

Writing the Case—Pinel as Psychiatrist

Philippe Huneman

Institut d'Histoire et de Philosophie des Sciences et des Techniques,
CNRS/Université Paris I Sorbonne

INTRODUCTION

Philippe Pinel's *Traité médico-philosophique sur l'aliénation mentale ou la manie*, published in 1802, is the cardinal book of *aliénisme* (the French word for the nascent field of psychiatry), and the work that, according to the myth of the birth of rational psychiatry, breaks with the ancient medical practices of treating the mentally ill. In it, Pinel defines the psychiatrist's field: it is a medicine of mental troubles that has its own kind of legitimacy, its own object of study—mental illness identified as mania, as opposed to somatic diseases and delirious fevers—and finally its own characteristic method, the “moral treatment.” The epistemological meaning and historical role of the *Traité médico-philosophique* have been extensively analyzed for several decades.¹ Foucault especially claimed that the legend of Pinel as the one who gave (some) freedom and respect to the insane is to a large extent historically inaccurate. According to Foucault, instead of the previous habit of setting aside those people seen as mad and putting them together with other diseased people, prostitutes, etc., in specific hospices where they were locked in chains, Pinel started to sort out insane people from among all these “abnormal” humans and let them live in special, psychiatric hospitals. But although they were out of their chains, they were submitted

I would like to express my deep gratitude to Patrick Singy for his impeccable reading and judicious suggestions on the essay. I thank Elizabeth Vitanza and Stefanos Geroulanos for the English translation.

¹ See Dora Weiner, “Observe and Heal: Philippe Pinel's Experiment at the Salpêtrière Hospice, 1802–1805,” in *Knowledge and Power: Perspectives in the History of Psychiatry*, ed. E. J. Engstrom, M. M. Weber, and P. Hoff (Berlin: Verlag für Wissenschaft und Bildung, 1999), 25–43; Dora Weiner, *Comprendre et soigner* (Paris: Fayard, 2001); Jackie Pigeaud, *Aux portes de la psychiatrie: Pinel, l'ancien et le moderne* (Paris: Flammarion, 2002); Michel Foucault, *Histoire de la folie à l'âge classique* (Paris: Gallimard, 1961).



Huneman, Philippe. “Writing the Case—Pinel as Psychiatrist.” *Republics of Letters: A Journal for the Study of Knowledge, Politics, and the Arts* 3, no. 2 (January 15, 2014): <http://arcade.stanford.edu/rofl/writing-case-pinel-psychiatrist>.

to the absolute authority of the mad doctor, to whom they were tied by a subtle link: doctors' knowledge and ability to cure was grounded in their hidden moral superiority, as placeholders of the Law, the Family, or the Society, whose medical practice consists in "offer[ing] a commentary of the ancient rites of Order, Authority, and Punishment."² The insane and the psychiatrist together form "a strange sort of couple, an undivided unity," through which the physician cures not on the basis of his knowledge but via his moral mastering of an individual who is not a genuine subject but someone in a state of minority:³

These powers [over the insane], by their nature, were of an order that was moral and social. They had their roots in the status of the mad as minors, and in the alienation of their character rather than their minds. If the medical character could circumscribe madness, it was not because he knew it but because he mastered it; and what positivism came to consider as objectivity was nothing but the converse, the effects of this domination.⁴

Many scholars have discussed this view; for instance, Marcel Gauchet and Gladys Swain objected to the claim that Pinel's approach was somehow a new kind of exclusion and domination of a category of people, and Andrew Scull has insisted on the role that alienism played in a specific new pattern of capitalist economy. In any case, the connection between the mentally ill, as people likely to be treated by a new kind of medicine, the psychiatrists themselves, and the psychiatric hospital is crucial in Pinel's discourse and practice. The present investigation intends to cast a new light on it by focusing on the grammar and rhetoric of the case study in Pinel's writing.

Any reader of the *Traité* (particularly of the first edition of 1802) will indeed notice that it largely comprises more or less long case studies. In contrast to Jean-Étienne Dominique Esquirol's later theoretical ambition, evidenced by *Des maladies mentales* (1818), which simply treats clinical elements as illustrations of his definition of theoretical entities and his discussion of classifications, Pinel's *Traité* is built entirely on clinical case studies, which are sometimes taken from the "Mémoires" read at the Société des Observateurs de l'Homme, which established statistical tables on admissions, recoveries, and so on;⁵ those "Mémoires" are certainly part of the body of the treatise, but Pinel reused them here in a work where the case histories figure most prominently. Understanding what is at play in psychiatry's inauguration thus also involves asking at a certain point why this took place in such a specific form—a collection of cases with commentaries, rather than a nosology or a theoretical treatise. Thus, I will analyze the specificity of the clinical case as it appears in Philippe Pinel's psychiatry and how the structure of its narrative clarifies certain aspects of the institution of medical psychiatry.

The clinical case is so often viewed as an obvious medical object that it seems today as though a doctor speaks of cases in the way a botanist speaks of plants. It is such a simple thing: a case—more commonly referred to as a case history or a case study in English⁶—is a short story that reports how someone has fallen ill, and with what illness, what has happened to the patient

² Foucault, *Histoire de la folie*, 626; Michel Foucault, *History of Madness*, trans. Jonathan Murphy and Jean Khalfa (London: Routledge, 2006), 506.

³ Foucault, *Histoire de la folie*, 627; Foucault, *History of Madness*, 507.

⁴ Foucault, *History of Madness*, 505–6.

⁵ exts published and annotated in Weiner, "Observe and Heal"; and Weiner, *Comprendre et soigner*.

⁶ By saying "*le cas*," the French language is more equivocal, referring at the same time to the depiction of a medical illness with its cure and to the object of its depiction itself. In what follows, "the case" will mean generally what "case history" means in English.

once he or she became ill, how the patient is being treated, and finally if the person recovers. “Case” then designates at the same time an ontological category—a case is a unique spatial-temporal entity, unlike a class, a property, or a rule—more than a discursive category; the case history is different from a demonstration, from an inference or a taxonomy.

Aristotle had already said that medicine does not treat man in general but rather *this man here*: it works at the level of the individual. There is no botanical or physical “case”; the case is essentially medical since medicine is essentially individualized, which is why its status is always debated, between science (a discourse of the general) and art (the practice of the singular), a debate going back to the Aristotelian interdiction of a science of the individual. The case, a singular story at its core, bears meaning only insofar as it deviates from the norm, a norm that could here be a priori termed health. At the same time, the case is connected to the universal in the sense that the disease in the case is a universal concept. The medical case’s ambiguous status is reflected in the tension between medicine as a science (which establishes the species) and medicine as a singular practice (which establishes an interaction with a given sick person). Finally, the case history in medical writing is singular in another sense: it exposes a unique therapeutic practice: “I, Aulus Cornelius Celsus, or I, Thomas Sydenham, have diagnosed this individual with such-and-such a disease, and I have treated him in such-and-such a way, and I have finally cured him (or not).”

Thus, in medicine the case establishes a double articulation: between the universal (a given pathology) and the individual (a given ill individual and his or her story); between the level of the visible at which symptoms take place and the invisible level of these symptoms’ signifiers and of the etiology supposed to explain what is invisible. Medicine’s configuration, in a given period of time, is seen and understood by the way the clinical case carries out this double articulation. Therefore, a case study is never something natural: the case obeys certain requirements and espouses certain forms that differ across different periods of medical history, different disciplines, and different schools that define what we could call the case system. This essay aims to show how, with the *Traité médico-philosophique*, French alienism specifies the medical case’s double articulation in a way that will later impinge on psychiatry in general, therefore constituting a case system that is properly alienist or (at least) Pinelian. Foucault held that, as subjectivity, the insane is somehow the subject of the alienist or, in other words, that his or her individuality is captured in a specific kind of apparel constituted by the psychiatrist’s science and the asylum as institution. Understanding the Pinelian case system, as a scheme for a specific articulation between individual and universal, will help us assess these views.

The clinical case in the *Traité* actually marks a dual difference: the first holds between the case system in the era of clinical medicine and the earlier case system; the second holds between the use of the case in the Pinelian *Traité* and that of the case in usual clinical medicine. For this second point of difference, Marie François Xavier Bichat’s work, contemporary to the *Traité*, serves here as a primary point of reference; a second contrast will be provided by Pinel’s own *Nosographie philosophique*, in which it is interesting to note that the use and grammar of the case history differs markedly from what is found in the *Traité*.

To begin, I will analyze the context of this dual difference, which situates the Pinelian case system. I will start (section 1) with the historical context of the institution, the hospital, briefly retracing its effects on the medical case system. I will then (section 2) provide a proper

philosophical context shared by Pinel, Pierre Jean George Cabanis, and Bichat: the Ideologues, often doctors themselves, and the influence of Cabanis's ideas.

Section 3 analyzes the psychiatric case system in Pinel's text. The analysis will not be able to avoid selecting a significant number of complete case studies in order to closely examine their language. I have pulled out eight from the text. After analyzing several general points, I consider three aspects successively: the type of temporality these case histories use and their relationship to causality; the presence of the hospital as a place of healing; and the rhetorical function of the case study within the broader Pinelian project. Taken together in these three perspectives, the multitude of the case histories and their specific handling in the *Traité* are not anecdotal but rather participate in the very movement of what could be called the Pinelian demonstration, as I will conclude: that is, the demonstration that madness is a disease, that as such it is curable, that a specific type of medical practice exists for it and is relatively autonomous in relation to established medicine, and that the natural place to practice this medicine is the hospital.

1. THE INSTITUTIONAL CONTEXT OF THE CASE SYSTEM IN PSYCHIATRY

Classical physicians—Sydenham, to take the most well known among them, or his model from antiquity, Hippocrates—exist between the body of the abstract, ideal book, from which they draw their knowledge, and the unique body of the patient, exposed to the doctor in a face-to-face relationship (since the ill are private patients). This holds true for what is called the medicine of the soul as well as for the medicine of the body: the classic works of Thomas Willis, François Boissier de Sauvages, and William Cullen and their pages on “*vesania*” (Latin for “insanity”) are loaded with case histories; there are even more in the ancient works.⁷ Psychiatry (which was not yet called psychiatry, the term originating with Johann Christian Reil at the beginning of the nineteenth century; it was not even yet called alienism, which was itself still not distinct from medicine) is a corpus where the same histories reappear from work to work, independently of doctrinal modifications, and where they are often used to illustrate different theories. The canonical example of this was Galen's diagnosing a pathological love passion by taking the ill person's pulse; later it was Herman Boerhaave's curing a dozen orphans by collectively scaring them; and finally, Willis's curing George III would become the most famous example before Pinel.

