

**Analyzing Nursing as a *Dispositif*
Healing and Devastation in the Name of Biopower**

A Historical, Biopolitical Analysis of Psychiatric Nursing Care
under the Nazi Regime, 1933-1945

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For Carmen

...again and again

ABSTRACT

Under the Nazi regime in Germany (1933-1945) a calculated killing of chronic “mentally ill” patients took place that was part of a large biopolitical program using well-established, contemporary scientific standards on the understanding of eugenics. Nearly 300,000 patients were assassinated during this period. Nurses executed this program through their everyday practice. However, suspicions have been raised that psychiatric patients were already assassinated before and after the Nazi regime, suggesting that the motives for these killings must be investigated within psychiatric practice itself. My research aims to highlight the mechanisms and scientific discourses in place that allowed nurses to perceive patients as unworthy of life, and thus able to be killed.

Using Foucauldian concepts of “biopower” and “State racism,” this discourse analysis is carried out on several levels. First, it analyzes nursing notes in one specific patient record and interprets them in relation to the kinds of scientific discourses that are identified, for example, in nursing journals between 1900 and 1945. Second, it argues that records are not static but rather produce certain effects; they are “performative” because they are active agents. Psychiatry, with its need to make patients completely visible and its desire to maintain its dominance in the psychiatric field, requires the utilization of writing in order to register everything that happens to individuals, everything they do and everything they talk about. Furthermore, writing enables nurses to pass along information from the “bottom-up,” and written documents allow all information to be accessible at any time. It is a method of centralizing information and of coordinating different levels within disciplinary systems. By following this approach it is possible to demonstrate that the production of meaning within nurses’ notes is not based on the intentionality of the writer but rather depends on discursive patterns constructed by contemporary scientific discourses. Using a form of “institutional ethnography,” the study analyzes documents as “inscriptions” that actively intervene in interactions in institutions and that create a specific reality on their own accord. The question is not whether the reality represented within the

documents is true, but rather how documents worked in institutions and what their effects were. Third, the study demonstrates how nurses were actively involved in the construction of patients' identities and how these "documentary identities" led to the death of thousands of humans whose lives were considered to be "unworthy lives."

Documents are able to constitute the identities of psychiatric patients and, conversely, are able to deconstruct them. The result of de-subjectification was that "zones for the unliving" existed in psychiatric hospitals long before the Nazi regime and within these zones, patients were exposed to an increased risk of death. An analysis of the nursing notes highlights that nurses played a decisive role in constructing these "zones" and had an important strategic function in them. Psychiatric hospitals became spaces where patients were reduced to a "bare life;" these spaces were comparable with the concentration camps of the Holocaust.

This analysis enables the integration of nursing practices under National Socialism into the history of modernity. Nursing under Nazism was not simply a relapse into barbarism; Nazi exclusionary practices were extreme variants of scientific, social, and political exclusionary practices that were already in place. Different types of power are identifiable in the Nazi regime, even those that Foucault called "technologies of the self" were demonstrated, for example, by the denunciation of "disabled persons" by nurses. Nurses themselves were able to employ techniques of power in the Nazi regime.

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1 Introduction

When I began this study, my interest was focused on the killings of nearly 300,000 psychiatric patients during the Nazi regime and more precisely, the killings that took place in the final years of the Second World War. The aim of my research was, at that time, to highlight the mechanisms that allowed nurses to come to view some patients as living “unliveable” lives and thus able to be killed.

My initial hypothesis was that a connection existed between scientific discourses, political rationalities, economic calculations of the killings, and nursing. The Nazi regime was a blatant example of what Foucault called “biopower.” (Foucault used the terms biopolitics and biopower interchangeably in order to describe the particular power constellation of biopolitics. I therefore do not delineate between biopower and biopolitics in this study.) The well-calculated killing of chronic, “mentally ill” patients was part of a huge biopolitical program that had a well-established “scientific” rationale to a recognized eugenic agenda. Nurses were a vital part of this program, supporting it in their everyday practice through the deliberate execution of patients. My analysis was to be based on nurses’ notes in patient records obtained from one specific psychiatric hospital in Hamburg, Germany. It was meant to decipher how, based on these documents, patients were identified as having “unworthy lives,” a particular construction of their identities that led to the deaths of thousands of people.

However, in the process of the analysis it became evident that certain patients were exposed to an increased risk of death much earlier than during the time of fascism. In addition, no differences could be found over time in how the notes were taken, nor were any differences identified in the content of the documentation on individual patients or in what treatment/therapies they received before, during, and after the Nazi regime. As a result, my suspicions were raised that psychiatric patients were being assassinated before and after the time

of the Nazi regime, implying, according to my hypothesis, that the motivation for these killings had to be investigated within psychiatric practice itself.

I thus shifted the focus of my analysis. Some of the records found in the archive of Hamburg were so voluminous and contained such a large number of nurses' notes that I began to question the meaning of these endless reports. It became apparent that if I wanted to understand in detail all the mechanisms at work and if I wanted to grasp the interplay between the different actors, I had to concentrate on one particular record, and for this reason, this research became a kind of case study.

This study also became very personal for three reasons. First of all, as a child born in Germany in the 1960s, I grew up, like many others of my generation, with the anxiety of not knowing how involved my parents were in the Nazi regime and in the Second World War. My parents were born in the 1920s, and although young, they were more or less active in different Nazi organizations and finished their studies in medicine shortly after the end of the war. However, my questions about their involvement with fascism and about what they knew about the Holocaust were never answered in a satisfactory manner. How they handled these questions was comparable to others of their generation as well as to those nurses and others who had been publicly accused of crimes against humanity. Most denied any knowledge about the crimes that had been committed and above all, denied any complicity in them. Any minor deeds they admitted they justified by the need to obey the party.

Thus, a rift had opened between the generations; large parts of family history were blank and parents remained mute about significant aspects of their lives. Simultaneously, the younger generation developed a guilty conscience for the unknown deeds of its parents, giving rise to the urgent claim to account for their actions during the Nazi regime – a claim that is still unsatisfactorily answered. It is perhaps because of my own personal background that I never felt contented with the explanations given by the older generation nurses for their involvement in the

killings, simply because their reasons sounded too familiar and their reasoning, I believed, was too comfortable.

Second, Germany's responsibility for fascism and for the two World Wars, as well as the escalating cold war during the 1950s and beyond, led some young German men, including myself, to refuse compulsory military service or to desert from the army. This was a criminal offence prosecuted with imprisonment. Following six months in jail, I was released to my military unit in order to complete my military service. When I refused again, I was committed to hospital to undergo an examination of my mental state. Due to the intervention of my mother I was released from the psychiatric asylum but I had learned how quickly one could be labeled mentally ill.

Third, I worked for more than eight years as a nurse in psychiatry, more precisely in a center for youth detoxification. During this time I became aware of the power that nurses had in their everyday interactions with patients and how uncritically their reports on patients were made. I remember countless discussions with colleagues during shift changes over what information should be documented and how certain kinds of information might influence our perception of patients. Most colleagues were amazed at my emphasis on charting because most of them considered nurses' notes redundant and not worth talking about. Apart from any theoretical considerations, all of these personal experiences helped shape my perspective on this study and led me to focus particularly on nursing reports and the impact they had on both psychiatric practice and patient treatment.

1.1 Research Objectives

In the struggle to understand how nurses, who are usually more closely connected with the characteristics of nurturing and healing, were able to kill some of their patients, several different perspectives have emerged in the literature. Some authors have blamed the crimes committed by nurses on a combination of different factors: on their working conditions, on the political conditions of the fascist system, on the powerlessness of nurses, and on the nurses'

moral fallibility (due to the lack of ethical guidelines in nursing).¹ In contrast, my research aims to highlight the mechanisms that allowed nurses to perceive patients as having lives not worth living and thus able to be killed. My analysis will center primarily on one rich medical record retrieved from the Langenhorn and Friedrichsberg asylums in Hamburg. The patient, Anna Marie B., was first admitted in 1931 and after multiple re-admissions over the following years, died in the asylum in 1943. Her medical file is particularly useful because it spans the years before and during the Nazi regime. The analysis will focus not only on the content of the nurses' notes but will also pay attention to the psychiatrists' notes in attempting to highlight the significance of the medical record in constructing patients and their identities in particular, often deadly, ways.

1.2 Research Questions

What role does the patient record play in psychiatric practice? What was the role and impact of the nurses' notes themselves? What discursive mechanisms in and around the patient record enabled nurses to contemplate the killing of "mentally ill" patients? How were the identities of patients constructed?

1.3 Organization and Structure

Chapter two contains a short historiography of the "euthanasia" killings and the involvement of nurses in these killings. In the discussion of the existing research it becomes apparent that most historians have used a social historical approach, which differs significantly from the theoretical approach chosen for this study. I thus discuss some of the historical frameworks that have been used in nursing history research on this subject, in particular, social history and case study history, and distinguish them from the discourse theory approach to history that I have employed for this study. Chapter two ends with a short account of the records used for the study and the method of analysis.

As will be discussed in the historiography, the term biopolitics has designated what some authors have called the "biologisation of the social." I criticize this understanding as a reductionist perspective on biopolitics, and in chapter three, I outline the theoretical concept of

biopolitics and biopower as developed by Foucault. I emphasize that biopolitics must be understood as a specific mode of governing that is not based on the state, but rather on a multitude of experts. Power is achieved not only through top-down coercion, but rather it develops in relationships that enable it to produce certain effects by enabling specific actions. Using Foucault's concept allows us to understand the productivity of power and its different combinations that spread throughout other levels of society in the Nazi regime, and it provides the tools to distinguish among them.

The empirical part of the study begins in chapter four with a description of the development of the Langenhorn asylum. It continues by outlining the psychiatric system found in the city of Hamburg from 1899 to 1945 and highlighting the struggle of the psychiatrists and medical directors to gain absolute control over this system. Psychiatrists began very early on to connect mental illness to genetic defects, and to use these apparently "dangerous" links to set themselves up as official agents for societal protection. As head of the asylum, the medical director thus claimed absolute power within the realm of psychiatric practice.

The subsequent three chapters focus on the file of one particular patient record. Chapters five and six analyze in detail the year 1931, the year of Anna Maria B.'s first admission to a psychiatric asylum, and illustrate the mechanisms that enabled her murder twelve years later. These chapters concentrate closely on the record and its impact on psychiatric practice, suggesting all the ways in which Anna Maria B. became subjectified as a schizophrenic person. This process of subjectification would be reversed in the following year – and this reversal is the focus of chapter 7. Interrupted only by short stays in her parental home, B. spent the rest of her life in psychiatric hospitals. During this time she disappeared from the record – hardly any trace of her could be found. "Unlivable zones" were erected in psychiatric practice - zones without any subjectivities that were ruled by a sovereign power without any limitations. Those who were condemned to exist within these zones experienced "living deaths" and were literally not visible.

In 1943 B. was killed in Hadamar, which is where the study ends as well. A short conclusion follows.

¹ To name just a few: Hilde Steppe, *Krankenpflege im Nationalsozialismus* (Frankfurt a.M.: Mabuse, 2001); Hilde Steppe and Eva-Maria Ulmer, "Ich war von jeher mit Leib und Seele gerne Pflegeri," *Über die Beteiligung von Krankenschwestern an den 'Euthanasie'-Aktionen in Meseritz-Obrwalde* (Frankfurt a.M.: Prisma, 2001); Hilde Steppe, "Das Selbstverständnis der Krankenpflege in ihrer historischen Entwicklung," *Pflege* 13 (2000): 77-83; Hilde Steppe, "Nursing in Nazi Germany," *Western Journal of Nursing Research* 14, no. 6 (1992): 744; Hilde Steppe, "Nursing in the Third Reich," *History of Nursing Society Journal* 3, no. 4 (1991): 21-37; Ulrike Gaida, *Zwischen Pflegen und Töten. Krankenschwestern im Nationalsozialismus. Einführung und Quellen für Unterricht und Selbststudium* (Frankfurt a.M.: Mabuse, 2006); Bronwyn Rebekah McFarland-Icke, *Nurses in Nazi Germany: Moral Choice in History* (Princeton, N.J.: Princeton University Press, 1999); Christoph Schweikhardt, "Krankenpflege im Nationalsozialismus," in *Quellen zur Geschichte der Krankenpflege. Mit Einführungen und Kommentaren*, ed. Sylvelyn Hähner-Rombach (Frankfurt a.M.: Mabuse, 2008), 554-564; Susan Benedict and Jochen Kuhla, "Nurses' Participation in the Euthanasia Programs of Nazi Germany," *Western Journal of Nursing Research* 21, no. 2 (April 1999): 246-263.

2 Historical Background of the Killing of Sick Persons

2.1 Historiography

This section provides a brief overview of the course of the killings of patients during the Nazi regime and summarizes some of the significant research results in the field of the “euthanasia” killings and in the history of the involvement of nurses in these killings. It is followed by a description of my theoretical approach to history and the method of the data collection and their analysis.

As a growing numbers of studies demonstrate, events around the killings of patients are complex and interwoven with other events that at first glance seem to be independent of them. Although a brief summary is difficult to make without losing significant aspects of this research, it should nevertheless enable the integration of this study into the broader frame of “euthanasia” killings and as well highlight the fact that patients were killed before and after the Nazi regime.

2.1.1 *The coordinated mass murder of “Aktion T4” and the decentralized patient murders of the second phase*

The killings of patients during the Nazi regime must be divided into several phases. The first systematic mass destruction in National Socialism was named “Aktion T4,” after the street address of the central government agency in the Berlin *Tiergartenstraße* 4. Aktion T4 was a centrally coordinated mass murder of patients in asylums and of residents in nursing homes for disabled people (*Heilerziehungsanstalten*). The extermination action was carried out under Hitler’s orders and in cooperation with the Ministry of the Interior.¹ The plan for killing certain designated categories of asylum patients was presented in 1939 by Philipp Bouhler and Viktor Brack from the chancellery of the Führer to a circle of influential psychiatrists. All physicians attending this meeting declared themselves ready to collaborate in the program.² They were to identify patients hospitalized for more than five years, or who were categorized as schizophrenic, “feeble-minded,” epileptic, or in the final stages of neurological disease – all those who were not able to work or able to do only “mechanical work.” Included in this list were all mentally ill

persons charged with criminal offences, as well as non-German patients who were to be divided by race. Identification of these people was thus made under the following selection criteria: “heritability,” “incurability,” “productivity,” “anti-socialness,” and “race affiliation.” War-disabled persons, persons suffering from diseases of aging, and some non-Germans were initially deferred. From the spring of 1940 on, Jewish patients were to be centralized in particular asylums. In 1939 they had already been centralized at the Langenhorn asylum, however, from which they were deported and killed, demonstrating that some patients were killed before Aktion T4 was even in place.³

Between January 1940 and August 1941, a system of selections, transports, and killing facilities assassinated more than 70,000 patients in gas chambers. The capturing and selection of the victims took place through a nationwide dispatching of report sheets (*Meldebogen T4*), documents that had to be completed by each asylum and submitted to two psychiatric reviewers and a supervising psychiatric expert. In specific asylums in Austria and in the Bethel asylum, which was run by the Protestant church, medical commissions of Aktion T4 selected the victims.⁴ These committees decided over life and death. After these bureaucratic committees had made their selections, transport lists were compiled and the patients were directly transported to the killing facilities or to specific intermediary asylums, from where they were later transported to one of the six “gas-killing facilities” at Grafeneck⁵, Brandenburg, Hartheim, Sonnenstein, Bernburg, or Hadamar.⁶ Soon after arriving in these killing facilities, patients were given a short medical “examination,” had their identities verified, and the plausible causes for their deaths decided. They were then suffocated with carbon monoxide in gas chambers. Relatives received falsified “consolatory letters” (*Trostbriefe*), which were constructed in a sophisticated system of utmost secrecy and which suggested that the sick persons had been released from their suffering.⁷

On 24 August 1941 Hitler ordered the end of the mass gasification and thus the centrally organized Aktion T4 was officially ended. The true reasons for his abandoning the gassing have long remained obscured, particularly after the Nuremberg tribunal asserted that no written

documents on it existed.⁸ Heinz Faulstich emphasized that early “euthanasia” trials and scientific publications assumed that widespread concern in the population and the resistance of the churches had prompted Hitler to abandon the Aktion. However, some scholars, including Klaus Dörner, considered the influence of the war on the course of the killings. At the time of the Aktion, the country needed to concentrate all its resources on the struggle against the Soviet Union. Another explanation came from Ernst Klee, who suggested that the planned target of 65,000 to 70,000 cases had been obtained by August 1941. According to the so-called Hartheim statistics, exactly 70,273 people had been “disinfected” by 1 September 1941. Heinz Faulstich pointed out that this “fulfillment of the plan” hypothesis was repeated continuously in the “euthanasia” literature from then on, leading some authors to consider it even as the sole reason for the stop.

Götz Aly and Hans-Walter Schmuhl, however, believed this hypothesis to be just one of many causes.⁹ Faulstich also emphasized that Ernst Klee probably never wanted to over-promote this idea of a scheduled closure of the Aktion when he cited the Hartheim statistics because “he knew very well...that the protagonists of the action were surprised on all sides by the Fuehrer’s order and that numerous Westphalian and Hanoverian patients that should have been killed at Hadamar remained in the Hessian intermediary asylums.”¹⁰ When the mortality rates in the intermediary asylums escalated between the years 1941 and 1942, it appears that these patients then became victims of a decentralized killing that was occurring after the official stop of Aktion T4. Most recently, there seems to be a general consensus within the scientific community that Hitler halted Aktion T4 because it proved impossible to keep the killings secret. Even though the population in general was indifferent to or even openly approved of the killings, since they believed that these were lives “unworthy of living,” Bishop Clemens August Graf von Galen publicly condemned the assassination of mentally ill persons on 3 August 1941.

With the stop of the “euthanasia” killings and the official abandonment of Aktion T4, however, the killing of patients did not come to an end. Further planned killing actions continued

and 42 bureaucrats continued to examine report sheets (*Meldebögen T4*) at the main “euthanasia” office on the *Tiergartenstraße 4*. Not only did killing continue in the asylums at Hartheim, Hadamar, and Bernburg, but during and after this “second phase” of the “euthanasia” killings, an extensive but silent dying took place in psychiatric asylums and nursing homes for disabled people. These hidden, decentralized patient murders occurred through starvation, medication, and neglect.

The scope of these murders has proven to be so large and diverse that research has not yet been able to uncover every detail. Since the beginning of the most recent research in the field of “euthanasia,” which began in the 1990s, the number of victims has continuously changed. The most recent attempts at quantification added 150,000 to 200,000 victims of these decentralized murders of sick persons to the total of 70,200 victims of Aktion T4.¹¹ In his detailed study of the Wehnen asylum, Ingo Harms illustrated how patients were killed by starvation and neglect.¹² Unemployed personnel of the disbanded Aktion T4 had found further work in the extermination camps in Eastern Europe.¹³

2.1.2 “Aktion Brandt”

“Aktion Brandt” evolved from 1941 onwards. Officially known as disaster medicine, it polarized the scientific community around the question of whether or not nurses and physicians had intentionally assassinated patients in hospitals. Suspicions were raised that they were killing psychiatric patients in order to obtain hospital beds for physically injured war victims. From the summer of 1942 on, the escalating air war and the disaster management needed to care for war victims, which was initially the responsibility of regional offices, became reasons for the deportation and subsequent murder of patients.

A process of reorganization took place on a central planning level. The T4-front organizations were put under the control of the Ministry of the Interior. The nomination of Herbert Linden as appointee of the empire (*Reichsbeauftragter*) for the asylums (*Heil- und Pflegeanstalten*) on 23 October 1941 aimed to strengthen centralizing the administration of the

asylums. The physicians involved in the organization of Aktion T4 were thinking about a reorganization of German psychiatry, and the continuation of the “euthanasia” program was an integral part of this planning. Some of the primary actors – for example, Hans Heinze – criticized the “wild euthanasia” in the outlying regions as due to lack of central control and the non-scientific execution of patients.¹⁴ The term “wild euthanasia” was therefore a term utilized and invented by the National Socialist offenders.¹⁵

The progression of the war and the increasing threats to cities as targets of severe air raids influenced central planning, at least from 1943 on.¹⁶ The concept of disaster medicine that was developed in this context became known as Aktion Brandt because Brandt, Hitler’s personal physician, became the chief representative for the public health sector. In the course of this operation, asylums in the particularly endangered regions – the metropolitan areas of Berlin and Hamburg as well as the strategically important industrial zones of the Rhineland and Westphalia – were evacuated in order to make room for contingency hospitals for injured patients from these affected regions. Psychiatric patients were therefore deported to asylums outside these regions. On 7 July 1943 the so-called barrack decree (*Barackenerlaß*) allowed the construction of wooden barracks on the grounds of psychiatric asylums in order to obtain more space for psychiatric patients. Two months later the “double bed decree” (*Doppelbetterlaß*) was enacted with the aim of doubling the space again by putting beds on top of existing patient beds. However, both decrees did not have the expected effects because of war conditions and the deficiency of construction materials.¹⁷ Furthermore, the influx of deported patients to the interim asylums continued and led to the overcrowding of these outlying asylums. The “solution” in this situation was to continue with the murder of patients.

Peter von Rönn described conditions in the asylums to which patients from the Langenhorn asylum in Hamburg, the focus of this analysis, were deported. The asylum of Lübeck-Strecknitz, for example, was assigned as a makeshift hospital for mentally ill patients from Hamburg, necessitating the removal of the mentally ill who had been hospitalized in Lübeck

to create space for the patients arriving from Hamburg. At the end of September 1941 more than 600 patients were deported from Lübeck, nearly 400 of who had earlier been transferred from the asylum at Langenhorn. Even the top officials in Hamburg's health administration – Kurt Struve, for example - did not have an idea where the Lübeck patients had gone. Some were transported to the asylums at Eichberg and Weilmünster, some were also transferred to Hadamar. All of these asylums were also used by Langenhorn to directly deport its patients. About four-fifths of the patients from Hamburg perished in these asylums under miserable conditions.¹⁸ In the asylum at Eichberg chaotic conditions prevailed; barely any physicians were on staff and those that were were likely to be addicted to morphine. There were only a few nurses, leaving most of the wards understaffed or “nurse-free,” and with the shortage of beds, many mattresses were placed on the floor. The patients had been abandoned.¹⁹

2.1.3 *Assassinations of sick persons outside Aktion T4, the second phase, and Aktion Brandt*

Beyond the killing plans already described, other centrally ordered actions took place.

Historians date the onset of the killing of children under the scope of the *Reichsausschuss zur Erfassung erb- und anlagebedingter schwerer Leiden* to the summer of 1939, before the start of the adult “euthanasia” killings. From the summer of 1939 till the end of the war, about 5,000 children and juveniles were killed. Simultaneously, psychiatrist Paul Nitsche of Saxony developed his *Luminalscheme* that killed psychiatric patients by narcotic injection. In 1939 Nitsche, head of the Saxon asylums, ordered the psychiatrists under him to use more narcotics in order to “guard the surroundings from outrages of sick persons.”²⁰ Nitsche's scheme was combined with the concept of “systematic weakening” (*Niederführung*) of the patients, which meant enfeebling patients by starvation in order to use smaller amounts of Luminal to kill them.²¹ Both killing methods were practiced during Aktion T4 and during the war,²² and characterized a regionally initiated systematic extermination of patients that took place outside the zones designated for the centralized killing action. According to Heinz Faulstich, the Saxony asylum's mortality rate “outside of Aktion T4” was higher than in all other regions in Germany.²³

This Saxon killing method, known as the “Saxon special path” in the “euthanasia” historiography, was copied by psychiatric hospitals in various parts of Germany and in countless numbers of other asylums in such places as Meseritz, Hadamar, Eichberg, Uchtspringe, and the Steinhof in Vienna.²⁴ However, most of the hospitals preferred to kill their patients through starvation and drew on their experiences in the 1930s. Schmuhl observed that in 1938, patients were already being killed through starvation. Klee contended that the starvation method as a war measure had also already been discussed in the Ministry of the Interior in 1937.²⁵ Faulstich wrote that a decentralized form of starvation was already a general phenomenon in the asylums between 1933 and 1937.²⁶

As already mentioned, the killing of 1,000 to 2,000 Jewish patients was centrally organized and was carried out by a “special action” (*Spezialaktion*) in 1940.²⁷ In another action called “special treatment 14f13” (*Spezialbehandlung 14f13*), which was continued even after the stop of Aktion T4, around 20,000 concentration camp inmates were killed in the facilities used by Aktion T4.²⁸ Ultimately another 1,000 people who were classified as “criminal mentally ill persons” and who were interned in psychiatric asylums according to paragraph 42 of the criminal code, became victims of the “extermination through working” program in different concentration camps. Even in European countries raided by Germany, mentally ill persons were killed. After its annexation, Poland, for example, became an experimental field for murders that paralleled the preparations of Aktion T4, and at least 20,000 Polish psychiatric patients were shot, gassed, or starved to death. Together with their patients, many Polish psychiatrists and nurses were killed as well.²⁹ Faulstich calculated that 80,000 people died in Polish, Soviet, and French asylums.³⁰

As the example of Nitsche’s killing method illustrates, psychiatric patients were also being killed in the outlying regions from the end of 1939 on. Two cases are especially noteworthy: the special unit of the German Danzig SS under the command of *Sturmbannführer* Eimann executed 1300 patients from the Pomeranian asylums in the woods of Neustadt in

November 1939, and more than 1,500 patients from East Prussian asylums were killed in mobile gasification cars near Soldau in May and June 1940 by the special unit “Lange.”³¹

2.1.4 *Assassinations of sick persons during the Nazi regime before 1939*

As already mentioned above, the “systematic weakening” (*Niederführung*) through starvation and narcotics that Paul Nitsche ordered in the summer of 1939 must be considered part of Aktion T4. However, even before that time, patients in some parts of the country were being systematically undernourished.³² Heinz Faulstich contended that in 1936, Nitsche had introduced on his own accord a slurry food dedicated – according to a later official definition – to all those who were not able to appreciate what they ate. No doubt this applied to chronic, incapacitated, and bedridden patients.³³ Götz Aly argued that “the artificial dying within the German asylums had already begun in 1938” and he saw in the generally increasing mortality rates “the non-legitimized, practical precursors of the killings in the asylums” that were later “bureaucratically formalized” on Hitler’s command in 1939. Ernst Klee also assumed “that the preparation for the Euthanasia began far earlier than generally supposed.” As evidence he pointed to the discovery of records from the Hephata asylum in Treysa, which was run by the “Inner Mission,” an organization of the Protestant church. No patients were transferred from Hephata during Aktion T4, but numerous patients were transported away between the years 1936 and 1939. Other non-governmental transports of patients, for example, from Catholic institutions, have also been documented. According to Klee, these transports had grown to threatening proportions by 1937.³⁴

If the rising mortality rates within psychiatric hospitals are seen as a measure of intentional neglect of patients with potentially deadly effects, then in 1936 and 1937 respectively, the increase in deaths that occurred in most psychiatric hospitals within the Deutsche Reich cannot be detached from the “euthanasia action,” as Faulstich indeed concluded.

2.2 Explanatory Approaches

Historian Hans-Walter Schmuhl asserted that “after nearly three decades of intensive research we are far from a generally accepted interpretative model of the genesis” of the “euthanasia” program of the National Socialists. Historian Uwe Kaminsky stated too that it would be an almost impossible endeavour to provide an overview the development of the research in the field of National Socialist “euthansia” and to give an account of the present state of research.³⁵ However, this introduction tries to delineate two main explanatory models that exert considerable influence on the debate about the origins of the “euthanasia” programs.

2.2.1 *“Euthanasia” as “final solution of the social question”*

A particular approach, which incidentally could also be used for explaining the genesis of the Holocaust, can be found in the groundwork provided by Götz Aly and his collaborators. The “euthanasia” actions were planned and carried out mainly by a more or less homogeneous “expertocracy” legitimized under Hitler’s authority (*Führerermächtigungen*). These experts pursued a purportedly rational, economic, and demographic political program. The aim of the “final solution of the social question” was to select and exterminate the “useless.”³⁶ According to Aly’s hypothesis, the rationale of the killings was based on the above-mentioned plans of psychiatric experts to re-organize and “modernize” the German psychiatric system under a divided plan, which would provide “active” therapy for the treatable, and concurrently, would exterminate the non-treatable, unproductive, and chronically ill patients.

The explanation of “euthanasia” as the final consequence of a health and social policy in a capitalistic industrial society was most clearly developed by scholar Klaus Dörner. The National Socialists, along with members of the traditional bureaucracy and human sciences, saw the use of Germany as their “historic mission” to prove to “the rest of world once and for all that a society, once freed from its whole social burden by taking the painful risks of finally solving the social question – even if it meant losing a third of its whole population – would be able to set free the total potential of industrialization and become economically, militarily, scientifically, and

certainly culturally, invincible.”³⁷ According to Dörner’s hypothesis, industrialization in the nineteenth century was only realizable when a population was released from its obligation to care for family members. Hence a modern system of institutionalization and professionalization of care took place. “The onset of modernity around 1800 is not only characterized by the marketization of the economy and the industrialization of work but also by the elimination of caring for family members unable to work.”³⁸ The decoupling of economy and science from a religious and philosophical idea of what it means to be human enabled the perception that “up to a third of society was a drain on society and thus what to do with these people was seen as a question of financial costs.”³⁹

Dörner’s position was close to that of sociologist Zygmunt Bauman, who argued that the Holocaust was a symptom of this kind of rational modernity.⁴⁰ Dörner’s model was sharply criticized by historian Dirk Blasius, who focused on its teleological tendencies.⁴¹ In the end, Dörner’s explanation is based on a Marxist analysis of capitalism, and Schmuhl pointed out that in Marxist analyses the social question of the nineteenth century was synonymous with the “labour question” of the proletariat. Dörner’s model adopted the social question to the *Lumpenproletariat*, which in Marxist theory is the lowest, most degraded stratum of the proletariat, and described those members of the proletariat, especially criminals, vagrants, and the unemployed, who lack class consciousness.⁴² However, as my critique of the Marxist approach to history emphasizes in the next section, even if one concedes that regarding everything – even human beings – as objects of use is inherent in capitalism, nothing at all is explained. Emphasizing the primacy of socio-economic factors in this kind of historical analysis always produces the same results. Distinguishing between structures and the “rest” constructs the historical subject as a rational being and does not allow for “irrationality” or “free will.” This approach thus cannot explain why many assassinations were carried out in a more or less unorganized manner and independently from orders issued under the centralized planning actions.

2.2.2 *“Euthanasia” and a “Developmental Biopolitical Dictatorship”*

For a long time research assumed that there was a close interrelationship between eugenics and “euthanasia.” Schmuhl explained “euthanasia” as the endpoint in the radicalization of Nazi health policy on race and genetics and related it to the general political conditions under the “Third Reich.” The pre-history of the Nazi program of “euthanasia” can be found in the discussions on racial hygiene in the 1890s, in its apparent triumphal procession in science, society, and state during the time of the Weimar Republic, and finally, in its elevation to state doctrine in 1933. The interconnections between government and party institutions enabled extraordinary, confidential, and even extra-legal interventions that were justified by an increasing threat of racial impurity.⁴³ The succession of forced sterilizations, the abortions performed due to eugenic indications and the “euthanasia” of children apparently seemed to manifest this radicalization of eugenic ideas. This position was criticized by historians like Michael Schwartz and others, who emphasized that the concept of eugenics was politically polyvalent and adopted by different political parties and systems, implying that a categorical difference existed between eugenics and euthanasia.⁴⁴ An international comparison underlines this aspect: eugenic movements existed in democracies – the USA, Canada, Great Britain, Scandinavia, Switzerland, etc. – and in authoritative states or dictatorships such as those found in National Socialist Germany or Stalinist Soviet Union.⁴⁵

Schmuhl later refined his thesis, underlining the interrelationship of eugenics and euthanasia on the same discursive level.⁴⁶ He defined discourse as a “‘ruling mode of speaking’ that determines what can be talked about and in which language – and what supposedly should remain silent.”⁴⁷ According to Schmuhl, it was apparent that since 1890, discussions about eugenics and the “extermination of life unworthy of life” were based on the same premises: “the categorization of humans and groups of humans according to their worth, the move to biologize the social, the absoluteness of the supra-individual community of origin, the abolishment of the idea of human rights anchored in natural rights, the exclusion of illness, disability, feebleness, old

age, pain, and suffering from the *conditio humana*.”⁴⁸ Despite appearing to coincide with the theoretical perspective of this study, Schmuhl’s definition of discourse in my view is imprecise and rough and he does not fully explore the potential of a theoretical discourse approach to history. Even his latest writings do not clearly differentiate between discourses and ideologies; they do not lay out exactly how discourses functioned and what the benefits of using this approach are. As the theoretical discussion over the course of this study will highlight, a deeper theoretical perspective is able to demonstrate that discourses have far-reaching and material consequences for the objects of this study. It appears to me as if Schmuhl used the concept of discourse more in order to “prove” his original assumption that “euthanasia” was a radicalized form of eugenics. In the end, he remained within the more traditional framework of the history of ideas and insisted that socio-economic conditions and the specific circumstances of the Second World War were decisive moments generating the mass assassinations of patients. At this point, Schmuhl is no longer arguing from a discourse theory perspective.

Schmuhl defined the “Third Reich” as a “developmental biopolitical dictatorship” aimed at controlling “birth and death, sexuality and reproduction, body and genetic dispositions.”⁴⁹ The point of reference for this political entity was the collective subject of “people,” defined as a bio-organic body. The developmental biopolitical dictatorship was based on two pillars – one on health and heredity and the other on race. According to Schmuhl, these related streams were under scientific leadership that aimed to establish a stratified society. At its top would emerge a social egalitarian, biological homogeneous *Volksgemeinschaft* (or folk community) in which class disparities would be resolved. The relevance of the biosciences within the National Socialist state thus cannot be overestimated. As Schmuhl stated, the “scientists from these disciplines envisioned – even before 1933 – a technocratic model of policy counseling through which ‘scientific expertise’ would dissolve politics into multiple factual constraints, political decision processes would become ‘rational’ solutions, with the consequence that science and technology

would take the place of politics.”⁵⁰ Schmuhl described this process as “reciprocal instrumentalization of science and politics.”

I also use the term biopolitic in this study, but I am taking a more Foucauldian perspective than Schmuhl. I argue that Schmuhl loses some critical potential in his understanding of the concept. The role of racism, for example, has a specific strategic function in Foucault’s conception of biopower, which I feel becomes somewhat blurred in Schmuhl’s approach. Whereas biopower from a Foucauldian perspective is a particular mode of governing that is bound to multi-level technologies of power, Schmuhl’s conception of the term tended to reduce biopolitics to a biologized social. He linked biopolitics exclusively to the Nazi regime and reduced it to a kind of “social engineering” through eugenics. He and other historians have perceived the ideas behind eugenics and the actions of carrying out “euthanasia” killings as imposed by a coercive dictatorship and its technocratic elite. But as historian Michael Burleigh has emphasized, the procedures of sterilization and “euthanasia” were not always imposed top-down by a coercive state apparatus.⁵¹ And as this analysis demonstrates as well, many German doctors and nurses made their decisions based on their own understanding of eugenics. In the context of a widespread campaign of propaganda and public education, even parents often requested eugenic measures for their own children.⁵²

Biopolitics under the Nazi regime cannot be reduced to a simple killing of the unfit. As historian Robert Proctor highlighted in his book, the Nazi’s attempt to defeat cancer was the most decisive and vigorous attack on the disease then known to humankind; German cancer research was the most advanced in the world by the time Hitler assumed power in 1933, and the anticancer measures likely caused the disease to decline among the post-1945 German population.⁵³ Throughout the world over the course of the twentieth century, there was not a clear distinction between preventive medicine and eugenics, between the pursuit of health and the elimination of unfitness, between consent and compulsion. Sociologist Nikolas Rose emphasized that even “under National Socialism – which was, as Foucault points out ‘a paroxysmal development...a

coincidence between generalized biopower and dictatorship that was at once absolute and retransmitted throughout the entire social body' ... biopower was a complex mix of the politics of life and the politics of death."⁵⁴ Proctor's book has shown especially that biopolitics under the Nazi regime entailed "not merely the exercise of state power but strategies for governing life developed by many other authorities. Nazi doctors and health activists, not acting solely under the direction of a sovereign state, waged war on tobacco, sought to curb exposure to asbestos, worried about the overuse of medication and X-rays, stressed the importance of a diet free from petrochemical dyes and preservatives, campaigned for whole-grain bread and foods high in vitamins and fiber, and many were vegetarians."⁵⁵ My study demonstrates that the decisions doctors and nurses made in regard to the killings of patients were not forced by the state or by a technocratic elite but rather were deliberately made by the psychiatrists and nurses themselves in the Langenhorn asylum based on scientific categorizations and internalized normative conceptions. This is an impressive example of what Foucault called "self-techniques" and "self-regulation."⁵⁶ Understanding biopolitics as being composed of different power technologies and carried out by a multiplicity of authorities and experts independently from "state apparatuses" forces one to analyze the connecting lines between eugenics, "euthanasia," and biopower in psychiatric practice as such. Furthermore this perspective enables one to understand why the killings of patients were carried out independently of central planning, as I demonstrated above, and why sick persons were being killed both before the National Socialists came to power and continued after the end of the Second World War. These concepts of biopower and biopolitics will be discussed in detail over the course of this study.

2.3 Deaths in Psychiatric Hospitals before and after National Socialism

The discovery of high mortality rates within psychiatric hospitals, asylums, and nursing homes before and after the time of fascism is a fact that has yet to attract significant historical attention. Historian Heinz Faulstich, who published a detailed study on the killings of sick persons, did shed light on killings before and after the Nazi regime. He assumed that the comparative neglect of this situation by historians is due to the attempt to come to terms with the atrocious crimes of the program of “euthanasia.” I believe, however, that the reasons for this neglect must be searched for in the models developed to explain the “euthanasia” killings. All of these models focus on the Nazi system of power and relate the killings to the specific circumstances that occurred under the Nazis. The models cannot explain though why the killings began before the Nazi regime and continued after the Nazis lost power, and this, I believe, is the reason why these killings have been ignored so far by historians.

The following study is an attempt to highlight some of the mechanisms that were part of psychiatric practice and that enabled nurses and doctors to kill their patients. Simultaneously, it is a plea to expand the focus of research from the “euthanasia” killings to a broader analysis of the “murder of sick persons.”

2.3.1 *World War I and earlier*

It is an undisputed fact that during the First World War, starvation prevailed within psychiatric hospitals. The controversial question remains, however, whether or not this starvation was intended or was simply a consequence of war and the general famine in Germany due to the continental blockade. Historian Heinz Faulstich, who dedicated a large part of his book to this problem, assumed that the high mortality rates were apparently accepted due to the patriotic consideration that a lot of German soldiers lost their lives in the war.⁵⁷ High mortality rates in the asylums are often linked to the so-called *Rübenwinter* [turnip winter – a synonym for the winter of 1916/17 when nothing other than turnips was available as food] as well as to the influenza pandemic of 1918. As will be discussed, mortality rates in the Langenhorn asylum nearly doubled

in 1916 and nearly quintupled one year later, and prolonged starvation was identified as the reason why Langenhorn had more than 1800 patients at the beginning of the war but only 1300 remaining at its end. Historian Ingo Harms also demonstrated for the Wehnen asylum, the 1918 influenza pandemic did not play as dominant a role in the mortality rate as is generally thought.⁵⁸

According to Klaus Dörner, reasons for the high mortality rates in asylums during the First World War could well have been due to an intentionally provoked shortage of food. The purposeful undernourishment of patients led to the death of 70,000 inmates in the asylums through starvation, and during the Second World War, this method of reducing the asylum population was simply repeated.⁵⁹ This hypothesis, however, supposed a top-down, state-organized action that led to the killing of as many victims as did Aktion T4 during the Nazi regime. Even though the intentional nature of these killings cannot be proven, the fact that mortality in nursing homes and psychiatric asylums exceeded that in the general population cannot be denied.⁶⁰

2.3.2 *Weimar Republic and hyperinflation, 1923*

The increase in mortality during the period of hyperinflation in 1923 was merely the peak of a famine that did not end with the WWI ceasefire but rather lasted late into the 1920s. Patients in psychiatric hospitals were hit especially hard. According to Faulstich, a general consensus now perceives psychiatric patients as victims. The economic misery that continued after the end of the war suspended their right to live.⁶¹

2.3.3 *Mortality after World War II*

Faulstich's 1998 study leaves no doubt that in the postwar period, deaths within psychiatric hospitals in all four zones of occupation did not come to an end, leaving the high mortality rates in need of explanation. Although the author relates these deaths once again to an avoidable lack of food, he rejects the idea that any occupying power was intentionally withholding food. He emphasized that food distribution was organized by and under the responsibility of German authorities.

2.4 Nursing Historiography

Contrary to the large body of research on the “euthanasia” killings that historians in the field of social history of medicine have developed, the current state of research in the history of nursing is comparatively limited. As the brief description above highlights, medical historians have not only carried out countless regional studies but they have also entered into a theoretical debate about how eugenics, “euthanasia,” and their connections should be classified and what the rationales were behind these killings. Over the course of this lengthy process, which began with the Nuremberg trial and has encompassed more than fifty years of research, the complexity of the “euthanasia” killings becomes apparent as well as the fact that these killings cannot be detached from the Holocaust.

However, nurses seem to be irrelevant and are strangely absent in these studies, which is astonishing if one considers that without nurses, the whole “extermination program” could not have been possible. If nurses are mentioned at all, conclusions historians have reached have followed similar patterns. Henry Friedlander, for example, assumed that psychiatric nurses were always dependent on their physician bosses and became willing helpers in the machinery of sterilization and “mercy killings.”⁶² Michael Burleigh explained that there was “no great psychological mystery about why these ‘carers’ became killers.” Nurses were complicit because they were tired, frustrated, and were already desensitized to the suffering of others. Many had internalized common pejorative attitudes about the mentally ill and saw nothing in the patients in front of them to change their minds.

In March 1984 a group of German nurses tried to critically assess the role of nurses during the Nazi regime. The authors understood their work as an attempt to write nursing history from below, as an engagement of nurses with their own history. Their book, *Nursing during National Socialism*, was edited by nurse Hilde Steppe and by 2001, nine editions had appeared.⁶³ This book seems to have set the research parameters because subsequent nursing history studies have not gone beyond this book’s framework. To my knowledge, regional studies about the

involvement of nurses in the killings of sick persons in specific asylums have not been published, implying that little is known about the nature of nursing work.

Most of the nursing history studies carried out so far have tried to draw an all-embracing picture of nurses' roles in the killings of patients. For this reason Steppe's political appraisal of the "euthanasia" killings was never contradicted and seemed to establish consensus in the scientific community.⁶⁴ For Steppe, "race hygiene ideologies and capitalism's interest in profit must be considered as the main reasons for the deadly logic of the National Socialist's extermination politics."⁶⁵ This approach resonates with Dörner's view of "euthanasia" as the final solution of the social question. According to Steppe, the main criteria for killing patients centered on their inability to work because psychiatric patients were only of interest to the system if they could be used as cheap labour. Another consensus persists in the question of the relation between eugenics and "euthanasia." Similar to Schmuhl and his early work, most nursing historians seem to be convinced that "euthanasia" was the culmination of a process of radicalization of Nazi policies on race and health genetics.⁶⁶ Furthermore, Steppe's study was based on the assumption that killings were centrally planned and systematically carried out, an assumption that is refuted by newer research in the field of "euthanasia" and especially contradicts the perspective of this study. For Steppe and others with similar perspectives, nurses can only be perceived as helping to actualize the program. Steppe also clearly distinguished between killings in asylums and the killing that took place during the Holocaust, a position most nursing historians accept without contradiction. Again, newer research in the history of medicine highlights how interwoven were these different aspects of killings. Despite these insights, research in nursing history can roughly be subdivided into nurses in concentration camps,⁶⁷ nurses in psychiatric asylums, and nurses in killing facilities. Other research concentrates on the involvement of nurses in specific aspect of eugenics or "euthanasia," as in, for example, children's "euthanasia."⁶⁸

Most of the studies mentioned above used testimonies of nurses who killed patients and analyzed them from an ethical perspective. Authors agree that the involvement of nurses in these

crimes can only be understood against the backdrop of the specific situation of nursing in Germany. I want to summarize very briefly these undisputed assumptions. Most of these studies began with historical overviews of the development of nursing as a vocation in Germany, highlighting the fact that German nursing was particularly powerless due to its traditional connection to the Protestant and Catholic churches.⁶⁹ Because of this connection, German nurses were trained especially to obey and to understand themselves as subordinated to physicians and religious authorities. The Nazi system was thus said to have exploited this condition by indoctrinating nurses with race ideologies, reorganizing their vocational organizations, and using psychological methods in order to brainwash nurses to do their duty and follow orders even if their conduct fell outside the realm of moral acceptability. Nursing historian Susan Benedict and historian Jochen Kuhla developed an analytic framework for understanding nurses' participation that seems to have provided the basis for many other studies: ideological commitment, obedience, religion, nursing education and nursing professional organizations, putative duress, and economic factors.⁷⁰

This study seeks to extend this analytical framework, because it does not ask why nurses voluntarily participated in the killings of patients, but rather how the killings were carried out in an ordinary psychiatric asylum and what was the role of nurses in these killings. This study thus concentrates on the crucial role that nurses played in the construction of "lives unworthy of living" through their observations and reports that were documented in the medical record. However, the study also attempts to break new methodological ground by using a discourse theory approach to the history of nursing.

2.5 Discourse Theory Approach to History

The majority of historical research on the program of eugenics during the National Socialist era in Germany is positioned within a social history framework.⁷¹ As developed in detail in the first section of this chapter, historians such as Hans Walter Schmuhl explained the “euthanasia” program as the culmination of a radicalized process of the National Socialists’ racial policy against inheritable diseases, which was linked to the political context of the Third Reich. This context was characterized by connections among the charismatic National Socialist regime, racist state doctrine, and a polycratic structure of the state.

As Michael Burleigh pointed out, eugenic solutions “became attractive to policy makers, once the Depression had highlighted the gap between resources and the scale of institutionalized provision.”⁷² This perspective emphasized the cost-cutting considerations of welfare policy during and after the Depression.⁷³ As noted too, it has been adopted by nursing historians and supplemented by their description of the powerless status of nurses in National Socialist Germany. According to this approach, nursing was fully dominated by a scientific, medical community “that needed assistants who could follow directions and who could give patients the care and attention that doctors no longer could or would give.”⁷⁴ Nurses had to obey because, due to their poor education, they lacked the medical knowledge of physicians. Thus, it seemed that it was vital for the well-being of the patient for nurses to obey all orders.

A social history approach privileges a socio-economic context and perceives it as the basis for unintended actions. Seen from this perspective, culture is nothing more than a descriptive surplus that has little importance.⁷⁵ According to historian Jürgen Kocka, “events, actions, and persons must, as much as possible, be analyzed and understood through a structural historiography”; that which cannot be integrated into a generalizable framework able to explain societal social structures must be considered only a story.⁷⁶ Social historians, often using a Marxist analysis of class, concentrate on the structures of social class as a way to understand the history of society. By distinguishing between the social structures operating in society and the

“rest,” they view the historical subject as acting with an instrumental rationality, leaving no room for “irrationality” or free will. Max Weber introduced this ideal-type conception of the subject, who makes decisions according to a means-end analysis.⁷⁷ Hegel and Marx also assumed that certain societal laws existed. According to Hegel, for example, history was nothing more than the deployment of reason, and societies were the result of necessary evolution. Marx’s sense of history was based on the “laws” of economic opposition between the dominant and subordinated classes, which were modified through the introduction of communism as the ultimate mode of production.⁷⁸

However, the most striking influence on the historiography became the “linguistic turn,” which philosopher Richard Rorty defined as an attempt to find the lowest common denominator of all epistemological positions in the constitutive role of language and of symbol-systems in the construction of reality.⁷⁹ It was at this time that the first books of Foucault, Lacan, Barthes, Berger/Luckmann and Derrida were published, all of them concerned with the construction of reality and the importance of language within this process. Aside from huge theoretical differences, the French texts especially converged in an approach that denied that language functioned merely as a mirror of reality but rather that it worked in the construction of social reality and in the perception of what is perceived as “nature.” Whilst this perspective has had a huge impact on the social sciences, it has had less influence on the history of science even into the present, a situation that applies to the history of nursing as well and, at least to my knowledge, to the studies on the history of the “euthanasia” program in Germany.

2.5.1 *Foucault, social history and discourse*

As demonstrated above, social history is based on two assumptions. First, the majority of social historians are convinced of the existence of empirical, objectified “facts” in the areas of politics and state governance. They are also convinced that reality is based on economic conditions and these conditions can be reconstructed. This implies that certain social categories exist as the result of objectified structures. Historians who follow this approach are convinced of

the existence of language-free and consequently norm-free economic and institutional basic structures. They use a wide variety of sources to make sense of complex social relations, and they often justify their work by referring to their identification with the culture they are analyzing.⁸⁰

The second assumption of social history is that language is a controllable medium and can serve as a mirror of past realities. Historian John Walsh questioned the ability of primary source texts to represent “truth” or “facts” but at the same time argued that “an exclusive focus on discourses leaves little room for analyzing experience or for recovering a sense of agency on the part of the oppressed groups.”⁸¹ Nevertheless, literary theorist Roland Barthes demonstrated that the past represented in the writing of history is a construction of the historical narrative itself. According to Barthes, historical discourse does not follow the real; rather, it endlessly repeats what happened and thereby constructs the narration of the past. Barthes called this the *cercle paradoxal* (the paradoxical circle) because the narrative structures developed in the melting pot of fiction through myths, and epics become simultaneously the signs and the proof of reality.⁸² Historian Hayden White claimed that historians construct narratives or “emplotments” based on a leading literary genre; they construct the past itself.⁸³

While social history searches for long-lived structures to explain historical phenomena – always discovering new strata or isolating new entities – it overlooks both the regularity and patterns of the phenomena that are part of specific series.⁸⁴ Classical historiography, for example, uses hermeneutical understanding to speculate on and rationalize the reasons behind conscious actions; the acts of great individuals could be explained as being driven by rational intentions.

2.5.2 *Discourses and the production of “truth”*

In contrast to a social history approach is a Foucauldian discourse analysis. This approach is based on two assumptions. First, discourses are historically delineable possibilities of thematic speech, which define the borders of meaningful speech and coherent social acting. Second, discourse theory designates language as a medium that dictates its conditions on speech. Foucault argued that regimes carry (and disseminate throughout the space they occupy and the subjects they organize) their own truth, and that indeed, a regime of truth is a precondition of power.⁸⁵ Therefore, discourse analysis does not ask why something happens, because, as Foucault argued in his studies of power, the question “why” often presumes that one knows in advance the nature of what he or she is analyzing. Approaches like social history inadvertently ontologize the discursive organization of the present and naturalize the very terms needed to subject it to genealogical disruption, in order to understand what kind of social order and subject a discourse either brings into being or stabilizes. According to Foucault,

[An analysis of power should] refrain from posing the labyrinthine and unanswerable question: ‘Who then has power and what has he [sic] in mind? What is the aim of someone who possesses power?’ Instead, it is a case of studying power at the point where its intention, if it has one, is completely invested in its real and effective practices...Let us not, therefore, ask why certain people want to dominate, what they seek, what is their overall strategy. Let us ask, instead, how things work at the level of ongoing subjugation, at the level of those continuous and uninterrupted processes which subject our bodies, govern our gestures, dictate our behaviours, etc.⁸⁶

These short remarks illustrate that Hans Walter Schmuhl’s definition of discourse does not grasp the focal point of a Foucauldian discourse analysis. The latter concentrates on the question of how discourses are interconnected with power and what these power/knowledge links enable or disable. Humanity, according to Foucault, does not gradually progress until it arrives at a universal reciprocity, but proceeds from one domination to another. Thereby, humanity inflicts violence with impersonal systems of rules that are empty, violent, and not finalized in and of themselves. The successes of history belong to those who are capable of using these systems of

rules and of replacing those who had used them, inverting their meaning, and “us[ing] them against those who had initially imposed them.”⁸⁷ That is what Foucault meant by genealogy:

The isolation of different points of emergence does not conform to the successive configurations of an identical meaning; rather, they result from substitutions, displacements, disguised conquests, and systematic reversals. If interpretation were the slow exposure of the meaning hidden in an origin, then only metaphysics could interpret the development of humanity. But if interpretation is the violent or surreptitious appropriation of a system of rules, which in itself has no essential meaning, in order to impose a direction, to bend it to a new will, to force its participation in a different game, and to subject it to secondary rules, then the development of humanity is a series of interpretations. The role of genealogy is to record its history: the history of the concept of liberty or of ascetic life; as they stand for emergence of different interpretations, they must be made to appear as events on the stage of historical progress.⁸⁸

In any society, the production of discourses is simultaneously controlled, selected, organized, and redistributed by special procedures. This means that in any given historical period we can write, speak, or think about a given social object or social practice only in very specific ways.⁸⁹ “What can be said or not about something is neither absolutely fixed (because it varies historically) nor is it open to the whims of the moment.”⁹⁰ Foucault assumed that his objective was to create a history of the “different modes by which, in our culture, human beings are made subjects.”⁹¹ This is to say that a subject does not pre-exist to discourses but is constructed through them. This is also the objective of this study: to reconstruct empirically how patients became subjects in the medical record.

2.5.3 *A Critique of Social History*

The aim of this historical analysis is not to analyze institutions, ideologies, or theories from a social history perspective but rather to study the practices and the conditions that made them acceptable. Practices are not governed by institutions, prescribed by ideologies, or guided by circumstances, but to a certain point are pushed by their own logic, their strategies, their evidences, and their reasons.⁹² I argue that this is a radical approach to nursing history. I am not using the case records to attempt to uncover the real history of nurses involved in the killing of patients. A historical analysis, according to Foucault, must analyze the *régime de pratiques* to

decipher the patterns they impose on societies, the ways in which these practices are justified, and what were the intentions and evidence of these practices.

The starting point of such a historical analysis is discontinuity – when rationales suddenly change. As Foucault asserted, a discontinuity is always caused by a problem that must be resolved; the historian’s task is to uncover the transformations that made these reversals possible.⁹³ Unlike a social history approach, a Foucauldian historical approach emphasizes the event – a rupture of evidence on which our knowledge and our practices are based, a “singularity,” to which the analysis must refer instead of to historical constancy or anthropological attributes. This should be the first theoretical-political function of what Foucault called *l’événementalisation*, the multiplication of the connections, power plays, and strategies that emerged at a specific moment and functioned from then on as evidence, universality, or necessity.⁹⁴

Foucault agreed that there were non-discursive practices, including relationships between institutions, social and economic processes, behaviours, normative systems, and technologies that influenced discourses. These non-discursive relations did not define the objects of science, but rather enabled their appearance and allowed one to juxtapose them against other objects.

However, non-discursive relationships neither limit the discourse nor are they able to impose specific discursive forms. They function around the edges of discourse because they determine the possible relations that the discourse must effect in order to be able to talk about certain objects, to be able to deal with them, to indicate them, to classify them, to analyze them, to explain them, etc. These relations do not characterize the language that the discourse uses, nor the circumstances in which they unfold, but rather they portray the discourse itself as a kind of practice.⁹⁵

A discursive practice is an ensemble of anonymous historical rules that are always determined by time and space within a given era, which includes its economical, geographical, and linguistically given conditions.⁹⁶ Foucault supported that “non-discursive practices are

elements which discursive practices take up and transform. These external elements do not have productive powers of their own whereby they can contribute to the introduction of new objects, concepts, and strategies, nor do they just perturb in a random way what is being said.”⁹⁷

Thus the central point of historical analysis is the production of truths and falsehoods because the question driving the research is how humans govern themselves and others through the production of truth. Truth cannot be equated to the production of statements, but rather is the arrangement of domains where practices of truths can simultaneously be regulated and be meaningful.⁹⁸ Historical analysis is a history of thinking, which does not simply mean a history of ideas or of representations, like “anthropologically oriented cultural history,” but is an attempt to answer the following questions. How could a specific knowledge constitute itself? How could the dominant thinking, as it is connected to the truth, have a history? Historical analysis tries to answer the question of what is the history of the relationship that thinking maintains with truth.⁹⁹ The starting point of analysis thus begins with a problem that has emerged in the present – Foucault’s meaning of *généalogie*.¹⁰⁰ Foucault spoke of the “history of the present,” meaning that the present “reflects a conjunction of elements inherited from past and current innovations.”¹⁰¹ A problem does not signify representation of a pre-existing object or the creation of a non-existent object through discourse. The interplay of discursive and non-discursive practices enables something to get into the game of true and false and these practices constitute this something as an object for thinking; this might be in the form of a moral reflection, a scientific knowledge, or a political analysis, etc.¹⁰²

This kind of analysis enables one to highlight how experiences are constituted and how the relationship one has to oneself and to others is formed. As already mentioned above, nursing history approaches that anchor history in experience (for example oral histories), or newer approaches to the history of the “euthanasia” killings that try to decipher the real lives of patients in the records (for example, case studies) with the aim to document the lives of those omitted or overlooked in mainstream history, are highly problematic, as historian Joan W. Scott pointed out.

The lived experience of a subject seems to be both the direct vision of and the unmediated apprehension of the world; that which is visible is privileged and writing is put at its service.¹⁰³

Scott demonstrated that the problem with these approaches, which remain within the epistemological frame of mainstream historiography, is that they

take as self-evident the identities of those whose experience is being documented and thus naturalize their differences. They locate resistance outside of its discursive construction, and reify agency as an inherent attribute of individuals, thus decontextualizing it. When experience is taken as the origin of knowledge, the vision of the individual subject (the person who had the experience or the historian who recounts it) becomes the bedrock of evidence upon which explanation is built.¹⁰⁴

By making experience visible, these approaches gamble away the possibility of analyzing the workings of the systems of categorization themselves, their binary, fixed categories of representation and fixed identities – like man/woman, black/white, homosexual/heterosexual, normal/abnormal, mentally ill/rational – and what these categories mean and how they operate. However, “experience” makes it possible to criticize normative practices, but not their inner workings or their inner logics. Scott claimed that historians must “make visible the assignment of subject positions” and try to “understand the operations of the complex and changing processes by which identities are ascribed, resisted, or embraced and which processes themselves are unremarked, indeed achieve their effect because they aren’t noticed.”¹⁰⁵ Identity is always constructed through difference; the emergence of a new identity is a discursive event that implies experience and language cannot be separated.

This concept is an important objection against some of the writing in nursing history on case studies, for example, in Gerhard Füstler’s and Peter Malina’s case study briefly introduced above, and the latest work of the research group around Petra Fuchs and Gerrit Hohendorf et al.¹⁰⁶ Using a case study approach argues against the notion that social control is entirely dominating and that individuals experience life outside its parameters that stipulate that they are the autonomous originators of their actions.¹⁰⁷ Case studies set up the relationship between subjects

and social structures as oppositional. Those who impose social control are on one side; those who respond to it are on the other. But as Scott wrote, though subjects possess agency, they

are not unified, autonomous individuals exercising free will, but rather subjects whose agency is created through situations and statuses conferred on them...Subjects are constituted discursively, experience is a linguistic event (it doesn't happen outside established meanings), but neither is it confined to a fixed order of meaning...Experience is a subject's history. Language is the site of history's enactment. Historical explanation cannot, therefore, separate the two.¹⁰⁸

A similar critique could be made from another perspective as well. As historian Roger Chartier pointed out, old tales can be known only through a fixed, written form authored by folklorists. To qualify both the written document – the only trace of a practice – and the practice itself as a text, means to confuse the logic of written expression with “the logic that shapes what ‘practical sense’ produces.”¹⁰⁹ Nursing historians who try to reconstruct the actions of nurses in the killing of patients based on files and testimonies depend on the report that has been made of an event, which means that the event becomes the result of the act of writing. The real text stands between the observer and the spoken text. These works perceive written text only as a means of access to understanding. Nevertheless, the analysis should focus on the discursive function of the written text; the aim must be to decipher the function of the text.

2.5.4 *Final remarks*

A social history framework is inadequate to answer the questions posed in this study. This study focuses on how patient as subjects are constituted discursively in the record and through the nurses' notes. Related to this aspect is the question about what normative conceptions determined that some lives could not be perceived as lives. Whilst a social history approach answers this question within a social, economic, and political context, a Foucauldian discourse analysis can bring new and unexpected answers to light; this is the innovative potential of my research project.

2.6 Method and Data Collection

The theoretical considerations and the chosen perspective for this study as described in part one of this chapter shaped the collection of data and the method of analysis. The following section briefly describes how the data were gathered.

2.6.1 *Method*

As already mentioned in the introduction, the original approach of this research project was to analyze the continuities and discontinuities between the psychiatric and nursing notes in a patient record constructed before, during, and after the Nazi regime. The idea was to use a comparative analysis to make visible the scientific assumptions on which the nurses and physicians based their writing. This analysis was to concentrate specifically on the Langenhorn asylum in Hamburg, with the initial hypothesis being that continuities did exist between the different periods and that it would be possible to determine the criteria used in decisions taken on which patients were killed and which survived. In order to demonstrate that the notes were based on a broadly accepted psychiatric discourse, the records obtained from Langenhorn would be further contrasted with those obtained from asylums in other parts of the country and with those from Aktion T4.

Of the 4,907 sick persons transferred to other facilities from Langenhorn, of whom more than two-thirds were killed, 2676 records are still kept in the Archives of the City of Hamburg [*Staatsarchiv der Freien und Hansestadt Hamburg*]. Historian of medicine Michael Wunder contended in his research that 80 percent of the records still exist, but included in his calculation were those records that were sent to other asylums and not returned.¹¹⁰ The Langenhorn asylum was chosen because its records have already been extensively explored in one research project and in two dissertation projects.¹¹¹ These projects concentrated on a statistical analysis of the patient data in the records, aiming to explain the criteria used by psychiatrists to select patients. Furthermore, earlier historical research in the 1980s had tried to come to terms with Hamburg's involvement in the "euthanasia" killings and the specific circumstances in the city during the

years of the war, as further developed in the chapter on the history of Langenhorn.¹¹² Finally, the situation in Hamburg had polarized the scientific community around whether or not the assassinations of hospital patients could be attributed to the intentional actions of the nurses and psychiatrists.¹¹³ My qualitative analysis would therefore benefit from the results of this earlier research.

However, in the course of the data collection, it soon became apparent that the role of the records in psychiatric practice was so complex that I decided to shift the scope of the data analysis. What was the relationship between the many detailed observations I found, especially those written by nurses, and the functioning of the medical file on the treatment of patients, many of whom were killed in the end? At this point, I decided to analyze one record in detail and to use the other records as references in order to corroborate the evidence collected. The record of Anna Maria B. was chosen because she was first admitted to hospital before the Nazi regime era and was admitted several times thereafter until 1943. Her record, which covers nearly the whole period of Nazi fascism, did not differ in its construction from all the other records found in the State archive, it was complete, and it comprised more than 500 pages.

In order to analyze such a huge amount of data, the file was divided into administrative records, psychiatrists' documents, and nurses' recordings. (The construction of the record is described in detail at the beginning of chapter 5.) Each part was chronologically divided according to the different stays of Anna Maria B. in Hamburg's asylums. I used the software program MAXQDA 10 in my analysis to systematically evaluate and interpret the documents. The whole record was transcribed into a Word document and integrated into the MAXQDA10 program in order to code all description in the notes written by the nurses and psychiatrists, as well as all the disciplinary and therapeutic interventions and the application of medications, etc. The program thus enabled linking all these different aspects in order to analyze the emergence of specific patterns between, for example, certain description in the nurses' notes or disciplinary interventions. The code- or category system (Code-system) that evolved over the course of the

analysis was then linked to the scientific discourses found in psychiatrists' textbooks, nursing textbooks, and articles in scientific journals. This procedure permitted tracing the sources of the categories and descriptions employed by nurses and psychiatrists to describe Anna Maria B.'s behaviour. Furthermore, the MAXQDA 10 program allowed me to highlight similarities and discrepancies between the psychiatrists' and nurses' notes, and in turn, to connect these notes to the administrative documents in the record. This proceeding enabled me to demonstrate that the descriptive categories employed by nurses and psychiatrists were derived from scientific discourses and to highlight the role of these notes and of the record as a whole. The code system is part of the appendix.

2.6.2 *Sampling Method*

The 2767 records from which this sample was obtained were arranged in alphabetical order. In the first round, a random sample was gathered from every fifteenth record of each alphabetical letter. These records were then briefly inspected to ascertain whether or not they were complete and contained nursing notes. Some of the records were photocopies of the originals because the original records were kept in the asylum where the patients had been transferred. These copies never contained the nurses' notes and were therefore discarded. In the second round, every forty-third record was pulled. Finally sixty-one patient records remained of those patients who were transferred to other asylums and killed. I chose this complicated process even though this is a qualitative research project because I wanted to be sure to achieve the widest possible variety.

Furthermore, I obtained twenty-five records from patients who were admitted to Langenhorn in 1934. Some of these patients were discharged in 1939 or later, even though they had been hospitalized more than five years – one of the criteria on the report sheet for Aktion T4. Another section of these records were on patients who survived the Nazi regime in the asylum but remained hospitalized after the end of the war. This last sample was intended to analyze any

changes in the nurses' and psychiatrists' notes that might have taken place after the end of the Second World War.

The content and construction of the records differ in some significant ways. The patients who were admitted to Langenhorn directly in the late 1930s had very thin records because almost no notes on them had been taken. However my analysis highlights that this lack of record keeping was a mechanism in Langenhorn that was already in place before the Nazis came to power. With the advance of war, the patients often stayed just a couple of days in Langenhorn before they were transferred to other asylums.

2.6.3 *The sample from Hadamar*

In the archive of the asylum at Hadamar (the facility in which Anna Maria B. was eventually killed) I found another thirty records from patients transferred from Langenhorn. These records were exactly the same as those found in the Hamburg archives. They contained a large number of notes from the nurses and psychiatrists – striking because Hadamar existed solely as a killing factory.

Before beginning the discussion of these records, the following chapter explains in more detail my theoretical framework for the analysis. In it I describe Foucault's concept of biopower and the role of what he called State racism, emphasizing the potential of this perspective on the empirical analysis of one specific record from one asylum in Hamburg.

¹Heinz Faulstich, *Hungersterben in der Psychiatrie 1914-1949. Mit einer Topographie der NS-Psychiatrie* (Freiburg im Breisgau: Lambertus, 1998).

² Hans-Walter Schmuhl, *Rassenhygiene, Nationalsozialismus, Euthanasie-Von der Verhütung zur Vernichtung 'lebensunwerten Lebens' 1890-1945* (Göttingen: Vandenhoeck und Ruprecht, 1987), 191; Udo Benzenhöfer, "Bemerkungen zur Planung der NS-"Euthanasie", in *Der sächsische Sonderweg bei der NS-"Euthanasie" - Fachtagung vom 15. bis 17. Mai 2001 in Pirna-Sonnenstein*, (Ulm: Klemm&Oelschläger, 2001), 21-53.

³ Friedlander, *The Origins of Nazi Genocide : From Euthanasia to the Final Solution* (Chapel Hill: University of North Carolina Press, 1995).

⁴ Klee, "Euthanasie" im NS-Staat. Die »Vernichtung lebensunwerten Lebens« (Frankfurt a.M.: Fischer, 2009).

⁵ A detailed study about the history of killings in Grafeneck exists in Thomas Stöckle, *Grafeneck 1940. Die Euthanasie-Verbrechen in Südwestdeutschland* (Tübingen: Silberburg-Verlag, 2005).

⁶ A detailed description of the functioning of the killing facility in Hadamar can be found in Uta George et al., eds., *Heilstätte, Tötungsanstalt, Therapiezentrum Hadamar* (Marburg: Jonas Verlag, 2006).

⁷ Gerhard Baader, "Die Aktion T4. Der Gasmord an Psychiatriepatienten in den Jahren 1940 und 1941," in *Tödliche Medizin. Rassenwahn im Nationalsozialismus*, (Berlin: Wallstein Verlag, 2009), 60-61; Klee, "Euthanasie" im NS-Staat; Faulstich, *Hungersterben in der Psychiatrie 1914-1949*.

⁸ Alexander Mitscherlich and Fred Mielke, *Medizin ohne Menschlichkeit: Dokumente des Nürnberger Ärzteprozesses* (Frankfurt a.M.: Fischer, 1978), 204; Faulstich, *Hungersterben in der Psychiatrie 1914-1949*, 271.

⁹ Schmuhl, *Rassenhygiene, Nationalsozialismus, Euthanasie-Von der Verhütung zur Vernichtung 'lebensunwerten Lebens' 1890-1945*, 210; Götz Aly, *Medizin gegen Unbrauchbare*, eds. Götz Aly et al., *Beiträge zur nationalsozialistischen Gesundheits- und Sozialpolitik* (Berlin: Rotbuch Verlag, 1985), 29.

¹⁰ Faulstich, *Hungersterben in der Psychiatrie 1914-1949*, 272.

¹¹ Petra Fuchs et al., eds., *Das Vergessen der Vernichtung ist Teil der Vernichtung selbst. Lebensgeschichten von Opfern der nationalsozialistischen "Euthanasie"* (Goettingen: Wallstein, 2008); Maike Rotzoll et al., eds., *Die nationalsozialistische "Euthanasie"-Aktion "T4" und ihre Opfer. Geschichte und ethische Konsequenzen für die Gegenwart* (Paderborn: Schöningh, 2010). Most recent estimates range from 300,000 killed persons in the course of the "Euthanasia." This figure comprises the victims of "Euthanasia" that were killed in Poland and the Soviet Union. Heinz Faulstich, "Die Zahl der "Euthanasie"-Opfer," in "Euthanasie" und die aktuelle Sterbehilfe-Debatte. Die historischen Hintergründe medizinischer Ethik, eds. Andreas Frewer and Clemens Eickhoff (Frankfurt, New York: Campus, 2000), 227-229.

¹² Ingo Harms, 'Wat mööt wi hier smachten...' Hungertod und "Euthanasie" in der Heil- und Pflegeanstalt Wehen im "Dritten Reich" (Oldenburg: Druck & Verlagscooperative GmbH, 1996).

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- ¹³ Baader, Die Aktion T4. Der Gasmord an Psychiatriepatienten in den Jahren 1940 und 1941, 64; Aly, Medizin gegen Unbrauchbare; Wolfgang Rose, "Der dezentrale Krankenmord. "Euthanasie" durch Meddikamente und Nahrungsentzug," in *Tödliche Medizin. Rassenwahn im Nationalsozialismus* (Berlin: Wallstein Verlag, 2009), 104.
- ¹⁴ Ibid., 104; Angelika Ebbinghaus, Heidrun Kaupen-Haas and Karl Heinz Roth, *Heilen und Vernichten im Mustergau Hamburg. Bevölkerungspolitik im Dritten Reich* (Hamburg: Konkret Literatur Verlag, 1984).
- ¹⁵ Karl Heinz Roth, "Großhungern und Gehorchen. Das Universitätskrankenhaus Eppendorf," in *Heilen und Vernichten im Mustergau Hamburg. Bevölkerungs- und Gesundheitspolitik im Dritten Reich*, eds. Angelika Ebbinghaus, Heidrun Kaupen-Haas and Karl Heinz Roth (Hamburg: Konkret Literatur Verlag, 1984), 116-118.
- ¹⁶ Faulstich, Hungersterben in der Psychiatrie 1914-1949, 608.
- ¹⁷ Ibid., 308-314; Rose, Der dezentrale Krankenmord. "Euthanasie" durch Meddikamente und Nahrungsentzug, 105
- ¹⁸ Peter v. Rönn, "Auf der Suche nach einem anderen Paradigma. Überlegungen zum Verlauf der NS- 'Euthanasie' am Beispiel der Anstalt Langenhorn," *Recht und Psychiatrie*, no. 9 (1991): 52.
- ¹⁹ Ibid., 53.
- ²⁰ Nitsche, cited in Faulstich, *Hungersterben in der Psychiatrie 1914-1949*, 291.
- ²¹ Ibid., 292; Heinz Faulstich, "Der sächsische Sonderweg," in *Der sächsische Sonderweg bei der NS- 'Euthanasie'. Fachtagung vom 15. bis 17. Mai 2001 in Pirna/Sonnenstein*, ed. Arbeitskreis zur Erforschung der nationalsozialistischen "Euthanasie" und Zwangssterilisation (Ulm: Klemm&Oelschläger, 2001), 56.
- ²² Ibid., 57.
- ²³ Ibid., 60.
- ²⁴ Ingo Harms, "Krankenmord in der Heil- und Pflegeanstalt Wehnen - Forschungsprobleme," in *Berichte des Arbeitskreises zur Erforschung der nationalsozialistischen "Euthanasie" und Zwangssterilisation, Tagungsband Wehnen, Herbst 2009* (Münster: Klemm und Oelschläger, 2011, in print), 4.
- ²⁵ Klee, "Euthanasie" im NS-Staat. Die "Vernichtung lebensunwerten Lebens," 62.
- ²⁶ Faulstich, Hungersterben in der Psychiatrie 1914-1949, 318.
- ²⁷ Rose, Der dezentrale Krankenmord, 100
- ²⁸ Ibid., 100; Gerrit Hohendorf, "Ideengeschichte und Realgeschichte der nationalsozialistischen 'Euthanasie' im Überblick," in "Das Vergessen der Vernichtung ist Teil der Vernichtung selbst" *Lebensgeschichten von Opfern der nationalsozialistischen "Euthanasie"*, eds. Petra Fuchs et al (Göttingen: Wallstein Verlag, 2008), 40-41; Faulstich, Die Zahl der "Euthanasie"-Opfer, 218-234.
- ²⁹ Ibid., 101.
- ³⁰ Faulstich, Die Zahl der "Euthanasie"-Opfer, 226.
- ³¹ Rose, Der dezentrale Krankenmord, 101
- ³² Schmuhl, Rassenhygiene, Nationalsozialismus, Euthanasie-Von der Verhütung zur Vernichtung 'lebensunwerten Lebens' 1890-1945, 180-181; Uwe Kaminsky, Zwangssterilisation und "Euthanasie" im

Rheinland. Evangelische Erziehungsanstalten sowie Heil- und Pflegeanstalten 1933-1945 (Köln, Bonn: Rheinland Verlag, 1995), 224-225.

