Repute and Remedy: Psychiatric Patients and their Treatment at Bethlem Royal Hospital, 1930-1983

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

Jennifer M. Walke

Abstract

Bethlem Royal Hospital is Britain's oldest and arguably foremost mental hospital; a centre of psychiatric innovation notable for its early acceptance of voluntary, predominantly middle-class, patients. The study begins with the 1930 Mental Treatment Act, which endorsed voluntary and outpatient psychiatric treatment, and ends with the 1983 Mental Health Act, which placed legal controls on certain therapies, and introduced the Mental Health Act Commission. Although not wholly representative of other institutions, scrutiny of Bethlem can inform debates on the flux of ideas and methods within twentieth-century psychiatry, and further knowledge of the hospital in this era.

The primary research aim is to analyse the changing nature of institutional care for psychiatric patients in mid twentieth-century Britain, through a case study of Bethlem Royal Hospital. Secondary objectives are to:

- Explore the role of legislative frameworks in shaping the institution in terms of admissions and governance;
- Investigate changing definitions of mental illness through analysis of the composition of patients with respect to their diagnosis and social factors;
- Examine the impact of scientific developments in the theory and practice of psychiatry on service organisation and treatment.

At the local level, combined admissions data and qualitative evidence provide a detailed, contextualised account of the Bethlem inpatient 'journey'. Four national level themes emerged: first, a consumerist model of mental health was evidenced through hospital marketing materials, and, reciprocally, the preferences of patients and their families. A second key theme was a mid twentieth-century transition from aetiologic to diagnostic frameworks of mental illness. Thirdly, gender-specific attributions and treatment observed in interwar records were followed, in subsequent decades, by signs of a 'meeting of minds' in recorded experiences of male and female inpatients. Finally, this thesis addresses how changes in patients' backgrounds, knowledge, and

expectations, were intertwined with the development of psychotherapeutic approaches.

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Abbreviations

AEGIS	Aid to the Elderly in Government Institutions
BBC	British Broadcasting Corporation
BMA	British Medical Association
BMJ	British Medical Journal
BRHAM	Bethlem Royal Hospital Archives and Museum
CAT	Computerised Axial Tomography
CBT	Cognitive Behavioural Therapy
CHU	Charles Hood Unit
DPM	Diploma in Psychological Medicine
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECT	Electroconvulsive Therapy
EMS	Emergency Medical Services
GPI	General Paralysis of the Insane
GRO	General Register Office
ICD	International Classification of Diseases and Causes of Death
IoP	Institute of Psychiatry
IPA	International Psycho-Analytical Association
LC	Lunacy Commissioners
LCC	London County Council
MRC	Medical Research Council
MRI	Magnetic Resonance Imaging
NAMH	National Association for Mental Health
NHS	National Health Service
PET	Positron-Electron Tomography
RAMC	Royal Army Medical Corps
RMPA	Royal Medico-Psychological Association
SAP	Society of Analytical Psychology
SLAM	South London and Maudsley
WFMH	World Federation of Mental Health
WHO	World Health Organization
WWII	World War Two

Acknowledgements

Chapter 1: Introduction

Situating Madness

Andrew Scull posited that, between the eighteenth and twentieth centuries, 'the place occupied by madness has varied sharply, symbolically as well as concretely'.[1] Traditional legal emphases on containment and protection of the insane are still reflected in varying degrees in modern mental health legislation,[2] with diverse historical interpretations vying for dominance.[3] The nineteenth-century convergence of humanitarian concern and patient-authored exposés[4] granted an early glimpse into the inner life of the institution, and, arguably, facilitated statutory regulation. Yet, even the supposedly 'reformed' institutions retained a largely clandestine existence, socially and physically isolated from the wider community; a climate that, according to Steven Cherry, had supported the persistence of an abundance of historical tropes:

> nineteenth-century asylums have been generally depicted as hierarchical, male-dominated, isolated communities, offering forms of control ranging from custody to cure and involving processes of control....there has been less research on twentieth-century hospitals, although the 'war neuroses', controversial physical and pharmaceutical treatments, patients' rights and the debate surrounding de-institutionalisation and community care have attracted considerable attention.[5]

There was a pronounced rise and fall in psychiatric inpatient populations between the opening and closing decades of the twentieth century.[6] Yet, developments of this period have been largely overshadowed by the ideological pillars of the psychotropic drug 'revolution' and decarceration, both serving as distractions from the continued existence of psychiatric hospitals, their staff, and patients. Asylum literature

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[1] Andrew Scull, "The Insanity of Place," *History of Psychiatry* 15, no. 4 (2004): p.417.

[2] Joanna Moncrieff, "The Politics of a New Mental Health Act," *British Journal of Psychiatry* 183, no. 1 (2003): pp.8-9.

[3] Kathleen Jones, *A History of the Mental Health Services* (London: Routledge, 1972), p.153.

[4] See, for example, Urbane Metcalf, *The Interior of Bethlehem Hospital* (London: The Author, 1818).

[5] Steven Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum, St. Andrew's Hospital, 1810-1998* (Suffolk: The Boydell Press, 2003), p.305.

[6] Trevor Turner, "The History of Deinstitutionalization and Reinstitutionalization," *Psychiatry* 3, no. 9 (2004): p.1.

consequently has the capacity to make important contributions to current understandings of the recent history of psychiatry and its institutions, and to dispel thriving misconceptions. Furthermore, a refocusing of attention on the everyday life of individual institutions can help to deconstruct the notion of a prototypical 'asylum' experience, replacing it with a more nuanced picture of the cultures of different hospitals and the people connected to them.

Contributors to the asylum history genre have included health professionals, academics, patients, or their family members; a spectrum of background and opinion which raises issues of author subjectivity, in that 'the historian of the contemporary scene must work from a viewpoint'.[7] Moreover, such work can lack critical distance and any appreciation of the wider sociopolitical and scientific environment, drawing instead on a select corpus of (often promotional) institutional records. Lindsay Granshaw and Roy Porter proposed that 'accounts of individual institutions have barely scratched the surface of their significance'. Being predominantly written by doctors, they are inclined to focus on medical staff rather than patients or other hospital employees.[8] David H. Clark typified this trend in chronicling Fulbourn Hospital[9] where he previously occupied a consultancy role. Nevertheless, Granshaw and Porter believed that mental hospitals are now receiving renewed historical interest as one facet of a wider social critique encouraging investigation of a range of institutions. They identified a number of key sources from which valuable hospital information could be ascertained, without recourse to doctors' published memoirs.[10] Jonathan Andrews provided additional explanation of the rationale, strengths and challenges in the historical use of patient casenotes,[11] whilst, in his analysis of the casebooks of Victorian era patients in Ticehurst (a private madhouse) Trevor Turner also outlined the key aims and potential benefits of research involving this genre of archived

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[7] R. Hunter and I. Macalpine, *Psychiatry for the Poor: 1851 Colney Hatch Asylum - Friern Hospital 1973* (Folkestone: Dawsons of Pall Mall, 1974), p.12.

[8] Lindsay Granshaw and Roy Porter, eds., *The Hospital in History* (London: Routledge, 1989), p.1.

[9] D.H. Clark, *The Story of a Mental Hospital: Fulbourn, 1853-1983* (London: Process Press Ltd, 1996).

[10] Granshaw and Porter, eds., *The Hospital in History*, pp.1-3.

[11] Jonathan Andrews, "Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century," *Social History of Medicine* 11, no. 2 (1998): pp.255-281.

material. [12] Barbara Taylor further proposed that historians may find themselves witnesses to, and, on occasion, participants in, the 'disintegrating remnants' of the recent past.[13] Within the present research, 'madness' is situated within the experiences of twentieth-century psychiatric inpatients, and interpreted through a range of lay and professional perspectives. Practical and ethical issues of such enquiry are fully explored in chapter 3, which outlines methods used in this thesis, and the respective contributions of particular asylum histories are further discussed in the literature review.

Twentieth-Century Psychiatry

The twentieth century witnessed a trajectory of attempts to understand, to treat, and to otherwise cope, with mental illness. New theories of mental life emerged, with psychosocial and organic frameworks jostling for supremacy. On the one hand, there was the inception and diffusion of Freudian psychoanalysis;[14] on the other, well-documented 'breakthroughs' in the efficacy and availability of drug-based treatments.[15] Shifting beliefs surrounding the origins of mental illness contributed to the ascent of physical treatments, many of which are now subject to scientific and ethical doubt. Meanwhile, the mental health profession expanded and diversified, its language and ideas permeating mainstream society.[16] This cursory 'snapshot' conveys the vibrancy of psychiatric interest and activity over the past century, and the field's escalating impact on everyday life, but alludes also to the sometimes transitory support for ideas and methods.

Spearheading a 'period of experiment and reform' the 1930 Mental Treatment Act heralded the arrival of an era in which mental disorder could finally be regarded as an integral part of medicine. Although not repealing the 1890 Lunacy Act, it 'provided

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[12] Trevor Turner, "A Diagnostic Analysis of the Casebooks of Ticehurst House Asylum, 1845-1890," (University of London: Unpublished thesis, 1990).

[13] Barbara Taylor, "The Demise of the Asylum in Late Twentieth-Century Britain: A Personal History," *Transactions of the Royal Historical Society (Sixth Series)* 21: December (2011): p.193.

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

[15] David Healy, *The Creation of Psychopharmacology* (Cambridge, MA; London: Harvard University Press, 2002).

[16] Dean Rapp, "The Early Discovery of Freud by the British General Educated Public, 1912-1919," *Social History of Medicine* 3, no. 2 (1990): pp.217-243.

another system to parallel it, and, it was hoped, in time to render it out of date'.[17] Key features included provision for voluntary treatment in mental hospitals, funding for outpatient work, and the abolition of older terminology. Thus, from the 1930s, institutions had to reconsider the suitability of diagnoses and therapies offered to rising numbers of 'informal' admissions. This typified a general trend towards patients as care consumers, and prompts questions about the role of this new clientele in shaping treatment provision.

Alex Mold suggests that, 'making patients into consumers is a process that began many decades ago and has yet to reach a conclusion'. In 1960s Britain, 'it was not uncommon for patients to be told little about their illness, its prognosis or treatment' or to be used for teaching or research purposes without their consent or knowledge. In this climate, consumerism offered practical tools by formalising rights, representation, and regulation.[18] More broadly, Matthew Hilton asserts that consumerism was intertwined with class and gender, such that 'In the first half of the twentieth century … the consumer was considered largely a working-class housewife …By mid-century [a] middle-class housewife, [and]… By the 1950s had increasingly become a gender neutral category'.[19]

As one facet of the emerging 'welfare state', The National Health Service (NHS) Act revolutionised the structure and operation of healthcare services in Great Britain. Responsibility for all but small psychiatric homes became a national rather than local authority concern, and treatments free at the point of delivery. Nearly half the beds absorbed by the fledgling NHS were in mental or mental deficiency hospitals, together with inmates of the Poor Law institutions and thousands more awaiting admission or requiring community care. Prior to the NHS, hospitals were dependent on middle-class patients to boost both their income and reputation. The social class of admissions also exerted an influence on treatment directions, in terms of financial costs, patient/family expectations and clinical judgements on the 'suitability' of certain approaches, notably

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[17] Kathleen Jones, *Asylums and After. A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s* (London: The Athlone Press, 1993), p.135.
[18] Alex Mold, "Making British Patients into Consumers," *Lancet* 385, no. 9975 (2015): pp.1286-1287.
[19] Matthew Hilton, "The Female Consumer and the Politics of Consumption in Twentieth-Century Britain," *The Historical Journal* 45, no. 1 (2002): p.103.

psychotherapy. The latter approaches, whilst gaining credibility and popularity in the interwar years, proved costly and time-consuming. Subsequent decades heralded both a proliferation of psychiatric nomenclature and increased pharmaceutical industry involvement in shaping notions of mental illness causation and cure. This array of competing demands has led to speculation of the validity of novel diagnoses, and disagreement as to whether new methods were adopted on the basis of clinical results, or simply because they aligned with economic and social imperatives.

The 1960s have been regarded as *the* critical decade in British psychiatry, with radical overhauls of existing health policy and service organisation. In his 'Watertower Speech' of 1961, Minister for Health, Enoch Powell called for large-scale asylum closure in favour of community-based services; demands based reportedly declining long-stay mental hospital populations.[20] This rousing address foreshadowed the National Hospital Plan (1962), within which psychiatry was to become a core speciality of new District General Hospitals, and mental hospital provision halved. Other motives ascribed to this policy include a desired convergence with general medicine, therapeutic optimism, and comparison with pioneering general hospital units.[21] Furthermore, anti-psychiatry works of the 1960s and 70s popularised the notion of insanity as a social construct, problematised by medicine, politics and law; views which gathered support from both inside and outside of the psychiatric profession. Jones described how biological and constructionist views on the origins of mental illness were similarly invoked as justification for spending cuts and asylum closure.[22]

The 1983 Mental Health Act represented official acknowledgement of the civil rights movement's welfare concerns, further empowering patients with respect to consent and discharge, narrowing taxonomies of mental illness, and strengthening the community care role of social services.[23] The Act also created the Mental Health Act

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[20] G.C. Tooth and Eileen M. Brooke, "Trends in the Mental Hospital Population and Their Effect on Future Planning," *Lancet*, no. April 1 (1961): pp.710-713.

[21] R. Mayou, "The History of General Hospital Psychiatry," *British Journal of Psychiatry* 155, no. 6 (1989): p.772.

[22] Jones, *Asylums and After*, p.193.

[23] MIND, *The Mental Health Act 1983: An Outline Guide* (2009 [cited 20/09/13]); available from http://www.mind.org.uk/help/rights_and_legislation/mental_health_act_1983_an_outline_guide.

Commission to monitor the quality of care received by patients.[24] Further investigation can help ascertain whether historians have exaggerated the influence and novelty of such views in effecting institutional reform in this period; identify the various opportunities and challenges posed by the community care model, and the consequences of local government restructuring.

Research Aims and Objectives

Having depicted the twentieth century as a period of vital change in psychiatry and mental health therapies, this thesis will now examine how these issues played out within a specific institutional setting. In so doing, the study is located within the aforementioned new generation of asylum historiography, which takes the hospital as the starting point for examination of wider sociocultural and therapeutic phenomena. The primary research aim is to analyse the changing nature of institutional care for psychiatric patients in mid-twentieth-century Britain, though a case study of Bethlem Royal Hospital. The specific timeframe of 1930-1983 is apposite on both local and national levels. The study is thus 'bookended' by key mental health legislation, whilst 1930 also marked the relocation of the hospital from London to Kent, the implications of which are explored below.

Secondary objectives are to:
- Explore the role of legislative frameworks in shaping the institution in terms of admissions and governance;
- Investigate changing definitions of mental illness through analysis of the composition of patients with respect to their diagnosis and social factors;
- Examine the impact of scientific developments in the theory and practice of psychiatry on service organisation and treatment.

Bethlem Royal Hospital

Founded in 1247, Bethlem Royal Hospital is Britain's oldest and, perhaps, most prominent, mental institution, and represents a unique case study through which to

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[24] Jones, *Asylums and After*, p.209.

address some of the unresolved issues in the history of psychiatry. As a registered hospital,[25] exempt from the provisions of the 1890 Lunacy Act, Bethlem was dwarfed by the sprawling county and borough asylums, which received a larger proportion of the mentally ill in the early twentieth century. Before relocating to rural Kent in 1930, its Southwark base had just 200 beds, with an additional 50 becoming available after the move to its current site. Thus, it was situated close to the metropolitan heart of intellectual developments within twentieth-century psychiatry. The availability of an extensive and well-conserved archive also provides a superb platform from which to probe the minutiae of patient and practitioner records, and augment understandings of their experiences.

Since the late nineteenth century, Bethlem had styled itself as a semi-private institution and actively courted a better class of patient with a good prognosis. Medical opinion was marginalised in decisions relating to admissions; rather, hospital regulations and, increasingly, interests of patients and their relatives took precedence. Physical ward capacity and escalating overcrowding were ongoing considerations in admissions to the hospital, but other factors influenced the amount and type of patients accepted. The creation of the NHS heralded changing priorities, with an externally-imposed 'district commitment', informal and outpatient treatment options, and the burgeoning range of disorders all exerting an influence on the nature of admissions. This inevitably raises questions over how far Bethlem managed to sustain an exacting social and clinical selection process.

Another key issue for exploration is the extent to which Bethlem was distinctive in its aims and operation. Although, in some respects, there was nothing particularly unusual about the hospital's admissions procedure, in other ways, its practices were pioneering and presaged future mental health policy, notably its early acceptance of voluntary patients. Moreover, Bethlem achieved a unique popularity amongst the educated middle-classes, who were attracted by its comfortable environment, well-

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[25] Colin Gale, Bethlem Archivist, proposes that the term 'registered hospitals' denoted institutions which admitted lunatics, but were not (a) county lunatic asylums/mental hospitals or (b) licenced houses. Such institutions had to register with the Lunacy Commissioners/Board of Control, print regulations and send copies to the Commission, maintain a resident medical attendant, and were subject to the Commission's inspection regime. (C. Gale, personal communication, 1 May 2015).

publicised success rate, and relatively low fees.[26] This will be further discussed by reference to annual statistics and other archival data. The categories featured in admissions records afford insights into prevailing theories of mental illness causation, and the current research will apply a selective, but consistent range, across which fluctuations and longitudinal patterns can be established. These include total patient numbers, admission status, gender, social class, age, diagnosis and treatment allocation, length of admission and recovery rates. This will be accompanied by qualitative examination of treatment approaches at the hospital, drawing on a wider range of documentary sources, and interviews with former Bethlem staff members. As aforementioned accounts have demonstrated, such a combination of methods can prove fruitful in uncovering and untangling official and latent influences on therapeutic decision-making.

In 1948, Bethlem merged with the Maudsley Hospital; a move which granted it teaching status (and consequent exemption from the control of NHS Regional Hospital Boards) but also precipitated internal conflict over therapies, funding and staffing. Differing approaches nevertheless contributed to significant service expansion and diversification. Following the merger, the introduction of a district commitment, new specialisms and modes of accessing mental health care all significantly changed Bethlem's carefully honed patient demographic, narrowing the socioeconomic divide between the Joint Hospital and the area it served.[27] The present research will thus address the symbiotic relationship between institutions and their patients in service development, and the effects of 'democratised' access to treatment. Investigation will focus chiefly on Bethlem Royal Hospital for the pre-1948 period, as during this time, it was under separate administration to the Maudsley, and records for the latter institution are more limited. Subsequent to the merger, a growing proportion of services and record-keeping was conducted jointly, although discrete admissions registers were maintained for each 'partner'. These statistics show patterns of admission, treatment and outcome within the hospital itself, and possible disparities between hospital policy and practice in some of these areas. They will also enable comparisons with other institutions and contemporaneous social trends.

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[26] Jonathan Andrews et al., *The History of Bethlem* (London: Routledge, 1997), pp.649-651.
[27] Ibid., p.665.

Thesis Structure

The following chapter, chapter 2, comprises a literature review, subdivided into five separate areas. Thus, the first of these addresses contested views of the purpose of the asylum, debates surrounding decarceration, and the impact of anti-psychiatry. Declining inpatient populations, effective new drugs, and the desirability of aligning the treatment of mental illness with that of physical illness, all, by various accounts, precipitated the closure of psychiatric hospitals in the latter twentieth century. However, vociferous opponents viewed the move as primarily an economic measure, with psychiatric patients facing disposal to inadequate services, and a society oblivious or hostile to their needs. A second section considers emerging narratives on the relationship between psychiatry and twentieth-century British society, the roles of mental hygiene, governance, and 'psychological subjectivity'. This is followed in section 3, by an exploration of gender and mental health, and then, in section 4, by analysis of therapeutic trends and the delivery of mental health care both before and after the inception of the NHS. Attention is here devoted to the provenance of key physical, pharmaceutical, and psychological approaches, and contextual influences on their acceptance or rejection both within psychiatry and amongst the general public. A final section reflects upon how specific institutions, including Bethlem and the Maudsley Hospital, have responded to these wider legislative, social, and therapeutic developments.

Chapter 3 provides a detailed methodology, which outlines and justifies the qualitative and quantitative approaches selected for the study, their particular benefits (especially the historical use of patient casenotes) and the challenges encountered throughout the course of the research.

Results are presented across four chapters, the sources and themes of which are discussed below. Chapters 4 and 5 use information obtained from Bethlem admissions registers, to scrutinise the changing sociodemographic and clinical composition of the hospital's patients from the 1930s to the 1980s. Follow-up casenote and correspondence data provide finer detail of emerging trends, which are discussed in the context of contemporaneous institutional developments, General Register Office (GRO) statistics, and scientific literature. They also start to bring into view the lived

experience of the individual patients behind the numbers. Thus, chapter 4 concerns the age, gender, legal and social class, occupation, and marital status of Bethlem admissions, and the influence of such factors on proclivity to psychiatric diagnosis, hospital experiences, and prognosis. There is exploration of heightened attention to mental problems affecting the youngest and oldest sectors of society, and the emergence of hospital-based services and establishment of community links to these populations. Chapter 5 proceeds with an investigation of the changing forms and attributed causes of mental disorder, length of stay, and readmissions. Particular areas of concern are the emergence of 'new' diagnoses, the varying recognition and understanding they enjoyed from the psychiatric profession, and the spread of psychological discourses and language to wider society.

Changing attitudes and approaches to the treatment of mental illness are explored in chapters 6 and 7. In contrast to the statistical emphases of the previous two chapters, these sections are based on qualitative investigation of patient casenotes, unit-level records, staff publications, and interviews with a range of former Bethlem employees. Chapter 6 centres on physical and drug-based treatments within psychiatry, charting the twentieth-century advent and application of particular approaches and substances, and juxtaposing their use at Bethlem with both textbook guidance and institutional practices elsewhere. A parallel account of psychological therapies is presented in chapter 7, which outlines the suggested theoretical roots of a proliferation of 'talking treatments' from the early twentieth century, and considers the diverse external and localised determinants of their wavering acceptance, implementation, and credibility within public and professional spheres. It is acknowledged that this physical-psychological treatment dichotomy represents a somewhat artificial distinction, given the increasing overlap of these approaches, especially the use of drugs and psychotherapy. Both chapters nevertheless delineate the heritage of these methods, and build on the earlier database findings, in their recognition of a symbiotic relationship between therapeutic innovation, the changing social and clinical profile of psychiatric patients, and new ways of accessing treatment.

A final discussion chapter provides the opportunity to consolidate and reflect back on key findings from previous chapters, and to establish how this new evidence both fits

with existing institutional literature and contributes to macro level knowledge of the recent history of psychiatry. The local and national importance of the study is therefore delineated, the latter including Bethlem's contributions to debates on psychiatric diagnosis, the role of gender, the marketplace of psychiatric care, and the emergence of psychotherapy.

Chapter 2: Literature Review

There now follows an examination of interconnected debates within the recent history of psychiatry, highlighting areas of neglect or uncertainty for consideration in the present study. There is also consideration of the approaches and contributions of previous institutional case studies in this field, within which to situate the present research.

1. Perspectives on Asylums

Historical debate on the emergence and role of the psychiatric hospital has typically adopted a position at some point on the spectrum of curative to coercive explanations. Leading proponents such as Kathleen Jones have thus presented a benevolent reading of the asylum system and its associated legal reforms.[1] On the other hand, Scull himself variously condemned such 'museums of madness'[2] as 'a convenient way to get rid of inconvenient people',[3] whilst Michel Foucault regarded even the 'self-restraint' ethos of moral treatment as reliant upon instilling fear and guilt. Moreover, he believed that, through their internalisation of control, such methods naturally presaged psychotherapy, which 'doubled the absolute observation of the watcher with the endless monologue of the person watched – thus preserving the old asylum structure of non-reciprocal observation but balancing it, in a non-symmetrical reciprocity, by the new structure of language without response'.[4] These perspectives are revisited in later discussion of evolving institutional cultures in chapters 4-7.

Other positions have been offered in the curative/coercive debate. For example, following a more benevolent reading, Joan Busfield argued that a new package of welfare provisions arriving in the early twentieth century actively challenged the (Poor Law) philosophy that benefit should be a last resort. Former Bethlem archivist, Patricia

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[1] Kathleen Jones, *Asylums and After. A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s* (London: The Athlone Press, 1993).

[2] Andrew Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (London: Allen Lane, 1979).

[3] Andrew Scull, *Decarceration. Community Treatment and the Deviant: A Radical View* (Cambridge: Polity Press, 1984), p.33.

[4] Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. Richard Howard, 2003 ed. (London: Routledge, 1989; reprint, 2001), pp.234-238.

Allderidge, described 'cycles' in the care of the insane, challenging the notion that monitoring of institutional conditions or concern for inmate/inpatient welfare are wholly modern phenomena.[5] As one facet of such humanitarianism, high-profile asylum exposés initiated by mental hospital patients and staff in the nineteenth century accentuated ethical and welfare concerns, pressing for a review.

Mental Nursing

A (1922) protest work penned by Dr Montagu Lomax alleged neglect and casual cruelty at Prestwich Hospital.[6] Whilst this 'evidence' was largely discredited, it nevertheless prompted a formal investigation of hospital conditions,[7] which generated a set of principles around which mental nursing might develop. However, according to Peter Nolan, 'the Enquiry made clear its feeling that general nursing was the superior discipline by stating that mental nurses should ideally undertake both mental and general training, while general nurses need only spend a short time in mental training!' A 1946 Working Party sought to address recruitment problems by reducing mental health nurse training to two years, removing restrictions on married staff, and promoting part-time roles and use of male nurses.[8] Yet, Russell Barton was critical of the primacy given to training over temperament, suggesting

> In many cases nobody has ever shown [the sister] how to treat patients properly and how to handle them without browbeating them. Until a year or so ago, that know-how would not have helped her to pass the examinations necessary to get qualifications for the very job she was doing.[9]

The above account suggests a formal responsiveness and accountability to welfare concerns, but equally, a disregard for, or ignorance of, the value of mental health

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[5] P. Allderidge, "Hospitals, Madhouses and Asylums: Cycles in the Care of the Insane," *British Journal of Psychiatry* 134, no. 4 (1979): p.333.

[6] Montagu Lomax, *The Experiences of an Asylum Doctor : With Suggestions for Asylum and Lunacy Law Reform* (London: G. Allen & Unwin, 1922).

[7] Jones, *Asylums and After*, p.127.

[8] Peter Nolan, *A History of Mental Health Nursing* (London: Chapman & Hall, 1993), pp.83-84; 104-105.

[9] Russell Barton, *Institutional Neurosis*, 1st ed. (Bristol: Wright, 1959), pp.18-19.

nursing. In so doing, it typifies more general suppression of patient and public voices by entrenched professional prejudice; a theme which is revisited later in the thesis.

Dissenting Voices

The critical position of seeing psychiatric hospitals and the discipline itself as fundamentally coercive appears to underpin the social and cultural shift that occurred in the 1960s. Some factions desired more dramatic changes to mental health care than were already underway, with a rare convergence of left and right-wing support for asylum closure. Leftwing authors depicted psychiatry as one manifestation of the controlling arm of the bourgeoisie; for feminists it became emblematic of more general patriarchal power and gender inequalities. Sociologist Erving Goffman proposed that the 'total institution' actually aggravated long-term difficulties for people by fostering dependency, routine and isolation from normal everyday life.[10] In *Madness and Civilization,* Michel Foucault argued that mental illness was an eighteenth-century social construct, depicting institutions as tools of oppression and depersonalisation; their staff as agents of social control.[11] Furthermore, libertarian psychiatrist Thomas Szasz denied the very existence of mental illness, viewing psychiatric disorders as the product of medical misinterpretations imposed on social deviants,[12] whilst Ken Kesey's *One Flew Over the Cuckoo's Nest* also conceptualised psychiatric patients as nonconformists.[13] Within Britain, the work of R.D. Laing gained particular prominence, rejecting medical psychiatry and encouraging greater attention to patients' lived experiences.[14] His ideas and impact are explored in greater detail in chapter 7.

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[10] Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York: Anchor Books, 1961).

[11] Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. Richard Howard (London: Tavistock Publications, 1965).

[12] Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York: Harper & Row, 1974).

[13] Ken Kesey, *One Flew over the Cuckoo's Nest* (London: Picador Thirty, 2002).

[14] R.D. Laing, *The Divided Self: An Existential Study in Sanity and Madness* (Harmondsworth: Penguin Books, 1965).

Edward Shorter instead proposed that the backlash against asylums could be traced back to 'flourishing' anti-psychiatry lobbies in the nineteenth century,[15] and Freeman claimed that anti-psychiatry rhetoric actually exerted a comparatively minor influence on British psychiatry. Far more damaging, he suggested, were inconsistencies in care arising from trenchant professional hostilities between social workers and psychiatrists; a situation exacerbated by the (1968) Seebohm Committee's decision to withdraw the psychiatric social worker role. Thus, 'patients with severe disorders suffered at the hands of mental health workers who did not accept the reality of mental illness' and the 'instrumental and pragmatic' question of where patients should be treated 'was somehow converted into an ideological question, in which all inpatient care was assumed to be 'oppressive''.[16] The Royal College of Psychiatrists was finally established in 1971, after prolonged and persistent lobbying. In an attempt to align their training with that of other medical specialisms, the longstanding postgraduate Diploma in Psychological Medicine (DPM) was replaced by a new entrance exam.[17] This was followed by the inaugural Maudsley Lecture under the new College, entitled 'Morale in Clinical Medicine'.[18]

Introducing the 1975 White Paper, 'Better Services for the Mentally Ill', Labour Secretary of State, Barbara Castle, conceded the shortcomings of the Hospital Plan, cautiously noting the limited scope for progress within the near future, and voicing concern over the running down of mental hospitals before community-based alternatives were available. The text of the report was more positive, outlining idealistic proposals for expansion of social services, localisation of facilities, improved service coordination and increased staffing.[19] However, the widening chasm between medical and social workers allowed politicians to invoke both arguments in their attempts to justify spending cuts. Thus, if psychiatry was indeed a medical specialism, it warranted no additional provision; if, on the other hand, mental illness was a myth

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[15] Edward Shorter, *A History of Psychiatry: From the Asylum Era to the Age of Prozac* (New York: John Wiley and Sons, Inc, 1997), pp.273-277.

[16] Hugh Freeman, "Psychiatry in the National Health Service, 1948-1998," *British Journal of Psychiatry* 175 (1999): pp.6-7.

[17] Jones, *Asylums and After*, p.184.

[18] John Richardson, "Morale in Clinical Medicine: The Forty-Sixth Maudsley Lecture," *British Journal of Psychiatry* 120, no. 559 (1972): pp.593-599.

[19] Department of Health and Social Security, "Better Services for the Mentally Ill," (London: HMSO, 1975).

or social construct, then the development of dedicated community care facilities was unnecessary, if not harmful.[20]

At the inception of the NHS, the state took over many roles previously served by voluntary agencies, forcing them to review their structure and objectives. The National Association for Mental Health (NAMH) was founded in 1946 through a merger of three other organisations with shared experience of providing psychiatric support for war veterans, and later, civilian community care. The NAMH initially worked with both 'mentally deficient' (now 'learning disabled') and mentally ill populations, offering training courses for teachers and health and social workers, and running several institutions. With these functions being subsequently absorbed by the Department of Health, and having resisted an attempted takeover by the Church of Scientology, the NAMH embarked on a high-profile fundraising and public education campaign in 1971. The marked success of this activity prompted the rebirth of the organisation as 'MIND' the following year, and a concomitant shift in emphasis to legal advocacy and welfare rights.[21] In 1965, the pressure group AEGIS (Aid to the Elderly in Government Institutions) was established by Barbara Robb to campaign about the treatment of elderly people in the psychiatric and geriatric wards of British hospitals.[22] Robb's (1967) publication of *Sans Everything: a Case to Answer*[23] prompted government debates and formal investigation of conditions at several hospitals nationwide.

Outwardly sharing a similar ethos and agenda to earlier civil rights groups, the 1970s and 80s also saw the ascent of psychiatric service-user groups. This has been largely attributed both to a political climate which emphasised a voice for traditionally oppressed factions, and to an inevitably increasing number of people with experience of both inpatient and community care provision. The new groups were analogous to workers' trade unions, empowering mental patients to defend their rights against

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[20] Jones, *Asylums and After*, pp.190-193.

[21] MIND, *Our Achievements* (2013) [cited 24/04/15]; available from: http://www.mind.org.uk/about-us/our-achievements/.

[22] Two decades earlier, Aubrey Lewis had voiced concerns about the profound and multifarious challenges that an ageing population could present for mental health services; issues that are explored further in chapter 4. See also: Lewis, A. (1946) Ageing and senility: a major problem of psychiatry. *Journal of Mental Science*, 92, pp.150–70.

[23] Barbara Robb, "Sans Everything: A Case to Answer. Presented on Behalf of Aegis," (London: Nelson, 1967)

perceived political oppression and social control. One such 'Mental Patients' Union' was founded in 1972 by a small group of mental patients and supporters. With a strongly Marxist core, they demonised psychiatry as an instrument for social control of the working classes within a capitalist society; the psychiatrist himself cast as the "high priest" of technological society, exorcising the "devils" of social distress through physical therapies and drugs.[24]

Such accounts point to a gradual recasting of the psychiatric patient in terms of agency and entitlements, and highlight potential contributions of the current research in exploring whether this new emphasis on patients' rights was discernible within the institution.

2. Psychiatry and British Society in the Twentieth Century

A number of emerging accounts underline the need for scrutiny of new therapeutic domains and the interactions between patients and service providers, as a vital part of the changing landscape of twentieth-century psychiatry. Although the asylum has remained at the heart of psychiatric historiography, late twentieth-century decarceration has also provided momentum for a new generation of community-based studies[25] and patient-authored literature.[26] Nikolas Rose argued that the First World War resulted in increased governance of citizens' subjectivity; a 'battle for the mind' waged through new organisations, expertise and techniques. Madness was henceforth framed in terms of social hygiene, with early intervention and prophylaxis key to preventing large-scale neurosis and economic decline: 'winning the war was to require a concerted attempt to understand and govern the subjectivity of the citizen'.[27]

The conceptualisation of neurosis represents a particular challenge to asylum literature, because we have yet to learn how it played out institutionally. David Armstrong argued that, from the 1920s, new medicines, clinics, research

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[24] Andrew Roberts, "A Crusade for Dignity," *Guardian*, Wednesday September 3 2008.
[25] Val Harrington, "Voices Beyond the Asylum: A Post-War History of Mental Health Services in Manchester and Salford," (Unpublished Doctoral Thesis: The University of Manchester, 2008).
[26] Barbara Taylor, "The Demise of the Asylum in Late Twentieth-Century Britain: A Personal History," *Transactions of the Royal Historical Society (Sixth Series)* 21: December (2011), pp.193-215.
[27] Nikolas Rose, *Governing the Soul: The Shaping of the Private Self* (London; New York: Free Association Books, 1999), pp.15, 20-21.

establishments, and the early intervention of child guidance, all served as safeguards against unwanted outcomes in adult life, thus extending the reach of the 'psychiatric gaze' into an as yet asymptomatic population. The formulation of novel diagnostic groups – e.g. the 'nervous child', the 'difficult child' – captured clinical and educational interest, with particular concern reserved for the 'solitary child', who was construed as precariously normal, as liable to slip into inappropriate or problem behaviour without constant vigilance'. However, requisite controls could only be deployed, he argued, through comparable medical scrutiny of other domains of human activity, including homes and workplaces.[28] Armstrong conceptualised psychiatric epidemiology as a reciprocal shaping force in how people thought about mental illness, with the 'invention' of the neuroses a pivotal moment in the 'blurring of the distinction between the normal and the abnormal', which legitimised the sweeping medical gaze, permitting psychiatry to 'intrude into the very practice of medicine itself, observing, checking, correcting, monitoring'.[29]

Discussing the concept of 'suburban neurosis', Rhodri Hayward proposed that, rather than being 'an emergent phenomenon generated solely through...urban development, consumer opportunity, and individual psychology...its appearance was dependent upon new ways of imagining human nature, pathological anxiety, and epidemic infection that appeared in Britain after the end of the First World War'. He also ascribed the 'peculiar character of the suburban neurotic – her odd mixture of existential emptiness and sexual frustration' to competing theories of anxiety espoused by rival groups of psychiatrists,[30] thereby framing new terminology as partly a product of professional disagreement. The present study (chiefly chapter 5) provides a chance to test the above claims regarding the origins and implications of novel psychiatric diagnoses within the twentieth century.

Kathleen Jones described improvements in mental hospital conditions after the Great War, and linked the appearance of neuroses in returning soldiers to a reformulation of

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[28] David Armstrong, *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century* (Cambridge: Cambridge University Press, 1983), pp.26-27.
[29] Ibid., p.69.
[30] Rhodri Hayward, "Desperate Housewives and Model Amoebae: The Invention of Suburban Neurosis in Inter-War Britain," in *Health and the Modern Home*, ed. Mark Jackson (New York; London: Routledge, 2007), p.45.

psychiatric definitions and interventions.[31] However, Mathew Thomson challenged the centrality of the 'shellshock story', and academic elites, in the move from organic to psychological explanations of mental illness. Instead, he saw this as a fertile age for new understandings of mental health, and attributed greater agency to the 'subjects' themselves, in seeking, and formulating, new approaches. Thus, rather than the 'psy' disciplines infiltrating medicine, Thomson proposed that such ideas also penetrated the popular imagination. He believed that although wartime struggles may have led some people to turn away from the perceived 'indulgence' of psychology; for others, their faith challenged and anxieties raised by the conflict, it offered possible answers. Thomson saw self-fulfilment and individualism as integral to this wave of popular enthusiasm, which, he suggested, was disseminated through mass-market literature and social clubs, and often oriented towards an aspirational, female constituency.[32] This population would appear similar to the middle-class, voluntary, clientele prioritised by Bethlem in the early twentieth century, and the construing of them as a target market is discussed in chapter 4.

Jonathan Toms' *Mental Hygiene and Psychiatry in Modern Britain* also argues for a greater connection between concepts of self-government and mental health than that afforded by a Foucauldian framework of power/knowledge and 'governmentality'. In so doing, he is informed by, and builds upon, the contributions of Armstrong, Rose and Thomson, in mapping the wider terrain of psychological governance and subjectivity. Contra Thomson, Toms regards the Great War as a turning point for stimulating interest in psychoanalysis and developments within mental health services. Moreover, he considers (what Rose critically termed) the 'psy' professions, as crucial in opening up the family to scrutiny in the ensuing decades.[33] The present research (notably chapters 4 and 5) seeks traces of such governance or subjectivity within hospital records, as a means of testing this proposal. Perspectives on the public and professional reception of psychotherapy post-World War II are also explored later in the current chapter.

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[31] Jones, *Asylums and After*, p.142.
[32] Mathew Thomson, *Psychological Subjects: Identity, Culture, and Health in Twentieth-Century Britain* (Oxford: Oxford University Press, 2006), pp.7-9, 49-53.
[33] Jonathan Toms, *Mental Hygiene and Psychiatry in Modern Britain* (Basingstoke: Palgrave Macmillan, 2013), pp.34-35.

Contemporary readings of a new psychological subjectivity and selfhood have thus offered insights into shifting patterns of asylum usage and provision in the twentieth century. The current research will now permit testing of these ideas, and of the more specific hypotheses of Armstrong and Thomson, within a reputedly middle-class institutional milieu. Specifically, if Thomson is correct, we could expect to see elements of a consumerist agenda emerging in asylum care, with Bethlem the ideal place to look for its characteristics, given what is already known of its clientele. Scrutiny of the hospital will also afford insights into whether the idea of neurosis and a reframing of normal/abnormal behaviour were indeed taking hold, and the implications of this for admissions, diagnosis and therapy. Bethlem is again well-suited for this purpose, on the assumption that metropolitan staff were close to the heart of new ideas and therapeutic developments. Finally, an understanding of how new lay understandings were evolving can also help to trace the early glimmers of psychodynamic approaches, which are the focus of chapter 7.

3. Gender and Psychiatry

During the interwar period, the mental health needs of particular populations were thrown into sharp relief. Rising democratic and welfare concern took place alongside the growth of preventative models and early intervention work. The idea of a formative mother-child bond acquired popular and academic support, whilst child guidance clinics were established nationwide, numbering seventy by 1944.[34] Environmental changes acquired new significance with professional acknowledgment that, for children, 'evacuation has produced more troubles than bombings'.[35] A changing social environment also accentuated trends for increased longevity - especially amongst women - and the concomitant problem of hospital overcrowding.

Feminist scholarship over the last thirty to forty years has raised important questions about the 'predominance' of female psychiatric patients. Yet, the focus of historical

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[34] British Psychological Society, *A Chronology of Psychology in Britain 1853-1987* (2009 [cited 07/09/13)); available from http://hopc.bps.org.uk/document-download-area/document-download$.cfm?file_uuid=50A64D0E-1143-DFD0-7EA1-CE53AEADF8DC&ext=pdf.
[35] E. M. Creak and B. J. Shorting, "Child Psychiatry," *Journal of Mental Science,* 90, no. 378 (1944): p.375.

work has tended to be more on the gendering of the medical/diagnostic literature (and on literary representation) rather than on the asylum. Moreover, where female preponderance in the asylum has been noted it hasn't been explored.[36] Amid debates about coercive institutions and the rise of neurosis, key questions remain outstanding.

A well-documented female predominance in psychiatric historiography is ubiquitous but potentially misleading on several counts. Elaine Showalter argued that women were adversely constrained by social norms, whilst economic dependency placed them at greater risk of poverty-induced institutionalisation.[37] Phyllis Chesler also conceptualised mental illness in terms of sex roles, and asserted that women were doubly disadvantaged, whether they conformed to, or deviated from, accepted norms of behaviour and emotional expression.[38] She further implicated the asylum system in raising the *visibility* – rather than *amount* – of female patients, and clinicians in perpetuating misogynistic ideas and practices under a guise of scientific progress.[39]

The aforementioned phenomenon of neurosis has been of particular interest to historians of gender. Mark Micale described how a 'mysterious battery of shifting complaints' including anxiety, fatigue and obsessions, defied conventional classification and treatment, becoming known as the 'functional nervous disorders' (later referred to as 'neuroses').[40] The most prominent of these new disorders was 'neurasthenia', the precursor of 'nervous breakdown' and purportedly caused by the pressures of modern civilisation.[41] It came to represent a socially-acceptable malaise for a new class of patient, a turning point in the traditional doctor-patient relationship, and was intrinsically linked to the growth of so-called 'office' psychiatry for less serious forms of mental disorder.[42] This development was intertwined with the post-1930 expansion of psychoneuroses and voluntary treatment, and points to a need for closer scrutiny of the shifting relationship between aetiology and diagnosis, and of the

[36] Edgar Jones and Shahina Rahman, "Framing Mental Illness, 1923-1939: The Maudsley Hospital and Its Patients," *Social History of Medicine* 21, no. 1 (2008): pp.115-116.
[37] Elaine Showalter, *Hystories: Hysterical Epidemics and Modern Culture* (London: Picador, 1997), p.13.
[38] Phyllis Chesler, *Women and Madness*, 25th Anniversary ed. (London: Four Walls Eight Windows, 1997), pp.53-55.
[39] Ibid., pp.74, 97.
[40] Mark S. Micale, "The Psychiatric Body," in *Companion to Medicine in the Twentieth Century*, ed. Roger Cooter and John Pickstone (London: Routledge, 2003), pp.325-328.
[41] Showalter, *Hystories: Hysterical Epidemics and Modern Culture*, pp.64-65.
[42] Joan Busfield, *Managing Madness: Changing Ideas and Practice* (London: Hutchinson, 1986), p.301.

localised implementation and therapeutic consequences of psychiatric labels. This is developed in chapter 5 of the current study. More pragmatic considerations are the female bias in the general population and the effects of (gender-specific) ward closures.[43] The current research will allow an assessment of the relative influences of both external and localised factors in shaping the gender balance of Bethlem admissions[44] and thereby inform accounts of gendered influences on twentieth-century psychiatry.