Cabanis, Bichat, Pinel, and the authors of the second half of the eighteenth century in general experience another way of situating the doctor. The horizon upon which they worked was effectively circumscribed by an institutional event: the invention of the hospital as no longer a place of hospitality but as a place of cure. Historians have for several decades retraced and reflected upon this major moment of medical history, often by way of divergent approaches. Toby Gelfand magisterially recounted the social and institutional context of rivalry between doctors and surgeons and more generally between clergy and doctors upon which this invention was built.⁸ Erwin Ackerknecht studied the hospital's role in the emergence of Paris's clinical school.⁹

⁷ Thomas Willis, *Two discourses concerning the soul of brutes which is that of the vital and sensitive of man* (London: Thomas Dring, 1683); François Boissier de Sauvages, *Nosologie méthodique, ou distribution des maladies en classes, genres et espèces selon l'esprit de Sydenham et la méthode botanique* (Lyons: Mercier, 1771); William Cullen, *First Lines of the Practice of Physics* (1777; London: Cadell, 1784).

⁸ Toby Gelfand, *Professionalizing Modern Medicine: Paris Surgeons and Medical Science and Institutions in the Eighteenth Century* (Westport, CT: Greenwood Press, 1980).

⁹ Erwin Ackerknecht, *La médecine hospitalière à Paris: 1794–1848* (Paris: Payot, 1986).

On a larger scale, Michel Foucault argued that what is now called “the medicalization of the hospital” was essential for turning populations into a major concern for modern politicians. Andrew Scull and George Rosen showed how the hospital’s therapeutic mission was inscribed in new and developing social imperatives linked to capitalism.¹⁰ Even more than Scull and Rosen, and contrary to Ackerknecht and Gelfand, Foucault asserted that the hospital’s clinical medicine was not born just because doctors, via surgery, came closer to patients within the hospital, rather than evolving in a world of theories and abstract nosological entities. More recently, Antoine Ermakoff has analyzed the Conseil Général des Hospices de Paris to show the convergence of separate medical, economic, and political logics that at the end of the eighteenth century and in the first twenty years of the nineteenth century modeled the function and idea of the modern hospital.¹¹

It is therefore in the hospital, a key emerging institution, that we first encounter the clinical case. Beginning in the 1830s the mentally ill were sent to the psychiatric asylum, but Pinel, arriving at the Bicêtre in 1793, then at the Salpêtrière in 1802, was responsible for a section of insane patients in a hospice. It was there that he initiated the process of demanding a separate psychiatric hospital that Jean-Étienne Dominique Esquirol and his followers (Leuret, Georget, the Falrets, Fodéré, etc.) would later continue and that would lead to the law of 1838 that stipulated conditions for confinement and ordered a psychiatric establishment for each *département* of France.¹²

In the hospital, a case is no longer this individual who represents an abstract being, as Thomas Sydenham’s or Boissier de Sauvages’s patients were for the ontological types that “diseases” were in nosological medicine.¹³ Here, the patient was taken from a collection of ill people, a token within a series. The example/idea relationship that had characterized the clinical case in classical nosologies was no longer valid for doctors at the end of the eighteenth century, being replaced here by the somehow statistical relationship between an individual and a collection. The relationship is embedded in each diseased body of the collection, whereas the collection itself is constituted by procedures outlined by the institution of the hospital: regular checks on a wide range of parameters, the recording of a medical history upon admission, and so on.¹⁴ The case, in this context, means a structured triplet: a name, a group of successive perceptible symptoms, and a written account of observations drawn from a wide range of daily measures. Clinical work aims to confer an intelligible consistency upon this tripartite structure. The clinical case in medicine that appeared (at least) in France starting in the 1750s thus belongs to a double space: the ideal space of pathological species, among which Cullen’s (1784), Boissier de Sauvages’s (1771), and

¹⁰ Foucault, *Histoire de la folie*; see also Michel Foucault, “La politique de la sante au XVIIIe siècle,” in *Dits et écrits, 1954–1988*, vol. 2, 1976–1988 (Paris: Gallimard, 2001), 725–42; Foucault, “L’incorporation de l’hôpital dans la technologie moderne,” in *ibid.*, 508–21; George Rosen, *Madness in Society: Chapters in the Historical Sociology of Mental Illness* (London: Routledge, 1968); Andrew Scull, “From Madness to Mental Illness: Medical Men as Moral Entrepreneurs,” *Archives européennes de sociologie* 16 (1975): 218–51.

¹¹ Antoine Ermakoff, “Le conseil général d’administration des hospices civils de Paris: Science d’administration des hôpitaux et médecine clinique (1801–1832)” (PhD thesis, University of Paris–VII, 2012).

¹² On this point, see Robert Castel, *L’ordre psychiatrique: L’âge d’or de l’aliénisme* (Paris: Minuit, 1976); and Jan Goldstein, *Console and Classify: The French Psychiatric Profession in the Nineteenth Century* (Cambridge: Cambridge University Press, 1987).

¹³ Boissier de Sauvages, *Nosologie méthodique*.

¹⁴ Antoine Ermakoff (“Le conseil général d’administration des hospices civils de Paris,” sec. 3) studied the minute, specifically administrative procedures unique to the hospital that contributed to the creation of the “clinical case” that the medical works would later relate. These “paper technologies” followed economic imperatives, using rudimentary statistical tools, and ultimately defined a “hospitalization of medicine” that Ermakoff shows has played a major role in the emergence of anatomical-clinical medicine.

finally Pinel's (1798) nosologies are the best examples and references of the time; and the social space of the hospital, where the case history is taken from the collection. Typical of the connection between these two spaces, pathological species and hospital, is the complementarity between Pinel's 1797 *Nosographie philosophique* and his *Médecine clinique*, which aims to accompany the *Nosographie philosophique* by presenting numerous clinical cases that aimed at helping the new doctor recognize his role with regard to the many types of diseases analyzed in the *Nosographie* by applying them to the hospital environment. The collection that is *Médecine clinique* yields a rather concrete basis for the practice of philosophical nosography, and Pinel writes:

It's hard to express the fluctuation of opinion, the uncertainty, and the extreme uneasiness that I felt, about twelve years ago, when I was called to practice medicine in hospitals. I had naturally to try, during my ordinary visit to the patients, to elaborate a rigorous account of everything I could observe and to at least avoid dangerous mistakes. Yet so many obstacles kept on confronting me—because of the confusion of objects! Indeed, what a disparate scene, and always in motion, can constitute an assembly of 150 to 200 sick people, struck by simultaneous or successive symptoms, more or less serious, some due to the specific nature of a disease, others just due to the place or to some individual dispositions, yet others, finally, due to the special influence of seasons or the atmosphere! Could I chart my way on the basis of singular histories that are so often weighed down by superfluous details?¹⁵

The jumble of meanings created by the accumulation of patients in the hospital must, according to the exchange between *Nosographie* and *Médecine clinique*, be organized in the doctor's own mind beginning with a series of clinical cases that are connected by rational relationships. (Note that the history of the hospital as an institution consists of producing within it a similar movement, by the separation of the ill into distinct pathological territories, or the ordering of "singular histories" (*histoires particulières*) that reduce "superfluous details.")¹⁶ The clinical case in pure medicine and as a discursive category is a means to create order out of the jumble of individualities that make up a collection of hospitalized patients; it is an intermediary order, between the disorder of "first impressions" and the ideal order of taxonomy. The first agent in this transformation is thus the more or less minute recording of modifications of variables that characterize an individual's state during his or her hospitalization, with the understanding that this record is just one part of a large class of observations that supposedly correspond to other patients afflicted with analogous pathologies.

Before studying how the psychiatric case system differs from the medical clinical case, it is important to point out that medical discourse in the strict sense is not homogeneous, particularly when it relates to the hospital. A quotation from Bichat's *Anatomie pathologique* establishes its contrast with the Pinelian case in the *Médecine clinique*:

One observes the inflammation in the envelopes (*gaines*) of the ligaments of the wrist and the finger, etc. There is an infection within the envelope (*gaine*) of the flexing muscles of the hand, and ravages it; the finger inflates without redness, but with an acute pain on its palm-side. Soon,

¹⁵ Philippe Pinel, *La médecine clinique, rendue plus précise et plus exacte par l'application de l'analyse* (Paris: Brosson, 1804), i.

¹⁶ On this, see George Weisz, *Divide and Conquer: A Comparative History of Medical Specialization* (Oxford: Oxford University Press, 2006); Ermakoff, "Le conseil général d'administration des hospices civils de Paris," sec. 2.

pus accumulates and is compressed between bones and the synovial membrane. It seems that most of what occurs due to this infection should be linked to this cause. One finds, when opening up the corpse, the *capsule* all red and full of infectious pus (*ichoreux et sanieux*).¹⁷

The anatomical-clinical medicine that Bichat initiated clearly avoids the case history, since it relies on cadavers (in pathological anatomy), which the discourse links in a loose and *nonindividualized* way to the formerly living ill person.¹⁸ It is this type of discourse, characterized by its strong focus on sensory qualities and its insistence on the narrative's phenomenological precision, that Foucault treats as typical of the epistemological slippage introduced by clinical medicine in his *Birth of the Clinic*.¹⁹ But, conversely, as we can see in the former examples, Pinel's clinical medicine, like his psychiatry, is not centered on the autopsy room and does not first and foremost reference it. It focuses on the clinical case, linked to the hospital where the doctor meets his patients,²⁰ so that the discursive existence of disease is neither the purely phenomenological one of lesions that can be observed whether the patient is alive or dead nor the attempt to grasp an ideal essence of disease in the manner of medicine in the classical era. Pinel's *Nosographie* certainly does continue the nosological project proper to the latter, but its connection with *Médecine clinique* in some way carries the Pinelian pathological entity out of the ideal space of the medical taxonomies that preceded it, at the same time that it creates a manual for hospital medicine. Whereas Bichat thought that anchoring pathology in the autopsy room was the way to move classical medicine and its "species" toward anatomical-clinical medicine, the connection to the hospital via *Médecine clinique* pulls Pinelian medicine out of the classical nosological framework where his *Nosographie* seemed embedded.