³³ Faulstich, *Der sächsische Sonderweg*, 55; Faulstich, *Hungersterben in der Psychiatrie 1914-1949*, 196-202.

³⁴ Klee, "Euthanasie" im NS-Staat. Die "Vernichtung lebensunwerten Lebens", 66-70.

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3 Biopower and Racism

In chapter two I discussed some recent historical research in the field of “euthanasia” and I particularly emphasized the approach of historian Hans Walter Schmuhl. His approach seems, at first glance, close to the kind of perspective I have taken on my study. Schmuhl defined the Nazi regime as a developing biopolitical dictatorship because biosciences had a pivotal relevance for National Socialism. Schmuhl characterized this dictatorship as a reciprocal instrumentalisation of science and politics.¹ Biopolitics in Schmuhl’s perspective is to biologize the social and he links biopolitics to a coercive dictatorship and its technocratic elites.

Schmuhl’s approach was criticized in the introduction for its reductionist perspective and I emphasized that biopolitics under the Nazi regime cannot be reduced to the killing of the unfit. The following chapter is the attempt to delineate the concept of biopower and biopolitics from a Foucauldian perspective with particular attention to the interrelationships between biopower and racism.

3.1 The Roots of State Racism

In 1976, Foucault analyzed the genealogy of two different kinds of power.² He began by summarizing his research of the previous fifteen years on “disciplinary” power, a form of power that acts on the body and which uses techniques of surveillance, normalization, and a panoptical organization of institutions like prisons, schools, or hospitals. In his last lecture at that time he also introduced another kind of power, what he called “biopower,” a kind of power that is directed towards a population and the “life of the living.” In the years to come, Foucault developed this analysis of power further with the concept of “governmentality.” This kind of power developed from the sixteenth century onward through the dispositifs and technologies of the reason of state (*raison d’état*) and the police. The question of these two forms of power – the disciplinary and the biopower, their specificity, and their articulation – are central to Foucault’s analysis. He used the concept of war as a frame to analyze the correlations of power and he

described the emergence of what he called the birth of a “historical-political” discourse of the fight between races.³ The following considerations try to grasp the impact of this perspective on an analysis of the killings of sick persons.

The challenge of all genealogies⁴ lies in the question “What is this power whose interruption, force, impact, and absurdity have become palpably obvious over the last forty years, as a result of both the collapse of Nazism and the retreat of Stalinism? What is power? Or rather – given that the question ‘What is power?’ is obviously a theoretical question that would provide an answer to everything, which is just what I don’t want to do – the issue is to determine what are, in their mechanisms, effects, [and] their relations, the various power-apparatuses that operate at various levels of society, in such very different domains and with so many different extensions?”⁵ Once again, these kinds of questions differ from the questions asked by social history, which deduces power from economy, a fact that Foucault called the “‘economism’ in the theory of power.” The above quotation highlights one of the central concerns of my study, because it tries to decipher how power precisely functioned in psychiatric asylums and how aspects of power emerged in the interplay between psychiatry and nursing.

Foucault based his genealogical analysis on the reversal of a principle formulated by Clausewitz, who had stated that “war is no more than a continuation of politics.” According to Foucault the principle should be formulated as “politics is merely a continuation of war by other means,” something that he contended existed long before Clausewitz, and that had determined politics since the seventeenth and eighteenth centuries.⁶

Foucault described a historical paradox. Beginning in the Middle Ages as states developed, military practices and institutions were concentrated in a centralised power. Henceforward, only the state could engage in wars and manipulate instruments of war, and as a result, the military apparatus was developed, defined, and controlled by the state. Thus, war was virtually removed from the center of society and transferred to its limits; a new discourse developed – new because it was the first “historical-political discourse about society.

According to Foucault, this discourse began with the end of the religious wars in the sixteenth century and developed further in the seventeenth. It emerged first in England where it was used by the parliamentary opposition and the Puritans. This discourse recounted the English history as follows: Since the eleventh century, English society had been a society of conquest. The monarchy and aristocracy with its aristocratic institutions had been imported from the Normans, although the defeated Saxons had been able to conserve some of their natural liberties. This new discourse differed from the “philosophical-juridical” discourse of the past, which had been centred on royal power and celebrated the exploits of heroes and kings and their battles and wars. It was a history that recounted wars and explained the right of the king to govern a country. In contrast, the new historical-political discourse made all social relations warlike by perceiving wars and battles as pervading all institutions of law and peace. The same kind of analysis was later used in France, especially from aristocratic circles at the end of the reign of Louis XIV. It was a malleable discourse, because it was used in England and France as a weapon of the bourgeoisie, the popular masses as well as the aristocrats, against the monarchy. From its beginning then, it was a heterogeneous discourse useful in many diverse movements both in England and elsewhere.

This discourse can also be found in the biological, eugenic, and racial discourses at the end of the nineteenth century. In contrast to the philosophical-juridical discourse, power in historical-political discourse does not begin when war ends. War guides the birth of nations; law and peace develop out of the blood of battles. But the law is no pacifying force because war continues underneath and inside all mechanisms of power. War is the motor of all institutional order; one has to decipher the war beneath the peace. As Foucault stated, “we are therefore at war with one another; a battlefield runs through the whole of society, continuously and permanently, and it is this battlefield that puts us all on one side or the other. There is no such thing as a neutral subject. We are all inevitably someone’s adversary.”⁷

This new discourse was important in three different ways. First, the subject who talks in this discourse, the one who says “me” or “we,” cannot speak from a universal or neutral position. The subject is always in battle; it has enemies and is fighting for a particular victory. It claims a right but this right is partial since it is the right of one’s family or race. Truth depends on position in the battle and on the victory one tries to achieve. It becomes a weapon, because it is used within a relationship of force.⁸

Second, this discourse was based on several sets of series. One was on a set of brutal, physical-biological facts and differentiated between “we” and “Other” on aspects like physical force, energy, proliferation of a race, or the feebleness of the other. Another series had to do with randomness or contingency such as, for example, defeats, victories, failures or successes of revolt or alliances. A final series was comprised of psychological and moral elements, like courage, hate, or mistrust. These sets of series developed calculations, strategies, and ruses as rationales to maintain victory or to reverse power relations.

Third, this discourse developed solely within the context of history by trying to discover forgotten battles beneath established institutions. It used traditional myths and mythologies to recount stories about great victories, forgotten giants, or wounded or dead heroes. It was also concerned about the rights and the possessions of the first race that were stolen by the invader, and about the promise of the day of revenge, when the new chief comes to save the poor.⁹ It was a discourse that could be used as much for the nostalgia of the aristocracy as for the vengeance of the proletariat. In Foucault’s words, “in short, and unlike the philosophico-juridical discourse organized around the problem of sovereignty and the law, the discourse that deciphers war’s permanent presence within society is essentially a historico-political discourse, a discourse in which truth functions as a weapon to be used for a partisan victory, a discourse that is darkly critical and at the same time intensely mythical.”¹⁰

From early on, this discourse contained fundamental elements, including ethnic differences, different languages, forces, energies and violence, or conquest and enslavement of

one race over another, which enabled the maintenance of war. Foucault wrote that “the social body is basically articulated around two races. It is this idea that this clash between two races runs through society from top to the bottom which we see being formulated as early as the seventeenth century. And it forms the matrix for all the forms beneath which we can find the face and mechanism of social warfare.”¹¹

Two different transcribing processes developed from this idea of the war of races. The first was a biological transcription that was in place long before Darwin’s ideas took hold. The historical-biological theory of races was a discourse as malleable as the historical-political discourse, articulated on the one hand, by national movements in Europe and used in national battles against powerful state apparatuses in Austria and Russia, and on the other hand, used by the European colonist in the colonies.

The second transcription was the theory of social war, which appeared at the beginning of the nineteenth century. This theory tried to eradicate all trace of racial conflict and to re-define them as battles between classes. Based on this theory, a biological-social racism developed from the understanding that the other race did not come from outside society but was a permanent part of it and understood as the social body. This discourse functioned to split a single race into upper and lower levels, into a super race and a sub-race. In the beginning, this discourse was an instrument used in the struggles waged by decentred camps of opposition, but it was later re-centred by the State and became the discourse of a centered, centralized, and centralizing power, used to define the real and only race that holds the power and is entitled to define the norm. This power had to fight against those who deviated from the norm and who jeopardized its biological heritage. Out of this concept developed State racism. Foucault contended that this kind of racism is a racism that “society will direct against itself, against its own elements and its own products. This is the internal racism of permanent purification, and it will become one of the basic dimensions of social normalization.”¹²

This centralized, biological State racism was utilized and transformed by specific strategies in the twentieth century. Nazism reused a nineteenth-century concept of a “popular, almost medieval, mythology that allowed State racism to function within an ideologico-mythical landscape similar to that of the popular struggles which, at a given moment, could support and make it possible to formulate the theme of race struggle.”¹³ This State racism was accompanied by a large number of elements such as, for example,

the struggle of a Germanic race which had, temporarily, been enslaved by the European powers...It was also accompanied by the theme of the return of the hero, or heroes (the reawakening of Frederik, and of all the nation's other guides and Führers); the theme of the revival of an ancestral war; that of the advent of a new Reich, of the empire of the last days which will ensure the millenarian victory of the race, but which also means that the inevitable apocalypse and the inevitable last days are nigh. We have then a Nazi reinscription or reinsertion of State racism in the legend of warring races.¹⁴

Simultaneously, the homogenization of technological knowledge began in the middle of the eighteenth century. Motivated for both political and economic reasons, much research was done, for example, on artisanal methods or on mining practices in the attempt to normalize and centralize technological knowledge. Big technical schools were created, for example, for mining or road construction. In the second half of the eighteenth century, medical knowledge was also homogenized, normalized, classified, and centralized. At this historical juncture, institutions like hospitals and dispensaries developed, and both the medical profession and medical knowledge were codified. At this time too, nurses' training was formalized. Large-scale campaigns in public hygiene were conducted. All these phenomena had three aspects in common: selection, normalisation, and hierarchical control. It was the era of the development of disciplinary power, as described by Foucault.¹⁵

The eighteenth century was the century when knowledges were disciplined, or when, in other words, the internal organization of everyday knowledge became a discipline which had, in its own field, criteria of selection that allowed it to eradicate false knowledge or nonknowledge. We also have forms of normalization and homogenization of knowledge-contents, forms of hierarchicalization, and an internal organization that could centralize knowledges around a sort of de facto axiomatization. So every knowledge was organized into a discipline. These knowledges that

had been disciplinarized from within were then arranged, made to communicate with one another, redistributed, and organized into a hierarchy within a sort of overall field or overall discipline that was known specifically as science.¹⁶

3.2 Biopower and Biopolitics

In his last lecture given in 1976, Foucault introduced the concept of biopolitics (biopower), attempting to grasp the changing characteristics of power that occurred in the nineteenth century. From that point on, power was concentrated on humans as living beings – what he called the “*étatisation du biologique*,” or state control over the biological.¹⁷ The right over life and death is one of the fundamental rights of the sovereign; it is the right to make death and to let live. In front of this power, the subject is neither living nor is it really dead. As Foucault argued, “from the point of view of life and death, the subject is [was] neutral, and it is thanks to the sovereign that the subject has [had] the right to be alive or, possibly, the right to be dead.”¹⁸ Foucault called it the right of the sword, since the right was realized only at the point when a subject was about to be killed.

But in the nineteenth century this political right was transformed. Foucault emphasized that the right of the sovereign did not disappear, but was modified, penetrated, and complemented by another political right – the opposite right to the right of the sovereign. “It is the power to ‘make’ live and ‘let’ die. The right of the sovereign was the right to take life or let live.”¹⁹ This new form of power appeared on two different levels. In the seventeenth and eighteenth centuries, technologies of power materialized that were directed towards the individual body; the body was seen as a machine. At this level, everything curved around the difficulty of drilling the body and augmenting the abilities of the individual to integrate the body into economical control systems. This level of disciplinary power Foucault called the anatomo-politics of the human body.

From the middle of the eighteenth century forward a new kind of power emerged. It was no longer disciplinary; it was not directed towards the individual body but towards humans as “living beings.” Foucault termed this new non-disciplinary power “biopower.” This new

technology “that is being established is addressed to a multiplicity of men [sic], not to the extent that they are nothing more than their individual bodies, but to the extent that they form, on the contrary, a global mass that is affected by overall processes characteristic of birth, death, production, illness, and so on.”²⁰ Therefore, this technology concentrated on humans as a species, comprised of an ensemble of processes deriving from mortality, birth or fertility rates – all processes related to economic and political problems. From this moment on, statistical and demographic surveys became vitally important, or what Foucault termed “biopolitics.”

Biopolitics discovered population as a scientific and political problem, as a biologic problem of power engaged with collective phenomena that influence economy. These phenomena are random and unpredictable in detail, but they establish constants on a collective level, which can be detected at the level of populations. These phenomena develop over long periods of time; hence they are phenomena of series. Biopolitics is directed towards phenomena that are essentially, “aleatory events that occur within a population that exists over a period of time.”²¹ Biopolitics use mechanisms that are very different to those used by the disciplines. First of all, it uses statistical surveys and global measurements, intervening on a global level by installing a regulatory mechanism and trying to establish a kind of homeostasis. Foucault wrote that “security mechanisms have to be installed around the random element in a population of living beings so as to optimize a state of life. Like disciplinary mechanisms, these mechanisms are designed to maximize and extract forces, but they work in very different ways. Unlike disciplines, they no longer train individuals by working at the level of the body itself.”²² It is therefore not a matter of taking the individual at the level of individuality but, “on the contrary, of using overall mechanisms and acting in such a way as to achieve overall states of equilibration or regularity; it is, in a word, a matter of taking control of life and the biological processes of man-as-species and of ensuring that they are not disciplined, but regularized.”²³

3.3 Norm, Normalization, and Statistics in the Age of Biopower

While disciplinary power is established in institutions, like schools, hospitals, or prisons, biopolitical power is bio-regulation by the state. It depends on a large number of organizations outside the administrative apparatus of the state like medical, nursing, insurance, or social security organizations. This form of power needs experts, an idea that Foucault developed further in his discussion of governmentality. Of utmost importance in this context is the technological knowledge of medicine, because medicine is a “power-knowledge that can be applied to both the body and the population, both the organism and biological processes, and it will therefore have both disciplinary effects and regulatory effects.”²⁴

The latter concept applies to nursing as well. Nurses occupy an important strategic position at the intersection between the individual and the population. However, the decisive element within a society of regulation is the norm, which circulates between the disciplinary and the regulative pole of power. The norm operates, on the one hand, towards a body that power tries to discipline and, on the other hand, towards a population that power tries to regulate. A normalizing society is, according to Foucault, a society “in which the norm of discipline and the norm of regulation intersect along an orthogonal articulation. To say that power took possession of life in the nineteenth century, or to say that power at least takes life under its care in the nineteenth century, is to say that it has, thanks to the play of technologies of discipline on the one hand and technologies of regulation on the other, succeeded in covering the whole surface that lies between the organic and the biological, between body and population.”²⁵

3.3.1 *Norm and normalization*

American philosopher Judith Butler argued that the norm “transforms the negative restraints of the juridical into the more positive controls of normalization,” transforming juridical power into a productive form of power.²⁶ Philosopher François Ewald, a former student of Foucault, emphasized that the norm acts independently of the law, although normalization relies in part on legislation.²⁷ The norm has the specific capability to simultaneously individualize and

create comparability between individuals. Individualization is achieved through the location of spaces “indefinitely, which become more and more discrete.” At the same time, these spaces never enclose “anyone in such a way as to create a nature for them” because individualisation is nothing more than the expression of a relationship, “a relationship which has to be seen indefinitely in the context of other.” The norm can be defined as a “principle of comparison, of comparability, a common measure, which is instituted in the pure reference of one group to itself, when the group has no relationship other than to itself, without external references and without verticality.” Normalisation means, from this perspective, that the norms, or the normative spaces, know no outside. The abnormal is not defined as different by nature, it appears to be different through comparison. This means that the norm “integrates anything which might be an attempt to go beyond it – nothing, nobody, whatever difference it might display, can ever claim to be exterior, or claim to possess an otherness which would actually make it other.”²⁸

Butler criticizes this conception of “social norm” because it does not allow one to resignify or displace the norm itself, because any opposition is already contained within the norm. According to her, the norm produces the field within which it will be applied and, simultaneously, “produces itself in the production of that field.”²⁹ Norms constitute the background for the perception of what seems to be “real,” they delineate what can be observed, and, simultaneously, they are reproduced by bodily practices, as this study will highlight in analyzing nurses’ observations. However, according to Butler, these bodily practices also have the “capacity to alter norms in the course of their citation.”³⁰

German sociologist Jürgen Link distinguished, as did Foucault, two discourse-complexes that have developed in two different directions since the eighteenth century. Link distinguished between these two complexes by using the terms “norm” and “normalization.”³¹ Within the complex of normativity, a binary norm exists and an action is judged according to this norm; an action either conforms to the norm or it does not. The transgression of the norm is linked to

sanctions against the abnormal. One has to conform to existing norms in order to be an intelligible being and for those who do not successfully adopt a norm, a subject status is denied.

In contrast, the normal, according to Link, that which is acceptable, is based on accumulated mass-data and statistics, and defined through averages *en gros*. Within this discourse-complex, the boundary between normality and abnormality is drawn; it is an important technology of the biopolitics. The “normal curve of distribution,” symbolised by the Gaussian curve, positions most individuals within an array of average or maximal normality. The further one is detached from the average, the greater the threat of falling into abnormality. Thereby, the continuity of the distribution curve is crucial, because within the continuum every individual is positioned between two neighbours against whom they can benchmark themselves. This means one is positioned between a neighbour who is “a little bit more normal” and a neighbour who is “a little bit less normal,” generating a feeling of assurance in sharp contrast to the binary normativism that is based on a principle of discontinuity of yes or no decisions. Normalism is thus systematic and historically limited to societies that accumulate mass-data. Within the term normalism, two levels of meaning converge: evaluation and description. Normalism designates set value and just value; “the statistical mean itself [can become] a social norm, a norm of a second order.”³²

The delineation between norm and normalism enables one to distinguish two different strategies. One possible strategy is the maximum compression of the normality-zone with the tendency of fixation and stabilisation. Link called this protonormalistic strategy (*Protonormalistische Strategie*) and argued that this strategy was predominant at the beginning of normalism. From a Foucauldian perspective, this is a strategy of the juridical repressive form of power, a strategy of the disciplines. This strategy is linked to the necessity to normalize individuals from above and from outside. The study will demonstrate that psychiatric practice must be considered an example of the protonormalistic strategy, because this practice (termed a practice and not a discourse because the asylum cannot be understood by scientific discourses

alone) was characterized by disciplinary power; it was an anonymous power that aimed to influence the conduct of the patient from above.

The rivaling strategy is flexible normalistic strategy (*flexibel-normalistische Strategie*) which normalizes through “maximal expansion” and “dynamization” of the normality zone. This strategy, which was established in Western societies as recently as the post-Second World War era, constitutes “boundaries of normality” only provisorily and sees them as, in principle, reversible. This strategy is not based on obedience, but rather on the willingness of “self-normalization” in view of uncertain “normality-boundaries.”³³

The Nazi regime must be analyzed as a combination of the two normalization strategies described above. It is important to acknowledge that the Nazi regime is also a blatant example of modern population policy that was from the beginning connected to multiple detailed statistical surveys. During the Nazi regime, most of the data were evaluated with the newest technologies. The administration systematically used punch cards to enable the analysis of large amounts of data. Even the Holocaust was organized by using these technologies (and could not have been realized without this technological support) and the company IBM gained notoriety, because it delivered the infrastructure enabling these data collections and analyses.³⁴ The same is true for the organization of the killings of sick persons and the capturing of so-called hereditary risks. The former president of the German statistical society (*Deutsche Statistische Gesellschaft*), Friedrich Zahn, noted in 1940 that “statistics is closely related to the National Socialist movement.” As he continued, “the demographic policy enjoys the particular interest of the State. It is not anymore solely a quantitative population policy but rather has developed into a qualitative and psychological population policy and therefore demands from statistics increasing and deepened insights, which can be implemented using the energy of our Führer.”³⁵

Under the direction of the police, the health and welfare administration, and the statistical office of the German Reich, an efficient system of different registers, censuses, registration laws, and identification cards developed after 1933. All these measurements aimed to register and

classify the population. In 1933 and 1939, population censuses were carried out but they were not the only actions of registration: The work book (*Arbeitsbuch*) (1939), the health family register (1936), the obligation to register (1938), the German People's Party (1939), and finally, the personal identification number (1944) were the bureaucratic pre-conditions for a graded system of gratification and penalty, for selection and extermination. With the raw material of the population census from 1939, a register was installed for all non-Aryan peoples within the German Reich; it contained the names, dates and places of birth, places of residence, occupation, and "grade of crossbreed." The political office for matters of race (*Rassenpolitisches Amt*) of the German National Socialist Worker Party (NSDAP) began in 1934/35 to install a "register of asocial elements" (*Assozialenkartei*), followed in 1935/36 by the special register of Jews, gypsies, and other "foreign ethnics" (*Fremdvölkischer*). From 1934 on, "hereditary sick persons" were registered by the health administration. Especially in the latter cases, nurses played a decisive role because they were mainly the ones who reported these persons.³⁶ Historians Götz Aly and Karl Heinz Roth described the effectiveness of statistics for population policy as follows:

Only through the work of statisticians with anonymous data do people become part of "problem areas" with their own so-called fertility probability, with their own probability of divorces, their own social behaviour, etc. Thus people are indexed by character profiles that can be differentiated endlessly and, even more important, can be randomly combined. Only then it is possible to further subdivide people in the process of population politic and social politic. By this means, it becomes possible to enact laws, decrees, and regulations for ever smaller groups of people. These laws, decrees and regulations become less and less comprehensible and understandable.³⁷

3.3.2 *The impact of numbers in biopolitics*

The theoretical considerations around the impact of statistics in biopolitical societies highlight the fact that discursive statements are not solely linguistic.³⁸ A statement can be an entity that has any kind of linguistic structure. Important forms of statements are figures, statistics, and maps.³⁹ Accounting, for example, forms a body of knowledge that often competes with the knowledge of other experts, but calculative devices allow it to direct actions within organizations and within society.

Figures are an indispensable part of complex technologies used by governments. Only through using figures does it become possible to intervene in specific areas and to demarcate the delineations and inner characteristics of populations, economies, and societies.⁴⁰ Sociologist Peter Miller demonstrated the interrelationship of political and economic forces in a society in which accounting systems are often a mechanism through which power is exercised.⁴¹ Accounting is a partial and interested language in the service of particular classes and functions as a disciplinary matrix to write the world; it is rhetorical. Through accounting techniques it is possible, for example, to calculate variances at the level of the asylum as a whole, and at the level of every accountable person within the asylum. This offers a way of governing individuals and the economic life of the asylum in a form of a “scientific management.” Accounting obscures the explicit value judgements within it. Miller argued that the borders between accounting and other bodies of expertise, particularly law, are shifting. Accounting is a technique to govern the conduct of individuals through indirect means. It is a form of action on the action of others, especially through the single figure that contains compressed and complex information. This process will be highlighted in the next chapter on the history of the Langenhorn asylum. The annual statistics of the asylum highlighted that the administration was from 1900 on anxious to summarize different aspects of patients’ diagnoses and biographies into a single combination of figures and letters. In doing so, relations between the different aspects of the person were implicitly established by

statistics; annual statistics became statements of their own about the relationship between, for example, alcoholism and degeneration.

The work of sociologist of science and philosopher Ian Hacking on the impact of statistical operations in biopolitics is very illustrative. Hacking understands his work as supporting Foucault's theoretical concept of biopower and refers to the open and subversive effects of statistical operations.⁴² Even though the quantity of statistical operations increased markedly from the beginning of the nineteenth century and generated an immense quantity of data, they were seldom effective in controlling or influencing populations, at least in an intended sense. But, there was an unintended, subversive effect, because counting needs categories. Hacking mentions as an example the establishment of social class at the beginning of the nineteenth century as a means for counting, which led to the fact that society was henceforward perceived in classes. From 1800 on, a radical transformation occurred in the manner of how the population was perceived due to the fact that it was registered in terms of employment. Bureaucrats constructed easily ascertainable categories under which everybody henceforth was subsumed.

Hacking showed that any category has its own history, which is influenced by two vectors. The first vector, according to Hacking, is the "labelling from above" emanating from a community of experts, which creates a reality. Distinguishable from this first vector is the vector "autonomous behaviour" of the persons labelled in such a manner. This second vector generates a pressure from the bottom up, which creates a reality that any expert has to consider. Hacking calls this "dynamic nominalism," which remains an intriguing doctrine, arguing that numerous kinds of human beings and human acts come into being hand in hand with our invention of the categories labelling them. "It is for me the only intelligible species of nominalism, the only one that can even gesture at an account of how common names and the named could tidily fit together...our spheres of possibility, and hence ourselves, are to some extent made up of our naming and what that entails."⁴³

Hacking demonstrated this interrelation exemplary in the history of suicide. From the nineteenth century on, suicide became the property of medicine. Henceforward, the concept of the accepted, noble suicide came into being as well as the suicide of honour of state, which had previously existed. The “rest” became part of the new medicine of madness. Until the mid-nineteenth century, there was a broad consensus that no suicide could exist that was not predated by signs of madness. The physicians started to relate the body and its past tense with its self-destruction. Statisticians counted and classified the bodies. Every detail of the suicide became fascinating and the statisticians designed forms, which had to be completed by physicians and police officers. These forms retained every detail, from the time of death to the objects found in the pockets of the dead. The different types of suicide demonstrated specific patterns and became symbols of national character. The French preferred carbon monoxide and drowning, whilst the English hanged or shot themselves. At the end of the nineteenth century so much information existed about French suicide that Durkheim could use the rate of suicide as a measure for social pathologies. The suicide rate drastically increased at this time in all European countries, which was seen from an administrative perspective as a problem. Hacking interpreted the relation between the suicide rate and the reports about suicide as follows: the “system of reporting positively created an entire ethos of suicide, right down to the suicide note, an art form that previously was virtually unknown apart from the rare noble suicide of the state...Even the unmaking of people has been made up.”⁴⁴

The latter considerations highlight that biopolitics is a complex power technology that cannot be reduced to merely eugenics and “euthanasia.” The specific characteristic of biopolitics is that it is oriented towards normalization and that is the reason why psychiatry became so important for a biopolitical society of regulation. After all, psychiatry is the paradigmatic science of biopower, because psychiatrists were charged with establishing the norm and deciding who was to be considered abnormal.⁴⁵ As the chapter about the history of the Langenhorn asylum will highlight, psychiatrists struggled to be acknowledged as the sole professionals able to determine

the threshold between normal and abnormal behaviour. However, if society under the Nazi regime must be considered a biopolitical society, the question remains as to what enabled this society to kill parts of its population. This question will be the focus of the next section.

3.4 The Paradox of Biopolitics and the Problem of Racism

A paradox obviously exists within biopolitics, because this form of power is, on the one hand, anxious to provide the means to sustain a population and allow it to prosper and, on the other hand, to possess weapons of mass destruction and to wage wars of unimaginable brutality. This power is able to send whole populations to their death, as the example of the Second World War demonstrated, although this is actually a characteristic of a sovereign power. From the moment it uses weapons of mass destruction it is no longer a biopower. The question arises then how biopower is able to kill if its aim is truly to support life. To answer this question one has to consider Foucault's reflections about the role of racism within biopolitics. Biopower, according to Foucault, inscribes racism into mechanisms of the state.

Racism has two functions. First, it is a means to introduce a distinction between those who are allowed to live and those who must die. This rupture in the biological continuum of the human species enables differentiation between races, allows them to be hierarchically sorted, and qualifies some races as superior to others. Racism, in other words, introduces difference into populations. As Foucault noted, "this will allow power to treat that population as a mixture of races, or to be more accurate, to treat the species, to subdivide the species it controls, into the subspecies known, precisely, as races."⁴⁶

Secondly, racism allows the introduction of a seemingly positive relationship into a differentiated population: "the more you let die, the better you will live." This bellicose conviction implies that "if you want to live, you must kill your enemies," which transforms this warlike statement into a statement that is compatible with the exercise of biopower. The more that inferior species disappear, the more that abnormal individuals are eliminated, the better the

species will become. As Foucault explained, “racism makes it possible to establish a relationship between my life and the death of the other that is not a military or warlike relationship of confrontation, but a biological-type relationship: ‘The more inferior species die out, the more abnormal individuals are eliminated, the fewer degenerates there will be in the species as a whole, and the more I – as species rather than individual – can live, the stronger I will be, the more vigorous I will be.’” Killing the other within a system of biopolitics becomes acceptable if a biological danger is targeted and if the elimination of this danger will strengthen the race; it is not a question of victory. In a normalizing society, race or racism is the precondition that makes killing acceptable. “When you have a normalizing society, you have a power which is, at least superficially, in the first instance, or in the first line, biopower, and racism is the indispensable precondition that allows someone to be killed, that allows others to be killed. Once the State functions in the biopower mode, racism alone can justify the murderous function of the State.”⁴⁷ In other words, if the normalizing power wishes to exercise the old sovereign right to kill, it must become racist. Foucault emphasized that to kill someone does not only imply the physical extermination of the other, but could also mean an indirect form of murder like “exposing someone to death, increasing the risk of death for some people, or, quite simply, political death, expulsion, rejection, and so on.”⁴⁸

Darwin’s theory of evolution developed out of this background of biopower and became the means to imagine colonial relations, the necessity of war, criminality, the phenomena of madness or mental illness, and the history of societies with their different classes. The concept of evolution became the frame through which to imagine killing and the potential of war. War did not only eliminate the opposite race, but it also regenerated one’s own race through a selection of those battling for life. The more who die among us, the more our own race will be purified and strengthened. Henceforth, criminality was thought of in terms of racism and it became possible to kill criminals, the insane, or people with other perceived “defects.” Foucault demonstrated that the peculiarity of a modern form of racism is not that it is a kind of ideology linked with

mentalities, but that it is a part of the techniques of power. Racism is associated with an efficient state because it is obliged to use race as a way to exercise sovereign power. “The juxtaposition of – or the way biopower functions through – the old sovereign power of life and death implies the workings, the introduction and activation, of racism. And it is, I think, here that we find the actual roots of racism.”⁴⁹

3.5 Nazism

The paradoxical character of biopower became the foundation of the Nazi regime. It became the most disciplinary society and the one most concerned with providing insurance. Controlling the random element inherent in biological processes was one of the regime’s immediate objectives. This society was, according to Foucault, also a society which “unleashed murderous power,” a power that was based on the old sovereign right to take life. This power to kill pervaded the whole society and was “first manifested when the power to take life, the power of life and death, was granted not only to the State but to a whole series of individuals, to a considerable number of people.” Everyone had the right to kill and could perform the power of life and death “over his or her neighbors, if only because of the practice of informing, which effectively meant doing away with the people next door, or having them done away with.”⁵⁰

Canadian historian Robert Gallately takes this aspect as the focus of his book, *Backing Hitler*. In it, he highlighted the broad participation of Germans in Nazism and emphasized that the explanatory model of the Nazi regime as a brutal police state, which forced its citizens into cooperation with the state, cannot capture the effectiveness of the Nazi regime.⁵¹ Based on an analysis of documents from the archives of the former Nazi Secret State Police (*Geheime Staatspolizei*, *GeStaPo*) Gallately argued that the police system could only have functioned so effectively because of the voluntary cooperation of Germans.⁵² It was not the case that secret police agents were everywhere, on the contrary, a low level of staff coverage made it impossible to control the population as a whole. Many police arrests were enabled only because many

Germans voluntarily informed on their neighbours or acquaintances to the police.⁵³ Gellately further contended that the Germans would have known everything about the crimes committed by the Nazi regime and concluded – perhaps a little bit too forthrightly – that most Germans agreed with these crimes.⁵⁴ In discussing the “euthanasia” killings, Gellately emphasized that most relatives of patients who were killed did not want to know too much about the killings and “numerous German families were prepared to accept the murder of their closest relatives without protest, even with approval. By so doing, they created the psychological conditions for the genocidal policies carried out in the years to come. If people did not protest even when their relatives were murdered, they could hardly be expected to object to the murder of Jews, Gypsies, Russians, and Poles.”⁵⁵

But the destruction of the other race was only one facet of the project; the other side was to expose one’s own race to the absolute and widespread risk of death. As Foucault asserted, “exposing the entire population to universal death was the only way it could truly constitute itself as a superior race and bring about its definite regeneration once other races had been either exterminated or enslaved forever.”⁵⁶ In other words, Nazi society was both the absolute generalization of biopower and the absolute generalization of the old sovereign power with the right to kill. It was, in Foucault’s words, “the final solution for the other races, and the absolute suicide of the [German] race. That is where this mechanism inscribed in the workings of the modern State leads. Of course, Nazism alone took the play between the sovereign right to kill and the mechanism of biopower to this paroxysmal point. *But this play is in fact inscribed in the workings of all States.*”⁵⁷

Foucault stressed this relationship between racism and biopower as the foundation and pre-condition of modern States on several occasions. At a conference in Tokyo in 1978, he described the latter as a kind of constant in modern states. According to him, although fascism and Stalinism were singular phenomena, it would be a mistake if one denied that in multiple aspects, they did nothing else but expand on a whole series of mechanisms which already existed

in the social and political systems of the Occident. After all, the organization of huge parties, the development of police apparatuses, and the existence of technologies of repression were inherited from the Occidental liberal societies, an aspect also stressed by philosopher Hannah Arendt.⁵⁸ It was within these societies that these series were first developed. According to Foucault, both fascism and Stalinism utilized mechanisms that already existed in most societies, and despite their internal madness, they did nothing more than utilize the ideas and the procedures of our political rationality on a large scale.

3.6 Potentials of the Theoretical Perspective

The potentials of the perspectives developed above can be summarized into five points. First of all, this view of National Socialism enables an integration of Nazism into the history of modernity. National Socialism was not a relapse into barbarism, but rather it used “modern” power technologies that were already in place before the Nazis came to power. To analyze Nazism as a “modern” society means to acknowledge the dark site of modernity and to deny that there is always a positive connotation to modernity.

Second, the multiple practices of exclusion under the Nazi regime appear to be extreme variants of scientific, societal, and political practices of exclusion whose genesis and legitimacy have already been analyzed by Foucault.

Third, the different forms of power as analyzed by Foucault – sovereign power, disciplinary power, biopower – are identifiable within the Nazi regime. Even the positive, productive character of power understood as a self-subjugation of subjects under a regime of power is recognizable, for example, in the voluntary cooperation with the dictatorship of the National Socialists and the practices of denunciation. With regard to this study it must be emphasized that nurses voluntarily cooperated with the regime and they were an important professional group of experts who carried out the biopolitical program of the Nazi regime. The concepts developed by Foucault, the strategies and logics of power that he described are useful

for an analysis of the National Socialist system. They allow highlighting the different facets of the regime and of the society. Furthermore, this perspective makes it possible to integrate the National Socialist practices of domination and their legitimation on a historical curve and therefore enables one to describe modifications and discontinuities against a backdrop of continuity.

Fourth, Foucault's writings allow a concrete discussion about National Socialism although they are not meant as an all-embracing analysis of Nazism. Nevertheless, a perspective on Nazism as a multifunctional power system that cannot be reduced to a single anti-modern logic also allows for questioning events after 1945.

And finally, as already described in the chapter on the historical approach of this study, this perspective implies a methodological decision – a discourse theory approach to history that situates texts as the foundations of analysis. This study analyzes patient records along specific lines that examine the constitution of objects, the strategies of their materialization, subject positions, and the institutional space of their emergence. These analytical steps are necessary in order to identify statements as the smallest units of discourse.

According to political scientist Silke Schneider, a discourse-analytical perspective on Nazism should comprise different levels and questions: “on the one hand, [we need] to question the concepts of social order of State and society that legitimated the National Socialist's practices of domination. On the other hand, we need to look at how people are classified and become objects of specific scientific discourses. Finally, we should explore how the self-formation of subjects functions on the basis of attributions and how these classifications and identifications emerge in practice, because these knowledge orders were the frame for both the classification of the victims and the acceptance of the spectators.”⁵⁹

The following study is an attempt to translate this theoretical approach into an empirical analysis. The question of how subjects are constituted in discourses and discursive practices will be the primary focus of the following study.

¹ Hans-Walter Schmuhl, "Die Genesis der 'Euthanasie.' Interpretationsansätze." in *Die nationalsozialistische "Euthanasie"-Aktion "T4" und ihre Opfer*, eds. Maïke Rotzoll et al (Paderborn: Ferdinand Schöningh, 2010), 66-73; Hans-Walter Schmuhl, "Das 'Dritte Reich' als biopolitische Entwicklungsdiktatur. Zur inneren Logik der nationalsozialistischen Genozidpolitik," in *Tödliche Medizin. Rassenwahn im Nationalsozialismus* (Göttingen: Wallstein Verlag, 2009), 8-21.

² The following considerations are based on a series of lectures by Michel Foucault from 1976 entitled "*Il faut défendre la société*." Michel Foucault, *Il faut défendre la société. Cours au Collège de France. 1976* (France: Gallimard Seuil, 1997); Michel Foucault, *Society must be Defended: Lectures at the Collège de France 1975-1976*, ed. Arnold I. Donaldson, trans. David Macey, (United States of America: Picador, 2003). It was in the last class of that year that Foucault introduced the concept of biopower and biopolitics (he used these terms interchangeably) and he took this concept up in the first volume of the *Histoire de la sexualité* that appeared in the same year. Michel Foucault, *La volonté de savoir. Histoire de la sexualité. Vol. 1* (France: Éditions Gallimard, 2001); Michel Foucault, *Der Wille zum Wissen. Sexualität und Wahrheit 1*, trans. Ulrich Raulff and Walter Seitter (Frankfurt a.M.: Suhrkamp, 1989). In the context of the book *Il faut défendre la société* the concept was very clearly connected to the idea of war and racism, whereas in *La volonté de savoir* the emphasis was laid on the productive character of biopolitics. It is in the latter book that Foucault seemed to make a rudimentary differentiation between biopower and biopolitics.

³ Alessandro Fontana and Mauro Bertani, "Situation du cours," in *Il faut défendre la société. Cours au Collège de France. 1976* (France: Gallimard Seuil, 1997), 247-263.

⁴ Genealogy can be defined as a central methodological term in Foucault's work. It designates the discontinuity of historical systems of thought and of discursive formations (see also chapter 2). Instead of searching for origins, for static entities, for explicit intentionality, or for metaphysical finalities, the genealogical method searches for balances of power that affect historical events. For the genealogist neither an individual nor a collective subject influences history.

⁵ Foucault, *Society must be Defended*, 12-13; Foucault, *Il faut défendre la société*, 13-14.

⁶ *Ibid.*, 41.

⁷ Foucault, *Society must be Defended*, 51; Foucault, *Il faut défendre la société*, 44.

⁸ *Ibid.*, 46.

⁹ *Ibid.*, 49.

¹⁰ Foucault, *Society must be Defended*, 270; Foucault, *Il faut défendre la société*, 242-3.

¹¹ Foucault, *Society must be Defended*, 60; Foucault, *Il faut défendre la société*, 51.

¹² Foucault, *Society must be Defended*, 62; Foucault, *Il faut défendre la société*, 53.

¹³ Foucault, *Society must be Defended*, 82; Foucault, *Il faut défendre la société*, 72.

¹⁴ Foucault, *Society must be Defended*, 82.

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- ¹⁵ See Michel Foucault, *Discipline & Punish: The Birth of the Prison*, trans. Alan Sheridan (New York: Vintage Books, 1995); *Überwachen und Strafen. Die Geburt des Gefängnisses*, trans. Walter Seitter (Frankfurt a.M.: Suhrkamp, 1994); *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. Alan M. Sheridan Smith (New York: Vintage Books, 1994); *Wahnsinn und Gesellschaft*, trans. Ulrich Köppen (Frankfurt a.M.: Suhrkamp, 1969); *Madness and Civilization : A History of Insanity in the Age of Reason*, trans. Richard Hower (New York: Vintage Books, 1973); *Die Geburt der Klinik. Eine Archäologie des ärztlichen Blicks*, trans. Walter Seitter (Frankfurt a.M.: Suhrkamp, 2002).
- ¹⁶ Foucault, *Society must be Defended*, 181-182; Foucault, *Il faut défendre la société*, 161-2.
- ¹⁷ Foucault, *Il faut défendre la société*, 213; Foucault, *Society must be Defended*, 240.
- ¹⁸ Foucault, *Society must be Defended*, 240; Foucault, *Il faut défendre la société*, 214.
- ¹⁹ Foucault, *Society must be Defended*, 241.
- ²⁰ Foucault, *Society must be Defended*, 242-3; Foucault, *Il faut défendre la société*, 216.
- ²¹ Foucault, *Society must be Defended*, 246; Foucault, *Il faut défendre la société*, 219.
- ²² Ibid.
- ²³ Foucault, *Society must be Defended*, 246-7.
- ²⁴ Foucault, *Society must be Defended*, 252; Foucault, *Il faut défendre la société*, 225.
- ²⁵ Foucault, *Society must be Defended*, 253; Foucault, *Il faut défendre la société*, 225.
- ²⁶ Judith Butler, "Gender Regulations," in *Undoing Gender* (New York: Routledge, 2004), 49.
- ²⁷ François Ewald, "Norms, Discipline, and the Law," in *Law and Order of Culture*, ed. Robert Post (Berkeley: University of California Press, 1991), 138.
- ²⁸ Ibid., 173,
- ²⁹ Butler, *Gender Regulations*, 52
- ³⁰ Ibid., 52 see also Hannelore Bublitz, "Täuschend natürlich. Zur Dynamik gesellschaftlicher Automatismen, ihrer Ereignishaftigkeit und strukturbildenden Kraft," in *Automatismen*, eds. Hannelore Bublitz et al (München: Wilhelm Fink, 2010), 153-171; Hannelore Bublitz, *Diskurs* (Bielefeld: transcript, 2003).
- ³¹ Jürgen Link, *Versuch über den Normalismus. Wie Normalität produziert wird* (Göttingen: Vandenhoeck und Ruprecht, 2006).
- ³² Anne Waldschmidt, "Normalität," in *Glossar Der Gegenwart*, eds. Ulrich Bröckling, Susanne Krasmann and Thomas Lemke (Frankfurt a.M.: Suhrkamp, 2004), 191.
- ³³ Link, *Versuch über den Normalismus*, 51
- ³⁴ Edwin Black, *IBM und der Holocaust. Die Verstrickung des Weltkonzerns in die Verbrechen der Nazis*, trans. Cécile Plieninger, Ursel Schäfer and Heike Schlattner (München: Ullstein, 2002).
- ³⁵ Götz Aly and Karl Heinz Roth, *Die restlose Erfassung. Volkszählen, Identifizieren, Aussondern im Nationalsozialismus* (Frankfurt a.M.: Fischer, 2005), 12.

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- ³⁶ Ulrike Gaida, "Eugenik im Deutschen Reich und im Nationalsozialismus," in *Quellen zur Geschichte der Krankenpflege. Mit Einführungen und Kommentaren*, ed. Sylvelyn Hähner-Rombach (Frankfurt a.M.: Mabuse, 2008).
- ³⁷ Aly and Roth, *Die restlose Erfassungs*, 8
- ³⁸ Michel Foucault, *L'archéologie du savoir* (France: Gallimard, 2008).
- ³⁹ Nikolas Rose, "Numbers," in *Powers of Freedom: Reframing Political Thought*, ed. Nikolas Rose (Cambridge: Cambridge University Press, 2005), 197-232; Nikolas Rose, "Governing by Numbers: Figuring Out Democracy," *Accounting, Organizations and Society* 16, no. 7 (1991): 673-92; Peter Miller, "Accounting as Social and Institutional Practice: An Introduction," in *Accounting as Social and Institutional Practice*, eds. Anthony G. Hopwood and Peter Miller (Cambridge: Cambridge University Press, 1994), 1-39; Peter Miller, "Accounting and Objectivity: The Invention of Calculating Selves and Calculating Spaces," *Annals of Scholarship* 9, no. 1-2 (1992): 61-86; Peter Miller and Timothy O'Leary, "Accounting and the Construction of the Governable Person," *Accounting, Organizations and Society* 12, no. 3 (1987): 235-265.
- ⁴⁰ Rose, *Numbers*, 197-232.
- ⁴¹ Miller, "Accounting as Social and Institutional Practice," 1-39
- ⁴² Ian Hacking, "Making Up People," in *Reconstructing Individualism: Autonomy, Individuality, and Self in Western Thought*, eds. Thomas C. Heller, Morton Sosna and David E. Wellbery (Stanford: Stanford University Press, 1986), 222-237; Ian Hacking, "Biopower and the Avalanche of Printed Numbers," *Humanities in Society* Band 5 (1982): 279-295.
- ⁴³ Hacking, "Making Up People," 227.
- ⁴⁴ Ibid., 235.
- ⁴⁵ Michel Foucault, *Abnormal. Lectures at the Collège de France 1974-1975*, ed. Arnold I. Davidson, trans. Graham Burchell (USA: Picador, 2003); Robert Castel, *The Regulation of Madness: The Origins of Incarceration in France*, trans. W. D. Halls (Great Britain: University of California Press, 1988).
- ⁴⁶ Foucault, *Society must be Defended*, 255; Foucault, *Il faut défendre la société*, 227.
- ⁴⁷ Foucault, *Society must be Defended*, 256; Foucault, *Il faut défendre la société*, 228.
- ⁴⁸ Foucault, *Society must be Defended*, 256; Foucault, *Il faut défendre la société*, 227-8.
- ⁴⁹ Foucault, *Society must be Defended*, 258; Foucault, *Il faut défendre la société*, 230.
- ⁵⁰ Foucault, *Society must be Defended*, 258; Foucault, *Il faut défendre la société*, 231.
- ⁵¹ Gellately, *Backing Hitler: Consent and Coercion in Nazi Germany* (New York: Oxford University Press, 2009).
- ⁵² This is also an aspect of the newer historical research in the *Volksgemeinschaft*. This research also highlights the fact that the Nazi regime must be analyzed under the perspective of the voluntary cooperation of Germans with the system. See, for example, Frank Bajohr and Michael Wildt, eds., *Volksgemeinschaft. Neue Forschungen zur Gesellschaft des Nationalsozialismus* (Frankfurt a.M.: Fischer,

2009); Detlev J. Peukert, *Volkgenossen und Gemeinschaftsfremde. Anpassung, Ausmerzung und Aufbegehren unter dem Nationalsozialismus* (Köln: Bund-Verlag, 1982).

⁵³ Robert Gellately, "Denunciation as a Subject of Historical Research," in *Denunciation in the 20th Century*, ed. Inge Marszolek (Köln: Quantum, 2001), 16-29.

⁵⁴ Silke Schneider, "Diskurse in der Diktatur? Überlegungen zu einer Analyse des Nationalsozialismus mit Foucault," in *Foucault: Diskursanalyse der Politik. Eine Einführung*, eds. Brigitte Kerchner and Silke Schneider (Wiesbaden: VS Verlag, 2006), 123-144.

⁵⁵ Gellately, *Backing Hitler: Consent and Coercion in Nazi Germany*, 107; Götz Aly, "Medicine Against the Useless," in *Cleansing the Fatherland: Nazi Medicine and Racial Hygiene*, eds. Götz Aly, Peter Chroust and Christian Pross (Baltimore and London: Johns Hopkins University Press, 1994), 93.

⁵⁶ Foucault, *Society must be Defended*, 260; Foucault, *Il faut défendre la société*, 231-2.

⁵⁷ Foucault, *Society must be Defended*, 260; Foucault, *Il faut défendre la société*, 232.

⁵⁸ Hannah Arendt, *The Origins of Totalitarianism* (United States of America: Harvest Book, 1994).

⁵⁹ Schneider, *Diskurse in der Diktatur?* 140.

4 The History of the Asylum of Langenhorn from 1893 to 1945

4.1 From the “colony for the insane” (Irrenkolonie) Langenhorn to the “General Hospital of Langenhorn” (Allgemeines Krankenhaus Langenhorn)

In 1888, medical director of Hamburg’s academic psychiatric asylum Friedrichsberg, Dr. Wilhelm Reye, first proposed the foundation of an agricultural institution to the city’s hospital council (*Krankenhauskollegium*, the executive committee of the Senate of Hamburg for Hamburg’s hospitals). At this time, Friedrichsberg was the central asylum for the city of Hamburg, and he believed that a new institution would free up space in the overcrowded established asylum. The rapid rise of industrialization and the consequent growth of Hamburg’s population had increased the number of mentally ill persons needing hospital care. At the start of the industrialization period, Friedrichsberg had held 1200 beds but now that capacity had to be increased.¹ Based on a report mandated by health authorities, it was determined that the proposed “colony for the insane” should be reserved for mentally ill persons who were supported by welfare, whose insanity was likely long-term but who could work. The report determined that in order to address this need for more space, a manor should be purchased and several houses, constructed along the lines of the pavilions in Friedrichsberg, should be built to house about 200 patients. Central administrative buildings and coverage areas should be added to provide support for the increased number of patients.

Based on this report of May 1888, the health authorities mandated public health officer Dr. C. Reinhard to analyze possible solutions for the management of the overcrowding at Friedrichsberg. In a memorandum, Reinhard developed three possible solutions: the first was to alleviate Friedrichsberg by either enlarging the asylum or by founding another one entirely; the second was to place a large number of patients under family care; the third potential solution was to place part of the patient population in an agricultural colony. Reinhard rejected the first possibility because enlarging Friedrichsberg would make it increasingly difficult for the psychiatrists and administration to control the institution. It also seemed impossible because

Friedrichsberg did not have enough land surrounding it because of its proximity to the city of Hamburg. He also believed that constructing a new, closed asylum would not only have been too expensive but also hard on patients, who, although chronically ill, were still able to work. Likewise, he rejected the option of placing patients in family care, justifying his decision on how difficult it would be to find suitable families to take on such a responsibility, and how much of the patient workforce would be lost to private households. Furthermore, he argued that without an agricultural sector “to occupy the patients,” the asylum would be reduced to a storage institution (*Bewahranstalt*) or an institution for the infirm (*Siechanstalt*). The only feasible alternative that remained was to develop a new agricultural colony, for which Reinhard had a precise vision.

It is important that the whole must appear, as far as possible, as a wealthy village, because then the sick persons will feel more comfortable. That is why the residential houses must avoid being all the same size and constructed in the same style, since an awkward monotony would be created that unintentionally evokes the idea of modern proletarian quarters near the factories. It would be best to construct houses for forty, thirty, and twenty mentally ill persons and to further sub-divide the former two into two sections.²

The health authority approved the memorandum and mandated a commission to find a suitable property and develop an organizational plan. The commission decided in favour of an area of 185 acres called “fir tree pasture” (*Tannenkoppel*) situated far outside of Hamburg, in Langenhorn. No transport connection existed at this time; the nearest public transport was a kind of trolley-car drawn by horses. The organizational plan designated Friedrichsberg as the exclusive referring institution for the new colony. Reinhard recommended that the direction of the institution should be assigned to a psychiatrist under whom all employees would be subordinated, while he himself would answer to the medical director of Friedrichsberg.³ It was also determined that male patients would work on the farm and in the workshops, with female patients in the kitchen, the sewing centre, or in the garden. After completion of the first four fifty-bed houses to care for the patients (male patients in houses one and two, and female patients in houses twenty-one and twenty-two), the agricultural colony for the insane (*Landwirtschaftliche Kolonie für*

Geisteskranke) was officially inaugurated on 1 April 1893. As of that date, the colony accommodated 119 patients, where 99 percent of the male patients and 88 percent of the female patients were working.

The first annual report defined the agricultural asylum as an institution designed for the “admission of quiet and chronically ill patients with the ability to work.”⁴ This report also emphasized the health benefits of the colony’s location, as it resided within a forest and thus in an area without traffic. Furthermore, the report highlighted the “open-door-system” (*Offene-Türen-System*) that it claimed produced a village-like atmosphere at the colony. However, this ideal was apparently never quite realized. By 25 April 1895, the public health officer, Dr. Deneke, described the quality of the accommodations in a letter to the Medical Council (*Medizinalkollegium*). “Hitherto the existence of a colony in Langenhorn cannot be perceived; the asylum with its checkered buildings distributed in a confined space has nothing in common with a rural settlement.”⁵ According to Deneke, Langenhorn seemed to be a “military complex of buildings like those one would find on a firing range.” (See Figure 1)



Figure 1: Photography of one of the original houses constructed (around 1900).⁶

Nevertheless, the “open-door-system” was understood as a continuation of the “no-restraint-principle,” which had been introduced in 1861 by Ludwig Meyer with the intent to abolish coercive treatment in Friedrichsberg. The pre-condition for this system was the “selection of suitable sick persons,” as noted by the annual report. At the end of 1894, the asylum housed 150 male and 49 female patients, with the nursing auxiliary force made up of 11 male guards and 4 female guards.⁷

4.2 From the “Colony for the Insane” to the “State Asylum” (*Staatskrankenanstalt*)

In 1894, plans were developed to enlarge Langenhorn again. Dr. Theodor Neuberger, a senior psychiatrist at Friedrichsberg and Langenhorn’s medical director from 1898 on, supported the idea of transferring patients unfit for work from Friedrichsberg to Langenhorn, because the number of patients able to work was limited and Friedrichsberg needed a certain number of working patients in order to maintain its own infrastructure. The patient population (*Krankenbestand*) in Friedrichsberg had changed significantly, according to Neuberger, because through the transfer or discharge of “orderly, quiet patients that are able to work, many beds had become free and were now taken up by partly unreliable, unsocial, or even physically sick persons.” He claimed that “pavilions must be constructed in Langenhorn for patients that were not constantly able to work and for restless mentally ill patients” in order to create normal conditions in Friedrichsberg.⁸ On 5 April 1897, the health authority approved Neuberger’s concept and began the construction of new houses at Langenhorn.⁹ Surveillance houses were constructed to accommodate unsocial patients and patients perceived as dangerous to public safety. Observation houses for semi-quiet patients were also built, as well as rural houses to accommodate quiet sick persons who were relatively free to circulate. From this point on, Langenhorn treated many different categories of mentally ill persons and consequently, the open-door system was practically abandoned. Accordingly, the name was changed on 20 March 1899 to “Lunatic Asylum Langenhorn” (*Irrenanstalt Langenhorn*), and altogether now accommodated 500 patients.

From 1896 to 1899, Langenhorn experienced on average an increase of seventy-two patients per year. Responding to this steady growth, Neuberger prepared a position paper (*Denkschrift*) demanding a second enlargement of 860 beds, with a view to a subsequent increase of 1400 beds.¹⁰ He justified his claims of expanding the institution on the basis that the nearby major city of Hamburg was producing larger numbers of mentally ill persons and mentally ill criminals, and that the city was not providing any relief of its lunatic asylums through “family care.” Neuberger’s report was accepted but it must be emphasized that the Provincial state government of Hamburg counted the construction of a specifically secured house (House #9) for the accommodation of mentally ill criminals a high priority and approved its construction in 1902, while the general enlargement of Langenhorn did not take place until 1904-1906 (See Figure 2).¹¹ From 1904 onward, Langenhorn admitted patients directly without them first being admitted to Friedrichsberg, and took in remand prisoners from the penitentiary of Fuhlsbüttel to observe their mental state, as well as people who came into conflict with the law due to a mental illness. From this moment on, Langenhorn had a vital position in the penitentiary system of Hamburg.



Figure 2: “Secured House” after the first enlargement (around 1904)

During these years, three events regarding patient treatment are noteworthy. The first two aspects are related to a planned modification of the “Ordinance concerning the Regulation of the Service for the Insane” (*Verordnung betreffend das Irrenwesen*) which had been in force since 1899 and was modified due to organizational changes in the asylums in Hamburg. The first issue concerned the patients’ right to complain, while the second centered on the question of who had legal responsibility for the decision to discharge patients from the asylum. The third event highlights modifications in the upkeep of the statistical annual register. All three aspects are discussed here in some depth because they caused disputes between psychiatrists on the one side, and the administration, police, and medical officers on the other, highlighting how resolutely the psychiatrists fought for their right to gain absolute control over the asylums in Hamburg and the patients.

4.2.1 *The modification of the right to complain*

In 1906 the provincial government of Hamburg designated Langenhorn as a facility able to admit convicted offenders and remand prisoners. As a result, a debate took place within the Medical Council regarding patients’ right to complain about both their treatment and the conditions in Hamburg’s asylums. The critique of the asylum medical directors (especially the director of Langenhorn, Neuberger) illustrates the self-understanding of psychiatrists in Hamburg at that time, and underlines the degree to which these psychiatrists cared about ensuring their own reach of power outside any kind of control. The fight for this uncontrolled power rose to the surface in 1906, and again in the 1920s and 1930s when the question arose whether or not patient incapacitation had to be a pre-condition for compulsory hospitalization.

The right to complain was regulated by paragraph six of the “Medical Ordinance” (*Medizinalordnung*) that was instituted in December 1899 and modified in 1904. According to the later modification, residents and their relatives had the right to complain to the Commission of the Medical Council for the Regulation of the Service for the Insane (*Kommission des Medizinalkollegiums für das Irrenwesen*). The management of the asylum had to provide

complainants with the necessary writing utensils to submit their complaint and had to forward complaints to the commission, which was composed of representatives from the Senate of Hamburg and psychiatrists from Hamburg asylums.¹² This modification became the focus of a long-lasting conflict between the health authorities and the medical directors of Hamburg's asylums. At the end of 1906, Dr. Neuberger argued in his defence that the number of complaints had increased since the secured house for "deranged criminals and lunatics dangerous to public safety" had been inaugurated in November 1905.

From December 1905 to 20 October 1906 the management of the asylum had to forward 40 complaints to the commission of the medical council. Of these 40 submissions, 39 derived from a stock of only 50 sick persons, all of them accommodated in the secured house. Of the rest of the sick houses that are occupied by circ. 600 residents, only one complaint was admitted since December 1905. The sick persons appealing from the secured house (20) were all, except for one, previously convicted criminals. In looking over their records one can find particular sick persons with 28, 22, 20, 16, 12, 9, 8, 7, 5, 4, 3 etc. reported previous convictions, among them 14 people who will always need care (*Pfleglinge*) from the hard labor penal facilities (*Zuchthaus*).¹³

Furthermore, Neuberger argued that in Friedrichsberg between 1900 and 1906, only sixty-one complaints were submitted by "sick persons who had no previous convictions and who were not criminals," because they want to be discharged earlier and "this wish finds enough attention by the medical directors of the asylums."¹⁴ Although he described the "ordinary Lunatic" as "less harmful" as compared to those considered "criminal," he assumed that all mentally ill persons were dangerous and only differed in danger by degree. Criminal lunatics, however, were "pathologically uncritical and inclined to hold the physician responsible for their incarceration in the asylum, even though the physicians would be happy if they could discharge these lunatics." Neuberger believed that these patients used their right to complain to take revenge on psychiatrists, hindering patient treatment and perhaps more importantly, weakening the position of the psychiatrist. Neuberger summarized his arguments by stating that "through the right to complain the correct treatment for the individual sick person is hindered. Rather, frequent

excitements and impairments are caused that could have been averted, and the position of the physician towards the sick person becomes more difficult because the position of the physician will be decreased, which disturbs the work of the physician.” Neuberger supported his arguments by using a former decision of the Higher Regional Court of Hamburg (*Hanseatisches Oberlandesgericht*) from 1888. According to this legal decision, the medical director of the asylum decided on all matters concerning the sick person based on what was determined to be best for his or her healing process. Only the medical director of the asylum could determine how far patients’ rights extended, a conclusion that was based on the sick person’s condition or the reasons for his or her incarnation. Neuberger argued that, in the city of Hamburg, the patient’s right to complain superseded the medical director’s control over the patient and hence, contradicted the older judicial order. He contended further that sick persons were granted the right to complain because of the “lay public’s” impression that “mentally healthy persons could be taken to the asylum and be detained there.” He claimed that this fear was completely unfounded because “it could be scientifically demonstrated that a truly healthy person... was not kept in an asylum, but rather, the asylums kept only those persons who were proven to be mentally ill.”¹⁵ The paper ended with the request to withdraw the right to complain from inmates of public asylums.

Neuberger could not get his ideas entirely accepted, but his argument highlighted several important aspects. Although his paper began by rejecting the right of criminal inmates to complain, it became obvious that its true aim was to reject this right for all asylum inmates. Neuberger’s justification for rejecting these claims revealed his fear over reducing the power of the asylum’s medical director. If inmates of the asylum had the right to complain, then the absolute will of the medical director was jeopardized because mentally ill persons could not assess the damages that they might cause to themselves or their surroundings. Furthermore, someone lacking psychiatric knowledge could neither make informed decisions about inmates’ complaints nor understand their pathological background. The scientific knowledge that

psychiatrists possessed precluded them assigning patients to an asylum if they were not mad, implying that only psychiatrists were able to assess the need for asylum care. As well, throughout the course of his paper, Neuberger distinguished between different classes of inmates.

Along with arguing against patients' right to complain, Neuberger also protested against a planned modification of the "Ordinance concerning the Regulation of Service for the Insane" (*Verordnung betreffend das Irrenwesen*) regarding the legal authority over patient admissions and discharges. Questions regarding this issue would flare up many times during the next twenty-five years, and the germ of Neuberger's arguments would resurface again and again.

Paragraph thirteen of this draft regulated the discharge of patients from the asylum, with section 4 introducing a kind of rubber stamping of decisions to discharge patients who were considered incapacitated but whose reasons for admission had been judicially abolished. In these cases, according to the draft, these patients should be immediately discharged.¹⁶

Regarding Paragraph 13: section 4 has to be omitted. Discharging patients because their perceived incapacitation has been legally revoked or abolished raises several objections. Revoking the incapacitation of sick persons does not prove that they are mentally stable or that treatment in an asylum is not necessary, but only serves to inhibit the threat of legal recourse by them. Not every form or every degree of mental disturbance qualifies for the label of incapacitation, a designation which should only be issued if the sick person is unable to take care of legal concerns. The need for treatment or incarceration in an asylum cannot be determined by a court order or a refusal to consider patients incompetent.¹⁷

In order to highlight the danger that might arise if decisions on admission and discharge were delegated to the legal system, Neuberger narrated a fictitious story about a "psychically disordered man" whose admission was revoked and who became a major danger to public safety outside the asylum. Note the type of mentally ill person Neuberger had in mind:

I am especially concerned about the degenerative feeble-minded who are observed to have less obvious symptoms of mental disorder in the asylum but whose pathological incapability comes to the fore once they are left to their own resources. Then they demonstrate that *they are not able to conduct a moral life* due to the pathological organisation of their brains.¹⁸

This last sentence highlights what Neuberger seemed to acknowledge as the real purpose of psychiatry – the appraisal of a “moral conduct of life,” which could only be estimated by an expert who possessed the scientific knowledge of psychiatry. The inability to “conduct a moral life” was suggested twenty years later by Neuberger’s colleague, Dr. Kankeleit, a psychiatrist from Langenhorn who in 1925 published an article “What do the inferiors cost the state?” (*Was kosten die Minderwertigen den Staat?*). The article dealt primarily with the social Darwinist theory of devolution, which would take place through uncontrolled reproduction of “inferiors,” and he claimed that Germany needed sterilization laws modeled on those in the United States. As evidence, he cited the example of one particular family.

An examination of 709 out of the 834 direct offspring of Ida Jukes, born in 1740, revealed that 106 were illegitimate, 181 were prostitutes, 142 were beggars and vagabonds, 64 were accommodated in poorhouses, and 76 were criminals (among them 7 murderers). All in all they had served 116 years of prison, received 784 years public welfare and had cost the state 5 million Marks for 75 of those years in prison, welfare, and direct damages. In the fifth generation all the women were prostitutes and all the men criminals.¹⁹

Neuberger, however, had explicitly mentioned the “degenerative feeble minded” whose prominent characteristic centered on the difficulty of determining the pathological disorder from which they suffered. Although they might have seemed “normal” at some periods of time, over time psychiatric experts could unmask their “abnormality.” The degenerate thus represented a state of abnormality rather than one of illness. Neuberger’s linking of the “moral conduct of life” and the theory of degeneration was no coincidence but rather described the self-concept of psychiatry at that time. In his examination of the development of modern psychiatry, historian and philosopher Michel Foucault emphasized that the most important part of the theory of degeneration was the perception that the “degenerated” person was abnormal. According to him, the theory of degeneration provided psychiatry the opportunity to fold any kind of deviance, discrepancy, or “retardation” into a diagnosis of degeneration, allowing for a wide-ranging interference in human behaviour. Even more importantly, directly relating deviant behaviour with

theory allowed psychiatry to extend its power beyond its traditional focus on curing. The idea of incurability had formerly represented a kind of psychiatric horizon, since it defined the effective limits of treatment for diseases that had been perceived as essentially curable. Nevertheless, from this moment on, madness appeared to be more the technology of the abnormal, and when the status of abnormality was fixed by heredity onto the individual, the project of curing no longer made any sense.²⁰ Kankeleit made this correlation visible when he argued that, although it would be easier and less expensive to “re-integrate the inferiors as viable members into society,” the power of psychiatry was insufficient to achieve this goal. As he asserted in the case of children, “however successful the care, it can only reform but it can never transform inferiors into normal humans.”²¹

Foucault also argued that as the pathological content of the psychiatric domain disappeared, so too did the therapeutic dimension of psychiatry.

Psychiatry no longer seeks to cure, or in its essence no longer seeks to cure. It can offer merely to protect society from being the victim of definitive dangers represented by people in abnormal condition (and this actually occurs at this time). With the medicalization of the abnormal and by dispensing with the ill and the therapeutic, psychiatry can claim for itself the simple function of protection and order.²²

The notion of heredity allowed psychiatry to take on a generalized social defense role and at the same time, provided it with the grounds to interfere into the sexuality of the family. Psychiatry set itself up as the scientific protector of society, and as it became the science of the biological protection of the species, it reached the zenith of its power. This contention of social authority helps explain the intense struggle with the legal system during the first thirty years of the twentieth century over defining who was considered a danger to society and the need for asylum custody. It was on the basis of claims that psychiatry’s role as the general defender of a society was being eroded from within that psychiatrists claimed the right to substitute for the judiciary.

At this point, this psychiatric reasoning introduced the kind of racism that Foucault defined as scientific racism of biopolitics (see chapter 3) and which explains why German psychiatry functioned so smoothly under Nazism. This racism, which was based on the linkages between notions of degeneration and heredity, was a racism against the abnormal “against individuals who, as carriers of a condition, a stigmata, or any defect whatsoever, may more or less randomly transmit to their heirs the unpredictable consequences of the evil, or rather of the non-normal, that they carry within them.”²³ As already emphasized in the last chapter, this kind of racism does not function as prevention or as defence of one group against another, but rather its aim is to detect inside a group the elements that may constitute a danger.

Certainly, there were very quickly a series of interactions between this racism and traditional Western, essentially anti-Semitic racism, without, however, the two forms ever being coherently or effectively organized prior to Nazism. We should not be surprised that German psychiatry functioned so spontaneously within Nazism. The new racism specific to the twentieth century, this neoracism as the internal means of defense of a society against its abnormal individuals, is the child of psychiatry, and Nazism did no more than graft this racism onto the ethnic racism that was endemic in the nineteenth century.²⁴

The self-conception of psychiatry in Hamburg was based on the basic approach that it was responsible for the detection of dangerous elements within society and that only the psychiatric expert could carry out this important task. Psychiatric discourse enabled relating every aspect of abnormal behavior to ideas of heredity and degeneration, as the development of record keeping in Langenhorn demonstrates.

4.2.2 *Entry form to annual statistics at Langenhorn*

An analysis of Langenhorn’s annual statistics reveals that they became part of the broader context, described above, that influenced which aspects of inmates were highlighted in the annual report and accordingly, what was noteworthy about them. Among the existing sources from Hamburg’s public record office (*Staatsarchiv Hamburg*) is a folder that contains handwritten and typewritten duplications of Langenhorn’s annual statistics from 1893 to 1924.

These statistics were part of the asylum's annual reports for the health authority and became part of the foundation of yearly statistics collected by the government of the German Empire. From the year of its inauguration in 1893 and in the years following, Langenhorn's annual report contained a completed data entry form. This printed form was originally just a single page subdivided into three parts, and directions indicated that the form had to be completed each year by all asylums and was to include the asylum's name and the province wherein it resided. It is noteworthy that this form from the beginning designated Langenhorn as a "lunatic asylum," even though until 1899 it was considered a "colony for the insane." Evidently, the government administration did not differentiate between the status of an asylum and a colony before that date, suggesting that apparent differences between asylum and colony were artificial from the beginning. In reality, no real difference existed between the two. Furthermore, these entry forms were signed by the medical director or his representative, indicating that they were well aware of the name. In fact, the form did not even permit any other designation, implying that from the beginning, Langenhorn was officially counted as an asylum. The second part of the form requested general information about admitted patients, including gender and the number of inpatient days. The third part of the form, entitled "specified frequency," was designed as a table. (See Figure 3 and Table 1)

The specified frequency table classified Langenhorn's patients into four categories that were not, in fact, very selective. Though there seemed to be little purposeful difference between the categories, it is interesting to observe that already by 1893, heredity was a decisive criterion to sort inmates. How heredity was "proven" is evident by analyzing the admission forms, which posed questions about the patient's family history. (See the chapter on the analysis of the records.) A proven hereditary defect meant nothing more than a perceived "abnormality" in the inmate's family history; this could include a remote relative who drank or who had drawn attention because of a criminal offense or other wrongdoing.

Offiziale 1 24

Stempel Nr.

Stempel 2
zum Versteigern des Grundbesitzes

Irrenanhalt Langenhorn

in Langenhorn
Stadt Hamburg

I. Mangelnder Angaben.

Nam des Befugten: Emm Hamburg
Zahl der Betten oder Plätze: 400
Zahl der Verpflegungstage im Jahre 18 93 | für männliche Jren 16041
| für weibliche Jren 7014
Zahl der im Jahre 18 93 verpflegten | männlichen Jren 135
| weiblichen Jren 64

II. Rechnung im Aufseher.

Krankheitsformen.	Rechnung aus 1. Januar		Zugang im Jahre		Abgang im Jahre		Zugang im Jahre		Abgang im Jahre		Verbleibende aufgeworben bei Aufnahme am 1. Jan. und Zugang im Jahre	
	absent.	verst.	absent.	verst.	absent.	verst.	absent.	verst.	absent.	verst.	absent.	verst.
1. Akute Entzündung	0	0	114	43	7	7	-	-	1	56	16	57
2. Chronische Entzündung	0	0	1	-	-	-	-	-	-	-	-	-
3. Entzündung mit Epilepsie, mit Epilepsie	0	0	9	5	2	-	-	-	2	2	4	-
4. Dementia (angeboren), Dementia, Dementia	0	0	9	4	1	-	-	-	4	5	7	-
5. Tumor cerebralis	0	0	-	-	-	-	-	-	-	-	-	-
6. Nicht geklärt	0	0	-	-	-	-	-	-	-	-	-	-
Summe	0	0	133	52	10	7	-	-	1	72	21	63

90. Wenn je bei Aufnahmeverfahren die Irrenanstellung keine Angabe gemacht, steht der Platz bei Beginn des Jahres an demselben Ort, wo die Aufnahme stattfand, wenn sonst angegeben.

27. 2. Schaefer.

für richtige Offiziale
Hamburg, den 11. November 1896.
Joh. Meißner, Linné.
S. 188

87

kind of illness	stock on January 1		admission during year		reduction over the year				heredity proven in the stock at January 1 and admissions during the year		
	male	female	mal.	fem.	general		through death		mal.	fem.	total
					mal.	fem.	mal.	fem.			
1. simple mental disorder	0	0	114	43	7	7	-	1	36	16	52
2. paralytic mental disorder	0	0	1	-	-	-	-	-	-	-	-
3. mental disorder with epilepsy, with hysterioepilepsy	0	0	9	5	2	-	-	-	2	2	4
3. imbecility (congenital), idiocy, cretinism	0	0	9	4	1	-	-	-	4	3	7
4. delirium potatorum	0	0	-	-	-	-	-	-	-	-	-
5. not mentally ill	0	0	-	-	-	-	-	-	-	-	-
amount	0	0	133	52	10	7	-	1	42	21	63

Table 1: Translated diagnostic table with specified frequency for the year 1893.