4. Therapeutic Developments

The historiography suggests that the twentieth century was a period of therapeutic optimism about symptom management, buoyed both by the arrival of new drugs and legal frameworks, and with the emphasis on mind more than body. The present study will explore whether the Bethlem experience conforms to this view.

According to Roy Porter, psychiatry has traditionally addressed contentious twin goals of achieving a scientific understanding of mental illness and of healing its sufferers. The former objective was prioritised in the late nineteenth century, as psychiatry sought acceptance as a bona fide profession, within a strongly positivistic medical climate.[45] However, Micale depicted psychiatry by the twentieth century as characterised by efforts to 'determine the place of the body in the sciences of the mind'. The resulting theories were broadly classified as either 'psychosocial' – emphasising external factors in the onset and ontogeny of mental illness – or 'organic', viewing such problems as a product of genetic or physical deficit. Although some psychiatrists endeavoured to treat both brain and mind, Micale suggested that theoretical developments remained polarised, and that, from its nineteenth-century roots, 'European psychiatry ministered to suffering psyches, not diseased bodies'.[46]

It is commonly held that transitions in the locus of mental health care over the past half century have resulted from improved psychotropic medication and the

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[43] Andrews et al., *The History of Bethlem*, p.657.
[44] Ray Fitzpatrick and Tarani Chandola, "Health," in *Twentieth-Century British Social Trends*, ed. A.H. Halsey and Josephine Webb (Basingstoke: Macmillan Press Ltd., 2000), p.106.
[45] Roy Porter, *Madness: A Brief History* (Oxford: Oxford University Press, 2002), pp.183-184.
[46] Micale, "The Psychiatric Body," p.323-324.

ascendance of institutional critiques amidst a backdrop of fresh welfare concern. Yet, critics such as Scull have implicated fiscal considerations as the major impetus, and dismissed changes as merely shifting control styles, thus 'decarceration in practice is unlike liberal rhetoric on the subject, the latter being 'ideological camouflage', allowing economy to masquerade as benevolence and neglect as tolerance'.[47] However, mental hospital populations were already declining in the 1950s as drugs were just being introduced, and there is little evidence of their curative value in mental illness. Busfield contends that new drugs contributed to a spirit of therapeutic optimism,[48] but the admissions anomaly warrants additional investigation of their reception and use at institutional level.

Clive Unsworth stressed the significance of the 'consistently medical discourse' of the 1930 Act as a replacement for the former 'antique and moralistic' language.[49] Phil Fennell further proposed that the 'legal immunity' offered by the legislation

> created a favourable legal and ideological climate for a period of experimentation with a wave of new psychiatric treatments...to make a reality of the representation of mental hospitals as places where people were admitted for a short period of treatment and then discharged'.[50]

A comparable trend was also documented by Akihito Suzuki in his study of early twentieth-century admissions to a Tokyo brain hospital. He described a growing gap between the experiences of public and private patients, and concluded that, by the late 1930s, hospital stays were increasingly determined by the therapeutic course, rather than other clinical or financial concerns.[51]

A rapid rise in voluntary admissions after the Second World War, lends weight to several possible hypotheses: The first of these, an 'aftershock' scenario, proposes that

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[47] Scull, *Decarceration*, pp.152-153.
[48] Busfield, *Managing Madness*, p.329.
[49] Clive Unsworth, *The Politics of Mental Health Legislation* (Oxford: Clarendon Press, 1987), p.17.
[50] Phil Fennell, *Treatment without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People since 1845* (London; New York: Routledge, 1996), p.119.
[51] Akihito Suzuki, "A Brain Hospital in Tokyo and Its Private and Public Patients, 1926-45," *History of Psychiatry* 14, no. 3 (2003): p.354.

morale acted as a buffer to civilian wartime stresses, but problems arose belatedly from the pressures and anxieties of war.[52] Secondly, following Thomson's thesis, more enlightened public attitudes towards mental illness and treatment (partly resulting from the 1930 legislation) and a new 'popular psychology' were coupled with readier access to treatment. Finally, mental health service provision was improved further with the peacetime resumption of provisions, with facilities and staff freed from their wartime roles. Examination of admissions and casenote data will provide a means of testing these theories. Moreover, Kathleen Jones believed that 'the (legal) distinction was not one of social status, degree of illness or need, but simply one of volition'.[53] Despite some efforts to improve attitudes, mental illness and certification continued to be highly stigmatised; indeed, Diana Gittins suggested that this was an 'important reason' why few relatives reclaimed their kin from certification at Severalls Hospital.[54] Yet, while institutional historiography has offered some insights into how stigma shaped admission and treatment, Thomson countered that an interwar popular psychology encouraged self-improvement and examination of mental processes.[55] The coincidence of these trends with the (1930) legal endorsement of voluntary admission, may have served as dual enticements to mental hospital admission, especially amongst the aspirational middle-classes. Legal reform is thus framed as having wider - and sometimes unanticipated – implications for psychiatric practice, which may be identified through further institutional investigation, particularly in chapters 5 and 6.

Psychiatric Nosology

Hereditarian views of mental illness exerted a continued influence on psychiatric diagnosis into the early twentieth century, and were later reinforced by international influences. Writing in 1867, Henry Maudsley acknowledged the common 'concurrence of cooperating conditions' rather than any singular cause, and delineated 'predisposing' (hereditary) from 'exciting' (environmental) factors in mental illness.[56] Busfield proposed that the reductionist psychiatry of nineteenth-century German-

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[52] Aubrey Lewis, "Mental Health in War-Time," *Public Health*, no. December (1943): p.27.

[53] Jones, *Asylums and After*, p.136.

[54] Diana Gittins, *Madness in Its Place: Narratives of Severalls Hospital, 1913-1997* (London: Routledge, 1998), p.36.

[55] Thomson, *Psychological Subjects*.

[56] Henry Maudsley, "On Some of the Causes of Insanity," *British Journal of Psychiatry* 12, no. 60 (1867): pp.488-489, 497-498.

speaking Europe inherently shaped psychiatric diagnoses and concepts of mental illness within Britain. Notably, Emil Kraepelin (1856-1926) distinguished 'dementia praecox' (schizophrenia) from manic-depressive psychosis (bipolar depression) and thereby laid the foundation for basic classification of mental illness. In accordance with dominant ideology, he implicated heredity as the main causal agent in madness, thus delivering a bleak prognosis to patients and psychiatrists alike.[57] Dementia praecox became 'schizophrenia' in 1911, when the term was coined by Eugen Bleuler (1857-1939).[58]

From 1907 onwards, asylum records in England and Wales employed two medical coding sequences, to record both the type of illness and its suspected causes. For each set of codes, the Lunacy Commissioners - subsequently the Board of Control - published keys to the codes in the form of printed schedules[59] (see Appendix). In 1931, a 'psychoneurosis' category was added, exclusively for use with a new cohort of voluntary patients admitted after the 1930 Mental Treatment Act.

By 1952, continuing efforts to explain and categorise mental illness resulted in the publication of the first edition of the American Psychological Society's *Diagnostic and Statistical Manual* (DSM). However, within British psychiatry, the World Health Organization's *International Classification of Diseases* (ICD) was the preferred framework. After 1948, the new Joint Hospital gradually adopted the latter system, initially as descriptions only, but later also as standardised codes. The ICD underwent several revisions in the late twentieth century, further details of which feature in chapter 3.

Conceptual Concerns

Building on Kraepelin's system, taxonomies multiplied with each successive version of the ICD and DSM, 'symptoms' and terminology fluctuating in accordance with

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[57] Joan Busfield, "Mental Illness," in *Companion to Medicine in the Twentieth Century*, ed. R. Cooter and J. Pickstone (London: Routledge, 2003), p.641. For comparative purposes, see also Richard Noll, *American Madness: The Rise and Fall of Dementia Praecox* (Cambridge, Mass; London: Harvard University Press, 2011).

[58] Tom Burns, *Psychiatry: A Very Short Introduction* (Oxford: Oxford University Press, 2006), pp.40-44.

[59] Commissioners in Lunacy, "Schedule of Forms of Insanity as at the Time of Record (Forms 1b and 2b of Rules of Commissioners in Lunacy)," (London: 1907).

prevailing scientific and social opinion, thus fuelling the idea of psychiatric diagnosis as socially-determined.[60] In this vein, Mark Jackson described the twentieth-century popularisation of the concept of 'stress', and the varied and versatile discourses on its causes, manifestations and perceived costs or benefits to modern society.[61] Considering hysteria, Micale posited that a 'drastic redefinition of the concept created the illusion that the pathological entity itself had disappeared' (as opposed to having been relabelled).[62] He further portrayed it as a 'diagnosis of exclusion', whereby the legitimate sphere of diagnosis should contract as knowledge of organic illnesses increases' and hysterical 'symptoms' were largely reabsorbed into other psychiatric domains.[63] Additionally, Mikkel Borch-Jacobsen cautioned against 'iatrocentrism' - assuming diseases to be 'transcultural and transhistorical realities' - and highlighted the conformity and collaboration of patients themselves with psychiatric categories.[64] Such frustrations resonate with R.E. Kendell's (1975) assertion that 'the fact is that any definition of disease which boils down to 'what people complain of', or 'what doctors treat', or some combination of the two, is almost worse than no definition at all'.[65]

Debates surrounding the aetiology of mental disorder, and the relative weighting of organic and environmental factors, can be informed by the Bethlem study. Chapter 5 of the present research will help to discern trends in the prominence of hereditary attributions, and the significance of this for diagnostic and treatment experiences.

Containment and Cure: A New Phase in Therapeutic Debates

New interest in psychiatry after the Great War, effective physical (somatic) treatments, and legal reform of older terminology, ostensibly helped to reduce stigma and promoted a more positive outlook on mental illness.[66] However, there was, reportedly, a marked contrast between public acceptance of Freudian approaches - focusing on

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[60] Porter, *Madness: A Brief History*, pp.213-214.

[61] Mark Jackson, *The Age of Stress: Science and the Search for Stability* (Oxford: Oxford University Press, 2013).

[62] Mark S. Micale, "On the "Disappearance" of Hysteria: A Study in the Clinical Deconstruction of a Diagnosis," *Isis* 84, no. 3 (1993): pp.496-526.

[63] Ibid., pp.502, 510.

[64] Mikkel Borch-Jacobsen, "Making Psychiatric History: Madness as Folie À Plusieurs," *History of the Human Sciences* 14, no. 2 (2001): pp.2, 5.

[65] R. E. Kendell, "The Concept of Disease and Its Implications for Psychiatry," *British Journal of Psychiatry* 127, no. 4 (1975): pp.307, 314.

[66] Burns, *Psychiatry: A Very Short Introduction*, p.46.

patients' experiences - and opposition to the various physical interventions, which situated the body as the locus of treatment. There have been similar historiographical doubts expressed regarding the motivations for, and consequences of, somatic, approaches.

Prominent examples of this new class of 'shock therapies' were insulin coma therapy, electro-convulsive therapy (ECT) psychosurgery and, somewhat later, chemically synthesised psychotropic medication.[67] Porter viewed the 1930s 'vogue' for surgical techniques of lobotomy and leucotomy as reflective of a larger paradigm, in which, 'from the humble tonsillectomy upwards, operations had become routine, increasingly safe, and even fashionable'.[68] Furthermore, like other shock treatments, transorbital lobotomy - pioneered in America by Walter Freeman[69] - epitomised hope for patients themselves and the advancement of psychiatry.[70] Yet, despite reported successes in the treatment of schizophrenia and endogenous depression, there was little understanding of the workings of ECT, and continued use of what some consider a brutal method evoked fear and controversy.[71] Amidst such opposition, and with increasing availability of alternative methods, chapter 6 of the Bethlem case study can help in understanding the circumstances of, and justifications for, continued use of physical approaches.

Well-documented successes of antibiotics offered hope for comparable advances in psychopharmacy.[72] In contrast to the image of psychotropic drugs as a late twentieth-century phenomenon, Moncrieff reported the unassuming use of sedatives and stimulants before the 1950s; conversely, later psychopharmaceuticals were met with 'immense enthusiasm, verging on zeal', and were more openly discussed in clinical records.[73] She further proposed that drug innovations permitted a mutually-beneficial alliance, enhancing psychiatry's scientific status and presenting a lucrative new market

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[67] Busfield, "Mental Illness," pp.645-647.

[68] Porter, *Madness: A Brief History*, pp.202-203.

[69] Walter Freeman and James W. Watts, "Prefrontal Lobotomy in the Treatment of Mental Disorders," *Southern Medical Journal* 30, no. 1 (1937): pp.23-21.

[70] However, the prefrontal leucotomy procedure, developed by Egas Moniz in 1936, was more frequently used in the UK. See chapter 6 and: E.L. Hutton, G.W.T.H. Fleming, and F.E. Fox, "Early Results of Prefrontal Leucotomy," *Lancet* 241 (1941), pp. 3-7.

[71] Busfield, "Mental Illness," pp.645-647.

[72] Porter, *Madness: A Brief History*, pp.205-206.

[73] Joanna Moncrieff, *The Myth of the Chemical Cure* (Basingstoke: Palgrave Macmillan, 2008), pp.41-42.

for the pharmaceutical industry.[74] Although originally introduced as a short-term measure, many such substances had, by the late twentieth century, become mainstays of long-term treatment for serious and chronic forms of mental disorder, prompting questions over their efficacy, or potential harm. Tom Burns countered that the new medications initially humanised hospital wards, allowing staff to get to know their patients, and shortened the length of admissions, reducing consequent lifestyle disruptions.[75] However, for some observers and patients, this shift to a more scientific psychiatry entailed a certain loss of caring, epitomised by cursory interviews to check for drug side effects. Crucially, there was often the same limited quota of staff available to treat a large number of often short-stay patients, a situation that militated against the use of individualised programmes.[76]

Scull regarded the combination of psychoactive drugs and community treatment as merely another social control mechanism, rooted in capitalism.[77] He suggested that the new drugs aided early discharge by reducing (visible) symptoms; eased problems of community management, and led to doctors becoming over-optimistic and too readily persuaded of this "technological fix". He further criticised the lack of attention to either the long-term effects of psychotropic drugs, or patients' quality of adjustment after leaving hospital, and argued that community care had attracted insufficient investment.[78] According to Peter Barham, inadequate planning and funding contributed to psychiatric patients within the community facing social isolation and exclusion, service limitations, and the problem of an identity 'irrevocably tainted or spoiled by a diagnosis of mental illness'.[79] Freeman, however, opposed the idea that decarceration was just a cost-cutting measure, countering that provision of new facilities and services would prove more expensive than upgrading the existing hospitals.[80]

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[74] Joanna Moncrieff, "An Investigation into the Precedents of Modern Drug Treatment in Psychiatry," *History of Psychiatry* 10, no. 40 (1999): pp.486-487.
[75] Burns, *Psychiatry: A Very Short Introduction*, pp.53-54.
[76] Mary Hill, "The Development of Industrial Therapy in Britain," *American Journal of Occupational Therapy* XXI, no. 3 (1967): pp.161-162.
[77] Scull, *Decarceration*, p.33.
[78] Ibid., pp.88-89.
[79] Peter Barham, *Closing the Asylum: The Mental Patient in Modern Society* (London: Penguin, 1997), pp.59-60.
[80] Freeman, "Psychiatry in the National Health Service, 1948-1998," pp.7-9.

In the 1930s, London psychiatrists had predicted that the onset of another war would lead to an upsurge in demand for their services. On the contrary, it has been argued that public morale actually rose, although staff shortages and reallocation of facilities meant that psychiatric patients endured a return to more custodial regimes of earlier eras.[81] However, a recent article by Edgar Jones cast doubt on the positive messages promulgated by '... a government seeking to promote a picture of the British as competent and well organized'.[82] His account underscores the centrality of (especially physical) methods to therapeutic optimism, but such 'filtering' of information also alludes to an increasing disjuncture between public perceptions and the realities of twentieth-century psychiatric practice.

After World War II, day hospitals and industrial therapy schemes sought to strengthen community engagement and to help reduce the economic and therapeutic drawbacks of prolonged hospital stays. A 1953 World Health Organization proposal reaffirmed the changing demands on mental health care, outlining a service model utilising community-based 'tools'.[83] Moreover, greater integration of psychiatric services in district general hospitals was sought, with psychiatry becoming a core speciality.[84] Ward unlocking, therapeutic groups, cognitive behavioural therapy and social skills training became key features, better suited to an increased caseload of short-term patients, and the challenges of reintegration and independence.[85] Bethlem evidence presented (chiefly in chapter 6) provides a means of testing whether new treatment methods indeed created therapeutic optimism, and of examining how resource shortages influenced therapeutic developments at the hospital.

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[81] C. Hume and I. Pullen, *Rehabilitation in Psychiatry: An Introductory Handbook* (Edinburgh: Churchill Livingstone, 1986), p.25.

[82] Edgar Jones, "Neuro Psychiatry 1943: The Role of Documentary Film in the Dissemination of Medical Knowledge and Promotion of the U.K. Psychiatric Profession," *Journal of the History of Medicine and Allied Sciences* (2012): p.4.

[83] World Health Organization, "Expert Committee on Mental Health: 3rd Report " (Geneva: 1953).

[84] Hugh L. Freeman, "The General Hospital and Mental Health Care: A British Perspective," *The Milbank Quarterly* 73, no. 4 (1995): pp.656-663.

[85] Hill, "The Development of Industrial Therapy in Britain," pp.161-162.

Psychotherapy and Shifting Theoretical Frameworks

Porter suggested that the pessimism of asylum psychiatry and the intransigence of the somatists inspired the development of alternative, 'psychodynamic' approaches.[86] The most famous and comprehensive of these was Sigmund Freud's 'psychoanalysis', which reasserted the dominance of psyche (mind) over soma (body), describing the mind as controlled by extensive and powerful unconscious drives.[87] Whilst Freudian psychoanalysis only aimed to offer relief, rather than a remedy, for mental illness, Busfield proposed that it conferred other benefits on both therapist and client. For affluent patients, it dealt with less severe problems, required a certain degree of intellectual ability and by encouraging expression of fears, was a corrective to hypnosis which aimed to 'remove' them. For a growing class of private practitioners, psychotherapy represented a promising and cost-effective method, founded on a novel and specialised ideology, which could ultimately facilitate the professionalisation of therapeutic work.[88]

By the interwar years, psychodynamic ideology had fostered a belief that mental illness was not confined to the certifiably insane, but could manifest itself in the 'complexes' and neuroses of ordinary citizens. Besides Thomson's (aforementioned) emphasis on 'popular psychology' influences, Dean Rapp traced the earliest dissemination of Freudian ideas in the British press to 1912,[89] whilst Graham Richards outlined a 'convergence between the psychological conditions and needs of a substantial section of the post-Great War British population and the appearance, in psychoanalysis, of a system of ideas which promised to meet these needs'.[90] Alongside a 'normalising gaze'[91] and the extension of the 'psy' disciplines,[92] 1950s pop culture subsequently fashioned an array of increasingly glamorous psychological types,[93]

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[86] Porter, *Madness: A Brief History*, p.187.
[87] Micale, "The Psychiatric Body," pp.329-330.
[88] Busfield, *Managing Madness*, pp.301-312.
[89] Dean Rapp, "The Early Discovery of Freud by the British General Educated Public, 1912-1919," *Social History of Medicine* 3, no. 2 (1990): p.218.
[90] Graham Richards, "Britain on the Couch: The Popularization of Psychoanalysis in Britain 1918—1940," *Science in Context* 13, no. 02 (2000): pp.220-221.
[91] Armstrong, *Political Anatomy of the Body*, p.67.
[92] Nikolas Rose, *Governing the Soul: The Shaping of the Private Self* (London: Routledge, 1989), p.7.
[93] Porter, *Madness: A Brief History*, p.199.

though high-profile cases of criminal insanity and the continued seclusion of the mentally ill from mainstream society also fuelled more negative stereotypes.[94]

According to Edgar Jones, psychotherapy claimed a 'virtual monopoly' on individual approaches by the 1950s, yet there were few consultants employed in London teaching hospitals before the 1960s; a finding which Jones attributed to the field's obfuscatory jargon and the challenge it posed to orthodox British psychiatry.[95] Freudian approaches have remained the focal point of historical research, with a consequent neglect of the influences of lay beliefs on identity, health, and culture.[96] Further research can help to elucidate the degrees of reciprocity between external social and cultural shifts and the creation of new psychiatric services. In subsequent chapters, these shifts (rather than a simple response to policy) will be considered alongside patients' psychological 'literacy' and reasons for pursuing treatment as factors in shaping hospital practice.

The 'therapeutic community' concept is commonly believed to be grounded in the wartime experiences of army psychiatrist Maxwell Jones, who stressed that the structure of any institution impacts on the wellbeing of its occupants. His programme concentrated on education in a group environment, aiming to rearrange traditional hospital hierarchies, improve interaction between patients, nurses and doctors, and provide an opportunity for self-education and recovery.[97] Burns later asserted that, like psychotherapy, the therapeutic community became a 'victim of its own success', its teachings so widely accepted that their origins faded into obscurity.[98] Indeed, it remains unclear how an originally military approach translated into civilian practice, and how it operated and was positioned within existing mental health services.

Despite a tendency to view medical and legal paradigms as antithetical, the above evidence indicates that recognition of their commonalities and interactions affords a

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[94] Busfield, "Mental Illness," pp.636-637.
[95] Edgar Jones, "War and the Practice of Psychotherapy: The UK Experience 1939-1960," *Medical History* 48 (2004): pp.505-506.
[96] Thomson, *Psychological Subjects*, pp.2, 8-9.
[97] Sanctuary Leadership Development Institute, *Maxwell Jones* (2008 [cited 25/10/11)); available from http://www.sanctuaryweb.com/maxwell-jones.php.
[98] Burns, *Psychiatry: A Very Short Introduction*, p.55.

clearer understanding of twentieth-century developments in mental health care. The next section will focus on how institutions reacted to wider social, therapeutic, and legislative transitions, in terms of their patient profiles, ward regimes and treatment agendas.

5. Asylum Case Studies

Steven Cherry proposed that, despite recent analysis of psychiatric methods and disorders, asylum stereotypes have been 'explored but largely unchallenged', with little attempt to resolve contentious debates surrounding the relationship between hospital and community. Bethlem itself has long been the subject of historical and literary interest, whilst the history of the Maudsley Hospital has been recently documented by a number of current mental health professionals. These accounts are discussed later in this chapter.

At St Andrew's Hospital, Norfolk, Cherry identified a 'strong institutional storyline', which, he believed, served as a case study for the rise and fall of the asylum. With the institution's traditional Poor Law associations, the socioeconomic profile of admissions to St. Andrew's differed from that of Bethlem. Nevertheless, this analysis underscored intrinsic links between the age, class, and gender of patients, and the aetiologies and diagnoses they received.[99] Ultimately, the 1960s witnessed paradoxical growth in British mental hospitals, the older institutions benefiting from extra funding for new buildings and the development of new sub-specialisms.[100] Thus, Cherry described belated expansion and diversification at St. Andrew's Hospital:

> ...the hospital's last years were not to be a story of quiet decline. They were marked by a change of role and increasingly influenced by the search for a new strategy in health care provision; first in the context of wider hospital services, then with a more positive emphasis upon community services.[101]

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[99] Cherry, *Mental Health Care in Modern England*, pp.185-187.
[100] Freeman, "Psychiatry in the National Health Service, 1948-1998," p.7.
[101] Cherry, *Mental Health Care in Modern England*, p.286.

Having studied the hospital between 1810 and its closure in 1998, Cherry concluded that it 'probably still fared worse under the National Health Service (NHS), as the needs of mental patients were more remotely interpreted through a less sympathetic Regional Hospital Board in the light of centrally determined spending allocations'. Economic pressures also restricted the use of new physical treatments, but this, he considered, was 'no great disadvantage', given the limited understanding of these methods amongst the hospital staff.[102] In 1998, St. Andrews became a casualty of sweeping hospital closures; thus, there are lessons to be learned from an institution such as Bethlem that survived this tumult. How did it adapt to this changing social and medico-legal environment? What barriers existed to developing new services and accessing new populations? These issues are examined in chapters 6 and 7, and inform broader consideration of Bethlem's ongoing role within the marketplace of psychiatric care.

In her account of the Denbigh Hospital (formerly North Wales Lunatic Asylum) Michael sought to emphasise the institution's care and treatment roles, rather than its custodial function, and found a 'contradictory unity of ideas' operating, in the curing, protecting, and correcting, of patients. She also shed light on both the process of transfer to NHS control, and the key role of the Welsh language as a 'defining characteristic' of the hospital.[103] Both she and Cherry have thus described the idiosyncrasies of hospital customs, provided a lens though which to view the implementation of policy, and demonstrated the local and broader significance of institutional demise.

Severalls Hospital (Essex) was the focus of a comprehensive study by Diana Gittins, in which she explored areas such as the social dynamics of the institution, gender divisions on the wards, daily routines, and admission, discharge, and treatment patterns. Gittins' account challenged the speed and scale of legislative change on early twentieth-century mental hospital practices. She suggested, that, at Severalls, 'the proportion of voluntary patients remained lower than the national average until 1959';

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[102] Ibid., pp.305, 309, 313.
[103] Pamela Michael, *Care and Treatment of the Mentally Ill in North Wales, 1800-2000* (Cardiff: University of Wales Press, 2003), p.212-213.

that *any* mental hospital admission remained highly stigmatised, and that the new dispensation for voluntary admissions had contributed to the arrival of the 'revolving door' phenomenon from as early as 1935.[104] She attributed mid twentieth-century therapeutic shifts to 'better funding, the enactment of the NHS, and a new generation of young psychiatrists eager to prove themselves and their profession as 'scientific'' but also demonstrated how this overriding ambition could result in scarce resources being invested in 'new (somatic) techniques, for which evidence was, at best, scanty'.[105] The impact of legal reforms and the role of professional status are both topics addressed through the Bethlem case study.

Gittins' use of oral history interviews was particularly effective in bringing patients' voices into the discussion of late twentieth century changes at the hospital. Her conclusions resonated heavily with Foucauldian notions of omnipresent surveillance and control:

> Relationships, services, and treatments have been dispersed. Power is still exercised over them all, but in a new form of hierarchy, a less visible one than before, a hierarchy that operates through e-mail, bleepers, faxes and one-to-one encounters, rather than through daily face-to-face contact with many different, but familiar, people.[106]

Richard Hunter and Ida Macalpine noted that Colney Hatch Asylum (formerly Middlesex County Pauper Lunatic Asylum; subsequently Friern Hospital) took in 'society's impossibles….Its riches were its patients, not its image'.[107] They described how the institution's doctors 'worked under distinct social and financial disadvantage…. "Classification" meant using the facilities of the asylum and limited nursing staff to best advantage'. Yet, these privations are counterbalanced by the founding aspiration that the asylum should become a 'self-supporting rural community', thereby steering the reader away from discourses of containment or cure, towards an appreciation of the broader significance of the asylum to lifestyle and

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[104] Gittins, *Madness in Its Place*, pp.40-43.
[105] Ibid., pp. 196, 204.
[106] Ibid., p. 222.
[107] Hunter and Macalpine, *Psychiatry for the Poor*, p.11.

livelihood.[108] A recent paper by Taylor revisited Friern Hospital, and shared personal experiences of being an inpatient during its late 1980s 'twilight days'. Her case study – subsequently developed into a book[109] - spoke to the wider issue of how the transition to care in the community was managed, juxtaposed with the practical consequences for, and conflicting emotions of, the 'new long-stay' patient.[110]

The post-1930 introduction of outpatient clinics to Britain, and subsequent extensions of the Mental Health Act to cover nursing homes removed formerly contested barriers between asylums and other forms of care. Stan Cohen believed that (late twentieth-century) 'decarceration' actually precipitated a paradoxical rise in social control, allowing surveillance to spread beyond the asylum.[111] In a timely counterpoint to institutional accounts, Peter Bartlett and David Wright chronicled a lesser-known history of community-based support for mental illness.[112] They posited a more extended tradition of surveillance outside the so-called "total" institution. Appropriate conformity was reinforced in family settings equally, if not more restrictive, than institutional regimes, thereby challenging more progressive interpretations of community care rhetoric.[113] Within the same volume, John Welshman described the existence of such services in England and Wales between 1948 and 1974, and implicated drug breakthroughs, attitudinal shifts, and anxiety over predicted costs of elderly care, as factors generating support for community care policy.[114] This highlights the diversity of social and scientific influences framing psychiatric opinion; a theme that suffuses the current findings.

In sum, institutional historiography has hitherto focused predominantly on the 'rise and fall' of public asylums, often reiterating coercive paradigms. The present research

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[108] Ibid., pp.15-16.

[109] Barbara Taylor, *The Last Asylum: A Memoir of Madness in Our Times* (London: Hamish Hamilton, 2014)

[110] Taylor, "The Demise of the Asylum in Late Twentieth-Century Britain: A Personal History," pp.193, 212-213.

[111] Stanley Cohen, *Visions of Social Control: Crime, Punishment and Classification* (Oxford: Blackwell Publishers Ltd, 1985), Chapter 1.

[112] P. Bartlett and D. Wright, eds., *Outside the Walls of the Asylum: The History of Care in the Community* (London: Athlone Press, 1999).

[113] Ibid., pp.13-14.

[114] John Welshman, "Rhetoric and Reality: Community Care in England and Wales, 1948-74," in *Outside the Walls of the Asylum: A History of Care in the Community, 1750-2000.*, ed. Bartlett and Wright, p.209.

offers a departure from these settings and tropes, but will draw pointers from prior accounts to identify key areas for investigation. Examples will include: Cherry's account of the relationship between patients' socioeconomic status and treatment experiences (chapters 4 and 5 of the current study); Michael and Cherry's work on institutional character (particularly chapter 4); and Gittins' reflections on the postwar impact of the arrival of the new generation of psychiatrists (chapters 6 and 7).

Bethlem or Bedlam?

Bethlem Royal Hospital is Britain's oldest psychiatric institution, and as part of the South London and Maudsley NHS Foundation Trust, holds international renown in mental illness treatment and research. Historically, it also occupied a unique role in terms of its administration, clientele, and – not unrelated to the previous factors – its efforts to simplify and destigmatise the process of seeking support. Yet, the alleged disorder and neglect of the sinister 'Bedlam' has been the focus of more abundant historiography. This has arguably maintained an archaic and unhelpful caricature, and diverted attention away from a wealth of recent changes at the hospital. Two world wars, the creation of the NHS, merger with the Maudsley Hospital, and the late twentieth-century community care ethos have all impacted on Bethlem's persona and therapeutic protocol. This section will review existing historiography of Bethlem and the Maudsley Hospital, highlighting their changing politics, practices, and populations, and outlining objectives of the present research.

Keir Waddington proposed that, at Bethlem Royal Hospital, 'a historical image has been created of an institution that has come to symbolise all that was mad and bad in the management of the insane'.[115] A preponderance of early literature on the hospital is offset by more limited twentieth-century writing, thus concealing a number of key developments occurring within this period. General histories of psychiatry once diligently promulgated what former Allderidge termed the 'reach-me down cliché' of Bedlam, a chequered tradition populated by a succession of unscrupulous and

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[115] Keir Waddington, "Enemies Within: Postwar Bethlem and the Maudsley Hospital," in *Cultures of Psychiatry*, ed. Marijke Gijswijt-Hofstra and Roy Porter (Amsterdam: Rodopi, 1998), p.186.

uncaring governors, shackled lunatics and riotous freakshows.[116] Through age and renown, the hospital has also often been the unwitting villain of anti-psychiatry literature. Significantly, most commentaries on the hospital cease with the 1815 Select Committee evidence, somewhat implying that a reformed Bethlem was of lesser historical and/or public interest than its previous incarnations.

Alternative explanations such as Jonathan Andrews' thesis 'Bedlam Revisited' depart from such ideologies to extend the Bethlem tale in time and depth.[117] A multi-authored volume, *The History of Bethlem,* marked the hospital's 750th anniversary, and drew upon a substantial corpus of archived institutional records.[118] With over 200 pages devoted to the twentieth-century life of the hospital and its patients, the book clearly surpasses the chronological and thematic range of previous accounts. Changes in hospital administration, the character of admissions, diagnoses and treatments were observed, thereby mapping out the historical landscape for future exploration. A more recent work, Catharine Arnold's *Bedlam: London and Its Mad*[119] treads the well-worn path through Bethlem's history from its foundation to the present day. This salutary, if essentially populist, account sadly conforms to the apparent trend for relegating all post-1900 developments to a slender final chapter. Psychiatric luminaries of the Bethlem and Maudsley were often prolific contributors to scientific and medical journals, and these sources will be discussed in more detail as applicable. Additionally, in recent years, a number of clinicians have investigated key emerging treatment specialisms at the hospital, which will also be referenced as appropriate. These works represent a firm foundation from which to integrate new quantitative and qualitative findings into a broader, coherent narrative of twentieth-century development at the Bethlem, and to further bridge the enduring conceptual divide between historical and contemporary visions of the hospital.

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[116] Patricia Allderidge, "Bedlam: Fact or Fantasy?," in *Anatomy of Madness (Vol 2)*, ed. W.F. Bynum, R. Porter, and M. Shepherd (London: Tavistock, 1985), p.18.

[117] Jonathan Andrews, "Bedlam Revisited: A History of the Bethlem Hospital C.1634-1770," (Unpublished Doctoral Thesis: University of London, 1991).

[118] Andrews et al., *The History of Bethlem*.

[119] Catharine Arnold, *Bedlam: London and Its Mad* (London: Simon and Schuster, 2008).

Patricia Allderidge suggested that 'in every other way apart from physically, Bethlem has probably seen more change in the past 50 years than in the previous 400'.[120] Examples include a move from central London to suburban Kent, the advent of the NHS, amalgamation/absorption by the Maudsley Hospital, and the twin impacts of deinstitutionalisation and pharmacological revolution.[121] This section will develop and situate opinion on the respective early roles and clientele of the two institutions and their (1948) merger, and elucidate remaining questions for the current enquiry.

Establishment, Employment, Evolution

The current Beckenham site is the fourth that Bethlem has occupied as a psychiatric hospital. Mindful of the limitations of their overcrowded Southwark base, Bethlem's Governors sought a new location, and, in 1925, purchased an old country estate in Kent. Building work commenced immediately, with the actual move to the Monks Orchard Road site following in 1930. Bethlem thus came to occupy a prime country location in a building touted as being in the 'vanguard of mental hospital design'.[122] Although in many respects, the new site indeed granted Bethlem a fresh start, the relocation was to entail certain drawbacks. Records from 1923 detailed Bethlem's application to become a recognised school of the University of London. The Governors believed such a link would strengthen the reputation of their existing medical school, but were wary of the university acquiring undue control in the enterprise.[123] However, no longer readily accessible or attractive to London academics, its educational role diminished, with the (1927) closure of its outpatients' department, and eventual withdrawal of teaching status in the 1944 Goodenough Report. In these circumstances, merger with the Maudsley Hospital would subsequently provide Bethlem's only means of safeguarding its assets and administrative autonomy at the inception of the NHS.

In 1900, Bethlem employed 30 male and 35 female nurses, rising to 41 and 52 respectively by 1933; this figure falling only during the Second World War. There was a turnover of 593 nurses from 1915 to 1940, with most staying for less than two years.

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[120] Patricia Allderidge, *Bethlem Hospital 1247-1997: A Pictorial Record* (Chichester: Phillimore, 1997), p.104.
[121] Andrew Scull, "Bethlem Demystified?," *Medical History* 43, no. 2 (1999): p.251.
[122] Andrews et al., *The History of Bethlem*, p.538.
[123] BRHAM, "Bethlem Sub-Committee Minutes, 20th June 1923."

After 1930, a higher percentage remained in post longer, reflecting both institutional improvements and wider unemployment trends. Before 1948, Bethlem salaries remained low compared to those of other institutions, despite efforts to incentivise doctors to work at Monks Orchard Road. Mary Barkas became the first female House Physician in 1919, but thereafter no female psychiatrists were recruited until Elizabeth Lobl, Assistant Medical Officer (1945-1950), ostensibly an interim solution until a male candidate was appointed. The national picture of low pay and poor conditions for nursing staff was compounded and prolonged locally by the later expansion of the Joint Hospital.[124] In contrast, Bethlem's resumption of teaching status subsequent to the merger enabled it to increase doctors' salaries and to access a shared workforce. Formerly an institution with just three permanent doctors, it became part of a Joint Hospital employing a professor of psychiatry, an assistant clinical director, fourteen consultants, eleven junior physicians, fifteen registrars and nine house physicians.[125]

Who Were Bethlem's Patients?

Andrews et al. provide a thoroughgoing account of the scale and character of twentieth-century Bethlem admissions, which highlights diversions from formal policy, and explores the institutional and top-down influences on changes in the hospital's population. Broad trends will now be outlined, with statistical data and analysis presented in chapter 4.

Until the merger, more than three quarters of Bethlem's patients came from London or the Home Counties.[126] Latterly, catchment areas and patient profiles also reflected NHS policy and new specialisms; issues explored in chapters 4 and 5. Despite a drop in numbers due to the relocation, annual admissions to Bethlem rose overall from 203 in 1900, to 477 by 1939. This figure declined again during the war, but had grown to nearly 500 by 1947.[127] Voluntary patients constituted a large proportion of Bethlem's early twentieth-century expansion. Bethlem had been offering this service since the late nineteenth century, but official endorsement of the practice (in the 1930 Mental

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[124] Andrews et al., *The History of Bethlem*, pp.619-622, 631-633.
[125] Ibid., p.627.
[126] BRHAM, "Triennial Statistical Report, Years 1949-1951," pp.101-103.
[127] BRHAM, "Bethlem Hospital Annual Reports, 1930-1947."

Treatment Act) and heightened public awareness of such treatment, may have contributed to its increasing popularity. After 1948, patient numbers increased across both sections of the new 'Joint Hospital', with a range of often pioneering specialist services coming to reflect both wider social concerns and staff interests. A 1957 Bethlem summary listed 238 inpatient beds across 11 wards, plus '30-40' day hospital places. Ten consultants were also named; some, such as Edward Hare,[128] having responsibilities for multiple wards. Psychogeriatrics (Dr Post) and adolescent services (Drs Warren and Cameron) featured as nascent specialisms[129] and are amongst the initiatives explored further in chapter 4.

Yet, there remains a lack of qualitative detail as to the individual 'journeys' of Bethlem patients, or of their roles within the internal dynamics of the institution; their presence often acknowledged only at points of admission and discharge. Akihito Suzuki likewise proposed that in nineteenth-century Bethlem, 'there existed a complex process of struggle for the appropriation of power/knowledge, and the patient's own voice was a vital component for psychiatric modernity'.[130] To further develop these ideas, the present study will draw out the implications of the popularisation and penetration of psychology into cultural and institutional life, by examining how patients and their families influenced decision-making, and, reciprocally, how the hospital positioned itself in the 'marketplace' of care during the twentieth century.

According to Richard Hunter and Ida Macalpine, from the end of the nineteenth century, efforts to attract a 'better class of patients' to Bethlem variously resulted in the removal of criminal and pauper lunatics, a reduction in amount of free places offered, a decline in Bethlem's former work ethos, and the recasting of 'inmates' as 'clientele'.[131] Yet, further charges of lavish expenditure also reportedly prompted accusations that Bethlem was still more concerned with cosmetic accoutrements than

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[128] H.R. Rollin, "The History of Lunacy and the Scholarship of Edward H. Hare," *British Journal of Psychiatry* 174, no. 4 (1999): p.283.

[129] BRHAM, "Mcc: Medical Committee Documents and Minutes, 1955-1957."

[130] Akihito Suzuki, "Framing Psychiatric Subjectivity: Doctor, Patient and Record-Keeping at Bethlem in the Nineteenth Century," in *Insanity, Institutions, and Society, 1800-1914* ed. Joseph Melling and Bill Forsythe (London: Routledge, 1999), p.132.

[131] Hunter and Macalpine, *Psychiatry for the Poor*, p.45.

research and remediation.[132] Previous depictions of Bethlem have thus reinforced the centrality of marketing, social status, and voluntary admissions to the institution. However, less attention has been given to how promotional activity was conceived, conducted, and construed.

Chapters 4 and 5 will consider how national policy and the Maudsley merger influenced Bethlem's patient demographic and therapeutic agenda. For example, it has been proposed that Bethlem's traditional emphasis on 'curable and paying' patients allegedly discouraged young and old alike, with the 1940s creation of adolescent and psychogeriatric units having little immediate impact on this trend.[133] The availability of rich archival data (including exclusive access to the records of some patients and facilities) coupled with the first-hand testimony of individuals involved in the delivery of these services, now provides a unique opportunity to build on, and test, existing accounts, through the identification and investigation of therapeutic directions, and the processes or people instrumental to these circumstances. This will serve to both challenge prior claims and characterisations of specific institutional practice, and contribute to knowledge of mental health policy in twentieth-century Britain.

The Maudsley Hospital: Origins and Intended Role

The Maudsley Hospital possessed a differing tradition and remit to Bethlem, and discussion of its early existence offers a means of establishing the formative influence of this era on the later Joint Hospital. Founded in 1923 by leading psychiatrist Dr Henry Maudsley, the Maudsley was committed to research and treatment of early and acute patients. It was distinct from the Victorian asylums, modelled instead on the protocol of respected German university psychiatric clinics. These institutions endorsed Emil Kraepelin's (aforementioned) delineation of manic depression and dementia praecox, together with his emphasis on predisposing defective heredity.[134]

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[132] Waddington, "Enemies Within," p.186.
[133] Andrews et al., *The History of Bethlem*, p.658.
[134] R. M. Ion and M. D. Beer, "The British Reaction to Dementia Praecox 1893-1913. Part 1," *History of Psychiatry* 13, no. 51 (2002): pp.290, 301.