Médecine clinique, *Nosographie philosophique*, *Traité médico-philosophique sur l'aliénation mentale*: each of these Pinelian works is built upon the way it orders and presents case histories. Yet the *Traité* does not present the type of ordering that *Médecine clinique* and *Nosographie philosophique* do. There is an oft-noted gap²¹ between Pinel's alienist practice and the clinical medicine of his time, a medicine that precisely took his *Nosographie philosophique* as a methodological paradigm.²² In fact, the Pinel of the *Traité médico-philosophique*, the psychiatrist Pinel, starting from the same hospital experience as when he wrote *Médecine clinique*, has a different project. He seeks to institute psychiatry (*aliénisme*) as an autonomous discipline with its own object, its own modes of intervention, and its own territory. There certainly was moral treatment before Pinel, whether it was Samuel Tuke's medical practice at the Retreat or John Haslam's at Bedlam, or even what one can read in certain pages of Boissier de Sauvages. But the fact that Pinel defined "moral treatment" as a group of practices that he synthesized, compounded by the fact

¹⁷ Marie François Xavier Bichat, *Anatomie pathologique*, vol. 3 (Paris: Baillière, 1825), chap. 18, 308.

¹⁸ On the role of anatomical pathology in Bichat's work, see Philippe Huneman, *Bichat: La vie et la mort* (Paris: Presses universitaires de France, 1998).

¹⁹ Michel Foucault, *Naissance de la clinique* (Paris: Presses universitaires de France, 1963), 200ff.

²⁰ On some of the major outlines of the history of the case in psychiatry, see Paul Bercherie, *Les fondements de la clinique: Histoire et structure du savoir psychiatrique* (Paris: Seuil, 1980). On the specificity of mental illness in the structures of eighteenth-century "medical care," see William Bynum, "Health, Disease and Medical Care," in *The Ferment of Knowledge*, ed. G. S. Rousseau and R. Porter (Cambridge: Cambridge University Press, 1980), 211–54.

²¹ Pigeaud, *Aux portes de la psychiatrie*; Michel Foucault, *Le pouvoir psychiatrique* (Paris: Seuil, 2003).

²² We know that Bichat claimed to represent the founding of pathological anatomy, specifically of inflammations and local problems in tissues and the identification of these.

that he attributed to a single expert—the alienist—the mastery of this treatment, means that he constituted a new, legitimate relationship between a medical specialist, on the one hand, and a particular illness, on the other—a relation governed by its own rules. It was therefore both a medical project and a project that distanced itself from that being instituted in the same years in clinical medicine, whose elaboration relied on pathological anatomy as well as on the hospital as a machine to produce (more and more clearly after 1800) and to institute and order collections of case histories. To analyze the case system's specificity in the psychiatric alienist *Traité* (compared to the practice in the great books of Pinelian clinical medicine) is to therefore ask how psychiatry, at the very moment when it makes madness into a medical thing, is instituted according to rules and procedures that precisely do not come from the clinical medicine that is being established at the same time. But before examining these cases, it is worth outlining the second contextual point that clarifies their situation: the conceptual universe in which the thought of Pinel, like that of Bichat and of Cabanis, evolved.

2. CONCEPTUAL CONTEXT: IDEOLOGICAL PROJECT AND NEW LANGUAGE

Pinel and Bichat were Ideologues.²³ Bichat was Pinel's student, while Pinel was a close contemporary of Cabanis, and the exact title of Pinel's *Médecine clinique* is *Clinical Medicine Rendered More Precise and Exact by the Application of Analysis*. Bichat's own anatomy is an inquiry into final elements—the types of tissues—whose assembly constitutes organs and “apparatuses” (i.e., organic systems).

“Analysis” characterizes these doctors' shared affinity with Ideology. For them, the essential scientific task was analysis: identifying epistemologically final elements and recomposing concrete reality based on these elements. Bichat's science thus includes a general anatomy to identify elements, a descriptive anatomy to recompose them in order to account for the shape of different organs, and finally a physiology, which shows—through experimental procedures that decompose the processes of death in well-defined phases—interorganic correlations.²⁴ Pinel's medicine reactivates this ideological framework as much in the field of psychiatry as in that of nosology. Science searches above all for the simple types of disease, of which other illnesses are complex combinations.

Each of these facts, presented with precision and exactitude, thus offers a close-up picture that can be taken in at the blink of an eye and can easily be compared with any analogous sketch. It is the same with several facts that are included under the same label of a particular species, or several species included in a genus, several genera related to an order, or several orders traced back to the general heading of a class. . . . Diseases that are considered in this way, according to the relationship of their affinities, constitute a natural chain of ideas, are classified according to their external signs, like any other objects in natural history, and eventually get submitted to an exact and invariable naming.²⁵

²³ In the sense of the philosophical school of Cabanis, Destutt de Tracy, etc. On this connection with Ideology, see Kathleen Grange, “Pinel and XVIIIth Century Psychiatry,” *Bulletin of the History of Medicine* 35 (1960): 442–53.

²⁴ Huneman, *Bichat*.

²⁵ Pinel, *Médecine clinique*, ix.

This methodology prescribes the role of the narrative case study:

Such is the origin of the multiple stories that I give concerning acute sickness in this book, either to provide foundations for my principles of nosography or to offer a term of comparison for the study of clinical medicine or to facilitate the application of analysis and of the distinction between what I call simple species or complex species, so as to eventually show that any sequence of well-observed and well-described diseases can be reduced to an order as regular and as methodical as any other object in natural history. One must only take out of their notions any hypothetical opinion, restrain oneself—regarding their signs—to the impressions these make on the senses, and consider each disease as forming a single whole that results from the set and the succession of its symptoms.²⁶

In this way, the simple kind of pleuropneumonia, a disease of cellular tissue, leads to an observation,²⁷ and gastric pleuropneumonia leads to a case history;²⁸ the text illustrates each of the symptoms in order to generate a sort of general logic of types and genera based on their symptoms (see fig. 1).

ESPÈCES COMPLIQUÉES.

Péripneumonie gastrique.

Depargi, âgée de cinquante-deux ans, éprouve un frisson avec assoupissement.

2^e jour de la maladie. Au réveil, chaleur, douleur vive sous les côtes asternales droites; les jours suivans, paroxysme, rougeur des pommettes.

<i>Symptômes péripneumoniques.</i>	<i>Symptômes gastriques.</i>	<i>Symptômes communs.</i>
04. Douleur poignive au côté droit de la poitrine, gêne de la respiration, toux, expectoration muqueuse.	Douleur pulsante à la tête; bouche pâteuse, amère; langue recouverte d'un enduit jaunâtre; pesanteur à l'épigastre.	Chaleur forte de la peau, pouls plein, fréquent, paroxysme le soir. L'émétique provoque des évacuations abondantes.

ESPECES COMPLIQUEES

Péripneumonie gastrique

Depargi, âgée de cinquante deux ans, éprouve un frisson avec assoupissement.

2e jour de la maladie. Au réveil, chaleur vive sous les côtes asternales droites; les jours suivans, paroxysme, rougeur des pommettes.

Symptômes péripneumoniques.

Douleur au côté droit de la poitrine, gêne de la respiration, expectoration muqueuse.

Symptômes gastriques.

Douleur pulsante à la tête; bouche pâteuse, amère; langue recouverte d'un enduit jaunâtre; pesanteur à l'épigastre.

Symptômes communs.

Chaleur forte de la peau, pouls plus fréquent, paroxysme le soir. L'émétique provoque des évacuations abondantes.

Fig. 1. An example of the visual exposition of a type of nosological entity in the *Médecine clinique*. The table is a readable transcription of the picture.

²⁶ Ibid., vii.

²⁷ Ibid., genre XXIII, chap. 13, p. 131.

²⁸ Ibid., 135ff.

The case narrations thus have another function that comes from the precision of their situation and of their context: they show the hospital itself as responsible for the variety in the cases:

The diseases whose history I report here, compared to the same species observed in other hospitals, can offer striking differences, either as regards their intensity or as regards the collection or the modification of some of their symptoms, which can be due to the influence of location. It is therefore important to indicate here the major traits of the topographic position of the hospital, its internal distribution, and of the number and the particular state of these sick people (*infirmes*) who came here for asylum.²⁹

Thus, the institution of the hospital is generally always present within the constitution of the clinical case. In what follows (section 2.3), I will point out how this presence takes on a specific tone in the psychiatric case.

Like the clinical doctor, the psychiatrist pursues a scientific goal through his investment in the task of analysis. Certainly—and this will be made clearer below—the units of analysis are not as easy to specify as those of medical discourse, since perceptive acuity alone is not enough to grasp the group of traits that define a pathological category because, in turn, any behavioral or cognitive trait may be an integral part of a mental illness. The psychiatric project nevertheless does participate in the same analytical effort and reconstruction of disease types; analysis reaches here another level, not only because the psychiatrist must identify the disease types within the psychiatric field but because its practice also gives way to a new analysis of the human mind. In effect, the wide range of mental afflictions allows this breakdown of the mind's faculties to be established, just as Condillac and his followers aimed to do.³⁰

3. THE PINELIAN CASE SYSTEM

3.1. Generalities

Against the background of this intellectual project, it is critical to determine the grammar and use of the narratives in the cases offered in the *Traité*. I will start with two examples of these cases that I will use to illustrate some rather general common points. I will then examine further the two essential dimensions of time and causality, on the one hand (section 3.2), and the role of the hospital, on the other, in more depth (section 3.3). Throughout the analysis I will single out several case studies that illustrate each of these specific points. Section 4 will deal with the rhetorical function of the Pinelian case study.

²⁹ Ibid., xviii.

³⁰ Philippe Pinel, *Traité médico-philosophique sur l'aliénation mentale ou la manie*, 2nd ed. (Paris: Brosson, 1809) (originally published in 1802), 1.8, p. 32; translated by D. Davis as *A Treatise on Insanity, in Which Are Contained the Principles of a New and More Practical Nosology of Maniacal Disorders, That Has Yet Been Offered to the Public* (London: Cavell and Davies, 1806). Hereafter the English translation (which I have slightly revised) is cited as *TI*; the original French edition, when needed, is cited as *Traité*. For a detailed analysis of how psychiatry and the breakdown of mental functions are connected, see Philippe Huneman, "L'aliénisme, la nosologie et la décomposition des fonctions mentales," in *L'explication fonctionnelle en psychologie*, ed. F. Parot (Brussels: Mardaga, 2008), 49–66.