Nevertheless, the table imposed a relationship between heredity and other factors. In 1902, it listed not only “proven heredity” but also the category “proven alcohol abuse,” suggesting a connection between mental illness, heredity, and alcoholism that did not exist in 1893. Furthermore, the construction of the table itself made it obvious that the two variables of “heredity” and “alcoholism” were thought to intersect with one another. Not only were the two columns drawn side by side, but the figures were also often entered congruently, giving the impression that alcoholism automatically increased the hereditary risk for the inmate’s offspring to become mentally ill. Inversely, “abnormal events” in the inmate’s family history were considered threats to the inherited traits of inmates, automatically increasing their risk of alcoholism. Clearly, the way in which the table was constructed affected the relationship between different categories, and consequently how they were perceived. It imposed a range of assumptions on the reader who, without any knowledge or understanding of psychiatric scientific discourse of the time, could understand that mentally ill persons could be classified into four

distinct categories of mental illnesses that were all inheritable (even though their inheritance might not yet be “proven” in every case) and were connected to alcohol consumption in so far as alcoholism might have been the cause for the mental illness, or at least involved in its development. Furthermore, the table suggested a relationship between hereditary risk, alcoholism, and mental illness through its construction, making something visible that was invisible prior to its existence. This ability of annual statistics – to make certain aspects visible whilst others are rendered invisible – is used extensively in the years to come and is an aspect already discussed in the previous chapter on biopolitics and normalisation.

Further substantiation of this observation can be found in the drafts of these annual statistics. These handwritten drafts were also designed as tables but they contained more extensive and detailed information than was found in the annual statistics. Each year, a few tables were constructed for the male and female wards respectively, where each sick person was listed by first and last name, his or her date of birth, and date of admission. Adjacent to each other, the next three columns were entitled “statistical diagnosis,” “psychiatric diagnosis,” and “hereditary burden, alcohol abuse.” The column under statistical diagnoses was further subdivided into numerous psychiatric diagnoses. “Simple mental disorder,” for example, was broken down in 1903 into the following diagnoses: dementia praecox, catatonia, paranoia, dementia senile, degenerative mental disorder, etc. The next column contained information about alcohol abuse and hereditary burden, and ignoring the mutual exclusivity of these factors by combining them into one column, strengthened the impression that an interrelation existed between them. At the end of the table, the cases were counted according to their statistical categories and were then analyzed in relation to hereditary and alcohol abuse. For example, the draft from 1903 counted twenty new (male) admissions with the statistical diagnosis of “simple mental disorder.” According to the table, four of these admissions had a proven hereditary defect and were diagnosed with alcohol abuse. Furthermore, that same year, of the four people who were admitted with the statistical diagnosis of “paralytic mental disorder,” one had a proven hereditary fault and

was coincidentally abusing alcohol. The drafts highlight how interrelations between different diagnoses were actively constructed through the manner in which specific information was combined. They also pointed out that an enormous amount of work was required to create the annual statistical report, since the published tables condensed and displayed complex information in such a manner that it could be grasped at a glance.

This simplified table required several translation steps. First, the information from the admission record had to be inserted into the draft's hand-drawn table. In this first "simplification" stage, the patient's history was reduced to his or her name, place of birth, and a psychological diagnosis. Any abnormal events noted were translated into a hereditary burden. Alcohol consumption became the potential for "alcohol abuse." Through this translation process, the individual disappeared and became merely one number in the statistical table. Consequently, the huge amount of work necessary to create these short tables disappeared; the necessary effort can only be guessed at by the size of the drafts, which contained many hand-drawn tables and handwritten information. For 1903, for example, the draft comprised more than twenty pages – practically a small booklet.

The next part of the draft, concerned with the "reduction in stock" over the year, was divided into two distinct tables. The first table addressed the discharged sick persons and was designed in exactly the same manner as the admission table. Even here the variables of hereditary factors and alcohol abuse were explicitly listed. Nonetheless, the last table in the draft, on the deceased inmates of the asylum, is the most interesting, although as the number of deaths rose, this table was abandoned. This table is laid out in exactly the same manner as the others except for the last column on the patient's cause of death, which was accompanied by a particular diagnosis. Neither the causes for discharge or death were published in the annual statistics; however; in a manner similar to the handling of the admission forms, the discharge tables followed the same translation process in reducing information to single figures.

In 1908, the drafts were more formalised, as the former hand-drawn tables became printed forms with formally titled columns. The titles remained the same as those from previous years, except for the column entitled “hereditary burden, alcohol,” which was subsequently modified to either “able to work or bedridden.” To indicate that a patient was hereditarily tainted or abused alcohol, the capital letters “H” (for hereditas) or “A” (for alcoholism) were used. The table was further enlarged through two additional hand-drawn columns, one for “committed by the police, transferred from Fuhlsbüttel (the jail house of Hamburg) for observation,” and the other for “with criminal record of imprisonment or forced labour penalty.” These alterations corresponded to the previously noted change in 1904 that allowed Langenhorn to directly admit prisoners from Hamburg’s penitentiary. The increased complexity of the table allowed for more correlation of diverse factors. In the case of Anna Magdalena, for example, the statistical diagnosis of “simple mental disorder” was transformed into the psychiatric diagnosis of “dementia praecox.” According to the table, she was hereditarily tainted because her “father was a drunkard;” as a result, she was not able to work but she was not bedridden. Friedrich Wilhelm had a statistical diagnosis of “simple mental disorder,” but his psychiatric diagnosis marked him with “degenerative feeble-mindedness,” and the insertion of an A and H demonstrated that he was considered both an alcoholic and hereditarily tainted. Unlike Anna, he was able to work and was committed by the police (or came through the jail of Fuhlsbüttel). This information had a huge impact on the narrative of patients’ situations and prognoses, because it enabled editing and summarizing particular aspects of a person without knowing any details about them, demonstrating once again how a table constructed specific correlations and functioned as a statement. Even more importantly, the categories used in this 1908 table were similar to those used thirty-one years later under the Nazi regime as “report sheets” (*Meldebogen T4*) for the systematic recording of mentally ill persons. The tables regarding the discharged patients and those deceased did not undergo any modifications during these years; the cause of death was still noted and the deceased’s names were listed.

A further, albeit short-lived modification to these tables illustrated the ongoing efforts to compress and codify patient information. In 1909, the column entitled “able to work or bedridden” became a distinct category. The two columns introduced earlier regarding the patients’ criminal records were abandoned, and in their place the category “able to work” was differentiated into the four discrete columns of “able to work,” “able to work at all,” “bedridden,” and “can occasionally be occupied.” Coded with small letters from “a” to “d,” the state of the patient could thus be represented by a combination of letters and figures. For example, Albert Reinhard Gustav was coded as H2A2c, which is to say that he was diagnosed as “paralytic” (represented by the figure 2, because “paralysis” was the second diagnosis in the list of diagnoses in the annual statistics), hereditarily tainted (represented by the capital letter H), alcohol addicted (represented by the capital letter A), and bedridden (represented by the small letter c). This combination of letters and figures presented complex information about a patient in a succinct manner, and even though this system of compressed information did not outlast the year 1909, it nevertheless highlighted enduring efforts to compress information into the smallest units possible.²⁶ (See Figure 4). 1909 was also the first year that the patient’s cause of death was no longer differentiated. Only the names and the statistical diagnoses of the deceased were listed thereafter.

The analysis thus far has suggested that important patient information was compressed into a format that retained the most data in a minimal amount of space. After 1914, however, a further modification left deceased patients unnamed and anonymous. This change occurred at precisely the moment when the number of deaths began to rise dramatically, due more or less to the intentional starvation of sick persons in German asylums during the First World War. Even though a direct correlation between this change in bookkeeping and the murder of sick persons cannot be explicitly proven, it is noteworthy that all records concerning the increase in mortality rate in Langenhorn from 1913-1917 were oddly incomplete. Furthermore, by omitting the

individual names of victims, the patients lost their identity and could not be grieved for. It is as if they were reduced to a single figure; the dead lost their status as individualised dead.

Zuname	Vornamen	Geburtsjahr, Monat u. Tag	Wittgensteins	Statistische Diagnose	Psychische Diagnose	Erbliche Belastung Alkohol	Wittgensteins	Wittgensteins	Wittgensteins
1. [redacted]	1. [redacted]	1853. Sept. 4	3. Jänner	2. Paralyse	Paralyse				
2. [redacted]	2. [redacted]	1856. Aug. 21	" "	1. [redacted]	1. [redacted]	H. 1			
3. [redacted]	3. [redacted]	1857. Feb. 25	" "	1. [redacted]	1. [redacted]				
4. [redacted]	4. [redacted]	1853. Aug. 3	" "	1. [redacted]	1. [redacted]				
5. [redacted]	5. [redacted]	1848. Nov. 12	" "	2. Paralyse	Paralyse	H. 2			
6. [redacted]	6. [redacted]	1863. Aug. 7	" "	1. [redacted]	1. [redacted]	H. 1			
7. [redacted]	7. [redacted]	1858. Juni 29	19	1. [redacted]	1. [redacted]				
8. [redacted]	8. [redacted]	ca. 23. Sept. 40	" "	1. [redacted]	1. [redacted]				
9. [redacted]	9. [redacted]	1863. April 21	" "	3. [redacted]	3. [redacted]	H. 3			
10. [redacted]	10. [redacted]	1870. Dec. 7	" "	1. [redacted]	1. [redacted]				
11. [redacted]	11. [redacted]	1865. Dec. 22	" "	1. [redacted]	1. [redacted]				
12. [redacted]	12. [redacted]	1882. Nov. 14	5. Februar	4. [redacted]	4. [redacted]	H. 4			
13. [redacted]	13. [redacted]	1878. Aug. 5	" "	4. [redacted]	4. [redacted]				
14. [redacted]	14. [redacted]	1863. Dec. 12	" "	3. [redacted]	3. [redacted]	H. 3			
15. [redacted]	15. [redacted]	1875. Juli 19	3. März	3. [redacted]	3. [redacted]				
16. [redacted]	16. [redacted]	1851. Juni 17	" "	1. [redacted]	1. [redacted]	H. 1			
17. [redacted]	17. [redacted]	1867. März 1	" "	4. [redacted]	4. [redacted]				
18. [redacted]	18. [redacted]	1862. Okt. 29	" "	4. [redacted]	4. [redacted]				
19. [redacted]	19. [redacted]	1868. Jan. 31	16	2. [redacted]	2. [redacted]				
20. [redacted]	20. [redacted]	1854. Aug. 25	" "	3. [redacted]	3. [redacted]				
21. [redacted]	21. [redacted]	1854. Juli 19	" "	3. [redacted]	3. [redacted]				
22. [redacted]	22. [redacted]	1854. März 29	20	1. [redacted]	1. [redacted]				
23. [redacted]	23. [redacted]	1853. Jan. 29	" "	3. [redacted]	3. [redacted]				
24. [redacted]	24. [redacted]	1867. Jan. 18	30	3. [redacted]	3. [redacted]				
25. [redacted]	25. [redacted]	1879. Dec. 11	" "	3. [redacted]	3. [redacted]				
26. [redacted]	26. [redacted]	1862. Feb. 14	14 April	3. [redacted]	3. [redacted]				
27. [redacted]	27. [redacted]	1881. Juli 2	" "	3. [redacted]	3. [redacted]				
28. [redacted]	28. [redacted]	1875. Jan. 16	19. Mai	1. [redacted]	1. [redacted]				
29. [redacted]	29. [redacted]	1881. Dec. 29	" "	4. [redacted]	4. [redacted]				
30. [redacted]	30. [redacted]	1874. April 18	" "	3. [redacted]	3. [redacted]	H. 3			
31. [redacted]	31. [redacted]	1862. Juni 12	" "	1. [redacted]	1. [redacted]				
32. [redacted]	32. [redacted]	1878. Juli 18	" "	1. [redacted]	1. [redacted]	H. 1			
16 x 1. 4. 2. 76 3									
3 x 2. 1. 1. 3									
3 x 3. 1. 1. 3									
5 x 4. 1. 1. 4									

Figure 4: Original printed form with handwritten modifications.²⁷

Although the statistical table was resumed in its initial form in the 1920s, it never became as detailed as in the years between 1893 and 1908. The patients were individually listed with their names, but neither their ability to work nor a differentiation between statistical and psychological diagnoses was resumed. Even the causes of death were never again listed after the war.

4.3 The First Wave: Killing Sick Persons Through Starvation

From 1910 to 1914, a third enlargement of Langenhorn took place with the bed capacity increased to 2000. This enlargement was again justified due to overcrowding at Friedrichsberg and to the steady increase in the number of mentally ill persons needing admission, which was again blamed on the facility's proximity to the city.²⁸ At that time, the idea evolved that a third asylum should be built near Langenhorn. In a letter from 10 February 1910 to the mayor of Hamburg, Dr. Schröder, Neuberger cautioned against building "open houses." He warned that the type of sick people who must be "supervised more or less intensely or that are not fit for less secured housing accommodations" were estimated to make up the majority of the future patient population.²⁹ Neuberger further claimed that the planned new asylum should contain at least four pavilions, each one with thirty to thirty-five beds for class III patients who were mostly clerks and civil servants (*Büroangestellte*). These four pavilions, he wrote, should be divided into "two for males and two for females. On each side, one pavilion would be assigned to secure "*Pfleglinge*¹," those who required continuous care and were in need of monitoring, whereas each side of the II. hospital [Langenhorn] would accommodate the more harmless and sick persons eligible for a freer therapy."³⁰

As Neuberger's letter suggested, the grounds of Langenhorn were subdivided by a road with each side segregated by sex. Asylum construction was a technology of individualization and physical control, with the focus on the patient as an object of control rather than on having a disease amenable to therapy. One suspects that debates over restraint were not so much arguments between promoters of restraint and non-restraint but were more concerned with the mechanism (mechanical or architectural) best suited to the psychiatric practice of rationality.

¹ The German term "Pflegling" is difficult to translate into English. It is a term that is no longer in use in Germany. The term could approximately be translated as "care dependent sick person" but the German term implies a normative dimension because it reduces the care receiver to someone who will depend on care provided by others for his or her whole life. This term was only used in administrative records and in publications and thereby automatically connected to economic considerations, because someone who depends on care is an economic burden. In this study the translation 'care dependent sick person' is used as translation.

Debates in Hamburg over this issue were no different from other European countries.³¹ The desire for control and segregation was a central mechanism behind asylum construction; Langenhorn was a disciplinary space. However, architectural organization also expressed a distinct division of labour, since space within the asylum was distributed in accordance with a hierarchy of labour; volume and status overlapped to ensure that those who inhabited the higher echelons of the disciplinary apparatus obtained the largest amount of space. As sociologist Lindsay Prior has argued, “the greatest amount of space is assigned to the supervisors, less to the keepers, yet still less to the menial functionaries. It is an architecture of social hierarchy which echoes throughout the nineteenth and twentieth centuries, and serves to underpin the strict division of tasks which define modern medical practice.”³²

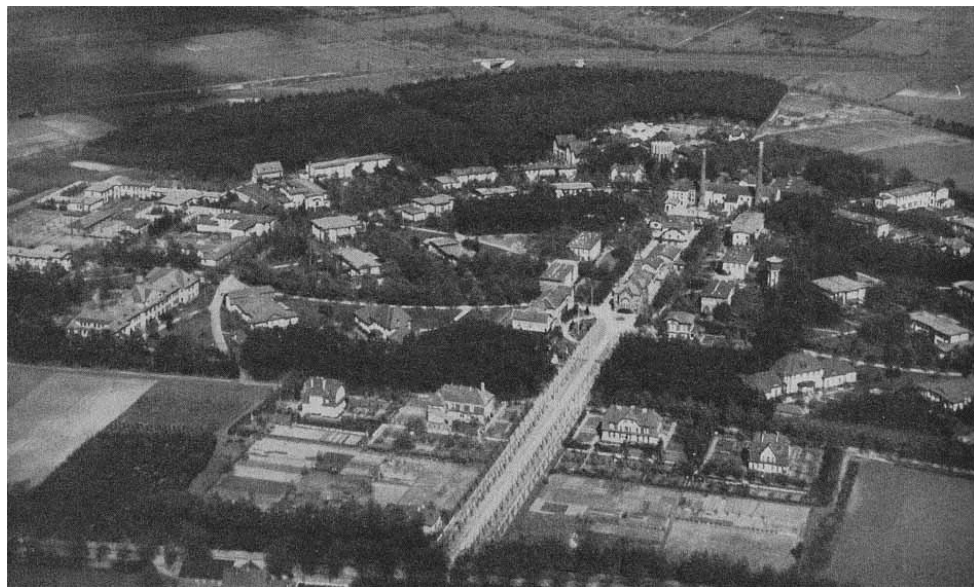


Figure 5: Aerial photography of Langenhorn around 1925.³³

The onset of the First World War prevented any expansion at Langenhorn, nor was a third asylum ever built. A 1913 tally of all people living and working in the asylum demonstrated that 10 psychiatrists, 34 clerks, 3 nurses, 341 guards (211 males and 130 females), and 181 supervisors, workers and mechanics attended to the needs of 1809 inmates.³⁴ This breakdown meant that each psychiatrist supervised approximately 180 inmates and each nurse approximately 603 inmates – though supported by 344 guards – which left each guard responsible for

approximately 5 inmates. According to this bed capacity, Langenhorn exceeded the size of Friedrichsberg.

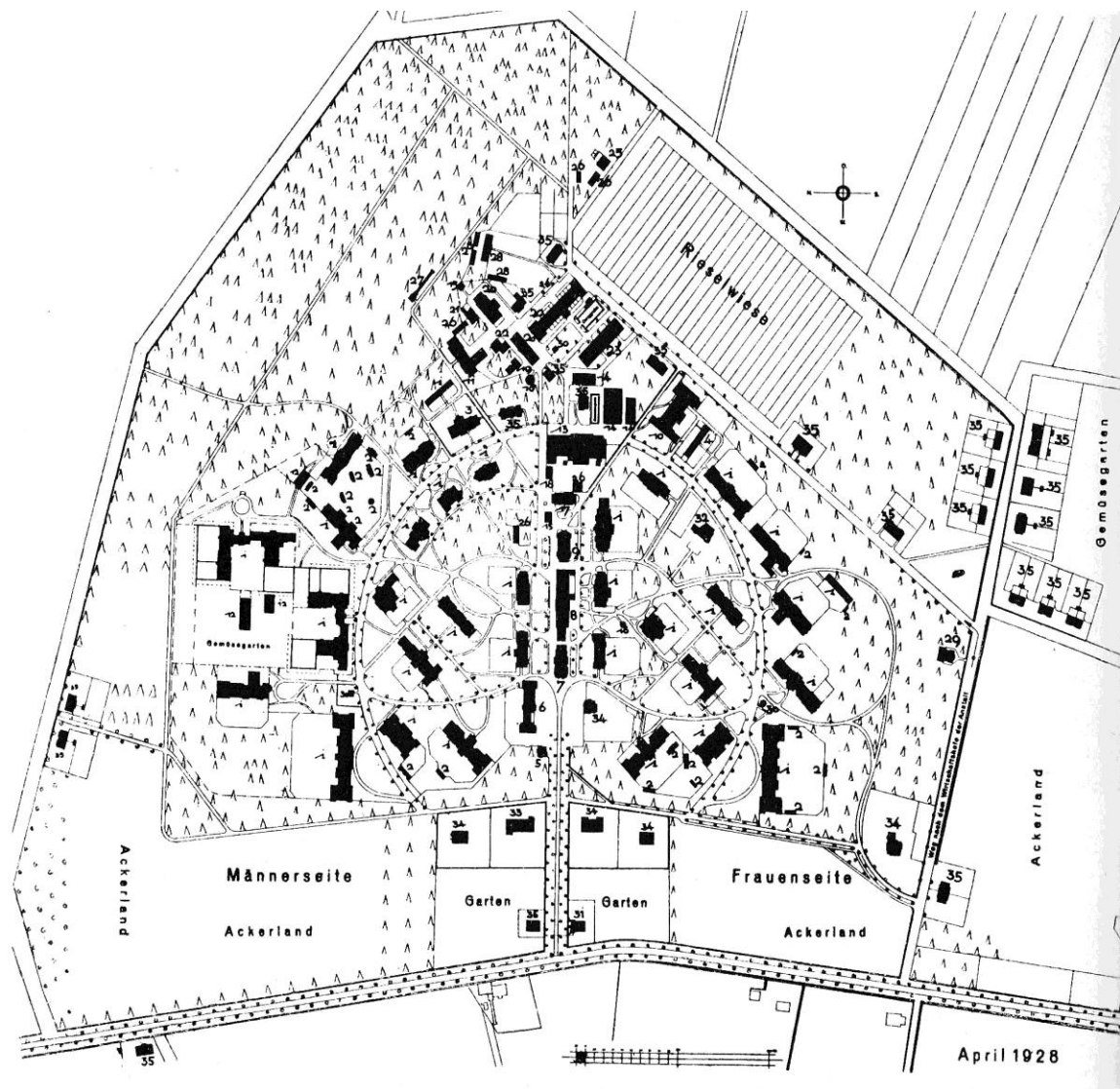


Figure 6: General plan of the asylum of Langenhorn, c.1925. Explanation: Left: men's side (*Männerseite*); Right: women's side (*Frauenseite*) 1) Houses for mentally ill patients, 2) Halls for tuberculosis treatment, 3) X-ray, 4) Nursing school, 5) Emergency room and pharmacy, 6) Administrative building, 7) house for social and religious events, 8) kitchen building, 9) warehouse, 10) laundry, 11) workshop, 12) houses for occupational therapy, 13) machine house, 14) coal storage, 15) well houses, 16) water towers, 17) bathhouse, 18) disinfection house, 19) workshop, 20) stables, 21) slaughterhouse, 22) cold storage house, 23) barn, 24) cart scale, 25) warehouse for agricultural machines, 26) warehouse, 27) bowling alley, 28) greenhouses, 29) morgue, 30) guard houses, 31) gatehouse, 32) residence of the medical director, 33) residence of the administrative director, 34) residences for senior physicians and ward physicians, 35) residences for civil servants and clerks.³⁵

During the First World War, many of the male personnel were called up to war service. At the end of 1914, 8 physicians and 282 civil servants and staff, including 179 guards and chief warders, had been drafted. Two years later most of the guards had gone. At this time, since almost 2000 patients were accommodated in Langenhorn, temporary staff was engaged and tradesmen took over the duties of the guards and nurses. Regardless of temporary staff hires, the quarterly report from October 1917 mentioned that no guards were available to monitor the secured houses.³⁶

With the beginning of the war in August 1914, all development had stopped at the Langenhorn asylum, and the proposed fourth enlargement was abandoned. At the outbreak of war, Langenhorn had more than 1800 patients but only 1300 remained at the end. Incomplete statistical records reveal the reason for this decline. Shortly before war broke out, approximately one hundred patients per year died in the asylum. This number nearly doubled in 1916 and nearly quintupled one year later.³⁷ The increasing mortality rate was the result of a catastrophic lack of supplies during wartime, which plagued Langenhorn as well as other asylums in the German Reich where hospitalized mentally ill patients became victims of a prolonged starvation.³⁸ In his function as the medical director of Langenhorn, Neuberger wrote a striking letter to Mayor Schröder on 5 June 1917 in which he pointed out that “we imposed such severe restrictions on the nutrition of sick persons and personnel that now we have achieved a limit beyond which we cannot go without considerable damage to the inmates of the asylum. The body weight of the patients has continuously and exceedingly diminished.”³⁹ Neuberger wrote his letter more than four years after the mass mortality began, and thus this protest seems comparatively gentle given the extent of the starvation in Langenhorn. Furthermore, quarterly reports from Langenhorn to the hospital council gave the impression that the mass deaths occurring in the asylum were not as alarming as believed. Neuberger had earlier written that

The general regulations regarding the reduction in food rations for the individual sick person, especially for men, have resulted in a more or less decrease in weight that is quite remarkable, nevertheless, one could not say

that this weight loss is, in general, especially considerable. It does not appear to be more than the weight loss that occurs in civilians living under the same conditions outside the asylum. We make sure that by cooking a combination of potatoes and cabbage, turnips or roots, along with the permitted amount of meat, that the sick persons at least receive a filling portion food at lunchtime ... Even though here and there some sick persons, especially those who were well known as big eaters, complain about too small portions, one has to emphasize that, in general, conditions due to the war are accounted for in an understanding manner and that even though the food rations are significantly reduced during war time, many patients are content.⁴⁰

Considering that in the first quarter of 1917 the death toll of patients who died from starvation exceeded that of the entire year of 1913, this letter makes a mockery of the conditions that they had to endure. Not wanting to alert the health authorities to this shocking phenomenon, Neuberger manipulated his statistics. Although he mentioned the increasing number of asylum deaths in the quarterly report of 14 April 1917, he compared the body count only from the first three months of the years spanning 1914 to 1917: thirty-two in 1914, twenty-seven in 1915; forty in 1916, and ninety-nine in 1917. These flawed reference points – especially since the mortality rate had already begun to increase in 1914 – played down the extent of starvation in Langenhorn. Even though the patient death rate was accelerating in 1917, in his 12 July quarterly report of that year Neuberger wrote that “recently the health status of the sick persons has become better. In an annual medical report that I received from the *Provinzial-Heil-und Pflegeanstalt Kreuzburg O.-S.* [another German asylum] I found a notice stating that the number of deaths in 1916 had doubled over 1915, due to the reduced food conditions. In Langenhorn, we counted 158 deaths and in 1916, we had [only] 208.”⁴¹

The increasing deaths of Langenhorn patients were further trivialized by comparing them to another asylum, which had nothing to do with Langenhorn. By referencing the degree of severity in this other asylum, the mass starvation of sick persons in Langenhorn appeared more moderate. In this situation as well, Neuberger used the years 1915 and 1916 as a comparison, withholding the fact that the number of deaths increased fivefold compared to 1913.

As previously highlighted, the manner in which the annual statistics were handled during wartime suggests that the reasons for the mass mortality rate were covered up. Recorded causes of death only add to this evidence. To a large extent, those who died of starvation were officially classified as dying from cardiac insufficiency. The striking increase in numbers of dead persons from this diagnosis occasioned the health authority (*Medizinalamt*) to ask officials at Langenhorn if this phenomenon could be explained by undernourishment. As they answered, “in such similar cases that can be conceived as due to undernourishment, we specified the cause of death as due to cardiac insufficiency.”⁴²

It is important to note that these strategies in dealing with the more or less intended assassinations of sick persons are exactly the same methods employed in a systematic manner during the Nazi regime. The asylums in Hamburg were inspected every year by the Commission for the Regulation of the Service for the Insane (*Kommission für das Irrenwesen*), which provided an annual report about the situation in Langenhorn. Each year the Commission had no complaints; the increasing number of deaths received no mention.⁴³ Furthermore, psychiatrists of the Weimar Republic appeared to agree on the results of starvation in German asylums from 1914 to 1918: “situations exist, in which the weal and woe of the stronger may override the right to live of the feeble,” was their response.⁴⁴ That these events had a decisive impact later is highlighted by the fact that the “Euthanasia planner” of the Nazi regime twenty years later referred to these incidents. Dr. Rautenberg, head of Hamburg’s main health authority (*Hauptgesundheitsamt*) under the Nazis, referred to these events during the legal proceedings against him regarding his involvement in euthanasia actions. “The first time I heard about euthanasia endeavours was at the end of the First World War, when the food situation became disastrous after the serious years of war while the asylums were full of mentally ill persons. At that time the question was raised – an unworthy life is an unnecessary eater.”⁴⁵

From 1914 to 1919 the number of inmates decreased in Langenhorn and Friederichsberg by approximately forty percent and thirty-five percent, respectively. Since only 1305 patients

remained in Langenhorn⁴⁶, the decrease in numbers enabled the first large conversion of psychiatric beds into space for the treatment of physical illnesses. The freed-up beds were used for the treatment of tuberculosis, and at this point, the asylum was renamed the Public Hospital Langenhorn (*Staatskrankenanstalt*). Using the asylum as a pulmonary sanatorium, however, lasted only twelve and a half years.

Not until the years 1927/28 did the occupancy rate regain the scale of the pre-war years with a total of 1846 psychiatric patients. Once again, talk developed in Hamburg about the overcrowding of public asylums. By 1925, two position papers from Langenhorn and Friedrichsberg had alerted the health authority that the situation in both hospitals had become unsustainable. Both of the medical directors at Langenhorn and Friedrichsberg argued that the number of patients forced not only quantitative changes in the asylums, but also qualitative changes due to an increase in the severity of mental illnesses observed. The number of surveillance rooms in Friedrichsberg exceeded the number of those offered in any other German asylum. According to the authors, the number of chronically ill patients had increased and developing therapeutic treatments, especially inoculation therapies, necessitated a more intensive observation of the patients. Underlying these complaints was the implicit suggestion that asylum space should be alleviated by transferring chronically ill patients to other facilities.⁴⁷ On 20 October 1926, Dr. Gerhard Schäfer, medical director of Langenhorn, proposed a modification of the penal code to allow for specific facilities that were half way between psychiatric asylums and prisons in order to accommodate especially those inmates deemed to have diminished capabilities. He named these institutions “inter-institutions” (*Zwischenanstalten*) ... [which did not necessarily need] to be accommodated in new construction. A portion of mentally inferiors ... resides in psychiatric asylums [but] a much larger segment can be found in prisons. I suggest designating and installing specific small prisons or independent parts of bigger prisons to be used exclusively as “inter-institutions.”⁴⁸

Schäfer's petition demonstrated that Hamburg's psychiatrists had begun very early on to differentiate between cases that should be kept in facilities with a more "prison like" character as opposed to those more like hospitals. This distinction enabled psychiatrists to transfer patients according to such criteria as their potential danger to society, their ability to work, and the chronic nature of their illness.

The health authorities adopted parts of this proposed strategy, but instead of constructing a third asylum in Hamburg, they decided to discharge patients deemed chronically ill from Langenhorn to a network of other asylums outside the city. The Lippischen Heilanstalt Lindenhaus, for example, agreed to accommodate sixty to sixty-five patients, and the city of Lübeck received budgetary funds to build houses in Heilanstalt Strecknitz, which would accommodate 400 psychiatric patients from Hamburg.⁴⁹

Psychiatrists determined clear criteria that dictated the kind of patients to be transferred to these external facilities. Langenhorn's medical director highlighted the reasoning behind the transfers in a letter initiated by a father's complaint to the health authority of Hamburg over his daughter's transfer to Strecknitz and his subsequent request to relocate her back to Langenhorn. To explain his actions, the medical director wrote that

The pat.[patient] was treated here [in Langenhorn] for schizophrenia from 2.8.1930 to 26.8.1937 and then transferred to Strecknitz/Lübeck. With short interruptions, this sick person has demonstrated throughout the years a completely catatonic disorder often accompanied by severe agitation, which was the reason why she had to be kept in an isolation room most of the time. The mother of the sick person was treated here for a long time for the same condition and was then discharged as reformed. Because we have had numerous referrals from Friedrichsberg, room had to be made and therefore even patients with good family support have to be transferred. Sick persons who rarely receive visits or no visits at all were already transferred long ago.⁵⁰

This short excerpt demonstrates that the criteria for the transfers to Strecknitz were the same as those employed by the Nazi administration during "Aktion T4." One criterion for transfer depended on the chronic nature of the illness, with the assumption that patients were incurable and needed extended care. This distinction between "hopeless" and curable cases was an integral

part of psychiatric practice, including that at Langenhorn. In 1931, a specific department with 400 beds was established there to accommodate “care dependent” sick persons. This department required lower hospital and nursing charges and alleviated other overcrowded welfare institutions in Hamburg by admitting their patients as well. Another criterion was the frequency of visits to a patient. The fact that sick persons who did not receive any visits were already transferred long ago illuminates a routine procedure that had existed for years, and therefore was not invented by the Nazis.

During this period, many facilities for the mentally ill were involved in transferring hundreds of patients to other facilities. The manner in which these transports were organized foreshadows the way transfers took place during the Nazi regime. For example, Langenhorn received a group of displaced patients from Farmsen, a welfare institution. When the medical director complained about the condition in which some of these patients arrived, Farmsen’s director replied that

During the quick transfer of 230 inmates from Farmsen to Langenhorn, Farmsen was in a difficult situation. The inmates wanted to stay in their familiar environment and expressed their aversion by protest actions, states of excitation, and attempts to escape. Therefore, it was necessary to smoothly evacuate the number of inmates requested by Langenhorn ... Even in the male group, a certain number were informed at the last minute about their transfer and therefore could not accordingly be treated ... In order to relieve their anxiety, inmates suffering from a disease that drove them to collect things were allowed to collect and keep their so-called property.⁵¹

I suggest that this evidence conflicts with earlier research that assumed large patient transfers took place only after the closure of Friedrichsberg in 1934.⁵² Furthermore, it clearly highlights the fact that these transfers, a strategy adopted by the Nazi administration, were more or less hidden from patients and their families as early as 1932. Long before the Nazis came to power a sophisticated selection system was already in place in Hamburg. From early on, a hierarchical system of institutions had enabled the dispersion of psychiatric patients according to their perceived prospects for cure, their tendency to become dangerous, and their ability to work,

etc – an organizational structure that was further developed and refined in the years to come. Since only Friedrichsberg undertook any therapeutic treatment, only patients believed curable remained there. Patients considered incurable were sent to Langenhorn, and if considered a hopeless case, were kept in the care-dependent department or further transferred to external facilities.

However, the transfer process initiated great controversy around who held responsibility for deciding which patients were to be admitted to asylums. In order to reduce the numbers of admissions in general, a welfare administration attempted to enforce a stricter admission procedure under the guidance of a medical officer in the years 1931 and 1932. This procedure was called “combing out,” (*Auskämmen*),⁵³ a method decisively rejected by the then medical director of Friedrichsberg, Prof. Dr. Wilhelm Weygandt. He especially protested against the idea that medical officers and the police should decide whether or not patients were a proven danger to public safety, a precondition for compulsory admission. According to Weygandt, only the psychiatrist in the asylum was able to detect the patient’s delirium and it was only within the asylum that the mentally ill person would display all of the symptoms to help determine his or her level of danger to public safety. He argued that the current approach to proving the danger of patients prior to their admission had resulted in serious consequences and casualties: “One lunatic whose admission was delayed because his danger to the public had yet to be proven, indeed proved his danger by assassinating his family.”⁵⁴

Although he believed that all mentally ill persons were potentially dangerous, Weygandt nevertheless maintained that only the psychiatrist was able to make this determination. He also rejected the idea that asylum administrators should encourage families of mentally ill persons to support their “harmless” maniac members as long as possible in order to reduce the stress on the asylums, stating that next of kin, as “inferiors,” were unable to estimate the real magnitude of the illness. “The idea of influencing the next of kin to keep the harmless sick person in the family means to act in a medically irresponsible manner. Most of the family members are wrongly

convinced of the harmlessness of their patient family member and one has to continuously convince them not to take them carelessly out of the asylum.”⁵⁵

The medical director of Friedrichsberg advocated for the central position of the psychiatrist within the welfare system. In 1923, he had already complained in a letter to the health authority about “sweetheart reports” issued by general practitioners who wanted to preserve the right to admit to the asylum, and affirmed that these medical officers did not have the appropriate knowledge to make these kinds of decisions.⁵⁶ However, the regulations of the “Ordinance concerning the Regulation of the Service for the Insane” from 1900 remained in effect. Mentally ill persons who became disruptive could be admitted directly to an asylum by the police and the police then had to initiate a subsequent examination by a medical officer to approve the admission.

The controversy about the legal responsibility for admission to an asylum and the duration of hospitalization was once again taken up in 1934 because of a specific case about a compulsory admission to Friedrichsberg. The debate centred on whether or not patients needed a legal designation of incapacitation before being admitted to the asylum, with the implication that they could be automatically discharged, thus bypassing the need for the decision of a medical expert, if this judgment was overruled. As described earlier, this same controversy had taken place around the year 1906, and, as had been feared before, the medical director perceived that this legal requirement would infringe on the right of psychiatrists to decide what was best for their patients irrespective of their legal status. “The question of whether a sick person can be discharged from the asylum is in many cases a question of subjective estimation – a so-called relative indication...Only the expert physician is able to decide; he can demand that the necessary confidence is given to him.”⁵⁷

However, psychiatric claim to authority over admissions and discharges was finally legalized on 21 February 1934, when the Nazi administration modified the previous ordinance by

eliminating the commitment that every admission had to be reviewed by a medical officer. In the end, the psychiatrists had achieved their goal.

Historian and philosopher Robert Castel has analysed this long-lasting dispute, ostensibly about the development of psychiatry as a “political science,” for France. He argued that this kind of power

constituted an assault upon the principle of the separation of powers. There was no longer, on one side, the administration, the transmission belt of the executive power and guardian of public order, and on the other, the magistracy, the guarantor of liberties because it possessed a monopoly of the decisions that could suspend that guarantee. A third power, the medical one, was legitimized and ensured a new balance between the two others. The sacredness of the principles of law gave way before the practical rationality that was presented by expertise.⁵⁸

Nonetheless, at a meeting of 29 April 1932 attended by all medical and administrative directors of Hamburg’s psychiatric asylums, Hamburg’s medical officer, and the senator of the health authority, administrative director Kressin, emphasized that admissions to Hamburg’s asylums had diminished continuously. In 1929, 2653 people had been admitted to the asylums while 2543 had been discharged or died in the same period, giving in absolute numbers an increase of only 110 persons. Over the next two years, the total number of admissions declined over each previous year’s admissions by 232 in 1930 and by 513 in 1931. Furthermore, in 1931, *the discharges and deaths outnumbered the admissions by approximately 65 persons.*⁵⁹

Years	Discharges (absolute numbers)	Percent (discharges compared to admissions)	Cases of death (absolute numbers)	Percent (cases of death compared to admissions)
1929	2229	84%	314	11.9%
1930	2155	89%	320	13.3%
1931	1702	90%	254	13.4%

Table 2: Statistical calculation of admissions, discharges, and cases of death presented by administrative director Kressin, April 1932.⁶⁰

These percentages are suggestive, especially when viewed against the backdrop of the events during and after the First World War. As the number of admissions had decreased, the percentage rate of discharges had increased, and more importantly, the percentage of deaths was also rising in the same time period. Nevertheless, in the same meeting, medical officer Dr. Holm suggested that it might be possible, by further “combing out” less serious cases, to shut down one asylum. This idea was realized a few years later. It was also emphasized that Langenhorn had generated a financial surplus of 5% in 1931.

4.4 Langenhorn, 1933 to 1939

The years after the takeover of the Nazi regime were characterized by a dramatic increase in the number of psychiatric beds crammed into the same asylum space. Two events aggravated the situation for Langenhorn: the closure of Friedrichsberg and the revision of the Greater Hamburg Act (*Groß-Hamburg-Gesetz*).

4.4.1 *The closure of Friedrichsberg*

In 1934/35, the psychiatric asylum of Friedrichsberg was closed down, a decision based on economic grounds. Patients were to be distributed among Langenhorn, Strecknitz, and a new asylum to be built, the Clinic for Psychiatric and Nervous Diseases at Eppendorf (*Psychiatrische und Nervenlinik Eppendorf*). In Langenhorn, a hutment [a kind of barracks] was to be erected to accommodate the transferred patients from Friedrichsberg. Most historians have emphasized the economic dimension of the so-called Friedrichsberg-Langenhorn Plan,⁶¹ but there is another interesting aspect to this restructuring of Hamburg’s asylums. On 7 October 1934, the Provincial State Government of Hamburg had declared that

curable sick persons shall be provided with the utmost medical care.
Incurable sick persons shall be kept in custody and their medical support should be reduced to a justifiable minimum. Physicians will not engage with this group inside the framework of the proposed university hospital, nor should these patients be used for scientific research since that will increase the cost of their care.⁶²

At this time, the Nazi administration officially legalized the already established practice of selectively sorting patients into different categories. Fourteen days later, the Provincial State Government decided to reduce the number of patients in Langenhorn in order to economize on the planned barracks. The result of this restructuring was that Langenhorn was described even by the Senator of Health, Martin Ofterdinger, as a “madhouse,” since the most severe cases were transferred there.⁶³

4.4.2 *Hamburg’s medical fraternity board and the question of sterilization*

On 8 March 1933 the Nazi Senate in Hamburg was legally established, a change of power that had significant consequences for Hamburg’s health policy and especially for the inmates in the asylums. As already mentioned, the “Ordinance concerning the Regulation of the Service for the Insane” was modified in 1934. A year before this event, the Federal Government in Berlin had adopted two fundamental laws: the “Law for the Prevention of Genetically Diseased Offspring” (*Gesetz zur Verhütung erbkranken Nachwuchses*) or the “Sterilization Law” (14 July 1933) and the “Law against Dangerous Habitual Criminals and their Restriction Order” (*Gesetz gegen gefährliche Gewohnheitsverbrecher und über Maßregeln der Sicherung und Besserung*) (24 November 1933). The former became effective at the beginning of January 1934; the latter had been in place since November 1933. Both laws were connected through their concern with genetics and the certain assumption that criminality was genetically determined.

Hamburg’s medical fraternity broadly supported the sterilization law of July 1933.⁶⁴ Even ten years prior to the Nazi takeover of power and the enactment of this law, Hamburg’s health authority had distributed a questionnaire to all asylums, nursing homes, and schools for mentally or physically handicapped children in the city. The goal of the questionnaire was to assess the thinking about sterilizing specific residents in these institutions. Among other things, it asked if sterilization based on eugenic considerations was already taking place and tried to elicit public opinion on this issue. Friedrichsberg denied that people were already sterilized in Hamburg but, at the same time, gave a differentiated list of those people whom the medical directors had already

sterilized: “15 epileptics, 30 feeble minded, 5 idiots.”⁶⁵ After the law was passed, Schäfer, Langenhorn’s medical director, provided detailed instructions on how to overcome resistance against sterilization from both mentally ill people and their family members.⁶⁶

4.4.3 *The revision of the Greater-Hamburg Act*

Through the revision of the Greater Hamburg Act (*Gross-Hamburg-Gesetz*), densely populated town areas became part of the administrative district of Hamburg and thus Langenhorn came within the district’s catchment area. Two other asylums in cities near Hamburg, Lüneburg, and Neustadt also became part of the district. All three institutions played an important role as intermediate asylums during the time of the “euthanasia” action under the Nazi regime. Langenhorn was renamed a Treatment and Nursing facility (*Heil-und Pflegeanstalt*) in 1938, belying its future use.

4.5 Langenhorn, 1939 to 1945

From 1939 on, Langenhorn became the interim “storage facility” for all Jewish patients in Schleswig-Holstein and Hamburg and the starting point of their deportation elsewhere. Although a so-called children’s special ward (*Kinderfachabteilung*) was established during these years, the asylum otherwise functioned as an admission, interim, and distribution institution from which inmates were transported to various other asylums. Although the number of beds in Langenhorn was reduced by half in these years, the number of treatments was reduced only by approximately a third, meaning that more patients were cycling through the same number of beds.⁶⁷ The number of admissions and discharges for the year 1944 resembled those from 1931; at this time, when Langenhorn had 1220 beds available, 1321 patients were admitted, with 1147 being discharged or transferred and 497 dying. Despite the high number of admissions, the occupancy rate decreased.⁶⁸ Nor were the nurses outnumbered: an estimated nurse to patient ration in the years 1944/45 is 1 to 3.7.⁶⁹ According to the statistical analysis of medical historian Michael Wunder, transports of patients were put together during the war years and sent off; the

table below (Table 3) compares the absolute number of transports in relation to the number of treatments to derive the deportation rate.

Year	deported pat.
1939*	04.72%
1940	05.50%
1941	33.39%
1942	11.75%
1943	33.55%
1944	12.67%
1945**	01.97%

Table 3: Deportation from Langenhorn 1 September 1939* to May 1945**⁷⁰

The heyday years of deportation were 1941 and 1943. Under Aktion T4, in 1941 the central medical commission required a report sheet on “euthanasia” (*Meldebogen-Euthanasie*) from every asylum within the German Reich. That deportations were taking place before the required use of the report sheet strengthens the evidence that selections and transports were already part of the practice at Langenhorn long before the Nazi regime. For example, all of the Jewish patients were deported and killed in 1940. As could be expected, the evacuation rate declined in 1942 because at this time the central office in Berlin was reorganized and the Aktion T4 was terminated. However, because the year 1943 in Hamburg was characterized not only by nights of bombings but also by the process of changing the largest number of psychiatric beds into acute care treatment beds in Langenhorn, the deportations continued and even intensified. As Wunder has demonstrated in his research, selections and transfers of patients were integrated into Langenhorn’s everyday routine.

The total number of patients transferred from Hamburg during these years amounted to 4600. Only two transports took place in the city without the involvement of Langenhorn, and thus, the total number of transferred patients from Langenhorn was 3848. However, even though a large number of patients were transferred elsewhere, the death rate in Langenhorn alone remained astonishingly high. If the number of treatments is related to the absolute number of deaths, the following mortality rates evolve.⁷¹

Year	Deaths
1939	05.73%
1940	05.79%
1941	07.56%
1942	12.49%
1943	10.36%
1944	17.74%
1945	20.53%

Table 4: Mortality rates in Langenhorn between 1939 and 1945.⁷²

At the 1960s' war crimes tribunal in Hamburg, the Polish court-appointed expert Jozef Radzicki issued a report for the prosecution in which he assumed that an annual mortality rate of 4 percent in the asylums during the pre-war years was considered normal. An increase of mortality to 8 percent could be perceived as average to normal during wartime itself. Any mortality rate beyond this limit must be evaluated as intentionally caused and precipitated.⁷³ Based on the above calculations, the annual mortality rates from 1942 onward were above 10 percent and as such, could be considered abnormal. However, if the mortality rate was already elevated in the interwar years, as I have suggested, then the scope of these crimes seems even larger, because the calculation base of Radzicki's report was already biased. This suspicion is also supported by the research of historians Ingo Harms and Heinz Faulstich.⁷⁴

Evidence also exists to support the contention that the killing of sick persons continued in Langenhorn after the end of the Second World War, even though no exact number of treatments exists from 1946 on. Asylum statistics reveal that 553 patients died in 1946 and 371 in 1947, indicating that many deaths continued after the end of the war.⁷⁵

4.6 The Role of Nurses in Selecting Patients for Transfer

Nurses, especially head nurses (*Oberpfleger*), played an important role in selecting patients for transfer. They compiled the proposed lists that were then countersigned by the psychiatrists, a procedure verified by the comments given after the war by surviving patient “W.” He also believed that nurses chose patients that “they wanted to get rid of.”⁷⁶ Dr. Saupe, senior physician in Langenhorn during the Nazi regime, described the selection process in his testimony at the tribunal as follows: “It is not that the most severe cases were transferred outward. On the contrary, only those patients who were physically healthy enough to withstand the transports, and patients whose next of kin did not live in the immediate proximity, were selected; bedridden patients were not at all transferred outward.”⁷⁷ Nurse Heinrich Roßburg also testified in 1946 that nurses had their own criteria for selecting patients for different places. “The selection of the patients was done by the head nurses and the physicians examined the cases. The head nurses naturally attached great weight to the fact that the so-called good worker, whom we could use here, preferably stayed here.” This procedure was further confirmed by the testimony of Dr. Knigge, medical director of Langenhorn during the Second World War, in his 1946 defence. If a transport was planned, the “hospital administration compiled a list of patients hand in hand with the head nurses and the superintendents.”⁷⁸

Because financial reasons often dictated that asylum personnel carry out the transportation of patients themselves, numerous nurses therefore came in contact with “euthanasia” facilities. This is especially true for the transfers to the killing facility at Meseritz-Obrwalde. As one nurse reported, “we drove our sick persons in a car to the Meseritz asylum. There, they went into a house and were distributed to different wards. We delivered the medical and administrative records to the administration as well as the patients’ valuables and other belongings. Afterwards, we drove back.”⁷⁹ Another nurse reported that “I participated two or three times in transports of mentally ill patients to Meseritz ... Indeed, we never stayed long in Meseritz, but rather drove back again shortly after. Nevertheless, here and there I occasionally

spoke to former patients.”⁸⁰ Likewise, nurse Sch. reported that she saw “in Meseritz a few familiar faces that were with us for a long time in House 9 and who were criminal patients. They were on the loose there.”⁸¹

In their testimonies, all of the nurses denied that they knew patients were murdered at Meseritz, although the patients themselves knew very early on what really happened there. Letters written by family members before or after the death of their sons or daughters suggest that their loved ones knew what was going on. During his admission to the academic medical centre at Eppendorf, Fritz Niemand, a patient who survived Meseritz, reported that he had already heard from other patients what the transfer to Langenhorn and the selections made there signified. In Langenhorn the patients lived in continuous fear of being transferred. Numerous testimonies of patients during the trials after 1945 proved that the events in asylums like Meseritz were understood by all inmates and visitors, and this knowledge could not be suppressed.

I want to stop the listing here because the aim of this study is not so much to demonstrate that the nurses were conscious of what they were doing, even though they probably were. As repeatedly stressed throughout the previous chapters, this study is more interested in considering the mechanisms that made the assassination of sick persons possible. The next two chapters attempt empirically to trace the complex interplay among the technologies, the nurses, psychiatrists, and administrators, which enabled these bureaucratically administered killings. As already mentioned in the last chapter, the study therefore concentrates on one patient record and traces the suffering of Anna Maria B., which began in 1931 at the age of 18 with her first admission to the asylum of Friedrichsberg.

¹ Klaus Böhme, ed., *1893-1993 100 Jahre Allgemeines Krankenhaus Ochsenzoll* (Hamburg: Sozialtherapiezentrum des AK Ochsenzoll, 1993), 8.

² Ibid., 10.

³ Michael Wunder, *Euthanasie in den letzten Kriegsjahren. Die Jahre 1944 und 1945 in der Heil- und Pflegeanstalt Hamburg Langenhorn* (Husum: Matthiesen, 1992), 36.

⁴ Ibid., 36.

⁵ Böhme, *1893-1993 100 Jahre Allgemeines Krankenhaus Ochsenzoll*, 15.

⁶ Gerhard Schäfer and Rudolf Birkenstock, "Staatskrankenanstalt Langenhorn," in *Hygiene und soziale Hygiene in Hamburg. Zur neunzigsten Versammlung der deutschen Naturforscher und Ärzte in Hamburg im Jahre 1928*, ed. Gesundheitsbehörde Hamburg (Hamburg: Paul Hartung Verlag, 1928), 202.

⁷ Böhme, *1893-1993 100 Jahre Allgemeines Krankenhaus Ochsenzoll*, 16.

⁸ Theodor Dr Neuberger, "Die Irrenanstalt Langenhorn," in *Deutsche Heil- und Pflegeanstalten für psychisch Kranke in Wort und Bild*, ed. Johannes Bresler (Halle: Marhold, 1910), 311.

⁹ Ibid., 313.

¹⁰ Böhme, *1893-1993 100 Jahre Allgemeines Krankenhaus Ochsenzoll*, 19; Wunder, *Euthanasie in den letzten Kriegsjahren*, 37.

¹¹ In the years to come, so-called criminal mentally ill patients became the excuse to tighten legal regulations. Housing "criminals" on the asylum grounds gave the impression that every mentally ill person could potentially become criminal (or violent at least), and each attempt at reform was rejected by various medical directors who referred to the potentially violent consequences that might ensue. This indirect link between "insanity" and "criminality" was employed especially if the medical directors perceived that their "all-embracing" power would be reduced. Long-lasting conflicts took place, for example, around the question of whether the medical director of the asylum or the police and justice system should decide on the compulsory hospitalisation of mentally ill persons.

¹² *Amtsblatt*, Public Law 152 (1904): 915.

¹³ Staatsarchiv HH 352-8-7 Staatskrankenanstalt Langenhorn 147 (hereafter StArch, Langenhorn Administrational Record LAR 147). Neuberger, 1906, position paper to Senate of Health [n.d., n.p.].

¹⁴ Ibid. "Within an asylum there are a certain number of people who are chronically or periodically agitated and due to their short-tempered disposition or their pathological restlessness they tend to complain without cause. Writing maniacs submit claims without any reason, again and again, simply because they have the right to complain. Lunatics or troublemakers set everything in motion to be discharged although they are clearly suffering from an underlying mental disorder. From a medical point of view, these mentally ill persons cannot always be allowed to leave the asylum, because we fear that they would encounter perils and disadvantages, or because a premature discharge would halt the healing process. If these persons personally approach the physician for a discharge, the physician might reasonably be able to influence them

by talking to them. In most cases, he usually succeeds in comforting them and alleviating the bad mood and resignation brought on by the rejected discharge. In comparison, notifying the commission for the service of the insane of the rejected complaint considerably affects the peace of the sick person, as experience has demonstrated.”

¹⁵ Ibid.

¹⁶ Staatsarchiv HH 352-3 Medizinalkollegium II L 1d Bd 1, p. 80-94 (hereafter StArch, Medical Council MC II L 1d Bd 1). Neuberger, position paper regarding the planned modification of the “Ordinance concerning the Regulation of Service for the Insane.”

¹⁷ Ibid., 97.

¹⁸ Ibid., 97-98, emphasis mine.

¹⁹ Dr. Kankleit, "Was kosten die Minderwertigen den Staat," *Hamburger Anzeiger*, (21 December 1925): 10.

²⁰ Michel Foucault, *Les Anormaux. Cours au Collège de France. 1974-1975*, eds. François Ewald et al (France: Seuil/Gallimard, 1999).

²¹ Kankleit, *Was kosten die Minderwertigen den Staat*, 10.

²² Foucault, *Abnormal. Lectures at the Collège de France 1974-1975*, eds. Arnold I. Davidson et al, trans. Graham Burchell (USA: Picador, 2003), 316; Foucault, *Les Anormaux*, 298.

²³ Foucault, *Abnormal*, 316-317; Foucault, *Les Anormaux*, 299.

²⁴ Foucault, *Abnormal*, 317; Foucault, *Les Anormaux*, 299.

²⁵ Staatsarchiv HH 352-8-7 Staatskrankenanstalt Langenhorn 139 (hereafter StArch LAR 139).

²⁶ This “compression” of data into a minimum of signs is a form of “action on the action of others” because, through the single figure, very complex contexts become manageable. Peter Miller, "Accounting as Social and Institutional Practice: An Introduction," in *Accounting as Social and Institutional Practice*, eds. Anthony G. Hopwood and Peter Miller (Cambridge: Cambridge University Press, 1994), 1-39; Jürgen Link, *Versuch über den Normalismus. Wie Normalität produziert wird* (Göttingen: Vandenhoeck und Ruprecht, 2006); Nikolas Rose, "Numbers," in *Powers of Freedom. Reframing Political Thought*, ed. Nikolas Rose (Cambridge: Cambridge University Press, 2005), 197-232.

²⁷ StArch LAR 139.

²⁸ Wunder, *Euthanasie in den letzten Kriegsjahren*, 37.

²⁹ Staatsarchiv HH 352-8-7 Staatskrankenanstalt Langenhorn 8 (hereafter StArch LAR 8). Letter from Dr. Neuberger to Dr. Schröder, 10 February 1910 [n.p.].

³⁰ Ibid.

³¹ Lindsay Prior, "The Architecture of the Hospital: A Study of Spatial Organization and Medical Knowledge," *The British Journal of Sociology* 39, no. 1 (Mar., 1988): 86-113.

³² Ibid., 106.

³³ Schäfer and Birkenstock, *Staatskrankenanstalt Langenhorn*, 200.

³⁴ StArch LAR 139 [n.p.], Tally of all people living and working in the asylum from the year 1913.

³⁵ Ibid., 208.

³⁶ Staatsarchiv HH 352-8-7 Staatskrankenanstalt Langenhorn 16a (hereafter StArch LAR 16a). Quarterly Report from Oct. 1917 [n.p.].

³⁷ StArch LAR 16a [n.p.], Annual Reports of the years 1916 and 1917. See also: Klaus Böhme and Uwe Lohalm, eds., *Wege in den Tod. Hamburgs Anstalt Langenhorn und die Euthanasie in der Zeit des Nationalsozialismus*, Forum Zeitgeschichte ed., Vol. 2 (Cloppenburg: Ergebnisse Verlag, 1993); Böhme, *1893-1993 100 Jahre Allgemeines Krankenhaus Ochsenzoll*.

³⁸ Böhme, *1893-1993 100 Jahre Allgemeines Krankenhaus Ochsenzoll*.

³⁹ Neuberger as cited in Böhme and Lohalm, *Wege in den Tod*, 28.

⁴⁰ StArch LAR 16a [n.p.]. Letter from Neuberger to the health authority, 24 January 1917.

⁴¹ Ibid.

⁴² Staatsarchiv HH 352-8-7 Staatskrankenanstalt Langenhorn 110 (hereafter: StArch LAR 110) [n.p.]. Letter from the administration of Langenhorn to the health authority, no signature, 1916.

⁴³ Staatsarchiv HH 352-8-7 Staatskrankenanstalt Langenhorn 17 (hereafter: StArch LAR 17) Annual reports of the Commission for the Regulation of the Service for the Insane, n.p.

⁴⁴ Wunder, *Euthanasie in den letzten Kriegsjahren*, 38.

⁴⁵ Böhme and Lohalm, *Wege in den Tod*, 29.

⁴⁶ Böhme, *1893-1993 100 Jahre Allgemeines Krankenhaus Ochsenzoll*, 24.

⁴⁷ Staatsarchiv HH 352-8-7, Staatskrankenanstalt Langenhorn 9 (hereafter StArch LAR 9), Copies of the position papers, one entitled "Memorandum regarding the Development of Care for lunatics in Hamburg," Langenhorn, 12 January 1925 and the other, "Memorandum regarding the Development of the Provision of Care for Lunatics in Hamburg," Friedrichsberg, 24 August 1925, [n.p.].

⁴⁸ Staatsarchiv HH 352-8-7, Staatskrankenanstalt Langenhorn 12 (hereafter: StArch LAR 12), Position paper of Dr. Schäfer regarding the "Intended Reorganization of Hospital Order Treatment (Penal Code)," 20 October 1926, [n.p.].

⁴⁹ Peter Delius, *Das Ende von Strecknitz: die Lübecker Heilanstalt und ihre Auflösung 1941: ein Beitrag zur Sozialgeschichte der Psychiatrie im Nationalsozialismus* (Kiel: Malik-Verlag, 1988).

⁵⁰ Staatsarchiv HH 352-3, Medizinalkollegium II L1d Bd.2 (hereafter: StArch MC II L1d Bd 2), 52, Letter from Langenhorn to the health authority of Hamburg regarding a complaint of a husband of a former patient of Langenhorn, 24 November 1937.

⁵¹ Staatsarchiv HH 352-8-7, Staatskrankenanstalt Langenhorn 15 (hereafter StArch LAR 15) Memo in order to prepare for a meeting of the medical and administrative directors of Hamburg's asylums and nursing homes with the senator of health, 16 March 1932, n.p., no signature.

⁵² Michael Wunder, "Die Auflösung von Friedrichsberg - Hintergründe und Folgen," *Hamburger Ärzteblatt* 44 (1990): 128-131.

⁵³ StArch AR 15, Minute of the meeting of the medical and administrative directors of Hamburg's asylums and nursing homes with the Senate of Health, 29 April 1932, n.p.

⁵⁴ StArch AR 15, Position paper to the health authority, 2 April 1932, n.p.

⁵⁵ Ibid.

⁵⁶ Staatsarchiv HH 352-3, Medizinalkollegium II L5 Bd.3 (hereafter StArch MC II L5 Bd.3), Letter from Weygandt to the health authority, only specification of the year 1923, n.p.

⁵⁷ Staatsarchiv HH 352-3, Medizinalkollegium II L1d Bd.2 (hereafter StArch MC II L 1d Bd.2), 42-43. Position paper of the medical director Prof. Dr. Rittershaus to the president of the health administration regarding the complaints of a former patient, 26 September 1934.

⁵⁸ Castel, *The Regulation of Madness: The Origins of Incarceration in France* (Great Britain: University of California Press, 1988), 189.

⁵⁹ StArch LAR 15 [emphasis mine], Minute of a meeting of 29 April 1932 attended by all medical and administrative directors of Hamburg's psychiatric asylums, Hamburg's medical officer, and the senator of the health authority.

⁶⁰ Ibid.

⁶¹ Wunder, *Die Auflösung von Friedrichsberg - Hintergründe und Folgen*: 128-131; Wunder, *Euthanasie in den letzten Kriegsjahren*; Böhme and Lohalm, *Wege in den Tod*; Böhme, *1893-1993 100 Jahre Allgemeines Krankenhaus Ochsenzoll*; Angelika Ebbinghaus, Heidrun Kaupen-Haas and Karl Heinz Roth, *Heilen und Vernichten im Mustergau Hamburg. Bevölkerungspolitik im Dritten Reich* (Hamburg: Konkret Literatur Verlag, 1984).

⁶² Staatsarchiv HH Hochschulwesen II, Gb 11, Bd. 1, p. 4, Declaration of the Provincial State Government of Hamburg, 7 October 1934.

⁶³ Staatsarchiv HH Hochschulwesen II, Gb 11, Bd. 1, p. 12, Position paper by senator of health Osterdinger, December 1934 [no exact date].

⁶⁴ Böhme and Lohalm, *Wege in den Tod*.

⁶⁵ StArch MC II L5 Bd.3, questionnaire mailed to all asylums, schools, education institutions, nursing homes, etc. by the health administration of Hamburg, 1924.

⁶⁶ Gerhard Schäfer, "Über einige Aufgaben des Arztes bei der Durchführung des Gesetzes zur Verhütung erbkranken Nachwuchses," *Ärzteblatt für Hamburg und Schleswig Holstein* 1, no. 15 (1934): 136-137.

⁶⁷ Wunder, *Euthanasie in den letzten Kriegsjahren*. The idea of "treatments" is being used in much the same way that we would use the number of hospital days.

⁶⁸ Ibid., 45.

⁶⁹ Ibid., 46.

⁷⁰ Ibid., 47.

⁷¹ Ibid., 47.

⁷² Ibid., 48.

⁷³ Staatsanwaltschaft HH Az. 147 Js 58/67, Bl. 3315-3419.

⁷⁴ Ingo Harms, "Krankenmord in der Heil- und Pflegeanstalt Wehenen - Forschungsprobleme," in *Berichte des Arbeitskreises zur Erforschung der nationalsozialistischen "Euthanasie" und Zwangssterilisation*,

Tagungsband Wehnen, Herbst 2009 (Münster: Klemm und Oelschläger, 2011, in print); Harms, 'Wat mööt wi hier smachten...' *Hungertod und "Euthanasie" in der Heil- und Pflegeanstalt Wehnen im "Dritten Reich"* (Oldenburg: Druck & Verlagscooperative GmbH, 1996); Heinz Faulstich, "Die Zahl der "Euthanasie"-Opfer," in *"Euthanasie" und die aktuelle Sterbehilfe-Debatte. Die historischen Hintergründe medizinischer Ethik*, eds. Andreas Frewer and Clemens Eickhoff (Frankfurt, New York: Campus, 2000), 218-234; Faulstich, *Hungersterben in der Psychiatrie 1914-1949. Mit einer Topographie der NS-Psychiatrie* (Freiburg im Breisgau: Lambertus, 1998).

⁷⁵ Arthur Kreßin, *Das allgemeine Krankenhaus Langenhorn in Hamburg: 1950* (Hamburg: Wöll, 1950).

⁷⁶ Böhme and Lohalm, *Wege in den Tod*, 116.

⁷⁷ Staatsanwaltschaft HH 147 Js 58/67, Bd, 1 u, 2, Bl. 17.

⁷⁸ Staatsanwaltschaft HH 147 Js 58/67, Bd, 1 u, 2, Bl. 45

⁷⁹ Ibid., 116.

⁸⁰ Ibid., 116.

⁸¹ Ibid., 117.

5 Anna Maria B.'s First Admission in 1931: Analysis of the Record

5.1 The Patient Record as a Network¹

The following chapter analyses one specific patient record in depth in order to highlight its function in psychiatric practice² and its role in the killing of sick persons. Patient records in psychiatric asylums and other hospitals have gained in importance in German historiography³ in recent years from their use in research on “euthanasia” killings.⁴ In this kind of research the record has often been considered a medium for the mere storage of information, and researchers have used it primarily to confirm whether or not these records represented events accurately.⁵

In contrast, in this research project I will argue that the records must also be analyzed independently from their content. In order to grasp how the record functioned in psychiatric practice it is necessary to focus on the production of representations within the records and how these representations were used.⁶ Documents and letters, even if they were written by the patients or their relatives themselves, were always written in the consciousness that they would become part of the record. This awareness is thus one reason why they cannot be considered the authentic voice of the patient.⁷ This study is taking the theoretical perspective that the record must be perceived as a technology operating within a network in which it assumes the functions of translation and coordination. Patient records highlight the fact that “discourses themselves must be understood as ‘technologies’ that do not impact institutions and technical apparatuses from the outside, but rather constitute, penetrate, and regulate them.”⁸ Only through the interplay of semiotic-discursive and technical-material structure can the effects of power and truth be understood.

This kind of analysis of technologies enables us to grasp how knowledge is inscribed onto the practical exertion of power, authority, and dominance. Using a metaphor of heterogeneous networks allows us to perceive power to be the result of a more-or-less-successful coordination or alignment of different actors. Here the Foucauldian analysis of power meets up

with the “sociology of translation” of Actor Network Theory (ANT), according to which every interaction with other humans is mediated by objects of various kinds. Technological objects define and distribute roles to human and non-human actors and are linked to various inscription devices. Technologies of psychiatric practice are not static, but rather become “[sites] of struggle, a relational effect that recursively generates and reproduces itself.” As sociologist John Law contended, power effects evolve “in a relational and distributed manner, and nothing is ever sown up.”⁹ Networks are oriented to establish and maintain a specific order but they continuously attempt to resist and limit other possibilities of ordering. The analysis of such “ordering struggles” is at the core of ANT. According to Law, “[t]he object is to explore and describe local processes of patterning, social orchestration, ordering and resistance. In short, it is to explore the process that is often called translation, which generates ordering effects such as devices, agents, institutions, or organisations.”¹⁰

This definition resembles Foucault’s perspective on power, which also assumes that power is not a static entity that can be owned but one that develops and changes in relationship to other objects or actors.¹¹ To analyze how power functions means to analyze power microscopically and to follow it in all its ramifications of capillary activities. Only from this perspective can the functioning of power be fully grasped, and this will be the approach taken in the following analysis of one particular medical record.

Along with an analysis of the patient record,¹² I will also illuminate the significant roles that nurses played within these “ordering struggles.” Law demonstrated that social actors can never be reduced to their mere physical corporeality but must be thought of as parts of a structured network of heterogeneous interrelations, or to put it another way, as social actors who emerge through networks. Human actors are therefore “generated in networks that pass through and ramify both within and beyond the body. Hence the term, actor-network – an actor is also, always, a network.”¹³ The patient record, too, is the result of a manifold interplay of different processes, instruments, reports, and measuring data. In the words of Bruno Latour, they are the

result of different “inscription devices,” which can be defined as apparatuses or specific configurations of objects that are able to translate “substance” into written documentation.¹⁴ Latour and Steve Woolgar demonstrated in their laboratory studies how laboratory rats and the chemicals used on them were transformed into paper. Inscriptions appear as a direct image of the original substance and they are relevant because, on the one hand, any inscription can be combined with any other and, on the other hand, paper is a medium that guarantees the conservation of these inscriptions beyond time and space. Latour used the term “immutable mobiles” to characterize this ability of documents.¹⁵ From the moment of their creation, these diagrams and images become the object of scientific disputes and function as evidence for the substances that they represent, even though these substances themselves can only be “seen” in the form of these inscriptions. In other words, the successful alignment of different inscriptions evolves into a “hard fact,” and as more inscriptions are gathered together in order to prove the existence of a fact, it becomes difficult to deny this fact. In the case of the psychiatric patient records, the body of the patient, for example, which is translated into fever charts, medication tables, laboratory results, weight tables, etc., is first and foremost constituted. Everyday institutional life and the psychic parameters of patients are translated respectively into psychiatrists’ and nurses’ notes.¹⁶ The patient record thus acts as a “mediator” because it mediates the interrelations that function and act through the record.¹⁷ The material activities and production stages that were necessary to construct the network of the patient record are invisible. The patient record appears as nothing more than a resource of information but it actually intervenes into the interactions of psychiatric practice; the record, as linguist John Austin stated for speech acts, is also “*performativ*.”¹⁸ This simplifying effect Law described as “punctualisation,” which occurs each time networks are perceived as “network packages – routines – that can, if precariously, be more or less taken for granted in the process of heterogeneous engineering.”¹⁹ Punctualisation makes it difficult for actors to recognize the active part that these simplified networks play in interactions because they work silently “behind their backs,” strengthening their effectiveness.

Latour used the term “black boxing” to highlight the fact that these simplified networks appear to the actors as black boxes whose complexities only emerge if the network encounters a kind of problem, because only in these moments does it become necessary to open them in order to find the fault that led to the problem. In these moments the complexity of the internal structure of the black box becomes apparent. The aim of the following analysis is to open the “black box” and to make visible the functioning of the patient record as mediator.

The above explanations highlight why I decided to analyze primarily one record in depth. Opening the “black box” of this patient record reveals such a complex network that it was not possible to analyze all the details in a completely organized fashion. The record is the product of a multitude of interactions between both human and non-human actors, the traces of which are illustrated in Figure 7.



Figure 7: Opening the “black box” of the patient record.

5.1.1 *The formal structure of the record*

The following overview summarizes the terms used in this analysis to describe the different parts of the record. The records from Langenhorn are unusual in one aspect, because strictly speaking, they consist of two case histories – one from Langenhorn and one from Friedrichsberg. As research on records from other hospitals has revealed, the record normally remained in the admitting asylum and was not given to patients who were transferred to take with them or, if it was sent, the record was returned to the admitting asylum.²⁰ That this situation was different in Hamburg highlights once again how close Friedrichsberg and Langenhorn were interconnected, and the fact that both records were available enables analysis of the interplay between these two asylums. However, the administrative record (*Personalakte*) remained in Friedrichsberg, which is to say that only the administrative records from Langenhorn were available for this analysis.

- Patient record: Collection of all patient documents consisting of administrative record and case history/medical history.
- Administrative record: Administrative processes of all kind, court decisions, correspondence, index of clothes, letters from relatives to the medical director, report sheet “Aktion T4.” The administrative record identification number is the connection between the inside world of the asylum and the outside world.
- Case history/medical history: Psychiatrists’ and nurses’ notes, collections of evidence on the patient’s madness (the record often contains drawings from the patients, patients’ letters, and other materials), reports of extraordinary events.

5.1.2 *The analysis of a particular patient record: the case of Anna Maria B.*

The following in-depth analysis was obtained from one patient record, which was useful from several perspectives. First, Anna Maria B. had a very long “asylum biography” that started before the Nazi regime and ended with her killing at Hadamar. Second, her “career” as a psychiatric patient began in a general hospital. Third, her record comprises more than 500 pages,

consisting primarily of nursing and medical notes. Due to the length of time she was a patient that consequently generated a lengthy patient record, it is possible to examine the differences and similarities in the content of the documentation on her over different time periods.

Anna Maria B. was first admitted to the psychiatric hospital (Friedrichberg) in 1931 at the age of eighteen. She had originally been admitted to the general hospital, Barmbek, on a suspected diagnosis of influenza, but was transferred to Friedrichsberg within the first week of her illness because her behaviour was classified as “abnormal.” From then on, she spent the rest of her life confined to either Friedrichsberg or the Langenhorn asylum, a period of twelve years interrupted only by short stays in her parental home. Her diagnoses included schizophrenia, dementia, dementia praecox, and feeble-mindedness. In 1935, she was sterilized against the will of both herself and her family. She endured any number of treatments, including shock therapy with the drugs Cardiazol, Insulin, Eugenzym (an unlicensed medication) in combination with Digitalis, Morphium-Scopolamine, or Paraldehyde, as well as continuous baths, isolation, and forced bed rest, to name a few. In addition, her problematic refusal to eat upon being first admitted resulted in the use of a feeding tube. She was eventually killed in Hadamar on 6 July 1943 after being diagnosed with tuberculosis of the bone, likely her final “death sentence.”

The ability to summarize the “institutional biography” of this woman sixty-seven years after her assassination demonstrates the capacity of records. The record preserves a documentary biography and a documentary reality of its own, which is activated at the moment it is read. Unlike conversation, the text remains the same no matter how many times it is read;²¹ it is non-responsive to the reader and remains unchanged by the history of its reading. This characteristic of written text is crucial for its role in institutions.

5.2 The Content of the Record

5.2.1 *The psychiatrists' notes*

Patients and their histories are actively produced through the written case history record that, like other forms of histories, follow a chronological time frame. As will be seen in this study's patient records, only psychiatrists were allowed to write a patient's history. Nurses merely produced "reports," and their writings were therefore called "nursing reports." Psychiatrists constructed the history; nurses delivered the constitutive parts.