Frederick Mott and Edward Mapother were amongst Maudsley staff instrumental in furthering understanding of shell-shock, and drew on their military experiences when the hospital was returned to its LCC incarnation.[135] The hospital finally opened to civilians in 1923, by which time an outpatients department had already been in operation for a year, and 'the idea of treating psychiatric disorders without admission was still novel, but not unprecedented'.[136] However, it has been suggested that a more limited range of treatments was offered to voluntary admissions, as 'the moment a patient took objection to a medicine or programme of activity, they were free to leave'.[137] This raises further questions about whether a patient's legal status, irrespective of clinical diagnosis, could affect their chances for receiving physical methods, or if coercive rationales underpinned the use of such measures. The link between legal status and treatment administration is discussed in chapters 5 and 6.

According to Rhodri Hayward, Mott's (1923) retirement marked a change in both administration and therapeutic outlook. Without discrediting Kraepelin's system, incumbents Frederick Golla and Mapother 'argued that disease categories were simply convenient fictions that had been developed to legitimate treatment regimes and facilitate hospital administration'.[138] Other accounts suggest that training and research requirements predominated over local community needs in shaping the Maudsley's interwar admissions policy.[139] Edgar Jones and Shahina Rahman found discrepancies between intended and actual demographic and clinical prognoses of admissions to pre-1948 Maudsley.[140] Their findings highlight institutional departures from official objectives, and indicate the potential for similar discoveries from Bethlem admissions data.

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[135] Edgar Jones, Shahina Rahman, and Robin Woolven, "The Maudsley Hospital: Design and Strategic Direction, 1923-1939," *Medical History* 51 (2007): p.357.
[136] Ibid., p.369.
[137] Ibid., p.377.
[138] Rhodri Hayward, "Germany and the Making of "English" Psychiatry," in *International Relations in Psychiatry: Britain, Germany, & the United States to World War Ii*, ed. Volker Roelcke, Paul J. Weindling, and Louise Westwood (Rochester, NY; Woodbridge: University of Rochester Press, 2010), pp.67-71.
[139] Jones and Rahman, "Framing Mental Illness, 1923-1939," p.107.
[140] Ibid., p.107, 114-116.

Wartime Requisitioning: Mill Hill and Sutton Hospitals

Between 1939 and 1945, the government-run Emergency Medical Services (EMS) commandeered civilian premises for the war effort, with Maudsley staff evacuated to Mill Hill Hospital and Belmont Hospital, Sutton. The Mill Hill contingent included Aubrey Lewis, Eric Guttmann and Maxwell Jones. Despite being one of the first British hospitals to use ECT,[141] protocol focused on social and occupational psychiatry, admitting both service personnel and civilians.[142] William Sargant and Eliot Slater were, respectively, Deputy Clinical Director and Clinical Director at Sutton. Although its history is less well-documented, this hospital was known to be more committed to physical treatment, and, unlike Mill Hill, administered insulin comas, leucotomies and lobotomies.[143] These years broadly strengthened psychiatric research and practice, but contrasting approaches at the sites prompted tensions when the hospital reunited.[144] Chapters 6 and 7 explore the postwar legacy of this period for somatic interventions, psychotherapy and therapeutic community approaches at Bethlem. The two hospitals were thus possessed of markedly different therapeutic objectives, influences and funding structures. To recap, Bethlem was a well-established, if somewhat imposing, destination, catering increasingly for voluntary, middle-class patients; by contrast, the Maudsley began as a military hospital, specialising in early and remediable cases, and attracted resources and expertise from further afield.

Creation of a Joint Hospital

David Russell proposed that 'The Bethlem and Maudsley hospitals have often been conscious that, just as their origins were different from the majority of hospitals in England, so their function and role would be different and distinctive'.[145] The Joint Hospital was officially anticipated as providing 'complementary not duplicate services'[146] but this proved to be an exaggeratedly rosy image, and animosity developed early on in the 'marriage of convenience'. The amalgamated institution was

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[141] Lothar Kalinowsky, "Electric-Convulsion Therapy in Schizophrenia," *Lancet*, no. December 9 (1939): pp.1232-1233.

[142] Jones, "War and the Practice of Psychotherapy," p.500.

[143] Claire Hilton, "Mill Hill Emergency Hospital: 1939-1945," *Psychiatric Bulletin* 30 (2006): p.107.

[144] Waddington, "Enemies Within," p.190.

[145] D. Russell, *Scenes from Bedlam: A History of Caring for the Mentally Disordered at Bethlem Royal Hospital and the Maudsley* (London: Balliere Tindall, 1997), p.196.

[146] BRHAM, "Aubrey Lewis Papers, Box 5."

clearly modelled on Bethlem's managerial system, and experience suggested that this hospital would emerge as the dominant partner. However, it was assigned an inferior position from the offset, and unfavourable financial and administrative disparities were soon apparent within the 'Joint Hospital'.[147]

The NHS Act had dispensed with the Boards of Governors, and Aubrey Lewis swiftly abolished Bethlem's physician-superintendent role. Bethlem was also poorly represented on the new Joint Committee, and subsequently swamped by Maudsley doctors. Little attempt was made to include junior and nursing staff in negotiations, arousing bitterness, resentment and resignations at all levels, with no original Bethlem members left on the new Joint Hospital's Board by 1955.[148] Additionally, there were to be marked changes to the character of Bethlem's patients after Lewis redistributed duties of care between the two hospitals, leaving Bethlem with the predominantly senile, chronic or organically mentally ill populations; more like the asylums it had once scorned than the paragon institution it aspired to be.[149] Further scrutiny of Bethlem data for this period will enable examination and testing of these ideas, in light of the aforementioned departures from admissions policy at the Maudsley.

John Crammer argued that the ongoing expansion fostered a growing separation of the research and clinical agendas of the Joint Hospital.[150] This was reaffirmed by recent research, which also found that the stereotype of Bethlem as more relaxed than the Maudsley Hospital was firmly entrenched in different generations of staff testimony, but was discussed with humour and irony. Yet, Bethlem's relative seclusion was equally thought to have provided the physical and intellectual space for therapeutic innovation, particularly that involving unpopular or controversial populations; an idea revisited later in this thesis. Several psychiatrists nevertheless alluded to the tacit existence of 'A' and 'B' streams, and former nurses recalled the Maudsley as being 'more forward-thinking than Bethlem', having 'a great intensity of purpose…there

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[147] Andrews et al., *The History of Bethlem*, p.539.
[148] Ibid., p.582
[149] Ibid., p.681.
[150] John L. Crammer, "Training and Education in British Psychiatry, 1770-1970," in *150 Years of British Psychiatry. Volume 2: The Aftermath*, ed. H. L. Freeman and G.E. Berrios (London: The Athlone Press Ltd., 1996), p.238.

were always people pounding the corridors looking purposeful and straight ahead'.[151]
However, a candidate's academic credentials were broadly construed and assessed,
and one professor reflected thus on his first encounter with Aubrey Lewis in the 1960s:

> I foolishly but intelligently said I wasn't going to read books on psychiatry; I
> expected to learn that when I got here. I [said I] was concentrating on the
> Russian novel, at which, the rest of the viva was entirely about my knowledge
> of Russian novels. He would pick out people who'd got membership of the
> Royal College of Physicians, university prizes, or a paper published...they were
> taking a responsibility for furthering the subject, and, if they thought you had
> academic potential, they would look after you no end.[152]

The current study will provide fresh insights into how novel populations and
approaches were assimilated into the hospital, and what impact they exerted both on
a wider scale and on the social and clinical profile of Bethlem's patients. It will further
address outstanding questions regarding dynamics of service demand and uptake, the
relationship between official policy and ward-level practice, and the implications of
multidisciplinary working.

Conclusion

The preceding discussion has established the twentieth century as a period of great
ferment within psychiatry, with prominent developments including the arrival of
'psychoneurosis', and the accompanying conceptual movement of madness from
bodily and institutional domains, to those of the life course and wider community.
These transitions were entwined with, and occurred alongside, powerful arguments
about appropriate physical or psychodynamic interventions.

Armstrong, Rose and Thomson are amongst leading proponents of alternative opinion
on the place of psychiatry within twentieth-century Britain, and have attempted to

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[151] Focus group participants, Bethlem Royal Hospital, 8th January 2014.
[152] Griffith Edwards, Interview by Author, 7th December 2010.

unravel some of the complexities of changes in attitudes and service usage. Yet, less is known of how these changes shaped institutional populations, policy, and practice. The current research will therefore permit testing of national-level concerns relating to governance, subjectivity, changing public attitudes to, and awareness of, psychological discourses. It will further provide an extension of previous accounts that have identified, but not investigated, gender anomalies in psychiatric admissions and treatment, and explore the significance of the post-1930 expansion in voluntary treatment. In essence, the study will examine the relationship between the growth of new diagnoses and therapies and the (re)positioning of the psychiatric patient and institution within the twentieth century.

Institutional histories have shed light on some aspects of mental health service development and delivery, and provided indications of themes and techniques for the current enquiry. Yet, these accounts have largely occupied themselves with chronicling the fates of public asylums, typically remaining within the accepted 'rise and fall' narrative. Rather, forthcoming chapters will demonstrate how an institution, located at the intellectual heart of twentieth-century therapeutic flux, responded through admission and treatment practices. The study navigates the ongoing realities of inpatient treatment before and during (what is widely perceived as) the community care era. It also contributes new perspectives on emergent psychological cultures, institutional dynamics, the mediating role of gender, and enables the testing of specific claims regarding novel psychiatric diagnoses, populations and services. At a local level, the Bethlem and Maudsley Hospitals each possessed distinctive strengths, cultures, and remits in the early twentieth century; documented, respectively, by Andrews et al., and Edgar Jones. Yet, in contrast to a wealth of earlier historiography, there has been relatively little attention to Bethlem's development in this period, and no prior attempt to synthesise statistical and qualitative hospital data into a coherent account of institutional, and individual, journeys. There now follows a detailed description of the methods and sources utilised within the current research.

Chapter 3: Methodology

A tripartite methodology comprised documentary research on administrative records and use of oral testimony to explore the impact of legal and managerial influences; an admissions database to chart trends in demographic and clinical features of hospital population; and documentary and oral history work relating to specialist psychotherapy services. Each aspect will be explored in more detail, together with practical considerations to conducting the research and justification of the selected approaches. There will also be a more focused discussion on the objectives, benefits and challenges inherent to research involving clinical patient records, contextualised by an overview of allied literature.

Location and Accessing Materials

Archival research involving patient-identifiable data was undertaken at Bethlem Royal Hospital Archives. Used in conjunction with wider scientific, historical and political sources, this allowed a more comprehensive insight into the genesis of ideas and practices at the hospital. Bethlem Royal Hospital Archives and Museum is approved by the National Archives as a repository for the archives of the South London and Maudsley NHS Trust and its predecessors, some of which are available online. Additionally, it houses a small library of materials relating to the Bethlem and Maudsley hospitals, and the more general history of psychiatry and mental healthcare. The archives and library may be accessed by appointment only, and materials are provided by the archivist and consulted at his discretion.

Ethical Approval

Due to the nature of materials to be consulted, the study required ethical review from both the LSHTM and NHS Ethics Committees. Approval was granted, contingent on patient-identifiable data being anonymised, securely stored and retained for only a limited period after completion of the study.

Admission registers contained names of patients, dates of birth, sometimes occupations and addresses, and always information of a highly personal and sensitive

nature concerning individuals and their immediate relatives. To anonymise these records, patient reference codes were substituted for names, and other precise personal information was omitted. Hospital-assigned reference codes were based on the chronological order of admission, and their usage had twofold advantages of preserving anonymity whilst allowing the study to be verified and developed by future researchers, subject to appropriate ethical clearance. Particular ethical concerns relating to the use of psychotherapy casenotes are discussed later in this chapter.

Preliminary Documentary Research

Initial study of the administrative records of Bethlem helped to establish the institutional context of treatment, covering issues such as admissions policies, finance and changing governance structures. Sources consulted include annual and statistical reports, committee minutes, general correspondence and in-house publications. These provided insight into the organisational framework of care both before and after the start of the NHS, whilst published scientific works of Bethlem consultants reflected changing ideas and therapeutic practices. These sets of records were open to public access and posed no ethical challenge.

Nature of Admission Registers

In recounting the shift from literary to medical opinion in hospital registers, former Bethlem archivist Patricia Allderidge characterised the recording of nineteenth century admissions thus:

> While the first, or Form, column is attributable to the medical staff alone, the second appears to make liberal use of the observations of friends and relations, clergymen, boarding-house keepers, and others better qualified than doctors to indulge in the practice of belles-lettres. The need to fit the elements of a novelette into a space 1⅜ inches wide produced a form and style in which, if elegance and even coherence are sometimes sacrificed to brevity, the

resolution of the inherent tensions is subtly accomplished, and the result is

frequently graceful and rarely less than felicitous.[1]

Asylum admission registers allowed a glimpse into prevailing theories of the origins of

mental illness. For instance, belief in the role of heredity led to birth order, family size

and relatives' psychiatric illness being recorded in the 1930s, whilst the 1950s focus on

social influences prompted the inclusion of details of matrimonial and domestic data.

However, rather than being a top-down directive, classification and diagnosis was a

more organic process, with diverse influences mediating between intended and actual

hospital protocol.

Admission and discharge summaries and medical registers from 1930 to 1983 were

used to provide an overview of the work of the hospital and the nature of its patients.

Bethlem and Maudsley admission data were always kept separate. Pre-war Bethlem

admission registers ran from 1919 to 1948; postwar admission registers from 1948 to

1973. There was then a gap until a run of admission and discharge registers from 1979

to 1991. For any year between 1973 and 1979, it was necessary to sample patients

from discharge summaries. Moreover, admissions were disrupted in 1930 as a

consequence of the hospital's relocation to Beckenham, making it preferable to

commence sampling in 1931.

Construction of Database and Coding

A database was created in Excel to generate a picture of changing admissions patterns

to Bethlem, and further details of this are appended. Categorical diagnoses were used

in conjunction with clinical casenotes, which gave additional domestic or occupational

context to such terms as 'prolonged mental stress'. It was thus possible to discern

changing diagnostic habits over the decades, and to establish links between purported

aetiology and the later development of specialised services.

The Joint Hospital adopted the World Health Organization's (WHO) *International

Classification of Diseases and Causes of Death* (1947). This featured 26 diagnostic

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[1] P. Allderidge, "Diagnosis as Literature," *Bethlem and Maudsley Hospital Gazette* 10 (3) (1969): p.28.

groups, many subdivided, but with three overriding assortments of 'psychoneuroses', 'psychoneurotic disorder' and 'disorders of character, behaviour and intelligence'. This represented a convenient system, although some cases still defied accurate diagnosis.[2] Key differences between the eighth and ninth revisions of the system (1967 and 1977 respectively) included an increased number of personality disorders, the introduction of an 'alcohol dependence syndrome', and declining subtypes of 'mental or neurological retardation'.

Separate worksheets were allocated for each year and column headings were based on the format of admission registers to be consulted. Data were thus recorded on age, sex, marital status, mode of admission (voluntary, temporary or certified), occupation, previous attacks/admissions, diagnosis, cause of illness, length of stay, and outcome. Official classification schemes were used for occupation, specific disorder and presumed aetiology, whilst a separate coding system was devised to facilitate data entry and analysis of other criteria. Details of these frameworks may be found in the appendix. Challenges also arose from inconsistencies of information recorded at different times, particularly with respect to diagnostic categories, causal factors and patient occupations.

Employment status was only included on admission records until 1947; thereafter, although it would often feature in patient casenotes, this would be in a non-standardised form, which prevented detailed analysis. Investigation of patient occupations in the early twentieth century was also impeded by the tradition for women to sometimes be assigned their husband's ('head of household's') occupation, or for patients to be classified on basis of last known employment, regardless of how long ago this was. Additionally, the early 1930s saw schematic changes in occupational coding (see Appendix) which also obstructed longitudinal analysis of trends. It was, nevertheless, possible to sort admissions on the basis of their occupational coding; an alphanumeric index of fields of industry and specific job titles. For instance, category 'X' covered commerce, finance and insurance; thus, a retail manager was 'Xa1', and a commercial traveller (travelling salesman) was 'Xa3'. Yet, despite this ostensibly clear framework, information recorded was subjective, and, sometimes, incomplete.

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[2] BRHAM, "Triennial Statistical Report, Years 1949-1951," ed. C.P Blacker and A.T. Gore, pp.7-8.

Moreover, differing job titles could be mapped onto a single code; a prominent example of this being 'CCa3', which attracted multiple variations along the lines of clerk, typist and secretary.

The following discussion refers only to the 1952-1983 register entries. Although separate Bethlem registers were maintained after the merger, these were less detailed than the previous versions, including, for example, patients' destination wards rather than actual diagnoses. Nevertheless, this information permitted approximation of diagnosis, and patient reference numbers allowed cases to be investigated in more detail within the archive. Formal ICD codes were entered into the worksheet, but this system was revised several times between 1952 and 1983, with subtle shifts in numbering and terminology between versions. As such, it was necessary to establish consistently representative codes for the data before attempting to evaluate diagnoses for this period. Whilst there are inevitable historical caveats to imposing retrospective classifications, these are countered by the necessity for long run categories in the analysis of psychiatric morbidity trends. Categories from ICD-8 (1967) and ICD-9 (1977) were compared, and a 17-item list of key mental disorders was obtained (Table 1), onto which postwar Bethlem diagnoses could be mapped. The list was shaped by the terms applied on these registers, rather than being a comprehensive rendition of ICD classes, and Chapter 5 features further discussion of notable changes occurring between the two versions.

PSYCHOSES			
1	**Dementia**	Alzheimer's Disease	Senile Dementia
		Multi-Infarct Dementia	Pre-Senile Dementia
2	**Toxic Psychosis**	Delirium Tremens	Drug/Alcohol Hallucinosis
3	**Schizophrenia**	Catatonia/Stupor	Paraphrenia
		Hebephrenia	Residual Schizophrenia
		Paranoid Schizophrenia	Schizo-affective State/Disorder
4	**Other Organic Psychosis**	Confusional State	Huntington's Chorea
		General Paralysis of the Insane (GPI)	Korsakov's Syndrome
		Puerperal Psychosis	
5	**Affective Psychosis**	Depressive Psychosis	Mixed Affective Disorder/Disturbance
		Hypomania	Psychotic Depression
		Manic Depression (all types)	
6	**Paranoid States**	Morbid/Chronic Jealousy	
7	**Other/Unspecified Non-Organic Psychosis**	Brief Psychotic Episode	Psychogenic Psychosis
		Childhood Psychosis	
NEUROSES, PERSONALITY DISORDERS AND NON-PSYCHOTIC MENTAL DISORDERS			
8	**Depression**	Affective Disorder/Illness	Melancholia
		Depressive Illness	Neurotic Depression
		Endogenous/Chronic Depression	Reactive/Agitated Depression
9	**Neurotic and Anxiety Disorders**	Anxiety	Neurasthenia
		Eating Disorders	Neurotic Breakdown
		Hypochondria	Obsessive Compulsive Disorder
		Hysteria	Phobia
10	**Personality Disorder**	Affective	Immature
		Anankastic	Impulsive/Aggressive
		Asocial	Inadequate
		Asthenic	Obsessional
		Borderline Personality	Paranoid
		Cyclothymic	Psychopathic
		Dependent	Schizoid
		Dysthymic	Sociopathic
		Histrionic	Unspecified
		Hysterical	
11	**Sexual Deviation**	Exhibitionism	Hypersexuality
		Homosexuality	Masochism
12	**Drug/Alcohol Use or Dependency**	Drug/Alcohol Dependency (Syndrome)	Drug/Alcohol Addiction
		Habitual Excessive Drinking	Drug/Alcohol Withdrawal
13	**Non-Psychotic Mental Disorder of Organic Origin**	Puerperal/Post Partum Depression	Traumatic Brain Injury
		Post-Operative Conditions	Arteriosclerotic Personality Change
14	**Childhood/Adolescent Behaviour Disorder**		
15	**Other/Unspecified Neurosis or Non-Psychotic Mental Disorder (incl. stress)**	Grief Reaction	Unspecified Adjustment Reaction
		Transient Situational Disturbance/Crisis	
MENTAL OR NEUROLOGICAL RETARDATION			
16	**Mental Retardation**	Borderline Intelligence	Educational/Mental Subnormality
		Intellectual Handicap	
17	**Neurological Disorder**	Epilepsy	Parkinson's Disease
		Frontal Lobe Syndrome	

Table 1: Coding Framework for Diagnoses of Bethlem Admissions, 1952-1983

Sampling: Techniques and Challenges

A preliminary objective was oversampling at the end two dates – i.e. recording details of *all* annual admissions – for the years 1931 and 1983. This assisted in formulating hypotheses and appropriate sample sizes for the intervening decades. To clarify, too small a sample risked failing to catch sufficient cases of potential interest, e.g. the youngest or oldest patients for a given year. One hundred inpatients were then randomly sampled from each of the following years: 1934, 1936, 1938, 1941, 1944, 1946, 1952, 1955, 1958, 1964, 1970, and 1976. Randomisation was achieved by dividing an entire year's patient intake by 100 to determine the intervals at which entries should be sampled. For example, from a starting population of 200, details of every second patient would be recorded. In this way, it was also possible to reflect the original gender distribution of admissions for the whole year regardless of 1930s transitions in register design affecting whether male and female data was separate or merged. Further length of stay information from before the focal period was later added, in order to clarify the extent and timescale of patterns observed in the 1930s. Until 1933, male and female patients were recorded within the same annual casebook of discharges and deaths; thereafter, separate books were maintained for men and women.

On the advice of the archivist, sampling began in 1931 rather than 1930. Although records were kept for the latter year, all patients were discharged or transferred out upon closure of the old site in June 1930, with registers for the new hospital only commencing in autumn of that year. Moreover, the hospital prioritised readmission of certified patients after this hiatus, which also rendered the early intake unrepresentative of normal practice. A total of 2669 admission entries were recorded, but, for the following reasons, it was not feasible to conduct follow-up research on each individual case. Changing register formats and incomplete, duplicate or unclear entries prevented all from being subjected to the same analyses. This was most pronounced in the 1983 data, where only 472 of 683 discharge register names yielded definitive diagnoses within a casenote follow-up. Possible explanations for this include records being wrongly filed, stored elsewhere (notably for children's records after 1970, or transfer patients) or simply not retained. Moreover, the earliest records (1921-30) were consulted for the specific purpose of further investigating patterns in

length of stay, on the basis of emerging trends from late 1920s and early 30s. Patient subsets were also later sampled to investigate key demographic or clinical trends, and further details were obtained by casenote linkage. Details of such enquiries are provided later in this section.

Archival research was impeded by inconsistencies in the information recorded at different times, particularly with respect to diagnostic categories, causal factors and patient occupations, whilst duplicates from readmissions or reclassification presented a further challenge. Bethlem itself had been admitting patients 'informally' since the nineteenth century, but 'voluntary' and 'temporary' categories were only officially endorsed in 1930. This greater flexibility meant that the same patient could be reclassified one or more times (typically from certified to voluntary boarder, or vice versa) thus acquiring multiple reference numbers and register entries within a single year. It was possible to avoid repeated cases when taking samples only, but it should be borne in mind that the 1931 data includes all admissions rather than all individuals. To clarify, from a total of 241 register entries for this year, 21 patients had multiple admissions (18 were admitted twice; 3 were admitted three times). In the latter circumstance, one patient was reclassified from voluntary, to certified, then back to voluntary status, whilst a further two were admitted voluntarily, reclassified to temporary, and resumed voluntary status towards the end of their stay. There were thus a total of 217 individual patients (88 males, 129 females) admitted in 1931.

The decision was, nevertheless, taken to retain all entries because of their potential value in understanding the causes and effects of reclassifying patients. Moreover, some patients were assigned different diagnoses and aetiologies for consecutive admissions, potentially a reflection of a fluctuating symptom course, coupled with the malleability of psychiatric categories in this era. From the 1950s onwards, readmissions were easier to identify, as they retained the same reference number throughout their Bethlem 'career'. Where duplicates were found in the 1983 data, only an individual's longest admission was retained for analytic purposes. Furthermore, women admitted to the Mother and Baby Unit were accompanied by their infant, who was also assigned a hospital reference number. These cases were also omitted from analysis so as not to bias results, especially for age-related trends.

Oral Histories

Interviews were conducted with 9 key informants who worked or trained at Bethlem in the focal period. These individuals were recruited through personal contacts, and the sample eventually comprised 5 former nurses, 2 professors of psychiatry, one senior administrator and his former secretary (the latter pair being interviewed together). Oral history data were intended to contextualise themes raised in the literature, and to provide personal insights into hitherto undocumented nuances of hospital life; namely, ward-level perspectives on patients, treatments, the everyday life of the hospital, and its links to the local community. There will now follow a description of the recruitment, interview and transcription procedures.

Oral history work was intended to build upon the main corpus of archival research, and to offer first-hand perspectives on the internal life of the hospital. Hence, a purposive sampling approach was used, deliberately seeking a small number of people likely to produce relevant and useful reflections on documented therapeutic or administrative changes. Interviewees were recruited through personal contacts provided by colleagues. A group of former psychiatric nurses who had trained together in the 1960s and '70s yielded 5 interviews. In the interests of achieving a diversity of backgrounds, other informants were drawn from clinical or administrative fields. Thus, one contact was obtained from the Bethlem archivist, one through an academic colleague, and another through personal recommendation from a previous interviewee. Contact was established through an introductory email or letter, including a study information sheet (see Appendix). Once a meeting had been arranged, participants were sent a topic guide (Appendix) though it was emphasised that this was intended merely as an aide memoire, rather than a linear narrative. Interviews were conducted in mutually-agreed and convenient settings. In three cases, this was a quiet university office, whilst four participants requested to meet in their home, and one in a workplace.

The researcher recognised the importance of establishing rapport, and endeavoured to put visitors at ease in the academic environment (or, when elsewhere, to not impose

on their space). Before commencing the discussion, participants were asked to sign two copies of a consent form (Appendix) to confirm they understood and were agreeable to the terms of the interview, and to express which of four levels of confidentiality and anonymity they would prefer. Participant and researcher each retained a copy of the document. The voice recorder (model: Olympus VN-960PC) was then turned on, and the interview began.

Judith Green and Nicki Thorogood outlined a number of ways in which qualitative research could be differentiated from other activities seeking to describe social life. Central to this, was the adoption of a critical approach to individual experience, thus: 'The subjective accounts generated through research are not simply taken as 'truth' about the world, but as situated, contextual accounts. The researcher's task is not to reproduce those accounts as if they offer a privileged representation of social reality, but to ask: why, and how, do people here come to think, behave and talk as they do?'[3] A semi-structured approach was adopted, whereby 'the researcher sets the agenda in terms of the topics covered, but the interviewee's responses determine the kinds of information produced about those topics, and the relative importance of each of them'.[4] This method therefore helped to ensure key areas were addressed, whilst also allowing flexibility within participants' answers and scope for new themes to emerge. Moreover, a reflexive framework required the researcher to engage in testing their own preconceived ideas, and be alert to disconfirmatory evidence. Efforts were made to avoid linguistic assumptions and jargon, and to employ open and non-judgemental questions. Although the same basic format was used for all participants, the relative significance and time allocated to particular themes was adjusted depending on the professional background of individual respondents and responses elicited. A copy of the interview schedule is appended.

In addition to the spoken content of the interview, attention was paid to the significance of body language – i.e. posture, eye contact, friendly demeanour and non-verbal cues – in putting the interviewee at ease and facilitating communication.

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[3] Judith Green and Nicki Thorogood, *Qualitative Methods for Health Research, Second Edition* (London: Sage Publications Ltd., 2009), p.29.
[4] Ibid., p.94.

Moreover, there was careful, non-pressurised use of prompts and probes to elicit greater depth of experience and reminiscences. Green and Thorogood also described the effects of social status in conducting interviews; notably, issues of power dynamics and autonomy of a PhD researcher speaking to senior health professionals. They proposed that such interactions may generate rather contrived and formulaic testimony,[5] resulting in a polished and 'public' rendition of events. However, for three respondents, this imbalance also had implications for their mode of recruitment (meeting arranged through a third party) and placed restrictions on the interview length and location.

Upon completion of the interview, participants were thanked for their time, and further questions or contributions were invited. They were also given the option of receiving future updates about the progress of the project. The audio file was subsequently uploaded from the voice recorder to a PC, and transcription completed in Microsoft Word. In the interests of confidentiality, files were then deleted from the recorder, and in transcripts, interviewees were referred to only by their initials. The decision was taken not to employ an external transcriber, given budgetary constraints, and risks of compromising the confidentiality of interview material. Moreover, there were potential benefits of the researcher undertaking this task personally and thereby acquiring greater familiarly with the data through repeated exposure.

Problems Encountered

i) Oral History

A number of challenges arose throughout the interview process. Whilst some of these were common issues with oral history research, others were more specific and unanticipated. General problems with memory impairment were exacerbated by the fact that participants were senior citizens being asked to describe events occurring up to fifty years ago. Whilst several had made preparatory notes, their clear frustrations at failing to recall key names or dates caused occasional distraction and threatened to disrupt the flow of the remainder of the interview. There was ongoing awareness of the need to maintain professional control of situation, whilst also building a rapport

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[5] Ibid., p.109.

with the participant and avoiding any barriers to effective communication. Moreover, care was taken to avoid 'leading questions', over-emphasising the importance of particular events or implying that the respondent was instrumental in matters where they wouldn't necessarily have viewed themselves as such.

Establishing contact with a group of former nursing colleagues was helpful to the research, but posed a risk of sampling bias, and presented further challenges with regard to maintaining confidentiality between individuals. Additionally, the discovery that one former staff member had also spent time as a psychiatric patient at the hospital posed an immediate ethical concern, given that they had been recruited in a professional capacity. The participant was willing to discuss both connections to Bethlem, and though these comments were accepted when offered, in accordance with ethical guidelines, memories of the 'patient experience' were not actively sought. Ultimately, the project attracted only a small number of participants. This can be attributed to inherent time limits on data collection, the order in which key figures were recruited, and delays in receiving responses to invitations. Thus, although the cohort of ex-nurses provided a convenient entry point to the oral history work - and yielded an unexpected heterogeneity of experience and opinion - senior clinicians and administrators (who weren't consulted until some months later) would have been better-placed to nominate potential interviewees for the study. Moreover, a greater volume of respondents, representing a wider occupational spectrum, may have generated further avenues for archival enquiry.

ii) Archival Research

As previously discussed, archival research in the recent history of psychiatry is beset by ethical and practical challenges: records relating to individual patients are closed to public inspection until one hundred years after their creation, and all other records are closed until they are thirty years old. Additionally, the benefits of ultimately acquiring access to hitherto unexamined sources are commonly offset by the physical condition and organisation of these materials, whilst classificatory changes, interruptions to series, and alterations in information recorded over time all pose obstacles to longitudinal study. Caveats also reside in the potential misuse of these sources for

retrospective diagnosis, drawing analogies with contemporary psychiatric conditions, or 'translating' or 'updating' anachronistic medical terminology. Relatedly, inherent gender biases were found in the reporting of occupational backgrounds; an issue which is expanded upon in chapter 4.

The majority of Bethlem records consulted had been appropriately catalogued and conserved, but the research was impeded by a number of problems in this area, thus: the combined effects of a rise in admissions, and the growing mass of additional test results and drug charts, meant that the physical dimensions of these sources grew to unmanageable proportions. This size and bulk of casebooks implied an economic imperative in collating the maximum number of papers into a single bound volume, with little expectation of their ever needing to be consulted again. Additionally, the research process was compounded by the varying and, occasionally, indecipherable, handwriting of casebook authors. Water damage to 1950s admission registers also restricted the years from which it was possible to sample patients, whilst psychotherapy unit records of the 1960s-70s were awaiting imminent preservation efforts, and somewhat precariously housed in their original lever arch files.

The absence of archival sources – e.g. those relating to a specific service, or timeframe - raises additional questions for the researcher. Sometimes this will indeed be because the material never existed; yet, it can also result from erroneous personal assumptions about what *should* exist, compounded by uncertainty over what might have been destroyed, misplaced, or simply deemed "irrelevant" by archivists or authors. It is, therefore, crucial to remember that cataloguing and sorting of material are subjective processes, which may have implications for how those sources are used in the future. A second level of self-imposed 'filters' also operate between historians and their sources, in terms of selection of specific materials, and - deliberate or accidental - omission of others. There is a fundamental need to strike a balance between letting background literature and hypotheses determine the search strategy, and maintaining an open-minded (but potentially time-consuming) outlook towards possibilities within the archive.

Patient Casenotes for Psychiatric Historiography

The use of patient records for historical investigation has gained increasing centrality in recent scholarship. Some examples of such work, its implications and applications, are outlined below, providing a backdrop of approaches and issues germane to the current study. Thus, topics under consideration will include the different ways historians have used patient records, the variety of asylum documents (e.g. admission registers, unit-level records, casebooks and patient correspondence) and the potential for using these materials in conjunction with other media.

In 1967, Erwin Ackerknecht was amongst the first writers to highlight the shortcomings of a history dependent on the writings of 'court physicians, academicians or university professors'; sources, which, he believed, failed to provide 'the most elementary facts of either medical practices or the social aspects of medical practice even for periods not very far removed at all'. This prompted Ackerknecht to call for a so-called "behaviourist approach" to historiography, with greater and more critical analysis of what doctors actually *did*, rather than simply what they thought and wrote.[6] Within Britain, Roy Porter led the move to bring the patient back into medical history. He thus argued that:

> ...this physician-centred account of the rise of medicine may involve a major historical distortion. For it takes two to make a medical encounter...Indeed it often takes many more than two, because medical events have frequently been complex social rituals, involving family and community as well as sufferers and physicians.[7]

Such accounts, he believed, ignored the significance of non-professional support or self-help; encouraged a preoccupation with therapeutics rather than routine health maintenance, and, ultimately, detached the experience of sickness from its cultural influences and implications.[8]

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[6] Erwin H. Ackerknecht, "A Plea for a Behaviorist Approach in Writing the History of Medicine," *Journal of the History of Medicine and Allied Sciences* XXII, no. 3 (1967): pp.212, 214.
[7] Roy Porter, "The Patient's View," *Theory and Society* 14, no. 2 (1985): p.175.
[8] Ibid., pp.193-194.

Developing this tradition some decades later, Guenter B. Risse and John Harley Warner noted historians' growing interest in the use of patient casenotes, which they declared to be 'surviving artefacts of the interaction between physicians and their patients in which individual personality, cultural assumptions, social status, bureaucratic expediency, and the reality of power relationships are expressed'. The authors drew examples from a variety of documentary classes to illustrate the strengths and weaknesses of using these materials, also highlighting the interplay between the changing purposes of records (whether administrative, promotional, or educational) and their evolving format, tone and content. However, they proposed that a major obstacle to this approach was its perceived impenetrability and labour-intensive nature: thus, 'Depending on institutional norms and personal preferences, textual meanings are deeply imbedded in the records and require tedious excavation and subtle interpretation. In other instances information useful to the historian lies exposed very near the surface'. Risse and Warner further outlined the risks of either extrapolating from individual case studies, or assuming the accuracy or completeness of data therein. In a more positive vein, they believed that the insights these sources afforded into context-specific ideology and behaviour could be gainfully applied to wider questions of social change, medical epistemology, and clinical decision making, and that the casenote could 'become one vehicle for a historiographic synthesis in which artificial distinctions between the intellectual and social dimensions of medical experience are dissolved'.[9]

Steven Noll provided an account of Caswell Training School, a North Carolina institute for mentally defective children, which opened in 1914. He asserted that, from the outset, Caswell lacked a clear focus, maintaining often conflicting residential, medical, educational and social control, functions. However, Noll believed that 'the use of patient records and correspondence allows the researcher to probe beyond the bureaucratic walls and examine the institution in a patient-centred manner'. He thus attempted to elicit historical stories from the range of documents held within patient files, including medical and administrative data, IQ test results, and personal correspondence, and applied pseudonyms in reporting his findings. Whilst the sources

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[9] Guenter B. Risse and John Harley Warner, "Reconstructing Clinical Activities: Patient Records in Medical History," *Social History of Medicine* 5, no. 2 (1992): pp.183, 189-190, 204-205.

consulted adopted a narrative rather than clinical tone, favouring 'mundane' everyday minutiae, Noll further proposed that, 'used judiciously and in conjunction with other source material, patient records can reveal the subtle dialectic between the lives of patients and the broader institutional goals of administrators and state officials'.[10] Conflicts were noted between patients' expected prognoses upon admission (based largely on IQ levels) and their actual experiences and progress in the School. Letters from family members expressed anger and distress at perceived wrongful admissions; fine-grained insights were adroitly contextualised by reference to the 'conflation of class and gender prejudices' which made some women more vulnerable not only to incarceration, but to becoming 'victims of a state-run sterilization program'.[11] Noll concluded that two distinct images of Caswell had emerged: one, a vision of 'social control at its most blatant'; another, representing the 'last resort for beleaguered patients and a measure of care and concern for patients'.[12] This would appear to imply that coexisting but dissimilar narratives should not, upon further inspection, be expected to yield to an unequivocal single institutional history. Moreover, this research underscored the value of case study detail when viewed through the lens of wider socio-political and medical concerns.

Jonathan Andrews focused on nineteenth-century administrative practices at Glasgow's Gartnavel Royal Asylum. However, he also described record-keeping at Bethlem in the same era, linking developments to surveillance concerns, rather than the declared 'diagnostic and therapeutic' intent, or as a means of acquiring further knowledge about insanity. This was perhaps surprising, given Bethlem's unique pre-1853 exemption from inspection under the Madhouses Acts. Andrews proposed that the timing of events was significant: the new system made no mention of recent scandalous revelations centring on the hospital; instead, casenotes sought to '...maintain Bethlem's traditional aura of independence by attributing reforms rhetorically to the move to a new site and building at St George's Fields'. He further cautioned that such documents were 'innately jaundiced' in the type of information they featured, often reflecting 'preoccupations of the medical regime', or biased in

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[10] Steven Noll, "Patient Records as Historical Stories: The Case of Caswell Training School," *Bulletin of the History of Medicine* 68:3 (1994): p.411-413, 415.
[11] Ibid., pp.417-419.
[12] Ibid., p.424.

favour of 'wealthy, educated, articulate, or extrovert' patients. Moreover, Andrews identified the likely conflicts of interests between patients' families and asylum superintendents in the recording of medical histories. Thus, while the latter party wished to accrue testable data (particularly in respect of hereditarianism) patients' relatives would, he suggested, have feared the consequences to reputation and livelihood of 'being tarred with the same brush'. He also highlighted the potential disregard of non-medical opinion, resulting in the subsequent altering or omission of such testimony on records. [13] Andrews reminded the reader that early patient correspondence granted only an isolated glimpse into subjective institutional experiences, and afforded no further insight into occupants' lives. However, the evidence he presented revealed a lesser-known influence of outside agencies on the inpatient domain, discussed the censorship of patients' writings and the contrast between inmates' supposed 'freedom of correspondence' with the Lord Chancellor and the Lunacy Board, and the frequent destruction of such letters by their esteemed recipients.[14]

The above excerpts have thus demonstrated how appropriately executed historical investigation of psychiatric records can contribute to knowledge of institutional regimes, challenge received wisdom, and offer more general insights into the often latent factors affecting inpatient care. They have reinforced the need for the researcher to be alert to both the context of creation and intended uses (promotional, administrative, or educational) and readership of sources under investigation; highlighted biases arising from author negligence or deception, and addressed the applications and implications of evidence so obtained. Having heeded these considerations, casenotes thus present an important avenue into a discrete period in the life of an institution or individual. Their intrinsic value lies not in the formulation – or, indeed, overthrow - of grand narratives, nor the search for a unitary 'truth' of madness. Rather, it is found in the gradual (and often painstaking) discovery and assembly of fragments of human experience; perspectives which can promote fresh understandings of the place and process of mental illness.

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[13] Andrews, "Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century," pp.256-257, 265-266.
[14] Ibid., pp.269-271.

Casenote Follow-Ups

At a later phase in the research, and whilst interviews were ongoing, post-hoc hypothesis-testing was achieved through the specific sorting and filtering of Excel admissions data. The main objective of this process was to ascertain the treatment received by particular groups of patients, namely, information not detailed in admission registers, but which would substantiate conclusions subsequently drawn. Prompted by emerging trends in both archival and oral history work, enquiries were conducted across the following areas, and the results are reported in chapters 4-7:

I. *Long-stay Patients*: Prewar data were sorted by length of admission, and the unique hospital reference numbers and discharge dates of the longest-staying 10% of patients extracted for more detailed follow-up. The aims of this exercise were to discover more about the circumstances surrounding their admissions; their prolonged inpatient experiences, and – where applicable – their plans for leaving hospital. Consultation of patient casebooks and correspondence files enabled important insights into the discursive interactions between hospital staff, patients, and their families, and cast new light onto institutional dynamics.

II. *Climacteric Patients*: Climacteric emerged as a prominent aetiology for both male and female patients, synonymous with the notions of menopause, or, more recently, 'mid-life crisis'. The Bethlem evidence challenged existing accounts of the application of this supposedly 'female' causal attribution, thus, further investigation of the backgrounds, treatment, and prognoses of these patients was considered necessary.

III. *Primary Dementia Patients*: A decision was taken to explore the usage of physical treatment (e.g. insulin, ECT) with this population, and, specifically, to test the idea that physical methods were more commonly used with certified patients. A sample of 40 patients was taken from 1931-1947, comprising equal proportions of male, female, certified, and voluntary admissions. As per

previous queries, patients' reference numbers and dates of discharge enabled casenote follow-up. References to treatment administered were recorded on an Excel spreadsheet for subsequent analysis.

IV. *Melancholia Patients*: This query served the primary aim of seeking evidence of pre-1950s psychiatric drug use for patients with one of the commonest forms of mental disorder. The sampling technique was as above, but for cases of 'recent melancholia'. An Excel worksheet was again created, and details were recorded of any treatment mentioned in casenotes, with particular reference to pharmaceuticals (whether psychiatric or generic).

V. *Affective psychosis/manic depression (female)*; The postwar ascent of this diagnosis, and its particular prevalence amongst female patients, prompted a casenote follow-up of 22 such cases from the period 1952-1983, to permit further insight into how it was diagnosed and treated.

VI. *'Hereditary' aetiologies*: divided into 'insane' and neurotic' subtypes (register codes A1 and A3 respectively). Casenote research on 22 patients sought to examine the differentiation between these classes, the role of gender, implications for treatment/prognosis and patients' self-perceptions. Macro-level concerns included the relationship between aetiology and diagnosis, and the utilisation and interpretation of patients' family histories.