Case A. [The dementia that we are treating] is generally accompanied by a turbulent and ungovernable mobility; by a rapid and unconnected succession of ideas, which appear to be generated in the mind without exciting their correspondent expressions upon the organs of the senses; by a continuous and ridiculous flux and reflux of chimerical objects that shock, alternate, and destroy each other without pause and without relation to each other; and by the same tumultuous course for moral affections, sentiments of joy, sadness, anger, which seem to be born fortuitously and to disappear without a trace and, throughout, without reference to external objects. An ardent, but ill-informed patriot, who used to be one of the most zealous partisans of the celebrated Danton, was present at the sitting of the legislative body when the writ of the accusation was pronounced against the deputy. He withdrew in consternation and despair, shut himself up in his apartment for several days, and surrendered himself to the influence of the most gloomy ideas. “What, Danton, a traitor?” repeated he without ceasing, “then no man can be trusted; the Republic is lost.” His appetite and sleep forsook him. Complete insanity ensued. Having undergone the usual treatment at this same Hôtel Dieu, he was transferred to Bicêtre. He passed several months in the infirmary of this hospital, in a state of tranquil reveries, incessantly uttering half-expressed and unconnected sentences. He spoke alternatively of daggers, sabers, dismasted vessels, green meadows, his wife, his hat, etc. He never thought of eating but when the food was absolutely put into his mouth, and in respect to his functions he was absolutely reduced to an automaton. (*TI*, 162)

Case B. A young religious enthusiast who was exceedingly affected by the abolition of the Catholic religion in France became insane. After the usual treatment at the Hôtel Dieu, he was transferred to the asylum at Bicêtre. His somber misanthropy was without equal. His thoughts dwelled perpetually upon the torments of the otherworld, from which he founded his only chance of escaping, upon a conscientious adoption of the abstinences and mortifications of the ancient anchorites. At length he refused nourishment altogether; and on the fourth day after that unfortunate resolution was formed, a state of languor succeeded that excited considerable apprehensions for his life. Kind remonstrance and pressing invitations proved equally ineffectual. He repelled with rudeness the services of the attendants, rejected with the utmost pertinacity some soup that was placed before him, and demolished his bed (which was of straw) in order that he might lie upon the boards. How was such a perverse train of ideas to be stemmed or counteracted? The excitement of terror presented itself as the only resource. For this purpose Citizen Pussin appeared one night at the door of his chamber and, with fire darting from his eyes and thunder in his voice, commended a group of domestics, who were armed with strong and loudly clanking chains, to do their duty. But the ceremony was artfully suspended—the soup was placed before the maniac and strict orders were left him to eat in the course of the night, on pain of the severest punishment. He was left to his own reflections. The night was spent (as he afterward informed me) in a state of the most distressing hesitation, whether to incur the resented punishment or the distant but still more dreadful torments of the time to come. After an internal struggle of many hours, the idea of the present evil gained the ascendancy and he determined to take the soup. From that time he submitted, without difficulty, to a restorative regimen. His sleep and strength gradually returned; his reason recovered its empire; and after the manner related above, he

escaped certain death. It was during his convalescence that he confessed to me the perplexities and agitations that he endured during the night of the experiment. (*TI*, 59ff.)

(a) First, the clinical case in psychiatry has the capacity to exemplify, through its description of precise behaviors and beliefs, a type of alienation: insanity in case A is an anomaly in the production of ideas; the cited case history illustrates this anomaly with skeptical ideas.

(b) Next, the case works to historicize this type of alienation, displaying it through time: the case makes a malfunction that affects ideas in general correspond to a list of behavioral and imaginary episodes. As in the Hippocratic paradigm (prodromes, the disease's occurrence, resolution), the case study marks crises and evolutions throughout this sequence, even if these examples lack the notion of "critical moment," namely the disease's unique predetermined rhythm. The end of the disease may not occur, so that the disease remains unresolved, or it can close the case history: thus, in case B, our patient recovers by means of asylum subterfuge.

(c) Finally, a patient's idea or demonstrated behavior—any subjective fact—becomes pathological only when it is integrated into the case history: any trait—a belief, an act, a chemical malfunction—can be a symptom. The case study is built out of an accumulation of facts of all types (talking about knives, not eating, etc.) that become symptomatic due to their inclusion in this temporal display. Everything is clinical in the psychiatric case, and this illustrates the generality of mental illness, which is one of the major tenets of alienism: neither physical nor chemical, it affects the individual "*au physique et au moral*," to use the phrasing of another Ideologue.³¹

With this in mind, it becomes easier to identify some characteristics of the clinical case's grammar and function: not every case possesses all of them, but each of these characteristics is part of the Pinelian case system, which, I will argue in the end, demonstrates the case system's solidarity with the very project of psychiatry.

3.2. *Time and Causality*

The case history is a history and, therefore, a temporal sequence; what are the rules of its enunciation? The psychiatric case always has a beginning: perhaps an identifiable cause, often contained within an event or a word; it can also take place as a long process whose causal relationship with madness itself consists merely in its temporal anteriority. Here are two examples of these two types, which I will refer to further on and which I call "The Friend" and "The Naïve Winemaker."

Case C. The Friend. A young gentleman, twenty-four years of age, endowed with a most vivid imagination, came to Paris to study law and flattered himself with the belief that nature had destined him for a brilliant station at the bar. An enthusiast of his own convictions, he was an inflexible disciple of Pythagoras in his system of diet: he secluded himself from society and pursued, with the utmost ardor and obstinacy, his literary projects. Some months after his arrival, he was seized by violent migraines, frequent bleeding at the nose, spasmodic oppression of the chest, wandering pains of the bowels, trouble with some flatulence, and

³¹ The phrase comes from Louis Lacaze, *Idée de l'homme au physique et au moral* (Montpellier : Moreau, 1755) and is used by Cabanis in the title of his main work. On physical/organic indeterminacy in Pinel, see Philippe Huneman, "'Animal Economy': Anthropology and the Rise of Psychiatry from the *Encyclopédie* to the Alienists," in *Anthropology of the Enlightenment*, ed. L. Wolff and M. Cipolloni (Stanford: Stanford University Press, 2007), 262–76; and Gladys Swain, *Le sujet de la folie* (Toulouse: Privat, 1977).

morbidly increased sensibility. Sometimes he came to me in a very cheerful state of mind, when he used to say, “how happy he was, and that he could scarcely express the supreme felicity which he experienced.” At other times, I found him sunk in the horrors of consternation and despair; thus, most acutely miserable, he frequently and with great earnestness entreated me to put an end to his sufferings. The characters of the profoundest hypochondriasis were now become recognizable in his feeling and conduct. I saw the approaching anger and I adjured him to change his manner of life. My advice was unequivocally rejected. The nervous system of the head, chest, and bowels continued to be progressively exasperated. His intervals of complacency and cheerfulness were succeeded by extreme depression and pusillanimity and terror and inexpressible anguish. Nearly overpowered by his apprehensions, he often and earnestly entreated me to rescue him from the arms of death. At those times I invited him to accompany me to the fields, and walking for some time, we conversed on subjects likely to recover the enjoyment of his existence: but, upon returning to his chambers, his perplexities and terrors likewise returned. His despair was exacerbated by the confusion of ideas to which he was constantly subject and which interfered so much with his studies. But what appeared altogether to overwhelm him was the distressing conviction that his pursuit of fame and professional distinction must be forever abandoned. Complete lunacy then established its melancholy empire. One night he decided to go to a play, to seek relief from his own too unhappy meditations. The work that was presented was the *Philosopher without Knowing It*; he was instantly seized with the most gloomy suspicions, and especially with a conviction that the comedy was written for the purpose of ridiculing him specifically. He accused me of having furnished materials to its author, and the next morning he came to reproach me, which he did most angrily, for having betrayed the rights of friendship and exposed him to public derision. His delirium knew no bounds. Any monk and priest he met on his walks he took for a comedian in disguise, dispatched there for the purpose of studying his gestures and of discovering the secret operations of his mind. In the dead of night, he gave way to the most terrifying apprehensions, believing himself under attack, sometimes by spies, at others by robbers and assassins. He once opened his window with great violence and cried out murder with all his might. His relatives eventually determined to have him undergo a plan of treatment similar to that adopted at the Hôtel Dieu and, with that in mind, sent him under the protection of a suitable person to a village near the Pyrenees. Since he was greatly debilitated in both mind and body, it was agreed that he should return to his family residence only some time later, where, on account of his paroxysms of delirious extravagance, followed by fits of profound melancholy, he was insulated from society. Ennui and insurmountable disgust with life, absolute refusal of food, and dissatisfaction with everything and everybody that came near him were among the last ingredients of his bitter cup. To conclude our affecting history: he one day eluded the vigilance of his keeper and, with no other garment on than his shirt, fled to a neighboring wood, where he lost himself, and where, from weakness and inanition, he ended his miseries. Two days afterward he was found a corpse. In his hands was found the celebrated work of Plato on the immortality of the soul. (*TI*, 54ff.)

Case D. The Naïve Winemaker. *A case of melancholy with bigotry.* A missionary, by his declamatory representations of the torments of the otherworld, so terrified a naïve wine-maker that this man fancied himself irrevocably condemned to everlasting perdition. To rescue his family from a similar fate, he sought by his own hand to confer martyrdom on them so that they could claim the mercy of heaven. The seducing descriptions he met in the lives of saints had impressed his mind with this dangerous prejudice. He first attempted to commit this horrible crime on his wife; but she fortunately made her escape before the intention was carried out. Two dear little infants, however, his own children, equally helpless and unsuspecting, fell victims to his cold-blooded barbarism; he immolated them to give them eternal life. For these acts of violence, which he deemed so meritorious in the sight of God, he was brought before the tribunal; but during his imprisonment and trial, he contrived to immolate one of his fellow prisoners—still with a view to carrying out expiatory work before the God of free and disinterested mercy. His insanity having been proved in court, he was condemned to perpetual confinement in one of the cells at Bicêtre. The isolation of a long detention—always capable of inflaming the imagination—working its influence together with the idea that he had escaped death, in defiance of the sentence that he supposed the judges to have pronounced upon him, aggravated his delirium and countenanced his belief that he was invested with omnipotent power or, according to his own assertion that he was *the fourth person in the Trinity*, “that his special mission was to save the world by the baptism of the blood,” and that all potentates of the earth, united in hostile alliance against him, could not take away his life. His derangement was confined to the subject of religion, for on every other, he appeared to be in healthy possession of his reason. After ten years of his solitary confinement had passed, his apparent calmness and tranquillity persuaded the governor to grant him permission to mix with other convalescents in the inner courts. Four years of freedom and of harmlessness seemed to confirm the propriety of the experiment, when, all of a sudden, his bloody propensities returned. On the tenth of Nivôse [Christmas Eve] of the year 3, he formed the atrocious project of making an expiatory sacrifice of all his fellow tenants of the asylum. For this purpose he got a knife and chose the moment when the governor was going downstairs to do his rounds, striking him from behind, but fortunately the instrument grazed his ribs, without producing any serious injury. It is shocking, however, to relate that he killed two maniacs who were then on the spot and would have persisted in his homicidal career until he had accomplished the whole of his purpose had he not been speedily arrested. It is scarcely necessary to add that his confinement was now made absolute and irrevocable. (*TI*, 73ff.)