A patient's raw medical record was a kind of booklet of empty, unlined pages, each with the printed heading "case history" and a column to the left side of the page for the date. The first page of this booklet, entitled *Staatskrankenanstalt Friedrichsberg Hamburg*, was the only pre-printed form in the booklet. At the top of this page was a space to enter a file number and the name of the admitting psychiatrist. Allocating patients a number brought them into being as a case. Other spaces on the form asked for patients' names, their date of birth and address, their occupation, and their date of admission to the asylum. Space was also reserved for information on how the patient arrived in the asylum (on foot or "*m. San. Kol.*," meaning by sanitary train) and from where. All of these blanks were filled in by hand by an admitting clerk – an informed assumption because the handwriting is very exact and suits the formal obligations of administrative handwriting of that time.

Once the standard demographic information was completed, two additional spaces were required to be filled in – one for the definition of the illness and the other for the admittance-attestation. The fact that the handwriting conveying this information was less legible and less exact implies that it was supplied by the psychiatrist (an observation strengthened by examining physicians' handwriting throughout the record). The formal spaces on the form are thus divided between personnel, with most of the non-medical information being completed before the psychiatrist transcribed the patient's medical information. The layout of the front page, with its specific arrangement of printed key terms and empty spaces, was structured to create a narrative.

The front page prescribed the linearity of the patients' story because the administrator could enter only the information requested by the form. The story formed the introduction to the entire medical record.

Following is the front page information from the Friedrichsberg asylum for patient Anna Maria B., with the handwritten parts marked in italics.

Name: *Anna Maria. D. B.*
Place of birth: *Hamburg*
Date of birth: *28.1.13*
Occupation: *Advertisement Designer*
admitted the *18.II.1931*
illness: *Schizophrenia*
comes m. San. Kol. v. d. A. K. Barmbek [from the General Hospital Barmbek]
Last residence: *Wagnerstr. 47 hptr* [ground floor], *b.d.* [at the] parents.
Admittance-Attestation: *Schizophrenia, catatonic clinical picture. Negativism (refuses any food consumption, completely withdrawn). Temporary states of agitation with hallucinations. signed Dr. R.²²* (See Figure 8)

Ärztliche Akte

Staatskrankenanstalt Friedrichsberg
Hamburg.

betr. *[Redacted]*

Anna Maria Barmbek
Bekanntmachung

geb. *28.1.13* zu *Hamburg*

Akt.-No.	angefommen	entlassen	gestorben	Diagnose
72235	18.2.31	24.10.31		<i>Schizophrenie</i>
72865	13.7.31	25.1.32		
73060	21.2.36			
85465	19.4.39	3.5.39	<i>gestorben</i>	<i>Hysterische Endenstand</i>

Aufnahme-Blatt

Seite Aufnahme-Bl. *70235* Aufnahmearzt Dr. *Liiffler*

Staatskrankenanstalt Friedrichsberg
Hamburg.

Name: *Anna Maria Barmbek*

Geburtsort: *Hamburg*

Datum der Geburt: *28.1.13* Geburtszeit: *18. II*

Krankheit: *Schizophrenie*

Kommen m. San. Kol. v. d. A. K. Barmbek.

Seite Wohnung: *Wagnerstr. 47 hptr. W. Eltern.*

Aufnahme-Risik: *Schizophrenie, katatonischer Charakter, negativistischer Zustand (verweigert jegliche Nahrung, zieht sich völlig ab), zeitweise Erregungszustände mit Halluzinationen.*
gez. Dr. Barmbek

Figure 8: The folder and the front page of Anna Maria B.'s medical record 28338 in Friedrichsberg.²³

The abbreviations used made the front page comprehensible only to those working in this specific organizational context. From B.'s form, we can discern her diagnosis, the definition of her illness, that she did not arrive voluntarily (she was brought by sanitary train) and that she was already hospitalized elsewhere before she arrived in the asylum. The form also revealed that she lived with her parents, and that the physician who diagnosed her was not the same psychiatrist who admitted her to Friedrichsberg (we know this because the name of the admitting psychiatrist on the top of the form was different from the "Dr. R" who signed the diagnosis.) How the diagnosis was obtained or why B. had been admitted to the general hospital of Barmbek is not perceivable to the reader. Furthermore, reading the first few pages of the record reveals that a lot of work was necessary to obtain the information assembled on the front page, work that was obviously invisible if one went no further than the first page. The front page formed a frame for other psychiatric observations that had a significant impact on how patients like B. would be described in the notes, and how the record as a whole would be constructed.

The booklet, which made up the core of the record, contained psychiatrists' notes, laboratory results, and other official medical documents. All of the papers in the booklet used by psychiatrists were officially designed and printed forms, providing a kind of status that helped to legitimize their work. Except for the booklet, all other kinds of documents in the record, including the nurses' notes, are found at the end (or are part of the administrative record), making them more difficult to find. As such, what counts as legitimate information is already defined by the material appearance of the record.

5.2.2 *The nurses' notes*

The notes written by psychiatrists and nurses differed more than in the content they contained. First, the psychiatrists wrote their remarks in ink (or sometimes their secretaries used a typewriter) on printed, unlined forms in which they were prompted to note only the date of their writing. Psychiatrists thus were at liberty to decide how much to write and in what way. As described above, the pages of the patient's record are fastened together into a kind of booklet, and

[illegible]

Figure 10: Nurse's reports, medical record 28338.

Most of the nursing notes at Friedrichsberg contained initials and some underlining from psychiatrists who controlled the nurses' entries and used them in their own notes to make clear that they had observed what the nurses described. The notes are also much more legible than those written by the psychiatrists, even though the nurses wrote in pencil (only the head nurse occasionally wrote in ink). The fact that they were written in pencil and thus relatively faint, however, gives the impression of the writing being more childlike, and thus the writer as more subordinate. This is to say that the material construction of the forms enforced a certain way of entering information and represented, in a concrete manner, the entire organization of psychiatric practice – a strategic interplay of different parts arranged around the absolute power of the psychiatrist.

Although they represented the largest part of the patient record, I argue that the formal appearance of these notes, which directed and controlled the observations of nurses, the nature of their being written in pencil, and their position at the back of the medical file, suggests that nurses and their work were considered subordinate within the hierarchical organization of psychiatric treatment at Friedrichsberg.

I argue further, however, that these same elements have continued to influence historical research, in that historians themselves have tended to ignore nursing notes. Until recently, a vast number of nursing reports have continued to be destroyed simply because they have been considered uninformative and thus unimportant.²⁴ Yet, as I contend in the case of Friedrichsberg, the material from these nursing documents contained critical information and useful observations on which psychiatrists themselves based their medical decisions. Without the nurses' notes, the psychiatrists' notes could not have existed. This is what is meant by the term "strategic" power distribution: nurses' information could only be useful if it was written in a standardized, easily readable manner and in an efficient style that enabled the psychiatrist to read through the notes in the shortest amount of time possible. Dr. Enge, medical director of the asylum of Strecknitz-Lübeck in the 1930s, emphasized the significance of clearly written nursing reports that suggested a style significantly different from that of physicians. "In order to allow the physician to inform himself rapidly and comprehensively about the condition of a sick person and to be informed about all incidents some demands must be fulfilled, demands that concern more the formal nature: articulate writing! Well-arranged ordering!"²⁵

5.2.3 *The admission ritual*

Following the chronology of Anna Maria B.'s medical file enables demonstrating the record's ability to initiate or influence a chain of action within psychiatric practice, and the role that it played in constructing the identity of patients. The introductory narrative at the front highlights the fact that B. was first admitted to the general hospital at Barmbek before she was transferred to Friedrichsberg. The following pages, which contain an excerpt from her file at

Barmbek, are written in the same handwriting as that on the front page, inferring that an office clerk at Friedrichsberg copied the case history from Barmbek. B. was originally admitted to Barmbek on 12 February 1931 with a diagnosis of “Morbus Internes (possibly the flu).”

Patient’s history: Information provided by mother: No nervous diseases in the family.

Family’s health history: nothing to mention.

Pat. [patient] has never been seriously ill. She is an apprentice of an advertisement designer. The parents did not notice anything specific, except for her demeanour which has been somewhat staring and empty lately. Since yesterday, [B.] has been very restless and strange in her behaviour. She apparently said that all people were against her and she did not know why. The doctor diagnosed her with the flu and admitted her to hospital. On Sunday (8.2.) she was tobogganing; the mother did not know anything about it. She had not slept for 3 nights and did not feel good during the days. She constantly talked about dying. She was to die; the mother should not worry about it, everybody had to die. The mother should cut open the artery on the wrist so that the soul could be released. Yesterday 38°C temperature. Before Sunday, the parents did not notice anything....²⁶

This part of the physician’s report from the Barmbek hospital summarized the mother’s testament as to why her daughter should be admitted. She had not noticed anything unusual in her daughter’s behaviour “before Sunday” and she and the general practitioner considered the changes in B.’s behaviour to be the result of a potential flu. The manner in which the note was written demonstrates that the physician had directed the interview and that he was concentrating primarily on the patient’s somatic symptoms. He described her as a “tiny pat. [whose] every movement seems weak, limp and without energy,” lying “in bed with her eyes closed and [reacting] to all stimulation in a sluggish and slow manner.”²⁷ Even more unusual behaviour still elicited no comments that B. might be mentally ill. “(15.2) Completely withdrawn. Doesn’t answer, doesn’t eat. Most of the time, she lies in bed uncovered, hair untidy in her face. Lifted her arms up straight in the air for a long time, without moving.”²⁸ Not until three days later was she finally transferred to Friedrichsberg.

The public health officer who examined her at Barmbek in order to refer her to Friedrichsberg translated the observations from Barmbek into the psychiatric diagnosis that

would later become the admittance attestation to the new institution. Unlike the previous physician, he did not focus solely on somatic aspects of her illness alone but rather interpreted the symptoms provided by the mother's interview and the Barmbek physician's notes as a mental illness. "Schizophrenia, catatonic clinical picture. Negativism (refuses any food consumption, completely withdrawn). Temporary states of agitation with hallucinations."

Obtaining the psychiatric diagnosis from the copied case history from Barmbek nevertheless took a great deal of work, as it rearranged and transformed observations to fit into a specific diagnostic frame. For example, the reported observation from Barmbek "arms up straight in the air for a long time, without moving" was translated into a "catatonic clinical picture." "Hardly accepts any food, lies in bed apathetically" became "negativism (refuses any food consumption, completely withdrawn)." Agitation and continual muttering about being poisoned by food was explained by her experiencing "temporary states of agitation with hallucinations."²⁹ Nonetheless, while the Barmbek physician did not acknowledge that B.'s symptoms might suggest she was mentally ill, she was receiving Luminal, a commonly prescribed psychiatric sedative at this time.³⁰ It was not until she reached Friedrichsberg, however, when a psychiatrist there noted that she had developed a "Luminal exanthema,"³¹ that we discover she was receiving this drug on a regular basis.

From the moment that B. received her psychiatric diagnosis, her record began to follow what seemed to be a predetermined course that was guided by her diagnosis. The terms used in the diagnosis would accompany her throughout her multiple stays in the psychiatric hospital. The diagnosis became the hidden pattern of psychiatrists' observations, functioning even retroactively to sustain a certain direction and coherence in these observations not possessed prior to the diagnosis. Simultaneously, the diagnosis linked B.'s Barmbek history with that obtained in the Friedrichsberg asylum, corresponding to published guidelines on examination techniques. Author Wilhelm Weygandt, medical director of Friedrichsberg since 1908, contended that the history of the patient should be written in a chronological sequence and psychiatrists should "describe the

past [of the patient] as far as possible in an objective manner.”³² Following these guidelines, B.’s clinical history was actually rewritten during her first examination in Friedrichsberg.

Nevertheless, the admission examination had an alternate motive. It followed a particular scheme that was more or less the same for every admission to Friedrichsberg, one that could be described as a kind of ceremony or ritual.³³ Furthermore, it was also the first demonstration of the medical power that ruled the asylum, conveying to the patient that he/she had entered into a specific space where the distribution of power had nothing in common with the “ordinary world.” As stated by Eugen Bleuler, influential Swiss psychiatrist who introduced the concept of schizophrenia,

During the admission no lies and no false promises are to be applied (...) In cases of emergency it is preferable to use violence or narcotics, because the sick person is most likely to forgive them afterwards. Nevertheless, violence is often unnecessary if one acts with caution. Most sick persons can be persuaded, without being ruffled, of the necessity of the decision [to be admitted to the asylum] – but in such an authoritative way that they feel that any discussion is useless and enough people are around who are capable of enforcing the will in case of resistance. One cannot forget that it is very rare to persuade the sick person to back down through logic itself, but rather through the appearance of the one who applies the logic....³⁴

According to Bleuler, the physical appearance of the psychiatrist alone should be sufficient to convince the patient that any resistance was futile. As such, the “logic” of the asylum was physically imposed on the patient, hinting at the rationale behind psychiatric practice.

The admission ritual was also characterized by a power imbalance that implied neither reciprocity nor equal exchange; Bleuler even characterized the admission of mentally ill persons as an “internment.”³⁵ The admission “exploration” (as Friedrichsberg psychiatrists called it) appeared as a threefold usurpation of the patient’s body. First, communication during the exploration did not exist as a free, equal linguistic exchange but rather was marked by the power of the psychiatrist. The patient was not encouraged to freely recount his or her experiences; instead, the psychiatrist posed questions that patients were compelled to answer in order to “convict” the madness. According to Weygandt, the “assessment of the mental condition” was the

most important part of the examination and he developed a long list of questions and “special methods” in order to establish the psychic status and the mental performance of the patient.³⁶ Nevertheless, this could only be a preliminary assessment because the patient’s status had to be regularly verified, and if necessary, rectified through observations and by repeating the interview.

Even though psychiatrists did not appear to personally address B. during the admission ritual in 1931, a power imbalance can be observed during her stay in the asylum and on the occasions of her subsequent admissions to Friedrichsberg in the years to come. The questions psychiatrists asked revealed that they possessed information that was not obtained directly from the patient but was derived from other sources, including documents and interview transcripts. Weygandt had also emphasized that the examination was to begin with research for records and other documents

that should underlie the expert report. Particularly, one should reclaim school reports especially in cases when the disorders reach back to adolescence. Furthermore, depending on the circumstances, one should reclaim reports of the time in the armed forces. In addition, any medical histories from earlier stays in hospitals or asylums come into consideration even though some parts of the content of the patient’s history, as far as they concern the history obtained from the patient himself or from his next of kin, must be critically considered.³⁷

Information on B. was derived from her record at Barmbek and the detailed information provided by her mother. However, the psychiatrist apparently did not entirely trust her mother’s statements, or even B. herself, as her later admissions demonstrate. Enge, too, had written that “the next of kin “are sometimes abnormal themselves and therefore suppress facts,” or they mix “popular conceptions, unclear associations into their statements.”³⁸

Psychiatrists asked patients questions unrelated to their personal situation that appeared to follow a specific formula. Other records revealed that these kinds of questions were standardized and were used to check “mental capacities.” Weygandt described the course of this examination procedure, which could be characterized more as an interrogation. Against the backdrop of information obtained from school records, medical histories from other hospitals,

military reports, and testimonies obtained from family members, etc., he believed that the psychiatrist was to question the patient for basic demographic information and then probe five areas of concern: heredity, birth and infancy, childhood and adolescence, maturity, and illness. Every detail seemed to be important in the context of the mental illness. Questions about heredity, for example, were meant to uncover not only mental or nervous illnesses of blood relations but also instances of possible alcoholism, criminality, instability, wastefulness, or any other striking characteristic, which more than anything else demonstrated psychiatric concerns for moral behaviour. Other questions, for example, could focus on the course of the mother's pregnancy and aspects of infant nutrition, or delve into such wide-ranging areas as whether or not the patient was lively or quiet, had wet the bed, had tried to run away from home, coped well with school or military service, performed well at work, or masturbated.³⁹ Finally, the psychiatrist was encouraged to ask about the illness itself.

What are the causes of the actual illness? Supposed psychic influences, sorrow, excitements, fear. Febrile illnesses, metabolism, lues, poisons like alcohol, morphine, cocaine, nicotine, plumb, sleeping pills. Regarding women, menstruation, pregnancy, birth, confinement, breastfeeding, climacteric period. Exhaustive circumstances. In what manner did the condition change? Suddenly or gradually? Changes in character? Weakness of memory? Excesses? Wastefulness? Changes in speech and script. Resentments, world-weariness, aptitude to self-murder? Obsessive ideas. Bodily functions; sleep disorder, digestion, headache, dizziness, faints, cramps? Confusion, misperceptions, delusional ideas, excitements, memory, striking behaviour, bizarre gestures, unresponsiveness, dysfunctional reactions?⁴⁰

From this list it becomes very clear that nearly any aspect of a patient's behaviour could become a symptom related to the diagnosis of a mental illness. However, only the psychiatrist could assess the interrelationships between the different dispositions and symptoms. Although diagnostic indications could be deduced from hereditary elements, they were warned that it would be a fault to overestimate the hereditary burden.⁴¹

Bleuler (1943) emphasized not only the significance of the questions but also the way in which they should be asked.

Of utmost importance is the manner of questioning. First of all, one has not to antagonize the patient, if possible at all; awkward aspects are set aside till the end. If possible one tries to gain confidence – of course without pretending anything. An examination under false pretences must be declined. If a patient does not talk one does not try to go further, but rather examines the body and occasionally poses a question that can be easily answered: Does this hurt, or the like, to make the patient talk. One observes certain things on mentally and bodily dimensions without patients noticing...⁴²

This advice also highlighted the fact that the admission ritual was a strategic procedure used to provoke certain answers from the patient in order to “trap” the madness and convict the patient of his or her illness. Weygandt’s own catalogue of questions was so extensive that the patient could only be “cornered” and forced to surrender.⁴³ Even so, he wrote, depending on the case, parts of the examination could be deepened. “In the case of a person with delusive ideas one has to go into detail about his pathological perceptions and the possible development of a system of delirium.”⁴⁴ If these “experimental-psychological examination methods” were not sufficient to trap the madness, one could apply even “more complicated experiments like, for example, [asking patients to] consecutively add up figures.”⁴⁵ And if this acceleration in the interrogation technique was still insufficient to provoke the decisive symptoms, Weygandt advised psychiatrists to resort to chemicals to settle the case.

So they administered cocaine (0.05 subcutaneous) in order to test for epilepsy and with a congruent disposition it was occasionally, but rather rarely, possible to cause a kind of epileptic seizure. I think it is more efficient not only in the case of suspected epilepsy, but also in the case of different types of degeneration to conduct an alcohol experiment. This means letting the person concerned quickly intake a bottle of wine, normally a sweet wine [Süßwein] with approximately 100 gr alcohol. Sometimes a kind of epileptic seizure, even with fixed pupils, is initiated [but] more often more slight disorders occur such as vertigo, headache, excitability.⁴⁶

By now, it is clear that the function of the admission ritual was to expose the patient’s central symptoms through specific layered techniques of questioning, and if necessary, through the application of chemicals, an aspect of the admission ritual that is analyzed in more detail below.

Also of interest to Bleuler was not only what the patient said, but the manner in which he or she spoke. “For the sick persons talking, their inflection can be abnormal, too loud, too low, too fast, too slow, through the fistula, grumbling, grunting, staccato, precipitous and so on....Speech manners often express a certain complex.”⁴⁷

Madness was apparently traceable even in a patient’s writing, made visible by a kind of “unconscious” confession that was manifested through the act of writing. According to Bleuler, the “written statements correspond[ed] to oral statements. Abnormalities in style [were] frequent.”⁴⁸ B. refused to provide a writing sample when she was asked to do so one day prior to her interrogation by the psychiatrist in Friedrichsberg. A nurse conducted the writing exercise, and the fact that B. was not seen by a psychiatrist until the next day implies nurses, as representatives of the psychiatrist, supplemented the admission procedure by rituals of their own. This will be further analyzed below. With each predetermined sentence, B. was either forced to acknowledge the power of the nurse as the representative of the psychiatrist’s power (like a teacher who dictates a text) or reveal her madness through her inability to write, if for instance she was not able to compose a grammatically correct sentence. In both cases, the act of writing was literally a demonstration of power by the psychiatrist and his representatives. (See Figure 11)

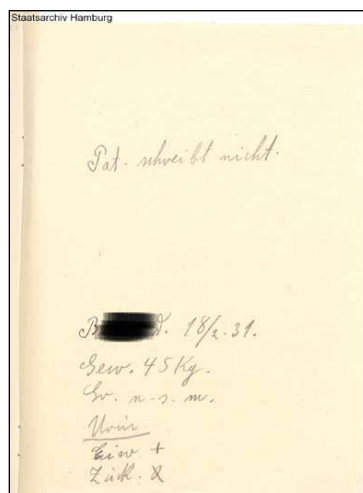


Figure 11: Handwriting Sample of B. The nurse noted: “Patient does not write”. Medical record 28338.

In some records, patients were asked to write their own biography. Enge called this exercise the “autoanamnesis” (*Autoanamnese*), meaning that the case history was based on the information obtained from the sick person. This autoanamnesis, which included a questionnaire and an unstructured written biography, was “of utmost importance. The manner in which a sick person is able to express himself, his capability to depict and to summarize something he experienced, his hand writing, his mistakes in language and spelling, give important reference points for the assessment.” The written biography was synonymous with patients’ “confession...of the history of [their] madness.”⁴⁹ The inability or unwillingness of B. to provide a writing sample became a demonstration of uncooperative behaviour and offered further evidence for her diagnosis.

Attempts to capture the mental state of the patient through the interrogation procedure were supplemented by a physical examination, which followed a thoroughly detailed and systematic process at Friedrichsberg that Weygandt had laid down.⁵⁰ This kind of examination was meant to help the psychiatrist link the psychic and the physical state of the patient.

Bodily symptoms found through the physical examination served to provide evidence for a particular mental illness diagnosis. When counterposed against the “cataonic clinic picture” that had described B.’s state on admission to Friedrichsberg, the slack muscle tone found at her physical exam only made her mental illness more visible. The examining psychiatrist’s failed attempt to provoke a reaction through “rough needle pricks” only underlined how “withdrawn” she was. The “narcoleptic” state of the patient could not be altered by speaking to her, nor did it change during a lumbar puncture. Even the “much greater resistance to blood work” was perceived as a sign of instability.⁵¹

In conjunction with the diagnosis, the description of these physical findings acted to introduce other observations. At the same time, however, her pre-determined diagnosis installed a kind of frame that made some aspects visible and others invisible. For example, no one mentioned that B. had been heavily sedated, not only by the Luminal she had received in

Barmbek but also by an injection of another heavy sedative, Morphine-Scopolamine, that she received in Friedrichsberg prior to her admission procedure and which had been marked only on the “fever chart.”⁵² These drugs may well have been implicated in the creation of B.’s catatonic state. Demonstrating the “power” of the record, she may well have received this last injection as a preventative measure because of the physical aggression recorded in the notes of both the psychiatrists and the nurses.

Physical examinations were attempts to map mental illness on the body. As Bleuler wrote, “due to an aberration of the brain, which is the cause for most of the brain illnesses, very often the bodily development gets off track. A huge number of sick people endure many more malformations than healthy people do.”⁵³ Of the six areas of bodily symptoms connected to mental illnesses that he listed, the fourth was especially noteworthy.

Bodily symptoms are the expression of an abnormal constitution that includes the whole personality and pre-disposes to psychic disorders: including first and foremost the “signs of degeneration” (...) subnormal size, cranial deformations...irregular tooth position, underdeveloped teeth...deformations of the genitals...Regarding the schizophrenic, those forms that are related to dumbing down on average have more signs of degeneration than those that are less severe.⁵⁴

However, Weygandt “caution[ed] against overestimating the signs of possible devolution” (*Entartungszeichen*) or characteristics of degeneration or *stigmata hereditatis*.

Only in cases of a large occurrence [of degenerative signs] the conclusion by analogy is allowed: If the miscellaneous organism, particularly in the range of the ectoderm, tends to deviate in serious extent from normal development then the assumption is obvious that the central nervous system and the cerebral cortex too, as carriers of the psychic functions, seen from their disposition have a certain tendency to deviations from the normal development.⁵⁵

Three constitutive aspects of psychiatric rationale appear in this short paragraph. First of all, the degeneration of the body was somehow related to mental degeneration. Second, it was not possible to draw direct conclusions from the existence of bodily signs of degeneration to probable mental degeneration. Owing to their medical expertise, only psychiatrists were able to

draw the right conclusions regarding the impact of bodily signs on the mental state. Third, Weygandt's statement regarding deviations from "the normal arrangement and the normal development" highlighted the fact that psychiatrists dealt with distinctions between "normal and abnormal," although he considered it difficult to clearly differentiate the two. The predominant number of "cases of mental disturbance do not show their deformity at first sight," he wrote, but rather a scientific diagnostic was necessary "even more for bodily disturbances in which the sick persons sense the illness themselves."⁵⁶ Lay persons, according to Weygandt, could only imagine a kind of "prototype" of lunacy which in reality equated only to a few of the most severe cases. They could not recognize the "average" mentally ill person, because his or her illness was not visible at first sight and waited to be discovered by the psychiatric expert. As this thinking suggests, psychiatric discourse at this point always related mental illness with a somatic component of degeneration and searched for the cause of the illness in the corporeal constitution or in the biography of the mentally ill person. Assuming that a degenerative constitution was a foundation for madness meant that the patient could not be cured because of the unchangeable nature of the constitution.

Since all of B.'s laboratory results were negative, the body disappeared in the psychiatrist's notes. As Bleuler had noted, it was often impossible to find an anatomical essence of schizophrenia "despite numerous efforts."⁵⁷ Only the nurses attempted to control specific bodily functions of the patient through the use of fever charts or handwritten forms that they themselves had designed. As B.'s file evolved, a clear distinction was drawn between the bodily life of the patient, which was represented on these forms, and the psychic life, which was represented in the nurses' and psychiatrists' notes. The body appeared to be mysteriously absent. It was no longer a question of which behaviour or which manner of speech belonged to which damaged bodily function, it became more a matter of whether or not a certain conduct, such as hearing voices, etc. should be classified as madness or not. As Bleuler stated:

The whole difficulty lies in the fact that there is no definition of ‘illness’ and that there cannot be one. It is so easy to examine how a human is and how he reacts and then from the factual, instead from the term, to draw the consequences and to determine our action.⁵⁸

An investigation into the genetic disposition was always part of the admission ritual, although the reason it was not given the same weight in all clinical records likely depended on the admitting psychiatrist. In B.’s file, an examination of her hereditary background was already part of the report from Barmbek and the Friedrichsberg psychiatrist had recorded “no abnormality detected.”

In schizophrenia, Bleuler believed that heredity or “congenital disposition [was] of critical importance” and considered schizophrenia to be a “heredodegeneration” even though he admits that no medical sound idea existed for the causes of schizophrenia.⁵⁹ The term heredodegeneration, a combination of “heredity” and “degeneration,” implied that the cause was to be found in the patient’s family history, that it was possible to locate the reason for the illness in former events that had induced a degeneration of a family member and was later passed on. The inability to find an organic cause of illness could be balanced by a kind of “virtual body,” the “body of the family.” Through heredity, it was possible to re-introduce a pathological “material substratum” and give the illness certain physicality.

Even though physicians could not distinguish any former event in B.’s family medical history as a cause for her pathological “disposition” during her 1931 admission, by the first draft of the medical report for the sterilization process in 1935, an alcoholic grandfather had suddenly been found. A “faulty” family history invented a new body because the illness, no matter what its nature might have been, could be passed off as a “meta-organic substrate” of madness from previous generations. The body was in reality the whole body of the family and the search for inherited traits replaced the individual body through a material correlation. As Foucault contended, psychiatrists attempted to construct a meta-individual “analogon.”⁶⁰

In B.'s case, the psychiatrist possessed information from the Barmbek record and he used his knowledge to construct a "biographic corpus" that included family, occupation, marital status, and medical observations. The admission ritual was the first step towards fixing this documentary identity onto individuals and, consequently, forcing individuals to recognize themselves in their documentary histories and in the documented events that took place during their stay in the asylum. For this reason, the interrogations were repeated regularly, which also served to emphasize the status of the psychiatrist as a doctor in a twofold manner: either patients showed their symptoms and in showing them, demonstrated that they were really sick, or they "confessed" their madness. In both cases the result demonstrated that they were really in need of treatment by a physician.

B.'s psychiatrist noted during the admission procedure to Friedrichsberg in February 1931 that:

19.2.31 Mother (addition to details in B [Barmbek])

On Feb. 9th in the morning she said to mother: "Mum, what a bad person I am!" Reproaches herself because she had told a colleague that she liked the business she was working in. She did not want to get professional training although she did not want to miss school before. After school she lay down in bed, then she became frightened: "You my dear, I have to leave you now...,etc." At night often [had] anxiety attacks. "My soul wants to get out..." Next day, same timidity: that is why in hospital. In previous evening, at a 2nd doctor's, she did not speak at all. Last school Humboldtstr. At the age of 12 in the upper. At the age of 16, graduated from school. Now advertisement designer with Ortmann, Pohlstr. She did not want be there at all, did not like the boss. Because at school she was told she was talented, she became a designer. Formerly, all in all quiet. Interests: only drawing and reading heavy, difficult books: Dostojewski, Schopenhauer, Zola. Never went out, did not dance, only went out with mother, was very attached to her. At school very hard working, punctual, conscientious. Felt very unhappy with her nose (broke back of nose when falling as child) and rejected. No interest in men. She loved nature and animals. Very economical, humble.⁶¹

In detailing the reasons for admitting B., the psychiatrist made choices in considering which information was deemed important to develop a picture of the illness and thus what should be included in the admission report. Using quotations and reported speech as stylistic devices

suggested an authentic objectivity on the part of the psychiatrist, which was further emphasized by his assertion that this additional information (to the report from Barmbek) was obtained from B.'s mother when B. herself kept silent. However, the direction of the report from Barmbek and the one written by the psychiatrist at Friedrichsberg differed considerably. Much of the Barmbek account was structured around symptoms and behaviours that appeared to stem from the pivotal event of her developing the "flu." In comparison, the Friedrichsberg psychiatrist, who was aware of the information contained in the Barmbek record, was more concerned with detecting early signs of madness in B.'s biography.

The physician at Barmbek believed that the precipitating event for B.'s illness was her flu-like illness, and this diagnosis seemed to shape his admission report. His suspicions were strengthened by the facts that she had been tobogganing on 9 February 1931, had not slept for three days afterwards, and now had a fever; all in all, she had not felt well during this time. Her parents reportedly had also not noticed anything different about her "before Sunday." Although the physician noted some "restless and strange" behaviour (and her gaze was "somewhat staring and empty"), he did not initially consider these definite signs for an underlying mental illness.

The Friedrichsberg psychiatrist also believed that 9 February was a significant date related to B.'s admission. However, he was more interested in the conversation her mother had reported from that day ("Mama what a bad person I am!"), as well as B.'s admission to a colleague that she liked her work, when in reality she did not. Connecting these sentences seems to suggest that the psychiatrist believed she felt guilty about something that was normally not worth mentioning. He ordered these and other details in such a way so as to provide an alternative framing to her illness. Although B. had not wanted to miss school before, he emphasized that she now did not want to attend and lay down immediately after coming home, indicating that something had been wrong for longer than previously thought. He reported her "anxiety attacks" at night that left her anxious and frightened, feelings that she had shared with her mother ("my soul wants to get out"). The use of "etc." and ellipses indicated that these were only some

examples of her confused thinking, and her refusal to speak suggested to the psychiatrist that her condition had rapidly worsened. Thus, the reasons for B.'s admission to Barmbek were transformed from the physical "morbus internus (flu?)" into the psychiatric diagnosis of schizophrenia.

The Friedrichsberg psychiatrist was also determined to trace the development of her illness from much further back than his Barmbek colleague. Highlighting B.'s discontent with her present job could perhaps be seen as a sign that, despite her talents, she had been pressured into this kind of work. The report hinted that her extreme attachment to her mother and her lack of interest in men, dancing, and going out was inappropriately gendered behaviour. Reading "heavy, difficult books" was suggested as somewhat abnormal despite apparent model childhood behaviour, and her unhappiness with her appearance pointed to psychic consequences from a broken nose.

With these admission notes, a new kind of "documentary temporality" was introduced.⁶² A "documentary temporality" was one of Enge's declared aims of the admission ritual, in that the prehistory of the case had to focus on the time of the outbreak and on the different mental and physical events that took place.⁶³ How B.'s behaviour was perceived to be mental illness lies in the manner in which the report was constructed. Labelling B. as a schizophrenic meant that all other aspects of her history become nothing more than evidence to support the officially recognized mental illness. Sociologist Dorothy Smith called this the "authorization rules," which are part of an official account and that instruct the reader as to what criteria to use in determining the adequacy of the description and credibility of the account. The actual events are not facts *per se*.

A fact is something which is already categorized, which is already worked up so that it conforms to the model of what the fact should be like. To describe something as fact or to treat something as fact implies that the events themselves – what happened – entitle or authorize the teller of the tale to treat that categorization as ineluctable. "Whether I wish it or not, it is a fact. Whether I will admit it or not, it is a fact."⁶⁴

B.'s account was based on the testimony of her mother, someone whom we would usually feel had her daughter's best interests at heart. In these circumstances it was not even necessary that B. had a voice, because the version was legitimized by the fact that it was given by her mother. The willingness of the psychiatrist, as the approved medical authority, to translate the mother's testimony into the official history, gives this account a privileged status. Any alternative account could only be speculative because the organization of this privileged status was constructed by people who were part of the event. However, an alternative interpretation was also made impossible by the lack of sufficient information. One feature of official accounts is that they do not contain irrelevant material, material which neither establishes the adequacy of the authorization procedures nor contributes to the conceptual organization. The construction of an alternative account that denies B.'s mental illness is not possible on the basis of the available evidence and its organization. This account became the foundation for all the events that occurred in the future: ten years later this first admission account would continue to be consulted.

However, this account and the way it was constructed has even deeper implications. In supporting B.'s psychiatric diagnosis with evidence from her history that included her very constitution as a cause for her illness, the psychiatrist constructed her from the beginning as a chronic and even an incurable case. This is to say, from the beginning he considered B. to be a "hopeless" case; the disturbances that occurred early in her childhood indicated that something, however hidden, existed underneath and demonstrated a form of degeneration even if it was not yet possible to find the source.

The search for the individual history is, according to Foucault, the attempt to demonstrate that, on the one hand, madness already existed before it expressed itself as real illness and on the other, that these signs were not yet the madness itself but rather the conditions of possibility. These signs were not really pathological, because in that moment they were nothing more than symptoms of an illness, but rather something like implicit signs that were related in a specific

way to the illness in order to be marked as signs or dispositions. The illness was thereby separated from the individual context and placed within a frame that could be characterized as “abnormal.” Abnormality was simultaneously the individual condition of possibility for madness and the precondition to demonstrate that what needed treatment were effectively pathological symptoms. A web of abnormality was the precondition enabling reasons for admission to be transformed into pathological symptoms. In this part of the admission ritual something like a “horizon of abnormality” was thus established.⁶⁵ As Enge implicitly acknowledged:

Of utmost importance is the *detection of the original disposition*. [original emphasis]. Poor mental ability (*Verstandesbegabung*), which later often becomes obvious in belated language development, points to mutagenic influences and, to a higher degree, it points to *pathological processes that were already established before or after birth* (syphilis, infectious diseases). Imbecility combined with pedantry is often found at an early state as concomitant of true epilepsy. The different forms of psychopathic disposition are mostly prefigured at an early state by a great vividness of the phantasy and pathological fiddling, by excitability, anxiousness, abjection or hilarity, saintliness, increased self-worth. Through behaviour it is possible to infer a shy, closed, stubborn constitution, an absence of will or adventurousness (*Unternehmenslustig*), lack of stability, cantankerousness, domination by one’s physical desires (*Triebhaftigkeit*), criminal affinities, or different forms of psychopathy. *Nearly every acute mental illness has its precursors.*⁶⁶

As this short extract illustrated, virtually any behaviour could be marked as a sign of mental illness, precursors that could be adequately interpreted only by psychiatrists.

The Friedrichsberg account on B. transformed the reasons for her admission into actual psychiatric symptoms. Whereas the admission to Barmbek took place due to a kind of helplessness on the part of her mother because her daughter’s behaviour had changed, this behaviour became in Friedrichsberg the symptoms of schizophrenia, and at the end of the admission ritual, B.’s diagnosis had transformed into fact.

Nonetheless, as Bleuler and Weygandt previously suggested, the admission ritual had a more far-reaching objective. The purpose of the interrogation was to reduce the illness to its “main symptom,” not only to make the subject acknowledge this absolute core but also to

effectively actualize it during the interrogation. It could be actualized in two different ways, either by means of a patient's confession like "yes, I hear voices," because in that moment the symptoms would be fixed to the individual in the form of a first-person statement, or by provoking a crisis, for example, by triggering hallucinations, an epileptic seizure, or a bout of hysteria. This is what Weygandt attempted to obtain through his administering the "alcohol test" or cocaine. The "rough needle pricks" and "pricks in the system" that B. experienced could be considered attempts to provoke a kind of aggressive reaction, efforts that were finally successful during the struggle to obtain her blood work.

This part of the admission ritual that aimed to provoke a situation in which patients could not avoid acknowledging their madness had a direct relevance to the development of psychiatric practice. Admitting madness meant that patients also admitted that they were actually ill, in need of a physician and of being interned, and that they were the kind of patients for whom psychiatric asylums were built. This moment Foucault called the "double enthronement" (*double intronisation*), when, on the one hand, the interned individual was "enthroned" as a sick person and on the other, when the interning individual was "enthroned" as psychiatrist and physician.⁶⁷

Interrogations can be analyzed on three different levels. The first level concerns the dimension of the disciplinary character as analyzed above. Foucault described the aim of the second level of the interrogation as

...constituting a medical mimesis in psychiatric questioning, the analogon of a medical schema given by pathological anatomy: first, psychiatric questioning constitutes a body through the system of ascriptions of heredity, it gives body to an illness which did not have one; second, around this illness, and in order to pick it out as illness, it constitutes a field of abnormalities; third, it fabricates symptoms from a demand for confinement; and finally, fourth, it isolates, delimits, and defines a pathological source that it shows and actualizes in the confession or in the realization of this major and nuclear symptom.⁶⁸

The interrogation recreates in a way exactly the elements that characterize the differential diagnosis in organic medicine in a form of a “mimesis” or “analogon.” For the third level of the interrogation is the level at which,

...through the play of sleights of hand, exchanges, promises, gifts and counter-gifts between psychiatrist and patient there is the triple realization of conduct as madness, of madness as illness, and finally, of the mad person’s guardian as doctor.⁶⁹

The psychiatrist had two functions in the everyday life of the asylum: the interrogation and the round. A psychiatrist made rounds through all departments of his asylum every morning in order to transform discipline into therapy – to control all the small wheels of the system, to inspect all disciplinary mechanisms, and to transform those parts into a therapeutic apparatus solely through the presence of the psychiatrist. The interrogation consisted of summoning the sick person to demonstrate his or her symptoms, and through these symptoms, to transform the psychiatrist into an acknowledged doctor. The whole disciplinary field functioned by means of these two rites, and to preserve these functions is why this ritual had to be re-enacted from time to time.

Portions of these rites are clearly recognizable in the records under study here. As initials and underlines in the nurses’ notes attest, psychiatrists maintained control over nursing information. Almost every paper that found its way into the patient record had to be signed by the medical director or his representative. Only at the moment that psychiatrists used fragments of the nurses’ notes in their own notes did nursing observations become an approved official part of the record. These mechanisms will be highlighted in more detail over the course of this analysis.

Completing the case history of a patient was one objective of a stay in the asylum and this objective was an important aspect of nursing work. According to Enge, it was important that the nurses not only understood the importance of the patient’s biography, in order to determine the causes for his or her mental illness, but also that they realized the process of gathering

information about the patient's prehistory never ended during the patient's stay in the asylum.

According to Enge, nurses must assist

...at times to complete the case history. Their constant interactions with patients allow the development of mutual trust, so that many a sick person confides in them more quickly and with less reserve than with their physicians. Therefore I feel free, if I know the exact skills, the psychological understanding and the discretion of a nurse, to give this particular nurse the order to obtain the pre-history.⁷⁰

This short section touches on the specific relevance of nursing within psychiatric practice. As will be suggested, nurses occupied a kind of strategic position, because the "mutual trust" relationship between the patient and the nurse enabled the psychiatrist to gather information that he himself was not able to obtain. This specific relationship between nurses and patients is sometimes reflected in the record. In some records, letters were found in which patients emphasized their appraisal of particular nurses.⁷¹ Anna Maria B.'s record contained, for example, a drawing with birthday greetings for a nurse named Maria. (See Figure 12) Something similar was never found for psychiatrists. However, the strategic relationship between nurses and psychiatrists is illustrated in the interplay between their separate records.

5.3 Nursing Records

The nurses were often the first hospital personnel the patient encountered when entering the institution, especially if the patient had been transferred from another hospital. Most were provisionally admitted by nurses and only over the next few days were they officially admitted by the psychiatrist. Like the admission rituals carried out by psychiatrists, admission procedures undertaken by nurses also had a ceremonial character, although with some important differences. While physician admission rituals were meant to demonstrate the power of the psychiatrist through making the patient understand their behaviour as madness, to realize that madness was illness, and to apprehend that they were under the control of the psychiatrist, nurses admission measures had a purely disciplinary aim that targeted the patients' body.



Figure 12: Drawing with birthday greetings for Nurse Maria, 1931. Patient record 23883.

This focus began the moment the patient arrived on the ward. A Langenhorn nursing school textbook described the procedure.

Every arrival is guided to the ward and gets a bath as a start; if he resists it despite persuasion the physician must be informed. The bath functions not only to clean the sick person but also provides a means to inspect his body for something like wounds, skin rashes, vermin (hairy parts!), abdominal ruptures and others. Also the clothing is to be reviewed during the bath (valuables, arms, vermin). After the bath the sick person has to be weighed and, if not decided otherwise, to be put to bed and kept under constant surveillance.⁷²

This procedure was also routinely carried out in Friedrichsberg when patients were admitted from home, but not when patients, like B. were transferred from another hospital. The meaning of the bath obviously extended beyond a simple cleansing of a patient's body; it signified the starting point for appropriating patients' bodies, because they were not only weighed and measured but every bodily function as well that was deemed beyond "normal range" became the target of specific nursing interventions.

Nurses used different forms to record their work, compiling individual fever charts, for example, from the moment patients were admitted to Friedrichsberg. B.'s fever chart was drawn up on the day of her admission, as was a weight table, the latter suggesting that the admitting nurses were already informed of her refusal to take any food. (See Figure 13) As other medical records demonstrate, the routine procedure was to weigh the patient on the day of admission, to note the weight in the fever chart, and to check the weight sporadically during a patient's hospitalization, if at all. In B.'s case, however, her weight was noted not only on the fever chart but also on a weight table. As we will later see, "facts" on the record had the ability to initiate further action, recalling sociologist Bruno Latour's concept of "chains of action."⁷³

Figure 13: Fever chart for the first days of admission in 1931. Medical record 28338.

Different forms suggest that there was a perceived need for continuous observation of particular bodily functions. For example, the fever chart predetermined the need for regular monitoring of body temperature and pulse, and that these and other factors (prescriptions, urine output, etc.) should be recorded in a predefined manner that was controlled by the construction of the chart. These charts also determined who was allowed to write on the form and above all, who

was allowed to enter what factors into the form. The writing of remarks, for example, was a task reserved for physicians, whereas temperature, pulse, defecation, weight, tube feeding, and medications were recorded by nurses. Occupying a pivotal position between psychiatrists and nurses, fever charts are especially interesting, because they were always compiled at least for the patient's first couple of days in the asylum and they sometimes initiated further consequences. The fever chart was thus a complex "inscription" because it graphically represented patient corporeality. As a kind of map, the fever chart integrated large amounts of different data onto one single form, relating this information in a specific way to make certain interrelationships visible. The fever chart was further connected to a wide range of "inscriptions devices," such as clinical thermometers, clocks, centrifuges, and catheters, and served both to initiate a series of organizational reactions and to facilitate the mutual co-ordination of individual nurses. The record had much more than an auxiliary role, however, because not only did it represent this co-ordination of work but it also initiated and mediated it. The record was a material form of semipublic memory; it was a "*structured distributing and collecting device*, where all the tasks concerning the patient's trajectory must begin and end."⁷⁴ Scribbling a "+B" (bacteria found in urine) onto the fever chart resulted in B.'s repeated catheterization, a detailed analysis of her catheterized urine, and the repeated verification of her body temperature, illustrating the pivotal role that these inscription devices played within the asylum. The record afforded the ability for "action at distance:" the act of writing on the nutrition chart about B.'s refusal to eat, for example, channelled a wide range of asylum resources around and through her body.⁷⁵ A forced feeding was ordered for B., for which it was necessary to bring her to a treatment room, find two nurses to hold her down, engage a psychiatrist to introduce the tube, prepare a specific diet, observe that she did not vomit afterwards, and so on. The patient's body was rendered transparent through further disciplining and material rewriting and through the production of comparable and combinable inscriptions that could be listed on a few sheets of paper. As sociologist Marc Berg, wrote, "the availability of such an over viewable, durable and moveable set of inscriptions

allow[ed] physicians the opportunity to extend their gaze across time and space.”⁷⁶ The patient’s body was disciplined through different interventions and made transparent by translating bodily functions into charts and lists (inscriptions). In the end, the patient became nothing more than sheets of paper.

Divisions on the chart prescribed when the specific information had to be charted, structuring nurses’ time and thus entering the sequential nature of the fever chart into the temporal organization of asylum work.⁷⁷ Each day was divided into two-hour stages. The column in the middle of each day, however, was a little broader than the others, signifying that the days were further subdivided into four two-hour columns, which resulted in eight-hour segments (According to the chart, the asylum day was only sixteen hours) The chart was thus constructed in such a manner that nurses entered their information during the morning and evening shifts. The chart enforced the idea that particular kinds of recordings had to be carried out in a predefined manner but other fields in the chart could be used for purposes other than what was intended.

The chart was laid out as an x-y axis graph, with the temporal dimensions of hours, days, and weeks charted along the x-axis, and the measurements of pulse, respiration, and temperature placed along the y-axis. The “normal” range of the latter measurements lay on a curve highlighted in bold in the middle of the graph, making them easy to monitor, to see their relation to each other and to other entries on the chart, and to note whether or not they were outside the normal range.

Within specific limits, however, the form could be adjusted to meet organizational necessities. The complex temporal structure of the asylum could only be maintained through a material infrastructure of lists, schedules, and so forth. Moreover, while the chart format structured the nurses’ time during their working day, the psychiatrist could choose on their own when to take notes or when to carry out specific tasks. The differential valuation of time between the professional groups in the asylum was built into the very structure of the record.

Nevertheless, the form did not simply determine the course of action it mediated nor did it just impose its structure on those working with it. It was not an uncomplicated intermediary

between the “intentions” of those who ordered particular tasks and the activities of those who performed it. Certain fields, especially at the top of the form, were not filled in. On B.’s record, for example, no one had written anything about the origins of her illness, her diagnosis, or her occupation. As ethnologist Harold Garfinkel contended, some indices were considered simply superfluous for the performance of everyday work, a fact that he stated was a general feature of record keeping in psychiatric asylums.⁷⁸ The fields on the lower part of the fever chart were also only partially used; for example, not one single record had the space for “comments,” filled in, not necessarily surprising since it was a fairly limited space in which to enter remarks for psychiatric patients. However, in many records, examinations, laboratory results, prescriptions, and interventions, etc., were entered on the fever charts even though they were not designed for this kind of detail. The fact that these forms were sometimes used in a manner other than that prescribed by their organizational structure highlights the fact that rules were constantly reinterpreted or overridden. Berg called these instances “repair work,” because it suggested an ongoing elaboration of what was or needed to be written down and what had to be done. “The continuous working around and re-interpreting of the record’s content allow the record to function – to distribute and collect, and thereby transform the very work of those who bring it alive.”⁷⁹

A kind of “insider knowledge” was necessary to read these charts. For example, although different colours were used to register body temperature and the pulse (red and black, respectively), most of the information entered on the fever chart was written in a “code-like” style, necessary not only because the space on the chart was limited, enforcing the use of abbreviations, but also because the entries were part of a “special discourse.”⁸⁰ (On the delineation between different discursive formations see the analysis below.) And although the red “E+Z ø” indicated that B.’s urine was free of protein and sugar, the code “+B” revealed some bacteria, and she was catheterized three consecutive times to obtain sterile samples. The “Einl. I”

in the “feces” column meant that she had received an enema, a successful procedure that was repeated four days later with a “clyster.”

The first entries on B.’s fever chart, begun on the afternoon of her admission on 18 February 1931, were her body weight (45 kg.) and temperature. Because her temperature was considered elevated and her weight low, these entries initiated a cascade of interventions in the days to come. The next day, the word *Punkt* (for *Punktion* or puncture) revealed that a lumbar puncture had been carried out. This procedure in turn led to new inscriptions – new recordings – when the psychiatrist filled out more lab requisitions. (See Figure 14 and 15) He sent the specimens he obtained to the laboratory for testing, and the results of the tests came back in diagram or table form, which were then posted on the chart by the laboratory assistant. From this moment on, these inscriptions became parts of the medical record, with B.’s internal bodily functions translated into graphs and figures.

Staatskrankenanstalt Friedrichsberg
Gedüngte Abteilung

Diagnosezettel A

Lab. No.: 114225
Name: B. [redacted]
Datum: 18.2.31
Diagnose: Schizophrenie, akut
Bemerkungen der Serologischen Abteilung:
Nicht ansteckend
Sch. mit [redacted]
Lfg.

Staatsarchiv Hamburg

Staatskrankenanstalt Friedrichsberg

Name: B. [redacted]
Lab. No.: 114225 (Diagnose: Schizophrenie, akut)
Akute No.: 70235 (Diagnose: Schizophrenie, akut)

Blut

untersucht: 3.5.2.1931
Wa. H. 45 kg. Norm. Rate: 0.2
Syst. Post. Lab. Rate: 0.2
Cholesterin: Fast: 0.2
Bismutkontrolle: 0.2
Bismut: 0.2
Syst. Post. Lab. Rate: 0.2
Verfärbungen: Cholesterin: Fast: 0.2
S. O. H. 0.2
B. H. 0.2

Gesamtergebnis (Blut):

Liquor: untersucht: 3.5.2.1931
Wa. H. 45 kg. Norm. Rate: 0.2
Syst. Post. Lab. Rate: 0.2
Cholesterin: Fast: 0.2
Bismutkontrolle: 0.2
Bismut: 0.2
Syst. Post. Lab. Rate: 0.2
Verfärbungen: Cholesterin: Fast: 0.2
S. O. H. 0.2
B. H. 0.2

Staatsarchiv Hamburg

Staatskrankenanstalt Friedrichsberg
Serologische Abteilung.

Herrn Dr. Niebeling

Normo-Mastixreaktion gefärbt
ausgeschlickt

Lab. Nr. 114225
Name: B. [redacted]
Liquor vom 19. Februar 1931
Abt.: Hs. 10
Ergebnis: negativ
Hamburg den 20. II. 31.

Figure 14: Requisition slips for laboratory analyses. Medical record 28338.

The fact that no abnormal physiological results were found supported, in a reverse manner, the diagnosis of schizophrenia. Laboratory analyses, obeying a rationality of “differential diagnosis” could only “prove” the physical symptoms of something like paralytic dementia or encephalitis because no laboratory measures enabled relating any specific mental illness to pathological processes in the brain. B.’s psychiatrist, who had written “schizophrenia, perhaps

encephalitis?” implied that there were only two diagnostic possibilities. Because the results falsified the hypothesis that B. might have been suffering from encephalitis, the actual diagnosis of schizophrenia was verified. Like the interrogation during the admission examination, the laboratory analyses recreated what Foucault had called a form of “mimesis” or “analogon” to organic medicine. Simultaneously, they served as objective evidence of B.’s schizophrenia and thereby underlined the chronic nature of her condition. If no pathological cause could be found, the cause of the disease therefore lay in what Bleuler had described as “heredogeneration” – in her constitution – implying that no hope for a cure existed. From the beginning then, the laboratory analyses constructed her condition as “hopeless.”

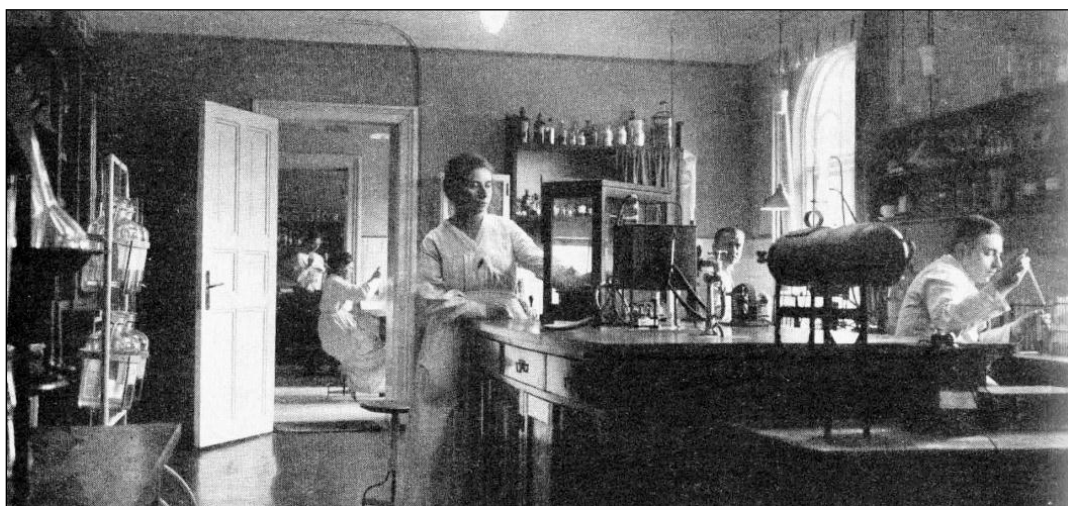


Figure 15: View into the laboratory of Friedrichsberg.⁸¹

Anna Maria B.’s weight (46 kg) was recorded again on 22 February. In combination with the fever chart, the weight table led to the construction of a nutrition plan. (See Figure 16) The nutrition plan was not a standardized form but was designed by the nurses themselves, who apparently also participated in establishing conditions that enabled surveillance of their work. Even though written in pencil, it was an official part of the medical record, and contributed to the organization of their daily work as well as to the number of interventions carried out on the

patient. Most notably, however, the nurses had also inserted a column for the psychiatrist's signature, suggesting that he was expected to monitor the entries in the table.

The figure consists of two handwritten medical records from the Staatsarchiv Hamburg. The left record is a nutrition plan for patient 'F. B.' (Friedrichsberg), dated 1/10/31. It lists food intake in columns: 'Morgens', 'Tischzeit', 'Mittags', and 'Abends'. The right record is a weight table for patient 'F. B.' (Friedrichsberg), dated 1/10/31. It has columns for 'Datum' (Date) and 'Gewicht' (Weight). The weight table shows a series of measurements over time, with the last entry being 41.5 kg on 13 April 1931.

Staatsarchiv Hamburg			
Name: F. B. 1/10/31 Friedrichsberg			
Datum	Gewicht	Datum	Gewicht
1.10.31	45.5		
2.10.31	46		
3.10.31	45.5		
4.10.31	46		
5.10.31	45.5		
6.10.31	46		
7.10.31	45.5		
8.10.31	46		
9.10.31	45.5		
10.10.31	46		
11.10.31	45.5		
12.10.31	46		
13.10.31	41.5		

Figure 16: Nutrition plan (left) and weight table (right). Medical record 28338.

The nutrition table was a consequence of the weight table, but it also resulted from the medical record from Barmbek where it had been reported that B. had refused to eat. From this point on, the nutrition “problem” was provable “objectively.” In other words, different tables and diagrams had made B.’s refusal of food visible – neither the family members nor B. herself had mentioned this aspect before – and it became the target of several disciplinary technical and nursing interventions. This “objective” information was supplemented by nursing reports in the medical file. Six days after B.’s admission to Friedrichsberg, both the data collection and the reports had not only led to the realization that her food intake was insufficient but also that she actually actively resisted any attempt to feed her. B.’s “aggressive-negativistic” conduct then led to the decision to feed her by force, a procedure that did not help to increase her weight. On the contrary, by 13 April 1931, she weighed just 41.5 kg.

As further analysis of the nursing notes demonstrates, the tube feeding was perceived as more a kind of educational intervention: the forced feeding was not aimed primarily at achieving a weight increase but rather to convince B. to start eating on her own accord. However, the interplay between the different inscription devices that dealt with B.'s weight loss demonstrates that the represented and the representation are wholly interdependent. The represented did not simply predate its representation; rather, the former only existed because of the latter and vice versa. Only by reading the weight table and the nutrition plan was it perceived, and proved, that B. had insufficient nutritional intake. The practices of reading and writing the record, then, are practices of reading and writing patients' bodies, as well as their subjectivities. As Berg noted,

the practices of representation are indistinguishable from the activities they supposedly represent. The intertwining of this distributing and collecting device with the hospital's organizational routines is what allows physicians to travel through a patient's body from behind their desk, to cross temporal, bodily and professional boundaries....⁸²

Nevertheless, that the documents directed the perceptions of the nurses becomes obvious when B. was readmitted to Friedrichsberg in 1936 and again in 1940. Although the nurses' notes mentioned that she was not eating sufficiently at those times, no nutrition plans were laid out. Although by 1936 the patient had lost more than twelve kg from her first admission to Friedrichsberg, her eating disorder is merely mentioned in the notes but never systematically observed and accordingly, did not become a target of nursing intervention. In 1940, no weight chart was even instituted, and thus neither B.'s weight nor her nutritional intake was monitored. At these points her weight was not a primary concern, and because it was not the subject-matter of specific inscriptive devices in the record, B. thus did not "have" an eating disorder.

From 24 February on, B. was force fed twice a day. (The German translation of the word *Fütterung* refers to the feeding of animals, somewhat unusual in special medical discourse when one would expect a word like *Sondenernährung*, which would be closer to the idea of nutrition.) Such a complex fever chart enabled viewing all relevant information of the patient's bodily

functions at a glance, or to use the terminology of Actor-Network Theory, all the bodily functions were translated onto the fever chart.⁸³ Furthermore, according to Garfinkel,

The expressions, the remarks that make up these documents [patient records] have overwhelmingly the characteristic that their sense cannot be decided by a reader without necessarily knowing or assuming something about a typical biography and typical purpose of the user of the expressions, about typical circumstances under which such remarks are written, about a typical previous course of transactions between the writers and patient, or about a typical relationship of actual or potential interaction between the writers and the reader. Thus the folder contents, much less than revealing an order or interaction, presuppose an understanding of that order for a correct reading.⁸⁴

Using abbreviations in the medical record was directed towards an economy of effort, since reports that were too long wasted the time of the writer as well as the reader, who wanted quickly to find the relevant information. However, the brevity and (seeming) incompleteness of these records worked since both reader and writer were part of the asylum medical personnel and were familiar with the language associated with those positions.⁸⁵ As this analysis has attempted to demonstrate, all bodily functions became the target of observations and interventions. Each was translated into an inscription in order to detect and correct possible “malfunctions” of, in this case, B.’s body. More importantly, by collecting physiological parameters and graphing them on, for example, the fever chart, it became possible to make visible trends that had not yet been physically manifested. As the following analysis demonstrates, this ability was an important aspect of psychiatric practice, and one that applied to nurses’ notes as well. Trends and tendencies not yet materialized can be said to be in a “space of possibility,” still in the process of becoming and thus in a purely virtual state. Although B.’s eating disorder, for example, was not yet fully developed, it became the target of multiple interventions in the hope of retarding any further progression. The struggle over the “virtual” behaviour of patients is the focus of the next section.

5.3.2 *Nurses' notes*

As previously mentioned, B. was first admitted to Friedrichsberg on 18 February 1931 by the nurses.

Afternoon, 18.2.31. New admission

Pat. lay in bed quietly, didn't answer questions, shouted out loud at certain times "I want to see my sister Gertrud, she is next door." Pat. only drank.
(Ha.) [nurse's signature]⁸⁶

As was the case for the psychiatric admission ritual that followed, this first entry contained nearly all the points that would guide future observations and reports on B., and all of these that are mentioned in these first few sentences were also part of the admittance attestation. The "general consideration (*Betrachtung*) of the sick person" was one of the "most important means" of obtaining a correct "detection of the disease (*Krankheitsfeststellung*)."⁸⁷ For example, according to Enge, a "comparatively simple aid for the detection of a disease is the position in the bed (*Bettlage*), the attitude and posture of the sick person. It can be perceived at a glance."⁸⁸ As the first clause revealed, B. was on bed rest, a typical nursing directive for psychiatric patients during these years, and one that presupposed an understanding of the usual nursing procedures for a correct reading.⁸⁹ Unusual activities in bed, however, might typically indicate a brain disorder. The phrase "did not answer questions" was more revealing, in that

...from the overall conduct of some sick persons by mere observation, without using any other method of examination, one very often obtains certain proofs of a disease. If one has for example a sick person who reacts to every advance (*Annäherungsversuche*) stiffly and with hostility, does not talk, freezes in a bodily position, always repeats the same movements, grimacing etc. then the diagnosis schizophrenia is not difficult to make.⁹⁰

From this perspective, the nurses had already confirmed the diagnosis of schizophrenia, supporting Enge's contention that it was "possible to perceive the suffering of a sick person 'at a glance.'"⁹¹

Although the psychiatric admission note had attempted to decipher the hidden truth of B.'s mental illness, the nursing records appeared to be less "directional;" nurses were apparently observing signs that might be connected to madness. The use of direct speech, as if the patients

were speaking for themselves, was an important strategic function of nurses' notes within the medical record that will be addressed later. Thus, in this short paragraph all the aspects of her diagnosis are assembled, and they will form the core of further observations about her during her stay in Friedrichsberg over the next few months.

On 19 February:

Night: Pat. slept. (Du.)

19.2. [Morning] :Pat. shouted continuously until 8[am]: "Muthorst, Gertrud aunty Hertha, Misses Kort I am still alive, one wants to kill me. Help, help, murder, murder, you villains, you beasts want to poison me. Help, help." Pat. could not be calmed down, took off her shirt, refused food, only drank. Pat. resists everything. Beats and lash out with feet. (Ge)

19.2. [Afternoon]: After coffee, Pat. was very lively, again and again sat upright in bed, laid her head over the barrier board (*Steckbrett*)⁹² and shouted: Cut off my head quickly, very quickly. Then pat. cried: "Now I won't see any of you ever again." Then, coffee time, pat. spat out everything, ate well for dinner. Food had to be given. Pat. slept well after dinner. (Schmi.) [all underlined passages here and hereafter in the original]

Night: Pat. was very restless and noisy. Threw around the bedding, did not let herself be touched, lashed out. (Du.) M. [Initialed by psychiatrist]

20.2. [Forenoon]: Pat. slept until 11 [am] became again very agitated threw herself around in bed shouted: "Please hack off my head, I have done wrong I want to die. O what a bunch of people are they, animals, beasts are they. O my head, my head hurts so badly." Pat. lashed out during feeding and clenches the teeth tightly. (Ge.)⁹³

For the first three days, the nurses charted regularly on B., although it was more frequent when events occurred that seemed noteworthy. Most entries consisted almost exclusively of quoting B., supplemented by the context in which she uttered her statements. One of the textbooks used at that time in the nursing schools at Langenhorn and Friedrichsberg pointed out that, since nurses spent more time than physicians with patients, their observations were of particular importance and that patients might be more willing to confide in them.⁹⁴ Apart from suggesting that psychiatric practice could not function without nurses, the text also spoke to the strategic position nurses occupied in relation their patients. As the author emphasized, "[the nurse] must be on his [*sic*] guard against giving an account of his personal opinion, but should

rather factually report what he himself has noticed, *without connecting it to any judgment*.”⁹⁵

Enge, too, believed that nurses should only offer descriptions of what they observed themselves, “the conduct of the sick person, all his doings, his talk, his moods, his habits and particularities, his bodily condition.”⁹⁶ The psychiatrist

wants to form his own opinion about the condition of the sick person. In order to do so he does not need an alien judgment but rather the knowledge of what happened during his absence. At this point very often mistakes are made with best intentions. It is not correct if the nurse reports, for example, that “The sick person hears voices and believes that he or she is being persecuted.” The physician wants to hear how the sick person behaves, for example, if he sits up and takes notice, if he stares into the distance, if he moves defensively or offensively: the physician wants to hear what the sick person says. The physician wants to draw the conclusions himself.⁹⁷

Nursing students at Langenhorn and Friedrichsberg were taught which descriptive categories and conceptual structures were important,⁹⁸ and the nurses’ notes from B.’s first three days in Friedrichsberg replicated these requirements. Everything the patient did became a sign of the underlying disease.

The use of direct speech implied that the nurses were reporting the exact image of events that had occurred, as if the madness was speaking for itself. It granted their notes a certain authenticity and their “objective, empiricist” language only strengthened this impression. A single quote from B. often stood as an exemplar for all of the statements she had made during an eight-hour shift, and was thus necessarily taken out of context. However, as sociologist Dorothy E. Smith suggested, this practice constructed “an account of behaviour so that it can be recognized by any member of the relevant cultural community as mentally ill type behaviour.”⁹⁹ She called this a “cutting out” procedure, accomplished “by constructing relationships between rules and definitions of situations on the one hand” and descriptions of mentally ill behaviour “on the other such that the former do not provide for the latter.”

Reporting in the asylum was done within the context of background knowledge and an understanding of normal courses of action. For example, B. was assigned complete bed rest when

admitted to the asylum, a fact that was not mentioned in the nurses' notes because it was a usual asylum-wide admission procedure. Thus, her behaviour in bed (sitting upright, laying her head over the barrier board, throwing herself around) was considered noteworthy because it deviated from the expected behaviour of lying quietly when on bed rest. This "observed" behaviour was enabled, or at least facilitated, by a form of institutional organization,¹⁰⁰ and its effects were similar to the trends made visible when various inscription devices were combined on the fever chart. It was the organization of asylum rules and regulations that provoked observation and classification of B.'s behaviour by both nurses and psychiatrists.

However, there is another dimension to the nurses' notes, because their thinking took place at the moment of writing – it was a "thinking in action," that was intertwined with artefacts. As Berg noted, "what we consider to be 'intellectual tasks' in fact often appear to be highly embodied activities."¹⁰¹ Latour termed this aspect "thinking with eyes and hands,"¹⁰² or "thinking is craftwork."¹⁰³ It is through writing that observations transform into manageable problems for the asylum's working routine.

5.4 The Interplay between Nurses' and Psychiatrists' Notes (part I)

In the process of writing, the nurses and the psychiatrist constructed a "clear case" on B.

On 20 February 1931, B.'s psychiatrist wrote that

At night restless and noisy, lashed out with her feet. Today in the morning also agitated: "Please, cut off my head. I have done wrong. I want to die..." Refuses food in an aggressive-negativistic manner. Liquor results proved negative (see attached).¹⁰⁴

His report more or less summarized the first three days of B.'s admission to the asylum, consisting almost entirely of information from the nurses' notes but reordering and representing them in a specific way. As Berg contended, representation involves the active work of ordering and is involved in the very event it represents: "'Representation' is not the (social) attaching of 'meaning' through which the (natural) world achieves its existence ... 'the social,' as a pure

category, is a chimera: practices always also include artefacts, architectures, paper, machines.”¹⁰⁵

As previously mentioned, psychiatrists underlined key features in nurses’ notes that they included in their own notes. In this instance, the first sentence is a combination of the nurses’ notes from 19 February. “Restless and noisy” came from the night nurse, and “lashing out with the feet” was noted in the afternoon. The psychiatrist’s report, however, suggested that this behaviour occurred every night because it no longer specified when these events were observed. The next sentence was taken as is from the nursing notes of 20 February but in using the term “also,” the psychiatrist implied that B. had been excited throughout the night, when in fact she had slept until 11 a.m. before becoming agitated. While the nurses may have noted that B. had had a bad headache and wished to cut off her head, this kind of context is absent in the psychiatrist’s note. His simple but terse statement on B.’s refusal to eat translated the detailed nursing descriptions into medical terms that had already been mentioned in the admittance attestation. The nurses’ note implied that she was being fed against her will (again using the German verb term *füttern*) which might well have explained her active resistance. In defining this problem in diagnostic-medical terms it became a medical problem and a symptom that must accordingly be treated. Moreover, the psychiatrist’s note became the official version of B.’s observed behaviour, helping not only to shape and maintain the course of B.’s asylum stay but also to illuminate the hierarchical relationships between B. and the psychiatrist and between psychiatrists and nurses.

The record functioned as a kind of “mediator,”¹⁰⁶ because it mediated the relations that acted and worked through it, transforming social interactions due to its “documentary capacity.” The “documentary capacity” of documents and texts in social organization refers to their ability to crystallize and preserve words detached from their local history. Through the materiality of documents, the meaning of lived processes is transformed, made and remade, at each moment of its course. Rather than being enforced by a sovereign individual, social consciousness is externalized by documents and texts, thereby objectifying reasoning, knowledge, memory, etc.¹⁰⁷

Two interrelated coordinating functions of the medical record within the asylum can be distinguished. First are the textually coordinated work processes, which construct the institutional realities that make the actual actionable. This is a form of “fashioning institutional representations.” From this perspective, the record establishes an “organizational time” by transforming the sequences of local events into another time frame; organizational judgment or information thus becomes an objectified documentary rather than a subjective process. Second, as seen in the translation from the nurses’ to the psychiatrists’ notes, “hierarchical forms of intertextuality in which texts on one level establish frames, concepts, and so on, [are] operating on and in the production of institutional realities.”¹⁰⁸ As Smith wrote,

The work of fitting the actualities of people’s lives to institutional categories that make them actionable is done at the front line. The categories, questions, or other particulars are governed by and responsive to frames established at a more general level.¹⁰⁹

The medical record is activated through practices of reading and writing: “These practices, in which the record is turned to, leafed through, read, used for jotting, communicated through, dispatched, form a crucial side in the sociotechnical organisation of medical work.” Without these practices the record would be without relevance. All of these activities “allow it to have its mediating role in the organization.”¹¹⁰ These interrelations of people and paperwork formulate the conditions so that the psychiatrist can be a psychiatrist, the nurse can be a nurse, and the patient becomes the diagnosed mentally ill person.

5.4.1 *The text – reader conversation*

The practices of reading and writing were crucial “in the production of the very possibility of “*doctoring*.”¹¹¹ The process of writing demonstrated the psychiatrist’s competence and his intellectual qualities. Every entry in the medical history entailed the active production of a historical piece of information with the result that every bit of information was transformed into a symptom of illness. The psychiatrist’s paperwork was a crucial feature in this transformative process, allowing it to create a representation of “the patient.” As Berg maintained, “its value lies

in the very fact that it is a highly selective, distanced, abstracted ‘representation.’”¹¹²

Furthermore, the patient is put into the temporal or psychiatric order of a mentally ill person’s life span. Through the record the patient is integrated into a kind of a biography of the mentally ill.

Through the writing of the patient’s medical history, he or she becomes part of a “new temporality”: the temporality of the psychiatric order. The psychiatrist’s notes are not simple recordings; his reading and writing cannot be disentangled from his thinking. The reordering of events as outlined in the medical history under study here demonstrate the simple but significant phenomenon that the psychiatrist’s own inscriptions become part of the information resources he had available as an element of the “thought processes” themselves.¹¹³

This analysis suggests that texts are active, not static, and thus are crucially significant in the asylum. The direct engagement of readers with texts “activates” them, creating a connection between the local bodily being and the translocal organization of “ruling relations,”¹¹⁴ which Smith described as “objectified forms of consciousness and organization, constituted externally to particular places, creating and relying on textually based realities.”¹¹⁵ (See Figure 17) In bringing these different levels (local/translocal) together into one dimension, the text can be viewed as actively organizing institutional relations. “Documents in action” construct particular visions of the world and structure identities of those served by the asylum in specific ways, whether they are known as patients, clients, or the criminally insane.¹¹⁶ Records are therefore “enrolled” in routine activity because they direct activities or serve as props in interaction; they enable the asylum to “perform.”

Nevertheless, it is important to recognize that not only is the text active but also the reader. A kind of “conversation” between the text and the reader takes place; text and reader enter into a dialogical relationship or a “duplex action.”