VII. *'Mental stress' aetiology*: divided into 'sudden' and 'prolonged' subtypes (register codes F1 and F2 respectively). Casenote research on 19 patients sought to examine the how the two subtypes were differentiated, to identify any gender differences in attribution, and to consider links to prognosis and treatment.

Further Qualitative Research

Upon completion of the database and preliminary quantitative analyses, further documentary research was conducted to explore trends emerging from the admissions

registers. Sources consulted included: patient casenotes (pre-1947), discharge summaries (post-1952), committee minute books, correspondence files, and institutional prospectuses. This literature allowed additional insight into decisions affecting patient care and hospital policy. Moreover, the combination of hospital marketing materials and patient correspondence data facilitated exploration of why individuals and their families sought treatment at Bethlem, and of their ongoing involvement in negotiating care, thereby informing ideas of health consumerism. Priority was further given to voluntary patients who stayed for over a year, potentially generating more correspondence. In all cases, content was either copied verbatim or abridged, and data were saved in Word format, with files arranged in appropriate folders and keyword text searches conducted as required. Medical textbooks and staff publications were also consulted at this point, as additional indicators of prevailing scientific and individual opinion on particular disorders.

Psychotherapy was a key growth area for the Joint Hospital in the postwar years, and a variety of inpatient and outpatient treatment services were offered across both sites, and this is reflected below in the choice of materials consulted. Psychotherapy records provided three important contributions: they shed light on what specific schools of thought Bethlem analysts subscribed to (e.g. Freudian, Jungian, Kleinian); they conveyed some impression of the mediating effect of patient gender on expression and interpretation of symptoms, and lastly, they facilitated further investigation of the publications and research interests of the unit's staff. This was achieved through the follow-up of footnotes or citations, or by conducting author searches of the electronic *PubMed* database.

i) Outpatient Psychotherapy

Outpatient psychotherapy was actually conducted at the Maudsley, but with interchange of staff from Bethlem. The two main classes of outpatient record available were assessment files and case summaries. Assessment files were kept from the 1960s to 1980s – a larger timescale than case summaries – and typically comprising 1-2 sides of A4, were also slightly longer than case summaries. They centred on patients' backgrounds and the circumstances leading to their psychotherapy referral. Because

these sources preceded case summaries, it was possible to use them to gauge the accuracy of psychiatrists' early impressions and recommendations for patients. The final case summaries gave a précis of treatment and outcome/prognosis within a group or individual setting, with many clients attending for a year or more and alternating between the different modes of therapy within this time.

A total of 43 outpatient case summaries were sampled, comprising 40 single patients (20 male, 20 female), one couple, one family, and one interim group summary. These records commenced in 1974, and patients attended a mix of individual or group therapies. A more extensive run of assessment files was available, with 9 files (PCT-01 to PCT-09) covering the period 1964-83. The small window of chronological overlap between the two classes of documents meant that only 11 patients (5 male, 6 female) could be conclusively followed-up in this manner, using PCT-03 (September 1973 – January 1976). Ten patients (5 male, 5 female) were also randomly selected per file PCT-01, 05, 07, and 09, in order to investigate longitudinal changes in psychotherapy services and clientele.

ii) Inpatient Psychotherapy

Bethlem itself hosted psychotherapy inpatient services during the 1970s. The Charles Hood Unit opened in 1972 and was run as a therapeutic community under the directorship of Dr Robert Hobson. Although Hobson himself was an eminent Jungian, referral and treatment procedures involved a range of other staff, therefore a singular underlying ethos was not assumed. Of particular interest was the autonomous nature of this facility: despite using Bethlem's premises and staff, it was otherwise detached from wider hospital life, with, for example, occupational therapists visiting the ward in person, and patients not interacting with those beyond the confines of their 'community'. Moreover, the somewhat enigmatic and elitist nature of this service could have manifested in a reluctance to keep detailed records, thereby contributing to the belated discovery of only a small quantity of records.

The unit consisted of a nine-bedded minimal supervision hostel, and a day ward, offering individual and group psychotherapy. Patients typically progressed from the

latter service to the greater independence of the hostel, although the reverse process also occurred. However, the unit was only in existence for a short period, and only a single folder of records was available, comprising 15 patient case summaries (6 male, 9 female) for residents discharged between 1976 and 1977. These records adopted a similar format to those of the outpatient department, detailing mode of arrival (self-referral, GP referral, or hospital transfer) reasons for admission, treatment regime and prognosis, and were typically 2-3 sides of typed A4. Information was either copied verbatim into a Word document, or, in the case of longer accounts, truncated to include only key details of patient backgrounds and Unit experiences. Discussion relating to content will be further developed in chapter 7.

This set of records posed additional ethical problems, beyond those considerations of anonymity applicable to the research in general. Thus, even where a patient was not named, the level of detail and – occasionally derogatory – comments on personal appearance or behaviour increased the risk that an individual could be identified from excerpts. Moreover, disclosure of such material to a wider readership than was originally intended could also prove distressing for its author (i.e. the therapist). Selective and careful use of this content was made, so that any such distress might be avoided.

Chapter 4: The Social and Demographic Characteristics of Bethlem Inpatients

Throughout the first half of the twentieth century, official published statistics relating to mental health services were scanty, and rates of mental disorder were seldom recorded beyond the confines of the Annual Reports of the Commissioners in Lunacy.[1] Moreover, there had been no concerted effort to collate available data for the purpose of establishing wider trends. Even by 1960, Eileen M. Brooke likened attempts to gauge the state of Britain's mental health, or otherwise, to 'fitting together a jigsaw puzzle, many of the pieces of which have not yet been cut out'.[2] From the 1950s, the publication of new governmental statistics and epidemiological surveys provided new representations of the scale of the problem of mental illness, and its impact on NHS resources. Reports from the Ministry of Health and the General Register Office detailed hospital admissions; Ministry of Pensions and National Insurance data included sickness benefit claims resulting from mental illness, whilst research also evaluated mental illness in general practice[3] and community[4] settings. Moreover, studies sought to identify how key sociodemographic features, or their interactions, were associated with psychological problems (diagnosed or self-reported) and the treatment patients received. The respective roles of age, gender,[5] marital status, social class[6] and occupation were scrutinised; other investigations attempted to disentangle the social and clinical determinants of length of stay in mental hospitals.[7]

The next two chapters will report and examine findings from a study of Bethlem Royal Hospital archival evidence from the early to late twentieth century, together with the oral testimony of former staff members. This will be contextualised by

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[1] Vera Norris, *Mental Illness in London*, *Maudsley Monographs, Number Six* (London: Chapman & Hall, 1959), pp.13-14.

[2] Eileen M. Brooke, "Mental Health and the Population," *Eugenics Review* 51, no. 4 (1960): p. 209.

[3] Michael Shepherd et al., "Minor Mental Illness in London: Some Aspects of a General Practice Survey," *British Medical Journal* 2, no. 5421 (1964): pp.1359-1363.

[4] F.M. Martin, J.H.F. Brotherston, and S.P.W. Chave, "Incidence of Neurosis in a New Housing Estate," *Brit. J. Prev. Soc. Med.* 11 (1957): pp.196-202.

[5] C.R. Lowe and F.N. Garratt, "Sex Pattern of Admissions to Mental Hospitals in Relation to Social Circumstances," *Brit. J. Prev. Soc. Med.* 13 (1959): pp.88-102.

[6] G.M. Carstairs et al., "Changing Population of Mental Hospitals," *Brit. J. Prev. Soc. Med.* 9 (1955): pp.188-189.

[7] R.W. Parnell, "Length of Stay in Mental Hospitals and Some Factors Influencing It " *British Medical Journal* 2, no. 5162 (1959): pp.1296-1300.

contemporaneous asylum histories, and provide a means of testing broader ideas relating to the ascent of psychological subjectivity and, or an encroaching medical gaze, as described in the literature review. The main objectives are to discover how the social and demographic features of Bethlem's patients changed over the course of the mid twentieth century, in such areas as class, age, gender, occupation and marital status, and to apply this evidence in re-evaluating existing institutional historiography. For example, Steven Cherry posited a link between the social backgrounds and clinical diagnoses of admissions to St. Andrew's Hospital, Norfolk,[8] whilst Diana Gittins described localised obstacles to implementation of voluntary treatment at Severalls Hospital, Essex.[9] The current study will address circumstances of admission, and ongoing dialogue and between hospital staff, patients, and their families. The subsequent chapter will shift in focus to the clinical dimensions of inpatient treatment, with the aim of identifying and explaining shifts in psychiatric diagnoses, aetiology, and length of stay. This will enable a succinct and accessible snapshot of changes in the psychiatric patient experience, yet it is acknowledged that the separation of demographic and clinical factors is a simplistic and artificial distinction. Attention will thus be drawn to interactions and areas of overlap, and their implications, where appropriate.

The present chapter will be thematically situated, with an overview of relevant existing literature serving as the backdrop for a description of statistical trends and analysis of supplementary archival evidence. Research methods and the ensuing construction of an admissions database have been outlined previously. However, it is germane now briefly to recapitulate the nature, content and limitations of these sources, and how this information can shed light on the hospital's patient profile. Pre-merger Bethlem admission registers were kept from 1919 to 1948, and post-war admission data from 1948 to 1983. The early registers included name, age, gender, marital status, occupation, legal status, form(s) of disorder, presumed aetiology, previous admissions/attacks, length of stay and outcome. However, after the (1948) merger, new record-keeping systems were adopted, which required less qualitative patient detail. The hospital gradually introduced the standardised diagnoses of the

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[8] Cherry, *Mental Health Care in Modern England*, pp. 185-187.
[9] Gittins, *Madness in Its Place*, pp. 40-43.

International Classification of Diseases (ICD), but such information was consigned to unit-level records or longitudinal statistical reports, with admission/discharge papers now listing only the destination ward. Likewise, other aspects of patients' social and clinical histories became less accessible. Such contrasts in the volume and type of information recorded at different times meant that pre and post-war information had to be considered separately. The next chapter will expand on the anomalies in classification schemes, and, where necessary, reflect upon the strategies devised in this study in order to achieve meaningful long-term comparisons of clinical data. As discussed previously, the research chiefly covered the period 1930-1983, but 1920s statistics were also considered where this was deemed beneficial in highlighting longitudinal patterns or drawing comparisons. Full details of archival sources and data collection may be found in the methodology chapter and appendices.

Patient Numbers and Admission Class Distribution

Before exploring the size and legal stratification of Bethlem's population, the broader context will be established through consideration of the national-level psychiatric inpatient profile throughout the twentieth century.

In his discussion of the changing remit of the asylum, Trevor Turner proposed that, following 1845 legislation, such institutions represented a 'place of disposal', wherein 'the number of inmates rose remorselessly from a few thousand to over 150,000'. However, less than a century later, this physical enormity, with a concomitant regime of compulsory admissions and moral management, was deemed outdated and unhelpful. Turner contended that such attitudes, occurring against a backdrop of scientific and legal reform, facilitated a move towards hospital closure, in favour of community care. He further attested that subsequent recognition of the potential for neglect and abuse of patients within community settings, contributed to post-1980 resurgence in statutory (sectioned) admissions, and a decline in long-stay psychiatric inpatient beds.[10] These trends should also be considered in the context of mounting public and media fears about the perceived threat posed by dangerous patients in the community. The emergence of forensic psychiatric services could prove equally

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[10] Turner, "The History of Deinstitutionalization and Reinstitutionalization," pp.1-2.

controversial by raising the visibility of this population. The establishment of Bethlem's medium secure unit was greeted by a three-year 'avalanche of objections', whilst a recent survey of local residents found most still substantially overestimated the percentage of Bethlem patients admitted through the prison system.[11]

Andrew Scull concurred with Aubrey Lewis' assertion that national figures on mental hospital populations, if taken in isolation, gave a misleading impression of when the deinstitutionalisation process began. Thus, 'they tend to mask the earlier changes at the local level and to obscure the degree to which the fall in overall numbers, when it did come, represented a continuation rather than a departure from pre-existing trends'.[12] Moreover, in reframing the chronology and contexts of declining psychiatric inpatient admissions, such accounts offer a compelling counter-narrative to the dominant theory of pharmacological revolution.

In 1956, W.P.D. Logan presented General Register Office data on mid twentieth-century psychiatric inpatient populations. As indicated in Table 2, the daily number of patients resident in mental hospitals in England and Wales rose from 35,000 in 1869, to 140,000 in 1939. Thereafter, numbers declined during World War II, but admission rates actually increased over the same period. On census night, April 8th, 1951, patients in mental hospitals comprised 34% of all individuals occupying NHS beds. Logan noted that resident patient numbers continued to rise slowly, reaching 148,000 in 1954, with a sharper increase seen in admission and readmission rates, particularly amongst patients over 65 years (Table 3). The figures indicate that admissions of patients under 65 increased by 24% between 1950 and 1954, whilst those of older people rose by 40% over the same period.

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[11] Sarah Chaney and Jennifer Walke, "Life and Luxury in Monks Orchard: From Bethlem Hotel to Community Care, 1930–2000," *Lancet Psychiatry* 2, no. 3 (2015): p.210.
[12] Andrew T. Scull, *Decarceration: Community Treatment and the Deviant - a Radical View* (New Jersey: Spectrum, 1977), p.83.

Year	Daily Average Inpatient Numbers	Annual Admissions
1869	35,000	10,000
1899	82,000	19,000
1929	122,000	22,000
1939	140,000	32,000
1948	136,000	51,000

Table 2: Daily Average Number of Patients in Mental Hospitals and Number of Annual Admissions, Selected Years, England and Wales. Source: W.P.D. Logan, "Patients in Mental Hospitals", *Proceedings of the Royal Society of Medicine*, 49 (1956), p.495.

Year	Patients Resident	Admissions			% Readmissions
		Under 65 yrs	65 and over	All ages	
1950	142,000	46,000	10,000	56,000	33
1951	143,000	47,000	12,000	59,000	35
1952	145,000	50,000	12,000	62,000	37
1953	147,000	54,000	13,000	67,000	37
1954	148,000	57,000	14,000	71,000	40

Table 3: Number of Patients Resident in NHS Mental Hospitals on Dec 31st of each year, and Number of Annual Admissions, 1950 to 1954, England and Wales. Source: W.P.D. Logan, "Patients in Mental Hospitals", p.496.

Age and gender differences were recorded in the legal status of admissions: for both sexes, voluntary admissions dropped sharply after the age of 65, whilst twice as many females than males were admitted on a temporary basis. Nationally, by 1937, voluntary patients accounted for 35.2% of mental hospital admissions, and in only 15% of these institutions did they represent more than half of new patients.[13] There were also regional variations in levels of voluntary admission, attributed to localised differences in admission policy.[14]

Bethlem Physician Superintendent, J.G. Porter-Phillips, was generally dismissive of the impact the 1930 Act would have on practices at the hospital. From the late nineteenth century, Bethlem had prioritised voluntary admission, and, as illustrated in Figure 1, this population had tripled between 1923 and 1939, by which time over 75% of cases

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[13] Board of Control, "Twenty-Fourth Annual Report of the Board of Control for the Year 1937," (London), p.15.
[14] W.P.D. Logan, "Patients in Mental Hospitals," *Proceedings of the Royal Society of Medicine* 49 (1956): pp.495-496.

were admitted 'informally'.[15] Porter-Phillips also opposed the Act's introduction of a 'temporary' patient class, on the basis that this compulsory treatment order lasting only six months was inadequate for proper diagnosis and care of often acutely ill admissions.[16]

Mirroring wider trends, temporary admissions to Bethlem were less common than certified or voluntary admissions; the number resident in this class never exceeded 15, and it was noted that many such applications failed to satisfy the requirements of the 1930 legislation in terms of severity or chronicity of symptoms.[17] However, death rates were initially much higher amongst this group,[18] a trend which Porter-Phillips attributed to the narrow time frame afforded for treatment of temporary patients.[19] In practice, Bethlem admitted very few temporary patients, but it was felt that the poor prognosis of the minority accepted had contributed to a stark rise in overall mortality rates.[20] Meanwhile, numbers of certified patients remained steady until the time of the merger, at which point it was decided that the exclusion of certain medico-legal classes was limiting the supply of valuable research material.[21] Further discussion of Bethlem's forensic unit follows later in this chapter.

Adult inpatient admissions to the new Joint Hospital rose steadily from 2636 in 1949-51, peaking at 3948 for the triennium 1961-63. Outpatient numbers underwent more dramatic growth following the merger, rising from 5151 patients in 1949-51, to 8599 in 1964-66. Bethlem's average bed availability between 1967 and 1969 remained constant, at 190 (adults) and 35 (children). Yet, this period saw the first downturn in (unique) patient numbers, which, rather than resulting from reduced capacity or increased length of stay, was attributed to increased readmissions.[22] By 1983, the most recent year under consideration, inpatient admissions totalled 753 (M = 374, F = 379), which translated as 683 individual patients (M = 328, F = 345).

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[15] Jonathan Andrews et al., *The History of Bethlem* (London: Routledge, 1997), p.655.
[16] BRHAM, "Report of the Physician Superintendent for the Year Ending 31st December,1930," p.8.
[17] BRHAM, "Report of the Physician Superintendent for the Year 1935."
[18] BRHAM, "Bethlem Hospital Annual Reports, 1930-1947."
[19] BRHAM, "Report of the Physician Superintendent for the Year 1931," p.9.
[20] Ibid.
[21] BRHAM, "Medical Committee Report, 18th December 1967."
[22] BRHAM, "Triennial Statistical Reports, Years 1949-1969," ed. C.P. Blacker and A.T. Gore.
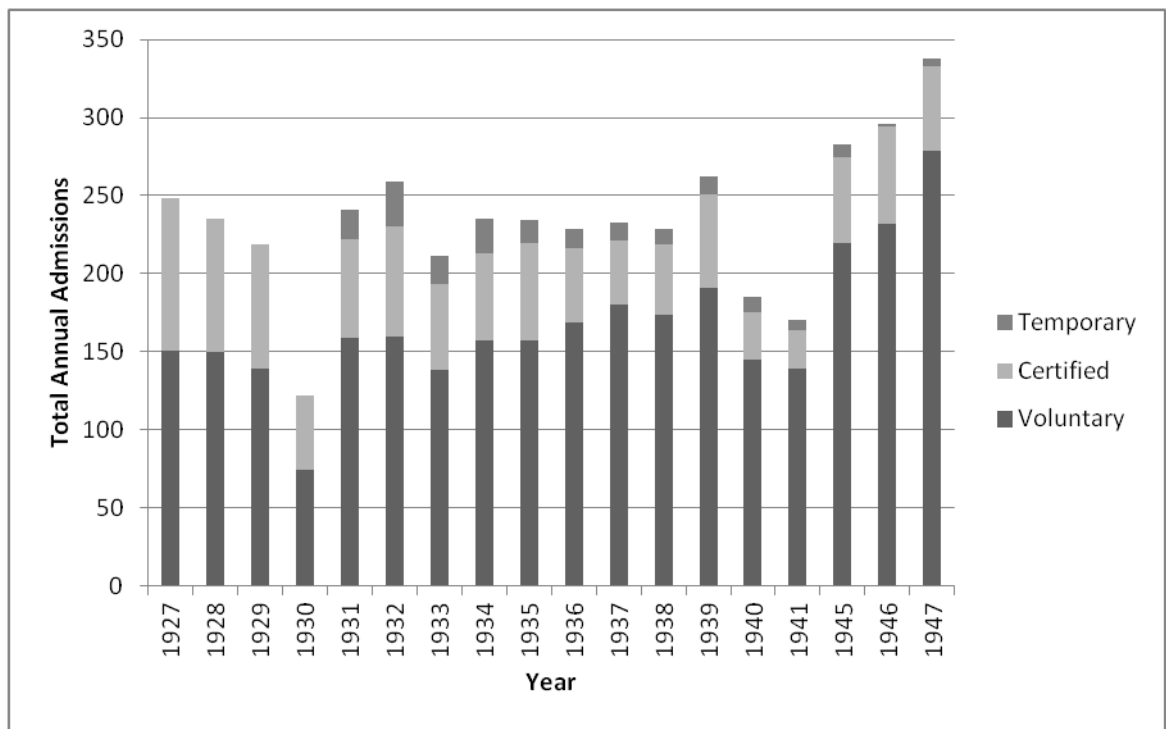
Figure 1: *Legal Status of Sampled Admissions to Bethlem, 1927-47*. Source: BRHAM, Annual Reports, 1928-47.

The Bethlem patterns corresponded to a general reduction in civilian patient numbers in wartime and subsequent to the publication of asylum exposés in the 1920s; the latter having damaged public confidence in mental hospitals. The increased uptake of outpatient services at the hospital in the postwar decades may imply a broad acceptance of easier and less stigmatised means of accessing psychological support, but perennial problems of measurement and definition render it difficult to accurately compare this to rates of mental disorder within the wider society. However, psychiatric consulting rates per 1000 of the population more than doubled for both sexes between 1955 and 1971, before dropping slightly to 55.4 (males) and 112.7 (females) by 1981-82.[23]

Since the late nineteenth century, Bethlem had styled itself as a semi-private institution and actively courted a better class of patient with a good prognosis. A 1930 advertisement for the new hospital invited 'contributions' of 5 guineas weekly, although applications for free or lower rate admission would also be considered by the Commissioner.[24] Investigation of 1930s patient correspondence files gave further

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[23] Fitzpatrick and Chandola, "Health," pp.106-109.
[24] BRHAM, "Bethlem House Committee Minutes, 10th July 1929 to 3rd September 1930."

indications of the circumstances in which voluntary care was sought at Bethlem, the concerns and expectations of patients and their families, and the dynamics of decision-making within the hospital. Moreover, these sources inform wider debates on psychological literacy and notions of stigma and mental illness. Equally, Bethlem's promotional literature from the same era reflected how the hospital positioned itself within an emerging medical marketplace, in terms of its key selling points and target clientele (somewhat tellingly, the hospital also kept a folder of advertising material from 'rival' psychiatric institutions). Chapter 6 also discusses the perceived significance of modern treatment apparatus to such efforts. A souvenir brochure from the opening of the new hospital emphasised Bethlem's heritage and 'long history of beneficence', yet also confidently claimed that

> Not only will its new home, built on the latest and most scientific principles and set in ideal surroundings, encourage rapid improvement in the health of the patients, but it is hoped that the new and up-to-date appliances for treatment and research will make the study of Psychological Medicine available to a large body of students who will have modern and attractive facilities offered to them...a system of separate blocks has been adopted in consonance with the newest ideas on the subject. The provision for the personal comfort of the patients varies considerably from the accommodation afforded in other mental hospitals...the patients are provided with single bedrooms all properly furnished, and in addition living rooms and other amenities such as obtain in good private houses....The corridors offer means of exercise in inclement weather, and sunny day rooms together with the billiard room for male patients and the writing and recreation rooms in the ladies' quarters provide for the associate life of the patients.
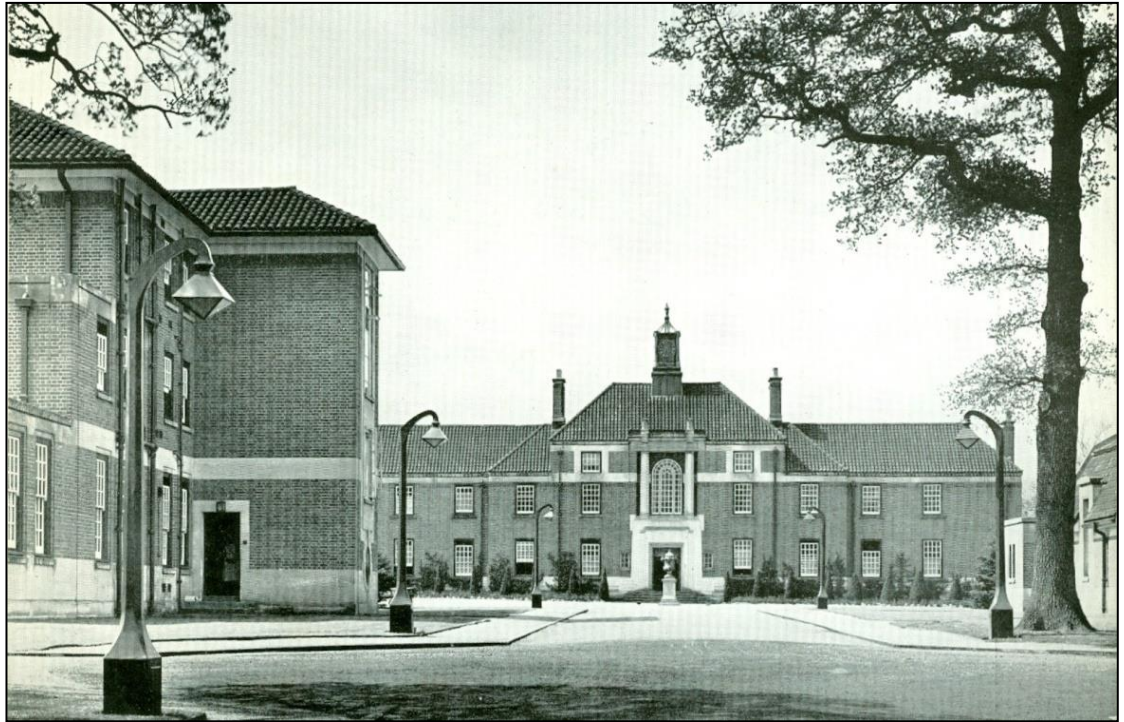
Figure 2: Main entrance, Bethlem Royal Hospital, *Prospectus*, c.1930, p.3. Image credit: The Bethlem Art and History Collections Trust.

" *The Dormitory,*" *which contains no more than four beds for cases requiring constant observation.*
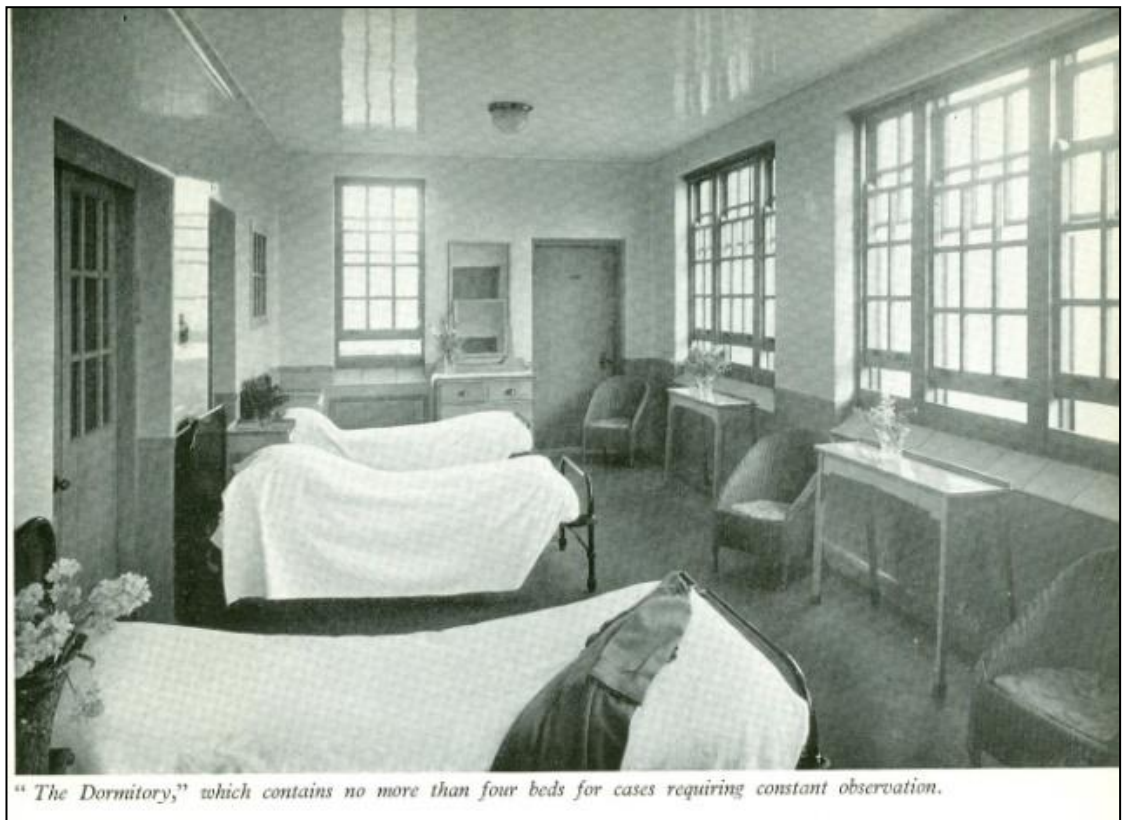
Figure 3: Dormitory, Bethlem Royal Hospital, Prospectus, c.1930, p.11. Image credit: The Bethlem Art and History Collections Trust.

There was further discussion of nurses' accommodation, details of electric and water supplies, and provision of detailed hospital plan, with full-page photographs of some buildings. In the first of the above images (figure 2) the hospital's main entrance assumes central focus; a grand edifice at the end of a tree-lined road, it contrasts markedly with austere and overcrowded institutional stereotypes of the era. Likewise, a depiction of a small dormitory (figure 3) alludes to a more personalised care, whist the presence of flowers and armchairs is also suggestive of comfort and family involvement. These images contrast markedly with the apparent austerity and regimentation of Shenley Hospital (figures 4-5), a Hertfordshire asylum which, by 1957, housed over 2000 patients; some of whom later sought care at Bethlem.[25]

More recent evidence affirms the existence of an enduring and pervasive Bethlem stereotype, accentuated when its staff or patients moved to other institutions:

> The idea of Bethlem as a luxury retreat became deeply embedded within psychiatric understanding. In the 1960s, one teenage patient newly transferred from Bethlem to Bexley was informed by staff that she was no longer at the "Bethlem Hotel", while some nurses trained at Bethlem and Maudsley in the same period recalled animosity from colleagues at other hospitals due to their "privileged" background.[26]

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[25] Mind in Harrow, *The Hidden Minds Project: Uncovering Voices and Information About Shenley Hospital* (2012 [cited 08/07/13)); available from http://www.stalbansoutofsightoutofmind.org.uk/documents/2x1m_Hidden_Minds_Project.pdf.

[26] Sarah Chaney and Jennifer Walke, "Life and Luxury in Monks Orchard: From Bethlem Hotel to Community Care, 1930–2000," *Lancet Psychiatry* 2, no. 3 (2015): p.209.

Figure 4: Main entrance, Shenley Hospital, c.1934. Image credit: Josie Hinton, *The Hidden Minds Project*, www.stalbansoutofsightoutofmind.org.uk

Figure 5: Large dormitory, Shenley Hospital, c.1934. Image credit: Josie Hinton, *The Hidden Minds Project*, www.stalbansoutofsightoutofmind.org.uk

Bethlem's souvenir guide ended with a timeline of the hospital from 1247 to the present – clearly 'bookending' the brochure with allusions to its long heritage. The historical background remained prominent in subsequent brochures, though these were prefaced by staff details, and information regarding admission procedures.[27] A 1932 prospectus offered further reassurance to 'ladies and gentlemen of a suitable educational status' that

> ...admission to this *Monks Orchard Hospital* carries with it the "Hall Mark" of curability, and as such, whenever the word "*Bethlem*" is used, it means "curable"'. Accommodation is provided for 250 patients – 141 ladies and 109 gentlemen – each of whom must be of a suitable educational status. Patients who are eligible may be admitted either on a Voluntary, Temporary or Certified footing, but in all cases treatment in the early stage of illness is advisable and, in fact, desirable. Patients are thus graded according to their varying type of symptoms, and the separate units, or houses, provide appropriate care and treatment for their individual needs, which is further enhanced by the provision of separate bedrooms, whenever deemed necessary.[28]

The following excerpts from 1930s correspondence files illustrate ways in which patients and their families shaped admission and treatment decisions. JR was a 22 year-old salesman, who arrived at Bethlem as a temporary patient, having suffered fits, confusion, and amnesia after a motor accident. With a long history of epilepsy, he was hopeful of gains from this admission, and – perhaps reflective of the aforementioned marketing efforts - 'has the idea firmly in his head that if a London Hospital had his head they could make it well'. Yet, in a subsequent letter to the Physician Superintendent, his mother noted her distress at her son's intention to leave, and desperately sought other means of making him stay:

> I am quite certain that he is in no way fit to be out in the world again, and alone, as he would be, and that if he leaves your hospital it will end in tragedy.

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[27] BRHAM, "Bethlem Royal Hospital: Opening of the New Hospital, Monks Orchard, Eden Park, Beckenham, by Her Majesty the Queen, 9th July 1930," pp.3-5.
[28] BRHAM, "Bethlem Royal Hospital: Prospectus, 1932," pp.6-7.

Can you not possibly get him certified so that you can force him to remain? I have been through so much with [JR] the last few years I really do not feel I can stand any more. I was hoping that he would stay at least four years and then perhaps we could have persuaded him to the Roman Catholic religion and got him accepted in some order or institution.[29]

Patient SH, a 21 year-old male student, was admitted voluntarily in 1931, diagnosed with dementia praecox, but given a favourable prognosis. However, his mental and physical condition deteriorated further, prompting the Board of Control to declare him unfit to continue informal treatment. In these circumstances, the patient's father was anxious to avoid certification, and opted instead to remove his son from Bethlem, thereby declining medical advice and rendering the patient ineligible for future admission to the hospital.[30] By contrast, other families welcomed, or even *sought*, the relief of formal detention for their loved ones. HW was a 55 year-old female with 'mild manic depression', previous mental breakdowns, and paranoia. Her sister supported her financially throughout her admission, but voiced concerns that 'she seems better but is beginning to worry me about leaving and there must be no misunderstanding in the sense of coming straight home. I do not think it can be done, as I cannot cope with the responsibility alone. I had too bad a time with her to do it again, and my own health suffered with the strain of a two months' visit'.[31]

The above excerpts thus indicate that nascent public appreciation of Bethlem's image operated alongside more traditional familial responsibility and stigma in motivating people to seek admission.

Assessing and Accommodating Faith

Religion was a common and central theme within many patient histories, despite no longer being routinely recorded on admission registers by the 1930s. As the following vignettes demonstrate, beliefs could find pathological manifestations (e.g. in religious guilt, fears of sin or abandonment); or - as in the case above – represent a possible

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[29] BRHAM, "Patient Correspondence Files, 1925-1947," ref. no. 685, discharged August 1944.
[30] Ibid., ref. no. 179, discharged February 1932.
[31] Ibid., ref. no. 807, discharged November 1935.

means of salvation. In other instances, local clergy could support a parishioner's request for admission to Bethlem or call upon them during their stay.[32]

Patient GB was a 59 year-old voluntary boarder, who arrived at Bethlem in 1931, and was treated for recurrent melancholia linked to traumatic injury. He was the second youngest in a family of seven, who, from childhood, was healthy, 'serious-minded' and 'very interested in religious matters'. He worked as a draper's assistant after leaving school, and was considered 'conscientious, painstaking, simple-minded and inoffensive', and 'retained a reputation of industry, outspokenness and love of truth' after moving departments. GB grew depressed shortly before his wedding to a childhood friend, which he attributed to worries over whether his marriage would interfere with his church work and vice versa. The couple married aged 31 and had two children, with GB described as 'excellent husband and a kind father'. Their first 27 years of marriage were reportedly 'uneventful', although GB nearly lost his job once after refusing to tell an untruth to a client. During the war, he enrolled in the Special Constabulary, his varicose veins having rendered him medically unfit for army life (GB was relieved by this, stating he had no wish to be killed). He was knocked down by car in 1929, sustaining bruising to the head but no cut. After resting at home for four days, he resumed work apparently fit and healthy, but a fortnight later felt 'unhappy and unproductive', and requested a further break, spending a month at home and taking holidays in Eastbourne and Wales. He subsequently collapsed at work and was, sent home, and later briefly admitted to the Maudsley. On presentation at Bethlem, he was considered 'very depressed, uncommunicative - felt he was neglecting his religious works and not worthy of God….'quite deluded', believing himself to be eternally damned for things he'd previously said, though not suicidal.[33] GB's case perhaps illustrates an antagonism between entrenched religious beliefs and latter-day concepts of selfhood. Thus, whilst framed/constrained within highly moralistic tones, his desire for personal fulfilment and, ultimately, his decision to seek voluntary treatment, also resonate with emergent psychological cultures and expectations which gained popularity at this time.

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[32] Ibid., ref. no. 1221, died July 1940.
[33] BRHAM, "Cwc: Departures and Deaths Patient Casebooks, 1923 -1953," ref. no. 84, discharged June 1931.

Patient WM was an 18 year-old engineer admitted as a certified patient in 1931. He was diagnosed with primary dementia, attributed to prolonged mental stress. The second of three children, his younger sister had had a nervous breakdown the previous year. Fourteen days prior to his admission,

> …he became very elated in spirits, pulled himself together and said he was going to do great things and make a success of his life. At this time he was sleeping badly, but reading the Bible in bed. Three days ago returned from work saying "my Mother cannot break my will" and was overcome with religious fervour. Broke a gramophone record because it was "imperfect", threw a cup at the wall, became depressed if people were unkind or considered him weak. Stressed and sleepless over "matters of Religion, Sex, Work and Play and I had got them all muddled up"….He was shouting incoherently, gesticulating wildly and generally behaving as if having lost all control. He went to take medicine and then suddenly and impulsively flung it away. His references to religion disclosed that he thought God and the devil were alternately responsible for his affairs.

On examination, WM 'does not appear hallucinated, is well orientated in time and place….prays aloud to God, easily distracted, lacks attention to anything other than that which takes his interest'. He later smashed a window, refused food and became 'impulsive and excitable, probably because of active hallucinosis'. He also heard voices relating to religious delusions, and threatened suicide by strangulation, warranting a constant observation order. During an apparently more reflective period, he declared – "I should be in a mad-house". On subsequent entries, he is quieter, but cannot recall previous meetings, nor how long he has stayed, and doesn't ask to go home or enquire after family. He believed 'sun' treatment had helped him. With further improvement in symptoms, was moved from Tyson House to Gresham House, reclassified as voluntary boarder, and transferred.[34]

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[34] Ibid., ref. no. 98, discharged April 1931.

Patient AA was a priest by training, but believed 'that God has turned his back on him and that because of this he cannot do his work'. During the second month of his voluntary admission, his wife sought the collaboration of the Physician Superintendent, in preventing contact between her husband and church representatives:

> I sent you a telegram yesterday asking that any letters not addressed to me [Mrs A.] should be held. My husband's last letter told me that he was considering writing to the Bishop and Archbishop, which must not be allowed. Or, should he write, they must not be posted – his pension has been granted and I begged him in my letter, today, to sign the Deed of Resignation on receipt of my letter and have it posted at once. I trust he will do this, because the Bishop has again requested my brother to have the Deed signed, as promised. We <u>have resigned</u>, but this Deed puts the finishing touch. I apologise for giving you this trouble.

Following reports of AA's continued agitation and depression, his wife duly arranged for a local Reverend to visit her husband, and endeavoured to reassure doctors of the compatibility of the guest's views with hospital orthodoxy, declaring that '[he]...does not belong to the Spiritualists. Should you ever meet him you will understand that he works with the physicians'.[35]

The Bethlem evidence suggests an institutional willingness to accommodate an individual's faith and external sources of spiritual guidance. Further indications of such flexibility are found in the hospital's (1930) prospectus, where images of the chapel (prominently located next to the main entrance) were accompanied by the weekly service schedule, and information on meditation, prayer, visits from ministers of other denominations and requisite dietary adjustments for 'orthodox devotees'.[36] Provisionally, this lends support to Mathew Thomson's contention that, despite early twentieth-century excitement about 'psychology's new potential', the discipline nevertheless 'had to adapt itself to be acceptable in relation to still powerful existing

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[35] BRHAM, "Patient Correspondence Files, 1925-1947," ref. no. 682, discharged April 1936.
[36] BRHAM, "Bethlem Royal Hospital: Opening of the New Hospital," p.16.

languages of the self, such as those centred on character and religion'.[37] Yet, the image promoted by the hospital in this respect differed from the individual vignettes, where religion could be interpreted as a mere proxy for underlying conflicts and stress. Such a reading resonates with Pamela Michael's (2003) account of the apparent twin supportive and 'corrosive' influences of religion on Denbighshire patients in the early twentieth century. Amidst an increasingly secular society, she believed that Welsh Nonconformity still promoted community responsibility, yet was also implicated in 'generating tensions, frustrations and fantasies, feelings of subconscious guilt, and sexual deprivation'. She retrospectively linked a 1904-1905 rise in "religious mania" admissions to Revivalist movements, which were 'followed by a popular reaction against enthusiastic religion and sentimentality', and a corresponding decline in casenote reports of religious images and delusions.[38] Although mental disorder is thus characterised as a corollary of the social zeitgeist, such trends would also, reciprocally, have shaped the recognition and rhetoric of 'symptoms' by patients' families and the medical profession.

Michael's focus is on a comparatively isolated community, yet the Bethlem data also convey some willingness on the part of this more metropolitan institution to accommodate patients' faith, but without completely disregarding more pathological interpretations. Thus, the parallel strands of religion as self-fulfilment, and as a destructive force, featured both in patient-professional dialectic, and even, as illustrated above, within individual case histories.

Age, Gender and Psychiatric Epidemiology

There now follows a broad overview of age and gender-related admission patterns at Bethlem and other contemporary institutions, before presentation of a more detailed study of different age groups of patients, and the specialist services that were developed to address their needs. In the first half of the twentieth century, the median age of admissions was 41, a finding which, overall, has not altered greatly since 1925, yet one which also conceals important trends and considerable variation (figure 6). For

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[37] Thomson, *Psychological Subjects*, p.54.
[38] Michael, *Care and Treatment of the Mentally Ill in North Wales, 1800-2000*, pp. 4-5, 103-104.

instance, the Triennial Statistical Report of 1949-51 observed that outpatients were generally younger than inpatients, but both groups featured an above average proportion of people in their late 20s and early 30s when compared to the Greater London population. In attempting to explain this effect, Bethlem authorities invoked the stricter medical selection of inpatient cases, and the 'stresses of marriage and child-bearing' amongst a 'productive and socially important age group'.[39] Ironically, this negated the significance of age-related mental deterioration, which was later to become a discrete specialism of the Joint Hospital. It also contradicted Henry Maudsley's emphasis on the advantages as well as pressures of 'modern life' acting as a buffer to mental wellbeing.[40] In addition to the development of age-specific services at Bethlem, the postwar decades also saw the emergence other new specialisms, such as addictions, which exerted an indirect age bias on admission trends, and are discussed later in this chapter.