3.2.1. *Origin and Duration*

In both cases, everything bears meaning in these processes so that, in retrospect, everything can be taken as an early symptom of madness. Such generality of madness stylistically translates into linking attributes together in a manner identical to a clinical enumeration of symptoms. For the case of the Friend, entire sentences are formed from nominal groups separated by commas. This same grammatical form appears in disease cases in the *Médecine clinique*:

Since a few days, loss of appetite, disgust, faint. During the night of Germinal 11, a very violent headache, thrills, unbearable abdominal pain, and nausea; finally, vomiting with strong shaking and abundant alvine ejections. The thrown substances are green, and those which are lost

by the anus are mixed with blood. The next day, at eight, the vomiting stops, dejection goes on, but the feces are no longer bloody. Colic pains persist; the tongue is covered in yellow, dry skin; in the evening, a light thrill, followed by some heat, with sweatiness.³²

The language of the psychiatric case is therefore the same language as the case in clinical medicine: an enumeration of signs, without subordinating hierarchies. There is also an indifference here as to the moral or physical nature of these signs: in Pinel's conception, madness is "a general disturbance of animal economy" (*perturbation générale de l'économie animale*).³³ More precisely, it is neither uniquely organic—Pinel points out that one cannot necessarily link it to brain lesions—nor only mental. Because madness involves the animal economy as a whole, it rarely saves the body and can be caused and treated by partly physical means.³⁴ The phrase "*some months after his arrival, violent migraines . . .*" indicates at the same time an unmentioned causal link that the reader must infer: Pinel is here referencing the old theme of madness caused gradually by excessive study, a convention in the medical study of the insane starting with Aretaeus.³⁵

However, the *causal event* is not completely left aside in the case of the Friend, and there is an analogy here with the case of the Naïve Winemaker, where the causal event is much clearer, as he was apparently made mad by a missionary's speech. Pinel writes about the Friend: "One night he decided to go to a play, to seek relief from his own too unhappy meditations." In this case, even if the departure from normality—from the minor annoyances of scholarship—occurs progressively, and in an incomprehensible way, still there must always be an event that can be viewed as the cause for the descent into madness, in order to make the movement into madness palpable and signal the discontinuity that separates the norm from the disease. After the play, Pinel therefore writes, "his delirium knew no bounds." Of course, one could certainly say that the cause here is reconstructed, with the play being but one step in a long process and, if not this play, something else would have doubtlessly led to overt madness. But the essential point here is that an event, a trigger, is necessary in order to separate normalcy from madness as well as indicate the origin of the latter. This, however, lends an arbitrary aspect to madness: it is as though it hangs between the chance of a triggering event and the mystery of the deterioration that preceded it and for which there is no explanation.

In many cases, the originary events—the speech accusing Danton for the patriot of case A and the speech that seduced the Naïve Winemaker—have no explicative, nomothetic value, as nothing in them necessarily leads to madness. In fact, they are rather banal—and what indicates madness is the fact that they can have such consequences. It is less that they provoke than that they manifest madness, since, as the truism goes, one must already be mad in order to be

³² Pinel, *Médecine clinique*, 23, a case of meningogastric fever.

³³ I have studied and analyzed this expression in "Montpellier Vitalism and the Emergence of Alienism in France (1750–1800): The Case of the Passions," *Science in Context* 21, no. 4 (2008): 615–47. Also see Swain, *Sujet de la folie*; and Gladys Swain and Marcel Gauchet, *La pratique de l'esprit humain: L'institution asilaire et la révolution démocratique* (Paris: Gallimard, 1980).

³⁴ On this concept of "animal economy," see Huneman, "Montpellier Vitalism"; and Huneman, "Animal Economy"; as well as Charles Wolfe and Motoichi Terada, "The Animal Economy as Object and Program in Montpellier Vitalism," *Science in Context* 21, no. 4 (2008): 537–79. On its role in the birth of French psychiatry, see Huneman "Animal Economy"; and Philippe Huneman, "Les théories de l'économie animale et la naissance de l'aliénisme," *Psychiatrie, sciences humaines, neurosciences* 2, no. 2 (2004): 47–59.

³⁵ Samuel-Auguste Tissot had brought this idea back into vogue with his famous *De la santé des gens de lettres* (1768); thanks to Patrick Singy for this reference.

made insane by a play. The fundamental category of the entry into madness is thus that of *revelation*. As a result, most cases will therefore be constructed based on a logic of the hidden versus the revealed. Certainly, the clinical case in medicine is often the appearance of something that was already there deep within the body; but the psychiatric case deploys this logic along its own parameters.

Generally speaking, the originary event generally does not explain anything, as Pinel's purpose is not to understand madness's cause. The cause remains a mystery. The doctor reconstructs an origin based on factual information and commonsense elements rather than on existing theoretical elements. It is often a matter of a type of narrative comprehension shared by all—for example, stereotypical phrases such as “sentimental disappointment made him mad.” For this reason, certain case stories can be complete and have a cause; others are not, and others give only a fragment of madness in order to illustrate a type of mental illness.

Thus, the origin of the madness is reconstructed; a narration follows in which the passage of time is marked by crises. This can be a *longue durée* temporality, unlike the case in clinical medicine:

A maniac of this description [melancholia] was under my care for about twelve years. He was already advanced in age. For the first eight he was made delirious by the chimerical fear that he would be poisoned. During this time there were no serious changes in his behavior, and no other marks of alienation. He supposed that his relations wished to disown him and to deprive him of his property. He was exceedingly reversed in his conversation; but what he said upon every subject, excepting that of his hallucination, was perfectly connected and correct. The idea of poison made him extremely suspicious, and he did not eat any victuals but what were cooked at the usual kitchen. Toward the eighth year of his confinement, his delirium suddenly changed in character. He then became a mighty potentate, sovereign of the world, equal to the creator, and supremely happy. (*TI*, 145)

This long term is also visible in the Winemaker's case, which is marked by changes in the focuses of delirium, or by the movement from latency to manifestation: “After ten years of his solitary confinement had passed, his apparent calmness and tranquility. . . . Four years of freedom and of harmlessness seemed to confirm the propriety of the experiment, when. . . .” In this case, it is notable that the mad person, in the long term, *appears* cured. Let us not forget that traditionally, penitence is a religious practice, and from a perspective influenced by it, isolation was freeing and potentially redemptive, and here, it is clearly important that the insane person is a religious fanatic. Following this Christian logic, and based on “appearances,” the patient must be saved/healed. But this is not what happens: “when, all of a sudden [which of course should be contrasted with “after ten years” above], his bloody propensities returned.” Building a case history consists thus in articulating the connection between the latent and the manifest and the long term (ten years, etc.) and the “sudden”: this vocabulary of instantaneousness defines the terms of how the hidden appears, of its revelation. Of course, and I will return to this point again, this *longue durée* assumes that there is a continuous means for controlling the patient; it assumes that he or she is in an asylum.

3.2.2. *Conflicts*

The opposition between the long term and the instant echoes that of the hidden and the revealed in a very specific situation, which often appears in the treatises, and which is characteristic of the clinical case: the motif of the *internal struggle*.

Consider three cases. First is the “internal struggle” of case B, the man who no longer wants to eat, when faced with the dilemma in which the governor has placed him. Next is the case of a man “formerly a mechanic, now in Bicêtre,” an exemplary case of mania without delirium—an individual at times afflicted by fits of rage during which “could he have possessed himself an instrument of offence, he would have sacrificed to his fury the first person that came his way. In other respects, however, he enjoyed the free use of his reason, even during his paroxysms. He answered without hesitation the questions that were proposed to him and evinced no incoherence in his ideas nor any other symptom of delirium” (*TI*, 153; *Traité*, 152). This ambivalence is translated as an internal struggle:

At Bicêtre, he experienced the same bouts of periodical fury, and his propensity to acts of atrocity was sometimes directed against the governor, to whose compassionate attention and kindness he never appeared insensible. These internal conflicts, in which he showed himself to be possessed of sound reason and, at the same time, to be actuated by bloody cruelty, occasionally overwhelmed him with despair. (*TI*, 154; *Traité*, 153)

The internal struggle is thus (in case B) a constitutive part of mania—always with a chancy ending—as well as what the doctor induces to cure the maniac.

Healing the patient is often a matter of artificially producing this internal conflict that accompanies madness, but producing it in a way that is biased: for instance, the doctor can often balance the delirious idea with an appeal to the strength of the survival instinct. The insane patient who—while he looks almost like a skeleton—refuses all food, but who is excitable, sweating, and drinking, has his water ration replaced by the governor with “a fatty broth.” Then:

For some time he wavered between two opposite impulses: one, a consuming thirst that irresistibly impelled him to swallow any liquid whatever; the other, his firm and unchanged resolution to accelerate by fasting the end of his life. His raging thirst at length prevailed and he drank copiously the broth. By way of recompense he was immediately restored to the free use of cold water. (*TI*, 179)

This type of recovery assumes that an apparatus is available for somehow simulating extreme conditions without actualizing them, in order to construct and play out this conflict that the patient must be internalizing. The case history recounts this conflict and its resolution: therefore, one can’t think of a case history without some such sort of available theatrical machinery. Hence, this is no more a question of medical discipline than of soothing words, both of them defining the extant alternative options available to earlier “psychiatry,” which had sometimes used medications for madness with physical origins and, at other times, consoling words for madness stemming from passions.³⁶ Alienism definitively presents us with a novel kind of case history.

³⁶ On this division of classical psychiatry, see Pigeaud, *Aux portes de la psychiatrie*, chap. 1; Huneman, “Montpellier Vitalism and the Emergence of Alienism in France.”