Texts have this capacity for a dialogic or dual coordination, one as they enter into how the course of action in which they occur is coordinated and the other in how the text coordinates a local and particular course of action with social relations extending both temporally and spatially beyond the

moment of the text's occurrence.¹¹⁷

Texts are read by a specific person in a particular local setting, but unlike conversation, they remain the same no matter how many times they are read. The text remains unchanged by the history of its reading and is unresponsive to the reader's engagement with the text. This characteristic of written texts is crucial for their role in institutions, because it is

key to the effect of institutional standardization across multiple local sites of people's work. It produces for any institutional participant reading the text a standardizing vocabulary, subject-object structure, entities, subjects and their interrelations, and so forth. They are the same for all readers, and as readers talk or otherwise act to coordinate across situations in relations to the text, it regulates the discourse effective amongst them. Sure, they may use other speech genres, some of which resist the institutional, but even resistance adopts the standardizing agenda, if only as foil.¹¹⁸

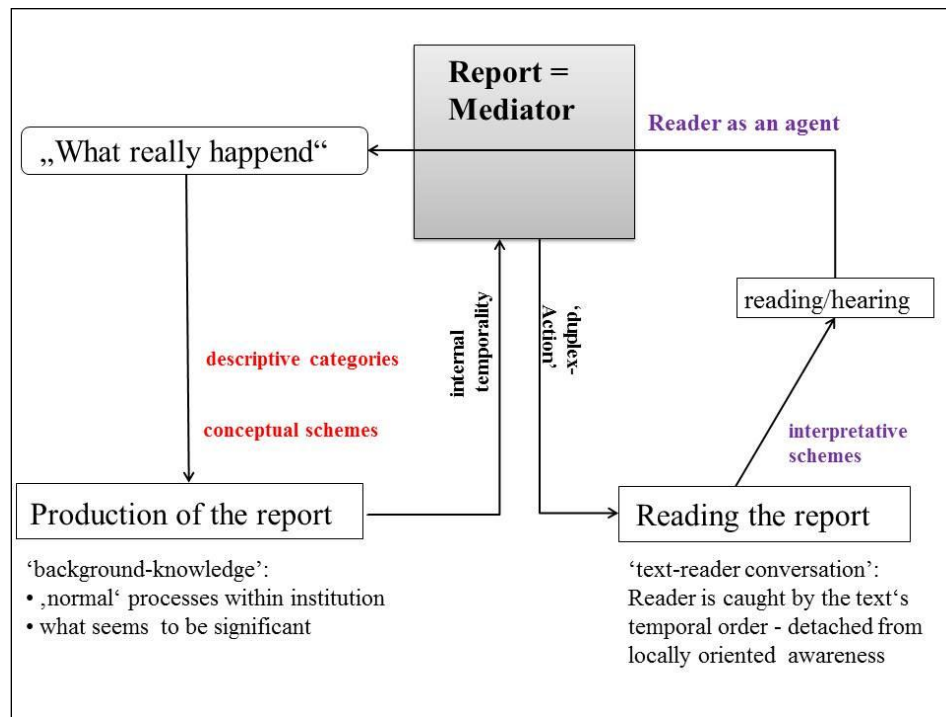


Figure 17: The report as a “performative” object.¹¹⁹

5.4.2 *Governing at distance*

To govern the asylum is a mode of action, which depends on a reality constructed through documentary processes. (See Figure 18) Writers of texts and their readers are separated in time and space, and texts can be read by different individuals, in different places, and at different times. These characteristics thus allow documents to coordinate people's activities translocally, and they play an important role in standardizing social organization in institutions. Through the text-reader conversation, readers are caught by the text's temporal order and detached from their local bodily presence. "When we read, the text contains our consciousness; it lifts us out of locally oriented awareness," and this containment of consciousness enables readers to recognize the "active" part that texts play in coordinating people's work.

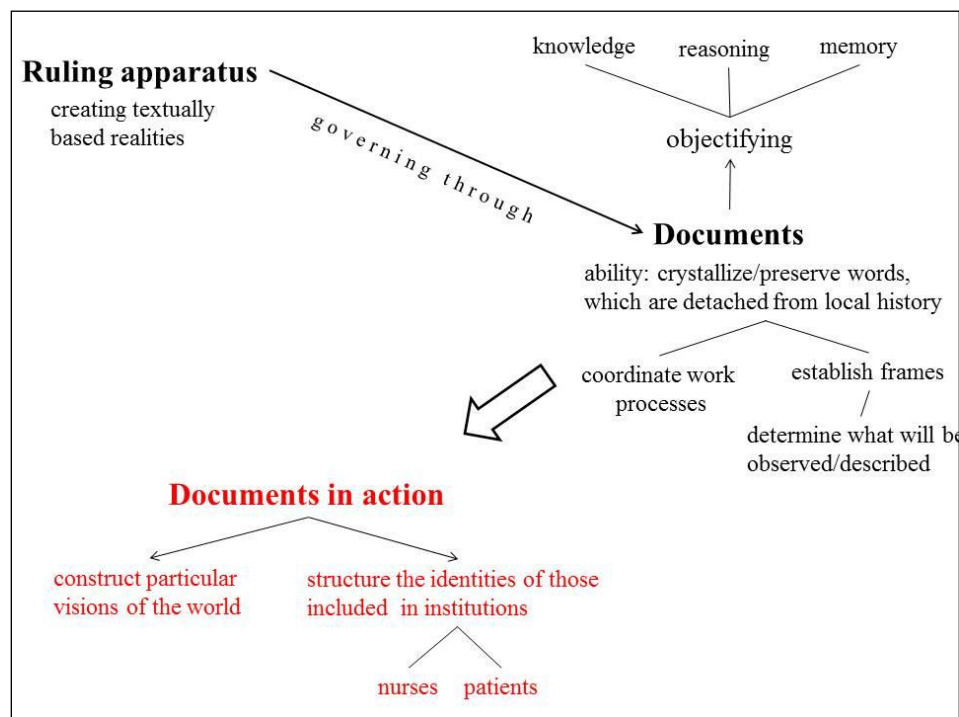


Figure 18: Governing at distance.

The reader activates the text, and in so doing, becomes the text's agent; the reader responds to it in whatever way.

The activated text is playing a crucial part in organizing definite sequences of action. One possible way of coordinating individuals within an institution is to initiate a sequence "that is

involved in coordinating more than one individual in an institutional course of action.”¹²⁰ Smith used the term “processing interchange” to characterize this form of work organization. “At each processing interchange, a text enters and is processed. It may then be passed on as modified or checked, or a new text built from resources of the original is produced and passed on. The individual whose case is organized in this process has been constituted textually.” The institutional schedule organizes the life of this individual. Who the individual is, how he or she is recognized, and how he or she may be required to perform “are established in the texts that make up the record of the case.”¹²¹

5.5 The Interplay between Nurses’ and Psychiatrists’ Notes (part II)

The mechanisms analyzed above can be detected in every note in B.’s medical record. For example, the next note written by the psychiatrist is found on 22 February 1931, two days after the previously analyzed entry.

Stuporous. Refuses food. Often asks for water but does not drink. In the afternoon she refuses food saying: “I mustn’t, I am so bad.” Stuporous, with closed eyes.
Luminal exanthema: [drug] received from 10.2.-18.3. 2.0¹²²

His note was based on nursing records from 20 February to 22 February:

20.2.31 After: Pat. is quiet, answers hesitantly questions. (Ha.) M.
Night: Pat. slept. (Du.)

21.2. Foren: Until coffee time pat. was very agitated, said: “O father why did you do such wrong and why do I have to pay for it. Pay for your deeds, mother, Gertrud help me. Nurse give me a lot of water I am burning, fast fast I can’t take it anymore.” When pat. received the water she poured it all over the bed to extinguish the fire. Pat. makes herself stiff and becomes violent when one want to take care of her. Pat. eats almost nothing. (Ge.)

After: At times, pat. cries quietly but does not finish a single sentence, suddenly stops. (Ha.)

21/22.2. Night: Pat. fell asleep at 11 [pm]. (Str.) M.

22.2.31 Foren: Pat. very often asked for water, spilled it in bed and cannot be made to drink. Pat. stayed in bed, mostly indifferent. Is very resistant when being fed, clenches her teeth or spits everything in the bed. Pat. consumed almost nothing. (Schm.)

After: Pat. was very apathetic on various occasions asked for water of which she also always drank a few sips; during visiting time pat. did not accept anything from her relatives, spat everything out and said: "I am not allowed to, I am so bad." Lay there her eyes closed almost all the time.¹²³

Since the psychiatrist reported on his patients only every two or three days, his opening assumptions that she was "stuporous" and "[refusing] food" characterized time between the notes. This was thus another effect of the notion of "documentary time" because time not mentioned in the record became time that did not exist. B.'s "local" time was detached from the "documentary time" in the record, enabling more than seventy-two hours of the "asylum lifetime" to be compressed into just three short words. Three days of her life were contained in twenty-six lines of the nursing record, but they were further compressed in the psychiatrist's note. This decisive capacity not only caused periods of "local embodied time" to vanish, it also implied that the undocumented periods were not worth documenting. Furthermore, the psychiatrist translated the underlined words "indifferent" and "apathetic" from the same day into the medical term "stuporous." Although the nurses had focused more on B.'s resistance and her indifference had been only a minor point in their eyes, in the psychiatrist's note it had become a clear symptom of her schizophrenia, and his reporting of her "closed eyes" only further emphasized this idea.

B.'s stupor and her refusal to eat became the main focus of the psychiatrist's medical reports from that point on and both, it should be noted, were already part of the admittance attestation. While the physician noted that B. often refused to drink the water she had asked for, the nurses had stated she had taken some sips, and that she had poured out the water because she thought her bed was burning, a context missing from the psychiatrist's report. Once again, he ordered all the symptoms to fit the frame of the diagnosis. The "rule violations" that the nurses recorded (does not stick to bed rest, becomes violent if one tries to care for her, does not adequately react to her relatives ,etc.) are marshalled to illuminate schizophrenic behaviour. And while nurses had at least used the word "patient" when they had written about her, B. as an individual vanished completely in his note.

The longer B. stayed in the asylum as well, the shorter the notes from the medical personnel became; they began to resemble a telegram more than anything else.

On 25 February 1931, three days later, the psychiatrist wrote that

Whines, at times timidly. Otherwise stuporous. Since yesterday tube feeding.¹²⁴

The nurses' notes from 23 to 25 February recorded that

22.2. Night: Pat. slept. (Jü.) M.
23.2.31 Pat. moans "o, o, I cannot stand it, I cannot stand it." Pat. often leans across the bed and lets Pat. T. lift her out of bed, became very restless and lively. Did not eat anything. (Ys.)
23.2. After: Pat. was quiet, did not speak, slept a lot. (Sa.)
Night: Pat. slept. (Sch.)

24.2.31 Foren: Pat. lay in the bed quietly and silently. Got a feeding. Pat. spat out any other food. After a lot of convincing from her mother, the Pat. consumed some chocolate and some orange. Pat. often vomits; does not urinate. (Sch.)
24.2. After: Pat. was quiet until 8 o'clock, [then]surged out of the bed, stood by the window and shouted: "Mama I'm dying!" Pat. did not eat or drink anything. (Sa.)
Night: Pat. had little sleep, stood continuously on the window sill, held on to it tightly and shouted "Mommy, mommy please get me out of here." (Jü.)

25.2. Foren: Pat. crawled onto the window sill in the morning and looked out. Otherwise she was quiet, slept a lot and consumed only chocolate pudding apart from the tube feeding. Pat. does not react to questions. (Sch).
25.2. Pat. slept a lot. (Ru.)
25.2. After: Pat. slept a lot, got a feeding. (Hu.)¹²⁵

This sequence illustrated that, in comparison to the nurses' note, those written by the psychiatrist notes had become even less detailed. Again, the psychiatrist had compressed the three intervening days between notes, and again, it confirmed what had already been decided about her behaviour. This time, however, no sentences had been underlined in the nursing notes. Although the first clause in the psychiatrist's note is taken from the nurse's chart on the twenty-third of the month, the word "stuporous" cannot be found, unless it was implied from the nurse's statements on the twenty-fourth. Furthermore, from the recordings on the fever chart it is perceivable that B. had developed a high body temperature (39°C) but to the psychiatrist, her behaviour seemed to be

nothing more than an aggravation of her mental condition, and indeed, the term “whines” can be viewed as pejorative.

Nevertheless, the overall picture in the nurses’ notes is one of patient resistance to asylum treatment – both to the nursing treatments (adjustment to the asylum schedule, bed rest, repeated catheterizations, clysters, etc.) and to the medical interventions (lumbar puncture, blood work, examination, interrogation, Luminal and Scopolamine injections, etc.), and from 24 February, to the forced feedings. All these interventions had taken place over this period of reporting on B., but were never mentioned in either the nurses’ or psychiatrist’s notes.

B.’s behaviour evolved in the record through the active interplay between these two sets of notes. On 26 February the psychiatrist noted

27.2.31 Sore throat. Stuporous, autistic. Only spontaneous comments: “I want to die, I don’t want to live anymore.”

28.2.31. Unchanged in stupor. Transferred to House 16.¹²⁶

Compare his note with those of the nurses from 26 to 28 February.

25.2. Night: Pat. slept. (Si.) M.

26.2. Foren: Pat. lay still, ate some milk and custard. (Li.)

After: Pat. lay still in bed, sleeps a lot. Pat said once: “I want to die, I don’t want to live any longer.” Otherwise does not answer questions. (Ru.)

26/27.2. Night: Pat. slept. (Si.) M.

27.2. Foren: Pat. lies continuously with her eyes closed, lets saliva drool out of her mouth, only ingested feeding. (Fr.)

27.2. After: Pat. was absolutely apathetic, lay with her eyes closed very quietly in her bed, only after the light was switched off did Pat. sat up in bed and look at her environment. (Hu.)

27/28 Night: Pat. slept with short interruptions. (Si.) M.

28.2. Foren: Pat. lays in bed quietly, does not answer questions. (Ru.)¹²⁷

The psychiatrist’s note from February 27 began with a medical diagnosis that was also written in pencil on the fever chart. This chart also noted that B. had developed a high fever for which she had received throat compresses (*Halsprignitz*) and chest inunctions with “Transpulmin.” Although these bodily symptoms may well have explained B.’s apathetic behaviour, the frame of reference in which the nurses and physicians were operating contained within it the possibility that other conditions could be ignored. The term “autistic” was also an

escalation of “stuporous” because it implied a disconnect with her surroundings, an aspect that became more emphasized after B.’s transfer to another ward in March 1931. The words “only spontaneous remarks” built on this impression since B. appeared to be giving “kneejerk” reactions to stimuli rather than being connected to real events occurring around her. And while the psychiatrist seemed to suggest that B.’s wanting to die was an example of her general state of mind over this time, the nurses’ notes revealed that she had made this remark only once.

In his last two notes from February 1931 in particular, the psychiatrist seemed to be focused only on verifying B.’s admission diagnosis to support the decision to transfer her. Observing newly admitted patients closely in order to decide their future placement within the asylum was a routine procedure at both Friedrichsberg and Langenhorn, but it is clear that decisions to transfer were based more on disciplinary rather than on medical considerations. The plan to transfer B. to House 16, one of the eleven so-called treatment houses for women in Friedrichsberg, confirmed not only her diagnosis but also the degree of trouble the asylum personnel thought she might cause. (See Figure 19) This impression is emphasized by the fact that all record keeping broke off between 28 February and 4 March, when the fever chart indicated that her “treatment” began again in House 16. Thus, for nearly one week, no detailed reports were written on B., another indication of what I have termed “documentary time.” The fact that this one week was not worth noting automatically implies that B.’s week was so “empty” and so monotonous that nothing important enough occurred to add to what was already known about her. The record enabled the literal disposing of a patient through non-observance; if the represented (the patient) and the representation (of the patient) were wholly interdependent, then not being represented in the record signified that the formerly represented disappeared and became non-existent. B.’s “non-existence” during that last week in February is strengthened by the content of the psychiatrists’ notes from House 16, which continued to emphasize her stuporous and autistic state as well as her refusal to eat; nothing had apparently changed. The “documentary time” of the record gave the impression that B. was already, at the end of February

1931, an “empty human shell” (*leere Menschenhüllen*),¹²⁸ a concept discussed in more detail in the next section.

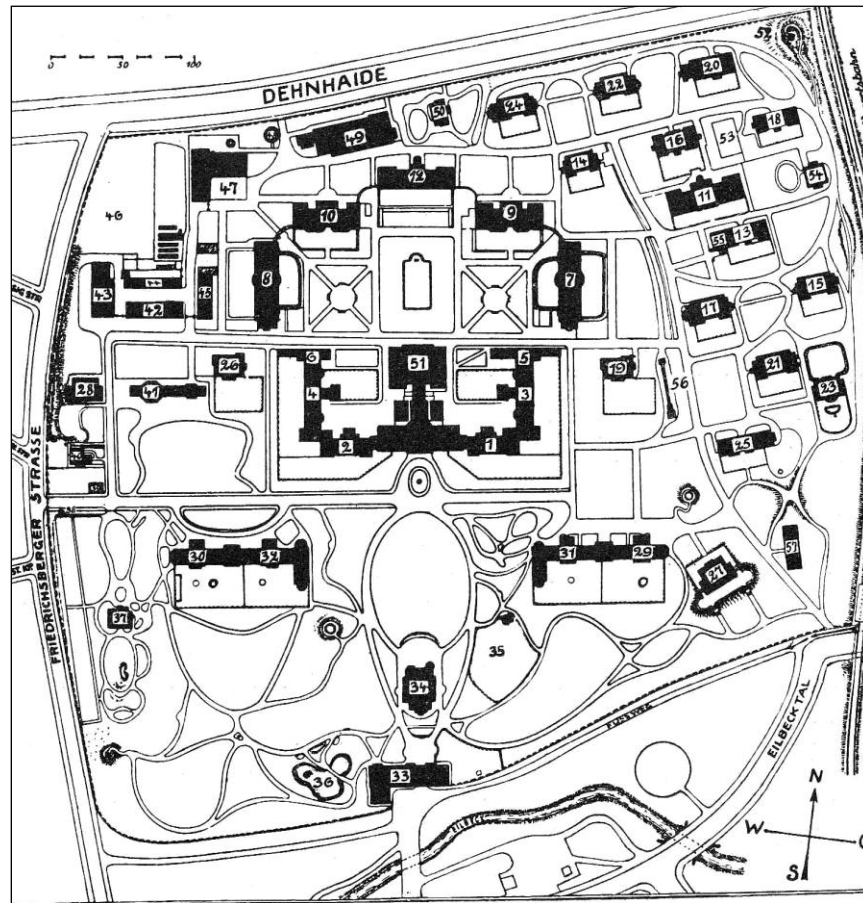


Figure 19: Friedrichsberg Asylum, 1931.¹²⁹ Explanation: House 1. and house 27: open section for men, house 2: Open section for women, house 7: House for agitated men, house 8: House for agitated women, house 9: Reception men, house 10: Reception women (Anna Maria B. was admitted to this house), houses 5, 11, 13, 15, 17, 19, 21, 25: Treatment houses for men, houses 4, 6, 12, 14, 16, 18, 20, 22, 24, 26, 28: Treatment houses for women (Anna Maria B. was transferred to house 16), house 23: House for adolescents, houses 29, 31: Nursing homes for men, houses 30, 32: Nursing homes for women, house 33: Administration, house 34: Concert hall, house 35: Game enclosure, no. 36. Lake, house 37: Residence of the director, house 38: Gatehouse, house 39: Residency of work master, house 41: Morgues, houses 42, 43, 44: Workshops, house 45: Stable, house 46: Nursery, house 47: Machine house, house 48: Water tower, house 49: Laundry, house 50: Residence for civil servants, house 51: Kitchen, no. 52. Vantage point, no. 53. Tennis court, house 54: Residence of senior physician, house 55: Surgery house, no. 56. Bowling alley, house 57: Animal shed.

Before continuing, it is useful to examine two other aspects of the nurses’ notes that involved the frequent use of different types of statements. First was the oft-repeated phrase “did not answer questions,” implying both that the patient was obligated to answer the questions posed by nurses, and that a hierarchical relationship between nurse and patient existed: it was the nurse

who asked and the patient who was to answer. Although it is unclear exactly what kinds of questions were asked, it is likely that they were designed to test B.'s mental status. Not answering the questions only confirmed her mental derangement and isolation.

Second, nurses' observations included every detail of a patient's life in the asylum, a phenomenon made possible by the structure of asylum life that enabled such boundless scrutiny. For example, the nurses provided detailed descriptions of B.'s behaviour during visiting hours, sometimes "quoting" what she had said to her mother or her activities after switching off the light. The emphasis on this type of reporting suggests that nurses had a clear idea of what "normal" behaviour in the asylum should be like. Nurses' use of the word "lively," which in general has no negative connotation, became a synonym for a behaviour that lay somewhere between quiet and agitated. The term "quiet" itself usually meant that patients did not disturb ward routines, but they could also be too quiet, which then referred more to them being apathetic and non-talkative.

The bed played a central role in these perceptions – more than 480 entries alone in her medical file between 1931 and 1943 (B.'s entire hospital stay) were related to her bed. We have already seen some of these comments: "[lying] with her eyes closed very quietly in her bed," suggested that she was expected to lie in bed with her eyes open but not make a disturbance. Sleeping during the day, rather than just at night, was evidence of illness. Even the simple fact of sitting upright in the bed could become an indication of abnormal behaviour. The same thing applied to descriptions of restlessness – throwing the bedding, shouting from the bed, etc. In general, it appeared that there was a certain "code of conduct" around bed behaviour, a set of rules that could also be applied to other activities.

Nevertheless, the nurses did not only observe B.'s behaviour but they also actively intervened to correct what they conceived as malbehaviour. With the transfer to house 16 not only the content of the notes changed but also B.'s treatment. This will be highlighted in the next chapter.

¹ This section is a revised version of a book chapter by the author, entitled "Regieren durch Akten. Die Funktion der PatientInnenakten bei den Krankenmorden während des NS-Faschismus," in *Strukturentstehung durch Verflechtung. Akteur-Netzwerktheorie(n) und automatismen*, eds. Hannelore Bublitz, Tobias Conradi and Florian Mühe (München: Wilhelm Fink, 2011), in print. All translations of quotations from the original German throughout the following chapter are mine.

² The idea of practice in this analysis is based on Foucault's conception of "pratiques discursives." According to his understanding, discourses are not simple "speech-coherences" or "esprits," but create epistemic objects within the historical possibilities of the episteme. They are effects of the discursive structure, which are historically locatable, have social outline, and are bound to specific media. Discourses thus follow specific "formative rules" that designate the conditions of existence of a given discursive dissemination; they are not simply an ensemble of signs, but rather practices that systematically produce the objects they are talking about. See Michel Foucault, *L'archéologie du savoir* (France: Gallimard, 2008); Philipp Sarasin, *Geschichtswissenschaft und Diskursanalyse* (Frankfurt a.M.: Suhrkamp, 2003). Discursive practice creates "objects that become real in the course of their representation. Bublitz, *Diskurs*, (Bielefeld: transcript, 2003), see also Andrea D. Bührmann and Werner Schneider, *Vom Diskurs zum Dispositiv. Eine Einführung in die Dispositivanalyse*, Sozialtheorie Intro ed. (Bielefeld: transcript, 2008). From this perspective, the discursive formation predetermines a discursive practice, as is the case for somatic medicine, for example, but psychiatric practice functions somehow differently. Here it is the "power dispositif" of psychiatry that appears as the productive instance of discursive practice. The discursive practice of psychiatry does not follow a discursive formation, but rather the disciplinary power of psychiatry develops techniques and strategies that in turn enable experiences and theories. In other words, the power of psychiatry generates a truth discourse within a power dispositif. Michel Foucault, *Le pouvoir psychiatrique. Cours au collège de France. 1973-1974*, eds. François Ewald, Alessandro Fontana and Jacques Lagrange, Hautes études ed. (France: Seuil/Gallimard, 2003), 171-180. According to Reiner Keller, practices could also be understood as "socially conventionalized fashions of actions," meaning that "typified routine models for ways of acting" are "taken up with more or less creative-tactical portions, learned, habitualized and carried out [translation mine]" Reiner Keller, *Wissenssoziologische Diskursanalyse. Grundlage eines Forschungsprogramms* (Wiesbaden: VS Verlag, 2008), 59-62.

³ A more general perspective on medical records tries to decipher how patients became psychiatric cases in the records. These approaches try to highlight how the reality of the patients was transformed by the record or was attempt to discover the "real" biography behind the documents. Sibylle Brändli, Barbara Lüthi and Gregor Spuhler, eds., *Zum Fall machen, zum Fall werden. Wissensproduktion und Patientenerfahrung in Medizin und Psychiatrie des 19. und 20. Jahrhunderts* (Frankfurt/New York: Campus, 2009).

⁴ Roelcke and Hohendorf, "Akten der 'Euthanasie'-Aktion T4 gefunden," *Vierteljahreshefte für Zeitgeschichte* 41, no. 3 (1993): 479-481; Peter Sandner, "Die 'Euthanasie'-Akten im Bundesarchiv," *Vierteljahreshefte für Zeitgeschichte* 47, no. 3 (1999): 385-400.

⁵ This can already be considered as a characteristic of the record. According to Don H. Zimmermann, documents appear as obvious and as nothing more than factual accounts of multiple events in the history of the patient, especially for the personnel in psychiatric asylums who treat the reports as mere facts. Zimmermann described this handling as a "taken for granted use of documents." Don H. Zimmermann, "Fact as Practical Accomplishment," in *Ethnomethodology. Selected Readings*, ed. Roy Turner, (Middlesex, England: Penguin, 1975), 143; Ulrike Hoffmann-Richter and Asmus Finzen, "Die Krankengeschichte als Quelle. Zur Nutzung der Krankengeschichte als Quelle für Wissenschaft und psychiatrischen Alltag," *BIOS. Zeitschrift für Biographieforschung und Oral History* 69, no. 2 (1998): 280-97; Guenter B. Risse and John H. Warner, "Reconstructing Clinical Activities: Patient Records in Medical History," *Social History of Medicine* 5, no. 2 (1992): 183-205.

⁶ Marc Berg, "Practices of Reading and Writing: The Constitutive Role of the Patient Record in Medical Work," *Sociology of Health and Illness* 18, no. 4 (1996): 499-524; Lindsay Prior, *Using Documents in Social Research* (London: Sage, 2008).

⁷ Dorothy E. Smith, *Institutional Ethnography. A Sociology for People* (Oxford: Alta Mira Press, 2005); Smith, "The Social Construction of Documentary Reality," *Sociological Inquiry* 44, no. 4 (1974): 257-268; Smith, "Textually Mediated Social Organization," *International Social Science Journal* 36, no. 1 (1984): 59-76; Michel Foucault, *Der Fall Rivière* herausgegeben von Michel Foucault. *Materialien zum Verhältnis von Psychiatrie und Strafrecht* (Frankfurt a.M.: Suhrkamp, 1975).

⁸ Bublitz, *Diskurs*, 58-9.

⁹ John Law, "Notes on the Theory of the Actor Network: Ordering, Strategy and Heterogeneity," Centre for Science Studies, Lancaster University, http://comp.lancs.ac.uk/sociology/papers/Law-Notes_on_ANT.pdf (accessed 3 May 2011).

¹⁰ Ibid.

¹¹ Michel Foucault, *Il faut défendre la société. Cours au Collège de France. 1976* (France: Seuil/Gallimard, 1997); Foucault, "Governmentality," in *Power. Essential Works of Foucault 1954-1984*, ed. James D. Faubion (London: Penguin Books, 1994), 201-222; Foucault, *Überwachen und Strafen. Die Geburt des Gefängnisses*, trans. Walter Seitter (Frankfurt a.M.: Suhrkamp, 1994); Alec McHoul and Wendy Grace, *A Foucault Primer. Discourse, Power and the Subject* (New York: New York University Press, 1993); Foucault, *Der Wille zum Wissen. Sexualität und Wahrheit 1*, trans. Ulrich Raulff and Walter Seitter. (Frankfurt a.M.: Suhrkamp, 1989); Foucault, "The Subject and Power," in *Michel Foucault: Beyond Structuralism and Hermeneutics*, eds. Hubert L. Dreyfus and Paul Rabinow (Chicago: University of Chicago Press, 1983), 208-226.

¹² In this research project the definition of patient record is relatively "open." The file is composed of handwritten and typewritten pages that concerned various aspects of the patient's therapy and that gained

an official status solely by the fact that they became part of the record. Practically every document in the record is stamped with the official mark of the medical director and signed by him or his representative.

¹³ Law, "Notes on the Theory of the Actor Network," 4

¹⁴ Bruno Latour and Steve Woolgar, *Laboratory Life. the Construction of Scientific Facts* (Princeton, New Jersey: Princeton University Press, 1986); Latour, *Science in Action* (Cambridge: Harvard University Press, 2003).

¹⁵ Bruno Latour, "Visualisation and Cognition: Thinking with Eyes and Hands," *Knowledge and Society*, no. 6 (1986): 7.

¹⁶ Actually the patient record produces multiple patient bodies, because different departments in the asylum and different official authorities perceive the body from different perspectives and represent it differently in the record. Marc Berg thus talks about the "multiple bodies of the medical record" and Annemarie Mol talks about "body multiple" to highlight the fact that in the patient record and in other materially heterogeneous work processes within the hospital, multiple patient bodies are produced. Marc Berg, "The Multiple Bodies of the Medical Record: Toward a Sociology of an Artefact," *The Sociological Quarterly* 38, no. 3 (1997): 513-37; Annemarie Mol, *The Body Multiple: Ontology in Medical Practice* (Durham and London: Duke University Press, 2002).

¹⁷ Bruno Latour, *Reassembling the Social: An Introduction to Actor-Network-Theory* (New York: Oxford University Press, 2005); Latour, "Pragmatogonies: A Mythical Account of how Humans and Nonhumans Swap Properties," *American Behavioral Scientist* 37, no. 6 (1994): 791-808.

¹⁸ The term 'performativ' refers to John L. Austin's speech act theory and is used here to highlight the fact that patient records put into effect what has been written. For example, from the moment a person is declared a schizophrenic in the record, the person becomes schizophrenic and remains so as long as this statement is part of the record. John L. Austin, *Zur Theorie der Sprechakte (How to do things with words)* (Stuttgart: Reclam, 2002); Judith Butler, *Excitable Speech. A Politics of the Performative* (London: Routledge, 1997).

¹⁹ Law, *Notes on the Theory of the Actor Network*, 5

²⁰ In his chapter Ulrich Müller describes the construction of the patient record in the research project on 'Aktion T4' in exactly the same manner. It can therefore be assumed that patient records were constructed in the same manner in all psychiatric asylums in the German Reich. Ulrich Müller, "Metamorphosen: Krankenakten als Quellen für Lebensgeschichten," in *'Das Vergessen der Vernichtung ist Teil der Vernichtung selbst.' Lebensgeschichten von Opfern der nationalsozialistischen 'Euthanasie'*," eds. Petra Fuchs et al (Göttingen: Wallstein, 2007), 80-96.

²¹ This does not imply that every reader understands the text in the same manner, on the contrary, but rather that the text in its materiality as written text remains unchanged from the history of its reading. See also Jacques Derrida, *De la grammatologie, Circuits critiques*, ed. (Paris: Éditions de minuit, 2006); Derrida, *Die Schrift und die Differenz* (Frankfurt a.M.: Suhrkamp, 1997); Derrida, "Signature Event Context," in

Margins of Philosophy, ed. Jacques Derrida (Chicago: Harvester, 1982), 309-329; Judith Butler, "Gender Regulations," in *Undoing Gender* (New York: Routledge, 2004), 40-56.

²² Staatsarchiv Hansestadt Hamburg 352-8-7, Staatskrankenanstalt Langenhorn, Abl.1-1995, Krankenakte 28338 (hereafter Patient Record (PR), Friedrichsberg Medical Records Section (hereafter FMR), psychiatric notes (hereafter PN). This designation will be used throughout to identify Anna Maria B's patient record; other patient files mentioned in the text will be identified by their unique file number.

²³ Staatsarchiv Hansestadt Hamburg 352-8-7, Staatskrankenanstalt Langenhorn, Abl.1-1995, Krankenakte 28338.

²⁴ During my research for the study I was asked by a person responsible for a hospital archive what the registrars should do with nursing notes due to the vast size of the hospital records and the confined space of the archive. The impression of this person was that nurses' reports were the most unimportant part of the records and that was why the registrars had reached an agreement to destroy them.

²⁵ Dr Enge, "Beobachtungsberichte des Pflegepersonals," *Geisteskrankenpflege. Monatsschrift für Geisteskranken- und Krankenpflege* 37, no. 1 (1933): 113-115.

²⁶ PR, FMR, PN.

²⁷ Ibid.

²⁸ Ibid.

²⁹ Ibid.

³⁰ Phenobarbital or phenobarbitone is a barbiturate, first marketed as Luminal in 1912 by Bayer. It became a commonly prescribed sedative and hypnotic in psychiatry, superseded as a sedative by the introduction of benzodiazepine in the 1950s. Patrick Kwan and Martin J. Brodie, "Phenobarbital for the Treatment of Epilepsy in the 21st Century: A Critical Review," *Epilepsia*, 2004, Wiley Online Library," <http://onlinelibrary.wiley.com.proxy.bib.uottawa.ca/doi/10.1111/j.0013-9580.2004.12704.x/full> (accessed 24 January 2011).

³¹ In an article from 13 May 1922, a Dr. Weber reported on a "luminal-exanthem" that to him resembled scarlatina. Hannes Weber, "Luminal und Luminal-Exanthem," *Klinische Wochenschrift* 20, no. 1 (1922): 998-9.

³² Wilhelm Weygandt, *Forensische Psychiatrie. II. Teil. Sachverständigentätigkeit* (Berlin, Leipzig: de Gruyter & Co, 1922), 22.

³³ The admission as a matter of ritual applied to the other records used in this research project. In almost all cases in which the patient was able to answer questions, the admission ritual was organized in exactly the same way. It was a standardized procedure and the questioning followed a determined progression. Once again, it was Weygandt who described the procedure. Under the subtitle "Examination and observation," Weygandt listed four aspects that could be found in every admission ritual: "1. Examination of the bodily condition. 2. Examination of the psychic condition. 3. Particular reactions. 4. Observation." Ibid., 18.

³⁴ Eugen Bleuler, *Lehrbuch der Psychiatrie* (Berlin: Springer, 1923), 163; Bleuler, *Lehrbuch der Psychiatrie*, eds. Manfred Bleuler and Josef Berze (Berlin: Springer-Verlag, 1943).

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- ³⁵ Bleuler, *Lehrbuch der Psychiatrie*, 162.
- ³⁶ Weygandt, *Forensische Psychiatrie. II. Teil. Sachverständigentätigkeit*, 27.
- ³⁷ Ibid., 19.
- ³⁸ Dr Enge, "Die Vorgeschichte (Anamnese) und ihre Bedeutung für die Krankheitsfeststellung (Diagnose)," *Geisteskrankenpflege. Monatsschrift für Geisteskranken- und Krankenpflege* 37, no. 6 (1933): 89.
- ³⁹ The complete list of questions is found in Weygandt, *Forensische Psychiatrie*, 22-23.
- ⁴⁰ Ibid.
- ⁴¹ Ibid., 24.
- ⁴² Bleuler, *Lehrbuch der Psychiatrie*, 107.
- ⁴³ Weygandt's catalogue of questions took up more than six pages in his book and included questions from twenty-one areas. Weygandt, *Forensische Psychiatrie*, 28-32
- ⁴⁴ Ibid., 32.
- ⁴⁵ Ibid.
- ⁴⁶ Ibid., 33.
- ⁴⁷ Bleuler, *Lehrbuch der Psychiatrie*, 305.
- ⁴⁸ Ibid., 308.
- ⁴⁹ Enge, "Die Vorgeschichte (Anamnese) und ihre Bedeutung für die Krankheitsfeststellung (Diagnose)," 87-88.
- ⁵⁰ Weygandt, *Forensische Psychiatrie. II*, 22-23
- ⁵¹ PR, FMR, PN.
- ⁵² Scopolamine (also known as hyoscine) is obtained from the night shade family of plants. It was first isolated by German scientist Albert Ladenburg in 1880, and used in psychiatry as a sedative and as a hypnotic. Scopolamine use was highly controversial in medicine because of its multiple side effects. In Friedrichsberg and Langenhorn Scopolamine was used almost exclusively in combination with Morphine. Side effects ranged from the physical symptoms of dryness of the throat and thirst to severe cramping, diarrhea, and decrease in respiration. Mental symptoms included the potential for nearly complete amnesia and hallucinations. Ullrich Hinrichs, "Über Dauerschlafbehandlung mit Scopolamin-Paraldehyd bei Geisteskranken," *Zeitschrift für die gesamte Neurologie und Psychiatrie* 105, no. 1 (1926): 626. This article attributed more than four deaths to Scopolamine use.
- ⁵³ Bleuler, *Lehrbuch der Psychiatrie*, 120.
- ⁵⁴ Ibid.
- ⁵⁵ Weygandt, *Forensische Psychiatrie*, 26.
- ⁵⁶ Ibid., 46-47.
- ⁵⁷ Bleuler, *Lehrbuch der Psychiatrie*, 122 pp.
- ⁵⁸ Ibid., 125.
- ⁵⁹ Ibid., 328-9.
- ⁶⁰ Foucault, *Le pouvoir psychiatrique*, 272.

⁶¹ PR, FMR, PN.

⁶² Smith, *Institutional Ethnography. A Sociology for People*; Dorothy E. Smith, *Writing the Social. Critique, Theory, and Investigations* (Canada: University of Toronto Press, 2004); Smith, *The Social Construction of Documentary Reality*, 257-268; George W. Smith, "Policing the Gay Community: An Inquiry into Textually-Mediated Social Relations," *International Journal of the Sociology of Law*, no. 16 (1988): 163-183.

⁶³ Enge, "Die Vorgeschichte (Anamnese) und ihre Bedeutung für die Krankheitsfeststellung (Diagnose)," 89.

⁶⁴ Dorothy E. Smith, "'K. is Mentally Ill': the Anatomy of a Factual Account," *Sociology*, no. 12 (1978): 35.

⁶⁵ Foucault, *Le pouvoir psychiatrique*, 271-5.

⁶⁶ Enge, "Die Vorgeschichte (Anamnese)," 89. [emphasis mine]

⁶⁷ Foucault, *Le pouvoir psychiatrique*, 273.

⁶⁸ Michel Foucault, *Psychiatric Power. Lectures at the Collège De France, 1973-74*, ed. Arnold I. Davidson, trans. Graham Burchell (New York: Palgrave Mac Millan, 2006), 275.

⁶⁹ Ibid.

⁷⁰ Enge, "Die Vorgeschichte (Anamnese)," 90

⁷¹ For example, patient record 13986 contained a letter to a relative in which one nurse was particularly mentioned as very friendly and adorable. However, it must be emphasized that letters like this were written in the consciousness that they would be read by the psychiatrists, which is to say that they cannot be evaluated as "unbiased."

⁷² Ludwig Scholz, *Leitfaden für Irrenpfleger* (Halle a. d. Saale: Carl Marhold, 1920), 71; Scholz, *Leitfaden für Irrenpfleger* (Halle a. d. Saale: Carl Marhold, 1904). This textbook was used throughout the period under study in the Langenhorn nursing school. It was first published in 1900 and was reprinted thereafter until WWII. The textbook can be considered the standard text on the education of nurses in the German Reich. The medical director of Langenhorn conducted an inquiry of several German asylums to decide what textbook to use for nursing education at the school, with the result that he chose Scholz's textbook. StArHH 352-8/7 Nursing staff. Education, inauguration of the school of Nursing for the lunatics (*Pflegepersonal. Ausbildung. Eröffnung der Irrenpflegeschule*). Scholz was also the main editor of the journal *Nursing for the Lunatics (Die Irrenpflege)*, which in 1930 was renamed *Nursing for the Mentally Ill (Die Geisteskrankenpflege)*.

⁷³ Latour, *Reassembling the Social*, 47

⁷⁴ Berg, "Practices of Reading and Writing," 499-524. [emphasis in original]

⁷⁵ Latour and Woolgar, *Laboratory Life*, 245; Latour, *Science in Action*.

⁷⁶ Berg, "Practices of Reading and Writing," 511.

⁷⁷ Paul Atkinson, *The Clinical Experience: The Construction and Reconstruction of Medical Reality* (Farnborough: Gower, 1981).

⁷⁸ Harold Garfinkel, "Good Organizational Reasons for 'Bad' Clinic Records," in *Studies in Ethnomethodology* (Cambridge: Polity Press, 2010), 186-207.

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- ⁷⁹ Berg, "Practices of Reading and Writing," 513.
- ⁸⁰ Link, *Versuch über den Normalismus. Wie Normalität produziert wird* (Göttingen: Vandenhoeck und Ruprecht, 2006).
- ⁸¹ Wilhelm Weygandt, ed., *Die Staatskrankenanstalt Friedrichsberg* (Hamburg: Paul Hartung Verlag, 1928), 192.
- ⁸² Berg, "Practices of Reading and Writing," 511.
- ⁸³ Latour, *Reassembling the Social*; Latour, *Science in Action*; Latour, *We have Never been Modern* (Cambridge, Massachusetts: Harvard University press, 2002); Latour, "Über technische Vermittlung," in *Technik und Sozialtheorie*, ed. Werner Rammert (Frankfurt a.M.: Campus, 1998), 29-81; Latour and Woolgar, *Laboratory Life. the Construction of Scientific Facts*; Ingo Schulz-Schaeffer, "Technik in heterogener Assoziation. Vier Konzepte der gesellschaftlichen Wirksamkeit von Technik im Werk Latours," in *Bruno Latours Kollektive*, eds. Georg Kneer, Markus Schroer and Erhard Schüttelpelz (Frankfurt a.M.: Suhrkamp, 2008), 108-152.
- ⁸⁴ Garfinkel, "Good Organizational Reasons for 'Bad' Clinic Records," 201.
- ⁸⁵ Berg, "Practices of Reading and Writing," 513.
- ⁸⁶ PR, FMR, nurses' notes (hereafter NN).
- ⁸⁷ Dr Enge, "Krankheitsfeststellung durch bloße Betrachtung," *Geisteskrankenpflege. Monatsschrift für Geisteskranken- und Krankenpflege* 40, no. 9 (1936): 129.
- ⁸⁸ Enge, "Die Vorgeschichte (Anamnese) und ihre Bedeutung für die Krankheitsfeststellung (Diagnose)," 88.
- ⁸⁹ Philipp Seibert, "Zur Pflege Geisteskranker," *Geisteskrankenpflege. Monatsschrift für Geisteskranken- und Krankenpflege* 44, no. 12 (1940): 149. After the admission bath the sick person "is brought to a bed with clean sheets and which was nicely prepared, during winter it is warmed up."
- ⁹⁰ Enge, "Krankheitsfeststellung durch bloße Betrachtung," 138.
- ⁹¹ Ibid., 138.
- ⁹² The "barrierboard" (*Steckbrett*) was a board that was inserted into the bed sideways in order to prevent the patient from getting out of the bed. As the notes in other records demonstrate this was a routine precautionary measure, especially on surveillance wards.
- ⁹³ PR, FMR, NN.
- ⁹⁴ Scholz, *Leitfaden für Irrenpfleger*, 71-73.
- ⁹⁵ Ibid., 72. [original emphasis]
- ⁹⁶ Enge, "Beobachtungsberichte des Pflegepersonals," 115.
- ⁹⁷ Ibid., 114-115.
- ⁹⁸ Scholz, *Leitfaden für Irrenpfleger*, 72-73.
- ⁹⁹ Smith, "'K. is Mentally Ill'," 50.
- ¹⁰⁰ Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York: Doubleday and Co., 1961).
- ¹⁰¹ Berg, "Practices of Reading and Writing," 499-524.

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- ¹⁰² Latour, *Visualisation and Cognition*, 1-40.
- ¹⁰³ Latour, *Science in Action*.
- ¹⁰⁴ PR, FMR, PN.
- ¹⁰⁵ Berg, "Practices of Reading and Writing," 500.
- ¹⁰⁶ Latour, *Reassembling the Social*; Latour, *Pragmatogoniess*, 791-808.
- ¹⁰⁷ Smith, *Institutional Ethnography*; Smith, "Textually Mediated Social Organization," 59-76.
- ¹⁰⁸ Smith, *Institutional Ethnography*, 186
- ¹⁰⁹ Ibid., 186; G. Smith, Policing the Gay Community.
- ¹¹⁰ Berg, "Practices of Reading and Writing," 501.
- ¹¹¹ Ibid., 504. [emphasis in original].
- ¹¹² Ibid.
- ¹¹³ Latour, *Visualisation and Cognition*, 1-40; David Gooding, "Putting Agency Back into Experiment," in *Science as Practice and Culture*, ed. Andrew Pickering (Chicago: University of Chicago Press, 1992), 63-112.
- ¹¹⁴ Smith, *Institutional Ethnography*, 102.
- ¹¹⁵ Ibid., 227.
- ¹¹⁶ Ibid., 102.
- ¹¹⁷ Smith, *Institutional Ethnography*, 103.
- ¹¹⁸ Ibid., 108.
- ¹¹⁹ Based on Dorothy E. Smith, "The Social Construction of Documentary Reality," *Sociological Inquiry* 44, no. 4 (1974): 261.
- ¹²⁰ Smith, *Institutional Ethnography*, 170.
- ¹²¹ Ibid., 171.
- ¹²² PR, FMR, PN.
- ¹²³ PR, FMR, NN.
- ¹²⁴ PR, FMR, PN.
- ¹²⁵ PR, FMR, NN.
- ¹²⁶ PR, FMR, PN.
- ¹²⁷ PR, FMR, NN.
- ¹²⁸ Karl Binding and Alfred Hoche, *Die Freigabe der Vernichtung lebensunwerten Lebens. Ihr Maß und ihre Form* (1920) (Berlin: Berliner Wissenschaftsverlag, 2006), 51.
- ¹²⁹ Weygandt, *Die Staatskrankenanstalt Friedrichsberg*, 187.

significant difference, however, was B.'s behaviour was not only observed and registered in every detail but also active interventions took place that influenced this behaviour. These interventions were partly chemical and partly educational, changing both the character of the nurses' notes and how they recorded these interventions. B.'s behaviour can only be grasped by an analysis of the interplay of different human and non-human actors. Questions arise as to what extent the behaviour observed by the nurses and recorded in their notes was a result of their own interventions. When B. arrived at House 16, the nurses began another fever chart, somewhat surprisingly since it was usually maintained only during the first days of admission. They may have begun this new chart because of her high temperature on 26 February, and likely the diagnosis of "sore throat" had raised doubts that this was the sole cause for the fever. Another urine examination was also carried out.

Against the backdrop of stuporousness and apathy that had described B.'s state at the end of February, she was prescribed a 10-day course of Digitalin (Digitalis) and Paraldehyde beginning on 4 March. Obtained from the seeds of the common foxglove, Digitalin was used not only in the treatment of cardiac arrhythmias but also appreciated as a narcotic in psychiatry, with the theory that the increased pulse rates accompanying an agitated state would drop, thereby calming the patient.¹ She was administered Digitalin even though its efficacy had already been widely questioned.² In B.'s case, the combination of drugs was meant to sedate her, but the fact that they were administered before a careful observation of her behaviour had been carried out highlights once more the power of the record. The apparent need to administer chemical sedation was based solely on the notes from her file and the drugs seemed to be a kind of prophylactic measure. However, as the comparison with other records demonstrates, drugs were rarely documented or discussed in the actual notes. Evidence of their use appeared only on medication cards or fever charts.

It should also be emphasized that while clinical observations in the admission ward helped to verify a diagnosis, in House 16 these same activities became treatment measures –

interventions in order to adjust patient conduct and physiological parameters. For example, because it had been noted in House 10 that B. had begun to vomit after tube feedings, she was medicated with a combination of Pepsin and hydrochloric acid in House 16. The House 10 notes initiated interventions in House 16, demonstrating that the assignment of non-human actants (feeding tube) prompted the intervention of further actants (Pepsin and hydrochlorid acid).

6.1.2 *The psychiatrists' notes*

On 6 March a kind of a medical readmission on B. was done in House 16 although in the psychiatrist's note, the administration of the different drugs was never mentioned.

6.3.31 Lies in bed mostly completely apathetic with eyes closed, even soils the bed. Does not react to any call. Must be tube fed. When she is sat on a chair undressed, she doesn't change her position at all; when put to bed, she lets herself be dragged there, with her feet dragging along the floor. In between though, she does act spontaneously and abruptly: jumps out of bed, joins another patient in bed and hugs her, or steps on the window sill naked, and similar things. A few times, the mother managed to get her to eat some slices of an orange, another time though she kept the chocolate in her mouth and smeared it all over the bed.³

The first part of the psychiatrist's description concerned B.'s catatonic state, the core of her admission diagnosis. B.'s condition, however, had worsened dramatically by now; she seemed to have lost any connection to her environment and was not reacting to any stimulation, even becoming incontinent. Not eating, which in House 10 had been considered a sign of negativism, became now another characteristic of her extreme withdrawal – a withdrawal so profound that she required tube feeding.

His wording could have been copied from Bleuler's Textbook of Psychiatry (*Lehrbuch der Psychiatrie*).

Sick persons do not move by themselves, but if one puts them in an arbitrary, even uncomfortable position, they keep it over a long period of time... Some sick persons resist the passive movement of their limbs; one can model their limbs like a wax statue.⁴

The description of B. in the psychiatrist's note resembled what psychiatrist Alfred Hoche had termed the "mentally dead." In his book that he had written with German jurist Karl Binding

in 1920, Hoche argued for the legal killing of patients who were in “conditions of ultimate incurably idiocy” (*Zustände endgültigen unheilbaren Blödsinns*) and who he claimed had no value for society or for themselves. He divided this group into two large groups, those cases in which mental death was acquired late in the course of their life but who once had been mentally full-fledged, or at least had been mentally average, and those in which the brain alteration developed due to “congenital conditions” or because it had been “acquired in early childhood.”⁵

According to Hoche, the first group contained those with senile dementia, paralytic dementia, arteriosclerotic alterations of the brain, and the huge group of “juvenile processes of idiocy (*Dementia praecox*).”⁶ From this perspective B. was considered part of the latter group since dementia praecox was another term for schizophrenia. Although he believed that equal degrees of idiocy could occur in both groups, Hoche argued that one had to consider

a difference in the condition of the mental inventory, even though it might be comparatively the same, like between a disorderly pile of stones that was never touched by a building hand and the ruins of a collapsed building....In our consideration these two groups of mentally dead persons must be differentiated as well as the relation of them to their environment. Among those who acquired their condition very early a rapport with their environment never existed, whereas those who acquired their condition late in life might have had an abundant connection. Their environment, their relatives and friends therefore subjectively have a completely different relation to the latter; mentally dead persons of this kind might have acquired a completely different “affection value” (*Affektionswert*); they have feelings of piety, of thankfulness; numerous, perhaps strongly sentimental memories are connected to this perception, and all this happens even in the case when they do not respond to their environment.⁷

Hoche contended that it was not difficult for physicians, especially alienists and neurologists, to identify mentally dead persons, because these people had no clear imagination, no feelings, wishes, or determination. They had no possibility of developing a “world view” (*Weltbild*), no relationship to their environment, and most importantly, they lacked self-consciousness or the possibility of becoming conscious of their own existence. They had no subjective claim to life because they had only simple, elemental feelings such as are found in

lower animals. A mentally dead person therefore was not able “to raise a subjective claim to life nor [was] he able to perform any kind of mental process.”⁸

All of Hoche’s criteria relating to the idea of mentally dead persons can be viewed in the short psychiatrist’s note on B. from 6 March 1931, perhaps already sealing her fate. The record as a whole can be read as the narrative of how B. came to be viewed as a hopeless case, or as the record’s folder indicated, how B. entered a “final state” (Endzustand) (See Figure 1). As in the case of the admission ritual in February 1931, the psychiatrist’s note functioned as a kind of introduction as to how B. should be described and what seemed to be noteworthy about her behaviour into the future.

6.1.3 *The interplay between nurses’ and psychiatrists’ notes*

In the first few weeks in House 16, the focus of the records from both the nurses and psychiatrists was on B.’s refusal to eat and on her sudden mood changes that ranged between complete withdrawal and wild, unpredictable activity. This behaviour was deemed dangerous, adding a new dimension to the perspectives of the medical personnel.

Psychiatrist’s note:

9.3.31. Prefers to lie down in other patients’ beds. Completely dumb, mannerism (maniert), blocked (gesperrt). Must be tube fed.
13.3.31 Most of the time in catatonic state, in between though very abrupt senseless actions. Screams: “Gertrud, Gertrud Mordhorst, I cannot take it anymore.” Spits.
14.3. Eats spontaneously today.⁹

Nurses’ notes:

9.3.31: Pat. lies down in other beds, and often stands up in the bed. Pat. did not speak or eat. (Me.)
Aftern: Kept quiet all afternoon, drank a cup of coffee by herself. At times sat up in bed. (No.)
Night: Pat. slept throughout the night. (Schi.) H.
10.3.31 Morning: Pat. was out of bed a lot. Otherwise quiet. Pat. spat out everything she had in her mouth. (Me.)
Night: Pat. slept with interruptions; pat. wet the bed once. (Schi.) H.
11.3.31 Morning: Pat. got out of the bed and said: “My mother is not a scrubbing brush.” To the remark that the pat. would get cold feet outside the bed, pat. answered “That does not matter, at least I will be dying that way.” Later pat. was quiet.

Aftern: Repeatedly said to her mother that she wanted to die and that she was so bad. Drank ½ cup of cacao, after the feeding she immediately wet the bed. Fell asleep right away. At 9 pm drank another cup of cacao by herself. (No.) H.

12.3.31 Morning: Pat. ate ½ cup of cacao and 1½ Zwieback. Otherwise pat. was quiet. (Me.) H.

13.3.31: Pat. was tube fed, otherwise lay apathetically in bed. (Mü.)

Aftern: Suddenly cried out loud and jumped out of the bed screamed repeatedly: “Gertrud, Gertrud Mordhorst! I can’t take it anymore” while trembling all over her body. After a short period of time she went back to bed again quietly. (No.) H.

14.3.31 Morning: Pat. lay still in bed, vomiting a lot. Pat. consumed ½ cup of milk and ½ cup of soup, solid food pat. spat out. (Nurse E.)¹⁰

The same mechanisms are at work in these last records as were analyzed in detail in an earlier section. Elements found in the psychiatrist’s note were clearly taken from the nurses’ notes with the typical generalizations, transformations, and reordering of events. For example, the psychiatrist’s remark that B. was “most of the time in a catatonic state” is contrasted with the nurses’ opinion, which seemed to emphasize her active behaviour. B.’s spitting was also charted three days earlier by the nurses than what the physician reported.

Some particular aspects of this passage are significant. First, the psychiatrist had written that B. “preferred” to lie in other patients’ beds, a term that implied a degree of intentionality, and in this case, a kind of intentional wickedness, since it was against the rules of the asylum and therefore unacceptable to the staff. Second, the sentence following contained a sequence of medical terms on B.’s mental condition that were found within the diagnostic frame of schizophrenia as it was understood at the time. He used the expression “completely dumb,” but according to the nurses, B. was not speechless. The term “mannerism” helped to strengthen the impression that B. had worsened. Mannerism had been introduced by Emil Kraepelin in his theory of “dementia praecox,” from which Eugen Bleuler had developed his theory of schizophrenia. According to Kraepelin, “another prominent symptom of this stage of the disease [sc. dementia praecox] is the mannerisms in facial expression and speech. Accompanying speech is a peculiar gesticulation, winking of the eyes, senseless shaking and nodding of the head.”¹¹ Bleuler specified that many schizophrenic people adopted particular poses.

Some try over years, for example, to act like Bismarck [the former Imperial Chancellor]; others want to present themselves as something special, almost always in an overblown (*gespreizter*), made up (*gemachter*), caricatured manner. Sometimes, however, only some actions are changed or carried out in an elaborate manner: Before ingesting a bite, people will knock their food three times on the plate, they will put the food on the fork seven times and again it will be thrown down before they get it to the mouth.¹²

The word “blocked” (*gesperrt*)’ inferred that B. was unapproachable and made up part of what early psychiatrists called “autism.” According to Bleuler, being blocked was one characteristic of schizophrenics because they lost “contact with reality; the less severe cases inconspicuously here and there, and the more severe ones completely.”¹³ When coupled with the psychiatrist’s observation of B.’s catatonic state and senseless actions, these three terms summarized, re-ordered, and again condensed the nurses’ notes to allow the psychiatrist to sum up her whole medical history in a succinct fashion.

This sequence also highlights another important mechanism functioning in the medical record. How “what really happened” evolved in the medical file has already been analysed. The previous examples on B. from House 16 demonstrate, however, that information from diverse sources was constantly being compressed into short statements to determine the “truth” of “what really happened” and “what was the case.” As the examples above show, the psychiatrist condensed the information gleaned from all notes written while B. was in House 10 – the nurses’ notes, her tests etc. – to create a concise statement of the relevant problems and their histories. B.’s history was thus selectively re-written. Detailed descriptions embodied in the House 10 records sink back into pages that are no longer “actual,” as was shown by the notes written on 6 and 9 March that summarized all the available information in the first two sentences. These continuous re-formulations and condensations were crucial for the functioning of the record; at particular points in B.’s psychiatric career, her whole history was compressed into a few words. This ongoing re-summarizing also contributed to the “construction of narratives in which the ambiguities, the ad hoc and fluid character of the medical work [were] lost,”¹⁴ a concept that

becomes particularly clear in a comparison of the notes from the psychiatrist and the nurses at the beginning of March 1931. Whereas the nurses' notes were ambiguous and did not describe B.'s behaviour as clear-cut even though nursing observations were guided by specific charting categories, these ambiguities were eliminated in the psychiatrist's note. These reconstructions were "needed to *produce* an account ordered enough to enable action or to communicate what [was] going on."¹⁵ As illustrated, each and every one of the three terms employed by the psychiatrist reflected a history of repeated reconstructive work. As Berg noted, the medical record (re)constructs the present and enables an "accountable, 'adequate' rendering of the Now and its History." It is an iterative process of summarizing that aids to construct a history which seamlessly and rationally predates and underpins the current "present." A history emerges in which the nurses' notes in particular naturally "lead to certain diagnostic conclusions, which then lead to a rational, therapeutic intervention." The interactive processes that shaped B.'s trajectory were replaced "by a clear-cut, step-by-step temporal sequence (observation → diagnosis → intervention), matched by a clear-cut causality underlying this sequence, and by a circumscribed and fitting set of 'signs and symptoms.'"¹⁶ From this perspective, what occurred after 14 March in House 16 could be described as a kind of permanent educational intervention based on the appraisal that B. was a severe case, as proven by the psychiatrist's notes.

The multitude of ad hoc articulations made, the wide array of elements involved, the way these elements were (re)constructed: all this is erased in this post hoc reification of a trajectory's history. Also, in this final mediation, the record ultimately deletes itself: it erases all traces of its own constitutive role in the production of medical work. It becomes no more than the simple "carrier" of information, a mere re-enactment of events-a humble object.¹⁷

6.1.4 *The nurses' notes*

As already mentioned earlier, the nurses' notes differed not only in the material appearance (written in pencil, highly regulated by the material construction of the forms, etc.) but they also differed from those written by the psychiatrist in the language that they used and the focus of their writing. The nurses were far less specific about the various psychological signs and

symptoms that they noted. The psychiatrists later underlined key terms and events that seemed to fit into their diagnostic frame, translating the nurses' descriptions into medical terminology. The nurses' notes appear as a kind of empirical database and the psychiatrists' notes seemed to be nothing more than inductively generated assumptions; this interplay gives the record its scientific character. Apart from the fact that the nurses' notes were very detailed and those written by the psychiatrists were not, the reports also emphasized different areas. The nurses were mostly concerned with rule violations (in the end the patient became conspicuous by deviating from expected behaviour) but the psychiatrists focused primarily on gathering symptoms. From the nurses' viewpoint, it appeared that any behaviour became a pathologic sign. Either the patient was too quiet (did not answer questions) or too lively (disrupted the regular course of action).

Nevertheless, even the nurses' observations appeared to be led by the diagnosis, which was especially clear in 1940 when they assessed B.'s behaviour somewhat differently from that occurring during her earlier admissions. From 1931 to 1936, B.'s behaviour had always been interpreted from within the diagnostic scheme of catatonic schizophrenia and "negativism." In 1940, however, the diagnostic frame changed when she was diagnosed with "dementia praecox," indicating that she was becoming completely stupified. This changed resulted in the nurses now considering B. helpless. The interrelation between diagnosis and nurses' observations is also traceable in B.'s refusing to eat, since the major efforts spent in feeding her in March and April 1931 appear to have been neglected later, even though her nutritional situation was apparently still as severe. But because the concern over her nutrition never again became part of the official diagnosis, it seemed to the nurses not to be worthy of note.

However, the nurses' notes also differ in other respects. They are characterized by a kind of tension resulting from the attempt to write in a scientific, neutral manner with bad grammar and in a Hamburg dialect. On the one hand, the nurses always used the term "patient" when they wrote about B. and they never used personal pronouns such as "I" or "me." When they reported their own impressions and observations, they often referred to themselves as "the nurse" or they

even used the impersonal “one.” For example, on 28 April 1931, one nurse wrote on B. that “if one tries to put on her shirt she throws it,” or again, on 31 May, “one tried to play a few games with her.” The notes resembled a kind of laboratory report, with the date and time of observations written as if the reported events were observed with a distant, all-seeing gaze. On the other hand, the reports were written in the everyday spoken style used by Hamburg’s proletarian class. For example, on 17 April 1931, one nurse wrote that “in the morning pat. was loud and agitated, threw her lunch on pat. Baade¹⁸ her bed,” or later that day, B. apparently “repeatedly stood high up in bed naked or lay down in pat. Baade her bed.” The turn of speech “pat. Baade her bed” was typical of Hamburg’s spoken dialect. Another example occurred on 31 May 1931 when the nurse wrote that “only as her mother left, she ran after her,” a particular word-order construction particular to those from Hamburg.

The fusion of “medical discourse” with everyday language was also illustrated through the use of particular terms that were characteristic of Hamburg’s dialect. For example, nurses used the adjective “nakedly” instead of “naked” (*nackend* instead of *nackt*) but the psychiatrists always used “naked.” This combination of different kinds of discursive formations also led to peculiar overblown language at times as well. For example, the word “high” as in “stood high up in bed” is redundant, since someone already standing up in bed cannot get higher. Nevertheless, the nurses were attempting to show that standing high up in bed was worse than just standing up in bed. The nurses’ use of the expression “did not ingest dishes” in place of “did not eat,” was also somewhat pretentious. Again, on 15 April 1931, the nurse reported that the “Pat. sits nakedly in bed for the entire afternoon, tears apart her shirts, or runs around the dormitory like this; lies down in patient Kuscher her bed and holds on to her so tightly that the same can hardly be freed. For tea time, the patient demands coffee, when passed using the hand (*hinreichen*) she knocked the coffee into the nurse’s face and threw the cup against the window.” This passage demonstrates the nurses’ efforts to write as much as possible in a neutral, objectified language. They often used the phrase “the same,” as noted on 27 April 1931, “when the patient’s mother

came, the same tried to feed the patient.” And rather than using the words “to give the coffee,” they wrote “when passed using the hand.”

The long sentences, arbitrarily subdivided by commas, also suggest that the nurses were not used to writing long passages. The way the nurses wrote has been termed “interdiscourses,” a hybrid form of discourse that mediates between specialized discourses, in this case, medical discourse, and what Jürgen Link called elementary discourse, which is a kind of everyday discourse.¹⁹ This perspective enables illustrating the structured character as well as the originality of “what people are saying”; the significance of establishing legitimacy and subjectification for everyday knowledge therefore can also be pointed out. The empirical findings demonstrate the relations between special knowledge and everyday knowledge.²⁰ “Interdiscourses” have the ability to combine parts of specialized and elementary discourses in order to transform specialized discourses and make them become more understandable for “lay persons” and a part of unquestioned everyday knowledge. In the nurses’ notes, these discursive formations of medical knowledge merge with everyday discourse.

Seen from this perspective, the journal *Irrenpflege* (from 1930 on renamed *Geisteskrankenpflege*) can be perceived as a forum for this interdiscourse, because leading psychiatrists published along with nurses and translated the special psychiatric discourse into an interdiscourse. However, different discursive formations are, according to Link, also characterized by a different power distribution; special discourses are more “powerful” than “interdiscourses” because they connect to knowledge considered “true.” Nevertheless, in the case of the nurses’ notes, the interdiscourse became powerful because of its material form in the record. As already highlighted, the nurses’ notes initiated a cascade of ever-simplified inscriptions that allowed the production of unquestionable facts and the translation into the special discourse. They are the basis for decisions on how to proceed with B. For example, on 11 May 1931 the nurses reported that B. tried to climb “over the fence, said she wanted to walk towards her mother,” which one week later the psychiatrist translated into “because she tried to

climb over the garden fence, she was transferred to House 14 on 12.5.” The nurses’ recorded observations thus implied direct consequences for patients, as further analysis will demonstrate, and they highlighted the strategic position of nurses within psychiatric practice. The notes seemed somehow less scientific than those written by psychiatrists and one could even argue that they appeared “unarmed.” The nurses functioned, however, as the physician’s “optical canal” through which his “scientific” or objective gaze could flow. This delegated gaze could only be performed by those who were at the bottom of the asylum hierarchy and whose discourses, observations, and relations enabled the constitution of this concentrated medical gaze. Only those at the bottom had this power, for only they were able to observe and report on “madness” as an everyday part of their job. In order to do so the nurses were below the patients they served; denials of their services must appear as pure consequences of asylum rules or the result of a psychiatrist’s order.

The nurse must keep in mind that he [*sic*] is not the superior but rather the servant and protector of the sick person....If the nurse must carry out an order that would likely provoke the sick person he has to draw on the fact that he must follow the request of the physician but avoid any criticizing (*Bekritteln*) of the request, if only with the words “I am sorry, but ...”²¹

As nurse Georg Roos described this strategic interplay, the nurse must “report to the physician everything he [observes] about the sick person” but a decision about a change in “therapy lies outside his competency.” The sick person not only needs the assistance of the nurse “but behind the nurse must stand the authority of the physician.” The physician lays out the “scientific treatment plan and the nurse is the one who carries it out. Therefore the nurse is subordinated to the physician.” Nevertheless, according to Roos, the “work of the nurse is not worth less. It is very difficult work and not everybody, not even the physician, is able to cope with it.”²²

These remarks suggest that juxtaposing the idea of “the powerful physician” versus “the powerless nurses” does not grasp the essence of psychiatric practice. According to Foucault, power is not something that one group owns but rather develops within relationships; power becomes effective through relays and specific disseminations, reciprocal endorsements and

different potentials. The power of psychiatrists only becomes effective through the interplay of physicians with other groups within the psychiatric system. This system of differences must be the focal point of the analysis because only within such a system can power act. Nursing had (and still has) an important strategic function within psychiatry and the question of how power functions is more a question of strategy in psychiatric practice. In order to demonstrate the hierarchical position of nurses and their role in psychiatry, “deputy head nurse” Oskar Stöbe argued in an article published in 1933 that nurses should consider themselves a member of a family, in which the psychiatrist is the father, the nurse the mother, and the patient the child.

If we imagine ourselves in all situations as a mother then we will often act in the way we normally would. It goes without saying that the mother *wants to educate the uneducated children*. With beating? Never, she would leave that to the father and therefore proceed with good advice and good examples. She knows from her own youth that children (we want to call the patients like this) are capricious and stubborn [and] often they become naughty. Perhaps they learned it in the street and think they can boast about this. The good mother will not get mean or nervous with her children. She tries, *and if it gets too hard alone, with the advice of the father*, find the right distraction or clarification [of this behaviour]. If the child spits in the mother’s face because of a fever during a severe pneumonia, she will not get angry. She will even not go away. She knows that the mental (*seelisch*) functions of her child are not normal. If we really and sincerely try to understand this mother role then, after just one week, life on the ward will be different compared to the current situation in which the maxim prevails that the nurse must be always the stronger of the two.²³

Stöbe emphasized that nurses were the educator of their patients. The nurses’ notes from Friedrichsberg illustrate that the main task of the nurses actually was to provide a kind of long term education based on discipline. Nevertheless, Stöbe demonstrated the idea of “strategic power distribution,” because it is the psychiatrist as father figure who constituted the center of the power distribution. All the power was arranged around this figure, but the “family” could only function through the interplay of the father and the mother, or in other words, psychiatric practice was characterized by the same kind of strategic power distribution as was found in so-called traditional families. The nurse, whom Stöbe portrayed as a good mother who was “always cleanly dressed and [who did] not rub perfume into her hair twice a day instead of combing it,”

was the educator with traditional female attributes such as “goodness, affection, self-mastery, cleanliness, and discipline.” It was the nurse who influenced the behaviour of the patient, not necessarily with physical violence but with a more subtle form of manipulation that was able to reach the patient in his or her innermost core. According to Stöbe, physical violence was necessary only if prescribed by the psychiatrist.

This passage highlights the entire rationale behind psychiatric nursing. It is important to understand that perceiving patients as children implied that their development stopped at one point in their lives, that madness thus became a kind of developmental standstill or retardation.²⁴ Regarding patients as children left them with few rights of their own, and they were seen as needing correction by the nurse, as mother, who knew “how afflicted her children [were] from this suffering.” The conclusions reached by Stöbe reflected the basic tenet of psychiatric nursing at this time: “Congenital or acquired, she [the mother/nurse] sees it as her greatest obligation to correct what can possibly still be corrected.”²⁵

6.2 Anna Maria B. Becomes Dangerous

The psychiatrists’ notes on B. resume on 8 April 1931 after a month’s interruption.

A little better. Eats spontaneously. But otherwise still very resistant and blocked (unapproachable). If pat. talks at all, speaks only with her mother. Often unprovoked agitation.²⁶

This record began with the psychiatrist noting that B. ate “spontaneously,” the same remark made in his last entry, which points out once again that time can disappear in the medical file. This is the same mechanism that will lead to B.’s later “invisibility” over long periods of time. Since B. remained resistant and unapproachable, however, the idea that she was “a little better” was likely more related to her nutritional status. The use of the term “spontaneous” is interesting because it implied that a personal action arose or proceeded entirely from a natural impulse. This word gave the impression that B. was reacting favourably to the intensive efforts used by the nurses to try to persuade her to eat, an impression strengthened by the following “but

otherwise” that suggested her educational nutrition program had been successful even if the nurses had failed to improve her mental state. And indeed, the nurses’ notes from March 1931 could be read as a detailed description of a nutrition training program. Nevertheless, it seems as if the psychiatrists were confident that B.’s eating problem was solved, which might also explain their more frequent entries in the medical file until May about other aspects of her treatment.

However, the “unmotivated agitations” noted at the end of this entry became a focus in subsequent notes from both the psychiatrists and nurses, and introduced the idea that B.’s actions were posing increased danger to nurses and other patients.

On the same day as the psychiatrist’s last entry, the nurses’ noted that

8.4.31: Morning: At lunch time pat. ate only a cup of soup. (Kl.)

8.4.31: Aftern.: Pat. did not eat anything for dinner. Pat. was very resistant and noisy while walking in the garden. Suddenly she threw herself on the ground and screamed and cried so that her entire body trembled.

(Schi.) *H.*²⁷

Apart from the mechanisms at play already analyzed above, also noteworthy here between these two sets of notes is the psychiatrist’s borrowing of the word “resistant” from the nurses. Usually a term only employed by the nurses, the word contained an active dimension that seemed to oppose the former emphasis on B.’s apathetic and catatonic state. To resist something implies that something exists against which resistance is possible; in this case, B. was appearing to resist asylum regulations. However, the recording of B.’s noisy resistance while out walking around in the garden suggested not only that a certain behaviour or code of conduct was expected of garden users, but also that these kinds of detailed observations could end up in the nursing notes.

Nevertheless, as both psychiatrists’ and nurses’ notes demonstrate, the content of the reports begin to shift away from a focus on B.’s catatonic state to her resistance and unpredictability. We can see three phases in this development. In the beginning she was described as being in a catatonic state, not interacting with her surroundings and refusing to eat. The intermediary phase, which continued through her transfer to House 16, maintained a focus on her “apathetic and withdrawn” state and her refusal to eat, although at times she was reported as

being restless and agitated. From April 1931 on, the focus shifted once more and B. was described as resistant and aggressive. These descriptions fit exactly into the frame of the admitting diagnosis, following even its sequence through "...catatonic clinical picture. Negativism (refuses any food consumption, completely withdrawn). Temporary states of agitation with hallucinations."

6.2.1 *The war against the madness*

The tendency towards increased reporting of unpredictability and signs of danger can be seen in the entries following 8 April. On 13 to 15 April, the psychiatrist wrote that

13.4. Wants to leave the room, verbally abuses the nurses, spits.

Resistant. Hits nurses and other patients.

14.4. Runs around naked, spits and strikes out. Often calls out the name Anita. Shouts: "You horrible women, you are all bad, the animals all cry for me, you pigeon catchers. Lord Jesus you are the best."

15.4. Obviously hallucinates, shouts: "oh, oh, that damned woman is coming again, that whore" while spitting in her bed. Strikes against the safety boards.

17.4. Still very agitated, spits, scolds: "this woman is coming again, this miser; Anita come here, now I am kicking my father to death." Must be tube fed.²⁸

This new focus of the reports, which transformed B. into a violent and unpredictable person, was accompanied by continuous note taking and observation. Until the end of April, the psychiatrists took notes nearly every single day. The note from April 15 is underlined, a procedure that occurred otherwise only in the nurses' notes, and it is noteworthy that the content of this sentence re-appeared in the medical decision-making on B.'s sterilization process in 1935, more than four years later.