At the turn of the twentieth century, there was a less pronounced gender divide in admissions to mental hospitals in England and Wales; it has been proposed that this trend only began to emerge as a post-1930 phenomenon. Lowe and Garratt mapped a departure from slightly elevated male admission rates in 1901, to the 1959 female excess. Chiefly, they reported a widening gender gap after the 1930 Mental Treatment Act, and the accentuation of this trend amongst middle-aged patients.[41] The suggestion that this pattern is at least partly a legislative artefact is supported by Joan Busfield, who argued that the presence of middle-aged female patients was amplified by the post-1930 proliferation of voluntary admissions, and the codification of psychoneurosis.[42] Moreover, gendered trends of mental hospital admission are inherently distorted by the differential longevity of men and women. Logan's (1956) statistics accordingly showed more female than male patients at all ages, but female admissions continued to increase into the uppermost (65 years and over) age bracket, whereas male admissions peaked between the ages of 45 and 54.[43]

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[39] BRHAM, "Triennial Statistical Report, Years 1949-1951," pp.15-16.

[40] Henry Maudsley, "Is Insanity on the Increase?," *British Medical Journal* 1, no. 576 (1872): p.36.

[41] Lowe and Garratt, "Sex Pattern of Admissions to Mental Hospitals in Relation to Social Circumstances," p.102.

[42] Joan Busfield, *Men, Women and Madness: Understanding Gender and Mental Disorder* (London: Macmillan Press Ltd., 1996), pp.132-134.

[43] Logan, "Patients in Mental Hospitals," p. 496.
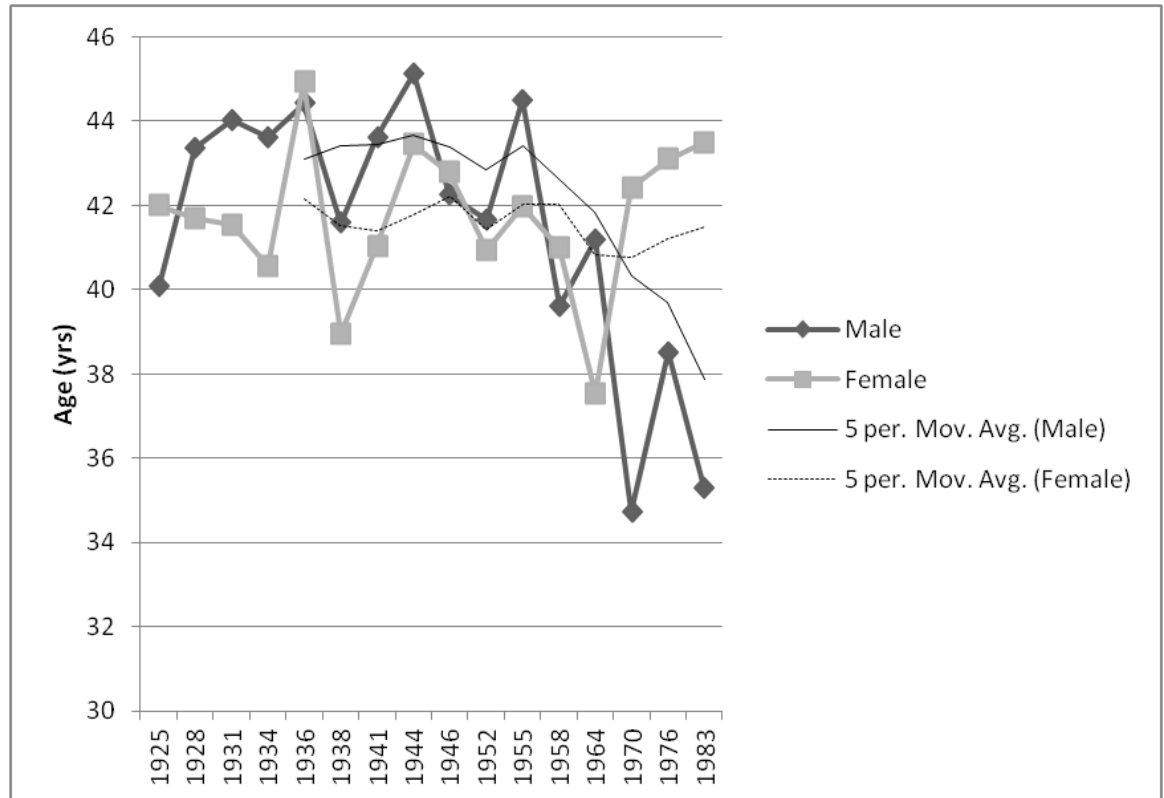
Figure 6: *Bethlem Inpatients, Mean Admission Age, 1925-83 and 5-Year Moving Averages*. Source: Admissions Database.

By 1969, the male/female inpatient ratio at the hospital was described as 'fairly constant', having fluctuated between 0.7 and 0.8 over the past six triennia.[44] However, from the late 1960s onwards, the gap between the average age of male and female admissions widened – as confirmed by a moving averages trendline (Figure 6) - with the most recent data (1983) showing an approximately 8 year difference (M = 35 yrs, F = 43 yrs). This may be partly attributable to gendered longevity effects, most accentuated within the two eldest age groups (Figure5). Moreover, this pattern accords with Logan's 1951 admission statistics, which revealed that female admission rates increased steadily with age, whereas male rates declined between 35 and 54.[45] The biggest interwar gender differential in Bethlem admissions occurred amongst the 30-39 year olds (Figure 7); a gap which almost closed in later years. In 1964, just 4.55% of male admissions and 3.57% of female admissions were aged 70 or over; by 1983, the direction and magnitude of this difference had changed, with 4.26% of men and 12.79% of women in the equivalent age bracket. Similar patterns were observed in the

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[44] BRHAM, "Triennial Statistical Report, Years 1967-1969," ed. E.H. Hare, pp.6-7.
[45] Logan, "Patients in Mental Hospitals," p.496.

60-69 years category over the same period. Thus, in 1964, 9.09% of males and 10.41% of females admitted were of this age, whereas in 1983, the figures were 5.17% of men and 12.5% of women. Data from 1931-47 show less of an age contrast between men and women. However, there were markedly fewer patients in the uppermost age range, namely, 1.2% of men and 1.7% of women, although 5.9% of men and 7.7% of women were aged 60-69. The minimum age of admission to the psychogeriatric unit, Gresham House, was raised from 60 to 70 in 1976. Although it was, supposedly, a mixed ward, some former nursing staff recalled no male patients.[46] This reinforces the view of Carstairs et al., who proposed that the combination of new facilities and increased longevity of (particularly female) patients served to artificially inflate the numbers of long-stay patients over 65 years of age.[47]

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[46] Rhiannon Harlow Smith, Interview by Author, 2nd September 2010.
[47] Carstairs et al., "Changing Population of Mental Hospitals," p.188.
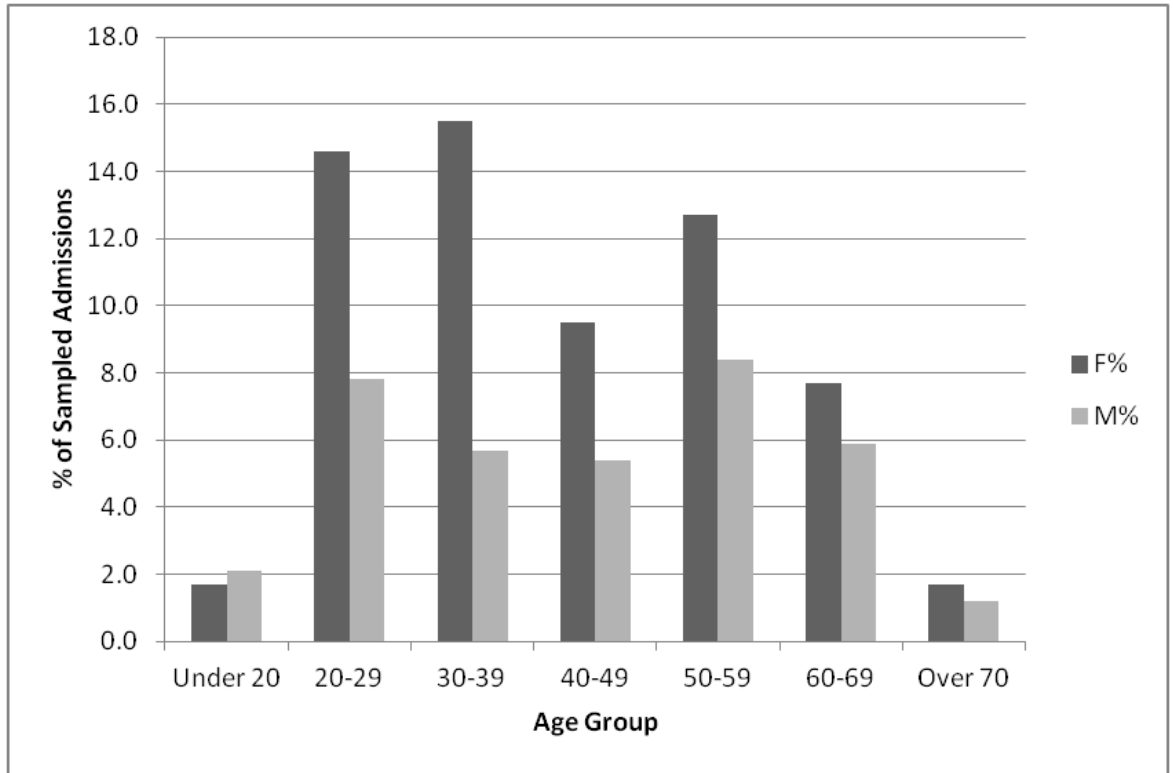
Figure 7: Age Distribution of Sampled Bethlem Inpatient Admissions, 1931-47. Source: Admissions Database.
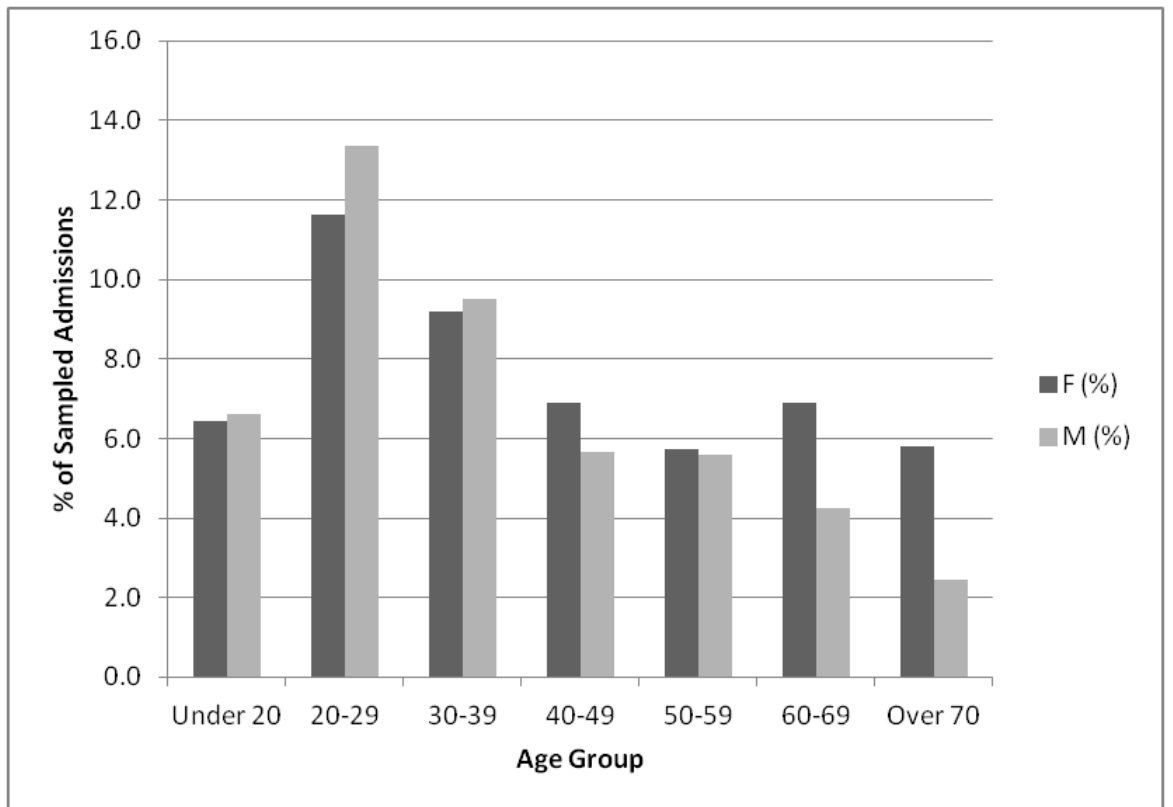
Figure 8: Age Distribution of Sampled Bethlem Inpatient Admissions, 1952-83. Source: Admissions Database.

Referral Routes

For the triennium 1949-51, the majority of inpatients (56%) arrived at Bethlem via the outpatient department, usually following a GP referral, although 4% were admitted directly as emergencies, so bypassing outpatient services. St. Francis Hospital's observation ward, or other psychiatric departments/hospitals were, respectively, the second and third most common referring agencies.

 Bethlem's first psychiatric social worker, Muriel Norris, was appointed in 1947[48] and a 'Domiciliary Service' introduced the following year. This was the next most popular referral route, and accounted for 170 (5%) of 3,245 inpatient admissions recorded in this period. It was described as 'a local service, on which an increasing demand is made by local practitioners' and was used twice as often for female patients than male.[49] By 1955, however, this role was thought to overlap with those of the Duly Authorised Officer (DAO) and the Health Visitor. A memorandum by C.P. Blacker proposed that the three services which 'at present take little notice of one another, could work together'. It was specifically suggested that Health Visitors (rather than DAOs or Psychiatric Social Workers) should assume responsibility for home visits, but acknowledged that this experimental scheme would lack applicability beyond the 'unique' environment and clientele of the Joint Hospital.[50] Such problems remained evident in 1958, when Blacker recounted the 'flux and uncoordinated change' of the various referral agencies, and anticipated a rise in domiciliary visits for geriatric patients. He further stressed the need for the Joint Hospital

> to ensure a constant supply on patients suitable for teaching and research…This is threatened by the tendency to elimination of observation wards (e.g. St.

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[48] Andrews et al., *The History of Bethlem*, p.621.
[49] BRHAM, "Triennial Statistical Report, Years 1949-1951," ed. C.P Blacker and A.T. Gore, p.37.
[50] BRHAM, "Mcd.82/55: Memorandum by C.P. Blacker: Possibilities of Domiciliary Care and Treatment," (1955).

Francis, St. Pancras) and the efforts of some mental hospitals to keep the whole of their catchment areas closely under their wing.[51]

There will now be consideration of how the Bethlem figures corresponded to admission patterns elsewhere. Vera Norris examined the age distribution of patients admitted to observation units in two different hospital catchment areas of London in the triennium 1947-49 (Table 4). Such facilities were housed within general hospitals, and provided temporary accommodation for 'persons of unsound mind', following statutory referral by a DAO, and pending a decision on their subsequent care. Area a) was homogeneous, comprising largely working class or lower middle class residential areas. Conversely, area b) was 'markedly heterogeneous', encompassing 'the slums of the East End.... red light areas in Soho and Paddington...but also the best residential areas in London...the artistic and intellectual colonies in Chelsea and Bloomsbury'. Norris also highlighted the influence of 'nosocomial' factors, namely, that 'the work of a hospital unit is greatly influenced by the propinquity of other units or special hospitals dealing with similar types of patients'.[52]

	MEN		WOMEN	
	Unit A (%)	Unit B (%)	Unit A (%)	Unit B (%)
16-29 yrs	18.6	21.9	13	16.1
30-49 yrs	28.2	36.3	27.6	33.2
50-69 yrs	26.7	25.8	26.9	30.5
70 yrs and over	26.5	15.9	32.5	20.2
Total Admissions (100%)	1,500	2,876	1,851	2,766

Table 4: *Percentage Age Distribution of Persons admitted to Observation Units A and B, 1947-49* Source: Vera Norris, *Mental Illness in London*, *Maudsley Monographs, Number Six* (London: Chapman & Hall, 1959), pp.58-59.

	1946		1952	
	M (%)	F (%)	M (%)	F (%)
< 30 yrs	33.3	22.4	30	32
30-49 yr	24.3	46.3	32	34
50-69 yrs	33.3	28.4	32	26
70 yrs and over	9.1	2.9	6	8
Sample Size (100%)	33	67	50	50

Table 5: *Percentage Age Distribution of Sampled Inpatient Admissions to Bethlem Royal Hospital, 1946 and 1952.*

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[51] BRHAM, "Mcd.48/58: Mentally Ill People over Sixty-Five: Need for Better Means of Future Disposal," ed. C.P. Blacker (1958).
[52] Norris, *Mental Illness in London*, pp.54-55, 58-59.

Table 5 represents only a sample of patients admitted to Bethlem in 1946 and 1952; yet, a rather different picture emerges from these data. First, we observe that Bethlem had a much lower concentration of elderly admissions than either of the observation wards did at this juncture. Although the psychogeriatric unit had opened in 1948, for both years in question, individuals aged 70 and over comprised less than 10% of sampled admissions. Compared to the observation wards, there was also a much more even distribution of ages across the three other groups, together with a higher proportion of patients under 30 years. The youngest patient admitted to Bethlem in1946 was aged 16; in 1952, this figure had fallen to 11 years, chiefly reflecting developments occurring in children's services in the intervening years, a theme which is explored further below. Moreover, the gender disparity (i.e. female predominance, with consistently low male admissions) hitherto apparent in the 30-49 years bracket had levelled by 1952, suggesting this had been reflective of wartime admissions criteria; a factor which would, arguably, have had less impact on the shorter-stay observation wards. Closer examination of the data presents partial support for this hypothesis, with admissions amongst this age group increasing slightly for female patients between the 1930s and 1940s, but declining for males, thereby enhancing the existing gender imbalance. Thus, patients aged 30-49 years represented, on average, 30.88% of sampled male admissions between 1931 and 1938, but 28.57% between 1941 and 1947. For females, the respective figures were 38.89% and 41.63%.

These trends also resurrect wider debates concerning the degree to which Bethlem prioritised distinct needs, rather than the general mental health of its local community. Evidence explored thus far indicates that emerging research demands were instrumental to service development, but, in some cases, service uptake was slow and patient numbers small, with a disjuncture between actual and envisaged ward operation.

There was a consistent female bias in numbers of patients admitted to Bethlem, diagnoses of some (especially neurotic) disorders and administration of so-called

'special treatments', including ECT and convulsive drugs such as Triazol.[53] Women typically stayed longer than men, although it is not immediately clear why this was the case. There were also a greater number of elderly female patients than male. One source from which male admissions to Bethlem exceeded those of women, was that of spontaneous outpatient referrals from agencies other than GPs. These included the labour exchange, Ministry of Pensions, Public Assistance Institutions and Services Welfare Organisations.[54]

As has been demonstrated, it is difficult to extricate the specific effects of patient gender, given that its influences were - and, to some extent, remain - obscured by those of age and social class. However, one is immediately struck by the disproportionate number of female admissions to Bethlem before the NHS, and – as we will soon see - their contrasting treatment experiences and prognoses compared to those of male patients within both physical and psychological therapies. Gender differences were also apparent in educational materials, professional attitudes and interpretations, issues which will be further discussed in later chapters. Moreover, as mentioned in the methodology, gendered terminology permeated pre-war admission register descriptions of non-working patients; thus, males were more commonly "retired" or "student", yet women were "nil" or "housewife" status.

The Role of Children and Adolescents in Service Development

Younger adult patients featured prominently in the postwar figures, and the modal age group for 1952-1983 (all patients) was 20-29 years. There was also an increase in the number of juveniles admitted from the 1950s, though this, as we shall see, was inexorably linked to the hospital's expanding interests in the treatment and research of childhood disorders. Other specialist services and diagnoses arriving in the 1960s also favoured a younger clientele; the average inpatient on Bethlem's Witley drug

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[53] BRHAM, "Triennial Statistical Report, Years 1949-1951," p.42.
[54] Ibid., p.37.

treatment wards was male and in his twenties,[55] whilst personality disorder cases were also typically under 25 years old.[56]

Children had been treated at the Maudsley Hospital since its 1923 inception, with this service recognised by London County Council as a school clinic in 1931. It also took referrals from charities and advised the Schools' Medical Service (SMS) on whether cases required specialist institutional provision. Admission procedures included checks for physical abnormalities or 'stigmata', whilst treatments 'ranged from dream interpretation and dietary supplements to drug treatment and sensory deprivation… within a framework of mental evolution, drawing particularly from instinct theory'.[57]

Research in child and adolescent psychiatry had also been conducted by Bethlem and Maudsley staff since 1931. Bethlem's children's block opened in 1939, accommodating 25 patients under the age of 12. There were several key differences noted in admissions to this unit when compared to wider hospital trends: overall patient populations were smaller and boys outnumbered girls (a reversal of the standard gender differential of adult patients, where women consistently predominated). Inpatients represented only a minority of total child patients, yet comprised the greater part of the adult patient population. Juvenile outpatients were seen at a Maudsley clinic.[58]

Following the merger, services for young people became an early collaborative venture between Bethlem, Maudsley and a range of community referral agencies. An inpatient adolescent unit opened at the Bethlem site in 1949, one of only two such facilities nationwide, whilst outpatient clinics were held at the Maudsley. Continuity of care was enhanced by an overlap of medical staff, nurses and psychiatric social workers across inpatient and outpatient departments.[59] Before 1949, adolescents were often admitted to general wards at Bethlem, but with the creation of dedicated facilities,

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[55] BRHAM, "The Bethlem Royal and the Maudsley Hospital Report, 1970-75. Part I - Text," ed. Robert Cawley and Margaret Myers, p.64.

[56] BRHAM, "Triennial Statistical Report, Years 1967-1969," p.8.

[57] Bonnie Evans, Shahina Rahman, and Edgar Jones, "Managing the `Unmanageable': Interwar Child Psychiatry at the Maudsley Hospital, London," *History of Psychiatry* 19, no. 4 (2008): pp.455-456, 460-462.

[58] BRHAM, "Triennial Statistical Report, Years 1949-1951," p.82.

[59] BRHAM, "Triennial Statistical Report, Years 1961-1963," ed. E.H. Hare, pp.40-42.

referrals were taken from a variety of practitioners and establishments, thus enhancing the visibility of this population. The Adolescent Unit housed 16 boys and 18 girls across the two wards of Tyson East. Of 180 discharges between 1961 and 1963, the most common diagnoses were psychoneurosis (35% of patients) secondary habit disorder - i.e. compulsive behaviour or tics - (24%) and psychosis (16%). The median age of patients was 13 years six months, though there were notably more boys under the age of 11, and more girls over the age of 13. Inpatients stayed an average of four months and received multidisciplinary interventions and continued schooling. Statistics collated over five triennia indicated that 10-13% of this population had relatives who had also received psychiatric treatment.[60]

In addition to the aforementioned service expansion, the Maudsley Hospital School opened in 1950, and staff collaborated with the nearby Brixton Child Guidance Clinic from 1951. The Maudsley also hosted special clinics for children with brain damage, epilepsy, and mental handicap, together with what the 1975 Hospital Report termed 'the general run of psychiatric problems'. Approximately 500 new outpatients attended yearly (albeit this number had declined by the 1970-72 triennium) whilst Brixton Child Guidance Clinic saw 260 cases per annum. Bethlem's Hilda Lewis House (described below) opened in 1970, and was part of a community service remit for mentally retarded and multiply handicapped children. The Joint Hospital thus maintained a local commitment but played an increasing role in the provision of specialist advice and treatment for children and their families nationally and abroad.[61]

The hospital also had an outreach remit for vulnerable younger patients. At Mayford Approved School, Woking, it was reported 'a necessary clinical service is being provided for a group of children whose needs are particularly urgent and whose very rebellion may represent their good potentialities'. The student body comprised 102 boys aged 13-15 years, who were 'in committal', approximately 30% of whom received a psychiatric referral. Bethlem staff viewed this enterprise as a chance for postgraduates to combine clinical experience and research at the forefront of a rapidly developing field. The programme started with individual assessments of the selected

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[60] Ibid., pp.42-44, 55.

[61] BRHAM, "The Bethlem Royal and the Maudsley Hospital Report, 1970-75. Part I - Text," p. 90.

boys, with subsequent involvement of a psychiatric social worker, a home visit and a team conference. In this way, it was noted, the system 'reversed' the conventional approach of individual therapy (i.e. by beginning, rather than ending, with one-to-one consultations).[62] From the late 1950s, the hospital's Forensic Unit comprised a range of services distributed across various settings. Medical and nursing staff attended a local Remand Home, prison and Approved School; separate children and adults' forensic outpatient clinics were held at the Maudsley, and there were teaching visits to prisons, courts, borstals and the Family Service Unit. Thus, 'Registrars gain familiarity with the problems of crime and delinquency and learn the role of the psychiatrist in cooperating with courts and remedial institutions'.[63]

Hilda Lewis House opened in 1970 as a purpose-built unit for children with severe learning difficulties and behaviour problems. The unit initially admitted children up to the age of 16, but this limit was later lowered, as greater therapeutic gains were reported for younger children. One former employee who had originally trained as a nursery nurse (NNEB) responded to an advertisement in *The Lady* magazine. She recalled:

> There were two separate sections of children. One room was called the lions, which were the bigger, more aggressive, children, and another one was called the lambs, which were the smaller, vulnerable, but equally difficult children.

Initial assessment was conducted in the community, and then repeated on the ward. Reasons for admission included epilepsy, Tourette's, self-injury, or communication difficulties. The unit's core approach was behaviour modification, supplemented by occupational therapy, outings, and onsite schooling. Patients stayed an average six of months, with their progress scrutinised and logged and home visits granted when feasible.[64] With its clear emphases on family intervention, and the delineation of

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[62] BRHAM, "Mcc: Medical Committee Documents and Minutes, 1955-1957."MCD.23/57: Report on the Psychiatric Service to Mayford School, Woking, Surrey.
[63] BRHAM, "Triennial Statistical Report, Years 1958-1960," ed. E.H. Hare, pp.63-54.
[64] Joyce Burrage, Interview by Author, 22nd July 2014.

learned from organic behaviour, ward protocol echoed that of Doctors William Moodie and Rosalie Lucas at the interwar Maudsley.[65]

The lead consultant at Hilda Lewis House was John Corbett.[66] Additionally, it had a senior registrar, a registrar, four psychologists (including Dr Janet Carr[67]) two occupational therapists, 'about twenty' nurses, plus students and teaching staff. As an innovative mental health service, the unit was subject to curiosity and contempt from fellow professionals.

> We had visiting doctors and professors. Lorna Wing[68]....came to assess a child for us, and that child got called autistic. But before that, they were called mentally handicapped...If you said – 'I'm sorry, we can't do anything because this child has a mental handicap' - that was devastating for the parent. But if you said – 'your child is autistic, we think your child is autistic' - that made all the difference in the world.

> We didn't mix with the main hospital...They didn't understand what we were trying to do. And we got quite a few comments if you met them out - oh, there's that mad lot. You know? But it didn't worry us.[69]

Addictions Treatment and Research

The Addiction Research Unit was established at the Institute of Psychiatry in 1967, and headed by Dr Griffith Edwards.[70] It brought together research into, and treatment of,

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[65] Evans, Rahman, and Jones, "Managing the `Unmanageable'," pp.464-465.

[66] John A. Corbett, Michael R. Trimble, and Thomas C. Nichol, "Behavioral and Cognitive Impairments in Children with Epilepsy: The Long-Term Effects of Anticonvulsant Therapy," *Journal of the American Academy of Child Psychiatry* 24, no. 1 (1985): pp.17-23.

[67] Carr became noted for her longitudinal study of Down's Syndrome. Saba Salman, "Janet Carr: They Used to Say 'They're Never Likely to Walk or Talk'" *Guardian*, 19th November 2014. Available from: http://www.theguardian.com/society/2014/nov/19/janet-carr-research-downs-syndrome-family (accessed 4th April 2015).

[68] Lorna Wing and Judith Gould, "Severe Impairments of Social Interaction and Associated Abnormalities in Children: Epidemiology and Classification," *Journal of Autism and Developmental Disorders* 9, no. 1 (1979). Wing and Gould jointly founded the Camberwell Case Register, to track psychiatric epidemiology in this area.

[69] Joyce Burrage, Interview by Author, 22nd July 2014.

all forms of addiction, including alcohol, drugs and (tobacco) smoking. From 1968, an outpatient clinic was held three mornings a week at the Maudsley. Inpatient provision was based at two wards on the Bethlem site, divided between Witley 2 (oral users, 11 beds) and Witley 3 (injectors, 10 beds). For the triennium 1970-72, there were 66 male admissions to Witley 2 (48 new patients, 18 readmissions) and 30 female (25 new patients, five readmissions). For Witley 3, the respective figures were 127 males (80 new patients, 37 readmissions) and 49 females (35 new patients, 14 readmissions). Amidst recognition of high comorbidities with other mental disorders – some patients were also receiving therapy on other wards - the addictions service sought to 'use, as required, the totality of psychiatric treatment', including 'individual therapy, group therapy, special methods such as ECT, behavioural therapy…though psychoactive drugs and night sedation [are] administered more rarely'. This was delivered by a multidisciplinary team comprising 23 nurses, one consultant, two registrars, two social workers, a psychologist, an occupational therapist, a research assistant and a secretary.[71] Edwards was also instrumental in setting up charities, a day centre and therapeutic community (Phoenix House) for addicts, all based on a harm minimisation model.[72] By 1971, the Addictions Research Unit had evolved into a 38-strong team, under the joint surveillance of Edwards and Dr D.L. Davies, with Michael Russell[73] leading the Smoking Section, and P.H. Connell[74] in charge of the Clinical Research and Treatment Unit.[75]

The Joint Hospital also underwent a marked reversal of its constituent institutions' traditional policies on the acceptance of criminal patients, culminating in the eventual establishment of a medium secure facility, the Denis Hill Unit, in 1985, amidst protracted neighbourhood opposition. Leslie Paine, House Governor (1962-1985) recalled efforts to assuage public hostility towards this development:

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[70] Griffith Edwards and Milton M. Gross, "Alcohol Dependence: Provisional Description of a Clinical Syndrome," *British Medical Journal* 1 (1976): pp.1058-1061.
[71] BRHAM, "The Bethlem Royal and the Maudsley Hospital Report, 1970-75. Part I - Text," ed. Robert Cawley and Margaret Myers, pp.59-60.
[72] Griffith Edwards, Interview by Author, 7th December 2010.
[73] M. A. H. Russell et al., "Effect of General Practitioners' Advice against Smoking," *British Medical Journal* 2, no. 6184 (1979): pp.231-235.
[74] Ramon Gardner and P. H. Connell, "One Year's Experience in a Drug-Dependence Clinic," *Lancet* 296, no. 7670 (1970): pp.455-459.
[75] BRHAM, "Bethlem and Maudsley Hospital Gazette, Autumn 1971," pp.36-37.

I had to take a team, consisting of the matron and a couple of the consultants, round the whole of the West Wickham, Shirley, all round there, to educate the public. We appeared in public halls, church halls, and told them all about what was going to happen, and explained exactly how the unit would run, and so on. And there was a hell of a lot of opposition – there was again afterwards, when they decided to extend it, some years later, after I'd gone. It was quite clear...there were more people against it than in favour, but they were also under many delusions...I mean, the number of local mothers who told me that we were putting their sons and daughters in danger, by having these violent criminals.[76]

In sum, it may be argued that the mid twentieth- century expansion of age-specific services at Bethlem partly reflected national trends in extending the reach of psychiatry, but was likewise stimulated by localised research interests and the concerns of (potential) patients and their families.

Psychogeriatrics: A New Focus on Older Patients

Changing patterns were also observed at the opposite end of the age spectrum, in the admission of elderly patients. Marjory Warren's seminal paper of 1943 emphasised an urgent need for research on senile diseases, and called for the creation of dedicated general hospital facilities for the chronic sick.[77] Nevertheless, Claire Hilton described how, with the possible exception of neurological investigations, there was a general lack of pre-NHS attention to the specific mental problems of older people[78] and accompanying professional disregard for the establishment of the psychogeriatrics specialism.[79] A 2008 witness seminar brought together people who had been instrumental to the development of old age psychiatry between 1960 and 1989. Key themes arising were the serendipitous route through which these individuals came to work with older mentally ill people; the eclecticism of their cultural and medical

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[76] Leslie Paine, Interview by Author, January 25th 2011.
[77] Marjory W. Warren, "Care of Chronic Sick," *British Medical Journal* 2, no. 4329 (1943): pp.822-823.
[78] Claire Hilton, "The Origins of Old Age Psychiatry in Britain in the 1940s," *History of Psychiatry* 16 (2005): p.270.
[79] Claire Hilton, "The Provision of Mental Health Services in England for People over 65 Years of Age, 1970-78," *History of Psychiatry* 19, no. 3 (2008): pp.302-303.

backgrounds; and their need to cope with professional isolation and opposition, and to grasp opportunities. Refugee psychiatrists at Crichton Royal Hospital in Dumfries in the early 1940s contributed significantly to knowledge of older mentally ill people; work which developed into assessment and treatment services in the following decade. However, Hilton traced the origins of psychiatry for older people to Felix Post's late 1940s appointment to the Joint Hospital, to run the proposed 'Geriatric Unit'.[80]

A Jewish émigré from Berlin, Felix Post had worked with Aubrey Lewis at Mill Hill and D. K. Henderson in Edinburgh, before spending eighteen months in the Royal Army Medical Corps. He had been at the Maudsley for a year, when, in 1948, Lewis nominated him to lead a proposed psychogeriatric service at Bethlem.[81] This encompassed Gresham I (27 female beds) and Gresham 2 (20 male beds) plus outpatient clinics, and the pioneering Gresham (aftercare) Club.[82] Post's teaching and research interests included the social determinants of mental breakdown and recovery,[83] and the interaction of somatic and psychic disturbances among an older population.[84] Yet, according to Hilton, Bethlem's Medical Committee restricted further psychogeriatric provision, prohibited long-term inpatient treatment of dementia, displayed frequent negativity and undermined service development for older people.[85]

When interviewed, Former Bethlem staff felt that the hospital had represented a suitable backwater to launch such an experiment, without impinging on the Maudsley's resources or reputation. A conflation of class and gender issues was observed in the clientele admitted: a former nurse likened the supposedly pioneering new unit to a rural hotel, whose patients were 'always immaculately dressed and coiffured', but recalled little of any specific therapeutic regime.[86] Bethlem's

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[80] Claire Hilton, Tom Arie, and Malcolm Nicolson, "A Witness Seminar: The Development of Old Age Psychiatry in Britain, 1960–1989. Themes, Lessons and Highlights," *International Journal of Geriatric Psychiatry* 25, no. 6 (2010): pp. 597-598, 600, 602.

[81] Claire Hilton, "Post, Julius Ferdinand Hans Ernst (1913–2001)" (Jan 2009) (Oxford University Press, 2006 [cited 13 Feb 2015]); available from http://www.oxforddnb.com/view/article/94935.

[82] BRHAM, "Mcc: Medical Committee Documents and Minutes, 1955-1957."

[83] D. W. K. Kay, Vera Norris, and Felix Post, "Prognosis in Psychiatric Disorders of the Elderly: An Attempt to Define Indicators of Early Death and Early Recovery," *British Journal of Psychiatry* 102, no. 426 (1956): pp.129-140.

[84] Felix Post, "Somatic and Psychic Factors in the Treatment of Elderly Psychiatric Patients," *Journal of Psychosomatic Research* 10, no. 1 (1966): pp.13-19.

[85] Hilton, "Post, Julius Ferdinand Hans Ernst (1913–2001)".

[86] Rhiannon Harlow Smith, Interview by Author, 2nd September 2010.

psychogeriatric unit only admitted voluntary patients with conditions deemed treatable,[87] yet age itself was also considered a barrier to certain interventions. Patients over fifty were not generally deemed suitable candidates for psychotherapy, although neuroses – the disorders most commonly treated by such means - were rarely diagnosed within this population.[88] Little had changed by 1980, when a 61-year-old male presenting at Bethlem with 'diffuse anxiety symptoms' was advised that 'most of our groups are composed of people in the age range 20-30 and not every therapist would be willing to take someone (his) age into a group and it may be that he would therefore be on the waiting list for a long time'.[89] Debates surrounding suitability for psychotherapy are expanded upon in chapter 7.

Trends for increased longevity posed particular health and welfare problems, and, from the mid twentieth century, expedited new attention to the needs of this population. Pat Thane reported that, by 1962, 900,000 older people were bedridden or immobile beyond their homes; 140,000 were in institutions, and a further 750,000 lived in private households. Doctors were also inclined to attribute symptoms to ageing rather than disease, thus leaving otherwise treatable conditions undiagnosed. Thane proposed that this situation was exacerbated amongst younger practitioners; a phenomenon which she linked to negative textbook depictions of older people as a social problem, emphasising their resource consumption, resistance to change, and assumed inactivity after the age of seventy. Although some of these attitudes were later redressed through challenges to stigmatising terminology (e.g. 'geriatric' as a noun; 'the elderly' as a generalization) counselling services for older people were slow to emerge, compared to similar provision for other populations.[90] Elizabeth Bott's (1976) paper[91] also found that – despite the prominence of community care rhetoric - there was a continuing demand for long-term custodial care, markedly observed in patients aged over 65; a trend seemingly impervious to concomitant treatment developments in social and clinical psychiatry. Increased longevity exacerbated the

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[87] Hilton, "The Origins of Old Age Psychiatry in Britain in the 1940s," p.282.
[88] D.M. Dunlop et al., eds., *Textbook of Medical Treatment* 1st ed. (Edinburgh: E. & S. Livingstone, 1939), p.1042.
[89] BRHAM, "Pct-07: Psychotherapy Assessment Reports, Oct 1979 – March 1981."
[90] Pat Thane, *Old Age in English History: Past Experiences, Present Issues* (Oxford; New York: Oxford University Press, 2000), pp.449-451, 455.
[91] Elizabeth Bott, "Hospital and Society," *British Journal of Medical Psychology* 49 (1976): pp.97-140.

diagnostic and treatment challenges posed by this group, for whom community measures were often unsuitable or inaccessible. Some years later, she concluded that her original research had placed undue emphasis on the internal workings of the case study hospital, and too little on its environmental context. Chiefly, Bott proposed that postwar changes in family structure and social network formation had made people more willing to seek psychiatric help, but, crucially, less able to care for relatives at home. In this climate, she believed that the newly-isolated groups included people who had lost their parents; middle-aged women; and elderly (sic) patients without relatives.[92]

Committee documents from 1958 suggested that the Joint Hospital was alert to wider concerns about an ageing population, and was already engaged in plans for 'new institutions to meet the problems of an extra-mural psychiatry which takes account of the social no less than the medical conditions of infirm people'. However, the hospital itself anticipated that the combined effects of 'unforeseen medical advances (and) women's greater longevity and proneness to mental disorder' would precipitate a 44% rise in psychiatric inpatients of this age group between 1951 and 1987, approximately two-thirds of whom would be women. C.P. Blacker, the report's author and Joint Hospital Treasurer, believed that one solution lay in the creation of 'compromise' institutions, half-way between a house and a hostel.[93] As part of the present research, a comparison of Bethlem's discharge figures allowed evaluation of the accuracy of these projections. In 1958, of 100 admissions randomly sampled, 14 (6 male, 8 female) were aged over 65. For 1983, the most recent records consulted, 86 of 683 annual discharges were of older people; of these, 25 (29.1%) were male, and 61 (70.9%) female. Whilst the earlier sample size is too small to support reliable conclusions on the ratio of elderly patients within the hospital, the latter finding appears broadly in agreement with Blacker's projections regarding the psychogeriatric gender divide. Furthermore, during the 1960s, the admission age for the geriatric unit was raised from 60 to 70 years, and, thereafter, female admission rates quickly exceeded males (figures 9-10).

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[92] Elizabeth Bott Spillius, *Asylum and Society* (1988 [cited April 7 2011)); available from http://www.moderntimesworkplace.com/archives/ericsess/sessvol1/Spilliusp586.opd.pdf.
[93] BRHAM, "Mcd.48/58: Mentally Ill People over Sixty-Five: Need for Better Means of Future Disposal," ed. C.P. Blacker (1958).

Figure 9: *Admission of Psychogeriatric Inpatients to Bethlem, 1964-83*. Source: Admissions Database.
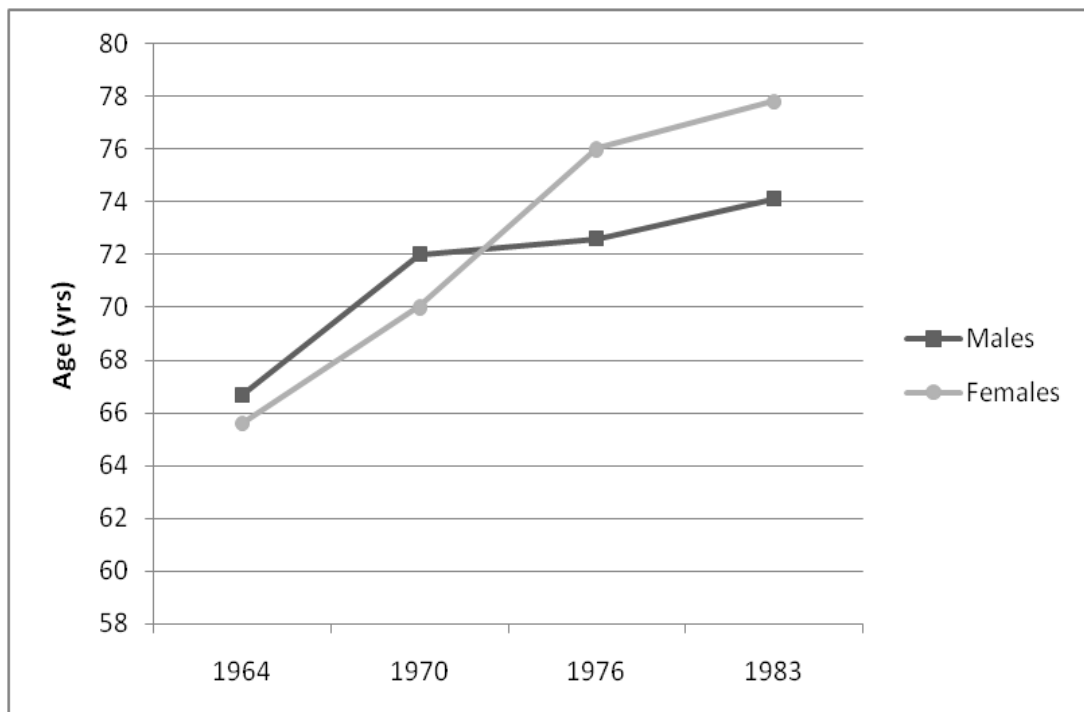
Figure 10: *Mean Age of Psychogeriatric Inpatient Admissions to Bethlem, 1964-83*. Source: Admissions Database.