3.2.3. *Artifice and Therapy*

The case history provides a proof of the psychiatrist's penetrating vision: he alone knows that behind the patient's decision, there is struggle, the possibility for conflict, and the psychiatrist knows how to induce and manage such conflict. This is precisely the sophistication of asylum practice: the *interior*, intimate conflict is paradoxically induced, controlled, and fabricated. The reality that traps the patient (hunger, thirst, danger, etc.) is paradoxical because it is artificially staged. To heal the insane requires a special approach rather than the admonishments or drugs of earlier mental therapy; this had been defined by the alternation of chemistry and speech. The clinical case requires an asylum-like institution, at the same time demonstrating the psychiatrist's intimate knowledge of the patient, his hold over the patient's intimacy. This is certainly the sense of the confession in the last sentence of case B: "he confessed to me the perplexities and agitations that he endured during the night of the experiment." This confession was made to Pinel and no other. Only the psychiatrist can hear the subject's inner lived experience when confronted by a terrifying experience that the psychiatrist himself has orchestrated.

The same occurs in the *Traité* when it comes to the story of the Friend (case C). The case of the friend is indeed designed to demonstrate the need for a hospital and a specific treatment, as the paragraph's subtitle suggests: *Histoire d'une manie où le traitement moral aurait été nécessaire*. The patient "eluded the vigilance of his keeper" in order to kill himself, which suggests among other things that treatment of insanity requires the means to permanently keep the patient under surveillance. The paragraph that immediately follows begins:

In the treatment of his case, it is true that I had it in my power to use a great number of remedies; but my opportunities for the employment of those means that appeared almost exclusively applicable were altogether wanting. At a well-regulated asylum, and subject to the management of a governor in every respect qualified to exercise over him an irresistible control and to interrupt or divert his chain of maniacal ideas (*soit propre à exercer sur lui un empire irrésistible et à changer la chaîne vicieuse de ses idées*), it is possible, and even probable, that a cure might have been effected. (*TI*, 60)

This passage exemplifies the idea that healing the insane requires the duality of "a well-regulated asylum (*un hospice bien ordonné*) . . . subject to the management of a governor (*l'étroite dépendance d'un homme*)."³⁷ One cannot exist without the other: Pinel cannot carry out this "irresistible control" over his friend without the asylum, a device through which the psychiatrist can substitute his own virtuous chains of thought for the patient's vicious ones. In the book, the following cases, including B's, illustrate how this hospital and this individual doctor succeed at breaking such chains. The reference to the governor (*l'homme*),³⁷ who has complete "control" over the insane patient, does not mention his medical qualifications at all; it is a matter only of his personal ones—a personal relationship that is also internal to the system. That is Pinel's definition of psychiatric practice, which the case of the Friend clearly illustrates in a contradictory way.

The cases of the Friend and the winemaker (cases C and D) are paradigmatic in the text because they most closely represent ideal examples of the case history. To begin with, they are complete, as opposed to incomplete cases that omit a pathology's origin, episode, or resolution;

³⁷ Here in the English translation, "governor" does not translate *surveillant*, which in general refers to Jean-Baptiste Pussin (the superintendent of Bicêtre), but *l'homme*, the man upon whom the insane person is dependent, namely the physician who rules the asylum.

these two cases also have a strong relationship to the hospital. The case of the first patient, who would have been cured in a hospital, is thus aimed at demonstrating its utility and necessity; the case of the second, since no medical practice would have been able to heal him, forces the hospital to reveal its secondary function of internment—not because it is punitive like a prison but because only a hospital, as the place where the doctor practices, can prevent certain normal-seeming though insane individuals from causing harm.³⁸ As both cases suggest, the psychiatrist's case histories hinge on the hospital, which is an essential parameter of the Pinelian clinical case system.

3.3. Hospital and Healing

3.3.1. *The Hospital as Norm*

First, let's better situate the *Traité médico-philosophique sur l'aliénation mentale ou la manie* within the context of the institution. Pinel had been assigned to Bicêtre, though psychiatric asylums had not yet been created. There was simply a place in Bicêtre for the mad. Pinel experimented there with what he would later call "moral treatment," coming to the practice by way of Jean-Baptiste Pussin, the *surveillant*.³⁹ The *Traité* details this practice and advances a new definition-classification of psychiatry and some theoretical positions on its nature, calling for a certain type of institution devoted solely to the treatment of the insane. Moving shortly thereafter to Salpêtrière, Pinel was able to continue working toward the creation of this type of institution, though it would not be a reality until the 1838 law.⁴⁰ The *Traité* is thus more militant than the *Médecine clinique*, which only attempts to reconstruct types of disease from the jumble of cases a doctor might see upon entering a hospital. This is why the case of the Friend is so exemplary: it is presented as the medical institution's failure and, more broadly, as an original failure of medicine of the soul that must be fixed by the reform Pinel suggests out of the movement that led to the publication of Jean Colombier and François Doublet's *Instructions* in 1785⁴¹ and Jacques Tenon's remarks in *Mémoires sur les hôpitaux*⁴² on the healing nature of an institution for the insane.⁴³ More generally, the *Traité's* clinical cases establish relationships between disease and hospital and between hospital and society. As opposed to the cases in *Médecine clinique*, which occur within the hospi-

³⁸ The necessity for a doctor to write "health letters" that freed the mad, which Pinel notes (*TI*, 292), certainly comes from this logic of the "hidden." On the ability of only the psychiatrist to discern who has recovered and who has not behind seemingly normal appearances, see Huneman, "Les théories de l'économie animale et la naissance de l'aliénisme," 56–59.

³⁹ Among the mass of historical analyses of Pinel's entry into Bicêtre, see Jacques Postel, *Genèse de la psychiatrie—les premiers écrits de Philippe Pinel* (Paris: Le Sycomore, 1981); Jean Garrabé, ed., *Philippe Pinel* (Paris: Payot, 1994); Weiner, "Observe and Heal."

⁴⁰ Castel, *L'ordre psychiatrique*.

⁴¹ Jean Colombier and François Doublet, *Instruction sur la manière de gouverner les insensés et de travailler à leur guérison dans les asyles qui leur sont consacrés* (Paris: Imprimerie royale, 1785).

⁴² Jacques Tenon, *Mémoires sur les hôpitaux de Paris* (Paris: Chez Royez libraire, 1788).

⁴³ On this movement to professionalize psychiatry and the institution of hospitals more generally, see Swain and Gauchet, *La pratique de l'esprit humain*, chap. 4; Bynum, "Health, Disease and Medical Care"; Goldstein, *Console and Classify*; and the sociological analyses developed by Andrew Scull that present an interpretation in terms of social relationship: Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700–1900* (New Haven, CT: Yale University Press, 1993); Andrew Scull, "Madness and Segregative Control: The Rise of the Insane Asylum," *Social Problems* 24, no. 3 (1977): 337–51; Andrew Scull, "From Madness to Mental Illness: Medical Men as Moral Entrepreneurs," *Archives européennes de sociologie* 16 (1975): 218–51.

tal, and whose descriptions are necessarily taking place there, for the psychiatrist the case has a specific, complex relationship with the hospital. Here is one example.

Case E. *An instance of maniacal fury without delirium.* The following narrative will conspicuously highlight the influence of a neglected or poorly guided education in inducing, upon a mind naturally perverse and unruly, the first symptoms of this species of mania. The only son of a weak and indulgent mother was encouraged in the gratification of every caprice and passion to which an untutored and violent temper was susceptible. The impetuosity of his disposition increased with his years. The money with which he was lavishly supplied removed every obstacle to his wild desires. Every instance of opposition or resistance roused him to acts of fury. He would assault his adversary with the audacity of a savage; he sought to reign by force, and he was perpetually embroiled in disputes and quarrels. If a dog, a horse, or any other animal offended him, he instantly put it to death. Whenever he went to a celebration or any other public meeting, he was sure to excite tumults and quarrels that ended up in actual pugilistic encounters, and he generally left the scene with a bloody nose. This wayward youth, however, when unmoved by passions, possessed a perfectly sound judgment. When he came of age, he inherited an extensive domain. He proved himself fully competent in the management of his estate, as well as in the discharge of his duties; and he even distinguished himself by acts of beneficence and compassion. Yet wounds, lawsuits, and pecuniary compensations would generally result from his unhappy propensity to quarrel. Eventually, an act of notoriety put an end to his career of violence. Enraged at a woman, who had used offensive language against him, he threw her into a well. He was prosecuted and thanks to the deposition of a great many witnesses who gave evidence to his furious comportment, he was condemned to perpetual confinement in Bicêtre. (*TI*, 149)

Here then is the case of a subject who goes mad by “nuances,” this madness being—as in certain instances of mania—generally accompanied by an apparent calmness and bursting forth in fits. The event of madness is a criminal act, which makes this subject, who was previously considered normal, insane—and leads to his internment. The asylum penalizes the crime, and confinement there is the consequence of a madness that has been much earlier declared as such but that was only intermittently manifest: whatever its form, alienation must end at the hospital, as the prison (from which the subject has been protected at his trial thanks to recollections of his “furious comportment”) is not a proper place for it.

Compare this case with the following.

Case F. A medical observer will often see in society the incipient traits of dementia, of which the finished forms are to be met with in hospitals. Around the beginning of the Revolution, a man who had been educated in the prejudices of the ancient noblesse was advancing with rapid strides toward this species of mental disorganization. His passionate effervescence and puerile mobility were excessive. He constantly bustled about the house, talking incessantly, shouting and throwing himself into great passions for the most trifling causes. He teased his domestics with the most frivolous orders, and his neighbors with his foolishness and extravagances—from which he did not retain, even for a single moment, even the least recollection. He spoke of the court, of his periwig, of his horses, of his gardens, in the

most volatile terms, without waiting for an answer or allowing time to follow his incoherent jargon. A woman of great sensibility, whom considerations of rank had united to his destiny, fell victim, as a result of the unhappy connection, to the most profound and desperate hypochondria. (*TI*, 160)

This case shows that madness in society does not always lead to the hospice, but it also compares ordinary madness in society with the form that exists in the asylum. The asylum is the measure by which madness is judged (“A medical observer will often see in society the incipient traits of dementia, of which the finished forms are to be met with in hospitals”). Compared with the preceding case (E), the difference is the criminal aspect of the latter: the connection of society to the asylum comes from the judiciary mediation. If we want to call “medicalization of madness” the process that will take place fifty years later and that will turn madness into a mental illness studied by an expert (the psychiatrist) in its own setting (the asylum)—then reading these two cases demonstrates that such a process is not without a complex connection between the judicial and the medical, a theme that was completely absent from *Médecine clinique*.