Once again we can see how the psychiatrist based his note on information obtained from nursing observations.

9.4.31: Morning: Patient only ate a little. Otherwise, patient is unchanged (Kli)

9.4.31: Aftern: Patient ate some zwieback and drank a cup of cocoa in the evening. After the meal, pat. suddenly got up, went to the window, lashed out against the frame and shouted, I must get out of here. Open up.

(K. Spi.)

10.4.31: Morning: Pat. got a feeding.(Sch.)

11.4.31: Morning: Drank 1.5 cup milk. (Sch.)

12.4.31; Morning: Pat. had 1 cup of cocoa. Drank 1 cup of milk and 1 cup of soup. Apart from this pat. is unchanged. (Kl.)

Aftern.:Pat. unchanged. (Lü.)

13.4.31: Morning: Pat. drank 1 cup of milk, 1 cup of soup. (Kl.)

13.4.: Pat. jumped out of bed at 1.00 a.m., ran to the door noisily and screamed. When pat. was taken back to bed she insulted the nurse saying: “ bitch with the red cross, you Satan” Pat. spat at the nurse, scratched her and tried to bite her. Pat. was very resistant. After the injection, the patient got up again, went to the bathroom, said then, “Oh I feel so sick to my stomach.” Lay down flat on the floor, was persuaded to get up, went to the dormitory and lay down in patient Kuscher’s bed, propped herself with both feet against the bed, so that it was very difficult to get her out. At 2:00 a.m. patient fell asleep again. This disruption woke up all the other patients. (Wa.) H.

14.4.31: Morning: Patient very agitated and noisy, could not be held in bed, tried over and over to leave the room. When holding her back she would lash out, bite and spit. She also lashed out and spat at her fellow patients. When her mother came, she screamed loudly and cried at first, did not eat in her mother’s company either. (No.)

14.4.31: Aftern.: Pat. very noisy and agitated, ran around the room nakedly [sic] showed her tongue, lashed out, insulted and spat at the nurse, threw everything out of the bed, wet the bed. When patient was handed over [sic] dinner, she knocked the food out of the nurse’s hand, and threw it in the room, after dinner patient demanded water, but had only a few sips and tried again, to throw the cup. Pat. often called the name Anita. (Schi.)

14.4.: Night: Pat. did not sleep, took off the shirt, threw it in the room, lay in bed naked for the entire night, often came up, muttered to herself quietly, when patient was covered the same always threw back the bedding then turned from one side to the other restlessly. (Wa.) H.

15.4.31: Morning: Pat. is noisy and agitated, threw her bread and the cup containing coffee through the room, complained loudly. “You horrible women, you are all bad. Schubert is my grandfather. The animals all cry for me, you pigeon catchers. Lord Jesus, you are the best, mother, come here. Oh, it is getting worse.” Pat. stood high up in bed and said loudly “Lüdwicka here I am come to me,” then lay down again crying. Pat. did not eat anything. (Kli.)

15.4.31: Aftern.: Until the next shift started, pat. was very loud and agitated, hit and insulted her mother, tried to tear apart her mother’s dress shouting: “You are also such a mean woman!” Pat. sits in bed naked for the entire afternoon, tears apart her shirts, or runs around the dormitory like this; lies down in patient Kuscher’s her [sic] bed and holds on to the pat. so tightly that the same can hardly be freed. For tea time, pat. demands coffee, when handed she knocked the coffee into the nurse’s face and threw the cup against the window. Pat. makes loud speeches all the time, it

is horrible, "I can't take it anymore, this is the last filth! Oh, oh that damned woman is coming again, that whore; spits in her bed," smears herself with mucus or spits on the floor. "Herta! Come here, August B., it is your fault. Jesus! Christ, you are the best! Plutas, come here!" Pat. continuously strikes against the safety boards. (Schi.)

16.4.31: Aftern.: Pat. still unchanged very loud and agitated. Pat. didn't eat anything, was fed. (Schi.) *H.*

17.4.31: Morning: Pat. was loud and agitated, threw her lunch on patient B.'s her [sic] bed stood up high in bed, pointed at patient Fe. and said "Tante Minna, I am here. The dear good aunt Liesbeth never have I had anything to eat. Mother, this is Lina, this horrible woman. I don't like her." Patient had a cup of milk in the morning. (Kli.)

17.4.31: Aftern.: Pat. very noisy and agitated, repeatedly stood up in bed naked or lay down in patient B.'s bed, spat, insulted, "here comes this woman again, this miser. Anita come here, I am kicking my father to death." Patient did not eat, got a feeding. (Schi.) *H.*²⁹

The first sentence of the psychiatrist's note from 13 April ("Wants to leave the room, verbally abuses the nurses, spits") originated from the nurse's note from the night shift, although it is somewhat surprising that the psychiatrist reported an event that obviously occurred after his recording of it. This might well be an indication that the psychiatrists did not always record their notes on the date noted in the file, something that can be traced in other records as well. Still, the psychiatrist's note was once more composed of elements derived from the nurses' observations and once more, he appeared to impose on it a slightly different meaning by seeming to imply that B.'s actions were propelled by an overall drive to leave her room, whereas the nurses were describing just one specific event. Similarly, while the nurses attached B.'s abuse of them to the moment when they tried to take her back to bed, the psychiatrist seemed to suggest that B.'s overall behavior was senseless and "resistant." And although he stated in his note of 13 April that B. hit the nurses and other patients, that action did not appear in the nurses' notes until the following day. Other interplays between the two sets of notes took place in a manner similar to that previously analyzed.

More interesting at this point, however, is the fact that the nurses' notes changed significantly in character. Previously the nurses seemed only to be gathering evidence on B.'s

madness and verifying the admitting diagnosis, but now they were actively intervening in order to correct B.'s behaviour – something that was pointed out especially with the injection B. received as a consequence of her resistance on 13 April. From this point on, the nurses' notes can be read as a diary of the therapy (or education) that B. received. And since a kind of endless fight began between the nurses equipped with delegated power from the psychiatrists on one side, and B. and the power of her madness on the other, the notes read more and more like war reports.

6.2.2 *The nurses' notes as war reports*

As the notes from April illustrate, the nurses believed that they were already fighting a sinister, unleashed power that they felt needed restraining. B. appeared the symbol of complete madness. Foucault called this the "secret of the madness" because for him, madness consisted of a wrong perception of reality that tried to force its own understanding of reality on its surroundings. Foucault in both his lectures and book on madness, as well as Weygandt, sixty-eight years earlier, relied on a text of Descartes to help them discriminate between madness and reason.³⁰ Weygandt assumed in his text that "illusions and hallucinations sometimes occurred even in mentally sound persons," as, for example, in Descartes, who reported on particular optical and acoustical hallucinations (*Sinnestäuschungen*). According to Weygandt, the criteria for "these so-called alert hallucinations (*Wachhalluzination*) is that the person concerned recognizes them as something alien....The dream is a web of false perceptions (*Trugwahrnehmungen*)....It only becomes suspicious that this is a psychosis if the hallucinating person takes them for real and loses the ability to criticise them."³¹

Foucault estimated that Descartes' writing was the decisive text by which madness became the absolute "other" of reason. The causes of lunacy could not be determined but a lunatic could be identified without any doubt because he or she was different. In his text *Meditationes*, Descartes tried to find a unique factor that enabled him to distinguish his dreams from madness. "In the face of these maniacs who imagine themselves to be jars or made out of

glass,” Descartes immediately knew that he was not like them: “They were out of their minds.”³²

In his lecture on 14 November 1973, Foucault took up this text again. He wrote:

If you refer then to the texts of Descartes, where it is a question of madmen who take themselves for kings, you notice that the two examples Descartes gives of madness are “taking oneself for a king” or believing one “has a body made of glass.” In truth for Descartes and generally [Recording: we can say] for all those who spoke about madness up until the end of the eighteenth century, “taking oneself for a king,” or believing one has “a body made out of glass,” was exactly the same thing, that is to say they were absolutely identical types of error, which immediately contradicted the most elementary facts of sensation. “Taking oneself for a king,” “believing that one has a body of glass,” was, quite simply, typical of madness as error.³³

Nevertheless, the conviction of the lunatic that he or she was a king “is the true secret of madness,” because a delirium, an illusion, or an hallucination, etc. is analyzed as a conviction of being a king, “whether the content of his delirium is supposing that he [sic] exercises royal power, or, to the contrary, he believes himself to be ruined, persecuted, and rejected by the whole of humanity.” For the psychiatrist in the early years of psychiatry (Foucault called it “proto-psychiatric practice”)

The fact of imposing this belief, of asserting it against every proof to the contrary, even putting it forward against medical knowledge, wanting to impose it on the doctor and, ultimately, on the whole asylum, thus asserting it against every other form of certainty or knowledge, constitutes a way of believing that one is a king. Whether you believe yourself to be a king or believe that you are wretched, wanting to impose this certainty as a kind of tyranny on all those around you basically amounts to “believing one is a king”; it is this that makes all madness a kind of belief rooted in the fact that one is king of the world.³⁴

Being mad was “was to seize power in one’s head.” The real problem for psychiatry therefore was the question of how to persuade someone otherwise who believed herself to be a king. In the early 1940s, psychiatrist Heinrich Stadelmann described the mentally ill person as someone who “[was at home] in a different world than the normal thinking person,” which did not mean that mentally ill persons possess other “mental qualities than those one could find in mentally healthy persons.” As Stadelmann continued, “If the mental condition of the sick person *deviant from the norm* to such an extent that...*healthy opposing points of view cannot find*

adjusting entrance, how than can psychotherapy have a favourable impact and how can nursing be beneficial in psychotherapy?”³⁵

This problematic was emphasized by Bleuler too, who described vividly the characteristics of “negativistic schizophrenia” with which B. had been diagnosed.

When the sick person should get up, they want to stay in bed; if they should stay in bed, they want to get up. They neither want to dress nor do they want to undress, complying with an order or according to the asylum’s rules, neither come to eat, nor get down from the table; can they do all these actions beyond the claimed time or if they can somehow do it against the will of those surrounding, they will do it. They are not going to use the toilet spontaneously if they are accompanied there, they withhold their excrement in order later to soil their beds or their clothes. They eat the soup with a fork or with a dessert spoon, the dessert with a tablespoon. Many resist with might and main (*Leibeskräften*) against any influences, often with agitated insulting and swiping... It can develop into a real harassment (*Chicanose*), into an active desire to always annoy those surrounding them in a provocative manner.³⁶

This definition of “madness” was important in two ways. First of all, it implied that madness could only be explained by its opposition to what counted as “normal.” Madness could not be related straightforwardly to an organic cause nor could it be detected in specific brain damage, but rather was detectable only in behaviour. This aspect has already been touched on in the previous analysis of the admission ceremony and the role of the psychiatrist in deciding what behavior counts as abnormal. What counted as “normal” could only be defined through distinguishing “abnormal behavior,” or, in other words, reason can only be defined against its opposite; “we are not like them and that is why we are normal.” Only by collecting evidence for madness can reason be defined. Nurses and psychiatrists concentrated on demonstrating the insane nature of B.’s behaviour, because in doing so, they constructed themselves as “normal.”

Secondly, Bleuler’s remarks highlighted that the “lunatic” could not be convinced by logic, “one cannot forget that it is very rare to persuade the sick person to back down through logic itself.” The only possibility of influencing madness was through “purposeful education,” especially for the chronic cases who are, “for the most part to be trained to normal behaviour and work.” Nurse Heinrich Becker specified that the function of nursing was “to find out in all

patients how they are best to be disposed.” But in order to be able to do so, the nurse had to “try to infiltrate the trains of thoughts or peculiarities of the sick persons, and when he succeeds, to act out of this knowledge.”³⁷ Becker believed in the specific characteristic of nurses’ power “to infiltrate the train of thought” of the sick person in order to influence his or her internal behaviour, describing what Foucault called the disciplinary power of psychiatry that confronts the “sovereign power” of the mad and leads to an endless struggle.

The file on B. demonstrated that the medical and nursing personnel demonstrated an increasing awareness of behaviour that they considered dangerous, a factor found not only in B.’s record but in most of the other medical files analyzed for this project.³⁸ Using terms like “suddenly” made the outbursts of violence seemed unanticipated. The nurses’ notes made this danger visible and illustrated that therapy against this violence was the practice of asylum rules – the nursing domain in which nurses employed a multitude of disciplinary techniques from persuasion to physical and chemical restraints.

It was discussed earlier that the nurses’ notes, in conjunction with fever charts, medication plans, weight tables, and nutrition plans, etc., organized a complete takeover of B.’s life, registering and influencing every bodily function. Eating to excretion were all functions targeted by their particular interventions. Even the tube feeding itself became a disciplinary means, since before B. was forcefully fed, the nurses tried to feed her or convince her to eat by herself. All in all, more than 200 nurses’ notes referred to the tactics employed to convince B. to eat one way or the other. Nurse Becker, however, had recommended against force feedings, because one mostly “achieves the opposite, namely an ever-increasing persistence in refusing to eat. [Only after] one has unsuccessfully offered food from time to time...should one conduct an emergency tube feeding.”³⁹

In dealing with B.’s eating disorder a whole range of nursing interventions were used. For example, tube feeding was prescribed in February twice a day but at the same time, the nurses tried to get her to eat on her own. On 26 February B. ate a little at each meal, obviously not

actively resisting and therefore not receiving a tube feeding that day. The next day, however, she actively refused food and was force fed. It was thus not only the question of B. eating, but that she ate at the asylum's official mealtimes. In the months to come when B. wanted to eat again, she decided to eat at any time of the day and even took food from other patients, which again became a problem for the nurses.

From mid-April 1931 on, however, the recording of B.'s refusal to eat changed slightly. On 10 April, B. was tube fed but at this time, tube feeding had no longer been prescribed by the psychiatrist but rather depended on the judgment of the nurses whether or not they considered her food intake sufficient. Nevertheless, the decision for B. to be tube fed also depended on her behaviour in the asylum. In House 10, B. had received a tube feeding twice a day (according to the fever chart), but in House 16, it was much more flexible. On some days she had one tube feeding, but on 18 March, the systematic recording of the tube feedings broke off completely. It seems that a calculated and continuous alteration took place between offering B. food, talking to her in order to convince her to eat, forcing her to eat, and forcing a tube feeding when she refused everything else. Tube feedings also had an educational dimension. Up until 10 April B. had escaped forced feedings because she had fed herself, or at least had allowed the nurses to feed her. On that day, however, she did receive a tube feeding and the only thing that had changed in the nurses' notes was the description of B.'s behaviour. The next time she received a tube feeding was on 16 and 17 April, even though she had eaten almost nothing for a week. In the first case, B. received a tube feeding after only one refusal to eat dinner, but in the second case, she was forced fed only after refusing food for several days. The decision to tube feed also apparently depended on the behaviour that was noted in the record; the more aggressive B. became, the more likely it was that she would be tube fed. The eating problem accompanied the nurses' notes throughout the next months of B.'s stay and every time the nurses considered that B. resisted eating, they intervened. For example, a nurse noted on 21 May that "Pat. ate very little this evening, spat everything out again, was very resistant when being fed."

Being fed implied some violence – the nurses were determined to feed her despite resistance. But the nurses had more than force or coercion in their repertoire; rather they tried to convince B. to eat themselves or else they tried to influence her through her mother, because she seemed to be particularly successful in convincing her daughter to eat. These attempts Becker described as “[infiltrating] the train of thought” of the sick person in order to influence behavior from the “interior.” As mentioned previously, Becker believed that forcing sick people to eat would only increase their resistance to eating, although tube feeding could be used when all else failed.⁴⁰ Nurse Philipp Seibert urged nurses to encourage sick persons who believed that food was poisoned or forbidden to eat. “A warm word often helps in case of resistant sick persons and those in a bad mood.”⁴¹ As Bleuler described his strategy, “sometimes detours can be taken through which one can entice patients to eat; thus some of them will take food on the sly if food is left around for them.”⁴²

However, Bleuler advocated tube feeding if all else had failed, stating that the patient should be placed in a lying or sitting position in such a manner that a fight was impossible. With the tube fixed correctly through the nose, the nurses were to pour in a mixture of milk and eggs. This procedure obviously required a certain amount of force, because sufficient personal were needed in order to firmly restrain the patient while threading the tube, especially since it could very easily be introduced into the respiratory tract. However, this kind of force was not directed personally against the patient – not aimed to take revenge – but rather it was a kind of “clinical” violence characterized by the calculated employment of force necessary to correct a certain behaviour. It was a kind of “mute power” that used only as much force as was necessary to convince the patient that resistance would be useless. A similar situation occurred on 13 April when B. was given an injection after noisily jumping out of bed at night and insulting and assaulting the nurse when she tried to put her back.⁴³ Administering the injection in this case was a disciplinary means to get B. to stay in bed and to stop her disturbance but it was described in

neutral words and without any resentment. The injection was thus just a logical consequence of B.'s behaviour.

The “feeding strategy” was unsuccessful, for B. lost more and more weight; the weight table showed that she weighed only 41.5kg at the end of April 1931. Nevertheless, on another level, it did seem to work, because from the end of April 1931 on the nurses began to report more frequently that B. ate too much, ate food that was not hers, and began to eat at times outside the regular mealtimes. For example on 28 April, she refused her own bread at dinner “but took it away from other patients and bit immediately into it. Did the same with the beverage.”⁴⁴ On 6 June, she “was in a good mood. In the evening, she got out of bed all the time, took away patient M's chocolate.”⁴⁵ And on 22 June the nurses noted that “Pat. got up a lot. Got cake out of her bedside table, started eating. When the remaining cake was taken from her, she demanded it back and got up again.”⁴⁶ So even though it was obviously becoming more of a problem that B. did not eat according to asylum rules, she was eating “spontaneously.” This was a declared aim of therapy, and as the administrative chief inspector (*Verwaltungs Oberinspektor*) Sieben summarized, “the arousal and strengthening of the sick person's ‘will to be cured’ (*Heilungswillen*), the personal collaboration of the sick person with the physician and nurses, and a prudent and comprehensive attitude of the patient towards his suffering and his surrounding, can and must be achieved in the hospital.”⁴⁷

Disciplinary power thus had a productive dimension; it could not be reduced solely to oppression and negation but rather it influenced individuals profoundly, simultaneously producing them, or as Foucault described it, transforming the “somatic singularity”⁴⁸ into a subject and an individual in the first place.⁴⁹ The term “somatic singularity” is used as a kind of placeholder to indicate that the subject existed “pre-discursively” as a physiological body but achieved its subject status and its individuality only within the discourses that constructed it. This mechanism will be analyzed in more detail at the end of this chapter.

The nurses' notes also described an ongoing educational process meant to influence B. to eat in the prescribed manner. The note from 22 June demonstrated that the nurses intervened when B. behaved in an illegitimate manner and began to eat at night. The nurse reacted by taking away her cake, which in return provoked B. This action was exactly what was meant by an educational intervention; as nurse Seibert wrote, "all mentally ill persons are to be educated to tidy conduct and engagement."⁵⁰

Education was not limited to the problem of eating but rather was the core of what could be called psychotherapy at that time. As has been emphasized several times, nurses took control over most of B.'s bodily functions. But also discussed has been that the takeover of control went beyond the mere physical body, but this was only indirectly mentioned in the nurses' notes. As previously noted, continuous bed rest could only be perceived because the bed was very often the point of reference for the description of B.'s behaviour; in other words, we only know about the rule of continuous bed rest because of the frequent reference to the bed in nursing descriptions of B.'s negative behaviour. Even after B. was transferred to House 16, she spent most of her time on bed rest and was even washed and dressed by the nurses. On 17 March, the nurse on duty noted that "Pat. slept quietly, very resistant when she was washed."⁵¹ The manner in which this observation was made demonstrated that this "washing" was not a single instance but rather part of the daily routine. The reason why the washing of B. was noted this day was because she resisted. (Perhaps, since the night nurse wrote the note, it was because she was being washed very early in the morning.) Nursing notes relating to washing can be found during the first couple of months, as, for example, on 31 May, "in the evening, patient let herself be washed and went to bed quietly."⁵² Once again, we understand from this note that washing was a nursing routine that took place at least twice a day, as did dressing. For example, on 17 May, one nurse wrote that "in the evening, patient resisted being dressed in her nightshirt, went to bed naked, was quiet,"⁵³ and on May 28, B. "screamed when getting dressed."⁵⁴ First, these notes affirm that they were written for those working in the asylum and therefore needed to convey only information important for

the accomplishment of everyday work and, second, that they were only understandable against the backdrop of what I call “background knowledge,” because every nurse working in Friedrichsberg certainly did know that patients were on bed rest and that it was a nursing task to wash and dress them at least twice a day.

Nevertheless, these duties also implied a restriction on any “free space,” because patients could not decide for themselves whether or not they wanted to get washed and dressed. In the previously mentioned nurses’ textbook, nurses were admonished that patients who were unclean in clothing and body demanded the “indefatigable attention of the nurse” to clean them.⁵⁵ Again, these nursing interventions are performed on the patient’s body, with the washing and dressing done at prescribed times in a prescribed manner with specified (because patients had to wear institutional clothing and in B.’s case, usually nightshirts). “Sick persons who are prone to tear [their clothes], to undress, or to twist off buttons [were to] receive so-called closure shirts (*Schließkleider*) or suits made out of ‘untearable’ material in some asylums.”⁵⁶ However, increasingly limited and controlled “free space” for patients automatically implied that resistance would occur, because its restriction meant that nearly any behaviour appeared to be resistant, thus becoming even more evidence for a patient’s madness. As already mentioned also, “barrier boards” used to prevent patients from getting out of bed provoked attempts to climb out or beat against these boards, behaviour also deemed resistant. Measures employed to restrain madness apparently also served to inflame it.

The nurses’ reports can often be read as struggles to educate B. Although the notes only report on everyday minor occurrences in the asylum, they nevertheless highlight the rationale behind the nurses’ continuous micro-interventions. For example, on 14 April, one nurse wrote that “pat. very agitated and noisy, could not be held in bed, tried over and over to leave the room. When holding her back she would lash out, bite and spit.”⁵⁷ On 28 May 28, she “soiled herself and wet the bed” and screamed” when the nurse tried to dress her.”⁵⁸ And again, on 15 July, she undressed completely in the garden and “went jogging, very resistant to put on the dress again.”⁵⁹

These examples emphasize the everyday struggles between the nurses and B. The largest part of the nurses' interventions in 1931 consisted of continuous and patient correction of her erratic behaviour. This would change, however, in the years to come, as the disciplinary means became more and more severe. Even in 1931, there were indications that the nurses could deliberately tighten their war against the madness by drawing on the large repertoire at their disposal.

One way to discipline patients was to transfer them to another house with a stricter control system where there were fewer possibilities for distraction, or to place them in a ward where they would be under constant surveillance. From mid-April on, B. was more and more described as "completely" mad – no realm of her life seemed to be exempt from madness. She was hallucinating, was unpredictable in her behaviour, and aggressive with the nurses and other patients. The psychiatrist perceived B. as a child, writing about her on 4 May that she "climbs about everywhere, is very untidy, often runs around naked. Extremely infantile behaviour, in between times again unapproachable, negativistic."⁶⁰ This description of her was still within the diagnostic frame of schizophrenia but was supplemented by the childish dimension of B.'s behaviour. In mid-May, she was transferred to House 14.

12.5. Pat. was transferred from House 16 to here, behaved calmly. Played with a ball for a short period of time, then threw it away, and stood around with a melancholic expression on her face. When her mother gave her some bread, she took a bite and then threw it away. In the evening, patient danced to a few beats of some music with a smiling expression on her face and then suddenly stopped, closed her eyes and made a sad face. In the evening, pat. ate well without having to be encouraged, milk had to be given to her. (Oi.)⁶¹

It is noteworthy that the nurse's notes from House 14 are very detailed, and furthermore, that they read like a continuation of B.'s history. This continuation is once more made possible by the medical record, because the concentration on her eating behaviour demonstrated that the nurse was aware of B.'s problems from the previous house, again strengthening the thesis that the record intervened in asylum interactions. For example, on 18 May the psychiatrist wrote that

18.5. All in all a little more orderly. Keeps busy for a short period of time, then runs around in the garden again, laughs, is being silly. Because she tried to climb over the garden fence, she was transferred to House 14 on 12.5. In the morning while getting up she mentions: "What shall I, I am dead, I cannot live on one leg."⁶²

Again, the information in the psychiatrist's note is derived from the nurses' written observations. His reference to her "climbing over the garden fence" – an event that happened in another house one week before he wrote his note, highlights once more how the record enabled one to "travel back" in the patient's history. Even the fact that he judged B.'s behaviour as "a little more orderly," though he was seeing her for the first time, demonstrates the power of the record. But the fact that B. was transferred at all, because she broke a rule, illustrates that transfers within the asylum were not motivated by diagnostic considerations but rather by disciplinary rationalities.

B. was transferred because it was felt that she could be kept under better control in House 14. During May and June, however, the nurses wrote irregularly, recording their observations only if it seemed that something noteworthy had occurred in B.'s behaviour. The psychiatrists, too, rarely took notes more than two or three times a month, since the nurses were responsible for B.'s care and "education." Not only was the physical space divided in House 14, the time lapses between the documentation on her introduced another form of division, at this point, a division by time.

4.6.31: At times, patient was very disobedient, spat at other pat. and threw stones at pat. Gü., had to be taken to the noisy room.

4.6.31: Aftern: Patient threw stones at the inspector. Patient was quite lively all afternoon, could not be persuaded to lie down in the lawn chair, often got up at night. (St.) H.

5.6.31: Pat. had to be brought back to the room temporarily because she threw pebbles all the time and spat. (Gr.)

6.6.31: Aftern: Patient sang and danced around the garden, was in a good mood. In the evening, she got out of bed all the time, took away patient M.'s chocolate. (St.)

10.6.31: Patient was very restless, took off her socks and shoes all the time, took away needlework, book or things like that from other pat. Patient had to be taken to the noisy ward again. Later often out of bed. (St.) H.

15.6.31: Morning: In the garden, patient took off her dress and undergarment and went jogging, very resistant to put on the dress again. (Me.)

15.6.31: All afternoon, patient was very lively, jumped on benches and tables, ran around with her dress pulled up, tried to pick branches from bushes and spat all the time. (Sch.) H.⁶³

As these notes suggest, B. was transferred internally in House 14 for rule violations. Each time she became too noisy or too “resistant” she was put in either the “noisy room” or the observation ward, which prevented her from using the garden or circulating freely on the ward. On 4 June the nurse used the term “disobedient” because it characterized exactly what nursing interventions were about: to educate the patient to become obedient. Transferring patients to the noisy room against their will was possible only by force. In the Langenhorn nursing school textbook the procedure was described as follows “in order to avert a tussle (*Balgerei*) a couple of [male] nurses should be ready on hand; the sick person generally discerns that resistance is futile and complies. In case that he [the sick person] still resists, no rules can be designated how he could be handled gently. It is practical if the [male] nurses arrange beforehand which part of the body each one should catch.”⁶⁴ The use of force should be reduced to a minimum and should be applied strategically but the scenario should be such that the patient acknowledges that resistance is futile.

House 14 seemed to be set up for the purpose of applying many different types of disciplinary means. “Work therapy” was one means, and it was a nursing task to teach patients how to work, as was noted on 27 July when “pat. was encouraged to do some needlework but wasn’t of much use. Wound the wool around the needles and played horse with it, at times talking incoherently and senselessly.”⁶⁵ (See Figure 21) The nurses supervised this work and intervened in cases of misbehaviour when, for example, on 18 May when the nurse observed that “Pat. was very restless, knotted up her needlework, when patient was called, she said: ‘You bitch, I am absolutely not obliged to be here.’”⁶⁶



Figure 21: Sewing room in Friedrichsberg, c. 1928.⁶⁷

Because many notes related to B.'s behavior in the garden, they suggest that a secure space outside the building existed that too was highly controlled, since the nurses were able to observe everything that was going on and to intervene if necessary. For example, on 18 May "at noon in the garden, pat. hit pat. La. with her belt; when she was stopped for doing it, she said "I am allowed to do that."⁶⁸ Even though the patients at times felt unobserved, they were under scrutiny. On 4 July, one nurse wrote that "until 10 am, patient was very restless, climbed up the tree, as soon as patient felt unobserved, she'd climb into the basement, she also sat down in the garden, collected stones, had a bowel movement. When the nurse paid attention to her, patient was friendly and obedient."⁶⁹

However, the disciplinary repertoire of the nurses was broader than the use of violence and oppression. At times they appeared sympathetic to their patients. For example, on 12 May, B. "played with a ball for a short period of time, then threw it away, and stood around with a melancholic expression on her face."⁷⁰ Deacon Wilhelm Thielmann believed that the relevance of playing games in psychiatric practice – that the main task of nurses and psychiatrists – was to motivate sick persons to undertake serious activities during the day and then to allow them to have "leisure time after work."⁷¹ Games were a means to awaken the "stupid ones and idiots. Even if is difficult one must always try." Games enabled moving the "aimless, volatile activities of a schizophrenic in an orderly direction,"⁷² which accelerated their process of adaptation.

However “the day was to be primarily reserved for the work.” It was only the evenings that should be “filled with all kinds of board games, card games, and parlor games...[and] music should be cultivated as well as readings.” Nevertheless games should remain games and they should not lead to quarrels. “Only one person can win in the game [and] that must always be emphasized.” Games were meant to socialize patients into orderly behavior, both in the game and in other parts of asylum life, without them being aware of it. Playing games was just another strategic tool used to influence the patient to accept the reality of the asylum.

Again the role of the nurses must be emphasized. The break in the psychiatrists’ reports between February and March 1931, when the nurses continued to record their observations, is highly suggestive that the nurses had a great deal of autonomy. The psychiatrists wrote notes only on the rare occasion during this period, and thus the nurses appeared to have had a relatively long free period in which to interact with their patients. And because all information written by the psychiatrists continued to be derived from the nurses’ notes, the nurses thus occupied a very powerful position. It was they who ultimately defined what became a part of the psychiatrists’ reports and therefore it was they who defined the “image” of the patient that developed within the record. It was their written observations that identified targets for interventions, thus initiating further interventions, as in the case of B.’s transfer to House 14 in the first place in reaction to her attempt to climb over the fence, which they had recorded in the notes.

6.2.3 *Enforcing the asylum’s reality*

This analysis has demonstrated so far that the asylum regulations formed a backdrop to the nurses’ notes and that many of the nursing observations were a succession of recorded rule violations. Again, in September 1931.

2.9.31: The patient does not obey the nurses. She always gets what she wants. (Fb)

4.9.31: Patient is always very lively, talks all the time about her trips and that she had been to India. Is always very full of herself, says that she has had wonderful skin, but now her face was full of pimples. In the evening patient often talks with patient Jü., when she is told to be quiet she always talks back in a cheeky way and is still not quiet but thinks she must have

the last word. Patient is always hard working and wants to please.
(Nurse. F. He.) *H.*⁷³

Every daily entry referred to a hidden rule, and the last quote especially demonstrated that the nurses evaluated B.'s behaviour according to her capacity to submit – the reason why the nurses talked so often about her behaviour as “quiet,” “reluctant,” “noisy,” or “struggling against,” etc. The “wish to please” alone was not sufficient. However, it was only against the backdrop of asylum regulation that these observations could be made in the first place. According to Foucault, the objectified medical gaze, as the fundamental condition for the constitution of medical knowledge, requires a certain order and a particular distribution of bodies, gestures, behaviour, and discourses in space and time.⁷⁴ Only within such a regulated distribution can the medical gaze find its object. Distribution is enabled by the disciplinary order. Simultaneously, this disciplinary order is the condition for a durable cure of the mad because the transformation of the sick person into somebody who ceases to be sick is only possible within this regulated dissemination of power. The reality of the asylum is traversed by a complete power dissymmetry that is bound to a medical instance. This medical instance is endowed with an infinite power against which resistance is futile. The medical instance functions first of all as power and only thereafter can it function as knowledge. This is the reason why B. was transferred within the asylum according to her behaviour and not according to a specific diagnosis or nosography. This is similar for the treatments of other patients because in all the records used for this analysis, individual treatments are characterized by the same “psychotherapy” independently from patient diagnosis (see also Endnote 145). The only differences in treatments can be found in the medications administered but the psychotherapy as such was always the same. This is to say that the psychiatric asylum cannot be considered as an institution that functions according to specific rules, but rather it is a field that is polarized by an essential power dissymmetry that is physically constituted even in the body of the psychiatrist. That is the deeper meaning of Bleuler's assumption quoted earlier –“...that it is very rare to persuade the sick person to back down

through logic itself, but rather the appearance of the one who applies the logic,” or the bodily appearance of the psychiatrist that is important.

However the power of the psychiatrist was distributed in a system of differences. Around the psychiatrist was grouped a series of “intermediary” groups, one of which was the nurses, and the other, technologies. According to Foucault, the psychiatric asylum is a “curing dispositif” or a “curing machine” in which the actions of the physician constitute an absolute body within the institution, the rules, and the buildings. It is a kind of uniform body in which the walls, the rooms, the instruments, the nurses, the wards, and the psychiatrists are elements with different functions but with a common and most important purpose of achieving a particular effect through their interplay. It is striking that in the medical record under study here, nothing points to it being led by an anatomic-pathological discourse or a kind of nosography. In the final analysis it seems as if the psychiatric practice did not act in accordance with a theory but rather was composed of maneuvers, tactics, actions, and reactions. In brief, psychiatric practice appeared as a tactical corpus and strategic ensemble and this seems to be all that could be reported in the notes.⁷⁵

This disciplinary space of the psychiatric asylum is further characterized by the fact that nurses and psychiatrists were “masters of reality.” The notes demonstrate that nurses especially had to provide the idea of “reality” so strongly in order to seize and penetrate the madness to make it disappear. Under the authority of the psychiatrists, nurses became the supplementary force enabling reality to force itself onto the madness or, conversely, to prevent the madness from withdrawing from reality. Nurses appeared as an intensifying factor of the real. They were agents of a superior power of the real through which the real was forced onto the madness in the name of a power that claimed truth based on medical knowledge.⁷⁶ This enforcement of reality was based on the dispositif of psychiatry that enabled it to conduct and govern the madness. The superior power of the real is enabled by the interplay of different variables: the disciplinary power asymmetry, the imperative use of language, and the enforcement of a statutory identity in which the sick person must recognize himself or herself. The desire to find a way out of madness

implied acknowledging this medical power as all powerful, renouncing the omnipotence of madness, and accepting the documentary-biographical identity. The latter will be analyzed in more detail in the next section. Thus, the instruments employed by psychiatry in order to dominate madness become simultaneously the criteria for recovery. Foucault called this the “tautology of psychiatry” because, on the one hand, the asylum forcibly awards reality and, on the other hand, simultaneously represents reality as pure power, a reality that is intensified through medical and nursing functions.⁷⁷ In other words, the medical-nursing power-knowledge complex has no other function than being the agent of reality itself. To construct reality as superior power is enabled by the fact that this reality is reproduced within the asylum. On the one hand, the asylum is nearly completely cut off from the outside world; it is a specific world that remains completely under the control of a medical power (that defines itself by competency in medical knowledge). On the other hand, asylums must remind patients of everyday life as much as possible, with similarities to workshops and prisons. It seemed as if B. could only resist by fighting the nurses, wetting the bed, undressing, or tearing her own shirt; in the years to come she even began to self-injure. That these actions were forms of resistance is demonstrated by the fact that they can be found in most of the analyzed records.⁷⁸ However, as further analysis will highlight, disciplinary means became so strong in the years to come that finally, the disciplinary power of the psychiatrist turned into an absolute sovereign power and, in the end, enabled B.’s assassination.

As already mentioned above, the written reports were of particular importance for enforcing psychiatric reality on patients. Within B.’s medical file, a documentary-biographical identity evolved that subjectified the “somatic singularity” (as earlier defined). This mechanism will be analyzed in the next section.

6.3 The Record, the Script, the Dispositif⁷⁹, and the Subject

The analysis has so far suggested that psychiatric practice can only be understood if one considers the complex interplay of multiple actors. One mechanism not yet analyzed in depth is the significance of the record for the subjectification of the patients. The interconnections between different inscriptions and different technologies highlight one mode by which human beings are made subjects. According to Foucault, this mode can be described as an objectification through “dividing practices,” meaning that the “subject is either divided inside himself or divided from others...[a process] that objectifies him.”⁸⁰ The architecture of the modern asylum, for example, enabled the separation of mentally ill persons in such a way that it allowed for the control and the discipline of the insane. It was understood that the insane could be arranged geographically according to the perceived danger of their conduct, their ability to work, their ability to disturb asylum routine, or their gender, and rooms were constructed to enable wide-ranging surveillance of these patients. Asylum architecture was guided by the desire to closely regulate the behaviour of the mentally ill, an aspect that will be developed further later.

It was only within the modern asylum, which designated a specific space for the care of the insane, that the idea of the “insane” emerged in the first place. Subjectivity does not exist prior to discourse but is constructed through discourse, and modes of subjectification are always embedded in power relations, which cannot be analyzed, according to Foucault, on a legal model or by asking questions such as “What legitimates power?”⁸¹ It is not so much a question of

“such and such” institution of power, or group, or elite, or class, but rather a technique, a form of power. This form of power applies itself to immediate everyday life which categorizes the individual, marks him [*sic*], imposes a law of truth on him which he must recognize and which others have to recognize in him. It is a form of power which makes individuals subjects. There are two meanings of the word subject: subject to someone else by control and dependence, and the other, tied to his own identity by a conscience or self-knowledge. Both meanings suggest a form of power which subjugates and makes subject to.”⁸²

Based on Foucault's concept of subjectification and regulation as a twofold process, the process described above is a form of subject construction. According to Foucault, regulatory power "not only acts upon a preexisting subject but also shapes and forms that subject" and even disciplinary power has productive effects. For example, even though the nurses forced B. to eat, she, at times, did eat. Power is not only coercive but also has a kind of beneficial effect. However, "to become subject to a regulation is also to become subjectified by it," or in other words, a subject is brought into being through the act of regulation.⁸³

The following part of the analysis concentrates on the process of subjectification through documentation in the record. In the course of the analysis other technologies of subjectification will be discussed in more detail.

6.3.1 *Connecting discipline, the script, and the subject*

As already demonstrated in several instances, psychiatric practice targets complete possession of the body and an all-embracing control, both of which are connected to the written recording of observations. As a disciplinary power, psychiatric practice with its characteristic form of hierarchical continuum required the use of writing in order to register everything about a patient – everything that the patient did and what he or she talked about. The medical record enabled nurses to pass along information from the bottom-up and the documents, because they were written, allowed all information to be accessible at any time. Written documents therefore enabled and assured permanent visibility. It was also a method of centralizing information and of coordinating different levels within disciplinary systems. Graphing bodily functions allowed a direct and continuous relationship between writing and body to evolve. The visibility of the body and the permanency of the writing were not detachable from each other and produced the effect of what Foucault called, a "schematized and centralized individualization,"⁸⁴ centralized because all information regarding the patient was collected in a record that was entirely controlled and inspected by the medical director (or his representative).

The bodies, the gestures, the behaviours, and the discourses are all encircled by a web of writing, which registers, codes, and schematizes. However, the continuous visibility of the body through graphing enabled a further important effect by triggering an immediate reaction of disciplinary power. This effect was already analyzed in the section on the interplay between different inscriptions, which enabled the perception of something that had not yet been materialized or became visible only through inscriptions, as, for example, B.'s bladder infection or her eating disorder. This capacity inherent in documenting was also demonstrated at the times when B. became too excited and received "prophylactic" sedatives. Uninterrupted documentation enabled interventions to take place from the first moment of translation on the chart, virtually from the first sign or gesture on. The previous section that dealt with nurses' notes as war reports demonstrated the continuous concern of the nurses to document B.'s behaviour in such detail that it enabled them to intervene as quickly as possible when she behaved in certain ways. The least glimmer of a change in her mood, for example, could result in the nurses transferring her prophylactically to the "noisy room." This prophylactic intervention illustrates a further significant characteristic of disciplinary power because its aim is to enable intervention at a point of time when conduct is still virtual and only just about to be realized. The intervention takes place before the act itself, something that is only possible because of the complex interplay among surveillance, reward, punishment, and pressure, or, in short, through "infra-judiciary" forms of intervention.⁸⁵

Disciplinary power thus establishes a permanent pressure that is not only directed towards committed actions and their subsequent damage, but also toward the potential of such behaviour. Before any gesture is carried out its precursor must be identified to enable disciplinary power to intervene before the behaviour, the body, the gesture, or the discourse actually comes into existence. This dimension that is concerned with virtual possibility, the disposition, or the volition, can be characterized as "the soul."⁸⁶ Foucault called this interplay the "panoptical principle" (the ability to see anyone anytime) that consists of the following aspects: first, the

occupation of the time, the life, and the body of the individual; second, a centralized individualisation based on writing; and third, this principle also contains the possibility for continuous penalization that targets a virtual behaviour and that goes beyond the body to project something like the “psyche.” This is to say, interventions first and foremost constitute the psyche that is being “treated” in the asylum.

This interrelation between punishment, script, and technologies will be analyzed in more detail in the notes of the years from 1936 to 1938 and in 1940, where it will be demonstrated once again how multiple technologies were able to transform B. profoundly. But as these notes also highlight, deviant conduct was punished but conduct evaluated as “normal” was rewarded. The construction of the asylum helped to materialize these principles of disciplinary power since different asylum spaces and the spatial organization of the wards were constructed according to levels of punishment and reward.

As suggested earlier, “normal” behaviour was rewarded by allowing patients certain liberties such as “free” circulation on the ward or access to the garden. Especially in Langenhorn, the amount of food to which one was entitled depended on work performance, based on the logic that patients who were motivated to work could expect more and better food. This aspect had a decisive impact on the chances of survival in Langenhorn during the Nazi regime and more particularly, during the Second World War, because only those patients not accommodated in “secured houses” had a chance to organize supplementary food outside the houses.⁸⁷ Discipline thus functioned not only by oppressing behaviour considered undesirable but also by provoking or constituting behaviour considered desirable through continuous punishment and education (e.g. stimulating the desire to work in order to get better food).

However, the main effect of the disciplinary power was the profound re-creation of the relationship between the somatic singularity, the subject, and the individual. It is again Foucault who analyzed the impact of this mechanism in detail and the following section tries to grasp some

of his central ideas, because it enables us to more fully understand the rationale behind the documentary corpus of the record.

According to Foucault, sovereign power is characterized by specific ceremonies and procedures that create the process of individualization from the top down, and it is the sovereign who is the most individualized element in this system. Disciplinary systems, however, are characterized by the fact that the individualizing function disappears from the top. Those who are charged to direct the dispositif (in the case of the psychiatric asylum it is the medical director) are not important as individuals but only in their function. This function could be accomplished by a particular person, but it could in principle be carried out by anybody.⁸⁸ This was demonstrated in the analysis above when the nurses intervened in order to correct “misbehaviour,” they did so only in their function as nurses and not for personal revenge. I called this aspect the “anonymous power” of the nurses, because violence was justified only insofar as it enabled the education of the patient; it was simply a strategic consideration and not bound to a specific person. Foucault described this theoretical aspect as the democratic principle of the Panopticum, because even those who assume responsibility within this disciplinary system are themselves only part of a bigger system that controls them and in which they are disciplined themselves.⁸⁹

In contrast to a system of sovereign power, disciplinary power implies a strong individualization “from below.” Unlike in systems of sovereign power, in which the somatic singularity exists as a non-subjectified body, in systems of disciplinary power, the somatic singularity becomes subjectified: its body, its gestures, its place, its movements, its force, its lifetime, and its discourses. Disciplinary power thus constitutes this mode of subjectivity. Discipline is a power technique through which the subject mode is placed on and aligned with the somatic singularity, making “the body” into an individual. The most fundamental characteristic of disciplinary power is that it produces subordinated bodies by enforcing the subjectivity onto the body. Disciplinary power produces these bodies and distributes these bodies in a specific manner and thereby acts as an individualizing agent only through the fact that individuals are nothing

more than these subordinated bodies. The activities are bound to the system of surveillance-script (or, in other words, through a panoptic system) that projects a “psyche” as the backdrop or origin of the somatic singularity and implements the idea of normal as the obligatory principle in order to divide and normalize all the individuals constituted by this system.

Disciplinary power enforces the subject mode onto the somatic singularity through the combination of the sustained gaze, the script, the mechanism of endless minor penalties, the projection of a psyche, and finally, the subdivision of normal-abnormal. All these aspects together make up the disciplined individual and what can be described as an “individual” is finally nothing else than something to which political power can connect. What we call an individual, according to Foucault, is nothing other than the result of the amalgamation of the somatic singularity with political power. Discipline is the final, capillary form of power that constitutes the individual as its target, its partner, and its counterpart in relations of power. This is to say that the individual is neither antecedent to the subject function nor to the projection of a psyche nor to the normalizing instances. On the contrary, it was only because the somatic singularity became the carrier of the subject function that something like the concept of individual could appear within the political system. Only by encircling the body with endless surveillance, endless writing, and virtual penalization, with its subsequent subordination could something like the individual be constituted. Only because the normalizing instance distributes and excludes those “body-psyches” in a particular manner is the individual characterized. Due to the fact that the body was subjectified, which means that the subject mode was fixed on it, and because it was psychologized and normalized, something like the individual appeared. From this moment on it was possible to talk about the individual as an object of scientific inquiry.⁹⁰

6.3.2 *Fixing the subject function onto B.*

At the beginning of this analysis I contended that the documented biography in B.'s medical record had a wider aim than the simple reporting of particular events that occurred during her stay in the asylum. The admission ritual was the first step towards fixing a documentary identity onto individuals because, as I outlined in its analysis, it forced individuals to recognize themselves in their documentary histories and in the documented events that took place during their stay in the asylum. For this reason, psychiatrists regularly repeated interrogations and asked questions about events that they knew about only because they were reported in the nurses' notes. With the foregoing theoretical considerations in mind, it becomes easier to understand the importance of an interrogation that was carried out just before B. was discharged from Friedrichsberg in 1931. Two versions of this interrogation exist; one was written by the nurses and one by the psychiatrist. On 4 September 1931, the psychiatrist wrote:

4.9.31: Improved a lot lately. Eats a lot now and gained a lot of weight. At the ward cheerful, again busy with something. Talks a lot, seeks contact with other patients. During doctor's visit trusting behaviour.

Explor. [Exploration] Walks in happily, shakes hands, Takes an interest in the room. Did not have the feeling was ill during the recent time.

(Why didn't you eat?) I don't know; I couldn't eat.

(Why didn't you speak?) I couldn't; I didn't feel like saying something; I was like without consciousness, like numb.

(Why always naked?) I really don't know the answer to that

(Hearing voices?) Yes I am sure I have heard those; let me think; I heard music, all the time. I heard the music Frederic the Great has written. I heard clearly.

(Have you been to India?) Oh yes, sure. I have written books about it. Yes, beautiful flowers, nice trees, flags

(Also spoken?) As far as I know I have spoken also. With the birds that carry rubbish bins. As far as I know we took the ship Ambrades.

(When?) That was not long ago. I've just come back now. (But she is not quite sure about this,) But it all seems to me like a dream. It appears so unreal. I also don't know what those East Indians look like. (Shortly after she is more certain again) I was in Jokohama too; as far as I know I was there. The city is 200x bigger than Germany"

(Were you really there?) Yes, nobody believes me. It doesn't really matter; maybe I just read about it.

Talks about all this willingly and happily. Good mood. Very childish way of being.⁹¹

Two days earlier, the nurses had written:

2.9. To the doctor's question if the patient remembered that she had been tube fed, the patient replied smilingly "yes". Why not eaten? "I didn't like it." Patient used to run around the room naked a lot. To that patient replied: "but it is nice to run around like that when the sun is shining." [Asked] if patient wasn't ashamed to run around like this, it is not nice of a young girl, she promptly answered: "Ach, why, when it is so warm." To further questions concerning the trip to India, if patient had really been there with Mr. He., patient laughed and answered affirmatively, after further investigations about the trip patient admitted that it had all been made up. Patient behaves in an infantile/ childish manner and laughs all the time.
H.⁹²

Because the interrogation that took place on 4 September 1941 was pertinent for B.'s further "career," it was a decisive day for her. Following this interrogation B. was granted leave for a couple of weeks and then discharged from the asylum. The reason for her discharge must be searched for in the final interrogation and the statements B. made in the course of the interrogation. For the first time in the whole record, this minute of the interrogation provides a more or less detailed report on B.'s response to questioning and the stand that she took regarding her madness. From the perspective of the analysis outlined to this point, it is also significant because B. "acknowledged" her madness by recognizing herself in the documented biography of the record. The documentation thus comes full circle: what began with the admission ritual is determined by the final interrogation.

Before a discussion of the theoretical implications of this interrogation, some particularities of the content should be highlighted. Two versions of the interrogation exist and it is unclear if these versions refer to the same interrogation or if two took place. B. had been transferred to the house in which this interrogation took place just thirteen days prior, meaning that B. was personally known to the new team of psychiatrists and nurses for only a couple of weeks. All questions asked were related to events that happened in the past, events that the nurses and doctor could not have witnessed firsthand. These events were only knowable to them because they were documented in the record, again illustrating the mechanism analyzed in detail above.

The record is a biographical corpus from which a patient's history could be reconstructed. The comment about her improved disposition and her weight gain was gleaned from information contained in B.'s record, because the assessment of her ingestion especially referred to events that took place at the beginning of B.'s admission and in the other houses. B.'s weight gain could only be known by comparing the different entries in the weight table (according to the table B. put on 10 kg of weight). The depiction of her behaviour differed significantly from the admission ritual; whereas at the beginning she was perceived as catatonic, negativistic (refuses any food consumption), and completely withdrawn. Now she was described by the psychiatrists as "cheerful, busy with something, talking a lot, and even seeking contact with other patients," although she was still portrayed as childish. Despite this dramatic turnaround, however, the vocabulary used by the psychiatrists clearly indicated that they believed B. was still mad. For example, the term "cheerfully" implied that her behaviour was somehow inappropriate, and describing her as talking a lot suggested that she was "overshooting" in her attempts to overcome her previously non-talkative state. Although "shaking hands" implied a certain trust in her relationship with the psychiatrist, this type of unobtrusive behaviour strengthened the physician's impression that she had no insight into her illness. He believed that B. was still mad and that her behaviour had merely changed from being dangerous and negativistic to harmless and childish.

Between the nurse's note and that written by the psychiatrist, there is a slight difference in the manner in how B.'s answers are reported. In response to the question concerning B.'s previous refusal of food, the psychiatrist recorded that she "couldn't eat," while the nurse noted B. had not liked the food. Although the psychiatrist seemed to suggest that B.'s reluctance to take any food was somehow "unmotivated," the nurse's note demonstrated that B. justified her behaviour because she did not like the food. But what must also be emphasized at this point is that the nurse's note explicitly mentioned that the questions were related to the documented behaviour.

During this interrogation, it was also revealed that B. believed she had travelled to India, something that had never before been mentioned in either set of notes. Many drawings and writings produced by B. were found in an envelope at the back of her medical file, as well as kind of travel diary in which she wrote about her travels to India and described the fauna of the country. (See Figure 22) These drawings point out that B. was unwittingly involved in proving her madness, an aspect that was true for all the records analyzed in this project. Letters, drawings and any other object that could somehow be related to the madness of the patient and that could be used as an evidence for the diagnosis were kept in the records.

The interrogation followed the same format as already analyzed in detail for the admission ritual: the psychiatrist asked the questions and the patient had to answer them. Apart from the fact that both this interrogation and the admission ritual were demonstrations of power of psychiatric practice, and more precisely, the psychiatrist, they differ in some key aspects. The admission ritual focussed first and foremost on the constitution of a mental illness and sought to find its beginnings in early childhood. In this interrogation, the psychiatrist based his questions directly on the record's documented events, and the sequence of the interrogation followed exactly that found in the medical file. This clearly demonstrates what is meant by fixing a documentary identity onto individuals and, consequently, forcing individuals to recognize themselves in their documentary histories and in the documented events that took place during their stay in the asylum. The final aim of this interrogation was to convince B. to admit that "yes, it was me described in these events and that yes, I am mentally ill and therefore need the therapy, the psychiatrist, and the asylum."



Figure 22: Drawings and travel diary of B.'s virtual travels to India. At the top are pictures of Naples, and of her departure from Hamburg. The first drawing on the left in the middle is a kind of botanic description. The remaining drawings are from 1931. Patient record 28338.

Althusser used the term individual here with the same intent with which Foucault used “somatic singularity” as defined earlier, namely as a kind of placeholder. Althusser staged a social scene that was both “punitive and reduced, for the call [was] made by an officer of ‘the Law,’ and this officer [was] cast as singular and speaking. This scene was meant to be exemplary and allegorical, implying that “it never [needed] to happen for its effectivity to be presumed.”⁹⁵ Interpellation is a certain way of staging the call, “where the call, as staged, becomes deliteralized in the course of its exposition, and is figured as a demand of an ideology (or better, ideologies) to align with the ideology.”⁹⁶ It is a turning around to face the ideology and an entrance into the language of self-description – hence “Here I am.”

Before continuing with the analysis of subjectification, one must grasp the significance of Althusser’s concept of ideology. Stuart Hall pointed out that Althusser had developed the concept of ideology in his earlier writings and that the definition in these writings was broader and more “elaborated” than the one he used later.”⁹⁷ According to Hall, Althusser defined ideologies as “systems of representation – composed of concepts, ideas, myths, and images – in which men [and women] live their imaginary relation to the real conditions of existence.”⁹⁸ By defining ideologies as “systems of representation,” Althusser characterized them as essentially discursive and semiotic. In Hall’s words, “*systems of representation* are the systems of meaning through which *we represent the world to ourselves and to one another*. It acknowledges that ideological knowledge is the result of specific practices” or in other words, specific practices are involved in the production of meaning. This is to say that every social practice is constituted within the interplay of meaning and representation and thus meaning or ideas materialize in social practices. Hall formulated this interrelation as “there is no social practice outside of ideology. However, this does not mean that, because all social practices are within the discursive, there is nothing to social practice but discourse.”⁹⁹

This interrelation between social practices and the materialization of certain rationalities or ideas forms the central thesis of my analysis so far. Psychiatry as analyzed in this research

project can only be comprehended as a complex interplay between psychiatric practice understood as materialized discourses and psychiatric discourses understood as a result of psychiatric practice. B.'s medical record is thus the result of a process of the production of meaning and the tool of representation par excellence, which is to say that psychiatry can be defined as a practice or an apparatus. To use Althusser's term, the psychiatric asylum is an "ideological state apparatus" that produces the representations in which psychiatric patients live. It is important to emphasize that it is not possible to bring ideology to an end and simply live the real. "We always need systems through which we represent what the real is to ourselves and to others." This is to say, that we always use a variety of systems of representations in order to experience, interpret, and "make sense of" the conditions of our existence. "It follows that ideology can always define the same so-called object or objective condition in the real world differently. There is 'no necessary correspondence' between the conditions of a social relation or practice and the number of different ways in which it can be represented. It does not follow that, as some Neo-Kantians in discourse theory have assumed, because we cannot know or experience a social relation except 'within ideology,' therefore it has no existence independent of the machinery of representation..."¹⁰⁰

One experiences the world within systems of representation and this experience is the result of codes of intelligibility and schemes of interpretation, as demonstrated in my analysis for B.'s case record. The analysis of this record highlights the fact that what is represented in the record was the result of schemes of interpretations, and what was "experienced" by nurses and psychiatrists was bound up in their codes of intelligibility. As Hall stated, "consequently, there is no experience outside of the categories of representation or ideology."¹⁰¹ This relationship between the conditions of social conditions and the manner in which they are experienced is what Althusser called "imaginary" in his definition of ideology cited above. This returns us to the original question of "how it is that subjects recognize themselves in ideologies," or as Hall put it

“How is the relationship between individual subjects and the positionalities of a particular ideological discourse constructed?”¹⁰²

In order to answer this question it is helpful to consult Althusser’s definition of the interrelationship between ideologies and the category of the subject. “I say: the category of the subject is constitutive of all ideology, but at the same time and immediately I add that the category of the subject is only constitutive of all ideology insofar as all ideology has the function (which defines it) of “constituting” concrete individuals as subjects. In the interaction of this double constitution exists the functioning of all ideology, ideology being nothing but its functioning in the material forms of existence of that functioning.”¹⁰³

This definition not only implies that we are always already subjects but also that we constantly practice rituals of ideological recognition, which guarantee for us that “we are indeed concrete, individual, distinguishable and (naturally) irreplaceable subjects.”¹⁰⁴ This sentence describes exactly the functioning of the interrogation in psychiatry. I already mentioned that one decisive aim of psychiatry is to fix the subject function onto the somatic singularity and that the interrogation of the patient targets, among other things, the need for the patient to recognize himself or herself in the schematized and centralized biography of the documentation. However, the sentence also highlights that some of the basic positioning of somatic singularities (or individuals) in language are constituted through unconscious processes in the psychoanalytical sense, at the early stages of formation. These processes are already operating in early infancy “making possible the formation of relations with others and the outside world.”¹⁰⁵ To illustrate the power of ideology to constitute subjects, Althusser used the example of the divine voice that names, and in naming, brings its subjects into being. As philosopher Judith Butler explained,

Baptism exemplifies the linguistic means by which the subject is compelled into social being. God names “Peter.” and this address establishes God as the origin of Peter, the name remains attached to Peter permanently by virtue of the implied and continuous presence in the name of the one who names him. Within the terms of Althusser’s examples, however, this naming cannot be accomplished without a certain readiness or anticipatory desire on the part of the one addressed. To the extent that

the naming is an address, there is an addressee prior to the address; but given that the address is a name which creates what it names, there appears no “Peter” without the name “Peter.”¹⁰⁶

Social ideologies operate in an analogous way, according to Althusser. Setting aside that in using the divine voice, “Althusser inadvertently assimilates social interpellation to the divine performative,” the parallel to psychiatric interrogation is striking. I want to broaden his perspective to include the psychiatrist’s voice hailing the psychiatric patient in unfolding the biography of the record: “You are mentally ill.”

In requesting B. to recognize herself in the reported events of the record, the psychiatrist interpellates B. Nevertheless, the analysis above highlights that this naming cannot be accomplished without a certain readiness or anticipatory desire on the part of the one addressed. Only if B. recognized herself in these events and turned her face towards the psychiatrist’s power that hailed her, and only by admitting “yes it is really me who is described in these events,” was the naming successful.

In this sense, as a prior and essential condition of the formation of the subject, there is a certain readiness to be compelled by the authoritative interpellation, a readiness which suggests that one is, as it were, already in relation to the voice before the response, already implicated in the terms of the animating misrecognition by an authority to which one subsequently yields. Or perhaps one has already yielded before one turns around, and that turning is merely a sign of an inevitable submission by which one is established as a subject positioned in language as a possible addressee.¹⁰⁷

Again, this kind of analysis can be paralleled to the psychiatric interrogation, because the focus of the interrogation is to expose B.’s readiness to be compelled by the authoritative interpellation. Her turning was a sign of the inevitable submission to psychiatric power by which B. was established as a psychiatric subject positioned in language, and it was the pre-condition for her to be released from the asylum. This is the mechanism that decided whether or not B. could be considered incorrigible. In cases in which patients did not recognize themselves as individuals in the documented events in their record, their prospects of being “cured” were poor. In B.’s case, it was the last part of the interrogation that was of particular significance. When she

confessed that “nobody believes me. It doesn’t really matter; maybe I just read about it,” it was the first time that she had acknowledged that she might be wrong. At the end of her 1931 admission, we clearly see this “readiness to be compelled by the authoritative interpellation” of the psychiatrist, and therefore B. received permission first to spend a couple of weeks with her parents, and then was allowed a full discharge from the asylum, only to be re-admitted two months later in 1932.

After her last interrogation that included B.’s confession, a wondrous transformation took place in the psychiatrist’s notes. In the last line of his note he stated that she talked “about all this willingly and happily. Good mood. Very childish way of being,” which was a continuation of the reports of the last weeks. But although the patient was portrayed as a good-natured and somewhat feeble-minded child, all aspects of excitement and aggression had vanished from the reports, and she appeared ready for discharge. Following her return from a one-day leave, the psychiatrist noted on 16 September that she “Was home for 1 day. Much more lively than before the disease, when she was calm and withdrawn. All three – she and her sisters – were childish and infantile for their age, according to the mother.”¹⁰⁸ Stating that B. was livelier than ever before meant that he had obtained information from the admission ritual, the only place it had been recorded that B. had been withdrawn in her youth. He connected the information obtained from her mother during the admission interrogation with the current condition of the patient, in effect closing the circle with the suggestion that the amelioration of the patient’s condition was due to therapy and the result of psychiatric knowledge. Now he constructed a new narrative: the patient was childish in behavior because all of her siblings had developed the same way.

It should be emphasized, however, that a subject becomes a subject only by entering the normativity of language; according to Butler, the “rules precede and orchestrate the very formation of the subject.”¹⁰⁹ But entering into language has its price because the subject is differentiated against the “unspeakable”; the production of the “unspeakable” is the pre-condition for the subject formation. Along with Lacan, Butler argued that a “bar” exists in political life that

marks the point where the question of being able to speak is a condition of the subject's survival. Butler calls this "foreclosure" because it is prior to speech and is a reiterated effect of a structure. This means that the subject is performatively produced as a result of the "primary cut."¹¹⁰ And again, this is the theoretical formulation for what happened in the interrogation. Nevertheless, this theoretical claim has wide-reaching consequences, because it implies that the somatic singularity that is not able to enter into language automatically drops back into the "unspeakable." If it becomes impossible to be differentiated against the unspeakable then one is excluded from the realm of the visible and reduced to a "bare life."¹¹¹ If this happens, the disciplinary power of the psychiatrist transforms into a sovereign power. In front of this power the subject is neither living nor is it really dead. According to Foucault, it is the sovereign who can decide if the subject has the right to live or if the subject must die. However, the right of the sovereign is only realized at the moment when the sovereign is about to kill the subject, the reason why Foucault called it the right of the sword. This is what happened with B. in the years to come.¹¹²

Further analysis will concentrate on the question of how these "zones" within psychiatric practice were produced and what impact they had for patients like B. condemned to live in these zones. Before moving on, however, I want to highlight one important aspect that will be revisited during the following analysis: the implicit moral dimension in the nurses' notes.

6.3.4 *The moralizing dimension*

The nurses' descriptions of B.'s behaviour throughout her stay in the asylum contained a moral and gendered dimension. This was especially clear in the repeated descriptions of both B.'s inclination to run around in the nude and in her tendency to be incontinent. The nurses were disgusted by this behaviour and judged that B.'s behaviour was intentional and meant to provoke. B.'s aggressive behaviour and her unwillingness to participate in doing housework or needlework were also seen as unwomanly. The latter will be analyzed in more detail during the discussion of B.'s 1940 admission.

Between April and September of 1931, the notes described in detail how often and when B. was incontinent, particularly in June when the accumulating instances of incontinence were perceived as intentional misbehaviour. For example, the nurse noted on 17 June that “patient wet bed, even though she was taken to the bathroom,”¹¹³ and in the night of the same day “patient wet bed right after 10 o’clock, got up a lot and sat up in bed.”¹¹⁴ Although the first nurse emphasized that B. intentionally wet the bed, the second note linked her incontinence to her resistant behaviour in general. One day later the nurse reported that B. had removed her clothes in the garden and “[tried to] run around naked. In the room, patient wet the bed + was very lively.”¹¹⁵ Similar instances took place on 22 June, 1 July, and again on 18 July, when B. “wet the bed” and was “very noisy and disturbing.”¹¹⁶ The fact that the nurses spent so much time and energy in counting and describing the situations in which B. wet herself (or her bed) seems to indicate that this behavior was particularly disgusting to them. According to the notes, they spent a great deal of time washing and dressing her again. Patients apparently had few forms of resistance besides their excrement – reports of sudden incontinence can be found in many of the records consulted. Foucault found that these actions had a particular relevance for psychiatry because against the sovereign power of madness, which used excrement as an ultimate form of resistance, the disciplinary power of psychiatry, represented by the nurses, intervened to restrain, undress, and clean the patient, thus producing the patient’s body as “clean and true.”¹¹⁷ Once again, the functioning of disciplinary power was demonstrated through even these minor details.

Another aspect that was often described in detail in the nurses’ notes, both in B.’s record and in others, was the aspect of nudity. Although other behaviors were described in broad terms such as “restless” or “lively,” nudity was often described in every detail. That the nurses considered B.’s tendency to run around naked as shameless was especially clear in their final interrogation report. As the nurse revealed, she did not consider it “nice” for young girls to run around in the nude, placing a moral judgement on B.’s actions. The nurse linked B.’s undressing to other behaviours that they considered shameless, such as using coarse language, spitting, or

beating other patients, giving the impression that she behaved more like an animal than a woman. On June 16, for example, B. “took off her dress and undergarment and went jogging, very resistant to put on the dress again.” In the afternoon of that same day, she “was very lively, jumped on benches and tables, ran around with her dress pulled up, tried to pick branches from bushes and spat all the time.”¹¹⁸ On 17 August, “[t]owards the evening, [she] became very lively, refused to put on a shirt. Used coarse language.”¹¹⁹ Again, on 25 August, she “was very lively, jumped around the garden, dug on the grass, denuded the upper part of her body to let the sun shine on it.”¹²⁰

This day-to-day information that became part of the official record is not understandable without knowledge of the improvised but “normal” rules and theories utilized by nurses and psychiatrists, which were still supplemented by “common sense or folk typifications.”¹²¹ In other words, the nurses and psychiatrists had to map their observations onto medically relevant categories to justify their interventions, but they also combined this information with a kind of tacit knowledge that they received. This is to say, their observations and notes were influenced by knowledge of the world that appeared to them to be “deceitfully natural” or embodied knowledge.¹²²

That the nurses had an exact conception (embodied knowledge) about what it meant to behave as a “good woman” is illustrated in their notes. For example, most of the time, the nurses registered only how aggressive B. had been, even against her own mother. For example, they noted on April 15 that B. had been “very loud and agitated, hit and insulted her mother, tried to tear apart her mother’s dress shouting: ‘You are also such a mean woman!’”¹²³ During visiting hours on April 19, however, she “was at times lively, especially talking to a young aunt of hers. At times, lay down or bedded herself in her aunt’s arms, had her eyes closed almost all the time.”¹²⁴ Apart from the fact that both of these notes demonstrate the nurses’ meticulous surveillance of B., the latter comment was the first time during her admission that a positive anecdote was recorded. “[Bedding] herself in her aunt’s arms” was an obvious reaching out for

human contact, a searching made even more positive, in the eyes of the nurses, because it was to a close family member. The nurses judged this kind of behaviour positively because it fit with their moral standpoint – their embodied normativity – whereas her aggressive behaviour was thought to be abnormal and judged accordingly. It is also noteworthy that after the positive description of B.'s conduct her name was used for the first time in the nurses' notes.

However, B.'s life of suffering did not come to an end in 1931; in contrast the described incidents were nothing less than the introduction of an intensification of war against B.'s sanity in the years to come. One year later, in 1932, Anna Maria B. was once again admitted to the Friedrichsberg asylum and the following chapter continues with her second admission and B.'s slow but steady way into death at Hadamar.

¹ In his Handbook for practical pharmacology from 1851, Lessing listed Digitalis under the category of “narcotics” and described four nervous diseases that were qualified for treatment with it (mania, asthmatic cramps, alcoholic delirium, and epilepsy). Michael B. Lessing, *Handbuch der praktischen Arzneimittellehre. Für Studierende, praktische Aerzte, Physicats-Aerzte und Apotheker*, Vol. 2 (Berlin: Verlag Albert Förstner, 1851), 42-43.

² *Geisteskrankenpflege* had warned physicians in 1934 not to use the drug as a sedative. Nowadays we know that psychiatric problems were often manifestations of digitalis and may range from mild disorientation, lethargy, or restlessness to full blown delirium; or in other words, psychiatric problems in relation to the application of digitalis could be defined as “iatrogenic disorders.” Dr. H. Wietzki, “Über die Anwendung und Verabreichung von Arzneimitteln bei Geisteskranken,” *Geisteskrankenpflege. Monatsschrift für Geisteskranken- und Krankenpflege* 38, no. 3 (1934): 92-96; M. K. Shear and M. Sacks, “Digitalis Delirium: Psychiatric Considerations,” *International Journal of Psychiatry in Medicine* 8, no. 4 (1977-1978): 371-381.

³ Staatsarchiv Hansestadt Hamburg 352-8-7, Staatskrankenanstalt Langenhorn, Abl.1-1995, Krankenakte 28338 (hereafter Patient Record (PR), Friedrichsberg Medical Records Section (hereafter FMR), psychiatric notes (hereafter PN). This designation will be used throughout to identify Anna Maria B’s patient record; other patient files mentioned in the text will be identified with their unique file number.

⁴ Bleuler, *Lehrbuch der Psychiatrie* (Berlin: Springer, 1923), 116.

⁵ Karl Binding and Alfred Hoche. *Die Freigabe der Vernichtung lebensunwerten Lebens. Ihr Maß und ihre Form* (1920) (Berlin: Berliner Wissenschaftsverlag, 2006), 48.

⁶ *Ibid.*, 49.

⁷ *Ibid.*

⁸ *Ibid.*, 54.

⁹ PR, FMR, PN.

¹⁰ PR, FMR, PN.

¹¹ Emil Kraepelin, *Psychiatrie: ein Lehrbuch für Studierende und Ärzte*, Vol. 2, *Klinische Psychiatrie* (Leipzig: Barth, 1922), 181.

¹² Bleuler, *Lehrbuch der Psychiatrie*, 311

¹³ *Ibid.*, 293.

¹⁴ Marc Berg, “Practices of Reading and Writing: The Constitutive Role of the Patient Record in Medical Work,” *Sociology of Health and Illness* 18, no. 4 (1996): 519.

¹⁵ David Gooding, “Putting Agency Back into Experiment,” in *Science as Practice and Culture*, ed. Andrew Pickering (Chicago: University of Chicago Press, 1992), 76. [original emphasis]

¹⁶ Berg, “Practices of Reading and Writing,” 519.

¹⁷ *Ibid.*, 520.

¹⁸ All patients' names are anonymous.

¹⁹ Jürgen Link, "Dispositiv und Interdiskurs. Mit Überlegungen zum 'Dreieck' Foucault-Bourdieu-Luhmann," in *Foucault in den Kulturwissenschaften*, eds. Clemens Kammler and Rolf Parr (Heidelberg: Synchron, 2007), 219-238; Link, "Diskursanalyse unter besonderer Berücksichtigung von Interdiskurs und Kollektivsymbolik," in *Handbuch Sozialwissenschaftliche Diskursanalyse 1: Theorien und Methoden*, eds. Reiner Keller, Andreas Hirsland and Werner Schneider, Vol. 1 (Opladen: VS Verlag, 2006), 407-430; Link, "Warum Diskurse nicht von personalen Subjekten 'ausgehandelt' werden. Von der Diskurs- zur Interdiskurstheorie," in *Die diskursive Konstruktion der Wirklichkeit. Zum Verhältnis von Wissenssoziologie und Diskursforschung*, eds. Reiner Keller et al (Konstanz: UvK, 2005), 77-99.

²⁰ Anne Waldschmidt, Anne Klein, Miguel Tamayo Korte, Sibel Dalman-Eken, "Diskurs im Alltag-Alltag im Diskurs: Ein Beitrag zur empirisch begründeten Methodologie sozialwissenschaftlicher Diskursforschung," *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research* 8, no. 2 (June 2007): n.p..

²¹ Ludwig Scholz, *Leitfaden für Irrenpfleger* (Halle a. d. Saale: Carl Marhold, 1920), 68-69.

²² Georg Roos, "Beziehung des Krankenpflegers zum Arzt," *Geisteskrankenpflege. Monatsschrift für Geisteskranken- und Krankenpflege* 41, no. 12 (1937): 181.

²³ Oskar Stöbe, "Hilfsmittel in der praktischen Geisteskrankenpflege," *Geisteskrankenpflege. Monatsschrift für Geisteskranken- und Krankenpflege* 37, no. 6 (1933): 93. [Emphasis in original].

²⁴ Michel Foucault, *Les Anormaux. Cours au Collège de France. 1974-1975*, eds. François Ewald et al (France: Seuil/Gallimard), 1999.

²⁵ Stöbe, "Hilfsmittel in der praktischen Geisteskrankenpflege," 93.

²⁶ PR, FMR, PN.

²⁷ PR, FMR, NN.

²⁸ PR, FMR, PN.

²⁹ PR, FMR, NN.

³⁰ Wilhelm Weygandt, "Die ersten Zeichen der Geisteskrankheiten," *Die Heilkunde. Monatsschrift Für Practische Medicin*, no. 1 (1905): 2-10; Foucault, *Psychiatric Power. Lectures at the Collège de France, 1973-74*, ed. Arnold I. Davidson, trans. Graham Burchell (New York: Palgrave Mac Millan, 2006); Foucault, *Abnormal: Lectures at the Collège de France 1974-1975*, ed. Arnold I. Davidson, trans. Graham Burchell (USA: Picador, 2003). Foucault, *Les Anormaux*; Foucault, *Wahnsinn und Gesellschaft*, trans. Ulrich Köppen (Frankfurt a.M.: Suhrkamp, 1969).