The present findings broadly reflect a reconceptualisation from aetiology ('critical periods') to diagnosis, but one skewed by gender differentials in longevity, which thereby augmented the female predominance in Bethlem's inpatient population.

Social Class and Negotiating Care

As described previously, Bethlem's promotional materials of the 1930s courted an educated, middle-class clientele.[94] For some patients, class and reputation-based institutional comparisons, and the supposed detriment of mixing with those of inferior standing, were vital considerations in choosing a hospital. In this respect, it may be argued that patient choice became, reciprocally, a factor in perpetuating the class bias in Bethlem admissions. Yet, the Hospital Governors appeared amenable to negotiating periods of free or reduced rate voluntary treatment, which, in some instances, reduced financial barriers to care. Institutional histories have hitherto tended to focus on the role of stigma in preventing, or curtailing, mental hospital admission (Diana Gittins, for example, believed that 'certification acted as a social barometer which created a personal stigma for those mental patients discharged from the hospital').[95] However, evidence discussed so far alludes instead to a new dynamics of care and choice, and lends support to Mathew Thomson's emphasis on the appeal of practical psychology and 'self-improvement' to the aspirational middle classes in the early twentieth century.[96] However, the examples below also suggest a more nuanced discrimination, which conflated class and clinical status of prospective fellow patients. A friend of HL, a female teacher, sought admission for her on the following basis:

> Can you possibly do anything to ensure that she shall not be sent anywhere before you have time to see if Bethlem might have her finally...Bethlem is so different to an Infirmary life, kind as they are. She is <u>so</u> refined and nice and one shudders to think of that for <u>her</u>. She will have to stay in the Infirmary anyway, as she is penniless and will be, and cannot come out ever. But if instead of the Infirmary it could be Bethlem, it would be such a relief, as she <u>is</u> mental evidently....I know the Mental Hospitals in connection with the LCC

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[94] BRHAM, "Bethlem Royal Hospital: Prospectus, 1932," pp.6-7.
[95] Gittins, *Madness in Its Place*, p.43.
[96] Thomson, *Psychological Subjects*, p.39.

[London County Council] are excellent, especially the Epsom ones...But the London ones are more crowded, and they "grade" far less, and it might cause [HL] to become really mental to be with such very mental folks....Since writing the above, my friend has returned from the Highgate Infirmary and to her amazement and intense relief finds that [HL] was quite happily settled, with a lot of very old and poor ladies (quite different in social position) and she also dressed in the workhouse attire (poor soul!) which did not seem to worry her at all!! This, I think, proves how mental she is.[97]

Gittins acknowledged practical reasons for the use of (especially 'strong') regulation garments, but believed that 'the uniformity and harshness of hospital clothing constantly reminded patients of their loss of status, freedom and identity'.[98] The above reference to 'workhouse attire' reframes these concerns as stemming from the public imagination, whereby such clothing created further stigma and accentuated the boundaries between institutional populations (including staff) and wider society. Yet, the previous images of Bethlem and Shenley Hospitals (figures 2-5) actually reflect a greater heterogeneity in the appearance and aims of twentieth-century mental hospitals. The case of HL further illustrates the recurrent and potentially important distinction some correspondents made between 'insane' and mental', and implies that, in the popular view, these linguistic niceties were intertwined with social status and institutional reputation, reinforcing the concept of a hospital 'marketplace'. This was again evident in the case of EH, a 65 year-old businessman initially sent to Shenley Hospital; a destination that his wife and a local priest both regarded as inappropriate and damaging, the latter being

> ...convinced that the environment there is not really helpful, for the majority of his fellow patients are of a type and class which does not and cannot share any of his interests, so that he is intensely lonely, which, you will agree, is no help to melancholia.

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[97] BRHAM, "Patient Correspondence Files, 1925-1947," ref. no. 1209 (discharged November 1940).
[98] Gittins, *Madness in Its Place*, p.135.

For as long as she could afford it, the patient's wife instead paid for him to receive nursing care at home, before seeking his (re)admission to Bethlem. During his stay, two of EH's daughters both also experienced mental distress (later diagnosed as schizophrenia). Amidst a backdrop of eugenicist concerns, news of one daughter's engagement caused his wife anxiety about a possible hereditary taint, prompting her to ask the Physician Superintendent

> ...whether her father's illness is of such a nature that it is likely to be passed on to future generations in the event of her marrying or having children. If so, of course her fiancé must be told; I trust you consider his condition of nervous origin only.[99]

The relationship between mental disorder and social class was a recurrent theme within wider psychiatric epidemiology, with higher admission rates commonly recorded within Social Class V (unskilled occupations) compared to medium and upper ranks.[100] Brooke outlined the 'social class gradient' for schizophrenia, whereby members of the lowest social class were significantly more likely than those from other classes to receive this diagnosis.[101] However, this observation poses further questions regarding the direction of causality. Notwithstanding the possibility of a genuine clinical disparity between classes, explanations cited by Carstairs for the effect included a downward social mobility consequent to becoming ill; class biases in recognition and diagnosis of schizophrenia; and the greater willingness of more affluent patients to seek psychiatric help - coupled, perhaps, with their ability to pay for private treatment (and thus bypassing national statistics).[102]

Moreover, in an American survey, August Hollingshead and Frederick Redlich found an inverse relationship between schizophrenics' social class and mean age of first psychiatric consultation: thus, the patients' average age at first meeting ranged from 29 (Class I) to 33 (Class V), arguably giving the former group the advantage of earlier intervention. The pair also investigated the distribution of principal types of therapy by

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[99] BRHAM, "Patient Correspondence Files, 1925-1947," ref. no. 1221 (died July 1940).
[100] Logan, "Patients in Mental Hospitals," pp. 498-499.
[101] Brooke, "Mental Health and the Population," p. 213.
[102] Carstairs et al., "Changing Population of Mental Hospitals," p.189.

social class, highlighting a propensity for patients in social class V to receive 'organic' (i.e. physical) treatment (32.7%) or no intervention (51.2%) rather than psychotherapy (16.1%). Patients in classes I and II were, by contrast, approximately five times as likely to receive psychotherapy, and two-thirds less likely to receive organic therapy.[103] The hypothesised relationship between patients' social background and perceived suitability for particular treatments will be explored more in forthcoming chapters. Manic depression and alcoholism were amongst the few exceptions to this association between social class and psychiatric distress. Logan characterised upper-class alcoholics as 'victims of their comfortable circumstances'[104] whose decision to seek treatment may, Brooke proposed, have stemmed partly from concerns regarding employment and professional status.[105]

There were some difficulties in analysing related Bethlem data, as neither social class nor occupation were recorded on post-1947 admission registers, whilst, in prewar statistics, the status of female inpatients was generally inferred from the husband's profession. Hospital regulations from 1932 openly stated that 'preference will be given to patients of the educated classes', and removed a clause exempting 'those who have sufficient means for their suitable maintenance in a Private Establishment'.[106] However, the creation of the NHS heralded changing priorities, with an externally-imposed 'district commitment', informal and outpatient treatment options and the burgeoning range of disorders all exerting an influence on the nature of admissions. Figures from the 1949-1951 Triennial Statistical Report indicated that 9.5% of Bethlem's 1,145 male inpatients were in the top social class, compared to just 4.9% of the Greater London male population. However, just 3.3% of male outpatients shared this background, owing to the more rigorous selection process – and consequently narrower social spectrum – for inpatients than outpatients. Additionally, there was a 'more median distribution' of females, the overwhelming majority of inpatients and outpatients being of social class III ('skilled' occupations).[107] This also corresponds with

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[103] August B. Hollingshead and Frederick C. Redlich, "Social Stratification and Psychiatric Disorders," *American Sociological Review* 18, no. 2 (1953): pp.168-169.
[104] Logan, "Patients in Mental Hospitals," p. 499.
[105] Brooke, "Mental Health and the Population," p. 214.
[106] BRHAM, "Standing Rules and Orders, 1932."
[107] BRHAM, "Triennial Statistical Report, Years 1949-1951," pp.26-29.

the class profile pattern of employed women on the Great Britain electoral registers at this time.[108]

At the point of the merger, some 86% of Bethlem admissions came from the London area, with a minority from Kent, Middlesex or Surrey.[109] Yet, despite the 'democratising' effects of the NHS Act, a new 'district commitment' (targeting working-class Lambeth and Camberwell) and the expansion of outpatient and day services, by 1969, the Triennial Statistical Report (table 6) still recorded an excess of social classes I and II amongst the hospital's male inpatients when compared to 1961 census data.[110]

Social Class	In-Patients, %	Out-Patients, %	Hospital Patients, %			London
			1967-69	1964-66	1961-63	1961*
I	8	6	7	6	7	3.7
II	18	16	17	19	15	9.1
III c (clerical)	30	33				
				} 43	50	56.5
III m (manual)	10	11	11			
IV	17	16	16	15	10	16.3
V	17	19	17	17	18	14.4
Total known	100	100	100	100	100	100
Not known	3	13	10	6	6	
Total patients	1,213	3,456	4,417	4,520	5,539**	
*Occupied males, Greater London, Census 1961; ** Hospital patients, including not-new patients.*						

Table 6: *Social Class of Male Patients, 1967-69.* Source: BRHAM, Triennial Statistical Reports, 1967-69.

New services exerted an additional influence on the social class profile of Bethlem's clientele. Between 1956 and 1966, Bethlem's day hospital, 'Dayholme', attracted additional patients from neighbouring Surrey and Kent. They were typically older and of a higher social class than other Joint Hospital outpatients, reflecting Bethlem's

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[108] Anthony Heath and Clive Payne, "Social Mobility," in *Twentieth-Century British Social Trends*, ed. A.H. Halsey and Josephine Webb (Basingstoke: Macmillan Press Ltd., 2000), p.261.
[109] BRHAM, "Triennial Statistical Report, Years 1949-1951," pp.101-103.
[110] BRHAM, "Triennial Statistical Report, Years 1967-1969," p.9.

affluent suburban locale rather than the poorer boroughs to the east.[111] The introduction of the Camberwell Register in the 1960s provided a means of tracking residents' contact with psychological services, and was a key example of how social psychiatry connected aspects of research and treatment.[112] Bethlem staff also worked at St. Francis Hospital Acute Unit (Dulwich) in this period, these moves being cited as 'an illustration that the activities of the Joint Hospital are becoming increasingly merged with those of the general psychiatric services of the district'.[113] These developments again typify a more generalised departure from a body and hospital-focused service, towards one which embraced new settings and influences in the study and treatment of mental illness. Although this resonates with Armstrong's theory of encroaching surveillance and diagnosis of society, these moves can be viewed as a more benevolent and reciprocal dialogue between the hospital and those it served; a process which ultimately generated greater choice and accessibility.

General Register Office (GRO) figures from the 1950s reported 'a reversal of the social gradient at ages over 65 and a very much higher admission rate of patients in Social Class I than the other four classes'.[114] These patterns were clearly replicated in Bethlem's aforementioned psychogeriatric unit, which opened in 1948. Despite the therapeutic aspirations of consultant Felix Post, the atmosphere was allegedly something of a throwback to the 1930s hospital, with a typically upper-middle class clientele and sedate, ambience:

> It was very, very, very gentle, it was almost like, I don't know, a rural hotel
> [laughs]. You could imagine, actually, if something did happen, Poirot or Miss
> Marple would appear [laughs].....I don't think there was any talking
> therapy....Certainly, psychiatrists interviewed patients on admission. There was
> a patient conference every week, with Felix Post leading it, and his registrars

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[111] BRHAM, "Triennial Statistical Report, Years 1955-1957," ed. E.H. Hare.
[112] The Camberwell Cumulative Psychiatric Case Register was a continuous record of contacts with psychiatric and subnormality services by individuals living within the LCC Borough of Camberwell (subsequently the GLC Borough of Southwark). It was created to provide a sampling frame for the study of psychiatric illness, and to support service planning and evaluation. See: Lorna Wing, Christine Bramley, Anthea Hailey, and J. K. Wing, "Camberwell Cumulative Psychiatric Case Register Part I: Aims and Methods," Social Psychiatry, 3 (1968), pp. 116-123.
[113] BRHAM, "Triennial Statistical Report, Years 1967-1969," p.3.
[114] Logan, "Patients in Mental Hospitals," p.499.

and the occupational therapist and, if necessary - well, if relevant - psychologists, etc, etc, and a senior member of the nursing staff. And patients who'd just been admitted would be seen there, and others who might be coming up for discharge; it was an ongoing 'see how we're doing.[115]

Another nurse recalled dealing with the consequences of overprescribing, as a crucial first step in the treatment of older patients:

I think we had a few cases in, who'd come in from elsewhere, who had toxic confusional states. And that is where they'd had various drugs and the drugs had made them confused. And when they were taken off the drugs, or limited to just one, they became almost 'normal' individuals. We found it especially with elderly patients; they'd be fine during the day and totally confused at night.[116]

Such accounts fall some way short of Hilton's depiction of a revolutionary, holistic approach to mental illness in old people;[117] yet, they nevertheless demonstrated fresh, but pragmatic, attention to the psychological welfare of these patients. In accordance with the aforementioned findings of Hollingshead and Redlich, there was also a lingering belief – even into late 1960s – that only the social elite could benefit from psychological methods, whereas physical or pharmaceutical treatments were more evenly distributed between social classes, if not genders.[118] This idea will be expanded upon in subsequent chapters, together with the supposed desirability of certain characteristics to the psychotherapeutic process.

Occupational Backgrounds and Initiatives

Occupational status was often applied as index of social class, as discussed above, although recent scholarship has cast doubt on the legitimacy of this practice. Simon Szreter, for example, describes the genesis and limitations of the GRO social

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[115] Rhiannon Harlow Smith, Interview by Author, 2nd September 2010.
[116] Edelweiss James, Interview by Author, 23rd February 2011.
[117] Hilton, "The Origins of Old Age Psychiatry in Britain in the 1940s," p.278.
[118] BRHAM, "Triennial Statistical Report, Years 1958-1960," p.17.

classification of occupation, and its centrality within twentieth-century psychiatric epidemiology, as unscientific and based on outdated principles, He went on to criticise the largely unchallenged longevity of a nineteenth-century framework, founded on 'extremely tenuous propositions' including 'a single continuous scale of social position or status' which could be 'conceptualized and empirically measured' through occupational data.[119] Some heterogeneity of risk was also reported for specific jobs. For example, in 1955, Carstairs found that 'dock labourers, newspaper-sellers, and warehousemen contributed fewer schizophrenics than their numbers appeared to warrant; so also did the group of watchmen and caretakers. On the other hand, office cleaners, costers and hawkers, porters and kitchen-hands contributed significantly more than their share of such cases'.[120] Although no explanation was advanced for these findings, they could be indices of the conditions, responsibilities and/or stability of particular roles, or, conversely, reflective of the characteristics of individuals attracted to these careers.

There are a number of reasons why the aforementioned social class profile of Bethlem's patients cannot be reliably inferred from available occupational statistics. Anomalies and discontinuities in the recording of patients' jobs are issues which were addressed in the methods chapter. The present discussion will, necessarily, focus on the employment backgrounds of Bethlem patients in the decades preceding the hospital merger. Table 7 shows the occupational distribution of sampled Bethlem inpatients, at intervals between 1934 and 1946. Throughout this period, the majority of Bethlem inpatients were of class 'GG' - namely, not working. This included the retired, students, housewives and unemployed ('nil'), and a further breakdown of this group is provided in Figure 11. The next three most frequent occupational groups were: clerical, professional, and 'commercial, finance or insurance'.

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[119] Simon R. S. Szreter, "The Genesis of the Registrar-General's Social Classification of Occupations," *British Journal of Sociology* 35, no. 4 (1984): pp.538-539.
[120] Carstairs et al., "Changing Population of Mental Hospitals," p.189.

	1934		1936		1938		1941		1944		1946	
	M (n=45)	F (n=55)	M (n=34)	F (n=66)	M (n=36)	F (n=64)	M (n=33)	F (n=67)	M (n=25)	F (n=75)	M (n=33)	F (n=67)
Retired/Not Employed	22.22	65.45	35.29	66.67	22.22	65.63	12.12	71.64	32.00	69.33	27.27	64.18
Clerical	13.33	10.91	17.65	10.61	25.00	14.06	33.33	11.94	16.00	12.00	12.12	16.42
Professional	20.00	14.55	14.71	12.12	25.00	10.94	21.21	7.46	16.00	8.00	24.24	11.94
Commerce, Finance, Insurance	11.11	3.64	14.71		8.33		6.06	1.49	8.00	2.67	15.15	2.99
Personal Service	2.22	3.64		6.06		7.81		2.99	4.00	2.67		
Metal Work	4.44		11.76				3.03		4.00		6.06	
Public Administration and Defence	2.22		2.94		12.12		12.12		4.00	2.67		
Dress and Textiles	2.22				5.56			1.49	4.00		3.03	
Agriculture	2.22			1.52			3.03			1.33		
All Other Occupations	20.00	1.82	2.94	3.03	13.89	1.56	9.09	2.99	12.00	1.33	9.09	4.48
TOTAL:	100	100	100	100	100	100	100	100	100	100	100	100

Table 7: *Percentage of Sampled Patients by Industry and Gender, 1934-1946. Source: Admissions Database.*

Women were seldom described as 'retired'; the great majority of female patients were recorded as 'housewife' or 'none', yet there was an above average contingent of clerks, teachers and nurses.[121]
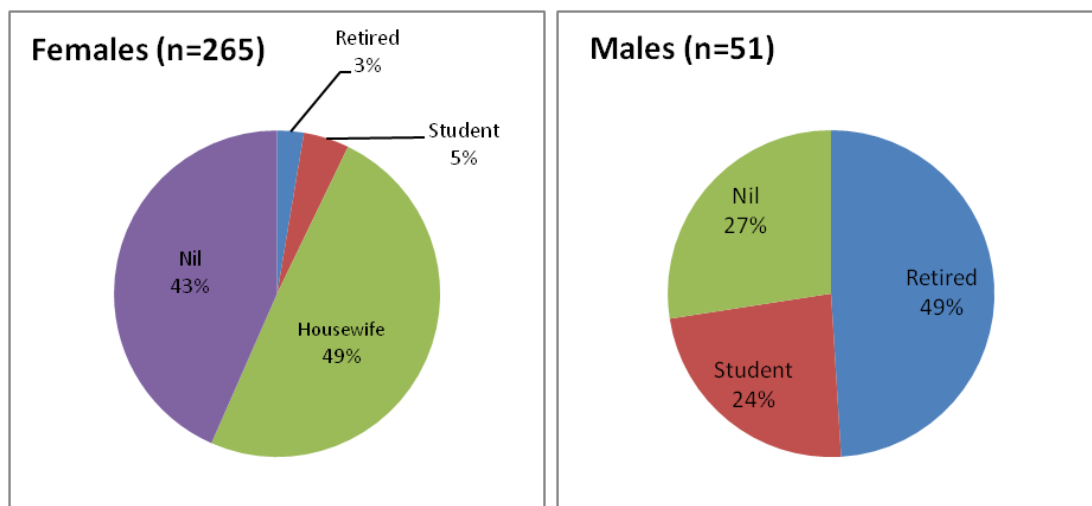
Figure 11: *Occupational Composition of Sampled Non-Working Bethlem Inpatients, 1931-1946.* Source: Admissions Database.

The finding of high proportions of 'not employed' females prompted further casenote investigation to discern the circumstances behind these figures. Moreover, although this pattern coincided with the peak in female admissions aged 20-39 years, the current enquiry sought to look beyond the 'neurotic housewives' trope. This revealed situations within which an individual was forced to give up work, as demonstrated by voluntary patient, MR, of whom it was noted that

> At the age of 26, she had a responsible position in an accountant's office. The work at times worried her, and she imagined that the figures were wrongly added up. For that reason, she left her office and decided to stay at home. [122]

A second factor identified was that of (under-appreciated) domestic pressures which both prevented women from taking other employment, and contributed additional mental stress. Patient MD was thus admitted voluntarily for two months in 1946. Her depression and insomnia were attributed to the 'continued strain of nursing her aged

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[121] BRHAM, "Medical Registers, Years 1918-1926."
[122] BRHAM, "Cwc: Departures and Deaths Patient Casebooks, 1923 -1953," ref. no. 283 (discharged 1932).

mother' and compounded by the recent deaths of her sister and sister-in-law.[123] Moreover, attributions for (especially female) breakdown were imbued with gendered occupational norms. Returning to the aforementioned case of HL, a friend believed that overwork was a precursor to her problems, yet framed her related inability to manage money or sustain employment as more enduring personality traits:

> [HL] got her BA degree when only 21. It unhinged her mind, the strain of the work, and alas she was in Bethlem for some time...She has never been certified, as she most certainly was not and is not <u>insane</u>. But there is some "kink", though up to last year she obtained appointments in France, latterly. Now she can get nothing, or if she does they never keep her, as she seems so "odd" and impossible to get on with in some ways, though her intelligence [is] keen. She is no use for domestic work as companion. Knows nothing about it, very bad at it, and again they would never keep her if she got it!' Father died when she was 21, brother killed in war. Mother struggled financially. Adore each other but separated since both worked as companions. [Her] "kink" is utter irresponsibility about money. She does not see why her uncles should not go on keeping her, never minds borrowing from anyone she can get hold of. I am sure it is mental. She is well and healthy but not lazy and it is not that. The landlady at last turned her out on Saturday. She never thought anyone would. [She] is now 46 and shows no signs of getting over this "kink" and the other kink of being unable to earn.

In a further letter to the Physician Superintendent, the patient vehemently expressed her desire to resume teaching, but alluded also to the dual impediments of being both female and a former psychiatric patient:

> The family view that I am "excluded from schools" has no relation to the facts. They never see me and have not really looked the matter up. Those who lead education would be willing to accept a health view from you. If you think me well enough to earn my own living, the next matter is the law. Anyone who attempts to exclude me from Schools could be dealt with legally...The Schools

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[123] Ibid., ref. no. 2971 (discharged 1946).

strictly should have paid for the illnesses they had caused. Compensation was due...Do you think I could claim compensation e.g. from a rich School like Farnborough? ...I think women are better earning their own living and being independent...I wish to be reinstated as in 1917 and 1923, but it takes some brain-work at this stage. After being described as an "ex-teacher" I am not sure how to proceed.

However, following further relapses, HL was eventually transferred to a convalescent home in Sussex; albeit, 'against my wishes and chiefly on account of lack of accommodation elsewhere', according to her plaintive letters of 1949 and 1950 (unsuccessfully) requesting readmission to Bethlem.[124] Anomalous against a backdrop of expanding choice and consumerism, this outwardly exemplifies rejection of a patient's wishes. However, her resounding sense of injustice at her circumstances is also suggestive of changing expectations/aspirations vis-à-vis patient rights and social roles. One may surmise that, whilst clearly vocal and intelligent, HL's gender, together with a lack of family, or financial, support, were to her detriment in negotiating treatment.

In other instances, the hospital could serve an important function in creating, or supporting, vocational opportunities for patients. This is further illustrated by revisiting motor accident victim, JR. Several years into his admission for dementia praecox, his mother wrote to Porter-Phillips proposing that her son 'might in time be able to take a minor post in the drawing office of some electrical firm' and requesting some 'elementary drawing exercises and reading books on allied subjects'. This idea was well-received, with the caveat that 'he is still rather delicate and fragile and should only be allowed to work for a very short time at any rate to begin with, and should not be unduly pressed as regards his studies'. Whilst considered unfit for National Service, the hospital attested to JR's suitability for a government-sponsored draughtsmanship course, to which he penned the following:

> A desire to express to you my appreciation for your endeavours to set your
> patient "on his feet" prompts me to send this note. On my part please be

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[124] BRHAM, "Patient Correspondence Files, 1925-1947," ref. no. 1209 (discharged November 1940).

assured I am daily devoting several hours for the same purpose: learning by reading, writing and inwardly digesting, whatever seems appropriate – trigonometry and mathematics, essentials for a draughtsman; and English, the papers, books, including the Bible.[125]

Oral history interviewees also attested to a high proportion of students amongst the 1960s and 70s hospital clientele, particularly within the therapeutic community:

Most of the people who came were...highly intelligent, a lot of them were academics, or were involved in the academic world in some form. Some of them were Oxford and Cambridge students.....One or two were writers, in the artistic sort of world.[126]

This trend may partly reflect a generalised increase in university attendance in these decades.[127] However, Dr R.W. Parnell of the Medical Research Council suggested that the prevalence of professionals and students within inpatient populations was often a corollary of their having a higher threshold for optimum recovery, and, thus, requiring longer or repeated admissions.[128] However, Bethlem evidence suggested that admission and extensions to a patient's stay were often the result of protracted negotiation between families and hospital authorities, the outcome of which was dependent on a range of circumstances. Whilst occupation, per se, was not necessarily linked to a specific recovery time, patients' economic and educational backgrounds could both affect their credibility and influence in such decision-making processes.

Mental Health and Marital Status: A Contested Relationship?

Differing prognoses have been reported for mental illness for men and women according to marital status. This has been achieved through analysis of the impact of

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[125] Ibid., Ref. no. 685, discharged August 1944.

[126] Participant 04, Interview by Author, 30th September 2010.

[127] The availability and uptake of university education increased significantly during the 1960s, and student numbers doubled in seven years to more than 50,000. House of Commons Library, "Education: Historical Statistics," Standard Note: SN/SG/4252 (London: HMSO, 2012). Available at: www.parliament.uk/briefing-papers/sn04252.pdf (accessed 3rd May 2015).

[128] Parnell, "Length of Stay in Mental Hospitals," p.1298.

marital status on key types of disorder, overall likelihood of psychiatric admission, and duration of admission. A key area of debate within the literature concerns whether current findings are due to the 'protection' offered by marriage, or to the initial 'selection' of partners. The latter process is potentially one in which those with a psychiatric illness may be disadvantaged,[129] especially those cases with an early age of onset. Likewise, Robert Rapoport observed that 1960s therapeutic community residents were often unmarried – a difference most pronounced in older, neurotic patients - but did not speculate on whether he felt mental illness to be cause or consequence of this circumstance.[130] An additional factor which isn't really considered in more recent accounts, but has more bearing on the prewar decades, is the role of social and/or eugenic concerns in preventing or delaying marriage for those with (especially serious) mental disorder.

In a Norwegian study, Ørnulv Ødegard observed the disproportionate levels of psychiatric admissions amongst single people, and the 'interesting and typical variations according to sex, age, diagnosis, occupation, etc'. He sought to examine the relationship between marital status and mental disorder, specifically testing the following three postulates:

i. *The hypothesis of hospitalization* – that single mentally ill people are more readily admitted to hospital, whereas their married counterparts are more likely to remain at home;

ii. *The hypothesis of selection* – the idea of a constitutional predisposition to mental illness, which manifested in early traits, thereby impeding the likelihood of marriage;

iii. *The hypothesis of protection* – that some aspect(s) of married life conferred defence against mental illness, even in cases of constitutional predisposition.

Ødegard found little support for the idea of marital protection, noting, for example, that widowers, having lost this hypothetical 'shield', showed only a moderately higher

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[129] Melinda S. Forthofer et al., "The Effects of Psychiatric Disorders on the Probability and Timing of First Marriage," *Journal of Health and Social Behavior* 37, no. 2 (1996).
[130] Robert N. Rapoport, *Community as Doctor: New Perspectives on a Therapeutic Community* (London: Tavistock Publications, 1960), pp. 311-312.

incidence of mental illness than that of married people, and still less than half of that found in the single population. He concluded that the pattern was attributable to selection by marriage, and, furthermore, that this selection was 'based upon personality rather than upon economic factors'.[131] A Birmingham-based study conducted by Lowe and Garratt also found married women's mental health to be less susceptible to environmental factors, as this group showed high admission rates across varying social milieux. Moreover, single women dwelling in the more prosperous periphery had the highest female admission rate; a figure exceeded only by that of men living in the town's deprived central wards.[132] Busfield later challenged both the simplistic assumption that differences in the mental health of married couples must be attributable to differences in married or gender roles, and the tendency to regard marital status as a constant, thereby 'ignoring marked variations in marital role between persons of the same marital status'.[133]

In his 1975 article on disease concepts and their implications for psychiatry, R.E. Kendell reviewed evidence for reduced marriage rates and fertility amongst mentally ill patients.[134] He proposed that the confinement of such individuals in asylums offered only a 'partial explanation' for the robust finding that psychotics married less than other people, and were more likely to remain childless. He stated that these trends had persisted, despite the introduction of open-door policies and greater opportunities for patients' social interaction. Kendell cited Aubrey Lewis' Galton Lecture of 1958, which located the cause of this low marriage rate and fertility in the personal characteristics of patients themselves, rather than their enforced residence in a mental hospital.[135] Evaluation of marriage statistics is further compounded by the fact that homosexuality was still considered a mental illness until the 1970s; the inclusion of this sub-group would, therefore, be expected to bias results in the wider patient population in the directions observed.

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[131] Ørnulv Ødegard, "Marriage and Mental Disease: A Study in Social Psychopathology," *Journal of Mental Science* 92, no. 386 (1946): pp.37, 56, 58-59.

[132] Lowe and Garratt, "Sex Pattern of Admissions to Mental Hospitals in Relation to Social Circumstances," pp. 96-98.

[133] Joan Busfield, "Mental Illness as Social Product or Social Construct: A Contradiction in Feminists' Arguments?," *Sociology of Health & Illness* 10, no. 4 (1988): p.525.

[134] Kendell, "The Concept of Disease and Its Implications for Psychiatry," p. 311.

[135] Aubrey J. Lewis, "Fertility and Mental Illness (Galton Lecture Delivered to the Eugenics Society in London, February 1958)." *Eugenics Review* 50, no. 2 (1958): pp. 91-106.

In her unpublished study of admissions to Bethlem and Maudsley, Vera Norris found no differences in length of hospital stay or treatment outcomes, for matched samples of married and single patients. As few of these patients stayed beyond a year, she concluded that contradictory patterns observed elsewhere indicated that differences between married and single patients were 'largely confined to the long-stay patients and that economic circumstances and family responsibilities do not apparently affect the hospital care of short-stay patients'. Norris relatedly proposed that economic liabilities (e.g. household expenditure and limited sickness benefits) may have prompted married women to avoid costly hospital admissions.[136]

Patients' marital status was included in prewar Bethlem admission registers, but thereafter not readily available outside individual casenotes or statistical summaries. Notable trends observed for this earlier period (Figure 8) included a gradual decline in the proportion of single women admitted between 1934 and 1944, and - with the exception of 1941 and 1946 - a slightly greater percentage of single women than single men. Moreover, there was an expected dip in admission of single men circa 1944 (32% of sampled male inpatients, compared to 52% in 1941) and a sharp rise to 55% thereafter. The latter two effects may justifiably be linked to wartime duties and their psychological ramifications. More widows than widowers were admitted, largely reflecting the aforementioned differences in longevity, and supporting the notion of women's economic dependency on men.[137]

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[136] Norris, *Mental Illness in London*, pp.254-255.
[137] Showalter, *Hystories: Hysterical Epidemics and Modern Culture*, p.13.
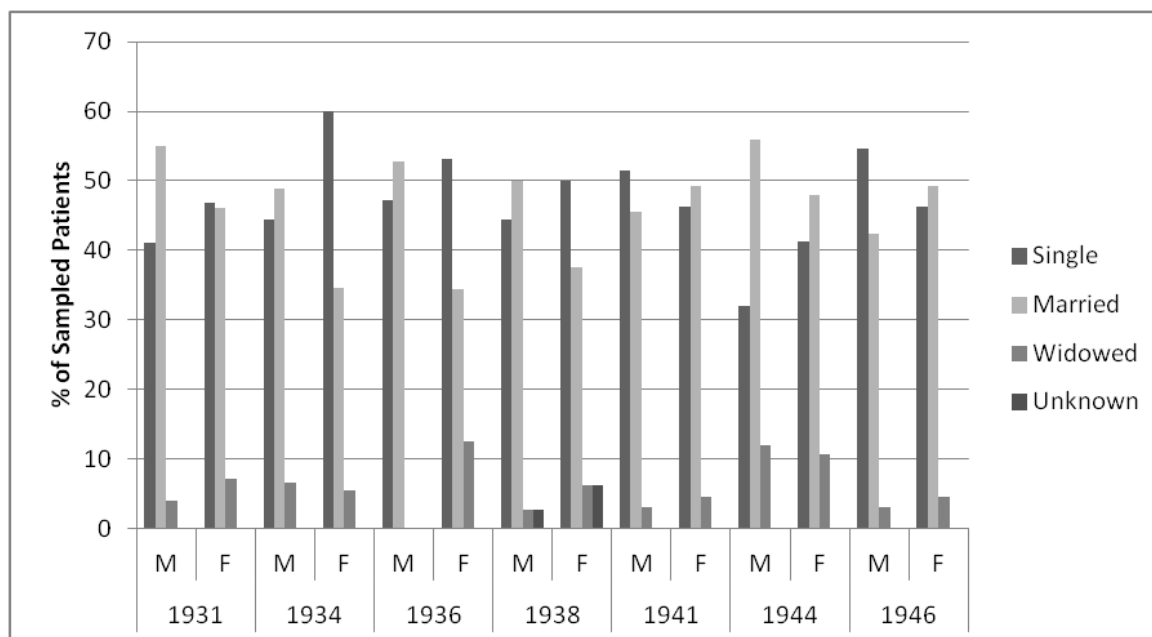
Figure 12: *Marital Status of Sampled Bethlem Inpatients, 1931-46.* Source: Admissions Database.

An analysis of gender differences in diagnosis by marital status was conducted on 1930s-40s Bethlem admissions figures, and results supported the idea that differences were largely in the types of disorders suffered by men and women, rather than their overall prevalence. Clinical trends will be discussed more in the next chapter, but key findings were as follows: single women showed the highest incidence of psychoneurosis, and had elevated risks over single men in all categories except primary dementia; single males recorded the highest overall rates of primary dementia; females – regardless of marital status – had higher rates than men of psychoneurosis.

When total inpatient numbers were considered, married women were less likely than either married men, or unattached females, to be admitted. Previous findings indicated that a higher percentage of female than male patients were married (purportedly because their behaviour was less tolerated and posed more of a 'burden' to the family).[138] It should, however, be noted that these trends were from 1900-16 and 1967-69, prompting the question of why the intervening period should yield an anomalous pattern at Bethlem. One possible explanation is a refocusing of psychiatric attention on the voluntary, single, psychoneurosis admission, and, later, male wartime casualties, occurring in this period. Published statistics from 1967-69 indicated a slight

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[138] Andrews et al., *The History of Bethlem*, p.658.

increase in the proportion of single patients, which was thought to result from the growing numbers of younger admissions. There was also a more noticeable rise in the proportion that were separated (i.e. married but apart)[139] lending support to Brooke's proposal that heightened vulnerability to mental illness was at least partly due to a lack of support at home.[140]

Discussion

The current chapter has used a combination of quantitative and qualitative data to relate the sociodemographic characteristics of Bethlem admissions during the twentieth century, thereby extending and enhancing knowledge of the psychiatric patient 'journey' in this era. Amongst the major trends observed, were a continued overall predominance of female inpatients, and a postwar rise in number of young adults and older (female) patients. There were also more single than married patients, although this could be an artefact of the age distribution of admissions. Where qualitative evidence was used to develop statistical evidence, some suggestive findings arose. Despite the hospital's somewhat atypical social profile, class – or, by proxy, educational level - appeared to be a key determinant in treatment decisions, especially in the use of psychotherapy. A survey of contemporary educational materials also highlighted outmoded representations of mental illness, and inter-professional variation in messages they espoused. Taken together, the above evidence suggests that diverse factors shaped identification of, and attitudes towards, insanity, and that personal background features – indirectly but inexorably - framed individuals' psychiatric experiences.

Consumerism and the Hospital Marketplace

Promotional materials, images, and correspondence files from early twentieth-century Bethlem shed further light on how the hospital promoted itself, which features attracted a new wave of (voluntary) admissions, and how patients and their family or friends influenced care regimes. This contributes to existing accounts of the influences of religion, class and stigma, and enables comparison to existing institutional

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[139] BRHAM, "Triennial Statistical Report, Years 1967-1969," p.9.
[140] Brooke, "Mental Health and the Population," p.213.

historiography and formulations of psychological subjectivity. In many respects, the provisions of the 1930 Mental Treatment Act underscored practices that had been introduced at Bethlem during the late nineteenth century. The hospital saw continued expansion of services to voluntary patients before the introduction of the NHS, although, like its contemporary institutions, failed to embrace the new 'temporary' patient class.

Bethlem had a socially homogenous and somewhat atypical intake: it had no formal 'catchment area' before the NHS, but was subtly affected by the Joint Hospital's Camberwell district commitment in the later twentieth century. By the late 1960s, diminishing GP referrals of non-local patients were felt to have contributed to an overall reduction in outpatient numbers.[141] However, the high proportion of student and professional inpatients (demonstrated through prewar registers and oral history interviews) accords with Parnell's thesis of higher intellectual recovery thresholds for these individuals, which necessitated longer stays or readmissions.[142] Evidence also suggested that social class – rather than clinical profile – often determined treatment decisions at Bethlem, underscored by a belief that psychotherapy would only benefit the educated elite, or the supposedly more subtle afflictions with which they presented. Whilst such attitudes are in keeping with the hospital's middle-class stereotype, this finding was, nonetheless, consistent with trends elsewhere for the same era,[143] and reinforced by the messages of popular medical textbooks.[144]

The foregoing discussion indicates a complex and enduring relationship between social class and mental illness, acutely evidenced in the supposed 'social class gradient' of schizophrenia.[145] However, in this instance, it remains unclear whether the consistently higher admission rates for patients of lower social classes, were a corollary of downwards social mobility, or, instead, were attributable to diverse mitigating factors, including attitudes towards seeking treatment, age of first consultation,[146]

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[141] BRHAM, "Triennial Statistical Report, Years 1967-1969," pp.7, 9.

[142] Parnell, "Length of Stay in Mental Hospitals," p.1298.

[143] Hollingshead and Redlich, "Social Stratification and Psychiatric Disorders," p.169.

[144] D.M. Dunlop et al., eds., *Textbook of Medical Treatment* p.1041.

[145] Brooke, "Mental Health and the Population," p.213.

[146] Hollingshead and Redlich, "Social Stratification and Psychiatric Disorders," pp.168-169.

reliance on NHS facilities, or diagnostic habits.[147] Alcoholism, however, affected a wider social demographic, with 'comfortable circumstances'[148] and retention of professional status[149] invoked, respectively, by commentators as possible causes of such problems, and motives for engaging psychiatric support. Social class could also affect patients' ability to leave the institution. Gittins asserts that, at Severalls Hospital in the early twentieth century, 'the ease with which one could get out ...depended to a great extent on social class'. Whereas a private patient could be discharged on the direction of the person who signed the original reception order, a pauper lunatic could generally only be discharged on the direction of the poor-law authority.[150] Such bureaucratic restrictions may therefore have been instrumental to the continuation of class biases within mental hospital populations. Although the Bethlem population was less socially heterogeneous, economic concerns were often instrumental to a patient's departure. Longer admissions were thus more likely to be the preserve of wealthier or educated individuals, who possessed stronger bargaining power within the hospital.

Bethlem's inpatient population continued to increase until the late 1960s, when the first drop in numbers occurred, with a concomitant rise in readmissions. It is possible that the post-1930 escalation of voluntary admissions further stigmatised certified patients and inherently biased the treatment they received in favour of quicker, physical interventions over psychological treatment; trends which will be explored further in the next chapter.

Psychiatric Approaches

A 1940s increase in the amount of certified males may be attributable to the requirement for only the most acutely ill men to retain inpatient status in wartime. Moreover, a founding objective of the Denis Hill Unit was to take on patients from the already overcrowded Broadmoor Hospital; thus, its inception cannot be viewed simply as a corollary of rising incidences of mental illness amongst offenders. However, the postwar medicalisation of certain formerly criminal behaviours arguably paved the way

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[147] Brooke, "Mental Health and the Population," p.213.
[148] Logan, "Patients in Mental Hospitals," p. 499.
[149] Brooke, "Mental Health and the Population," p.214.
[150] Gittins, *Madness in Its Place*, pp.35-36.

for the growth of this population, and, moreover, provides one potential explanation for the postwar transition in the gender profile of Bethlem's patients, as discussed later in this section.

Service expansion from the mid twentieth century was often directly or indirectly associated with particular patient age groups, with extended research activity and treatment provision for children, adolescents, and elderly populations. From the 1950s, there was an observed preponderance of Bethlem patients in their 20s and over 60. Evidence suggested that, whilst new specialisms (psychotherapy, addictions, geriatrics) were implicated in the trends observed, social forces were likewise instrumental in identifying and responding to these forms of mental disorder; a possible manifestation of what David Armstrong characterised as the extended 'deployment of the medical gaze'.[151].

A study of successive editions of a D.M. Dunlop's *Textbook of Medical Treatment* enabled further insight into the education physicians were receiving on mental illness. The first edition, published in 1939, featured no discrete chapter on mental disorders; elsewhere, even when the very naming of a disorder implied recognition of its mental origin - for example 'anorexia *nervosa'* or the 'cardiac *neuroses*' - it was still classified on the basis of its superficial signs, painting what would now be considered as a misleading picture of causality and cure.[152] Two key revisions occurring by the 1950 (5th) edition, were additional material on mental changes in old people, and the expansion of 'psychotherapy in general practice' to include treatment of alcoholism and drug addiction.[153] Increased attention to the problems faced by an ageing population, combined with the development of the psychogeriatric specialism may have provided the impetus for the upsurge in elderly psychiatric referrals at this juncture. However, neither the tone of the descriptions herein, nor gender differentials of longevity, satisfactorily account for the scale of female predominance amongst these patients. In relation to issues of alcoholism and drug (morphine or

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[151] Armstrong, *Political Anatomy of the Body*, pp.22-23.
[152] D.M. Dunlop et al., eds., *Textbook of Medical Treatment*
[153] D.M. Dunlop, L.S.P. Davidson, and J.W. McNee, eds., *Textbook of Medical Treatment*, 5th ed. (Edinburgh: E. & S. Livingstone Ltd., 1950), pp.311-312, 916-918.

cocaine) addiction, emphasis was placed upon the physical effects, and cases viewed mainly from a social and moral standpoint.[154]

Published in 1964, the 9th edition of Dunlop's training manual distinguished clearly between the physical and psychological processes of addiction. It further stressed the importance of the doctor-patient relationship,[155] a timely concern, given that the expected remit of the general practitioner now encompassed treatment of mild depressions, patients with slight mental defect, psychoneuroses and childhood disorders. However, the aforementioned omissions and misclassifications remained, and tentative moves towards a more holistic remit, were offset by wider remonstration from GPs against being 'burdened with confidences and intimacies which often seem irrelevant to [their] task and which [they] would gladly see patients take elsewhere'.[156] In a contemporaneous *Lancet* article, R.F. Tredgold reiterated the scale of mental illness treated in general practice, and proposed that 30-90% of 'organic' complaints dealt with by GPs had a psychiatric component.[157]

These findings underscore the fluidity of concepts and definitions of 'mental disorder'; the diversification of professional and personal attitudes shaping/appropriating the diagnostic process, and the over-representation of certain populations within (especially new) psychiatric categories.