3.3.2. *The Hospital and Its Goals*

The Pinelian system of the psychiatric case brings with it a necessary reference to madness in the hospital, even when the patient is not hospitalized and even when the patient is only a fictional character, as the invocation of La Bruyère’s Ménélaque in case F so eloquently demonstrates. Making this common reference to the asylum, all cases of madness follow the same syntax: case F, like the others, is characterized by an accumulation, a vague causal reference that any person with a basic understanding of history would understand (the relationship between the old nobility and the Revolution recurs as an interpretive framework in the *Traité*), and finally a fall (not internment, in this case, but a sort of contagion: the wife becomes a hypochondriac)—and only this fall rhetorically justifies the end of the narrative.

What is the purpose of this asylum? To read the cases and reinsert them into the Pinelian conception of madness is to understand that the asylum attempts first and foremost to offer a grasp on this rather deep existence of the human subject, which is imperceptible to the layperson in day-to-day life and which underlies the ongoing though rare manifestations of madness. The hospital allows this perspective through human means, through the isolation it allows, the mastery of time it makes possible, and finally by manipulating artifice and reality. In such manipulation, artifice is viewed as helpful to helping, supporting, and reconstructing the meaning of reality. Here is a clue to this function: an insane man (case N) gives “greater scope to his extravagance.” He cannot stop “promising to conduct himself more peaceably,” but he always resumes his angry bouts; the fourth “explosion of his proud and turbulent disposition” makes the governor feel “the necessity of impressing upon this maniac a deep and durable conviction of his dependence” (*TI*, 103). However, the doctor, as a simple individual, can always obtain illusory promises: therefore, for these to be trustworthy and lead to healing, he must impress “a deep and durable conviction” on his patient. The asylum provides the means for him to do so.

The goal is to ultimately obtain a *verbal agreement*: the patient’s word must count for something. Words are fundamental to society, and keeping one’s word is—in the political system of contract theories, at a time that coincided with Pinel’s—the minimal condition required for sociality. The insane person will therefore heal once he regains this very basic social faculty. This is

why the word is key to the process, as this other case of the furious military man illustrates: the doctor allows him “to vent fury in his solitude” until the man himself feels that “he was not his own master” (*n’est pas le maître de suivre ses caprices*). Then he speaks to the governor “in a more submissive air and tone”: “You have promised, upon my engaging to be peaceable and quiet, to permit me to go into the interior court. Now, sir, I beg of you the goodness to keep your word.” The governor, smiling, then tells of the pleasure he feels to see him returned happily to himself (TI, 61).

The asylum, throughout these cases, emerges as the framework or apparatus that can produce not so much an avowal—as Foucault’s analyses have long insisted⁴⁴—but rather a reliable speech. Rhetorically, this goal-speech, produced using the means of the asylum, stands in opposition to the symptom-speech, the delirious speech that can signal entry into madness and that must always be recorded when the case is written down; this is, in our case A, the allusion to Danton: “What, Danton, a traitor?” repeated he without ceasing.”

The hospital is then a machine that produces what in case N (see below) leads to the ability to promise, namely “deep impressions.”⁴⁵ Similarly, in the scene with the broth (case B) “*l’impression d’une crainte vive et profonde*” must strike the man who refuses to eat. The nature of this impression does not matter, the impression in Pinel’s conceptual framework is physical as well as moral, since biological life is for him essentially sensibility, just as it was for Cabanis or, earlier, for Bordeu⁴⁶ and Barthez.⁴⁷ The impression, in ordinary life, is slight and weak, unless an improbable chance event occurs—hence these stunning cases of sudden cure thanks to a chance event, according to a kind of contradictory balance between affects that exemplifies a specific scheme of the conception of madness. Pinel may have found this scheme in the psychiatric ancient tradition and justified it following the terms of the physiology of his time, for which “animal economy” is made of actions and reactions, as Ménuret wrote in the “animal economy” entry of the *Encyclopédie*.⁴⁸ Here is a case based on a chance event.

Case J. A literary gentleman, who was given to excessive eating and who had recently recovered from a certain fever, experienced in the autumn season all the horrors of the propensity to suicide. He weighed with shocking calmness the choice of various methods for accomplishing his death. A visit that he paid to London appears to have encouraged, with a new degree of energy, his profound melancholy and his immovable resolution to shorten his life. He chose an advanced hour of the night and went toward one of the bridges of that capital for the purpose of throwing himself into the Thames. But at the moment of his arrival at the destined spot, he was attacked by some robbers. Though he had little or no money about

⁴⁴ Foucault, *Histoire de la folie*, 160.

⁴⁵ The word appears several times: “l’impression produite sur l’esprit de l’aliéné a été des plus profondes” (*Traité*, 236; cf. case H further on).

⁴⁶ See Elisabeth Williams, *A Cultural History of Medical Vitalism in Enlightenment Montpellier* (London: Ashgate, 2003); Wolfe and Terada, “Animal Economy”; Huneman, “Montpellier Vitalism and the Emergence of Alienism in France.”

⁴⁷ Paul-Joseph Barthez, *Nouveaux éléments de la science de l’homme*, 2nd ed., 2 vols. (Paris: Goujon et Brunot, 1806); Théophile Bordeu, *Recherches anatomiques sur la position des glandes et leur action* (Paris: Quillau père, 1751).

⁴⁸ On the animal economy, see Wolfe and Terada, “Animal Economy”; Huneman, “Montpellier Vitalism and the Emergence of Alienism in France”; Jean Starobinski, *Action et réaction: Vie et aventures d’un couple* (Paris: Seuil, 1999), 107ff.

him, he felt extremely indignant at this treatment and made every effort to escape, though not without becoming absolutely terrified. Left by his assailants, he returned to his lodgings, having forgotten his original purpose. The encounter seems to have operated a thorough revolution in his state of mind. His cure was so complete that, though he has since been a resident of Paris for ten years and has subsisted frequently upon scanty and precarious resources, he has not since been tormented by disgust with life. This is a case of melancholic vesania which yielded to the sudden and unforeseen impression of terror. (*TI*, 242)

Of course, we cannot generally count on this type of event. The asylum aims to reproduce it in a controlled manner and thus to retain the mechanism that can leave a profound impression—something that could not be done in the religious/philosophical tradition of “directing the mind” or with drugs without relying on the vicissitudes of chance. Such is the meaning of the following case (case H). A worker during the Revolution believes that he is being threatened with death after making some critical remarks. “The idea of his death (*périr par la guillotine*) haunted him day and night.” Pinel thus invents an “expedient” to heal this patient upon his transfer to Bicêtre: he tells three young doctors to create a fake commission from the legislature that will examine his case, deliberate, and finally acquit him. Having done so, the Commission then “retired in silence and everything indicated that the impression it made on the patient’s mind was most profound” (*TI*, 225).

Yet such a “profound impression” provoked by simulating a big event clearly cannot be lasting if it is not supported: “without work” the worker would relapse, and if he happened to discover that the event was a ruse, his relapse would become irreversible. From this perspective, this case teaches two things. First, “in all public asylums as well as in prisons and hospitals, the surest and perhaps the only method of securing health, good order, and good manners is to carry into decided and habitual execution the natural law of bodily labor, so contributive and essential to human happiness” (*TI*, 216). Second, the asylum must be isolated, since the patient must not be in communication with the outside because the inherent random nature of such communication risks sabotaging the asylum’s effects. This is why prolonged contact with families is forbidden.

4. PINEL’S CLINICAL CASE RHETORIC

The case history is informative, but its narrative goes beyond simple cognitive usefulness. Rather, the case serves a cause: it seeks to demonstrate the importance of moral treatment and the need for an asylum in which to do so. This is why one of Pinel’s first cases concerns the friend whose treatment fatally lacked the context of the asylum (case C). The 1802 *Traité* is a militant book, with three main targets: it reveals the asylum’s nature as a place of healing and asserts that its existence is a necessity; as a corollary, it posits that madness is essentially curable; and this cure comes from a specific procedure, “moral treatment,” which is a prerogative that is unique to the psychiatrist. From this stems one of the case’s functions: an attempt not only to understand the nature of the madness by ordering it into types but also to justify Pinelian claims. The previously cited case N thus illustrates insanity’s curability:

A gentleman, the father of a respectable family, lost his property in the Revolution and, with it, all his resources. His calamities soon reduced him to a state of insanity. He was treated by the usual routine of baths, bloodletting, and coercion. The symptoms, far from yielding to this treatment, gained ground, and he was sent to Bicêtre as an incurable maniac. (*TI*, 103)

This unfortunate trajectory is an ordinary route for the time: Bicêtre housed supposedly “incurable” (*irrécupérables*) patients, and as its director, Pinel held a strategic position to valorize insanity’s curability in the face of arguments against it. Thus, “without attending to the unfavorable report which was given of [case N] upon his admission,” the superintendent, Pussin, “left him a little to himself, in order to make the requisite observations upon the nature of his hallucination” (*TI*, 104), and this patient ends up recovering.

Narrating the case is thus a rhetorical pursuit. It not only informs, not only convinces, but it also obtains effects via the narrative. This is crucial when it comes to narrating recoveries that are already often staged in the asylum but whose narrative also follows certain rules. The case generally has a resolution (*chute*): recovery, when it happens, following a procedure typical of the asylum, is a peak (*pointe*) in the almost rhetorical sense of the word used by La Rochefoucauld. To finish, here is one such exemplary case:

Case M. A celebrated watchmaker in Paris was infatuated with the chimera of perpetual motion, and to effect its discovery, he set to work with indefatigable ardor. As unremitting attention to the object of his enthusiasm coincided with the influence of revolutionary disturbances, his imagination was greatly heated, his sleep was interrupted, and, at length, a true delirium of his understanding took place. His case was marked by a singular and most whimsical illusion of the imagination. He fancied that he had lost his head on the scaffold; that it had been thrown promiscuously among the heads of many other victims; that the judges, having repented of their cruel sentence, had ordered those heads to be restored to their respective owners and placed upon their respective shoulders; but that, in consequence of an unfortunate mistake, the man who carried out that business had placed upon his shoulders the head of one of his unhappy companions. The idea of this whimsical exchange of his head occupied his thoughts night and day, which determined his relations to send him to the Hôtel Dieu. Thence he was transferred to the asylum at Bicêtre. Nothing could equal the extravagant overflowing of his heated brain. He sung, cried, or danced incessantly; and as there appeared no propensity in him to commit acts of violence or disturbance, he was allowed to go about the hospital without control, in order to expend, by evaporation, the effervescent excess of his spirits. . . . Toward the approach of winter his violence abated. . . . The idea of perpetual motion frequently recurred to him in the midst of his wanderings; and he would chalk on all the walls and doors as he passed the various designs by which his wondrous mechanism was to be constructed. The method best calculated to cure so whimsical an illusion appeared to be that of encouraging his pursuit of it until it was sated. His friends were, accordingly, requested to send him his tools, with materials to work upon. . . . The governor permitted him to fix up a workbench in his apartment. After about a month’s labor, . . . the various parts being completed, he brought them together and fancied that he saw a perfect harmony among them. The whole was now finally adjusted. . . . and he supposed [the motion] capable of continuing forever. . . . But, grievous to say, he was disconcerted in the midst of his triumph. The wheels stopped! The perpetual motion ceased! His intoxication of joy was succeeded by disappointment and confusion. . . . He declared that he could easily remove the impediment but that, tired of that kind of employment, he was determined in the future to devote his whole time and attention to his business. There still remained a maniacal impression to be counteracted—that of the imaginary exchange of his head, which

recurred to him unceasingly. A keen and unanswerable stroke of pleasantry seemed best adapted to correct this fantastic whim. Another convalescent of a gay and facetious humor, instructed in the part he should play in this comedy, adroitly turned the conversation to the subject of the famous miracle of Saint Denis. Our mechanician strongly maintained the possibility that this actually happened and sought to confirm it by referring to his own case. The other let out a loud laugh and replied with a tone of the keenest ridicule: “Madman, as thou art, how could Saint Denis kiss his own head? Was it with his heels?” This equally unexpected and unanswerable retort forcibly struck the maniac. He retired confused amid the peals of laughter, which were provoked at his expense, and never again mentioned the exchange of his head. (*TI*, 68ff.)

Spontaneous, spectacular healing serves here as a counterweight to the mythical yet also spectacular origin; it is an act of speech that puts the subject face-to-face with reality (he has a head!) as well as with his madness. The case narrative hangs between these two mythic events of falling into madness and coming out of it, between the origin of madness as an event and the instantaneous recovery as a peak (*pointe*). This general setup, which this case perfectly shows, lends the psychiatric case its originality, since the simple case lacks it, for it is only the narrative of a more or less sinusoidal process of healing or death. The narrative thus sheds light on its construction as a psychiatric case. On the one hand, there is the mythicized reconstruction of the origin: the subject works on perpetual movement and almost becomes a prisoner of this movement, since denying the unreality of this movement is the same as his denial of reality. On the other hand, there is the creation of a means for ensuring the possibility and efficiency of the type of speech that will resolve the case. To tell such a case one therefore needs to mobilize the doctor, his aids, material means, and even the complicity of other patients (a “convalescent”): in sum, a certain psychiatric community.

This case is eminently significant in terms of its connotations: here is a man who has lost his sense (*perdu la tête*, in French) and who, instead of knowing it and saying it, demonstrates this truth about himself of which he remains unaware. The fact of “literally” saying that he has lost his head means that he has lost it “figuratively.” The healing task consists therefore in reestablishing the use of language, that is, inverting this dichotomy of the literal and the figurative that madness destabilizes. In order to do this, the patient is placed in a situation where language alone will produce this effect. This case history is complete: the cause is an origin at once conventional (that too much mental activity leads to insanity is well known, with cases C and M using this topos) and inexplicable; it is followed by internment; a handling of the delirium through a device destined to block it, to lead to a sort of reality check (perpetual movement is impossible); and the final peak, the speech act in which the patient finally confronts his delirium. This rhetorical perfection shows madness to be curable, and above all, it shows that speech produces effects needed for recovery, on the condition that it is not used to reason with the patient but instead it emerges as the end point of a complex process that disarms the delirium. The patient’s language is disturbed—believing that he has lost his head is the same as actually losing his head (in French and figuratively)—so much so that language must be reordered by speaking with the patient; this is to assume that he indeed has access to language.⁴⁹ And at the same time, the patient does not have access to any language, and especially not the ordinary, symmetrical, spontaneous speech

⁴⁹ As Gladys Swain’s excellent analyses have argued (*Sujet de la folie*, esp. 100ff.).

that aims only to speak truth: this type of speech must be established in a controlled way, teasing out a configuration (unbeknownst to the patient) that only an asylum can systematically create—in particular, by protecting such speech from a third party that could break down artifices. The somewhat spectacular reconstruction in our case M most clearly reveals the clinical case in the *Traité médico-philosophique sur l'aliénation mentale ou la manie*: narration of a procedure and a specific mechanism of language, apt to produce a certain manifestation of speech as an authentic sign of healing—a narration itself that, as speech, must produce effects on our image of insanity and on our conception of its treatment.

CONCLUSION

There is no proper theory of moral treatment, not just because there is no causal theory of madness and of its cure, but also because this absence is somehow the very condition for the practice of psychiatry. Moral treatment is instituted in the space created by the lack of knowledge surrounding the cause of madness. It stems from the decision to ignore the cause and the investigation of its nature, to not commit to a chemical, organic, or moral justification in the diagnosis of madness (which is the basis for the section of the *Traité* that rejects any ascription of a seat to mania): we have seen how curtly the *Traité* treats the cause, or how mythically it reconstructs it. This is precisely why psychiatry—alienist medicine, as Pinel calls it—cannot provide the *medical-philosophical* treatise with a scientific theory or with a purely theoretical justification for its classification of *vesania* and its therapeutic procedures. The way it proceeds therefore consists in narrating cases, but narrating them in a grammar that closely resembles that of the medical clinical case (hence an effect of “medicalization,” which comes with reading the treatise). Above all, the cases are told in a way that emphasizes the utility of moral treatment as the only type that corresponds to these sorts of medical cases. The case story is at once both illustrative and essential because it represents, in its very writing, the requirement of an *autonomous* alienist medicine. Such a requirement emerges because the case, in itself, relates in various modes to the system of the hospital. And this relationship takes place primarily in the identification of madness, in the dialectics of the hidden and the manifest, and finally in the process by which the relationship between what is visible and what is invisible in madness can be seen only within the psychiatrist/patient relationship, with the doctor being effective only when he has a “well-regulated asylum” at his disposal (rather than a system of medical knowledge or a battery of explicative theories).

The psychiatric case according to Pinel thus obeys several related requirements: it is striking; it makes the process of entry into madness and recovery understandable even though there is no explanatory theory for this process; it establishes that, when there is no recovery, asylum and moral treatment were lacking. The case does so by the mythical reconstitution of the causal origin and healing; thus, it is not, as it is in clinical medicine, a singular narrative that corresponds to the actual complexity of a pathological species made of simple types, a narrative enabling the physician to reconstruct the nature of a given disease and teach it to a novice. Instead, the case is a narration built on other rules, those of the rhetoric of *origin* and of the “peak” (*pointe*), employing a temporality that reflects the hospital’s long-term time frame.

To this extent, we can nuance Foucault’s view evoked at the beginning of this essay. Foucault argued that the moral, and not knowledge, was the appropriate category to understand the birth of psychiatry. “It was not science that [Tuke and Pinel] introduced so much as a new character, who borrowed little more than the disguise offered by that knowledge, or at best used it as a

justification.”⁵⁰ But this Foucauldian view may stem from a biased appreciation of Pinel’s ambiguous take on insanity as mental illness—namely, that it is a disease but is not likely to have an etiology similar to ordinary diseases, cured by ordinary medicine. The knowledge and cure of these special diseases should thus require a special regime of understanding, and the very grammar of the clinical case somehow plays the role of what would be the guidelines for writing a proper medical etiology and a therapy assessment. Therefore, since psychiatry is not only about morality but also about knowledge, the subjectivity of the insane is not only a state of minority wholly dependent upon an authority that the psychiatrist seems to get from his knowledge but in reality gets from “society” at large. It is a subjectivity that is somehow wedded to the “management” by some “governor” but that is at the same time out of direct reach for any physician. For this reason, it is likely to be captured and explored only according to a specific way of writing—within which the individuality of the patient can be inscribed into some universal frames, whereas strictly speaking the taxonomical frames of organic medicine are lacking. And in turn, this way of writing is not something that stands on its own, but it is strictly integrated in an institutional practice where the physician and the asylum give reciprocally one to another their status and meaning. Therefore, *pace* Foucault, the conjoined authority of medicine and of the asylum not only is a representative of *la société*, or *la morale*, but is deeply rooted within the idea that, in what I call the Pinelian case system, something like the truth of the insane patient can indeed be articulated and written—a task that belongs precisely to the psychiatrist.

The case in clinical medicine indeed comes from the mass of hospital patients; by individualizing such a mass, its description individualizes the disease by analyzing the pathological species that constitute it. Such a case has individuality in relation to the rule, individuality that is sometimes marked by the individual’s last name. As for the subject, language is not a problem: he names himself and names his problem. On the contrary, the insane patient is always anonymous, yet his language individualizes him as an ill subject. Among the more or less delirious types that are organized on a continuum that moves from mania without delirium to delirium itself and that the *Traité* shows us, such language is already part of the psychiatric case, it defines a way of being insane, and it suffices to individualize a special case. Because the patient speaks, even though his speech is disordered, the patient’s insanity is almost always treated with speech. Yet this speech treatment may have special, artificial conditions because it is produced by a system that will soon become that of the psychiatric hospital, which is the only place that can combine a “well-regulated asylum” with the “management of a governor” in the way the *Traité* initially demands.

A place to stage such speech: this is the hospital that Pinel dreams of and calls for. To do this, he turns cases into the verbal rhetorical form of this staging. By putting this staging into words, the psychiatrist, with his “moral and physical qualities” and the tools of his “control,” is always there—at least for us, and even when the psychiatric patient thinks he is alone. This is the final difference with the case according to the *Médecine clinique*: this apparatus constituted by the physician and the asylum surrounding him is always present within the case itself—a difference slightly more subtle than the substitution of moral for knowledge pinpointed by Foucault. Such apparatus represents a third party that prevents the case from being the pure relationship between a pathological type and a human individual. Reciprocally, this third party is still capable

⁵⁰ Foucault, *History of Madness*, 505. Also, “it is a curious paradox to see medical practice enter the uncertain domain of the quasi miraculous just as the science of mental illness was trying to assume some sense of positivity” (507).

of highlighting the pathology where it is invisible to the layperson (in a dialectic of the hidden and the revealed), and of “deeply impressing” this kind of intrinsic depth proper to the patient, this depth which Pinel is careful to not identify as psychic or as organic, and from which mental illness is supposed to emerge, in all the modes that can be identified as such by this physician in the hospital’s confines. A