³¹ Weygandt, "Die ersten Zeichen der Geisteskrankheiten," 2.

³² Foucault, *Wahnsinn und Gesellschaft*, 177.

³³ Foucault, *Psychiatric Power*, 27; Foucault, *Le pouvoir psychiatrique*, 29.

³⁴ Foucault, *Psychiatric Power*, 28; Foucault, *Le pouvoir psychiatrique*, 29.

³⁵ Heinrich Stadelmann, "Psychotherapie bei der Geisteskrankenpflege," *Geisteskrankenpflege. Monatsschrift für Geisteskranken- und Krankenpflege* 46, no. 61 (1942): 62-63. [emphasis mine].

³⁶ Bleuler, *Lehrbuch der Psychiatrie*, 312.

³⁷ Heinrich Becker, "Der Umgang mit widerstrebenden Kranken," *Geisteskrankenpflege. Monatsschrift für Geisteskranken- und Krankenpflege* 40, no. 8 (1936): 117.

³⁸ Many files described how patients deemed "dangerous" were targeting with numerous combinations of medications and endured isolation and other shock therapies. Most were eventually killed. To mention just some of the more voluminous medical records: Staatsarchiv Hansestadt Hamburg 352-8-7, Staatskrankenanstalt Langenhorn, Abl.1-1995, Krankenakte 13986. The female patient of this record was admitted the first time in 1916 and killed in 1943 in Hadamar. She was diagnosed with Dementia praecox and later with schizophrenia. Even though nursing notes exist only from the years from 1928 to 1931, they highlight that no medical therapy took place but that the patient became the target of severe sanctions such as isolation and injections based on her perceived increasing dangerousness. Similar medical records: 10243; 26752; 23536; 2312; 23856; 27846; 16292; 22694; 23548.

³⁹ Becker, "Der Umgang mit widerstrebenden Kranken," 118.

⁴⁰ Ibid., 117.

⁴¹ Seibert, "Zur Pflege Geisteskranker," 151.

⁴² Bleuler, *Lehrbuch der Psychiatrie*, 166.

⁴³ PR, FMR, NN.

⁴⁴ Ibid.

⁴⁵ Ibid.

⁴⁶ Ibid.

⁴⁷ Verwaltungs-Oberinspektor Sieben, "Erziehungsfragen bei dem Krankenhausaufenthalt," *Zeitschrift für das gesamte Krankenhauswesen*, no. 23 (1938): 65.

⁴⁸ Foucault, *Psychiatric Power*, 46-58; Foucault, *Le pouvoir psychiatrique*, 48-60.

⁴⁹ Hubert L. Dreyfus and Paul Rabinow, eds., *Michel Foucault: Beyond Structuralism and Hermeneutics* (Brighton: Harvester, 1982); Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. Richard Hower (New York: Vintage Books, 1973); Alec McHoul and Wendy Grace, *A Foucault Primer. Discourse, Power and the Subject* (New York: New York University Press, 1993); Judith Butler, "Gender Regulations," in *Undoing Gender* (New York: Routledge, 2004), 40-56.

⁵⁰ Seibert, "Zur Pflege Geisteskranker," 152.

⁵¹ PR, FMR, NN.

⁵² PR, FMR, NN.

⁵³ PR, FMR, NN.

⁵⁴ PR, FMR, NN.

⁵⁵ Scholz, *Leitfaden für Irrenpfleger*, 73.

⁵⁶ Ibid., 75.

⁵⁷ PR, FMR, NN.

⁵⁸ PR, FMR, NN.

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- ⁵⁹ PR, FMR, NN.
- ⁶⁰ PR, FMR, PN.
- ⁶¹ PR, FMR, NN.
- ⁶² PR, FMR, PN.
- ⁶³ PR, FMR, NN.
- ⁶⁴ Scholz, *Leitfaden für Irrenpfleger*, 75-76.
- ⁶⁵ PR, FMR, NN.
- ⁶⁶ PR, FMR, NN.
- ⁶⁷ Weygandt, *Die Staatskrankenanstalt Friedrichsberg. Hygiene und soziale Hygiene in Hamburg. Zur neunzigsten Versammlung der deutschen Naturforscher und Ärzte in Hamburg im Jahre 1928*, ed. Gesundheitsbehörde Hamburg (Hamburg: Paul Hartung Verlag, 1928), 193.
- ⁶⁸ PR, FMR, NN.
- ⁶⁹ PR, FMR, NN.
- ⁷⁰ PR, FMR, NN.
- ⁷¹ Wilhelm Thielmann, "Das Spiel und der Kranke," *Geisteskrankenpflege. Monatsschrift für Geisteskranken- und Krankenpflege* 41, no. 10 (1937): 183.
- ⁷² Ibid., 184.
- ⁷³ PR, FMR, NN.
- ⁷⁴ Foucault, *Le pouvoir psychiatrique*.
- ⁷⁵ Foucault, *Psychiatric Power*; Foucault, *Le pouvoir psychiatrique*.
- ⁷⁶ Foucault, *Le pouvoir psychiatrique*, 131.
- ⁷⁷ Ibid., 165.
- ⁷⁸ It is noteworthy that the resistant behaviour described in B.'s record was similar to that found in most other patient files, not surprisingly since the asylum regulations did not give patients many options.
- ⁷⁹ In this study the French pronunciation of Dispositif is used in order to highlight that the term is part of Foucaults' theoretical approach. Whereas the term dispositive in English has multiple connotations, the term dispositif has a very specific relevance to Foucault's take on power, knowledge and subjectivity.
- ⁸⁰ Foucault, *The Subject and Power*, 208.
- ⁸¹ Ibid., 209.
- ⁸² Ibid., 212.
- ⁸³ Butler, "Gender Regulations," 41.
- ⁸⁴ Foucault, *Le pouvoir psychiatrique*, 53.
- ⁸⁵ Ibid.
- ⁸⁶ Ibid.
- ⁸⁷ Michael Wunder, *Euthanasie in den letzten Kriegsjahren. Die Jahre 1944 und 1945 in der Heil- und Pflegeanstalt Hamburg Langenhorn* (Husum: Matthiesen, 1992); Klaus Böhme, *1893-1993 100 Jahre Allgemeines Krankenhaus Ochsenzoll* (Hamburg: Sozialtherapiezentrum des AK Ochsenzoll, 1993); Klaus

Böhme and Uwe Lohalm, eds. *Wege in den Tod. Hamburgs Anstalt Langenhorn und die Euthanasie in der Zeit des Nationalsozialismus* (Cloppenburg: Ergebnisse Verlag, 1993); Götz Aly, "Medicine Against the Useless," *In Cleansing the Fatherland. Nazi Medicine and Racial Hygiene*, eds. Götz Aly et al, 22-99 (Baltimore and London: Johns Hopkins University Press, 1994).

⁸⁸ Foucault, *Psychiatric Power*; Foucault, *Le pouvoir psychiatrique*; Michel Foucault, *Die Geburt der Klinik. Eine Archäologie des ärztlichen Blicks*, trans. Walter Seitter (Frankfurt a.M.: Suhrkamp, 2002); Michel Foucault, *Überwachen und Strafen. Die Geburt des Gefängnisses*, trans. Walter Seitter (Frankfurt a.M.: Suhrkamp, 1994).

⁸⁹ Foucault, *Überwachen und Strafen*.

⁹⁰ Foucault, *Le pouvoir psychiatrique*, 21-39

⁹¹ PR, FMR, PN.

⁹² PR, FMR, NN.

⁹³ Louis Althusser, "Ideology and Ideological State Apparatuses: Notes Toward an Investigation," in *Lenin and Philosophy and Other Essays*, trans. Ben Brewster (New York: Monthly Review Press, 2001), 85-126.

⁹⁴ *Ibid.*, 118.

⁹⁵ Judith Butler, *The Psychic Life of Power: Theories in Subjection* (Stanford: Stanford University Press, 1997), 106.

⁹⁶ *Ibid.*, 107.

⁹⁷ Stuart Hall, "Signification, Representation, Ideology: Althusser and the Post-Structuralist Debates," in *Critical Studies in Mass Communication*, eds. R. K. Avery and D. Eason (New York: The Guilford Press, 1991), 88-113. Hall preferred to use a short section in Althusser's, *For Marx*, trans. Ben Brewster (USA: Verso, 2005) rather than the later definition from "Ideology and Ideological State Apparatuses," 85-126

⁹⁸ Hall, "Signification, Representation, Ideology," 101.

⁹⁹ *Ibid.*

¹⁰⁰ *Ibid.*, 102.

¹⁰¹ *Ibid.*, 103.

¹⁰² *Ibid.*, 104.

¹⁰³ Althusser, "Ideology and Ideological State Apparatuses," 116.

¹⁰⁴ *Ibid.*, 117.

¹⁰⁵ Hall, "Signification, Representation, Ideology," 104.

¹⁰⁶ Butler, *The Psychic Life of Power*, 111.

¹⁰⁷ *Ibid.*, 111-112.

¹⁰⁸ PR, FMR, PN.

¹⁰⁹ Judith Butler, *Excitable Speech: A Politics of the Performative* (London: Routledge, 1997), 135.

¹¹⁰ *Ibid.*, 138.

¹¹¹ Giorgio Agamben, *Homo Sacer: Sovereign Power and Bare Life*, trans. D. Heller-Roazen (Stanford, California: Stanford University Press, 1998); Giorgio Agamben, *Homo sacer. Die Souveränität der Macht und das nackte Leben*, trans. Hubert Thüring (Frankfurt a.M.: Suhrkamp, 2002).

¹¹² Foucault, *Il faut défendre la société. Cours au Collège de France. 1976* (France: Seuil/Gallimard, 1997), 214.

¹¹³ PR, FMR, NN.

¹¹⁴ PR, FMR, NN.

¹¹⁵ PR, FMR, NN.

¹¹⁶ PR, FMR, NN.

¹¹⁷ Foucault, *Le pouvoir psychiatrique*, 27

¹¹⁸ PR, FMR, NN.

¹¹⁹ PR, FMR, NN.

¹²⁰ PR, FMR, NN.

¹²¹ Aaron V. Cicourel, "Police Practices and Official Records," in *Ethnomethodology. Selected Readings*, ed. Roy Turner (Middlesex, England: Penguin, 1975), 85-95.

¹²² Bublitz, "Täuschend natürlich. Zur Dynamik gesellschaftlicher Automatismen, ihrer Ereignishaftigkeit und strukturbildenden Kraft," in *Automatismen*, eds. Hannelore Bublitz et al (München: Wilhelm Fink, 2010), 153-171.

¹²³ PR, FMR, NN.

¹²⁴ PR, FMR, NN.

7 The Intensification of the War against the Madness - B.'s Subsequent Admissions (1932-1943)

7.1 The Admission Ritual in 1932

Nearly nine months after her discharge from Friedrichsberg, Anna Maria B. was once again admitted to the asylum, on 13 July 1932. The administrative record (*Personalakte*) from the Langenhorn asylum contains a small typewritten informal paper, obviously a carbon paper from an official report and signed by a physician. This small paper was very powerful because it enabled the compulsory hospitalization of B. Dated 13 July, it contained only one sentence: "Anna B. must immediately be admitted to the asylum of Friedrichsberg because of a sudden emerging insanity. Signed Dr. Fuchs." Dr. Fuchs was the public medical officer who obviously did not possess any information about B.'s former admission to Friedrichsberg, because from his perspective her illness was sudden. Nonetheless, when she actually entered the asylum, his diagnosis was subsumed under B.'s previous biographical corpus and this new admission became nothing more than the continuation of her history that had begun in 1931. For someone not in possession of her record, B.'s insanity attack was a sudden irruption, but for someone who knew her history, it was a logical continuation of her diagnosis and an expected decline in her mental state. Once again the record preserves a biography that can at any time be reread and reused.

This second admission differed from the first one only because B. was forcibly committed. The same administrative process took place as previously analyzed; an admission sheet was completed from which it is apparent that B. arrived with a group transport. Similarly too, the nurses were the first persons in the asylum with whom B. had contact; although she arrived in the evening she did not see any psychiatrist until the next day.

13-14.7: Night: New admission. Pat. came in the room singing loudly, very wild behaviour in bed, impossible to hold patient down. Pat. got an injection which slowly showed an effect. Pat. screamed "God, take me in I have sinned too seriously," said the "Our Father," screamed again "the apple, it is the apple's fault, oh heaven how the women are bad, everywhere they want to be popular." Pat. alternately cried and laughed,

pulls out hair. (A. Ei.)

Morning: Pat. was very noisy in the morning, raved about the room and screamed, kicked the nurse with her feet when touched, got an injection, calmed down a little, did not eat. At 9AM patient was out of bed again, walked around the room restlessly, knocked on doors, said "Open up, give me my stuff, I must leave. Yak, yak, you bitch you animal, I'd prefer a snake any time." Then patient reached for the nurse's hands and said: "I am sorry. I did you injustice," and cried. Shortly after patient became very restless, climbed up on the windowsill and screamed the "Our Father" out of the window for half an hour. With the help of a second nurse, she was taken down, knelt on the floor, folded her hands, "Lord help me we have not deserved the water." Patient screamed for one hour, another injection. Fell asleep half an hour later. Pat. tore apart her shirt, did not eat. (Tu.)

Afternoon: After 4 PM, pat. is very noisy, sings, prays and quotes the Bible. Throws herself on the floor cries heavily. Becomes even louder, runs through the room with clenched fists, climbs on the windowsill and screams towards the garden. Transferred to Hs. 8 (S. K. Lu.)¹

At first glance these descriptions closely resemble B.'s first admission in 1931.

According to the notes she was completely trapped in her madness – the nurses were describing a succession of insane events. This time, however, B.'s "misbehaviour" was punished or corrected directly by injections or by force. Although she had received an injection shortly after her first admission to Friedrichsberg, it was more of a "preventive" intervention. This time the injection was clearly related to the apparent impossibility of controlling her wild behaviour. The next morning, after she "raved about the room and screamed, kicked the nurse with her feet when touched, she received an injection that calmed [her] down a little bit" – again clearly a reaction to B.'s behaviour. Continuing to scream "for one hour" she received another in a short space of time, and both of these were also noted on the fever chart as Morphium-Scopolamine injections. Furthermore, B. climbing on the windowsill and screaming out the window had also happened exactly in the same manner one year earlier, but this time the disciplinary power reacted with more insistence with the use of chemical means to calm her. Even more surprising was her transfer to another house after just one day in Friedrichsberg, where before it had taken a week before she was transferred. In 1931 it had seemed as if the time on the admission ward was used

to underline her admission diagnosis, but this time the diagnosis was already verified because it was part of the record. Both the immediate employment of chemical restraint and the rapid transfer to House 8 (See Figure 24) demonstrate that this time there was no question of assessing B.'s behavior but rather she was treated as if she had never left the asylum.



Figure 24: View on the secure House 8, c. 1928. Note the construction of the fences flush to the ground.²

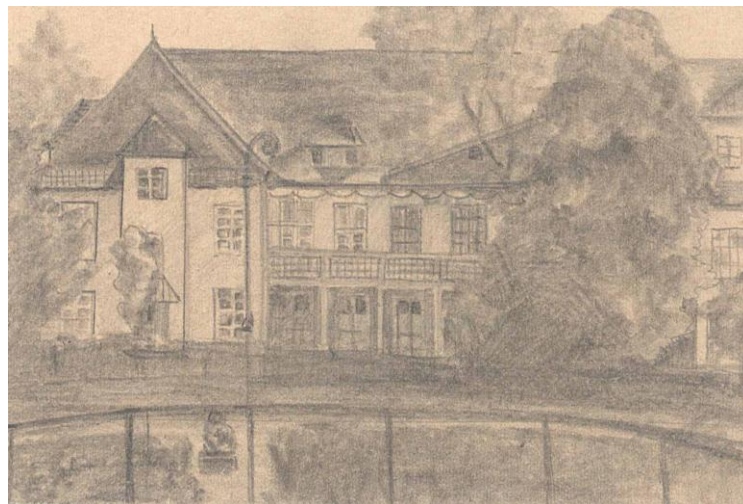


Figure 25: Anna Maria B.'s perspective from House 8. Patient record 28338.

As soon as B. was admitted a nutrition plan was also laid out, even though any eating problems were not reported. The decision to observe B.'s nutritional intake in detail was based on her "biographic corpus" already in place, underlining the fact that the record preserved a history

of its own that was activated at the moment of reading. This is also highlighted in the psychiatrists' notes.

As had happened in 1931, the psychiatrist began by questioning B.'s mother.

Mother: In the end, she was like before. Just complained about back pain all the time. Yesterday, she suddenly did all the laundry for the mother, packed up. She always wanted to bake. Washed the dishes in the morning as well as in the evening. She had read about natural healing methods. Voices, no, did talk to each other all afternoon. In the evening she suddenly jumped up, opened the window, screamed out of the window "Our Father in Heaven," etc. Could not be held back. Mother tried without success, father came for help. Pulled her back. People had already called the police in the street. Dr Fuchs came right away. She spat, scratched the wall paper etc.³

Equipped with this information the psychiatrist then began to question B., but this time he possessed not only the information provided by the mother but also that in the record. The interrogation began with a summary of the nurses' night and morning notes.

14.7.32 Leaves bed all the time, frightened, restless.

The course of the interrogation differed in some aspects from the one in 1931.

Orientation. Where lived/ with parents, street: + [symbol for 'positive' which means B. gave the right answer.]
Date/ month/ year: +.
Location here: +
Why here? Don't know how all this happened.
Sick?/No
Agitated?/ Don't know
Sang last night?/ Well, that's the way it is.
In a good mood?/ No, not at all, quite the opposite. Most people laugh about the bible.
Sect?/No.
What do you mean about the bible/ They take it all so for real and then they don't understand it
Divulgence of God's will/ Maybe. I preached aloud in front of the window
Visions, figures?/No
Heard voices, God's voice?/ No. Don't know
Paranoia, remote influence (control), observation?/ No
Workplace?/ 2 years apprenticeship with Arthmann Poolstr. Art Store
Learned writing (print). Left because of illness
What illness?/ Don't know. First Barmbek. hospital.
When?/ 1930, no 1929. No 1931. Until October in hospital. Then quit job.
I was here before. In the mental department. Once in house 16, then house 14.
Doctor?/ Dr. Badt.

Why were you here?/ Back then I always thought they wanted to poison me. Veronal that was.
 Who: they?/ My Mother. But I didn't believe it later anymore I also always talked about that.
 Any complaints now?/ Nothing.
 Memory?/ not so good anymore before I could always remember everything
 What did you do now, at home?/ I helped cleaning.
 What done in spare time?/ went for walks a lot.
 Girlfriend or boyfriend?/ Girlfriend yes. Boyfriend never. No interest in that.
 Why supposedly sad?/ Avoids answer.
 Why are you sighing?/ It is so horrible.
 I don't know how it happened that I have a STD[sexually transmitted disease].[one of the previous questions of the Ref had been have you ever had an STD?
 Why did you come to Barmbek before?/ I was too agitated, had such a feeling of being frightened.
 Starting again: It is so horrible, this disease. Is it going to go away again?

This interrogation is very similar to the one at the end of B.'s hospitalization in 1931. The psychiatrist was not at all interested in B. talking freely about herself but rather confined her to answering only the questions he asked. He is thus asking questions drawn from B.s biography, using the information he already possessed from his earlier questioning of the mother and from the record. The questions were aimed to assess how far B. was able to recognize herself in the biography contained in the record.

This interrogation highlights once again the mechanisms analyzed earlier. However, this interrogation is distinguished from the earlier one in 1931 because now there was little interest in obtaining information about the early signs of madness, the family history, or the hereditary aspects of B.'s madness. All this information was already part of the record and therefore it was unnecessary to ask again unless it was useful to see if B. gave right answers. Over the course of the interrogation B. began to actualize her symptoms through the psychiatrist's prodding about her "hallucinations." As discussed earlier, the purpose of the interrogation was to reduce the illness to its "main symptom," not only to make the subject acknowledge this absolute core but also to effectively actualize it during the interrogation. Actualization happened either by means of a patient's confession like "yes, I hear voices," because in that moment the symptoms would

be fixed to the individual in the form of a first-person statement, or by the provocation of a crisis, for example, by triggering hallucinations. In the course of this interrogation, the psychiatrist reported that B.

Suddenly touches her body in a hectic gesture: "It is such a strange feeling. It is so horrible, it is not my fault. That is what people say that it is my fault that I'm sick." Interrupts herself again "It is so unfair, It is not my fault. Can't one do anything about it? What if I'm pregnant? (Touches her body again) It is such a strange feeling in my stomach. Something is moving as well. It feels so strange. My body (belly) became bigger too." Do you have the feeling of something strange (foreign) in your body? Very relieved. Yes, that is the feeling. If I have a STD, I am going to infect everybody, or? You get a rash, don't you? Do you have a STD?/ Yes, I don't know how it is. And with the child, awful. What can one do about it? Is that all only an idea of yours?/ No, I don't think so. Hypnosis, electrification, remote influence/ No Suddenly starts crying hard. It is so awful.(calms down fast) Since when that feeling/ Only since today

Acknowledging their madness meant that patients also admitted that they were actually ill, in need of a physician and interment. These were the kinds of patients for whom psychiatric asylums were built.

The psychiatrist returned later to conduct a physical exam.

A little later, when she is examined again she is very agitated and says to the nurse on duty, she could be in trouble. Leaves bed all the time, tends to go in beds of other patients. When addressed during the doctor's visit, she runs off negatively. Frightened, restless, can be settled. Quite strong *Idées fixes* (Believes to be pregnant, STD the latter less intense) absorbed by her *idées fixes* (that's why only superficial replies to questions from other areas); For example she recalls year of her time in Barmbek hospital. First as 1929, then 1930, then 1931.) Sometimes superficial- depressive, then childish, jolly and silly [*läppisch*]. No optical or acoustic hallucinations. No "remote control" feeling. Superficial "relationship ideas" ("That is what people say," s.above.) Physical examination: Is very agitated when to be examined again. Prays loudly the "Our Father" with her hands lifted. Says to the doctor, "you must work hard but not the devil's stuff with dance and art." Lifts her hand to hit the Ref, cannot be examined. Recognizes the doctor as such, though.⁴

The psychiatrist assessed B.'s inability to recall correctly the year of her admission to Barmbek as a sign of her being absorbed by her "*idée fixes*." However, the words that he used to

describe B. – “sometimes superficial – depressive, then childish, jolly and silly [*läppisch*]” – is suggestive of the dehumanizing language psychiatrists employed after the Nazis came to power and especially after the official start of “Aktion T4 in 1939.”⁵ While the use of these terms in records may have grown during the Nazi regime, in this record, the dehumanizing process through language was already in use long before. As well, B. recognizing her doctor “as such” was similar to an earlier nursing observation from 1931, when B. “called the doctor and nurses to come to her [and] called their names.”⁶ In many records, it seemed to be important to psychiatrists that patients recognized them, since to do so meant acknowledging their superiority within the hierarchical structure of the asylum.

The psychiatrist noted that B. had been “very agitated although being in a good mood most of the time, which does change very much. Reacts strangely when talked to. Screams, sings in foreign, or made up language. Too noisy for House 10. House 8 downstairs.” His remarks highlight once again how the space of the asylum was effectively divided between those considered curable or incurable, quiet or agitated, compliant or resistant, or between those able to work or and those who were not, or those who needed punishment and those who did not, or between those patients who had to be observed continuously and those who needed only minimal supervision or even none at all. Asylum space was segmented by these variables and not by patient diagnoses of illness.

Nonetheless, the most significant aspect of B.’s move to House 8 was her “disappearance” in the record. From 14 July 1932, the date of her transfer, the nurses interrupted their note taking for more than three months. Although there is the possibility that their notes have been lost, it is somewhat suspicious that they stopped precisely on the day B. was transferred to House 8 and were only resumed on the day she was transferred to another house. Furthermore, the fever chart, the nutrition plan, other nursing forms, as well as B.’s drawings, are still part of the record, making it unlikely that only the nursing notes were lost. Simultaneously the psychiatrists wrote only rarely, and no longer did their notes contain any differentiated

information, strengthening the thesis that the nurses' notes were indeed interrupted and not lost, since the psychiatrists depended on them to write their own.

As had happened in 1931, B. received Digitalis, but now as daily injections. As well, this drug was often combined with Morphium-Scopolamine and given up to four times a day. She also received an enema every second day. The following few lines from the psychiatrists are all that remain of the next three months of B.'s life in Friedrichsberg's House 8.

15.7.32	Continuous bath
16.7.32	Continuous bath; injection; does not eat well
17.7.32	Sits outside the bathtub; cries; prays the "Our Father"
18.7.32	Pat. Eh. (Ingeborg) touched her on her neck to examine her; pat. defends herself. A few long scratch marks on her neck.
1.8.32	Continues to be agitated.
6.8.32	Later on a little calmer. Kept clothes on.
31.8.32	At times, out of bed.
12.9.32	Occasionally washes (the floor?); then naked again and continuous bathing
20.10.32	Still very agitated. ⁷

The style of these notes suggests that they might have been written in one day. Although they will not be analyzed in any detail, some differences do exist to those from 1931. First of all, they were apparently not aimed at outlining B.'s behaviour in any detail; her condition had already been described exhaustively in both the psychiatric summary and the nursing notes. B. seemed to be nothing more than an aggressive untouchable lunatic. With more of an emphasis on lab reports, they are more a depiction of how "treatment" was succeeding rather than a construction of her biography. And while the nurses' notes from 1931 revealed the different means used to "educate" B., this more recent writing on her is more a listing of the chemical and physical means employed to correct her behaviour. Against the lack of nursing notes, B. disappeared in the record; House 8 appeared to be a kind of "collection tank" for asylum residue.

7.1.1 *The psychiatric dispositif*

With the rendering of her invisibility, B. lost her "status as a subject," or was de-subjectivized, both aspects of Foucault's "dispositif." In discourse theory, dispositif can be

defined as the “material and ideational infrastructure” of discursive formations, comprising a “package of measures, systems of rules, and artefacts through which discourses are (re)produced and effects are constituted.”⁸ Foucault broadened this understanding, however, defining *dispositif* as a “heterogeneous ensemble” of differential elements like discourses, institutions, architectures, regulated decisions, laws, etc., – the spoken as well as the non-spoken. However, the *dispositif* is not simply the sum of these elements but rather it enables a focus on the network that can be established between these elements.⁹ Discursive and non-discursive elements connect to strategies that are the effects of specific power relations and at any given historical moment the *dispositif* had as its major function the ability to respond to an emergency. The *dispositif* therefore has a dominant strategic function;¹⁰ this is to say that the *dispositif* is a kind of operator in order to deal with and to resolve problematic social questions.

Gilles Deleuze pointed to the relationship between words and things and demonstrated Foucault’s definition through describing *dispositifs* as composed of different lines. To analyze a *dispositif* means to follow these different lines or dimensions in order to form a kind of map. Deleuze says that the “the first dimension of a *dispositif*, or those which Foucault addresses first, are the curves of visibility and the curves of enunciation. *Dispositifs* are like the machines of Raymond Roussel as Foucault analyzes them: these are machines to make see and make speak.”¹¹ According to this definition, each *dispositif* has its own “regime of light” (*régime de lumière*) a particular manner of how the light falls, “becomes blurred, and spreads throughout, distributing the visible and the invisible, giving rise to or making the object disappear; the object which would not exist without it.”¹² A *dispositif* acts in part by determining what we can see and say in a certain historical configuration of forces.

This description of a *dispositif* helps to explain B.’s disappearance in House 8, since it has the ability to illuminate certain elements or somatic singularities, making some visible and others invisible. It is as if the light was turned away from B. and she sank into the darkness of the asylum. As already analyzed in detail in the first part, the *dispositif* shed light on B. as a mentally

ill person— the result of B.'s subjectification process in the record. This is to say that even within the asylum something like a “zone of normality” existed, and the continuum between normality and abnormality was a decisive characteristic of disciplinary power. Within a disciplinary dispositif, every element occupies a defined place, for example, some elements give orders whereas others receive orders. As already discussed in some detail above, disciplinary systems classify, organize into a hierarchy, observe, etc. but the point at which these systems are in danger of breaking down is an encounter with somebody who cannot be classified, who escapes surveillance, and who cannot be integrated into the system. These are the residue – the irreducible, the non-classifiable, and the non-assimilable. Even within the asylum, which was already the collecting tank for the “residue of the residue,” “zones of normality” were erected for those able to subordinate themselves and to acknowledge the reality of the asylum. However, those who did not acknowledge the asylum's reality and who were continuously resistant could disappear into the invisible zones of psychiatric practice.

Apart from the “*régimes de lumière*” that exist in every dispositif, there is also a regime of enunciations (*régime des énoncés*). Deleuze emphasized this perceptual but also onto-creative aspect, describing the curves of enunciation that he says they are “not subjects and not objects, but the regimes which must be defined for the visible and the sayable, with their derivations, with their transformations, their mutations.”¹³

Thirdly, a dispositif is composed of “lines of force,” which intersect with the other two dimensions. This curve of power is produced in every relation between one point to another and it passes through the whole space of the dispositif. Invisible and nameless, it is closely intermingled with the other lines, however detachable.¹⁴ In other words, this is the dimension of power that is linked to specific knowledge, as analyzed earlier in detail.

The “line of subjectification” of a dispositif defines a process or a production of subjects; subjectivity is enabled and produced within the constraints of the dispositif.¹⁵ It is a kind of vanishing line. The Self is neither knowledge nor power. It is a process of individualization that

acts on groups or persons and results from established power relations such as those in constituted knowledge: it is a kind of surplus value.¹⁶

According to Deleuze, the *dispositif* is a heterogeneous, dynamic and a moving configuration. He calls it a “multilinear ensemble” and emphasizes the dishomogeneity and disequilibrium of these lines. Philosopher Jeffrey Bussolini emphasized in an article “Similar to the language of forces that Foucault uses, Deleuze notes that “each line is broken, submitted to variations of direction, changing tack and slipping, submitted to derivations.” He uses almost physical language to describe this interplay of forces and ongoing movement and interaction between the lines. Because of this, Deleuze maintains that in Foucault’s thought “Knowledge, Power, Subjectivity have no contours once and for all, but are chains of variables which fight between themselves.”¹⁷

The current analysis has tried to trace these different lines of the psychiatric *dispositif*. The first part concentrated on the aspect of the subjectification and the decisive role of the record in this process. Over the course of this analysis it has become clear that these processes can only be analyzed if one considers the power structure in psychiatric practice and its importance for the individualization process in the record. In the course of the analysis it was highlighted that the psychiatric *dispositif* does not only constitute subjects but is able to “turn the light away from certain subjects” and thereby de-subjectify them, because they seem to disappear in the record. This process will be analyzed in more detail below.

However, the above quote from the psychiatrist’s note demonstrates once more the war against madness and the importance of integrating the “line of force” in the analysis. As already mentioned above, the notes were a successive description of B.’s misbehaviour and the means used to correct it – namely continuous baths and injections as read on the fever chart. These interventions were used independently of an individual diagnosis because they were used in all cases of disobedient and resistant patients, as all the records used for this analysis highlight. Again, neither continuous baths nor Morphine-Scopolamine injections were guided by a

nosography or kind of medical-theoretical knowledge, but rather were used as techniques of discipline. Bleuler explained the benefit of continuous baths in the therapy of “agitated” patients.

[B]aths at nearly or full body temperate are an important tool for anxious patients and sometimes for those with depressions. Excitement is calmed down in the bath; a fatigue [that occurs] without decreasing the psychic or physical abilities lets the sick person become better accessible. But even in cases in which the bath is not so successful, the mild bath (35 to 36 degrees C) is an excellent place to stay for sick persons, because it keeps them continuously busy in a manner that is riskless for them, other people, and for surrounding objects.¹⁸

This description emphasizes that the continuous bath was part of a directive system, since interventions of this kind were awkward for patients and were utilized as a kind of punishment. As will be discussed later, B. was “treated” with different “shock therapies” and injections, as a way to apply discipline in the asylum to the body. Although the role of morphine apparently was to calm the patient’s nervous system, it was, in fact, quite simply the extension of the asylum regime, the regime of discipline, inside the patient’s body; it was to ensure the calm that was prescribed within the asylum and to extend this calm into the patient’s body.¹⁹ Once again, the asylum psychiatrist did not act solely on medical knowledge but redefined psychiatric theory through actual practice.

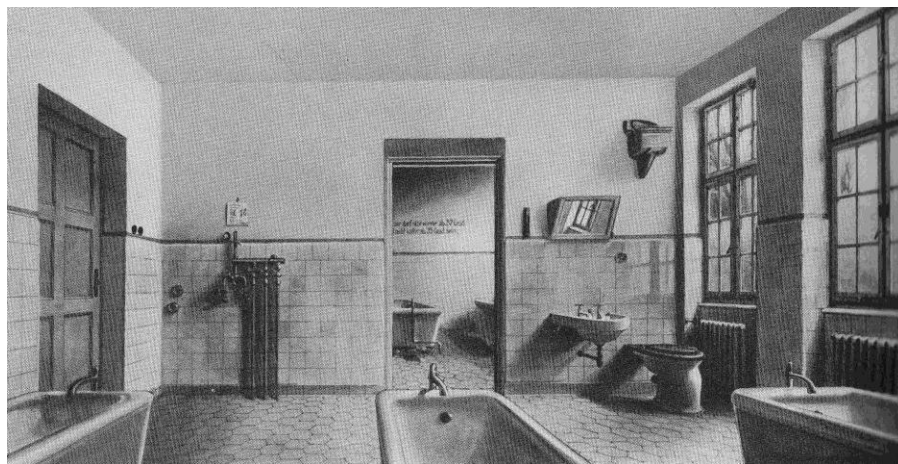


Figure 26: One of the halls for continuous baths in Friedrichsberg, House 30, c. 1928.²⁰

7.1.2 *The success of the “therapy”*

On 3 November B. was transferred back to House 10, and the nurses’ notes resumed again. They were condensed, however, and like the psychiatrist’s notes, were little more than a listing of disrobing behaviours on B.’s part and the nurses’ subsequent interventions.

Nevertheless, only the psychiatrists mention the regular application of continuous baths. From 27 November to 7 December 7 1932, the nurses’ notes are as follows:

24.11: Pat. presents nothing special. (O.)
Night: Pat. insulted loudly, got an injection. (H.)
27.11: Pat. is lively, a lot out of the bed, is annoyed. (O.)
Night: Pat. insulted and sung loudly, got an injection. (H.)
28.11: Pat. was more quiet. (O.)
Night: Pat. became loud, got an injection, slept. (M.)
29.11: Pat. ran around loudly, shouting and insulting. (E.)
Afternoon: Pat. behaved more quietly during the afternoon. (O.)
30.11: Pat. is at times loud, talked very much, got an injection. (O.)
Night: Pat. slept. (E.).
2.12: Pat. behaved quietly. (O.)
Night: Pat. slept. (E.)
3.12: Pat. browsed in newspapers. (E.)
Night: Pat. slept with interruptions, became loud, got an injection. (E)
4.12: Pat. all the time out of bed.(E.).
Night: Pat. became lively, got an injection. (H.)
5.12: Pat. fairly quiet. (O.)
Night: Pat. Slept. (E.)
6.12: Pat. quiet, good appetite. (O.)
Night: Pat. slept. (H.)²¹

Even though the nurses resumed their note taking it was obvious that these notes differ significantly in content from the notes taken in 1931. B.’s activities are effectively reduced in these notes to animal-like behaviour, with seemingly nothing “human” to be found in her conduct. The only course open to the nurses was to somehow to try to get her under control. Every time she exhibited signs of disobedience – even though her behaviour had not yet materialized and was still in a “space of possibility” or a virtual state in the process of becoming – they intervened with injections. The strategy – or therapy – appeared to be “working,” as B. became more and more helpless.

13.12: Pat. is often out of the bed, standing around in the room, does not know what she wants. Wets herself 2 times. (H.)

14.12: Pat. often out of the bed, goes to the toilet and didn't do anything, wets herself later. (H.)
14.-15.12: Pat. was disturbing, got an injection. (O)
15.12: Pat. often out of the bed and ran around helplessly in the room. (H.).²²

B. had never before been described as “helpless” or not knowing what she wanted. In 1920, authors Alfred Hoche and Karl Binding called this the development of “an empty human shell.” The nurses’ notes break off on 17 December and, after almost six months at Friedrichsberg, B. was transferred to Langenhorn on 20 January 1933. In her last months at Friedrichsberg, the psychiatrists reported on B.

5.11.32: A lot of continuous baths.
30.11.32: Helps washing the floor in the morning.
25.12.32: Drawings. Continuous bath. Scopol. Morph. Inj. –
20.1.33: Transferred to Langenhorn – Agitation – Schizophrenia. (Dr. K.)²³

7.2 B.’s first admission to the Asylum of Langenhorn

The fact that B. was transferred to Langenhorn after being described as “helpless” and as somehow empty illustrated the function of the Langenhorn asylum. All the records used in this analysis were cases that had been transferred from Friedrichsberg to Langenhorn and in all of them the same pattern can be discerned. Most patients were transferred at the moment they were perceived as chronic and hopeless. When no change in their condition was expected after a course of “therapy,” they were transferred to Langenhorn.

The Friedrichsberg medical record was always sent with the patient to Langenhorn, making it available for analysis in this study. The medical records used in Langenhorn were similar to those in Friedrichsberg but also contained an administrative record. Although the psychiatrists used similar forms, the nurses’ notes differed in many respects from Friedrichsberg. Whereas the nurse’s notes in Friedrichsberg were written on printed forms entitled “nursing reports,” the nurses’ notes at Langenhorn were written on ordinary writing paper, which became an official document with simply the handwritten title of “nursing notes.” Apart from the title and

the first entry, which were written in ink (indicating that the head nurse entered the data), they were written in pencil. The first entry always contained descriptions of the admission situation and the routine measurements of weight, length, body temperature, etc. The material appearance of these sheets of paper imparted a kind of impermanency; the writing appeared scribbled down, and neither the nurses' initials nor any underlining can be found. Their construction also made it difficult for nurses to write long descriptions because every sheet of paper had to be laid out, which was a time-consuming procedure. Nevertheless, other forms for nursing notes existed, comparable to those used in Friedrichsberg, but these were found only in records of patients directly admitted to Langenhorn. For the patients transferred from Friedrichsberg, the nurses used only the formless sheets of papers above described, the reason being that their notes were taken only for the first couple of days in Langenhorn. In B.'s case, they appeared for the first ten days of her stay at the new asylum.

These notes served first to decide in which house a patient should be accommodated, and thus they were taken at very close intervals. Every shift had to make a report and note the exact time of entries. The reason is, I believe, that the nurses were discovering whether or not a patient was suicidal or aggressive, and thus the notes functioned as proof of observation. Both the nurses' notes and the medical record in general were a source for continual and retrospective inspection of the adequacy of the staff's action. The record consists, according to ethnographer Harold Garfinkel, "of procedures and consequences of clinical activities as a medico-legal enterprise."²⁴ It makes public "what really happened" for supervisors, colleagues, and officials. Every note that became part of the record constituted a social event and was made with the awareness that it might be used later.

As had happened in Friedrichsberg, the nurses admitted B.; not until five days after her arrival was she examined by a psychiatrist. On admission, B. was still sedated, although she soon woke up. "Pat. comes from Friedrichsberg. Due to the narcotic she received there, patient is

dizzy. Is very noisy during admission. Hits a nurse. No problems when bathing her.”²⁵ The subsequent report was a direct continuation of the notes in Friedrichsberg.

20.1. 33: 11:30: Miss B. immediately soils her bed and the floor and demands food all the time. Pat. had to go to room 11 because she always carried around the bedding and was hit by Mrs. A. Miss B. says she is 18 years old and used to work as a drawing instructor. Patient says a lot of confused things and cannot be kept in bed.

Here all the elements are assembled that will accompany B. throughout her stay in Langenhorn. She is again depicted as being completely mad – and the “dirtiness” that came from her soiling the bed and floor reinforced a kind of animal-like behaviour. Room 11 was the isolation cell where B. spent much of her time and from where the nurses reported on her over the next few days.

8-11:30 p.m.: Miss B. slept after 8:30PM. (E.)

21.1.33: 11:30M-7:30a.m.:Miss B. sat on the floor without her shirt on and smeared urine. Miss B. eats and drinks on her own. Pat. went to wash herself and stayed in bed afterwards covered with her duvet. (N. P)

6:30 a.m.-3 p.m.: Miss B. spends a lot of time out of bed and keeps on packing and moving her bedding and the sac of straw, often demands food. (N. S)

3-11:30 p.m.: Miss B. is under her bedding and keeps quiet. Whenever the nurse enters the room patient demands food and something to drink. Has a good appetite. Slept till 11:30PM. (N. S)

22.1.33: 11:30 p.m.-7:30 a.m.: Miss B. spent a quiet night. In the morning patient was led away, but still wetted herself. Miss B. ate and drank on her own but demanded more and more food. (N. P.)

6:30a.m.-3p.m.: Miss B. kept on packing her bedding and soiled her room. Patient often demands food. (N. W.)

...

23.1.33: [no time specification] Miss B. is always out of bed and keeps packing and moving her bedding and the sack of straw back and forth. Patient is very restless and untidy. (N.H.)

24.1.33:11:30 p.m.-7:30 a.m.: Miss B. had a quiet night. In the morning she smeared herself with urine. Miss B. is very untidy. (N. P.)

6:30 a.m.-3 p.m.: Miss B. had a continuous bath treatment, Pat. went calmly in the bathtub and at times spoke insultingly and vulgarly. While eating, pat. behaved very unmannerly and spat out a lot of food. (N. K.)

3 p.m.- 11:30 p.m.:Miss B. took a continuous bath and at times sang very loudly, spat a lot. After 9:30PM patient was calm, fell asleep. (N.H.)

References to “packing her bedding” or to a “sack of straw” indicate the usual bedding in an isolation cell. Dr. Buder, a senior psychiatrist at the Winnetal asylum, described an isolation cell as a “bald room with solid, lockable, often doubled doors, with secured windows made of thick glass, without furniture, at the most a makeshift bed on the floor.”²⁶ B.’s behaviour, however, was paradoxically enabled by her segregation. Sitting on the floor without her shirt on and smearing urine was only possible because she was not disturbing other patients or the ward routine, and thus the isolation room provoked the very behaviour against which psychiatric practice fought. As Buder noted as early as 1918, if accommodation in a “single” room continued over a longer period of time, certain drawbacks occurred.

The sick persons neglect themselves [*verwahrlosen*] and run wild more and more; they become soiled, smear themselves and the single room with their excretions [*Ausleerungen*] throw their feces on the ceiling or at the faces of the physician and the nurses; they tear their shirt and bedsheets, waste the food... Finally one can try to lock the sick persons in the cell naked and to give them nothing more than goose grass so that they cannot tear anything.²⁷

Nevertheless, Buder emphasized the necessity of isolation cells for particular patients to render them harmless – those with a “criminal disposition,” who are “under the influence of hallucinations and misperceptions and therefore can become dangerous for their surroundings,” or the group of the degenerated [*Entartete*] or notorious criminals who try to plot against the physicians or the staff.”²⁸ Despite recognizing the value of isolation cells, he nevertheless believed that continuous baths, even at night, reduced the need for them, thus acknowledging that both segregation and enforced bathing were more disciplinary than therapeutic. For B., the cell as well took the place of the morphine-scopolomine injections that she had endured in Friederichsberg. The war against her madness continued with all means possible.

The psychiatrist’s admission examination was based on the record from Friederichsberg and also on the nursing notes from Langenhorn.

For the report of the physical examination, see Friederichsberg report There haven’t been any changes. Patient gives the impression of a demented schizophrenia. Catatonic symptoms, suddenly impulsively

agitated, tears apart sacks filled with straw, has to be isolated. Catatonic rigidity, negativism, very untidy must be cared for.
25.1.33. Always answers in a silly [*läppisch*], infantile way, suddenly a loud laughter, suddenly lashes out, tears down curtains.

Fully aware of her record from Friedrichsberg, the psychiatrist could assess B. for any behavioural changes, illustrating how the documentary biography and patient history could “travel” wherever needed. In Latour’s words, the record was an “immutable mobile,” which accounts for its power.²⁹ It enabled readers to “travel” through past events in order to actualize them in the present. Based on the history in the record and the nurses’ notes from Langenhorn, the psychiatrist labelled B. with “demented schizophrenia,” officially categorizing her as a hopeless case. The rest of the admission report was simply a listing of the diagnostic terms already used in the first admission diagnosis in 1931.

However, once at Langenhorn, B. seemed to have disappeared into a zone of invisibility. Although she spent nearly three years there, the psychiatrist’s notes fit into two pages and the nurses’ notes broke off completely at the end of January. For example, the entire psychiatric record from 1934, in which B. appeared to be little more than a bundle of instinctual reactions, consists of the following:

10.1.34: Always very noisy, completely unapproachable. Continuous bathing treatment necessary.
4.3.34: Very agitated. Does not speak. Tears apart clothes.
5.6.34: Agitated most of the time. Spits. Has to be isolated often.
3.9.34: Same condition. For a short period of time quiet and orderly, then agitated again.
5.12.34: Pulls her hair, tears apart clothes.

7.3 Bare Life

As philosopher Giorgio Agamben theorized, B. was thus reduced to a “bare life.”

Considering himself a successor to Foucault, Agamben could not understand why Foucault never investigated the concentration camps and the structures of the big totalitarian states of the 20th century – what Agamben considered the epitome of modern biopolitics. Agamben attempted to fill this gap with his study, *Homo sacer. Die souveräne Macht und das nackte Leben*, and tried to reformulate the Foucauldian term of biopolitics.

Agamben believed that the present was a catastrophic endpoint of a political tradition that had its origins in Grecian antiquity and which culminated in the Nazi extermination camps. For him, sovereign power was the core of biopolitics, and modern age does not mark a break with the occidental tradition (or the traditions in the Western world) but merely generalizes and radicalizes what was there originally.³⁰ The production of a biopolitical body was the original purpose of sovereign power, whose inclusion into the political community was only possible, if, at the same time, there were humans for whom the status of legal subjects was denied. Agamben concluded his study with three theses.

- 1 The original political relationship is banishment (meaning that in the “state of exception” a zone exists in which it is impossible to distinguish between outside and inside, or where particular groups are simultaneously included and excluded).
- 2 The fundamental performance of the sovereign power is the production of bare life. It is the original political element and functioned as a threshold for the connection between nature and culture, or *zoé* and *bios*.
- 3 The camp and not the state is the biopolitical paradigm of the occident.

According to Agamben, it is necessary to examine the exception to understand the functioning of sovereign power, because it is in the exception that the nature of state authority will be revealed. Agamben explored the “states of exception,” where a sovereign state declares a time or a place that the rule of law can be suspended in the name of self-defense or national

security.³¹ The sovereign decision over the exception is contained in the original juridical structure and principle in the Western World and is actualized through the declaration of the state of exception. The sovereign, who has the legal power to suspend the law, puts himself legally outside of the law; this is the paradox of sovereignty. The moment a sovereign declares the state of exception, he does so by declaring that there is no existence outside the law. “I, the sovereign, who is outside of the law, declare that there is nothing outside of the law.”³² The most prominent characteristic of the exception is that what is excluded in the exception is not, on account of being excluded, absolutely without relation to the rule.³³ What is excluded maintains itself in relation to the rule. “In this sense, the exception is truly, according to its etymological root, *taken outside (ex-capere)*, and not just excluded.”³⁴ The exception is not brought into being by an interdiction, but rather by means of a suspension of the juridical order.

The exception does not subtract itself from the rule; rather, the rule, suspending itself, gives rise to the exception and, maintaining itself in relation to the exception, first constitutes itself as a rule. The particular “force” of law consists in this capacity of law to maintain itself in relation to an exteriority. We shall give the name *relation of exception* to the extreme form of relation by which something is included solely through its exclusion.³⁵

The state of exception was not an invention of totalitarian governments but rather developed from a democratic-revolutionary tradition.³⁶ Every democratic constitution contains the possibility of declaring a state of exception.

Concentration camps were one attempt to make this structure visible. For Agamben, the camp and not the prison was the original structure of the law or *nomos*. The laws of prison administration are created by the legal system, but the camp is ruled by martial law. It is not possible to analyze the camp in the same way that Foucault did with asylums and prisons because the camp is the absolute exception and completely different from either of them. The camp is the “hidden matrix” of political space.

Agamben’s analysis is useful in thinking about the rendering of B. as invisible. As has been repeatedly emphasized throughout this study, psychiatric practice must be analyzed as a

form of disciplinary power that aimed to influence and transform patients at their very core. This practice is arranged around the absolute power of the psychiatrist and can only function because it is a hierarchical power distribution in which the nurses have a definite strategic function. One important characteristic of this anonymous power (anonymous because it is a form of power that intervenes without emotions and is independent from the person who has it) is that it subjectifies the somatic singularities in its reach by constructing a centralized identity and attaching this identity onto the somatic singularity. However, in B.'s records, as well as in all the other records that are part of this research, we find at some point the exact opposite operation, which appears to be a paradox: specific patients are suddenly de-subjectified and disappear into a zone of indifference. In these zones it seems as if anything was possible, because the little information that we have on these zones illuminates a severe intensification in the use of coercive means.

I do agree with Agamben that these zones of exception cannot be analyzed in the same way as disciplinary psychiatric practice, but I do not agree with him that Foucault did not consider them in his work. In regard to biopower, Foucault repeatedly emphasized, for example, that these new rationalities did not result in a disappearance of sovereign power. "On the contrary," he argued, "the problem of sovereignty was never posed with greater force."³⁷ Wendy Brown emphasized that Foucault's conception of power "[drew] on without unifying, centralizing, or rendering systematic or even consistent a range of powers and knowledges dispersed across modern societies." What Foucault did not analyze in depth was the aspect that the disciplinary power of psychiatry could turn into a sovereign power with the psychiatrist as sovereign, even though he often wrote about the psychiatrist as the one holding absolute power. Nevertheless, Foucault demonstrated that the particular aspect of a modern form of racism is not that it is a kind of ideology linked with mentalities, but that it is a part of techniques of power. As the analysis of Foucault's concept of biopolitics at the beginning of this analysis illustrated, racism is associated with biopolitics because it is obliged to use race as a way to exercise sovereign power. The juxtaposition of – "or the way biopower functions through – the old

sovereign power over life and death implies the workings, the introduction and activation, of racism. And it is, I think, here that we find the actual roots of racism.”³⁸

Agamben thus deepens an aspect of Foucault’s concept of biopolitics that he had already laid out. Using Agamben’s theoretical approach it becomes possible to conceptualize the “zones of invisibility” as zones of banishment or “zones of exception.” In these zones the patient is held in a “relation of exception [which is an] extreme form of relation by which something is included solely through its exclusion.” This again is exactly what happened to B. and other patients in Langenhorn because they were abandoned by psychiatric practice but simultaneously, it maintained control over their lives and even intensified corporeal interventions. Furthermore, as discussed earlier, from the end of the 1930s on, Langenhorn transferred thousands of patients to other asylums around Hamburg where most were killed. It seems as if in Langenhorn certain areas existed that could be described as “zones of exception” but these other asylums were nothing but “zones of exception.” Barely any information exists about what was going on in these asylums.

According to Agamben, the act of banishment is the purpose of exception, which means that the banished are abandoned by the law. The original power of the law contains within it the possibility of abandoning life but through this act, the law maintains control over life. Sovereignty then, becomes the point where it is impossible to distinguish between law and violence; it is the threshold where violence transforms into law and law transforms into violence, and at the same time, it is the threshold where nature and culture become indistinguishable. That is what characterizes sovereignty. For Agamben, the leading political differences since Grecian Antiquity have not been between friend and enemy, but the chasm between bare life (*zoē*) and the political existence (*bios*), or in other words, between natural existence and the legal entity of human. Agamben used the term *homo sacer*, a figure from Roman law, to describe a human who could be killed without punishment because he had been banished from the legal political community and reduced to the status of a physical existence. Whilst even a criminal had the right

to reclaim certain legal protection, the *homo sacer* was completely without it. Once one was excluded from the legal community, one could not be prosecuted nor become a religious sacrifice. “Neither completely living nor completely recognized as dead, the *homo sacer* was a sort of “living dead,” one who did not have even the elementary right to die like a human.”³⁹ A structural analogy exists between the sovereign exception and the *homo sacer*, in that they are two symmetrical extremes within the logic of sovereignty. A sovereign has the power to declare any person a *homo sacer*, but compared to a *homo sacer*, everybody could be a sovereign.

As already mentioned over the course of the analysis, the nurses carried out all interventions. Thus, they controlled these zones of exception and, therefore, it can be concluded that they claimed sovereignty. As the sovereign stands above the law, so is bare life outside the scope of the law, but at the same time, a part of it. Bare life is the essence of a political body that controls the existence and even the recognition of a human being. In psychiatric practice, nurses and psychiatrists had control over life and death of their patients, even to the point of deciding who could be recognized as human.

This, then, was the actual mechanism that enabled the killing of patients, and it was a mechanism that existed as an integral part of psychiatric practice and not as an invention of the Nazi regime. This transformation of the psychiatrist from a representative of disciplinary power into a sovereign was central to the very core of psychiatric practice. Psychiatry could not exist without it and it is the reason why the killings did not come to a stop after WWII. In Germany psychiatrists and nurses did actually assassinate sick persons but in many ways, these persons were dead long before. Foucault emphasized that killing someone is not simply the physical extermination of the other, but that there are also indirect forms of murder: “the fact of exposing someone to death, increasing the risk of death for some people, or, quite simply, political death, expulsion, rejection, and so on.”⁴⁰

7.3.1 *The psychiatric asylum as a camp*

Agamben defined the camp as a space without legal subjects (*bios*); in the camp only “bare life” (*zoē*) existed. The paradigmatic figure of the camp is *der Muselmann*,⁴¹ a being from whom humiliation, horror, and fear has taken away all consciousness and all personality as to make him absolutely apathetic and degraded.⁴² These people were not only excluded from the political and social context they once belonged to, but they also no longer belonged to the world of humankind, not even to the precarious world of the camp detainees who had ceased to recognize them. They remained mute and absolutely alone.⁴³ During 1932, B., too, was increasingly described as helpless and disoriented, a condition that became more pronounced in her later admissions from 1940 to 1943 and which eventually led to her killing. Dorothea Buck, a survivor of psychiatric system, described her experience of exclusion.

In 1936, 71 years ago-at the age of just 19, I went through the most inhuman experience of my life in a psychiatric institution, against which even buried alive during the 2nd World War paled into insignificance. I experienced the psychiatric system as being so inhuman, because nobody spoke with us. A person cannot be more **devaluated (devalued?)** than to be considered unworthy or incapable of conservation.⁴⁴

As Agamben stated, what is excluded in the camp and in the psychiatric hospital is included through its own exclusion. “But what is first of all taken into the juridical order is the state of exception itself. Insofar as the state of exception is ‘willed,’ it inaugurates a new juridico-political paradigm in which the norm becomes indistinguishable from the exception.”⁴⁵

Both the camp and the psychiatric hospital were “a hybrid of law and fact in which the two terms have become indistinguishable.”⁴⁶ Both the camp and the psychiatric hospital were characterized by the fact that their inhabitants “were stripped of every political status and wholly reduced to bare life.”⁴⁷ The camp and the hospital became biopolitical spaces, “in which power confront[ed] nothing but pure life, without any mediation.”⁴⁸ According to Agamben, this was the point where politics became biopolitics. Nevertheless, Agamben neglected the Foucauldian concepts of governmentality and the specific turn in political rationalities that he introduced with

the concept of biopower.⁴⁹ Due to this neglect, Agamben could not fully grasp the biopolitical dimension of the killing of patients within a National Socialist biopolitics in Germany.

However, Agamben notes that the question of “how crimes of such an atrocity could be committed against human beings” is often posed.⁵⁰ This question is the starting point of many historical studies in nursing as well.⁵¹ Nevertheless, I concur with Agamben that this kind of question is hypocritical and believe that he is correct in claiming that it would be more honest and, “above all, more useful to investigate carefully the juridical procedures and deployments of power by which human beings could be so completely deprived of their rights and prerogatives that no act committed against them could appear any longer as crime. (At this point, in fact, everything had truly become possible).”⁵²

Nevertheless, the bare life into which patients were transformed is not, according to Agamben, an extrapolitical fact, but rather produced through the decision of the sovereign. If the state of exception becomes the rule, then the juridical-political system becomes a deadly machine, as we can see in the killing of patients by nurses and physicians. “It is not that first, life exists as a natural biological given and *anomie* as the state of nature, and then through the state of exception, that law and order are imposed. On the contrary, the very possibility of distinguishing life and law, *anomie* and *nomos*, coincides with their articulation in the biopolitical machine. Bare life is a product of this machine and not something that preexists it, just as law has no court in nature or in the divine mind.”⁵³

In the case of the killing of patients during the Nazi regime, the sovereign established a symbiosis not only with the jurist but also with the physician, supported by the nurse. Alfred Hoche, a specialist in criminal law, and Karl Binding, a physician specializing in ethics, attempted to legitimate in 1920 the extermination of “life unworthy life.” In this book, the fundamental biopolitical structure of modernity found its first juridical formulation. Binding’s concept of “life unworthy life” and “mercy death” reappeared in the Nazi regime. Masked as a humanitarian problem – against the background of a new biopolitical determination of the

National Socialist state – the sovereign power practiced the power of decision over “bare life.” “Life unworthy life” was not an ethical but rather a political term because it allowed for the possibility of a person being able to detach the bare life (*zoé*) from *bios* in another person.

The National Socialist government never adopted a law regarding its “euthanasia” program; it was simply based on a secret decree that never gained legal force. All physicians and nurses involved in this program were thus in a doubtful judicial position; it was a state of exception. The sovereign decision over “bare life” shifted away from political motivation and entered an ambivalent terrain wherein the sovereign and the physician, along with the nurse, began changing places. The precondition for these killings was that all murdered persons were judged as already having been excluded from the political community. They were living in a borderland between life and death, between interior and exterior, where they were nothing more than bare life. They were reduced to *homines sacri* and in this “no man’s land,” the physician, nurse, and scientist were acting where, in former times, only the sovereign could act.

7.3.2 *B.’s forced sterilization or the psychiatrist becomes a judge*

This changing of places between the jurist and the ambiguous figure of the sovereign psychiatrist is particularly clear in the decision to sterilize B. in 1935. By 22 October 1935, B. had been in Langerhorn nearly three years. At this time, the psychiatrist noted that the “Sterilization report written. Continuing sudden alternation between calm and agitated phases.”⁵⁴

This report, which had a strong impact on B.’s future, was a consequence of the “Law for the Prevention of Genetically Diseased Offspring.”

(1) Any person suffering from a hereditary disease may be rendered incapable of procreation by means of a surgical operation (sterilization), if the experience of medical science shows that it is highly probable that his descendants would suffer from some serious physical or mental hereditary defect.

(2) For the purposes of this law, any person will be considered as hereditarily diseased who is suffering from any one of the following diseases:

- (1) Congenital Mental Deficiency,
- (2) Schizophrenia,

- (3) Manic-Depressive Insanity,
- (4) Hereditary Epilepsy,
- (5) Hereditary Chorea (Huntington's),
- (6) Hereditary Blindness,
- (7) Hereditary Deafness,
- (8) Any severe hereditary deformity.

(3) Any person suffering from severe alcoholism may be also rendered incapable of procreation.

Enacted on 14 July 1933, this law been in force since January 1934. The decision to sterilize was assigned to the "Genetic Health Courts," consisting of a judge, a medical officer, and a medical practitioner, "which shall decide at its own discretion after considering the results of the whole proceedings and the evidence tendered." The decision of the court could be appealed to a "Higher Genetic Health Court," but if the appeal failed, the sterilization was to be carried out with the law specifying that the "use of force [was] permissible."⁵⁵ In reality, physicians made decisions on their own to sterilize patients, with the judge involved only to make sure that legal obligations were respected in the process. These Genetic Health Courts held their meetings in asylums.⁵⁶

The note in B.'s record from October 22 was only the peak of a process that had begun in April 1934. The administrative record contains a typewritten copy of a remarkable letter that was obviously sent to court.

Langenhorn, 9.4.1934

The sterilization of the patient Anna Maria B. residing with her parents in...Hamburg is necessary, according to the law for the prevention of hereditarily diseased offspring. In order to carry out this surgical operation the consent of a legal representative would be necessary. The mother who could assume the trusteeship and could apply for the sterilization refuses to do so. This is the reason why an official trustee is requested. Signed: Dr. H., department physician

As this letter demonstrates, the psychiatrist knew that B. would be sterilized a year and a half before the sterilization report was officially submitted. The whole process was nothing more than a formality, since the decision had already been made by the psychiatrist. The mother's resistance was simply a problem to be solved by the appointment of an official trustee, although

who this was could not be determined from the file. Moreover, this letter was written just three months after the law took effect.

The administrative file also contained a letter written by her father, in which he stated that the condition of his daughter had improved and that he planned to take her home. He requested Langenhorn to transfer her back to Friedrichsberg, emphasizing that he paid 30 Marks every months and therefore thought that he had the right to claim this service. It is somewhat surprising, however, that her father judged B.'s illness improved since the few notes in her file suggest only that her condition continued to be disastrous.

7.3.3 *The sterilization report*

B.'s administrative record contains two handwritten drafts as well as a typewritten carbon copy of the final sterilization report, which is identical with the second handwritten draft. The medical files typically contain just the typewritten copy of the report that was submitted to the court, but in B.'s case, the two drafts imply that the report was the result of much work – work that was normally not visible in the final version. The two drafts differ in some aspects and highlight what Latour called “thinking with eyes and hands,” suggesting that “hard facts” do not solely exist in theory but rather were also crafted through the act of writing. As the different drafts showed, how B. was perceived in the final version of the sterilization report was not something that was just observed but had to be constructed carefully. Latour called this aspect the necessary “craftsmanship” that one had to master to convince others. It was a “strategy of deflation” because written notes and diagrams conflated complex data into a two-dimensional image on paper. Writing and drawing were “both material and mundane, since they [were] so practical, so modest, so pervasive, so close to hands and eyes that they [escaped] attention.”⁵⁷ In order to be convincing, the document had to be constructed in such a manner that it could “muster on the spot the largest number of well aligned and faithful allies,” which is to say, it had to align all the “hard facts” from nurses’ and psychiatrists’ notes, former examination reports, laboratory results, photography, etc. that had the potential to intervene in the decision-making. These

inscriptions were thus not only visualizations but also mobilizations, because they were able to convince those who could not “observe” B themselves. Latour described this necessity as having “to invent objects which have the properties of being mobile but also immutable, presentable, readable and combinable with one another.”⁵⁸ All of these factors applied to the sterilization report and the record, since they were both mobile – they were sent to the court, exchanged among different asylums, and could be read everywhere – with its text remaining stable independent of its readers.

The court requested that the medical record stand as evidence. At the same time, the sterilization report “governed from a distance” because of its construction as a questionnaire that asked only for predetermined information. This document not only determined how B. would be defined but it also standardized the terms that could be employed in order to complete the questionnaire, even if the same categories were used for years.

The six-page sterilization questionnaire resembled the construction of the admission ritual. The first page collected demographic information while the second was concerned with patients’ family history. In the first draft on B., the mother supplied all the information, including the fact that the maternal grandfather had used alcohol well into his old age – a fact that had never before been revealed in any of B.’s previous admission records. It was deleted in the final draft of the sterilization report, likely because it could not be used as evidence for a hereditary load. However, its appearance suggests that the psychiatrist was searching for any indication that could be used as evidence of B.’s “hereditary dangerousness.” The third page of the questionnaire recorded the patient’s own history. In the first draft again, it was noted that as a child, B. had often moaned with abdominal pain although no cause could be found – something that had been only marginally noted in her first admission ritual in 1931. The ability of the record to conserve information over the years to be used in different contexts was also clear when the psychiatrist repeated the symptoms noted on her first admission to Friedrichsberg; he wrote that she had been stuporous, aggressive, and negativistic, and refused food necessitating tube feeding. The fourth

and fifth pages of the questionnaire were devoted to the physical and mental condition of the patient. They demonstrate how years of confinement in the asylum could be compressed into a short, simple summary. B.'s mental state was described as "stump," and the psychiatrist wrote that she showed "severe states of excitation" and undertook violent attacks against both the nurses and her relatives. He also noted that she threw food and smeared her feces – although he reported that she also periodically lapsed into a catatonic state. According to her medical file, however, B. had only attacked her mother in 1931, and only once in 1933 did the nurses report that she had attacked them and this information was never recorded in the psychiatrist's report. Similarly, they reported only once that she had thrown her dishes and food. In this draft, the psychiatrist was obviously constructing a new narrative from a new combination of elements derived from the medical file. The sixth page of the questionnaire asked for her diagnosis, which was given as "schizophrenia" and the psychiatrist justified the request for sterilization on her "occasional catatonic states." He also warned that her "severe annoyance" might make surgery and her first treatment difficult.

The second draft and the subsequent final version differ in some significant ways from the first. This time the psychiatrist who completed the questionnaire had meticulously studied the record. For example, a sister, who had been mentioned only once in the entire record – at B.'s first admission in 1931 – replaced the grandfather. And where the first draft mentioned B.'s suffering from childhood abdominal pain in her childhood, the final version referred to her 1931 admission when the admitting psychiatrist reported her broken nose. Again, although this information appeared only once in the record, it is noteworthy that it reappeared more than four years later in the sterilization report. The final version also recorded more details from 1931, such as her school career and her lack of interest in men. Perhaps more importantly, the psychiatrist avoided the previous list of medical terms for a larger but vivid explanation of her symptoms, perhaps in order to allow a non-medical person like the judge to better understand the situation.

He argued that “the diagnosis [resulted] from a progression. In the past [she exhibited] delusional ideas (now [she] barely talks).” He went on to write that

B. was admitted to the AK [general hospital] Barmbek from 10.2.-18.2.31 and then transferred to Friedrichsberg due to agitations and was diagnosed with schizophrenia. In Barmbek she was periodically very agitated, was in a state of anxiousness, looked around wide-eyed, very afraid. Most of the time she did not talk and refused food. During the admission in Friedrichsberg she was noisy and lashed out. Nighttime very restless, periodically agitated. [She believed that] she should be decapitated because she did wrong. Periodically stuporous. Lay lethargic in the bed. Refused nutrition. During the last admission to Friedrichsberg anxious, restless, on the run from her bed. Delusional ideas (thought she was pregnant, suffering from venereal diseases).
Miss B. is not legally competent.

Signed Dr. H (department
physician)

Once again B.’s medical history was re-written, since all the elements contained in this summary were derived from psychiatrists’ notes from Friedrichsberg over a four-year period. Surprisingly, the psychiatrist never mentioned Langenhorn despite B. spending nearly three years in the asylum, the greater part of her hospital career. It is even more astonishing since Langenhorn “specialized” in observing patients for sterilization reports. I think this detail can only be explained because no traces of B. existed in Langenhorn; nothing had been reported on her because she was living in the “zone of exception” and was reduced to a kind of living death.

B.’s medical file assumed another far-reaching role in the sterilization process. The administrative record contains letters addressed from the court to B., strongly suggesting that they never made it to her house in the asylum for her to read. Every letter was also signed only by the medical director and not by her, as would have been the prescribed procedure.

The court decision and a document entitled “decline of legal means” are the most important documents. On 25 November 1935 the “Genetic Health Court” decided that B. must be sterilized. Psychiatrists had examined her and applied for her sterilization, and now physicians were again acting as judges in determining the accuracy of her examination and the application for sterilization. The asylum had transformed into a court and the patient became the accused.

According to the written court decision, B. was not represented by a lawyer, and since the final decision was contained in her file, she never saw it. B. also received the “decline of legal means,” which informed her that she had a right to object to the decision. Glued over the original text, which told her that she had one month to reply in writing to the court registry, was a modified version that gave her only fourteen days. The letter was sealed and signed and therefore endowed with legal power. Another letter for her arrived four days later from the General Hospital in Finkenau, informing her that her surgery would take place on the exact day the “new” objection period ended and that the police had the power to enforce this order if need be. This virtual procedure illustrates dramatically what is meant by “the judge and the physician changing places.”

A document claiming that B. had been properly informed about the nature of her sterilization surgery was also found in her file. B. had allegedly received a handout on her planned sterilization, although this “informed consent” was signed by the same psychiatrist who had written the sterilization report one day before the report had been submitted and one month before the court decision. B.’s sterilization had been decided long before her case went through the legal process.

Soon after the surgery, B. was discharged from hospital on the insistence of her mother.

In a letter dated 16 December 1934, three days after B.’s surgery, her mother wrote:

In possession of your letter from the 12th of this month I was informed that my daughter Anna was transferred to the gynecological clinic Finkenau in order to perform an operation. Now I want to ask for the permission to bring my daughter home from the Finkenau as soon as she will be healthy.
Heil Hitler
J.B.

B.’s mother was apparently informed about her daughter’s surgery only after she had been transferred to Finkenau and thus it is highly unlikely that she ever knew about the letters in B.’s file. The approval for her surgery had come from the same psychiatrist who had been

responsible for the entire process. B. herself seemed to realize what had occurred. In a kind of diary that was also found in her file, she wrote:

1935. Langenhorn. Discharged on the 12th December 1935. From here to the Finkenau, on Saturday the 13. operated (sterilized) 25. December 1st visit. On the 29th discharge. New Year's Eve party at home. At New Year walk. (See Figure 27)

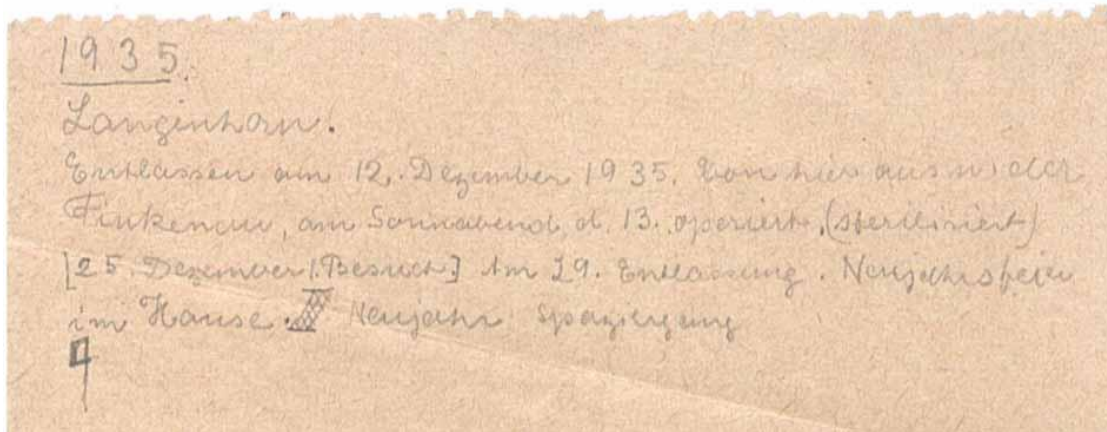


Figure 27: Anna Maria B.'s original "diary." Patient record 28338.

From this time forward, the fact that B. was sterilized was marked in red everywhere, including on the cover of her file, so that it became the first thing that caught the reader's eye. The sterilization itself thereby became strong evidence for B.'s severe mental illness and for her being a hereditary danger.

7.4 Admission 1936

On 10 February 1936, B. was committed to Friedrichsberg once again, although the medical officer this time remarked that she might be transferred to Langenhorn later. Her diagnosis was a logical continuation of her earlier admissions: "old schizophrenic with distinct defect symptoms; psychic desolation."⁵⁹ B. was once again placed in House 8, where the psychiatrists used terms like "dumb facial expression,"⁶⁰ "wrinkled face [*Faltengesicht*],"⁶¹ "mutistic," and "autistic,"⁶² to describe her. Although this admission closely resembled the one in 1932, she did experience an increased number of bodily disciplinary interventions, especially by chemical means. B. received so many injections in combination with other sedatives like

isolation cell. B. drew the bed in the isolation cell in black, indicating that she saw herself kept in this cell.