A mid twentieth-century psychiatric text presented a contrasting perspective to that of Dunlop et al. Whilst acknowledging the social implications of alcoholism, Mayer-Gross, Slater and Roth conceptualised it as a clinical syndrome, and stressed the importance of prophylaxis as a main plank of treatment.[158] Armstrong believed that the infiltration of psychiatry into everyday life was both reflected in, and reinforced by, literature and

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[154] For further context of twentieth-century recreational drug use, see: Virginia Berridge, *Demons: Our Changing Attitudes to Alcohol, Tobacco, and Drugs* (Oxford: Oxford University Press, 2013).
[155] Sir Derrick Dunlop, Sir Stanley Davidson, and Stanley Alstead, eds., *Textbook of Medical Treatment*, 9th ed. (Edinburgh: E. & S. Livingstone, 1964), pp.806-807, 814.
[156] Ibid., pp.822-827, 806.
[157] R. F. Tredgold, "The Integration of Psychiatric Teaching into the Curriculum," *Lancet* 279, no. 7243 (1962): p.1345.
[158] W. Mayer-Gross, Eliot Slater, and Martin Roth, *Clinical Psychiatry* (London: Cassell, 1954), pp.21-22, 343-344.

legislation.[159] Citing the example of D.K. Henderson and R.D. Gillespie's *A Text-Book of Psychiatry for Students and Practitioners*, he described how the 1927 edition[160] featured a brief historical review, culminating in 'Hospital Period'; but, by 1944,[161] an additional section on the 'Social or Community Period' recommended the extension of psychiatry into a range of community settings and industries.

Gender

The current findings resurrect debates over the gendered roles occupied by psychiatric patients. After 1930, there was an augmentation of the female predominance in admissions to Bethlem, and mental illness was still commonly defined by deviations from gendered social roles. However, allied changes in the backgrounds and knowledge/expectations of (especially) voluntary patients were to foster the growth of psychotherapeutic approaches; a finding which lends support to Thomson's suggestion of mounting public enthusiasm for psychological cultures and self-improvement.[162] Although correspondence files alluded to the emergence of greater reciprocity between patients and hospital authorities, evidence highlighted ongoing economic and gender biases in the former's ability to negotiate decisions, and their inpatient experiences. Before 1948, there had been an excess of women in their 20s and 30s admitted to Bethlem. Although the size of this population was accentuated by the wartime drop in male inpatients, evidence suggests that being a female of childbearing age enhanced one's perceived vulnerability to madness and propensity to (especially psychoneurotic) diagnoses.

The aforementioned investigation of medical educational materials also provided important insights into the inculcation and dissemination of theories of mental illness amongst professionals, and the potential bearing of such messages on the age and gender profile of psychiatric admissions. Chelsler's notion of clinicians propagating stereotyped ideas is partly supported by the discovery of postwar stagnation in case

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[159] Armstrong, *Political Anatomy of the Body*, p.69.

[160] D.K. Henderson and R.D. Gillespie, *A Text-Book of Psychiatry for Students and Practitioners* 1st ed. (London: Oxford University Press, 1927).

[161] D.K. Henderson and R.D. Gillespie, *A Text-Book of Psychiatry for Students and Practitioners*, 6th ed. (London: H. Milford, Oxford University Press, 1944).

[162] Thomson, *Psychological Subjects*, p.8.

study representations within psychiatric texts, and misleading classification of disorders within physician training manuals. In the present research, two key trends to emerge from scrutiny of these materials were an inter-professional variation in teaching on alcoholism, and the inculcation of GPs with stereotyped beliefs regarding female mental distress; perspectives which, necessarily, guided diagnosis and treatment practices. Thus, although these sources might not have deliberately perpetuated (gender) stereotypes, their failure to keep pace with the taxonomic and social changes affecting mental health care, rendered them flawed and potentially harmful tools, totemic of an entrenched and enduring patriarchy within psychiatry.

Having mapped the social profile of Bethlem inpatients during the twentieth century, the following chapter will now address their clinical backgrounds, and situate this narrative within the wider context of contemporaneous psychiatric admission patterns.

Chapter 5: The Diagnostic and Clinical Profiles of Bethlem Inpatients

Previous study of the relationship between class, gender, age, and diagnosis has generated a number of key debates, as outlined in the literature review. The asylum system itself, has been viewed as a tool of patriarchal oppression, and implicated in raising the visibility of women, certain age groups, or social backgrounds. Other commentators have suggested that 'new' mental disorders variously represented the fruits of drug company marketing, revised classifications, or legislative change, which, again, necessarily predisposed particular social groups to receiving a psychiatric diagnosis. Moreover, a postwar transition towards community treatment of less serious mental disorders, has, according to Joan Busfield, made women 'the prime objects of psychiatric intervention'.[1]

Continued investigation of Bethlem admissions can now further illuminate how the character of the hospital and its patients evolved during the twentieth century, contextualised by wider trends within psychiatric epidemiology. The present chapter seeks to address the construction and implementation of new diagnoses; the identification and attribution of causal factors; and factors determining length of hospital stay. A particular focus will be on the gradual transition from aetiological, to diagnostic, frameworks of mental illness, and the implications of this for psychiatric populations, services and theory. The following discussion will chart and describe the evolving clinical profiles of Bethlem inpatients, circa 1930-1983, including, where available, their forms and supposed causes of mental disorder, duration of admissions, and prognoses. Results will be structured around these areas, and, once more, contextualised by relevant archival sources, medical literature and wider institutional historiography. First, there will be consideration of processes and patterns of psychiatric diagnosis in twentieth-century Britain. The Bethlem data represent a prism through which to investigate both the trajectory of psychiatric opinion, and patients' subjective experiences.

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[1] Busfield, "Mental Illness as Social Product or Social Construct," p.537.

Classification and Diagnostic Trends

The current section will describe and explore the application of psychiatric diagnoses at Bethlem during the twentieth century, and situate these results within national trends. This will be followed by closer examination of some of the most commonly-used labels, providing insights into patient backgrounds, symptomatology, prevailing theory and attitudes. For the purpose of exploring diagnostic trends, fundamentally different approaches to record-keeping before and after the merger in 1947 initially made it necessary to consider the two periods separately. These issues are discussed in more detail in the methodology chapter. No 'incurable' patients were admitted to Bethlem after 1918, yet the Governors continued to feel a duty of care towards the small number remaining.[2] Contrary to official policy, statistical summaries showed the continued presence of cases of General Paralysis of the Insane (GPI) - a degenerative and often terminal consequence of syphilis - with 13 patients (10 male, 3 female) still being treated for this by the time of the merger.[3] Advancing years and fluctuating priorities also saw a reversal in the previous exclusion of epileptics; this condition becoming a focus of neurophysiological work from 1948.[4] Neuroses accounted for the largest proportion of total hospital patients from 1940 to 1957, averaging 43% of all diagnoses, although the figures were highest amongst females. For the same period, psychoses were the most common inpatient diagnosis.[5] The clinical picture changed somewhat over the following decade, and a variety of possible causes were invoked. As such, a reduction in cases of schizophrenia and manic depression was thought to be due to the district commitment, but parallel decreases in anxiety and hysteria cases a likely result of changing diagnostic habits. Finally, the mounting incidence of alcoholism and drug dependency was believed to reflect new specialist interests at the Joint Hospital.[6]

Within table 8, cases are expressed in terms of their overall prevalence amongst sampled inpatients for the selected years. With only one exception, melancholia was the most common diagnosis for both male and female patients, with rates of primary

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[2] Jonathan Andrews et al., *The History of Bethlem* (London: Routledge, 1997), p.650.
[3] BRHAM, "Triennial Statistical Report, Years 1949-1951," p.42.
[4] BRHAM, "Triennial Statistical Report, Years 1955-1957," pp.78-80.
[5] Ibid.
[6] BRHAM, "Triennial Statistical Report, Years 1967-1969," p.2.

dementia also consistently high for both sexes. Gendered diagnostic patterns were notable for 'psychoneurosis'. Added to the Lunacy Commissioners' recognised 'Forms of Insanity' in 1931, this category catered for the otherwise indefinable symptoms of a new generation of voluntary patients. It now included established conditions such as hysteria, hypochondria and obsessional neurosis, and was first applied to female patients in 1936, but not used for males until 1941.

	1931		1934		1936		1938		1941		1944		1946	
	M (n=100)	F (n=141)	M (n=45)	F (n=55)	M (n=34)	F (n=66)	M (n=36)	F (n=64)	M (n=33)	F (n=67)	M (n=25)	F (n=75)	M (n=33)	F (n=67)
Melancholia	40.00	38.30	40.00	50.91	44.12	33.33	30.56	42.19	42.42	38.81	36.00	40.00	33.33	38.81
Primary Dementia	32.00	43.26	35.56	30.91	17.65	12.12	33.33	21.88	27.27	11.94	32.00	17.33	27.27	25.37
Psychoneurosis	0.00	0.00	0.00	0.00	0.00	18.18	0.00	15.63	9.09	26.87	4.00	25.33	9.09	11.94
Mania	8.00	11.35	8.89	5.45	8.82	4.55	8.33	4.69	3.03	10.45	8.00	5.33	6.06	4.48
Confusional Insanity	1.00	2.13	2.22	9.09	5.88	16.67	8.33	12.50	3.03	7.46	16.00	4.00	3.03	5.97
All Other Diagnoses*	19.00	4.96	13.33	3.64	25.53	15.15	19.44	3.13	15.15	4.48	4.00	8.00	21.21	13.43
TOTAL:	100	100	100	100	100	100	100	100	100	100	100	100	100	100

*Includes minor male excess in GPI, alternating, delusional, and moral insanity.

Table 8: Major Diagnostic Categories, % of Sampled Inpatients, By Gender, Selected Years, 1931-1946. Source: Admissions Database.

The Lunacy Commissioners' framework remained in use until 1947, when the new 'Joint Hospital' gradually transferred to the International Classification of Diseases (ICD). However, as shown in table 9, by the period 1976-1983, anxiety and neuroses (arguably the successors of psychoneurosis) accounted for a larger proportion of male than female admissions (male = 16.74%, female = 9.89%). This represents a reversal of both previous trends and national stereotypes.

	1952-1958		1964-1970		1976-1983	
	M (n=117)	F (n=148)	M (n=71)	F (n=105)	M (n=230)	F (n=316)
Depression	40.20	40.07	25.41	33.82	10.28	12.25
Anxiety and Neuroses	16.76	17.98	9.28	12.55	16.74	9.89
Personality Disorder	3.10	3.07	10.47	8.64	9.00	13.99
Schizophrenia	9.53	12.38	11.25	16.09	17.56	13.70
Affective Psychosis	6.96	6.83	11.12	16.73	18.01	25.94

Table 9: *Changing Patterns of Key Diagnoses, Mean % of Sampled Bethlem Inpatients, Selected Years, 1952-1983.* Source: Admissions Database.

From the 1950s, knowledge of a patient's destination ward allowed for approximation of diagnosis, whilst patient reference numbers meant that cases could be investigated in more detail within the archive. As described in the methods chapter, examination of diagnostic trends between 1952 and 1983 necessitated the construction of a 17-item coding system, based on successive versions of the ICD. The use of retrospective classifications is a matter of historical controversy, and one cannot readily assume contemporary diagnostic equivalents for previous categories or their subtypes. In his discussion of the "disappearance" of hysteria, Mark Micale stressed that psychiatric labelling reflected 'the diagnostic behaviour of physicians at a particular historical moment', and that the proliferation of replacement modern diagnoses drew on a much wider array of theoretical approaches and vocabularies.[7] However, such concerns were offset by researchers' requirement for continuous categories in order to produce psychiatric morbidity trends; arguably an equally valid basis for the

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[7] Micale, "On the "Disappearance" of Hysteria: A Study in the Clinical Deconstruction of a Diagnosis," p.523.

selective and subjective use of diagnoses. It was in a similar vein, that Carstairs described the 'need to transpose archaic terminology into contemporary terms, if psychiatric populations were to be compared'.[8]

Although depression was more commonly diagnosed in females, incidences have decreased overall, from the late 1950s (for men) but figures for women showed a plateau until 1964, then declined. A longitudinal survey of diagnoses from 1931 to 1983 found that 'melancholia' was more frequently diagnosed pre-1947, than its (commonly-assumed) latter-day equivalent, 'depression'. However, this may be attributable to the subsequent expansion and diversification of diagnostic labels, or the combined effects of drug treatments and community care in managing milder cases outside the institutional system. Also, as indicated in the preceding chapter, one would expect psychiatric education and the messages disseminated by contemporary textbooks to have played a key role in shaping practitioners' awareness of, and attitudes towards, mental disorder. This was particularly relevant to the training of GPs and psychiatrists, given their increasing role as 'gatekeepers' to hospital admission and treatment allocation. Moreover, nursing manuals, together with the oral testimony of their readers, evoked crucial reflections on the ward-level implementation of care regimes.

Diagnostic Category	Regional Admissions, 1951 (%)		Bethlem Inpatients, 1955-57 (%)	
	M	F	M	F
Psychoses	65	73	48.6	52.1
Psychoneuroses	16	16	29.1	31.5
Character, Behaviour, and Intellect Disorders	8	3	11.9	5.9
Miscellaneous	11	8	10.4	10.5
TOTAL:	*100*	*100*	*100*	*100*

Table 10: *Percentage Distribution of Total Admissions by Diagnostic Groups*. Sources: W.P.D. Logan, "Patients in Mental Hospitals", *Proceedings of the Royal* Society *of Medicine*, 49 (1956), pp. 496-497; BRHAM, Triennial Statistical Report, 1955-1957.

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[8] Carstairs et al., "Changing Population of Mental Hospitals," p.190.

To help assess the representativeness of the Bethlem data, these figures will now be considered in the national context. Epidemiological surveys emerging in the 1950s calculated the average rates of key mental disorders across eleven selected Regional Hospital Board areas. Comparison of these nationwide data with Bethlem figures for a similar period (table 10) suggests that, although the gender distribution of the diagnoses was broadly parallel between the two studies, Bethlem recorded higher overall rates of psychoneurosis, and fewer cases of psychosis; arguably, due to peculiarities of its location and clientele. As outlined in chapter 4, the hospital attracted a preponderance of middle-class patients, and was a pioneer in voluntary admissions; trends which were arguably accentuated by the recommendations of the 1930 Mental Treatment Act, and the institution's relocation of the same year. The hospital also had an above average amount of patients with character, behaviour, or intellect disorders, when viewed in the national context. In discussing the findings, Logan posited that an observed excess of females with psychosis was due to their higher rates of manic depression. Moreover, the outwardly similar frequencies of psychoneurosis in men and women, though reflecting equal admission rates for anxiety for the two sexes, concealed a female predominance for all other psychoneuroses. Males, however, recorded higher admission rates for 'pathologic personality, behaviour disorders, consequences of syphilis, and epilepsy'.[9]

Novel psychiatric labels were applied to a large proportion of Bethlem admissions from the 1950s to 1980s, with a pronounced upsurge in personality disorder and affective psychosis diagnoses (table 9). The latter category comprised the various forms of manic depression and involutional melancholia, and, from 1970 onwards, grew more prevalent amongst females than depression, accounting for 32% of such admissions by 1983. The overall gender differential for affective psychosis in the period 1952-83 was males 14%, females 22%. Frequency of schizophrenia and anxiety or neurosis cases was more consistent, though, crucially, this was the leading cause of admission for 21-29 year-olds (the modal age group) from 1952-83. Schizophrenia rates were also similar between males and females, this narrowing of the gender divide endorsing Elaine Showalter's idea that its feminine connotation is cultural construction, and that

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[9] Logan, "Patients in Mental Hospitals," pp.496-497.

incidences of the condition are consistently 'about equal' in men and women.[10] Likewise, in reporting direct hospital admissions in 1951 by diagnosis, W.P.D. Logan stated that schizophrenia rates per million population were 271 for males, and 254 for females.[11] Moreover, in 1954, Carstairs et al. charted the age distribution of long-stay schizophrenic patients, and found that although men outnumbered women within younger age groups, there was a convergence point in the 45-54 years bracket; thereafter, female patients predominated.[12] Chesler further suggested that a propensity for male 'schizophrenic' behaviour to be regarded as criminal or sociopathic rendered such patients liable to imprisonment rather than hospital admission, and implicitly accentuated the visibility of females within inpatient populations.[13] The following sections will explore various labels in more depth, starting with primary dementia.

Primary Dementia

There were vague attributions as to the cause of primary dementia ('dementia praecox') despite the prevailing theory of Emil Kraepelin that it had hereditary/congenital roots.[14] From as early as 1931, related Bethlem records featured a variety of apparently interchangeable nomenclature, including 'schizophrenia' (with or without subtypes), 'schizoid', or reference to 'fits' or 'attacks' without further mention of the original diagnosis after the initial admission register entry. Primary dementia patients commonly had a previous psychiatric history, but not necessarily signs of inherited mental illness. Amongst the more common casenote manifestations of primary dementia, were psychoses, loss of touch with reality, and (often religious) hallucinations or delusions. Records for these patients also featured a prevalence of obsessive or paranoid belief systems and behaviours, chiefly concerning fears surrounding poisoning. This could often lead to the refusal of food and drink, but could extend into other areas of life. Thus, for patient MB, 'Nervous ideas – particularly one of contamination – preyed on her mind, and she got so afraid of hurting other people

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[10] Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (London: Virago, 1987), p.204.

[11] Logan, "Patients in Mental Hospitals," p.497.

[12] Carstairs et al., "Changing Population of Mental Hospitals," p.188.

[13] Phyllis Chesler, *Women and Madness* (London: Allen Lane, 1974), pp.54-55.

[14] Ion and Beer, "The British Reaction to Dementia Praecox 1893-1913. Part 1," pp. 290, 301.

by germs.[15] In a further case, patient MR 'imagined everything was dirty, and was always washing her hands, and still does so. She also had religious obsessions and a great aversion to dogs and cats'.[16]

Throughout the 1930s, treatment, where recorded, was by insulin coma, with a few instances of Triazol fits before the more general introduction of ECT in the 1940s. However, diagnosis and subsequent treatment of primary dementia could be impeded by patients' varied attempts at self-medication – for example, by chloral, opium, or alcohol – before admission. Thus, patient HY was a 35 year-old doctor, admitted voluntarily for 6 months in 1931. Diagnosed with schizophrenia, his notes also reported '7 years drug habit' and 'much alcohol when a student – but only when someone to drink with (one sea voyage bottle of whisky a day) and none since marriage'. In 1918, whilst serving as a House Surgeon, he had a nervous breakdown, attributed to a failed love affair. He met his wife two years later, but his parents were opposed to the marriage. In a subsequent dream, he imagined his wife was pulling at one arm, and his mother at the other. A psychologist diagnosed conflict, and HY continued to take chloral until his mother's death. In 1925 he took a chloral overdose, resulting in 18 hours of delirium and unconsciousness:

> The shadows in his bedroom took fantastic forms; he was climbing in and out of
> bed, and imagined there was an armed rabble in the street. This followed 2
> days after the stoppage of the Chloral in the Birkenhead Infirmary...later began
> to take opium to calm himself, and gradually got into the habit of taking it with
> Medinal and increased each month until September 1929....on medical advice
> he started to cut down the opium and Medinal, and after 3 weeks, he had cut
> them right out. Then insomnia became very bad, he worried about his [surgical]
> practice, felt he could not face anything in life, and had several attacks of a
> "sickening abdominal sensation" – so he began to take Luminal and Bromide.
> As he tried to cut this out, the symptoms of Chloral delirium began to recur – as
> though someone were waving a gauze veil over his field of vision and he was

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[15] BRHAM, "Cwc: Departures and Deaths Patient Casebooks, 1923 -1953," ref. no. 133 (discharged 1934).
[16] Ibid., ref. no. 283 (discharged 1932).

unable to find his way round in the dark. All the time, he has felt he was unable to bear the responsibility of practice, and the feeling had never left him.[17]

In the above example, the chance to chart, and contextualise, HY's case, suggests both a clinical attribution of diverse influences on primary dementia, and the incipient medicalisation of addiction through the conceptualisation of alcohol and drug use as habits or coping strategies,. Furthermore, it presents an additional perspective on the circumstances surrounding voluntary admissions, and, through allusion to the interpretation of dreams, indicates an acknowledgment of psychodynamic processes and approaches.

Affective Psychosis

The apparent upsurge uncovered in (especially female) rates of affective psychosis/manic depression from the late 1950s, prompted further investigation of some of these patients. Discharge summaries indicated the trajectory of psychiatric diagnosis at this juncture, with some such cases initially admitted with 'schizophrenic' symptoms;[18] others originally classed as reactive or agitated depression, but receiving the affective psychosis label after (typically) becoming 'more restless, incoherent, and difficult'.[19] Selected cases will now be explored.

Admitted in 1955, 30 year-old patient MT came from a 'united and happy' working-class family, but one with prevalent mental instability and 'low intelligence'. For this reason, her sisters were deemed 'very poor witnesses; their statements are incomplete and unreliable', leading to reliance on hospital notes for establishing her history. According to her notes, during previous episodes, MT had received insulin coma and ECT, and relapsed in a state of agitated depression one month ago, when 'incorrectly accused of stealing an umbrella and given notice....became agitated and restless, lacked concentration. Untidy in appearance and thought she smelled offensive to others and therefore could not travel on buses'. On examination, MT was

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[17] Ibid., ref. no. 137 (discharged 1931).
[18] BRHAM, "Bcs: Bethlem Case Summaries, 1952-1983," case no. B8610, discharged October 1955.
[19] Ibid., case no. K7036, discharged May 1958.

> Acutely disturbed, restless, untidy [with] constant stream of spontaneous talk, partly to herself and partly in response to surroundings. Amenable and elated. Speech contains rhymes, puns, rapid changes of topic. She is distractible and it is impossible to get any history from her. It is probable that she has auditory hallucinations. When questioned, she will admit to voices and is especially noisy and talkative when in her room alone at night. Insight – none.

She was treated with Largactil, and discharged on a lower maintenance dose of this drug. Although her symptomatology remained uniform, it was documented that MT later 'acquired greater insight into her condition'. However, there was lack of consensus on diagnosis: it was thought that the evidence favoured affective psychosis but - as in previous admissions - schizophrenia was still considered possible, if unproven. She was discharged home after three months, with the verdict the 'she may break down again but should do well in the interim'.[20]

In a second case, 66 year-old ES was transferred from neighbouring St Francis' Hospital following the sudden onset of depression and inability to continue with everyday life. She'd previously experienced a breakdown aged 34, following news of her mother's imminent death, and spent four years at Chartham Hospital, Kent, before being discharged to sister's care, with whom ES lived until her own marriage. She complained that her husband had changed since an operation one year ago and recently told her sister that she 'felt so funny she could not go out'. She later collapsed, would not move, and was admitted to St Francis. As her condition deteriorated, she was moved to Bethlem, where she was

> ...restless, uncooperative, inaccessible, untidy, refusing food, only taking fluids if forced...Continually picking at clothes, gesturing, mumbling to herself or laughing. Speech – "take this away I shan't need it any more" (pointing to wedding ring). "I am doomed to die, in the name of Jesus Christ". (Tapping wall) "I am sending cables and telegrams". Disorientated, hallucinated (visual and auditory) temporarily sustained.

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[20] Ibid., case no. B8610, discharged October 1955.

ECT was administered seven times, after which her 'mania subsided' and she 'returned to previous personality'. Discharged home, with outpatient follow-up, it was concluded that ES 'should remain well, but as there is a history of a previous manic attack in 1926, it is possible that further attacks may occur in the future'.[21]

The previous two vignettes point to Bethlem's position in the emerging hospital marketplace, and suggest that, in addition to being the favoured option for some patients, professionals regarded it as an appropriate destination for challenging or atypical cases.

A terminological flux remained apparent, despite the ongoing efforts at standardisation of mental disorders embodied in the ICD system. Thus, patients ostensibly allocated the same diagnostic code could actually still receive varying labels, including 'manic depressive psychosis' (itself with an array of 'circular', 'circular but manic', 'depressed' subtypes) 'depression with confusional state', 'mania and depression', or 'affective disorder'. Furthermore, this era saw an increase in the number of patients with dual, or multiple, diagnoses, and affective psychosis could also occur in the context of a personality disorder.

The notes of patients treated in the 1950s – or having had previous admissions - often referenced insulin, sometimes in combination with ECT, together with early mentions of 'supportive psychotherapy'.[22] By the 1970s, drugs such as Largactil, Lithium, and Haloperidol featured prominently in treatment regimes, whilst the arrival of depot medication arguably facilitated reductions observed in the length of inpatient admissions. Yet, despite these measures, and expansions in the breadth and availability of aftercare offered, the prognosis for affective psychosis cases was often guarded.

Personality Disorders

Personality disorders represented another major, but contentious, area of expansion within postwar psychiatry; a trend which was clearly evidenced from Bethlem records.

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[21] Ibid., case no. K7036, discharged May 1958.
[22] Ibid., Case no. D664, discharged June 1952.

The ICD-8, published in 1967, listed more than twenty possible variants of personality disorder, including two 'unspecified' kinds.[23] By the publication of ICD-9 in 1977, this had soared to forty-five possible subtypes.[24] Moreover, in its absorption of 'asocial' and 'amoral' typologies, the system was indeed reminiscent of the subjectivity that so characterised an earlier generation of asylum records. Much debate surrounded the introduction of the personality disorder concept, the clinical definition of which involved the attribution of constant states rather than transient, and, implicitly, treatable, disorders. Amongst key criticisms voiced, was that personality disorder represented a vague, unreliable diagnosis, which showed low levels of agreement in paired-opinion psychiatric interviews.[25] It was also founded on the increasingly outdated concept of a static personality, and recent years have witnessed consideration of the practical ramifications of such labelling, in terms of psychiatrists' attitudes and access to (inpatient) treatment. Joint Hospital clinicians, Glyn Lewis and Louis Appleby depicted personality disorder as psychiatrists' bête noire, after their research indicated such patients were more likely to be considered manipulative, unmanageable and undeserving of NHS resources. They concluded that 'scientific classification loses credibility if it contains value judgements or moral statements. A classification based on symptoms should be more reliable, and encourage a sympathetic approach to treatment'.[26] Latterly, attention has centred more on the medicolegal implications of the disorder, with the difference becoming enshrined in psychiatric nosology. The ICD-9 described personality disorder as:

> Deeply ingrained maladaptive patterns of behaviour generally recognizable by the time of adolescence or earlier and continuing throughout most of adult life, although becoming less obvious in middle or old age. The personality is abnormal either in the balance of its components, their quality and expression or in its total aspect. Because of this deviation or psychopathy the patient

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[23] World Health Organization, "Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death Based on the Recommendations of the Eighth Revision Conference, 1965, and Adopted by the Nineteenth World Health Assembly," (Geneva: 1967), pp.147-148.

[24] World Health Organization, "Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death Based on the Recommendations of the Ninth Revision Conference, 1975, and Adopted by the Twenty-Ninth World Health Assembly," (Geneva: 1977), pp. 194-196.

[25] N. Kreitman et al., "The Reliability of Psychiatric Assessment: An Analysis," *British Journal of Psychiatry* 107, no. 450 (1961): p.890.

[26] G. Lewis and L. Appleby, "Personality Disorder: The Patients Psychiatrists Dislike," *British Journal of Psychiatry* 153, no. 1 (1988): pp.47-49.

suffers or others have to suffer and there is an adverse effect upon the individual or on society.[27]

Psychotherapeutic approaches are the focus of chapter 7, but assessment files can, at this stage, illustrate ways in which personality disorders were viewed and managed at Bethlem. Firstly, a (1983) assessment of 34 year-old SC recounted his efforts at self-medication, but – contrary to aforementioned accounts - seemingly implied that the drug abuse, rather than his underlying diagnosis, was the obstacle to psychotherapy:

> ...presents the history of a personality disorder and a 15 year-long dependence on valium. He has a tendency to get easily angry or superior and an extreme vulnerability to stress; he will include among stressful events ordinary every-day relationships with people and demands from his job. Any of these forces him to take extra tablets of valium. He is also curious, somewhat intrusive, demanding or challenging. He has tried many treatments to control his pervasive anxiety, - meditation, relaxation, behavioural exercises, each of them for a short while, and was finally referred to us by his G.P. for an assessment for psychotherapy....He has a low tolerance to frustration and gets angry and contemptuous with great ease....He is intelligent, but I have not found him particularly insightful....The most obvious problem is his abuse of valium...He says that any stress decompensates him and forces him to use more tablets, and it is clear that any psychotherapy session would sooner or later upset his balance.[28]

In a second case, problems presented by 43 year-old VH in the late 1970s were seen to stem from the pathological influence of her personality-disordered mother:

> With a 'facies dolorosa', a politely controlled 'undertaker's voice' and skilful language she gave us a one hour non-stop report about a family and personal history which contained half of the pathological constellations and symptoms

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[27] World Health Organization, "Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death Based on the Recommendations of the Ninth Revision Conference, 1975, and Adopted by the Twenty-Ninth World Health Assembly," p.194.
[28] BRHAM, "Pct-09: Psychotherapy Assessment Reports, June 1982 – December 1983," case no. 670389.

of a textbook on neurosis and family dynamics. The corresponding spaces in her questionnaire are empty and probably she had the same difficulties in summing up which I have....Her mother appears to have been a very controlling, paranoiac, personality disordered woman who implanted the whole set of 'men are bad – sex is bad – stay with mum' belief system...now [VH] suffers from a whole stack of anxiety-conversion symptoms with phobic elements of avoiding leaving the house, entering shops and public places, etc...the patient's restrained aggression, the extensive influence of early pathology and the oedipal drama...appeared to be so massive and so integrated into her life that 'working through' in an analytical sense would be a mammoth task and most likely doomed to failure.[29]

Personality disorders came to account for a large proportion of post-war Joint Hospital admissions, and were particularly prevalent amongst those individuals staying longest or receiving dual diagnoses. From a baseline of zero (F) and 9.3% (M) in 1952, personality disorder diagnoses rose to 20% of annual female admissions by 1976, and, for men, peaked at 13.8% of admissions in 1970. The extensive and somewhat bewildering variety of subtypes recorded during this period included 'inadequate', 'hysterical', 'asthenic' and 'immature' personalities. Casenotes showed that patient RH was admitted to Bethlem in 1976 from the Emergency Clinic. She had a dual diagnosis of manic depressive psychosis, and aggressive personality disorder, with the present episode attributed to parental stresses. On examination, she was

Disinhibited, many obscenities. Mood labile...mainly cheerful but easily roused to anger and violence. Preoccupied with thoughts over family members. Maintains she does not need to be in hospital...extremely disturbed...talkative, particularly in ward group meetings. The slightest irritation would result in her destroying property on the ward in a violent outburst or attacking other patients. Behaviour was often made worse by communications from her mother, who has for many years been involved in litigation for the adoption of the patient's eldest daughter.

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[29] BRHAM, "Pct-05: Psychotherapy Assessment Files, June 1977 – Sept 1978," case no. 710564.

Over the two months, RH received beta blocker and antipsychotic medication, in addition to (the mood stabiliser) lithium, and had two successful periods of weekend leave. Despite varied support arrangements being made for her and her son, clinical prognosis was still 'guarded in view of stressful environmental factors and [the] patient's previous long history'.[30] Another patient, DS was a 32 year-old female, referred from Bethlem's outpatient department in 1983. Concerns were voiced that she had recently 'been behaving in a rather grandiose fashion', notably a failed emigration attempt to Italy, after which she stayed for a fortnight in a Mayfair hotel, spending all her savings, before returning home. Formally diagnosed with 'personality disorder with predominantly sociopathic or asocial manifestation', she had comorbid hypomania, and a history of postnatal depression and psychosis. DS had previously been off work pending complaints about her attitude, and, amongst other grievances, declared 'ferrets under her bed, which necessitate her urgent rehousing'. Admission reports quickly characterised her as a challenging addition to the ward:

> The consistent picture after several days' admission is of a remarkably unpleasant and manipulative person who seduces fellow patients into giving her their confidence with her nicely spoken entreaties, but who suddenly turns upon these same individuals with humiliating and unpleasant corruptions of their confidence in return. All who have met her have felt very strongly that she is fully aware of what she is doing and intent on upsetting as many people as possible.

This image is enhanced in subsequent entries, which suggested that DS 'unerringly upset everyone' in therapy groups, but that

> ...some strong limits were set upon her behaviour and she was started on a regular dose of depot phenothiazine. She agreed to attend the outpatient department and continue the limit setting approach and further management....Likely to be prone to relapse. [Prognosis] will depend on her cooperation with the treatment policy.[31]

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[30] BRHAM, "Bcs: Bethlem Case Summaries, 1952-1983."case no. 740699, discharged March 1976.
[31] Ibid.case no. 740747, discharged February 1983.

The above excerpts convey the complexity of psychiatric diagnostic systems in place by the late twentieth century, and the potentially negative connotations of a personality disorder label, in terms of (especially) inpatient care and outcomes. Features common to the selected cases included episodic social dysfunction, family stress and pharmaceutical treatment; a complex and challenging picture, perhaps compounded by (understandable) therapeutic pessimism towards the prospect of remediation.

A paper by Kendell et al. reported the ongoing clinical uncertainty surrounding personality disorder and the practical implications the diagnosis engendered for access to treatment. Given psychiatrists' apparent ambivalence towards treating personality disordered patients, one may speculate that this population's high level of comorbid diagnoses granted them an alternative and legitimate means of hospital admission. The article also proposed that the traditional theoretical basis for distinguishing personality disorder from mental illness faced challenges from emerging scientific evidence.[32] Consequently, it remains unclear whether this diagnosis represented belated acknowledgement of a hitherto concealed condition, or, rather, served as a salutary reminder of the limits of modern psychiatry and cause for renewed therapeutic pessimism. Personality disorder and other novel concepts were thus absorbed into standard diagnostic frameworks, but subsequently met with varying degrees of understanding and acceptance from the psychiatric community. Yet, as the following sections demonstrate, efforts to 'translate' older diagnoses into newer terminology also encountered practical and ideological challenges.

Diagnostic Continuities

This section will now consider the longer-run usage of common diagnoses, and their changing significance and application amidst classificatory expansion and diversification. Nosological shifts, arguably, resulted in finer-tuned distinctions between conditions formerly seen as related, whilst melancholia cases declined overall. Additionally, changing social mores, together with the availability of alternative

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[32] R. E. Kendell, "The Distinction between Personality Disorder and Mental Illness," *British Journal of Psychiatry* 180, no. 2 (2002): p.114.

care models, would necessarily have influenced the severity and chronicity of disorders receiving institutional treatment in the later twentieth century. One interviewee proposed that older people were amongst the beneficiaries of an expanded diagnostic range, itself facilitated by new investigative techniques and medication:

> There was all of this diagnostic refinement: the mentally ill old were no longer lumped together as just senile, there were distinct categories. And then, having got that sorted out, you could really see if they responded to the drugs as younger people would, and a lot of them did. If the brain was not dementing, if the brain cells were intact, there was room for a great deal of help for the elderly. But people at Bethlem may not have seen it, because a lot of this went on in the outpatient clinics.[33]

For men (figure 13) the current results suggested that the largest increase occurred in rates of (psycho)neurotic and anxiety disorders; for women (figure 14) incidences of affective psychosis (namely, the various forms of manic depression) were diagnosed with greater regularity. A (1959) review by Norris showed the female excess in manic depressive psychosis to be consistent on an international scale. Some studies, such as those conducted in the United States and Germany, revealed women to be at almost twice the risk of men for developing this disorder. Within London, expected diagnoses per 1,000 births were 8.0 (males) and 14.4 (females).[34] A comparable trend was evident in the GRO statistics presented by Logan, which showed that, in 1951, female admissions for manic-depressive reaction numbered 486 per million of the population, whereas for males, the equivalent figure was 258. [35]

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[33] Alwyn Lishman, Interview by Author, January 26th 2011.
[34] Norris, *Mental Illness in London*, p.138.
[35] Logan, "Patients in Mental Hospitals," p.497.
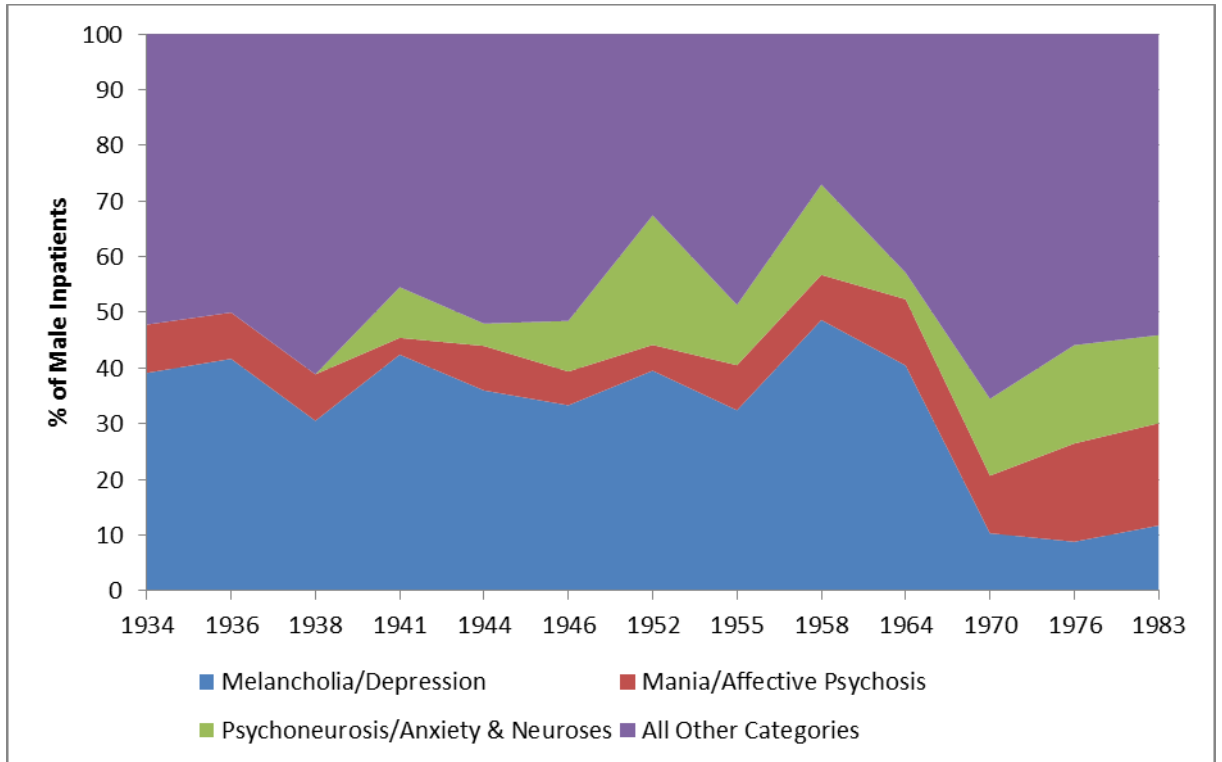
Figure 13: *Distribution of Major Diagnoses amongst Sampled Male Admissions to Bethlem, 1931-83*.
Source: BRHAM, Admission and Discharge Registers.
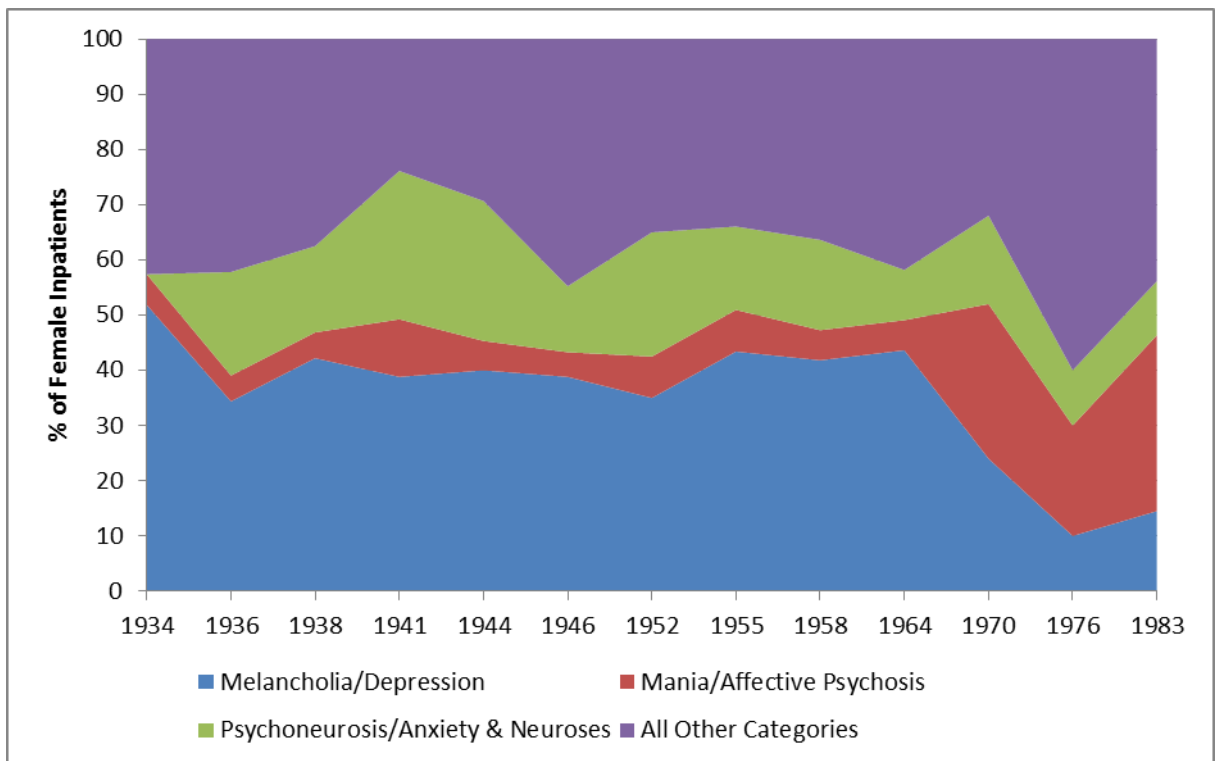
Figure 14: *Distribution of Major Diagnoses amongst Sampled Female Admissions to Bethlem, 1931-83*.
Source: Admissions Database.

