution of picric acid, or the patient isolated, but in some cases it called for more serious intervention. James P., a weaver who had been admitted to the asylum in June 1898, developed phlegmonous erysipelas on his left leg in March 1902. He was regularly sponged down to reduce his alarmingly high temperature, before “five long incisions were made in the leg” and antistreptococcus serum injected. It was a futile exercise: James died a few days later from septicaemia.¹¹⁷ Erysipelas was an infrequent but noteworthy cause of death among asylum patients, especially among general paralytics who were apt either to involve themselves in fights with other patients or fall when unsupported, leading to cuts and abrasions that were open to infection. A coroner’s inquest in 1883 attributed Joseph P.’s death to both erysipelas and general paralysis, noting that the erysipelas was the consequence of his fighting with another patient and receiving abrasions to his nose which became infected. His subsequent treatment had also been complicated by his persistent removal of his dressings, and this appeal to the destructive tendencies of general paralytics when explaining deaths was not uncommon, as I discuss further in Chapter “Bone”.¹¹⁸

Another photograph in the West Riding album that, like the images of Elizabeth B., calls attention to a physical condition while simultaneously revealing others outside the frame is that of William B. William’s right arm is held steady by someone outside the frame in order to fully reveal the large tumour above his elbow. This inclusion of hands in the composition can be seen in much nineteenth-century medical photography, serving to pose the patient’s body and draw attention to the condition depicted, but also to introduce a trace of professional medical attention and care.¹¹⁹ William, 50 years old, had had the tumour for around 20 years—causing