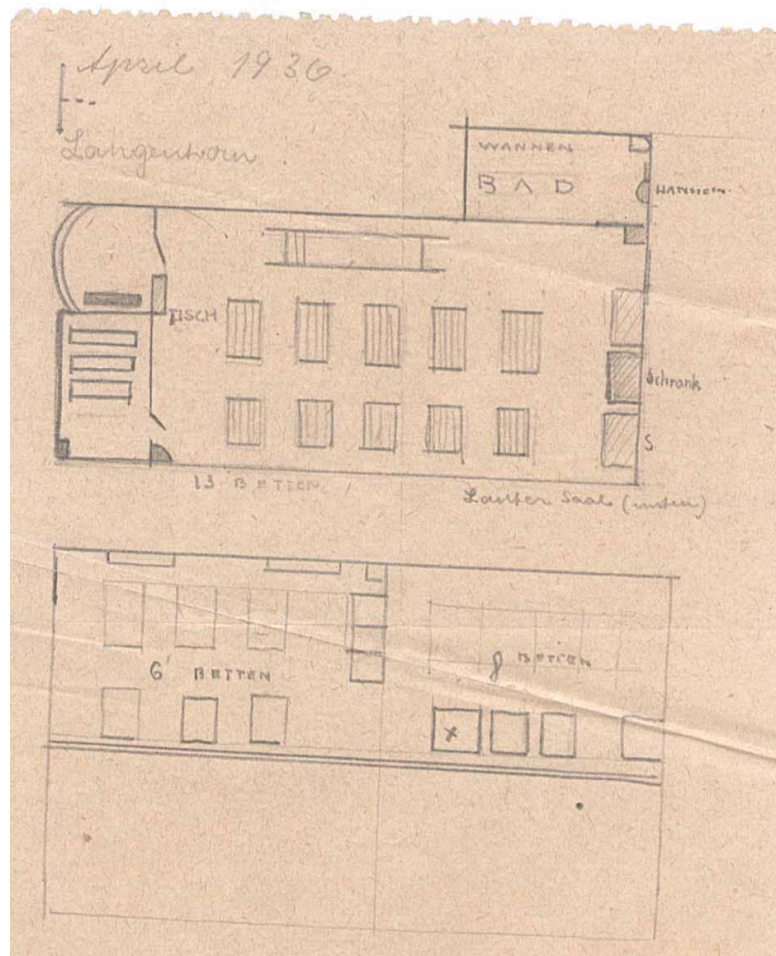


Figure 29: Anna Maria B.'s drawing of House 8. Translation: *Wannen Bad*: continuous bath; *Schrank*: cabinet; *Lauter Saal (unten)*: noisy hall (downstairs); *Betten*: beds; *Tisch*: table [the nurses' table]. Patient record 28338.

In September 1936, B. was again transferred to Langenhorn where again she was kept in an isolation cell most of the time. The psychiatrist noted on 23 September 1936 that she “[has] to be kept [*gehalten werden*] in the cell since she attacked other patients in her state of dementia. She runs around in the cell at times agitated, gesticulates, talks incomprehensibly to herself, must be fed, experiences her surroundings without any reaction.”⁶³ It is significant that the psychiatrist used the verb *gehalten werden* that refers usually to keeping animals.

At Langenhorn, B. was even being given non-approved medication in an illegal experiment, again pointing out that that she had lost any legal status and was vegetating in a zone of “bare life” in which anything was possible. As the psychiatrist wrote on 4 November 1937, B. “has taken Eugenocym for a couple of months (by request of the mother) without success.”⁶⁴

The method of continuous baths or “cold wet sheet packs” was used extensively in Friedrichsberg and Langenhorn and was mentioned frequently in the other records used in this study. Her situation could best be described by Dorothea Buck:

How were we given rest? With buckets of cold water poured over our heads, with long-duration baths in a tub covered with canvas with a stiffed high collar in which my neck was fixed for 23 hours, from one doctor’s ward-round to the next, with the “cold wet sheet packs” and with sedating injections of paraldehyde. In the case of the “cold wet sheet packs” one could be wrapped into them so tightly that one could no longer move at all. Due to the body temperature the sheets would become first warm and then hot. I would cry out in rage at this senseless restraint in these hot sheets.⁶⁵

B. was discharged home on 31 March 1938, not because the psychiatrists thought she should be but because B.’s parents intervened in favour of their daughter. The admission record, which contains the correspondence between her father and Langenhorn, suggest that the father’s demands had been ignored for months until the psychiatrist finally granted a one-month leave. During this leave, B.’s father believed that his daughter had clearly improved and asked for her complete discharge, which was approved by the medical director. It appears that without the insistence of her family, B. would not have been discharged.

7.5 Admission 1940

B.’s admission in 1940 to the Clinic for Psychiatric and Nervous Diseases at Eppendorf, which was the new name of the psychiatric asylum at the University of Hamburg after Friedrichsberg was closed down, is worth analyzing in some detail. Not only was she killed in 1943 after her subsequent transfer back to Langenhorn, but her therapy also took a radical twist at this time. To begin with, her diagnosis in Eilbektal (the abbreviated designation of the new

psychiatric asylum) differed from those given earlier. B. was now somewhat surprisingly diagnosed with “Dementia praecox,” a term derived from Kraepelin’s nosography. Her previous diagnoses of schizophrenia had been based on Bleuler’s nomenclature, demonstrating once again that psychiatric practice was not guided by a particular medical nosography but rather could be perceived as a distribution of disciplinary power aimed at transforming the patient to his or her very core. Dementia praecox, under Kraepelin’s nosography, led to a process of stupefaction that was irreversible, whereas Bleuler’s term of schizophrenia did not necessarily lead to stupefaction. The former implied that no curing was possible but the latter suggested that the patient could be cured. One month before B. was transferred to Langenhorn her diagnosis changed again to “hebephrenic,” although on the date of her transfer, she was returned to a “schizophrenic,” albeit “schizophrenic final state.”

On the day of this admission and under her modified diagnosis, B. was placed again in House 8. Similar to the earlier 1936 admission, the nurses laid out a medication plan in order to record the multiple Morphine-Scopolamine and Paraldehyde injections that she received. However, a new drug was introduced on 26 February.

26.4.40: Pat. often outside the bed, food must be administered. Got Cardiazol, pat. stayed in bed, was quiet. (N. O.)
Night: Pat. did not sleep until 2AM. Got Paraldehyde, slept immediately after this. (Ka.)
27.4.40: Pat. got Cardiazol, stood up in bed, got often out of the bed. Stands helplessly around. (N. O.)

Cardiazol had never been used before but was part of what Bleuler called “the active therapy” that complemented the “educational therapy of schizophrenia.”⁶⁶ Cardiazol shock therapy – intravenous injections of the drug to provoke an epileptic seizure – was introduced by Meduna in 1934 and from June 1936 on, Insulin and Cardiazol shock therapies were carried out at the asylum of the University of Hamburg. Higher doses of the drug were to be administered within a couple of minutes if any seizure occurred, but if no seizure could be provoked, further injections were to be held until the following day. According to Bleuler, patients would ideally

receive two shocks per week – fifteen to twenty in all.⁶⁷ Meduna's theory was that genuine epilepsy rarely occurred in combination with schizophrenia, creating what he called a "biological antagonism" between these two diseases. Because the two diseases were mutually exclusive, Meduna inferred that synthetically provoking artificial epileptic seizures should positively influence schizophrenia.

Psychiatrists usually gave the intravenous injections. The patients were fasting since they often vomited. To reduce the risk of injuries, a piece of rubber hose was to be inserted between their teeth to prevent them biting their tongue and they were to be laid in bed in a particular way.⁶⁸ Like other epileptic seizures, the induced seizures also left patients unconscious, although they often suffered dislocations of joints, bone fractures, and other surgical complications.

Widenmeyer, assistant physician at the Illenau asylum, explained that

most of the sick persons oppose the Cardiazol treatment, because in the short interval that lasts only several seconds between the injection and the beginning of the seizure which produces unconsciousness, the sick persons experience a displeasing feeling, especially in the cardiac region, that can bring on a mortal fear. Nevertheless, it is just a misperception that is not based on a real specific danger...⁶⁹

Josef Riepenhausen, a provincial medical councilor (*Provinz Medizinal Rat*), described that patients experienced a "feeling of impending doom," perhaps a more appropriate description.

Several hours pass by before the patients become fully conscious – usually they are responsive, clear and focused after 30 to 40 minutes. It is not unusual that episodes of amnesia occur for a period of several hours where their thoughts break off. The sick persons insist on single thoughts; their speech becomes formulaic and is always interrupted with a helpless gesture. The mood therefore is sad. The memory about the whole process is preserved and is experienced as inconvenient and sad. Before they recover full consciousness they experience a great nervousness. Some hours after the rest of the symptoms of the seizure have eased, the sick persons are more approachable and communicative.⁷⁰

As the nurses' notes pointed out, B., too, was quiet and more approachable after her shock treatments. Nevertheless, this therapy had severe consequences for patients, producing in them an existential crisis after the injection. Especially painful were the so called "abortive seizures" that occurred if the dose of Cardiazol was too low or if it was injected too slowly. As

described by L.v. Angyal and K. Gyárfás “uncoordinated movements occur in the extremities: the sick person screams, flounders back and forth, looks around distractedly, sometimes wets himself.” These authors distinguished four forms of “remissions”: “complete (A), good (B), social (C), and none (0).” Those with complete remission

can be considered those cases who attained complete insight into their illness regarding their pathological experiences, hallucinations, etc. and who are able carry out their work and who are also considered by those around them as completely cured, psychic healthy people.⁷¹

The definition of good remission is exactly the same criterion for patient recovery as was discussed regarding the final interrogation. The defining mechanism of the final interview was the questioning by the psychiatrist and the acknowledgement of the patient that the centralized identity in the record was really him or her. From this perspective, Cardiazol shock therapy became a means to achieve this confession, and as the statement above highlights, it can be defined as introducing the psychiatrist’s will into the body of the patient. A good remission was

constituted by patients with complete capacity to work and who can be fully integrated socially, but who are nevertheless characterized by light personality disorders such as mistrust, closeness...Patients with social remission are able to integrate themselves in their surrounding and can do any work despite their defects.⁷²

Again the criterion for therapeutic success concerned only the question of whether or not the patient was able to adapt to his or her surroundings and to return to work.

Shock therapy was a technique that contained the whole rationale of psychiatric practice, forcing the reality of the asylum onto the individual. The extreme resistance against the Cardiazol “therapy” and the need for surveillance even after the seizure had died away meant that patients had to be isolated in special treatment rooms. In B.’s case, the Cardiazol therapy was combined with the usual Morphine-Scopolamine injections and with Paraldehyde, but this time the Paraldehyde was often given via enema. Furthermore, the Cardiazol therapy was combined with insulin shock therapy, which had been developed by Manfred Sakel in the 1930s based on the theory that insulin antagonized the neuronal effects of products of the adrenal system, which were

considered the physiological cause of the patient's illness. "Deep insulin coma therapy" was extremely rigorous. It was administered in a separate unit, with the patients staying together with the same doctors and nurses throughout the therapy.

In the asylum at the University of Hamburg, insulin shock therapy was employed on a grand scale. The former medical director of the asylum, Prof. Dr. Hans Bürger-Prinz, emphasized in a book that he wrote after the end of the Second World War that a quarter of the patient beds were reserved for insulin shock treatments, or 80 beds out of 320.⁷³ Comas were induced on five or six mornings a week. Typically, the "therapy" began with an initial dose of 10-15 units of insulin with a daily increase of 5-10 units until the patient showed a severe hypoglycemia. Treatment continued until there was a satisfactory psychiatric response or until 50-60 comas had been induced. In B's case the "therapy" started with 30 units and with a daily increase of 10 units, reached up to 100 units on the ninth day (See Figure 30).

Experienced therapists in Great Britain let patients spend up to 15 minutes in "deep coma."⁷⁴ Bleuler believed that one could leave a patient in deep coma for up to one hour with hypotonia and absent corneal and pupillary reflexes.⁷⁵ Hypoglycemia made patients extremely restless and liable to major convulsions. Comas were terminated by administration of glucose via a nasal tube or through an intravenous injection. Patients required continuous nursing supervision for the rest of the day since they were liable to experience hypoglycemic "after shocks" and a doctor had to be immediately available.⁷⁶ Sometimes the responsibility for the insulin injections was left to the nurses.⁷⁷ As some authors pointed out "experiencing these forced unconsciousness in slow motion caused panicky anxiety states in the patients."⁷⁸ All the medical literature of that time reported on cases of death from shock therapies.

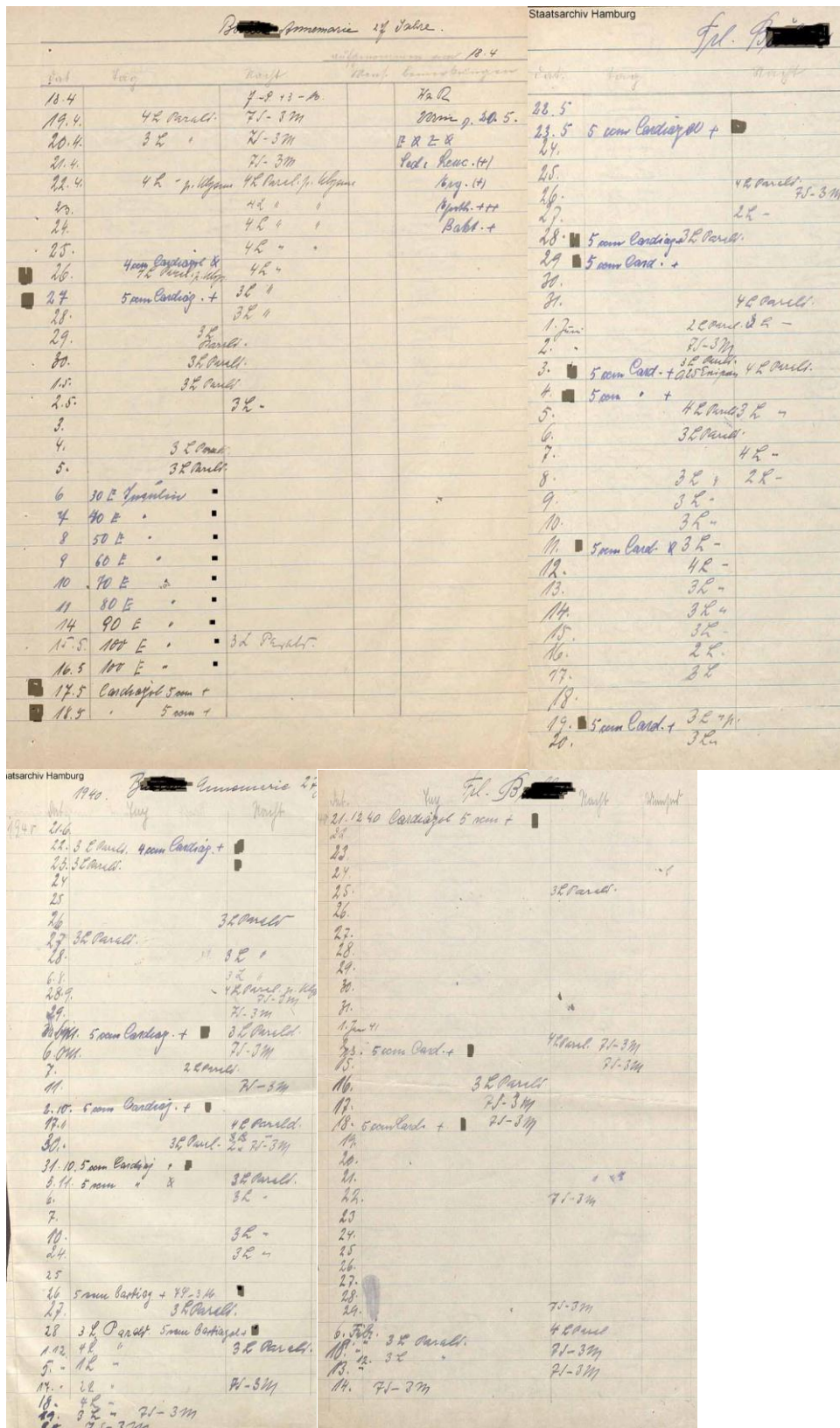


Figure 30: Insulin injection plan and Cardiazol injections for the years 1940-1941. The Cardiazol injections are marked with a square, the Insulin injection with a dot. Patient record 18338.

Historian Angelika Ebbinghaus presumed that the increase in the mortality rate was partly due to the new “active” therapies. According to her hypothesis, patients were already being killed by these shock therapies long before the beginning of the planned and systematic assassination of patients, and her hypothesis is strengthened by the results of her study. (See Table 5) While the table indicates that the number of admitted patients did not double between 1936 and 1941, the number of deaths more than tripled in the same period of time.

Year	Number of patients treated in the asylum of the University of Hamburg	Number of deaths in the asylum of the University of Hamburg
1936	1333	85
1937	1990	142
1938	2196	154
1939	2516	188
1940	2113	235
1941	2391	290

Table 5: Number of treated patients and number of patients who died in Eilbektal, the asylum at the University of Hamburg.⁷⁹

In B.’s case, different shock therapies were randomly deployed. According to accepted procedures of the time, Cardiazol therapy was to follow a precise scheme of two shocks per week at intervals of two to three days. However, in B.’s case no regular schedule was apparent. The Cardiazol injections started on 26 April with the usual dose for women but this was ineffective and the injections were repeated one day later with a slightly larger amount , which eventually led to a seizure. From then on, the nurses reported only from time to time on B.’s Cardiazol injections, and the psychiatrist did not mention them until 12 June, more than two months after they began. Nowhere were the Cardiazol injections defined as a “therapy,” whereas the insulin injections explicitly were. B. received the Cardiazol injections on an irregular basis; in June, for example, she was given seven while in July, she received none. Over the course of her stay, these injections became more and more a means to discipline her. She was also strapped to her bed over longer periods of time, although the fact that she was tied down can only be deduced from the nurses’ notes since it was never explicitly mentioned elsewhere (See Figure 30). On 22 May

1940, for example, the nurses noted that B. had received Cardiazol and was quiet but nevertheless kept trying “to get out of her belt.”

By this time nearly all disciplinary means available in the asylum were employed, but the use of Cardiazol as punishment was particularly evident. On 29 October 1940, the nurses wrote that B. had “beat a fellow patient with her slipper [and for that she] received Paral.” Two nights later she was restless and running around the room sobbing; after an injection of Cardiazol she was “more quiet but confused.” Between 24 and 28 November, she received both Paraldehyde and Cardiazol at least twice and was also strapped to the bed several times for her restlessness. The entry on the afternoon of 28 November, however, demonstrated well the aim of “treatment” and the type of behaviour that the nurses desired. At that time, she was “nice and orderly, [did] housework, [laughed] and [answered] questions.”

By January 1941, B. had received Cardiazol injections, however irregularly, for nearly one year. Within the dispositif, even medications that were initially prescribed according to a certain conception of the etiology of mental illness or its organic correlations were re-utilized in a directive system. Their disagreeable effects on the patient were used as punishments. On 20 February 1941 the psychiatrist noted that “she was completely unchanged and in character negativistic.” She remained alternately stuporous and excited, out of touch with her surroundings, and “must be strapped.” As a consequence, B. was diagnosed as “schizophrenic final state” and was transferred to Langenhorn two weeks later. The last episode of B.’s life began to take shape.

The psychiatrists and nurses knew very well what they were doing in using shock therapies. Bürger-Prinz’s assistant, psychiatrist Fred Kogler, stated that “insulin shock therapy and especially Cardiazol shock therapy are very brutal somatic interventions.” Patients become helpless and feeble “which clears the way for psychotherapeutic guidance... The shock itself might perhaps function like a concussion of the core of the personality due to the deep impact on vegetative and other cerebral functions and thereby influences the mysterious biological events of schizophrenia.”⁸⁰

That the psychiatrists and nurses consciously accepted that their patients would be harmed is seen particularly in the case of Richard Rudolf Heinrich A., who was admitted 6 May 1936 to Langenhorn after spending only four days in Friedrichsberg.⁸¹ A. was admitted with the diagnosis “progressive paralysis” and treated with countless medications. Even though he was not treated with a shock therapy (although he even received Cardiazol in the course of his endless therapies) he became the target of another kind of “active” therapy. The handling of the medications in this case is paradigmatic. His martyrdom began in 1936 with a Malaria-tertiana therapy that was stopped because he had a circulatory collapse. Even though he showed serious symptoms of cardiac insufficiency, he was treated further with a Bismogel-therapy (1936), followed by a Pyrifer therapy to which Cardiazol injections were added. The first three “medications” were used to provoke high fevers in patients to fight against syphilis, a cause of progressive dementia, and which A. had been diagnosed with, but Cardiazol was typically reserved for shock therapies in cases of schizophrenia. In August 1936 another Pyrifer therapy was started and was repeated in 1937. In 1938 a malaria therapy was again begun but stopped due to cardiac complications. It is obvious that A. was treated with therapies that had serious health hazards even for healthy patients, and A. received them even though the psychiatrists knew about his cardiac situation. Even if patients were not killed in the Hamburg University asylum, they certainly arrived in Langenhorn in a much-reduced bodily condition. Analyzing the interconnections between “active” therapies, reduced bodily conditions of patients, reduced nutrition, and the increase of mortality, is beyond the scope of this study, but it is clear that patients were killed by medical therapies both directly and indirectly.

7.6 Last Transfer to Langenhorn

B. arrived in the afternoon 9 March 1941 in Langenhorn and was treated by Morphine-Scopolamine injections and Paraldehyde. The psychiatrist saw B. for the first time on 10 March 1941 and described her as completely apathetic. His final remark, "Completely unapproachable. Completely autistic. Always opposing in negativistic manner," was derived from the nurses' notes in Langenhorn.

On 10 March the nurses' notes broke off after a certain period as was usual in Langenhorn. Nevertheless, at this time B.'s medical file contains small sheets of seemingly scrap paper with random, widely spaced documentation, as well as other papers containing kinds of summarized notes – papers that had not been found during any of her earlier admissions nor found in other patient records. The first of these papers is a report from 25 March 1941.

25.3.41: B., Miss Annamaria. Pat. is very restless, moves her bedding/covers around a lot, rattles the wooden bed rails, spits, attacks the nurses, is in every way unapproachable. Pat. hallucinates, talks to herself all the time, cries and accuses herself, "I am Jesus, have hung on the cross," and so on. Pat. does not eat well, makes little balls made of bread and throws them. Pat. must be taken away.

25.3.41: 11/2p.m.: Pat. is very restless often tries to attack the nurse, cries quietly, was given sleeping medicine. (S.)

30.3.41: Pat. still very restless, talks to herself in a very excited, lively way, cries a lot, is tormented a lot. Pat. is out of bed often, attacks patients and spits, Pat. was especially agitated during and after visiting time. (N. A.)

Three months later, the note from 25 March reappeared in the psychiatrist's summary.

26.6.41: Is very restless, moves her bedding around a lot, spits, attacks the nurses and other patients. Hallucinates, lively monologues. Cries and accuses "I am Jesus, have hung on the cross and so on!" Poor eater. Must get enemas. During visits autistic as well.

Once again the psychiatrist has combined events in a new fashion and it is not readily apparent that he has used the nurses' notes from the three previous months. The nurses, who continued to write B.'s history as if no breaks had occurred, added nothing new. It appears that they recorded their observations mainly just before the psychiatrist did his rounds, which in B.'s

As previously stated, the number of beds in Langenhorn was reduced by half at this time, but the number of treatments was reduced only by approximately a third, meaning that more patients were kept in fewer beds. Langenhorn was overcrowded, as were the asylums where Langenhorn transferred patients to be killed. Patients who had to sleep on the floors under horrific hygienic conditions literally inhabited “zones of exception.”

The psychiatrist wrote his assessment of B. on “Reporting form 1,” a questionnaire sent to all the German asylums in line with Aktion T4. (See Figure 31).

Figure 31: Anna Maria B.'s completed report sheet 1 (Meldebogen 1) of Aktion T4. Patient record 28338.

Although the form insisted that it “Must be completed with typewriter!” only the administrative part was; the rest was handwritten, and was thus likely a draft of the form that was finally sent on to Berlin. As was the case for the sterilization report, the form prescribed the type of information to be entered, limiting it to specific terms and a small space. This form is therefore another example of the ability of documents to “govern at distance.” The handwritten answers on her form are written here in italics.

Has been in other institutions, where and for how long *was in Friedrichsberg four times since 1931*
Twin: *no*
Mental illness in (blood)relatives/family: *not known*
Diagnosis: *Schizophrenia*
Clinical description(history, progression of illness, current condition):
vivid hallucinations, Very restless, at times aggressive, at times stuporous-shy & timid.
Very restless: *yes* **bedridden?** *Yes, yes often.*
Incurable physical diseases: *no*
Final condition: *yes* **diminishing:** *no*
Kind of work (detailed description of work): *Not working.*

This report provides another example of the continuous rewriting of B.’s history, since the terms used compressed more than ten years of asylum confinements. Simultaneously, it also officially confirmed that B. was a hopeless case. Nevertheless, the report was based on her medical file and it was obvious that B. was considered to be in a final state long before this form was completed. Nothing new was added to her biography but it allowed her whole life to be displayed on one page. In the end, it is not clear if the form was actually mailed to Berlin, because Aktion T4 was officially ended in August 1941. It was, however, a kind of official death sentence, even if not executed until 1943.

7.6.2 *Anna Maria’s way into death*

Only six nursing notes and five psychiatrist’s notes exist from 1942, and they are mostly reiterations of the same story. In October 1942, she was diagnosed with tuberculosis of the bone after a large abscess was drained. Transfer to Sahlenburg, an institution specializing in the treatment of patients with tuberculosis, was ruled out because of her “psychological condition.”

She was sent back to Langenhorn, where her long term prognosis was deemed “very uncertain, specifically because of the poor general condition the patient is in and because of her difficult eating habits,” a clear indication that even the surgeon judged B.’s life as worth nothing

However, her parents understood the impact of this diagnosis. Her father wrote the following letter to the medical director of Langenhorn.

Filled with great concern for the health of my daughter Anna Maria B. (House 4) I allow myself to ask if there isn’t anything that can be done to keep her alive.

Anna Maria is such a talented and hard-working person when she is healthy that one can say her life is worth living and is productive. I would be happy to pay any extra cost that might occur in connection with special treatment.

Would it be possible to send my daughter to a specialized clinic for respiratory diseases? If this is not possible, could you at least give her some whole milk and provide her with healthier food. Other patients with tuberculosis also get milk. She did not have this disease when she was admitted to your clinic so the disease should still be in its beginning state and should be curable with good food and fresh air.

I am looking forward to your reply.

With German regards,

J. B.

This letter is interesting from two perspectives. First, although B.’s father was implicitly criticizing the treatment in Langenhorn, he wrote somewhat defensively, seemingly aware that the letter would become part of the medical record and read by the medical director, as holder of absolute power and with the potential to use it against the patient. These letters thus cannot be read as undistorted historical documents. Second, it is clear that the parents knew what this diagnosis meant for their daughter. By referring to her productivity and thus worthy life when she was healthy was a way of using the logic of Nazi propaganda in an attempt to save the life of his daughter. It was a counterargument to the claim (particularly to authors like Hoche and Binding) that mentally ill persons were considered wasters of national wealth. The medical director, however, refused the father’s requests for better treatment and nutrition for his daughter, arguing that the parents had to pay for these extra expenses themselves. B.’s father paid 1.50RM out of pocket, more than one-fourth of the whole boarding wages.

The nurses' notes break off once more and are resumed only three months later just before the psychiatrist made his next rounds on 17 February 1943. The nurses wrote that B. remained "noisy and agitated" and that she "received package in which she didn't stay calmly," package meaning the cold wet sheet packs in which patients were tightly wrapped. The reference to "package" highlights once again the importance of background knowledge in the use of terms that were not self-explanatory.

In the final note in B.'s record, recorded on 20 June 1943, the nurse wrote that B. was "disoriented and very confused, mistakes people." She was "very agitated and loud, lashed out," hitting the head nurse on her back, after which she was confined to a single room. This last note might have been the trigger for the decision to transfer B. to Hadamar. As discussed earlier head nurses made the decisions to transfer patients to the other asylums or to Hadamar. For someone like B. who was already living in the "zone of exception," any incident could become a reason for transfer. In any case B. was transferred to Hadamar five days later, and on 5 July 1943, it was recorded that B. had come "down with intestinal catarrh and heart failure" and that her mother had been informed. On that day the senior psychiatrist wrote the following letter to her parents.

Your daughter Anna has developed the condition of enteritis. The progression of the illness indicates that it is the result of a tubercular process. As a consequence of its fast progression and the patient's irregular food consumption the patient's physical condition has weakened considerably. Due to the bad mental condition the patient is in, a deterioration of her general condition is possible. Visits are permitted.
5/7.43 H.

B. died the next day, her death attributed to "enteritis colitis." As pointed out in the introduction, this was the usual procedure in Hadamar – despite the letter, the reality is that B was killed in the gas chamber soon after she arrived at Hadamar.

7.7 Horrorism

Hannah Arendt, in her book *Origins of Totalitarianism*, presented a perspective on the atrocities committed by nurses and psychiatrists which can be read from a biopolitical standpoint. Focusing on concentration and extermination camps, she argued that victims were randomly chosen and “even without being accused, declared unfit to live.” Extending this analysis to sick persons in asylums, she wrote that

Freedom in this system has not only dwindled down to its last and apparently still indestructible guarantee, the possibility of suicide, but has lost its distinctive mark because the consequences of its exercise are shared with completely innocent people. If Hitler had had the time to realize his dream of a German Health Bill, the man suffering from a lung disease would have been subject to the same fate as a Communist in the early and a Jew in the later years of Nazi regime.⁸²

The concentration and extermination camps served not only as extermination machines but also as laboratories for experiments of all kind, especially medical experiments. Citing Adolf Hitler, Arendt presented the path to total domination, which for him could only happen

if each and every person can be reduced to a never changing identity of reactions, so that every one of these bundles can be exchanged at random for any other. The problem is to fabricate something that does not exist, namely, a kind of human species resembling other animal species whose only “freedom” would consist in “preserving the species.”⁸³

According to Arendt, under scientifically controlled conditions, the camps were to eliminate spontaneity as an expression of human behaviour and to transform “the human personality into a mere thing, into something that even animals are not.”⁸⁴ The camp was an experiment in total domination, transforming humans into “uncomplaining animals,” and thus into “the true central institution of totalitarian power.”⁸⁵ The horror of the concentration camps can never be fully reported “for the very reason that the survivor returns to the world of the living, which makes it impossible for him to believe fully in his own past experiences. It is as though he had a story to tell from another planet, for the status of the inmates in the world of the living, where nobody is supposed to know if they are alive or dead, is such that it is as though they had never been born.”⁸⁶

The camps were economically useless and even when shortages of building material and rolling stock appeared in the midst of war, the Nazis “set up enormous, costly extermination factories and transported millions of people back and forth.”⁸⁷ Arendt’s description of the extermination camps can be applied, on a smaller scale, to psychiatric asylums. The techniques of killing were developed and deployed in the asylums, even after the official end of Aktion T4, with some personnel moving into the extermination camps. Arendt goes even further than Agamben, however, because to her it was not only a question of distinguishing between *bios* and *zoé*, as in Agamben, but that the significance of “death” and “life” was decided on an ontological criterion. For Arendt, according to Adriana Cavarero, horror had to do with the human condition. “It consists precisely in the perversion of a living and a dying that, in the Lager [camp], are no longer such, because they concern a living being understood as ‘a specimen of the animal-species man’ in which the uniqueness of every human being, and hence the necessarily unique dimension of life that concludes with death, has been annihilated.”⁸⁸ From this perspective, horror “has to do with the *killing of uniqueness*” and consists “in an attack on the *ontological material* that transforms unique beings into a mass of superfluous beings.” The murder of these actively produced beings is, according to Arendt, “as impersonal as the squashing of a gnat.”⁸⁹ This analysis has highlighted many of the mechanisms and methods employed to transform “unique beings into a mass of superfluous beings.” What remained at the end were “ghastly marionettes with human faces”⁹⁰ that had nothing more of the human about them.

As was shown in B.’s case, this was often a lengthy process, one which often began long before the Nazis gained power. Arendt described these “ghastly marionettes,” these specimens “of the animal-species man,” as automatons who behaved like the dogs in Pavlov’s experiment. But, as Cavarero emphasized, this

Is not an example of the canine species observed in its natural behavior but rather a dog of a perverted kind. The “ghastly marionettes” are indeed perverted with respect to the natural spontaneity that is rooted in the uniqueness of every human being: they are the result of a systematic destruction of the human being that the laboratory of the Lager carries out

in order to demonstrate “that everything is possible.”⁹¹

To my mind, this is an exact description of what happened in the “zone of exception” within asylums. It is not enough to concentrate just on the killings that took place during the “euthanasia” action under the Nazi regime. In order to understand the role of nurses in these atrocious crimes, one has to carefully analyze how nurses themselves produced these “ghastly marionettes.”

¹ Staatsarchiv Hansestadt Hamburg 352-8-7, Staatskrankenanstalt Langenhorn, Abl.1-1995, Krankenakte 28338 (hereafter Patient Record (PR), Friedrichsberg Medical Records Section (hereafter FMR), nursing notes (hereafter NN). This designation will be used throughout to identify Anna Maria B's patient record; other patient files mentioned in the text will be identified with their unique file number.

² Wilhelm Weygandt, *Die Staatskrankenanstalt Friedrichsberg. Hygiene und soziale Hygiene in Hamburg. Zur neunzigsten Versammlung der deutschen Naturforscher und Ärzte in Hamburg im Jahre 1928*, ed. Gesundheitsbehörde Hamburg (Hamburg: Paul Hartung Verlag, 1928), 186.

³ Staatsarchiv Hansestadt Hamburg 352-8-7, Staatskrankenanstalt Langenhorn, Abl.1-1995, Krankenakte 28338 (hereafter Patient Record (PR), Friedrichsberg Medical Records Section (hereafter FMR), psychiatric notes (hereafter PN).

⁴ Ibid.

⁵ Klaus Böhme and Uwe Lohalm, eds. *Wege in den Tod. Hamburgs Anstalt Langenhorn und die Euthanasie in der Zeit des Nationalsozialismus* (Cloppenburg: Ergebnisse Verlag, 1993); Klaus Böhme, ed. *1893-1993 100 Jahre Allgemeines Krankenhaus Ochsenzoll* (Hamburg: Sozialtherapiezentrum des AK Ochsenzoll, 1993); Michael Wunder, *Euthanasie in den letzten Kriegsjahren. Die Jahre 1944 und 1945 in der Heil- und Pflegeanstalt Hamburg Langenhorn* (Husum: Matthiesen, 1992).

⁶ PR FMR NN.

⁷ PR FMR PN.

⁸ Reiner Keller, *Wissenssoziologische Diskursanalyse. Grundlegung eines Forschungsprogramms* (Wiesbaden: VS Verlag, 2005), 230.

⁹ Michel Foucault, "Le jeu de Michel Foucault," in *Dits et Ecrits*, eds. Michel Foucault et al, Vol. 3 (Paris: Gallimard, 1994), 299.

¹⁰ Ibid.

¹¹ Gilles Deleuze, "Qu'est-ce qu'un dispositif?" in *Michel Foucault philosophe. Rencontre internationale Paris, 9,10,11 Janvier 1988* (Paris: Éditions du Seuil, 1989), 186 [translation mine].

¹² Ibid.

¹³ Ibid.

¹⁴ Ibid., 186.

¹⁵ Ibid., 187.

¹⁶ Ibid.

¹⁷ Jeffrey Bussolini, "What is a Dispositive?" *Foucault Studies* 10 (2010), 100.

<http://rauli.cbs.dk/index.php/foucault-studies/article/viewFile/3120/3294> (accessed 10 January 2011).

¹⁸ Bleuler, *Lehrbuch der Psychiatrie*, 165.

¹⁹ Michel Foucault, *Le pouvoir psychiatrique. Cours au collège de France. 1973-1974*, eds. François Ewald et al (France: Seuil/Gallimard, 2003), 178.

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- ²⁰ Weygandt, *Die Staatskrankenanstalt Friedrichsberg, Hygiene und soziale Hygiene in Hamburg*, 194.
- ²¹ PR FMR NN.
- ²² PR FMR NN.
- ²³ PR FMR PN.
- ²⁴ Harold Garfinkel, "Good Organizational Reasons for 'Bad' Clinic Records," in *Studies in Ethnomethodology*, 186-207 (Cambridge: Polity Press, 2010), 198.
- ²⁵ Staatsarchiv Hansestadt Hamburg 352-8-7, Staatskrankenanstalt Langenhorn, Abl.1-1995, Krankenakte 28338 (hereafter Patient Record (PR), Langenhorn Medical Records Section (hereafter LMR), nursing notes (hereafter NN).
- ²⁶ Dr Buder, "Über das Alleinlegen," *Die Irrenpflege. Monatsschrift für Irren- und Krankenpflege* no.22 (1918): 2.
- ²⁷ Ibid., 7.
- ²⁸ Ibid., 6.
- ²⁹ Bruno Latour, "Visualisation and Cognition: Thinking with Eyes and Hands," *Knowledge and Society* no. 6 (1986): 7.
- ³⁰ Thomas Lemke, "Die politische Ökonomie des Lebens - Biopolitik und Rassismus bei Michel Foucault und Giorgio Agamben," <http://www.thomaslemkeweb.de/publikationen/Die%20politische%20D6konomie%20des%20Lebens%2001.pdf> (accessed 07 December 2007).
- ³¹ Paul Rabinow and Nikolas Rose, "Biopower Today," *BioSocieties*, no. 1 (2006): 195-217.
- ³² Agamben, *Homo Sacer: Sovereign Power and Bare Life*, trans Daniel Heller-Roazen (Stanford, California: Stanford University Press, 1998), 15; Agamben, *Homo sacer. Die Souveränität der Macht und das nackte Leben*, trans. Hubert Thüring (Frankfurt a.M.: Suhrkamp, 2002), 25.
- ³³ Agamben, *Homo Sacer: Sovereign Power and Bare Life*, 17; Agamben, *Homo sacer. Die Souveränität der Macht und das nackte Leben*, 26.
- ³⁴ Agamben, *Homo Sacer: Sovereign Power and Bare Life*, 18 [original emphasis].
- ³⁵ Ibid., 18. [original emphasis].
- ³⁶ Giorgio Agamben, *Ausnahmezustand*, trans. Ulrich Müller-Schöll (Frankfurt a.M.: Suhrkamp, 2004); Giorgio Agamben, *State of Exception*, trans. Kevin Attell (Chicago: University of Chicago Press, 2005).
- ³⁷ Michel Foucault, "Governmentality, " in *Power. Essential Works of Foucault 1954-1984*, ed. James D. Faubion, 201-222 (London: Penguin Books, 1994), 218.
- ³⁸ Michel Foucault, *Society must be Defended: Lectures at the Collège de France 1975-1976*, English series ed. by Arnold I. Davidson, trans. David Macey (United States of America: Picador, 2003), 258; Michel Foucault, *Il faut défendre la société. Cours au Collège de France. 1976* (France: Seuil/Gallimard, 1997), 230.
- ³⁹ Lemke, "Die politische Ökonomie des Lebens," 18.
- ⁴⁰ Foucault, *Society must be Defended*, 256; Foucault, *Il faut défendre la société*, 228-229

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- ⁴¹ Primo Levi, *Les naufragés et les rescapés. Quarante ans après Auschwitz*, trans. André Maugé (France: Arcades Gallimard, 2008); Primo Levi, *Si c'est un homme*, trans. Martine Schruoffenegger (France: Julliard, 2008); David Rousset, *Les Jours de notre mort* (Paris: Hachette Littératures, 2008); David Rousset, *L'univers Concentrationnaire* (France: Les Éditions de minuit, 2005).
- ⁴² Agamben, *Homo Sacer: Sovereign Power and Bare Life*, 185.
- ⁴³ Ibid.
- ⁴⁴ Dorothea Buck, "70 Years of Coercion in German Psychiatric Institutions, Experienced and Witnessed," <http://www.bpe-online.de/1/buck-wpa-2007-e.pdf> (accessed 10 April 2011).
- ⁴⁵ Agamben, *Homo Sacer: Sovereign Power and Bare Life*, 170.
- ⁴⁶ Ibid.
- ⁴⁷ Ibid., 171.
- ⁴⁸ Ibid.
- ⁴⁹ Judith Butler, "Indefinite Detention," in *Precarious Life: The Powers of Mourning and Violence*, (London, New York: Verso, 2004), 51-100; Judith Butler and Gayatri Chakravorty Spivak, *Who Sings the Nation-State?: Language, Politics, Belonging* (London ; New York: Seagull Books, 2007); Michel Foucault, "Two Lectures," in *Power/Knowledge: Selected Interviews and Other Writings, 1972-1977*, ed. Colin Gordon (New York: Pantheon, 1980), 78-108; Michel Foucault, "The Subject and Power," in *Michel Foucault: Beyond Structuralism and Hermeneutics*, eds. Hubert L. Dreyfus and Paul Rabinow (Chicago: University of Chicago Press, 1983), 208-226; Foucault, *Der Wille zum Wissen. Sexualität und Wahrheit 1*, trans. Ulrich Raulff and Walter Seitter (Frankfurt a.M.: Suhrkamp, 1989); Foucault, "Le jeu de Michel Foucault"; Foucault, *Governmentality*; Foucault, *Il faut défendre la société*; Michel Foucault, *Sécurité, Territoire, Population. Cours au Collège de France. 1977-1978* (France: Seuil/Gallimard, 2004); Michel Foucault, *Geschichte der Gouvernementalität I. Sicherheit, Territorien, Bevölkerung*, trans. Claudia Brede-Konersmann and Jürgen Schröder, ed. Michel Sennelart (Frankfurt a.M.: Suhrkamp, 2004); David Fraser, "Dead Man Walking: Law and Ethics After Giorgio Agamben's Auschwitz," *International Journal for the Semiotics of Law* 12 (1999): 397-417; Lemke, *Die politische Ökonomie des Lebens*, 18; Rabinow and Rose, "Biopower Today," 195-217; Katherina Zakravsky, "'Homo Sacer' and the Consequences. Two Remarks on Holocaust Commemoration and 'Bare Life' in Contemporary Art," <http://magazines.documenta.de/attachment/000000778.pdf> (accessed 27 December 2007) Katherina Zakravsky, "Zur Kritik des 'nackten Lebens'," <http://platform.factlink.net/fsDownload/Katherina%20Zakravsky-Enthuellungen.Zur%20Kritik%20des%20nackten%20Lebens.pdf?forumid=336&v=1&id=235172> (accessed 07 July 2009).
- ⁵⁰ Agamben, *Homo Sacer: Sovereign Power and Bare Life*, 171
- ⁵¹ Susan Benedict, Arthur Caplan and Traute Lafrenz Page, "Duty and 'Euthanasia': The Nurses of Meseritz-Obrawalde," *Nursing Ethics* 14, no. 6 (Nov., 2007): 781-794; Susan Benedict and Jane M. Georges, "Nurses and the Sterilization Experiments of Auschwitz: A Postmodernist Perspective," *Nursing*

Inquiry 13, no. 4 (Dec, 2006): 277-288; Susan Benedict, "Killing while Caring: The Nurses of Hadamar," *Issues in Mental Health Nursing* 24, no. 1 (Jan-Feb, 2003): 59-79; Susan Benedict, "The Nadir of Nursing: Nurse-Perpetrators of the Ravensbrück Concentration Camp," *Nursing History Review* 11, (2003): 129-146.; Susan Benedict and Jochen Kuhla, "Nurses' Participation in the Euthanasia Programs of Nazi Germany," *Western Journal of Nursing Research* 21, no. 2 (April 1999): 246-263; Maria Berghs, Bernadette Dierckx de Casterlé and Chris Gastmans, "Practices of Responsibility and Nurses during the Euthanasia Programs of Nazi Germany: A Discussion Paper," *International Journal of Nursing Studies* 44, no. 5 (Jul, 2007): 845-854; Barbara L. Brush, "Nursing Care and Context in Theresienstadt," *Western Journal of Nursing Research* 26, no. 8 (Dec, 2004): 860-871; Bronwyn Rebekah McFarland-Icke, *Nurses in Nazi Germany: Moral Choice in History* (Princeton, N.J.: Princeton University Press, 1999); Hilde Steppe, "Nursing in the Third Reich," *History of Nursing Society Journal* 3, no. 4 (1991): 21-37; Hilde Steppe, "Nursing in Nazi Germany," *Western Journal of Nursing Research* 14, no. 6 (1992): 744-744; Hilde Steppe, *Krankenpflege im Nationalsozialismus* (Frankfurt a.M.: Mabuse, 2001).

⁵² Agamben, *Homo Sacer: Sovereign Power and Bare Life*, 171.

⁵³ Agamben, *State of Exception*, 87-88.

⁵⁴ Staatsarchiv Hansestadt Hamburg 352-8-7, Staatskrankenanstalt Langenhorn, Abl.1-1995, Krankenakte 28338 (hereafter Patient Record (PR), Langenhorn Administrative Records Section (hereafter LAR).

⁵⁵ *Law for the Prevention Hereditarily Diseased Offspring*, (1935), <http://www.facinghistorycampus.org/campus/rm.nsf/0/81C67A69F8081A5885257037005E9C6A> (accessed 07 January 2009).

⁵⁶ During my archival research I found a file entitled "Sterilizations. Individual cases. 1934-1940, 1941" that contains a large number of lists with the dates of the court sessions in Langenhorn. From this list it is perceivable that the sessions were limited to fifteen minutes per case. This file contains also a large number of transport lists, because Langenhorn was designated to issue sterilization reports for persons who were not hospitalized. These persons were required to be admitted for a period of six weeks in order to be observed by the psychiatrist. Staatsarchiv HH 352-8-7 Staatskrankenanstalt Langenhorn 134, "Sterilisationen. Einzelfälle. 1934-1940, 1941."

⁵⁷ Latour, "Visualisation and Cognition," 3; Bruno Latour, "The Powers of Association," in *Power, Action, and Belief: A New Sociology of Knowledge*, ed. John Law (London: Routledge and Kegan Paul, 1986), 20-40.

⁵⁸ Latour, "Visualisation and Cognition", 6

⁵⁹ PR LMR PN.

⁶⁰ Ibid.

⁶¹ Ibid.

⁶² Ibid.

⁶³ Ibid.

⁶⁴ Ibid.

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- ⁶⁵ Buck, "70 Years of Coercion in German Psychiatric Institutions."
- ⁶⁶ Bleuler, *Lehrbuch der Psychiatrie*, 330.
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8 Conclusion

The aim of this research project was to highlight the role of nurses in the killing of psychiatric patients during the time of the Nazi regime, through an analysis of patient records obtained from two psychiatric hospitals in Hamburg. The research hypothesis was that scientific discourses of that time, found within medical textbooks and nursing journals, shaped the recordings of nurses and psychiatrists on the patients' files. This research focused on deciphering the interrelationships between these discourses and the patient notes in order to demonstrate that what was written in the notes was not dependent on the individual "author," but rather was the product of scientific classifications and discourses, and, as a result, produced the perception of having a life not worth living.

When the data collection and analysis of the records was initiated, it quickly became evident that the research study was significantly more complex than originally thought. First of all, it became clear that there were ongoing suspicions among historians that patients were being killed in German psychiatric hospitals long before the Nazi regime and that the killings continued after the end of World War II. My research supports theory that the killing of patients did not occur solely due to Nazi ideology but rather was founded on what can be referred to as "psychiatric practice." Second, many techniques to "treat" patients, ranging from enforced bed rest, isolation cells, continuous baths, to medications etc., were noted in the records. The deployment of these techniques suggests that the psychiatric practice somehow actively produced individual lives that asylum personnel considered not worth living. In order to understand the mechanisms that enabled the killing of psychiatric patients, it was necessary to analyze in detail the impact of these different techniques on the patient. Third, to understand how the killings were enabled necessitated examining not only with scientific discourses in psychiatry in vogue in the early twentieth century but also with actual asylum psychiatric practice.

The functioning of the asylum can only be understood by analyzing psychiatric practice as a strategic interplay of political technologies aimed at establishing a kind of reality that was forced onto patients. As such, the analysis had to be broadened in order to grasp this strategic interplay. Some records were several hundred pages long but others were very short and concise. While patients remained in hospital for various lengths of time, some “constructed” in these records endured a hospital “career” that spanned several decades. The record, and consequently the act of note taking to develop the record, therefore had specific relevance to the field of psychiatry. Psychiatric personnel reported their observations in them but patients’ very identities were constructed through these records. My results can be summarized into three distinct axes.

8.1 The Killing of Patients Before and After the Nazi Regime.

Evidence exists to support the fact that patients were already being killed in German asylums from the end of WWI on, and that the killings continued after the end of WWII. The reason for these killings must be searched for within the field of psychiatric practice. My findings suggest that psychiatric practice was a mechanism of “normalization” that continually attempted to classify what was considered normal behaviour and what was not, and who was deemed curable and who was not. The two hospitals that are the focus of my analysis can be distinguished by the fact that Friedrichsberg (asylum of the University of Hamburg and the admission clinic for Hamburg) was responsible for the “curable” patients, whereas Langenhorn (a long-term asylum) admitted those considered “hopeless.” Though the files used in my analysis were obtained from Langenhorn, the medical histories from Friedrichsberg are part of these records. Within these asylums, zones were erected to contain patients who were classified as being unworthy of living; persons who were already classified as socially dead before they were physically killed. My analysis highlights how these zones were constructed and how patients “disappeared” into what I have termed these spaces of exception.

8.2 Psychiatric Practice.

The psychiatric asylum was just part of a psychiatric practice that could best be described as a disciplinary practice. This practice was based on a power structure that hierarchically placed the psychiatrist at the top. The nurses, as the delegated representatives of the psychiatrist's power, were strategically positioned "beneath" the patient, because only from this position was it feasible for them to understand the patient in every detail and to influence his or her behaviour in depth. Psychiatric practice (termed a practice and not a discourse because the asylum cannot be understood by scientific discourses alone) was characterized by this disciplinary power, because it was an anonymous power that aimed to influence the conduct of the patient. Nurses played a crucial role in this practice, as they were able to reach out and influence the patients' innermost thoughts and behaviours. The problem, however, was that scientific knowledge had no considerable impact on psychiatric practice itself. For example, patient treatment remained the same regardless of individual diagnoses. Therapy always aimed to influence patients' behaviour and the means employed to treat them were always the same. Irrespective of any psychiatric theory (if such a theory existed), the practice of psychiatry continued to construct a strategic power field within the asylum.

The asylum can be metaphorically understood as the body of the psychiatrist: every part of the asylum and everyone working within the asylum functioned as an extension or part of his body. The psychiatrist, for example, signed every paper that was ultimately included in the record; nothing in the asylum could happen without his knowledge. This strategic power imbalance erected a reality within the asylum that had nothing in common with the reality of the patient. The insurmountable, disciplinary power of psychiatry thus confronted the "absolute" power of the insane – absolute because patients tried to force their reality onto their surroundings by, for example, by claiming that "somebody is talking to me." By imposing their own "rules," patients opposed the "reality of the asylum."

Opposing this form of power was the strategic power distribution of psychiatric practice, which intervened to correct and influence certain behaviours of the insane. It was not related to a specific person but rather performed through a complex interplay of different actors. As a result, the asylum became a space where a kind of war took place between the disciplinary power of psychiatry (representing the “absolute will” of the psychiatrist) and the absolute power of the mentally ill. Nevertheless, if psychiatric practice was not founded on scientific discourse but was based on nothing more than the play of disciplinary power, then the questions remains: Why should this space be marked as a medical space and why should the psychiatrist be considered a doctor?

Herein lies another aspect of the relationship of power. A psychiatrist can only take on the role of doctor if the patient demonstrates symptoms of a recognized illness, and only when the patient plays out the symptoms of a mental illness does the psychiatrist transform from jailer to physician. Simultaneously, only at the moment in which people accept that they have symptoms (or confess something like “yes, I hear voices,” etc.) do they become patients. Foucault calls this the “double enthronement” because this moment must occur in order for the psychiatrist to become a physician and for the patients, for whom the asylum was constructed, to acknowledge their mental illness. To the same effect, the record is constructed as a kind of “container of evidence” to support the insanity of the patient, because only with this collective evidence is the psychiatrist then maintained as the physician.

This leads to a paradoxical situation wherein psychiatric practice tries to anticipate certain behaviours or to intervene before they occur, yet at the same time it provokes these same behaviours. To analyze this strategic power field means grasping the intricate connections between a myriad of “technologies of power” that are directed onto the body of the patient and are aimed at profoundly transforming him or her. The asylum can thus be perceived as a kind of machine and psychiatric practice as a complex interplay between discourses, technologies, architecture, institutions – in other words, a *dispositif*. Apart from attempting to intrude the will

of the psychiatrist into the patient, the dispositif installs certain lines of visibility, which is to say that within a dispositif only those aspects upon which the dispositif sheds light are visible. The question of what becomes visible or not within the dispositif is bound up with technologies of power, which allow an understanding of how knowledge is inscribed within the practical exercise of power, authority, and rule. The focus of such an analysis includes what a specific form of knowledge does and makes possible, and how it operates in relation to organized regimes of institutional practices and practical rationalities. A specific knowledge shapes particular ways of representing, seeing, acting, and intervening. Within networks, power is more or less the result of the successful coordination or alignment of different actors. Technical objects define and distribute roles to humans and non-humans and are linked to inscription devices of various sorts that include checklists, codes, records, and official documents. My analysis highlights, for example, how the record constructed the identity of the patient and became the only reliable source of her biography. When Anna Maria B. ceased to talk altogether, the record spoke in her place. The record not only represented the patient, but it also distributed specific roles to the nurses, psychiatrists, administrators, and so on. Furthermore, it initiated further action, intervening, for example, in her sterilization process and in the selection of her for murdering.

Technology approaches the forces of the body and the aptitudes and capabilities of individuals in order to shape their behaviour. It is invested with a strategic rationality that seeks to subsume the patient's conduct to the requirements of psychiatry, to introduce the will of the psychiatrist into the patient's core. The success of these interventions was determined by their ability to influence patient behaviour. Every time B. behaved in a certain way that the nurses deemed illegitimate, they intervened with a whole range of specific devices that included patient restraints, isolation cells, and continuous baths. Even the shock therapies and medications used were first and foremost aimed at converting her behaviour, as the notes clearly indicated. This analysis highlights how this strategic interplay between different actors resulted in the production of patients as "empty shells" that could justifiably be murdered.

These technologies often produced effects that were not completely calculated. When B. was incarcerated in an isolation cell for long periods of time, she began to talk to herself, threw her excrement, and started to destroy the mattress on which she had to sleep. Her isolation was meant to prevent her from disturbing the routine of the ward but it also had the consequence of bringing out a panoply of symptoms, demonstrating that technologies employed within psychiatric practice often produced behaviours later treated as deviant. Technology was therefore the will of the psychiatrists made durable; the nurses were simply those applying it.

8.3 The Relevance of the Records.

The medical record played an active, constitutive role because it shaped and maintained the patient's trajectory in the asylum and was involved in the construction of hierarchical relations between patients and psychiatrists and psychiatrists and nurses. The record functioned as a "mediator" because it mediated the relations that acted and worked through it, transforming social interaction.

The medical record was activated through the practice of reading and writing. These practices, in which the record was turned to, leafed through, read, used for jotting, communicated through or dispatched, formed a crucial part of the socio-technical organization of medical work. Without these practices, the record would lack relevance. These activities allowed it to have its mediating role in the organization. The psychiatrist could only be a psychiatrist, nurses could only be nurses, and the patient could only be diagnosed as mentally ill on the condition that this interrelation of people and paperwork existed. As previously described above, psychiatric practice was a complete appropriation of the patient's body and implied its complete control of it. The act of writing the record was a necessary precondition in allowing this appropriation of his or her body. Without the record, the discipline of psychiatry could not produce evidence; the writing of the record enabled information on "everything" that transpired and everything" that the individual did to be transferred from the bottom up. Furthermore, these written records enabled

information to be accessible at anytime and hence assured the principle of the permanent visibility of the disciplinary system.

It is, of course, inaccurate to state that these scripts captured everything – every action and observation of the patient – because information was selectively compiled and included in the record. Not everything was noted because the space in the record was limited and the recorded information had to be written in such a manner that it was useable in the workspace. Since the written information became evidence of the madness of the patient, how the psychiatrists and nurses depicted this insanity depended on the descriptive categories they selected and employed in the record (and these categories were derived from scientific discourses). Information from diverse sources was constantly compressed into short statements of “what really happened” and summarized into “what was the case.” The psychiatrists condensed the information gathered from tests, patients, their relatives, nurses, and previous entries, to create a concise statement of the relevant “problems” and their histories. The patient’s history was thus selectively re-written. Detailed descriptions were lost within pages and were no longer considered factual. They were summarized in one sentence, and later, in one word, as was the case in the re-formulation of B.’s case history in the sterilization process and later in the *Meldebogen* T4.

This ongoing re-summarizing also contributed to the construction of narratives in which the ambiguities, the ad hoc and fluid character of the medical work, were lost. This restructuring was required to produce an account supporting specific actions or enabling effective communication of what was going on. This reconstruction work can be seen in the medical examination form for B.’s sterilization in 1935, the discharge letter from Eppendorf in 1942, as well as in the *Meldebogen* T4. Almost every sentence of these reports reflected a history of repeated reconstructive work.

Documents possess the ability to coordinate different levels within a disciplinary system and by “objectifying” information, they govern complex disciplinary systems. Documentary reality evolves and significantly affects the patient’s situation in the asylum. For example, the

Meldebogen T4 was specially designed as a kind of checklist to identify patients who were destined to be killed. Completing this report pronounced a verdict, thus making the form performative. A court proceeding was necessary to decide on B.'s sterilization. The asylum was transformed into a courtroom and the psychiatrist became simultaneously the expert witness, judge, and executioner. This process was a virtual process because all the correspondence between the court, the patient, and her family took place in the record; it became a Kafkaesque process because B. was not informed of what was going on, and the sentence was executed without providing her the opportunity to intervene.

Through the writing of the documents, a direct and continuous relation between the script and the patient's body was established. The visibility of the patient's body and the permanence of the script cannot be separated, an effect that could be called a schematized and centralized individualization. It is only through the record that the "somatic singularity" becomes an individual, and the biography that evolves becomes the history of the individual. The patient's body, gestures, behaviours, and discourses are surrounded by a script-tissue (a graphic plasma) that records, codes, and schematizes. This centralized individualization is of crucial significance for psychiatric practice, because the "insane" have to recognize themselves within their written biographies. They must acknowledge that the events reported in their own records really happened, and only if they are capable of recognizing themselves do they have a chance of being cured. The mechanisms of this "identity construction" correspond to Althusser's explanation of the constitution of subjects. Only at the moment that a somatic singularity is hailed by the power, and in turn, reacts to it, does it become a subject.

The analysis also demonstrated that the making of the text in the record proceeded through different stages. First of all, the nurses noted their observations according to descriptive categories that they had learned during their training. Second, the psychiatrists reformulated the nurses' notes according to their own diagnostic pattern, and seemingly followed from the nurses' notes as if they were based inductively on "what really happened." All of the work that the nurses

invested in their own notes (especially the utilization of different technologies) was invisible in those written by the psychiatrists. Third, the psychiatrists' notes become part of other official documents that led to further interventions (for example the *Meldebogen* T4).

Based on this understanding, the crucial point of my analysis is the following: if it is correct that the somatic singularity becomes an individual only through the fact that notes are taken and written down, then this implies that if the note taking stops, the individual ceases to be an individual and falls into a zone of indifference. The patient's identity breaks down, because the patient no longer exists within the documentation. If these patients cease to exist in the record, then this implies that anything could be done with them, because they are socially dead – reduced to their “bare life.” From a certain moment on, after some patients were transferred to Langenhorn, they seemed to disappear from the record. They existed only in the psychiatrists' notes, often taken irregularly, and in the administration record. In sum, patients like Anna Maria B. disappeared from the record, and then physically disappeared through their murders. Nonetheless, we must never forget that patients' intense suffering during their stay in the asylum was real and it must be acknowledged.

8.4 Limitations of the Study and Further Research

Finally, some important limitations of the present study must be emphasized. Two elements of the record were only barely mentioned in the analysis. The first was the photographs that the psychiatrists took throughout Anna Maria B.'s multiple admissions to the asylums and which have been placed in Appendix 2. These photographs deserve a detailed study of their own since they were “immutable mobiles” as defined in chapter 5, and made the madness visible at a glance. Also part of her record is the collection of drawings she did, only some of which were able to be mentioned. Psychiatrists, as “art critics,” labeled these drawings as “degenerate art” and thus they became more visible evidence of B's madness. They, too, need an analysis of their own. The drawings are contained in Appendix 3.

Although this study was supported by information gleaned from other patient records, it focused primarily on one medical file. Thus, there are obvious limitations on its ability to claim that the results can be generalized. To widen its scope, more systematic analysis could be carried out to understand the differences and similarities within different German asylums in the same time period as this study. Further research could also be conducted on files from different periods of time, especially the period after the end of the Second World War. Finally, studies of medical files from different countries and institutional settings, particularly in psychiatric practices, could provide an international perspective on the role and function of both the record itself and nurses' contributions to it.

Nonetheless, the strength of this study lies in its demonstration of how fruitful a detailed analysis of one medical record can be. The Nazi regime carries certain kinds of perceptions; it is viewed as a particularly brutal era but also one that is in the past. This kind of analysis, however, has implications for nurses and nursing practice that reach into the present. It sheds light on how concepts of norms and the idea of normalization – as a subconscious part of everyday medical practice – are transcribed onto the written record. It describes how the written record – and the role that nurses play in its construction – has real power to shape the identity of patients, with potentially devastating consequences for them. Since the medical record continues to be the prime form of communication about patients and their treatment, it is my belief that nurses need to know their history.

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Martha M. O. A.	13986
Elisabeth E. A. F.	10243
Richard R. H. A.	23121
Alwine K.	26752
Martha E. A.	16292
Werner A. F. R., Dr.	22694
Henriette A.	23548
Heinrich M.	27846
Erika W.	23856
Karl W. E. B.	23536

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10 Appendix 1 – Codesystem of the Analysis (MAXQDA 10)

Codesystem as generated in MAXQDA-10 for the Analysis of the Medical Record 28338. In []

the number of allocated codes.

Codesystem [2907]

Normality

- Talks well-regulated [1]
- Better approachable [8]
- Answering well-regulated [2]
- Nice and friendly [19]
- Doing housework [18]
- Being freer/lively [10]
- Playing games [2]
- Being outdoor (garden) [4]
- Being orderly/obliging [4]
- To put on clothes [1]
- Being industrious [18]
- Recognizing other people [1]
- Drawing/writing/looking at pictures [26]
- Searching for human contact/relatives [1]

Fever charts and schedules as inscription devices

- Pepsin-Salzsäure [48]
- Brustwickel/Transpulmin [5]
- Table of weights [14]
- Food schedule [9]
- Rise in temperature/fever chart [26]
- Tube feeding [15]
 - Forced feeding [10]
- Enema [5]
- Colonic irrigation [9]
- Catheterization [3]

Drawings and writings [7]

Disciplinary interventions

- Packing [1]
- Allowance of being outside/day room [17]
- Plugin bed board [9]
- Belt [12]
- Insulin [7]
- Cardiazol [22]
- Eugenzym [1]
- Bedrest [4]
- Isolation [55]
- Continuous bath [21]
- Overcome with other nurses [2]
- Paraldehyde [54]
 - per clysmas [37]
- Encouraging to work [1]
- Bringing the patient in [3]

Guard ward/noisy hall [18]
Digitalis [6]
Luminal [3]
Morphine-Scopolamine [63]
Injections [21]

From nurses' reports to doctor's reports [63]

From former hospital reports [3]
Interruption of the records (physicians) [7]
Interruption of the records (nurses) [29]

The search for symptoms:

The Friedrichsberg nurses' accounts

The introduction and the search for symptoms [1]

Agressions

Rampaged [7]
Agressions against herself [2]
Scratching [3]
Tears out her hair [11]
To be naughty/disobedience [8]
Getting mad [2]
Throwing things or food [13]
Sticking the tongue out [1]
Active resistance [17]
Blocks her ears [1]
Agression against nurses [13]
Agression against other patients/relatives [27]
Hits the nurses [15]
Hits other patients/relatives [24]

Patient unchanged [60]

Nothing remarkable/nothing new [9]

The bed

Trying to get out of the restraint belt [2]
Beating against the bed/destroying the bed [5]
Beating against barrier bed boards [8]
Throwing things out of the bed [5]
Packing around/walk around with bedclothes [27]
Wet the bed and incontinence [22]
'On the run' from bed (Bettflüchtig) [7]
Being outside the bed [92]
Lay down in other people's beds [6]
Sitting up in the bed, not disturbing [4]
Standing up in the bed, disturbing [13]
Quiet = staying docile in bed [34]
Quiet at night [197]
Too quiet = sleeping during the day [5]
To do nothing [2]
Trying to get into the bed [3]
Autistic [1]
No contact with others [2]
Hiding under the blanket/hiding her face [8]
Apathetic [5]
Listless in bed [5]

Refusal to speak [23]

Being quiet = not disturbing [77]

Submitting to nurses' orders [21]

Death wish [5]

Somatic aspects [0]

Infections [1]

Seizure without medication [1]

Back pain [3]

Injury/wound [4]

Angina/rise in temperature [2]

Retention of urine [1]

Vomiting [3]

Moaning [4]

Impassive or apathetic [11]

Running around senselessly [3]

Patient must be dressed [5]

Encouragement to do something [28]

Standing around helplessly/no interests [76]

Insane actions [36]

Often using the toilet [2]

Turning on the taps/dabble in water [6]

Cheeky and overestimation of her abilities [4]

Childlike way of behaving [2]

Does not recognize other people [3]

Taking things from others [2]

Doing something stupid [2]

Unable to play games [2]

Playing with knitting [2]

Trying to climb over the fence [3]

Sitting/Climbing at inadmissible places [5]

Taking the food of others [7]

Destroying own drawings [2]

Dirty [7]

Soiled things/herself with feces/urine [10]

Tearing the shirt/linen [7]

Surges out of the hall/garden [4]

Spitting around [26]

Sadness and crying [15]

Sudden change of mood [14]

Question - answer game

Answers to questions [11]

No answers to questions [14]

Annoyed or agitated [68]

Tenseness [2]

Sleepless or restless at night [49]

Shouting and disturbing [31]

Being unmannerly [4]

Irritated [3]

Furious [6]

Religious remarks [4]

Singing and laughing [25]

Talking to herself/talking senseless [41]

Being noisy [42]

In the night [49]

Reluctant (widerstrebend) and aggressive [12]

Nudity and obscene behaviour [30]

- Lively (lebhaft) [34]
- Impossibility to pacify the patient [5]
- Verbatim reports [45]
- Eating and drinking**
 - Wants to eat all the time [6]
 - Independently eating or drinking [88]
 - Persuasion to eat [15]
 - In need of assistance/Feeding [36]
 - Refusal to eat [52]
 - Aggressive resistance against feeding [9]
- Hallucinations** [14]

The Friedrichsberger medical accounts

- The Barmbek doctor's reports**
 - The introduction and the search for insanity [3]
 - Fear [2]
 - Nutrition refusal [2]
 - Locked (Abgesperrt) [3]
 - Nudity and appearance [1]
 - Hallucinations [1]
 - Tranquility and approachability [2]
 - Excitement and agitation [3]
 - Noisy, troublesome, and bluster [1]
 - Getaway from bed (Bettflucht) [1]
 - Drug administration [1]
 - Let insanity speak [2]
 - Aggressiveness and hazard [1]
- The introduction and the search for insanity** [3]
 - Diagnosis medical officer/admission's diagnosis [2]
 - See former hospital reports [3]
 - Interrogations and confessions [7]
- Insane actions** [11]
 - Ridiculous [2]
 - Unpredictable [11]
 - Religious remarks [2]
 - 'On the run from bed' (Bettflüchtig) [4]
 - Childish behavior [6]
 - Noisy [7]
 - Does not recognize people [1]
 - Drawing and writing [2]
 - Trying to climb over the fence [1]
 - Taking the food of other patients [1]
 - Destroying drawings/things [5]
 - Beating against the bed [1]
 - Senseless speech [9]
 - Lay down in other's beds [1]
 - Spitting around [5]
 - Surges out of the room [1]
- Refusal to eat** [8]
 - Tube feeding [3]
- Agitation (unmotivated)** [32]
 - Compulsive behavior [5]
 - Aimless [3]
- Stupor** [11]

- No affect/dismissive [4]
- Without any initiative [2]
- Not orientated [1]
- Does not talk/no answers to questions [8]
 - No rapport possible [3]
 - No nexus possible [4]
- No contact to other patients [4]
- Catatonia [3]
- Agressions**
 - Unpredictable changes aggressions-calmness [2]
 - Rampage [1]
 - Agression against herself [5]
 - Agressive-negativistic [8]
 - Throwing things [4]
 - Beating other patients [4]
 - Beating the nurses [2]
 - Agression and lash out [4]
- Dementia praecox** [1]
 - Hebephrenia [1]
 - Helplessness [1]
 - Impression of being forced [1]
 - Tenseness [2]
- Surgical intervention** [1]
- Old schizophrenic** [4]
 - Command-automatism [1]
 - Atonic posture [1]
 - Dumbing-down physiognomie [1]
 - Wrinkled face [1]
 - No mimic [2]
 - Psychic obliteration [2]
 - Already sterilized [3]
 - Deficiency syndrom [1]
- Dementia** [1]
- Frightend** [2]
- Unchanged** [9]
- Dirty** [2]
 - Must be supported [1]
- Hallucinations/paranoia** [12]
- Nudity** [4]
- Reluctant** [1]
- Mannerism (Manierismus, maniert)** [2]
- Transfer to another ward** [7]
- Autistic/Mutism** [14]
 - Agonized [1]
 - Paralysed [3]
 - Blocked (gesperrt) [9]
 - Dumb [3]
- Anxiously moaning** [1]
- Medical sterilization examination**
 - Sterilization report [2]
 - Sterilization [2]
- Disciplinary interventions** [6]
 - The murder [1]
 - Transfer to Langenhorn [2]
 - Transfer to Hadamar [1]
 - Cardiazol [1]

Insulin [1]

Normality

Beginning to be lively [2]

Orderly [1]

Quiet [3]

Getting in contact with others [2]

Reform [3]

Cheerful [1]

Spontaneously eating [3]

Increase in weight [1]

Busy with something [7]

Returning to normal [2]

Drawing [5]

The admission ceremony

Physical versus psychic [2]

Constitution [5]

Lumbar puncture and laboratory [1]

The medical certificate for admission/diagnosis [2]

The first friction in the behavior [1]

The search for crucial experiences [1]

Gathering the hereditary family situation [1]

The vocational/school biography [2]

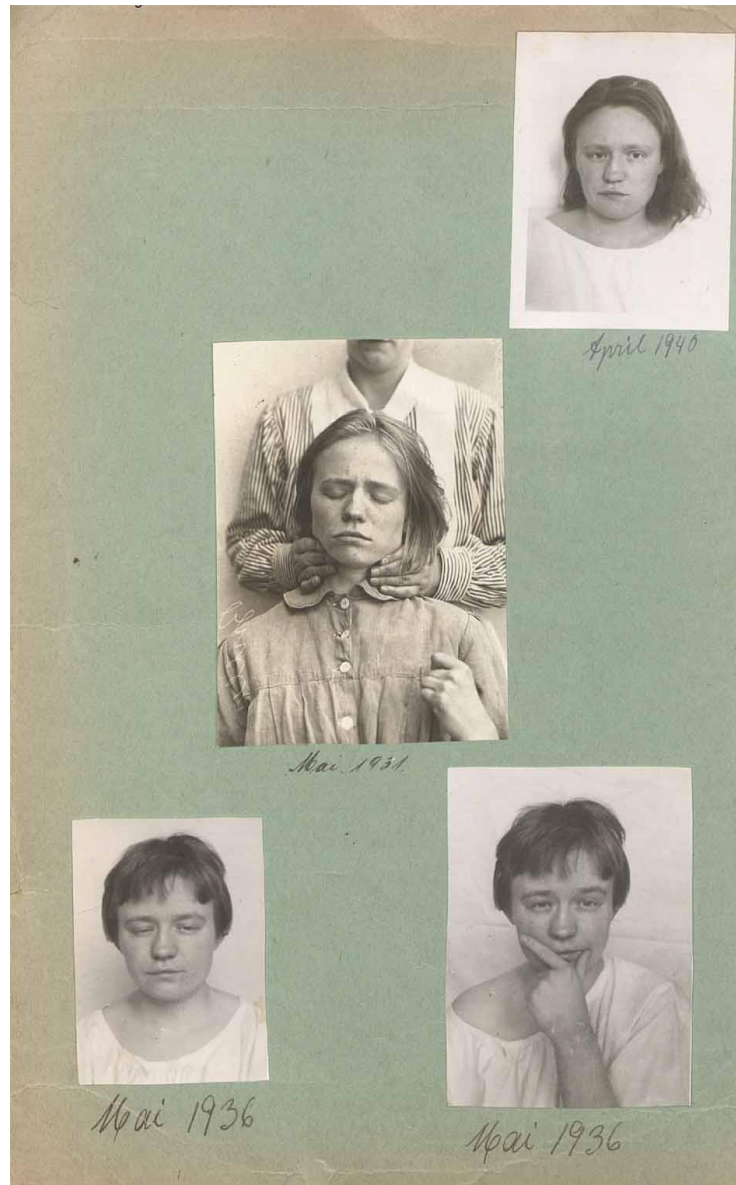
The first signs from the perspective of the relatives [2]

Behavior and talking prior to the 'official diagnosis' [1]

Behavior and talking after the 'official diagnosis' [1]

11 Appendix 2 – Admission Photographies of Anna Maria B.

Photographies of Anna Maria B. made by the psychiatrists, with the year specifications.



12 Appendix 3 – Drawings

Some of Anna Maria B.'s drawings.