The above graphs also suggest that, from the 1970s, taxonomical expansion contributed to a greater proportion of male and female inpatients being assigned 'other category' labels. This raises further questions about the fate of the 'disappearing diagnoses', and the inception of new terminology.

Diagnostic Flux

One finds a lack of consensus as to why certain conditions – formally or informally – fell from favour; the extent to which they paralleled modern conditions, and, relatedly, calls to reinstate some of these more traditional concepts. Such issues are prominent within recent discussions of hysteria[36] and melancholia. The latter condition was removed as a diagnosis with the publication of ICD-9 (1977) and, likewise, for DSM-III (1983). However, Max Fink countered that it was 'a distinctive clinical syndrome with a defined underlying biology that is distinguishable from other mood disorders' (i.e. depressions). He further suggested that contemporary scientific and theoretical developments, were, paradoxically, adding to the weight of evidence for melancholia as discrete disease, and promoting future investigation in this field.[37] Fink was recently amongst seventeen prominent authors to call for the reinstatement and positioning of melancholia as 'a distinct, identifiable and specifically treatable affective syndrome' within the forthcoming DSM-5.[38] 'Confusing' classifications of depression have also evoked longstanding criticism[39], with a recent article proposing that 'we still have little understanding of the precise aetiology of depression...our current nosologies remain as 'working hypotheses'...the 'true' classification of depression remains as elusive as it was 30 years ago'.[40] Writing in the *Lancet* in 1963, D.L. Crombie concluded that, having been devised partly by medical scientists, and partly by clinicians, the ICD was a

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[36] Micale, "On the "Disappearance" of Hysteria: A Study in the Clinical Deconstruction of a Diagnosis."
[37] M. Fink et al., "Melancholia: Restoration in Psychiatric Classification Recommended," *Acta Psychiatrica Scandinavica* 115, no. 2 (2007): pp.89-92.
[38] Gordon Parker et al., "Issues for Dsm-5: Whither Melancholia? The Case for Its Classification as a Distinct Mood Disorder," *Am J Psychiatry* 167, no. 7 (2010): pp.745-746.
[39] R.E. Kendell, "The Classification of Depressions: A Review of Contemporary Confusion," *British Journal of Psychiatry* 129, no. 1 (1976): pp.15-28.
[40] James Cole, Peter McGuffin, and Anne E. Farmer, "The Classification of Depression: Are We Still Confused?," *British Journal of Psychiatry* 192, no. 2 (2008): p.85.

'compromise' nomenclature, which failed to acknowledge the coexistence of organic and emotional aspects of mental illness.[41]

Perhaps reflecting similar antipathy, the present research indicated that by 1964, Bethlem registers remained riddled with anachronisms, notably the persistence of 'melancholia'. However, further investigation suggested that this was used for older patients with chronic mental health problems and previous admissions. Examples included 61 year-old AD, admitted in 1964 with 'agitated melancholia', and LK, aged 84, admitted in 1970 with physical complaints and 'involutional melancholia'. Both cases arguably reflected a reluctance to 'translate' former diagnoses into newer terminology, or to reassess (what were considered) familiar symptoms.[42] New codes were also often ignored or misused: of 100 patients randomly sampled in this year, 21 were assigned no diagnostic code; yet, a further 35 received multiple diagnoses, with one female attracting four separate labels (alcoholism, sexual deviation, immature and inadequate personalities). Moreover, the often brief descriptors such as 'depression' neglected finer subtype distinctions - e.g. 'endogenous' or 'reactive'- required by the ICD.[43]

Bethlem findings illustrated the variable interpretation and application of new diagnoses, compounded by a perseverance of older terminology. This reiterates both the absence of diagnostic certainty in psychiatry and the mediating role of patient characteristics – notably age and gender – in shaping such decisions. The following section explores causal frameworks for mental illness, and the shifting relationship between these attributions and novel diagnoses.

Causal Attributions

Throughout the first half of the twentieth century, aetiology (cause) was a separate consideration to 'form of disorder' (diagnosis). Moreover, whilst a primary cause – 'principal aetiology' – was based on medical opinion, one or more

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[41] D.L. Crombie, "The Procrustean Bed of Medical Nomenclature," *Lancet* June 1 (1963): p.1205.

[42] BRHAM, "Bcs: Bethlem Case Summaries, 1952-1983."Specific reference to case nos. G1196 (discharged February 1965) and 707055 (discharged June 1971).

[43] Ibid., case no. N5091 (discharged April 1966).

contributory/associated factors were often documented following discussion with a patient's family or friends. Although aetiology was not routinely recorded on admission after 1947, such information was often included in individual patients' files, either as a qualitative personal history, or, in the case of organic disorders, demonstrated through medical evidence.
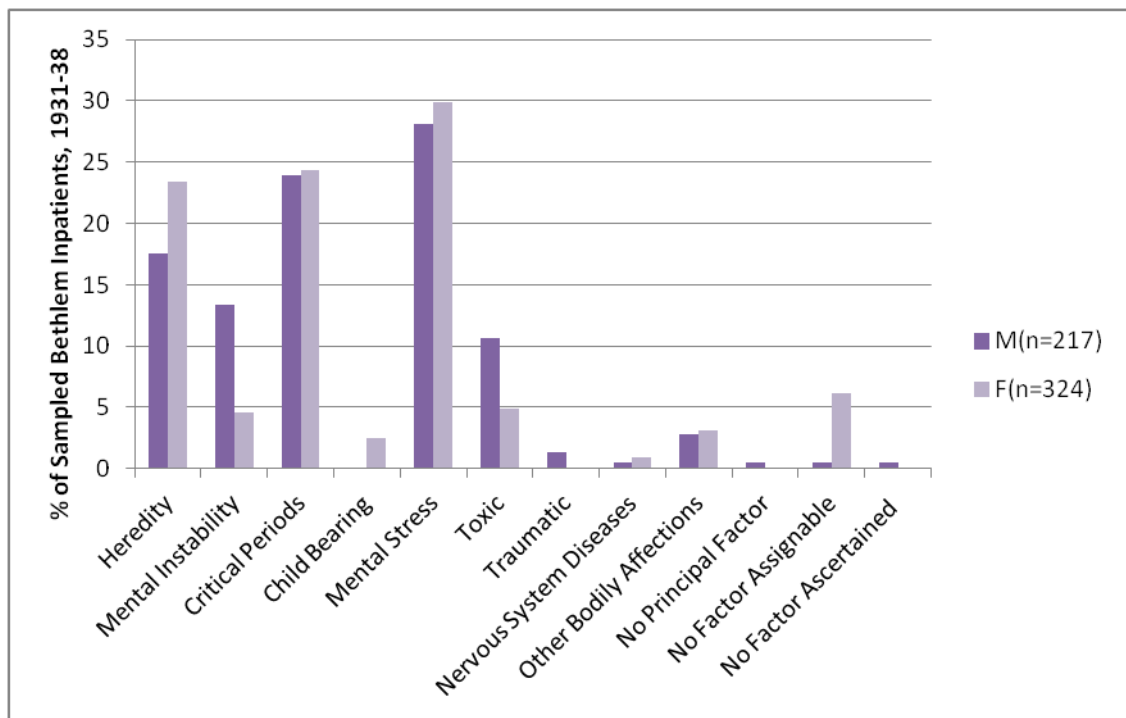
Figure 15: *Primary Aetiological Factors, Sampled Inpatient Admissions to Bethlem, 1931-38.*
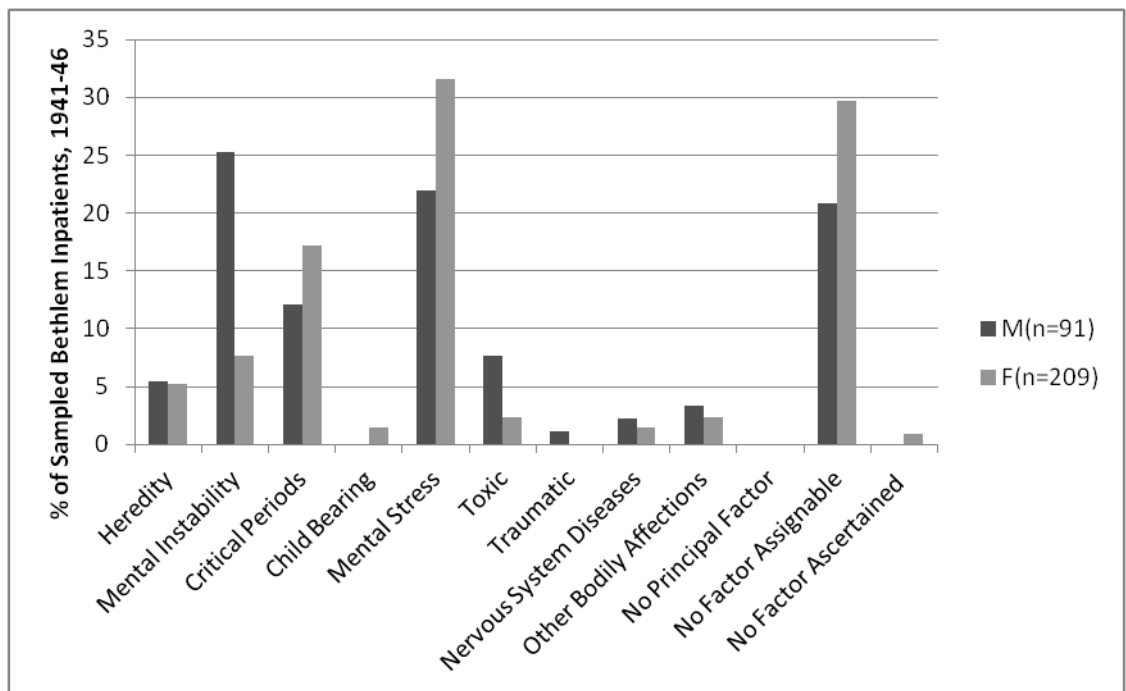
Figure 16: *Primary Aetiological Factors, Sampled Inpatient Admissions to Bethlem, 1941-46.*

The most popular aetiological factors assigned in this period (figures 15-16) were 'mental stress', 'critical periods' and 'heredity'. The 1940s also saw a large increase in the number of patients being admitted with 'no factor assignable'. This code was

applied when a patient's medical history was 'defective'; a situation possibly linked to new modes of referral and admission taking effect in this decade. Furthermore, the current analysis shows that a striking number of these patients were female, and had long hospital stays. Although this could be interpreted as evidence that women were admitted on less serious grounds, it could equally reflect administrative norms. In the latter circumstance, analogy with, for instance, occupational histories, would suggest that the recording of male patient data was routinely prioritised in pre-NHS Bethlem. Yet, the wartime rise in attributions of 'mental instability' amongst male patients, accompanied by a decline in those of 'critical periods', also speaks to changing perceptions of masculinity. There now follows discussion of some leading aetiological factors.

Mental Stress

The category 'mental stress' was subdivided into 'sudden' and 'prolonged' types, and this distinction marked by separate codes on admission registers (F1 and F2 respectively).[44] For the period 1931 to 1947, of 841 patients sampled, 33 (15 male, 18 female) had suffered sudden mental stress, whilst a further 211 (66 male, 145 female) were assigned the aetiology of prolonged mental stress.[45] Further casenote research was undertaken into the circumstances in which these terms were used. Interpretations of 'sudden mental stress' emerged as somewhat ambiguous, often alluding to a recent deterioration of mood or behaviour, rather than identifying a pivotal cause or event preceding this change. This is illustrated by the case of a 52 year-old housewife, admitted in 1931, diagnosed with recent mania. Her records recounted a litany of losses, including a previous miscarriage, extended marital separation and mistrust of her husband.

> Devoted mother but lost considerable weight when her husband was away
> without leave for over 3 years...started to become morose, resented her
> husband when he went out and suspected him of having an affair. Lost more
> weight and was sent to a home, but was continually depressed and grew

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[44] Commissioners in Lunacy, "Schedule of Causes and Associated Factors of Insanity (Forms 1b. And 2.A. Of Rules of Commissioners in Lunacy)," (London: 1907).
[45] BRHAM, "Ara: General Admission and Discharge Registers, 1931-1983."

thinner and thinner. Feeling that she was too weak to be any good to anyone, she made an attempt on her life.[46]

Here, the assignation of 'sudden mental stress' seemed to be grounded in an horrific self-destructive act, thereby implicitly reframing this as a discrete cause, rather than the culmination of a much more extensive symptomatology. In a separate case, GD, a 40 year-old architect with chronic melancholia received the same aetiology, having been 'impulsive in his actions and admitted recently having made an attempt on his life'. Further casenote investigation nevertheless revealed a more sustained pattern of business concerns and self-perceived shortcomings.

> In 1930, business became bad, and he was blamed (wrongly) for a time because he was not getting contracts. This apparently made him depressed, and the death of a friend upset him even more. This year, it was evident from his letters that he was ill, and his brother went to arrange to get him home (from China)....During the voyage, he was restless and rueful, self-accusatory, isolating himself from the others and slept poorly....May 18th 1931 he was found with his arm bleeding, the result of a self-inflicted wound with a razor blade. Since return he has been depressed and isolated, furtive, suspicious and reticent. Several times he has tried to get away, he says, "to get away and cure himself".

On examination, GD was reportedly restless and spoke in a low hesitant voice, saying he was a failure and had made a mess of his life. He believed this to be public knowledge: "the news has spread".[47] His account appears to speak once more to the contravention of gendered social roles as an excitatory factor in mental illness, here manifesting through internalised ideals and personal shame at failure to conform to normative expectations.

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[46] BRHAM, "Cwc: Departures and Deaths Patient Casebooks, 1923 -1953," ref. no. 135 (discharged 1932).
[47] Ibid., ref. no. 184 (discharged 1932).

'Prolonged mental stress' was a much more widely-used term, and one which encompassed a diversity of factors. In an era which predated the codification of 'post traumatic stress', many of the male patients in this subgroup were mentally scarred from wartime service. One 34 year-old man:

> Saw fierce trench warfare in France, but did not feel his nerves had suffered…. Later began suffering from headaches and drinking whisky as coping mechanism for when symptoms at their worst. These included: headaches, pallor, sweating, anxiety, depression, indecisiveness and loss of concentration, and came on about 6 times yearly.[48]

For female patients, such long-term stress appeared to originate in varied domestic and economic pressures, which were often compounded by moral piety. This was typified by MS, who was a voluntary boarder, aged 31, diagnosed with primary dementia. The eldest of four siblings, she left school at 14, to care for her tuberculous mother, and lived at home until the age of 24, only leaving then because of financial hardship during industrial strikes. She undertook nurse training, but found the regime stressful, argued with Matron, and suffered her first hysterical attack after changing from night to day shifts.[49]

Within the casebooks, 'sudden mental stress' was typically found to denote domestic problems for female patients, or 'overwork' for males. However, the label could also be assigned despite documented signs of hereditary insanity or predisposition, when lifestyle factors were deemed the major influence on a patient's symptoms. One such example was JC, a 61 year-old French master. His depression and hypochondria were formally attributed to prolonged mental stress, yet his case history revealed familial mental illness additional to his workplace pressures:

> His present breakdown began at the end of term after a conference, when his opinion was overridden by the headmaster. The exams and reports were just finished. Besides this strain he says that he felt he was responsible for his

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[48] Ibid., ref. no. 98 (transferred 1931).
[49] Ibid., ref. no. 116 (discharged 1931).

family. There is a brother who has been a nervous wreck for 20 years; his mother has frequent breakdowns, and a sister also subject to breakdowns.[50]

In a second case, recent (wartime) stresses were the principal stated cause of patient MF's recurrent anxiety hysteria, but her casenotes reported that her mother had puerperal insanity and later died in a mental hospital. The issue was further complicated by the verdict that 'she is probably quite right in thinking that the menopause is an important causative factor'.[51] There were also incidences of mental stress resulting from, or aggravated by, physical illness, trauma, or accident. In the latter example, MM, a 20 year-old female had was recorded as having suffered two previous periods of apathy, hallucinations, and restlessness, but it was felt that

> This attack dates from the time patient fell from a tree, fracturing her pelvis...the bones have healed perfectly, but for the past few weeks she has seemed rather suspicious, smiling and laughing at inappropriate times. Lately, she has admitted aural hallucinosis, but has been remarkably apathetic.[52]

In the above examples, casenote investigation showed that use of the 'mental stress' aetiology could conceal an array of (gendered) life events, and didn't preclude the involvement of organic influences. Furthermore, a wartime ethos may have had an adverse effect on causal attributions and attitudes towards mental illness, whilst also accentuating the varied 'costs' of inpatient stays for men and women. Some male admissions expressed fear of being conscripted for military service. Thus, for EB, 'being called up for the Army frightens and alarms him and he regards himself as good for nothing. Occasionally he has thought that suicide would be the best way out but he says he lacks courage even to do this.[53] The potentially brusque nature of care at this time is epitomised in the case of KB, a 54 year old housekeeper, admitted voluntarily for two months in 1944. Recent air-raids had reportedly terrified her and triggered further attacks, but doctors believed she should 'pull herself together'. During her admission, she 'complains of sleeping badly and had much self pity while trying to

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[50] Ibid., ref. no. 1165 (discharged 1938).
[51] Ibid., ref. no. 2054 (discharged 1944).
[52] Ibid., ref. no. 265 (discharged 1932).
[53] Ibid., ref. no. 2065 (discharged 1944).

show she is brave and mustn't be a nuisance...She shows little intention of hurrying home although she knows what the expense means to her employer'.[54]

The aforementioned evidence appears to be the antithesis of the image promoted by Bethlem in the previous decade; an indicator, perhaps, that wartime pressures heralded a climate of less tolerant or flexible treatment. Whereas voluntary admissions were previously courted with subtle appeals to their intellect and status, and the promise of comfortable, personalised care, resources were now constrained, and patients themselves arguably disenfranchised and disinclined to seek support. However, these also events occurred against a backdrop of shifting attitudes to, and beliefs, about, mental stress.

In their study of admissions to Devon asylums between 1910 and 1965, Joseph Melling and Nicole Baur observed an early twentieth-century focus on hereditarian or 'life cycle' attributions for mental disorder. Stress subsequently gained particular prominence as a secondary cause of illness for both men and women, but was more commonly associated with domestic, rather than professional, circumstances. Thus,

> ...doctors and patients dealing with the broad mass of mental patients in the postwar period rarely attributed serious mental illness to occupations or working life and more rarely still were inclined to characterize strain or mental stress to the workplace.[55]

Furthermore, Mark Jackson argued that, rather than just reflecting mankind's limited capacity to cope with a 'growing sense of personal and social instability', stress was elsewhere welcomed as 'a testimony to the modern aptitude for working productively, and a barometer of technological and social progress'.[56] Without necessarily endorsing this optimistic reading of stress, the Bethlem data are suggestive of circumstances in which it appeared to be regarded as a luxury phenomenon, not to be indulged.

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[54] Ibid., ref. no. 2595 (discharged 1944).

[55] Joseph Melling, "Making Sense of Workplace Fear: The Role of Physicians, Psychiatrists, and Labor in Reframing Occupational Strain in Industrial Britain, Ca. 1850-1970," in *Stress, Shock, and Adaptation in the Twentieth Century*, ed. David Cantor and Edmund Ramsden (Rochester: University of Rochester Press, 2014), pp. 206-208. Project website: http://dcmh.exeter.ac.uk/

[56] Jackson, *The Age of Stress*, pp.266-267.

Heredity

By 1911, F.W. Mott, pathologist at Claybury Asylum and a prominent figure in the early Maudsley Hospital, concluded that 'hereditary predisposition is the most important factor in the production of insanity, imbecility, and epilepsy', and described such inherited tendencies as the 'neuropathic taint'. Moreover, certain types of insanity were more frequently transmitted; mothers were more likely to pass on such disorders than fathers, and daughters more likely than sons to bear this inheritance.[57] In discussing the relationship between causation and modern treatment, there was an early belief that 'wards and laboratory are inseparable'. Analysis of the current data showed that the hospital demonstrated continued faith in the importance of heredity through the exploration of biochemical agents, rigorous intelligence testing and body type measurement.[58]

The notion of hereditable insanity retained a definite foothold within psychiatric diagnosis, clearly reflected in the detailed recording of patients' family histories. As an aetiology, this category comprised five separate variants: A1 – 'Insane Heredity'; A2 – 'Epileptic Heredity'; A3 – 'Neurotic Heredity [including only Hysteria, Neurasthenia, Spasmodic (idiopathic) Asthma and Chorea]'; A4 – 'Eccentricity (in a marked degree); and, A5 – 'Alcoholism'. Interestingly, 'Alcohol' also featured simultaneously within the separate, 'Toxic' aetiological class. No cases of epileptic heredity were found in the admission data consulted, and only one instance each of types A4 and A5. However, 67 patients (21 male, 46 female) were assigned A1, insane heredity, whilst a further 61 (21 male, 40 female) were deemed victims of neurotic inheritance, code A3.

In 1931, a 34 year old male, was admitted with hysteria, caused by 'neurotic heredity'. This was his second attack, and one of his brothers had also been invalided out of the army with "neurasthenic" fears and obsessions. Thus, the hallmarks of a biologically-determined condition are clearly spelled out, yet, it was subsequently noted that the patient 'realises that his illness resulted from the strain of trying to please people and

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[57] F.W. Mott, "Heredity and Insanity," *Eugenics Review* January, no. 2(4) (1911): pp.279-280.
[58] BRHAM, "Report of the Physician Superintendent for the Year Ending 31st December 1939," pp.8-9, 15.

by misfortunes in business'.[59] This indicates a blurring of boundaries, between entrenched hereditarian views, and nascent acknowledgement of the significance of environment. A similar classificatory antagonism was highlighted by Aubrey Lewis, in a (1938) paper, which described the uncertainty of ascribing aetiology and the growing acceptance of the multiple causes of mental illness.[60]

Cases of 'insane heredity' usually featured some evidence of parental or family attacks of mental disorder. Yet, in the absence of such a history, mention of a patient's or relative's temperament or lifestyle (e.g. 'five extraverted brothers'[61] or 'one eccentric paternal aunt'[62]) appeared to serve as a proxy for hereditary affliction. This was entwined with gendered social norms of behaviour, for example, a male patient 'admits being paid inadequately for his age, but has no intention of trying to improve himself'.[63] By contrast, 62 year-old housewife, AT, 'had begun to neglect household duties...though her husband notices that sometimes she can perform duties which she says she cannot'.[64] This case also reflected a tendency for suicides within a patient's immediate family to be considered in isolation from mental illness.[65] Thus, AT's records declared her to have no relatives afflicted with insanity, but later ventured that two of her sisters had committed suicide. This was seemingly regarded as a discrete issue and neither elaborated upon, nor linked to AT's self-professed guilt and suicidal ideation; the narrative instead focusing on her domestic role. In a further example, HB, a 43 year-old brass finisher, was admitted in 1931 with nervous depression, poor concentration, and memory loss, following the death of his wife eight years previously. It was initially reported that his mother had died from childbirth, aged 38, but notes added in different hand instead proposed that she had 'committed suicide', thereby raising questions over the original omission or suppression of this fact, and its influence on how HB's case was viewed. He was assigned 'neurotic heredity' aetiology,

[59] BRHAM, "Cwc: Departures and Deaths Patient Casebooks, 1923 -1953," ref. no. 167 (discharged 1931).
[60] Aubrey Lewis, "States of Depression: Their Clinical and Aetiological Differentiation," *British Medical Journal* October 29 (1938): pp.875-878.
[61] BRHAM, "Cwc: Departures and Deaths Patient Casebooks, 1923 -1953," ref. no. 1541 (died 1938).
[62] Ibid., ref. no. 2669 (discharged 1945).
[63] Ibid., ref. no. 800 (discharged 1938).
[64] Ibid., ref. no. 1107 (discharged 1938).
[65] Ibid., further examples include: ref. no. 267 (discharged 1932) - father, sister; ref. no. 1800 (discharged 1938) - daughter; ref. no. 2065 (discharged 1944) - father.

but no further information was provided on his mother's circumstances, other than that HB 'worries about' her death.[66]

In some instances, such as that of 29 year-old secretary, DT, the strain of (sometimes sole) caring for a mentally ill relative was a precipitating factor to nervous breakdown. On admission, it was noted that 'the patient's mother is said to be unable to give a history of the patient, being 'worse' than the latter. As she lives a good distance from London, no attempt has been made to bring her up'. This suggests that a convergence of organic and environmental features could be contained within an attribution of (insane) hereditary mental disorder.[67]

During the 1940s, wartime stresses were felt to have reignited pre-existing problems for a number of patients, and necessarily focused attention on environmental triggers. However, one may also speculate that the marked decline in attributions of heredity insanity at this time reflected the gradual demise of eugenics, as the horrors of the Nazi programme became clearer, and 'Social Darwinism became more self-conscious, more anxious to disguise its roots, and more concerned with an appearance of sophistication and the acceptability of its precepts as 'theory'.[68]

Climacteric Disorders

Given the prevalence with which 'critical periods' – specifically the 'climacteric' – were invoked as causes of mental illness, and their absorption of both hereditarian and mental stress criteria, this concept provides a logical progression to the current enquiry. The word 'climacteric' has been used interchangeably with 'menopause' in women, and, less frequently, applied to men of comparable age. Alongside puberty, pregnancy and senility, it represented one of several so-called 'critical periods', wherein mental disorder – chiefly, that occurring in women - was linked to biological flux. It drew on Emil Kraepelin's nineteenth-century concept of 'involutional melancholia'; namely, an age-related functional atrophy, manifesting in depression,

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[66] Ibid., ref. no. 211 (discharged 1932).
[67] Ibid., ref. no. 136 (discharged 1932).
[68] Greta Jones, *Social Darwinism and English Thought: The Interaction between Biological and Social Theory* (Brighton: The Harvester Press Ltd., 1980), p.177.

guilt, and mental agitation. Climacteric featured as an aetiological factor on asylum admission registers from 1907, but disagreement over its meaning contributed to its assumed instrumentality in any mental afflictions among patients in their fifties. In 1927, Henderson and Gillespie described the 'involutional period' thus:

> ...a physiological epoch common to men and women, bringing in its train certain mental and bodily changes. The mental faculties in general become less acute. There is a tendency to bewail the past, and to feel that the future has nothing in store. The mind is occupied with the "might-have-beens", and, in consequence doubt, indecision, fear and anxiety readily show themselves. The glands of internal secretion begin to fail in their functioning, and the bodily health is lowered. It is impossible to state definitely when the involutional period begins and when it ends, but, roughly, it may be put from forty to fifty-five years in women, and from fifty to sixty-five years in men.[69]

Opinion was divided on the existence, causes and symptoms of climacteric insanity, and its differing presentations in men and women. Gregorio Marañón's (1929) book *The Climacteric* was amongst the first concerted scholarship on this topic, which began with acknowledgment of, and an attempt to clarify, often confusing terminology:

> The menopause is an isolated phenomenon, the physiologic cessation of the menstrual flow. The critical age, or climacteric, is a period of life characterized by a complexity of phenomena, the central symptom of which is precisely this menstrual cessation, but which is accompanied by many other disturbances such as those of a circulatory and nervous nature.

Marañón distinguished 'usual changes in climacteric psychology' (chiefly, emotional instability and impatience) from rarer, genuine psychopathologies, including paranoias, melancholia, and manic depressive states. He advocated the early use of ovarian extract for physical and mental exhaustion, complemented, where necessary, by belladonna and opium preparations for excitation, or, in very intense cases, isolation,

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[69] Henderson and Gillespie, *A Text-Book of Psychiatry for Students and Practitioners* p.158.

rest, and hydrotherapy.[70] In 1936, Marie Stopes condemned 'widely credited gossip' concerning the changes occurring in later life, and proposed that, in some instances, 'through needless fear of going a little "queer", men, and especially women, have been driven into becoming actually a little "queer" at this time; though had they not been surrounded by a false tradition, they would have suffered nothing of the sort'.[71] Stopes also discussed the concept of a male climacteric in the same book, and later commented that medical men had found the idea 'odious'.[72]

Chandak Sengoopta depicted the 1920s as the 'golden years' of sex gland research, in which the 'blame' for nervous disorders shifted from the uterus ("wandering womb") to internal secretions. The discovery of hormonal "ambisexuality" – i.e. that males produced female hormones, and vice versa - impeded efforts to sustain the idea that 'woman is woman because of her ovaries', but Sengoopta believed that research activity was stimulated by the emerging possibilities for reshaping and rejuvenating the body.[73] The above accounts typify the recurring biological determinism in female psychiatric diagnosis; yet, the climacteric concept was also adaptable to changing social mores. As the forthcoming evidence demonstrates, climacteric attributions exploited an increasingly gradated explanatory framework, encompassing both organic and reactive agents. In this sense, the label provides a miniature rendering of broader trends in psychiatric aetiology at this juncture.

From 1931 to 1947, male and female admissions to Bethlem with 'climacteric' principal aetiology were of similar mean age and melancholia was their most common diagnosis (Table 11). Women outnumbered men, were more likely to be single, have previous psychiatric history and to be certified.[74] As indicated by the casenotes below, some climacteric patients had already trialled many ways of alleviating their symptoms; however, by the 1940s, ECT was administered to many climacteric women almost irrespective of their symptomatology and history. A majority of such cases were

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[70] Gregorio Marañón, *The Climacteric (the Critical Age)*, ed. Carey Culbertson, trans. K.S. Stevens (St. Louis: C.V. Mosby, 1929), pp.17, 197-200, 224-226, 400-402.

[71] Marie Carmichael Stopes, *Change of Life in Men and Women* (London: Putnam, 1936), pp.196-198.

[72] Marie Stopes, "Correspondence: The Male Climacteric," *British Medical Journal* July 3; 2(4878) (1954): p.46.

[73] Chandak Sengoopta, *The Most Secret Quintessence of Life: Sex, Glands, and Hormones, 1850-1950* (Chicago: University of Chicago Press, 2006), pp.4-6.

[74] BRHAM, "Ara: General Admission and Discharge Registers, 1931-1983."

treated voluntarily by this stage (65% of females and 71% of males between 1941 and 1947) suggesting that ECT had attained some level of acceptance amongst patients. This apparent attitudinal shift may be linked to wider efforts to promote the benefits of physical treatment of mental illness,[75] which are explored further in the next chapter.

The frequency with which climacteric was applied to male admissions at Bethlem was atypical, and challenges female-centred accounts of such disorders. Nevertheless, differences were observed between the histories, symptoms and treatment of men and women. Chiefly, illness onset in females was often linked to domestic worries, and a (perhaps unsurprising) sense of failure to fulfil housewifely duties. Patient HC was aged 53, with a previous history of depression and multiple admissions to nursing homes and the Maudsley, connected to her youngest child leaving for boarding school six years ago. Her symptoms had proved unresponsive to a range of interventions:

> She had tried many different forms of treatment including glandular treatment, hydrotherapy and plombière douches for toxic poisoning....still all the time she feels depressed, worried she cannot fix her mind, is no good to her children, she feels they are going away from her. Her husband's little mannerisms frequently irritate her and make her lose her temper. Worst of all is the feeling that he doesn't understand. Sometimes she feels that she can't go on...and has thought of suicide'. Easily tired, distrusting of people, and jealous of daughter who is keeping house. Husband, in turn, envies son, who patient feels is the only person who understands her.

HC initially refused to give voluntary consent, but returned the following week, and over two months, some improvement in her mood was observed. She was ultimately discharged 'relieved' at her own request, without mention of treatment administered.[76]

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[75] See, for example: Jones, "Neuro Psychiatry 1943."
[76] BRHAM, "Cwc: Departures and Deaths Patient Casebooks, 1923 -1953," ref. no. 168 (discharged 1931).

Climacteric appeared to serve as a 'shorthand' diagnosis for patients of a certain age: the term was rarely applied beyond the admission register entry, and linked casenotes showed a more complex aetiology, usually invoking both environmental and hereditary factors. Fifty year-old secretary-companion OE was admitted for two months in 1936, diagnosed with climacteric-induced paranoia. She had no prior mental illness, but her current attack had lasted four months, prompting admission to Hellingly Hospital, East Sussex, before her transfer to Bethlem. Her history described recent personality changes, which were arguably the basis for the assumed climacteric involvement:

> Three years ago, an insidious change occurred in her temperament: she became more arrogant, selfish, conceited and heedless of others' feelings. She asked for more money from her mother and when rebuked (by sister) she flew into storms of anger. In January 1935 her post as Companion ended. She made an attempt to look for work, lived in a flat in London at her mother's expense. In September, Dr Helen Boyle treated her in a nursing home at Hove; delusions of persecution were formed and on 4/12/35 she was certified and sent to Hellingly Mental Hospital.[77]

Moreover, in the following case, a wife's menopausal troubles were implicated in her spouse's climacteric insanity, as part of a wider montage of discontent. Patient JS was admitted in 1931 with alcoholism, having been previously discharged from the army with neurasthenia. Aged 47, he was married with six children, the youngest of whom was an 'aphasic mongol'. It was reported that

> He suffered shell-shock after being buried alive whilst serving in France and spent three years on the Somme front before being discharged in 1917. Very irritable, slept badly and no appetite for food...has never been the same since. Joined Civil Service but relapsed in 1927 – took to drink and admitted to Bethlem for seven weeks. Happily married and a good father until November 1929. Marriage broke down as a result of his drinking...He has had a trying time with the worry of his wife's menopausal symptoms, and the youngest boy's

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[77] Ibid., ref. no. 1071 (discharged 1936).

condition, and the row at the office which ended in his dismissal from the Civil Service.

During his admission and withdrawal from alcohol, JS became less worried and slept better, but still appeared depressed. It was also noted that he 'enjoyed outdoor exercise and fresh air', before being discharged 'recovered' after six weeks.[78] This account illustrates the diversity of influences embedded in the climacteric label, and the possible interplay of difficulties within couples. The male emphasis on active, moral treatment-style intervention is further reminiscent of nineteenth-century gender differences in treatment of neurasthenia.

Male climacteric admissions were, on average, 50% longer than female, and men were more often assigned a second, 'associated' aetiological factor. Business concerns featured prominently in their case histories, and complaints were often of a somatic or hypochondriac nature. Thus, one 54-year old engineer, admitted with mania consequent to overwork, was 'completely subsumed by his delusions of internal physical catastrophes...these are very varied and bizarre'. He spent almost two years in hospital, with no mention of any treatment administered, and was discharged 'not improved'.[79] Another climacteric male, aged 59, was diagnosed with paranoia, manifest in twin convictions that he was suffering from infectious syphilis, and was 'the victim of a persecutor seeking to prove that he is guilty of homosexual practices'. Resistant to all reassurances, he 'enumerated his thousand ills', and became obsessed with physical and spiritual cleanliness as a route to salvation. Whilst records noted that his stereotyped behaviour and hypochondriacal features waned, he grew agitated at the thought of leaving hospital, and was eventually entrusted to the care of his wife after a fifteen year admission - again, without reference to any therapeutic intervention occurring within this time.[80]

The Kraepelinian ideology of involutional periods seemed to have exerted sustained ward-level impact at Bethlem, with 'climacteric' representing a continuation of earlier,

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[78] Ibid., ref. no. 119 (discharged 1931).
[79] Ibid., ref. no. 763 (discharged 1936).
[80] Ibid., ref. no. 175 (discharged 1946).

deterministic views, instead of reflecting more contemporary research on the role of hormones. An early absence of treatment reinforced medical and popular opinion that these were routine and self-limiting disturbances. Yet, from the 1940s, ECT was administered to (female) climacteric patients, even when their depressions appeared wholly reactive; an apparent dissonance which will be further explored in the next chapter. The term 'climacteric' was applied on the basis of age as much as symptoms, and whilst biological/hormonal changes may have been assumed, corresponding investigations do not appear to have been conducted.

	Males	Females
N	38	85
% of all admissions	12.34	15.95
Mean Age (yrs)	53.76	50
Age Range (yrs)	22-65	18-64
Younger than 40 yrs (%)	5.26	5.88
Mean Length of Stay (days)	600	403
Longest Stay (days)	5354	4148
% First Attack	65.79	50.59
Single (%)	28.95	44.71
Married	68.42	47.06
Widowed	2.63	8.24
Voluntary (%)	71.05	67.41
Temporary	10.53	3.53
Certified	18.42	31.76
% Mania	13.16	5.88
% Melancholia	78.95	70.59
% Other	7.89	23.53
% Assigned Second Aetiological Factor	81.58	47.06

Table 11: *Characteristics of Patients with 'Climacteric' Principal Aetiology, 1931-47.* Source: Admissions Database.

The climacteric label became shorthand for a confluence of age, gender and class stereotypes. Writing in the *British Medical Journal* in 1935, J. Whittingdale outlined two clinical subtypes of women in the 'twilight of femininity'. He proposed that the well-to-do were more likely to present with 'the triad of obesity, hyperpiesia, [high

blood pressure] and arthritis of the knee joints' which he considered amenable to treatment by diet and thyroid administration. A second exemplar, was that of the 'small, thin worrier – the woman whose children have gone out into the world and whose husband has been nagged by excessive mother love into the public-house, the club, or the dog-track.....This type is benefited by bromides, sumbul, and valerian'. One finds an implied degree of personal responsibility and failure in the 'empty-nester's' descent into neurosis, and the inconvenience her 'tirades' or 'curious fancies' posed for her family. Whittingale alluded to the widespread stigma which deterred patients from seeking professional support, yet offered a resoundingly moralistic route to salvation:

> The most successful navigators of the menopausal rapids are those women who have been adequately educated and can direct their maternal instincts to social welfare, their physical activities to gardening or "Guiding", their fantasies to literature or Anglo-Catholicism. [81]

The article generated numerous responses within subsequent issues of the journal. Margaret Basden expressed concern that endocrinal therapies had already precipitated a move away from the practice of providing basic reassurance to women.[82] However, Dr. G.E. Bellamy deemed it 'surely unscientific to apply psychotherapy to cure the mental troubles of the menopause when it is now abundantly clear that they are but secondary effects of the primary upset of the endocrine balance in the body'. He reported a rise in climacteric disorders presenting at his practice over the last twenty years, and challenged the idea that modern women's education and purpose in life bestowed upon them any prophylactic value.[83]

Although nominally a gender-neutral term, Joan Busfield suggested that the longstanding pathologisation of menopausal women augmented their presence within

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[81] J. Whittingdale, "Problems of the Climacteric," *British Medical Journal* 1, no. Feb 9 (1935): pp.251-252.
[82] Margaret Basden, "Correpondence: The Climacteric," *British Medical Journal* 1, no. March 9 (1935): p.500.
[83] G.E. Bellamy, "Correspondence: The Climacteric," *British Medical Journal* 1, no. March 23 (1935): p.618.

this population.[84] On the other hand, Kenneth Walker, a genito-urinary surgeon, claimed in 1938 that 'the idea that a man passes through a period comparable to what in the woman is known as the menopause, is no new one. In ancient medicine a grand climacteric was recognized and was placed at the age of sixty-three'.[85] By 1947, the female climacteric was 'a well-known and recognized entity, with definite symptoms, age of onset, aetiology, and....the cessation of pregnancy'.[86] Yet, within the scientific community, the existence, definition, and treatment of a male climacteric remained contentious, given their lack of menses, and the apparent futility of hormonal extracts in remedying male climacteric disturbances.[87] Whilst some commentators remarked upon the unnecessary nature of such a transition in man, given his relatively protracted fertility and sexual desire,[88] others voiced indignation that 'the male does not desire to be excelled by the female in having one disease less'.[89] Only one of twelve workshops at the First International Congress on the Menopause (1976) dealt with the issue of the male climacteric, and even there the concept was declared 'nonsensical' and its clinical existence roundly dismissed.[90]

Trends in the use of the 'climacteric' label parallel those in other aetiological classifications. In 1975, Kendell suggested that as the focus of medical investigation expanded from the study of individuals, to that of populations, it became apparent that numerous internal and external factors were implicated in the development of a disease. This growing knowledge, he asserted, rendered 'increasingly arbitrary' the process of regarding one of these as 'the cause' and the rest as simply 'precipitating or exacerbating factors'.[91] The gradual departure from use of standardised aetiologies may also be linked to the assimilation of many former causal factors into new psychiatric taxonomies, on the basis of emerging scientific research and shifting social and legal opinion. Notable examples included the reclassification of alcoholism as a

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[84] Busfield, *Men, Women and Madness*, p.162.
[85] Kenneth Walker, "The Male Climacteric," *Postgraduate Medical Journal* April (1938): p.120.
[86] C.L. Malhotra, "Points from Letters: What Is Male Climacteric?," *British Medical Journal* November 22; 2(4533) (1947): p.844.
[87] Kenneth Walker, "The Accidents of the Male Climacteric," *British Medical Journal* 1, no. 3705 (1932): p.53.
[88] Ibid., p.50.
[89] Malhotra, "Points from Letters: What Is Male Climacteric?," p.844.
[90] P.A. van Keep, D.M. Serr, and R.B. Greenblatt, eds., *Female and Male Climacteric: Current Opinion 1978* (Lancaster: MTP Press, 1979), pp. vii, 133-136.
[91] Kendell, "The Concept of Disease and Its Implications for Psychiatry," p.309.

syndrome rather than a contributory behaviour; the replacement of 'critical periods' with specific, age-related diagnoses, and the conceptualisation of post-traumatic stress disorder and post-natal depression (as distinct from hitherto, nondescript, attributions of 'mental stress').

Length and Outcome of Stay

Cherry urged caution in the use of outcome figures from this period, suggesting that, from the mid twentieth century, "improved" rates were 'increasingly unreliable', given the rising proportion of voluntary patients able to discharge themselves, but routinely classed as "relieved".[92] Moreover, in his study of early twentieth-century psychiatric admissions in Japan, Akihito Suzuki proposed that (physical) treatment innovations contributed to therapeutic course becoming a key determinant of length of stay.

> After a relatively fixed period of time spent in the hospital and a definite fee paid, the patients would be discharged....staying at a psychiatric hospital became a service commodity which became psychologically easier to purchase and economically feasible to provide.[93]

As demonstrated in the next chapter, this has clear parallels with 1940s Bethlem, when patients were often admitted for a course of ECT, the administration and outcome of which provided the structure of their stay and the main focus of their hospital records. This apparent commodification of psychiatric treatment also fits with the notion of an institutional marketplace, as discussed in chapter 4. Andrew Scull further identified a general decline in the length of psychiatric admissions, prior to the widespread introduction of new drugs, which were commonly heralded as having driven this change and facilitated the growth of non-institutional care.[94] However, writing in the late 1950s, Vera Norris concluded that 'the resident population in mental hospitals is still increasing, and 85 per cent of the patients on any given day will have been there for more than one year'.[95] This finding was supported by Elizabeth Bott's account of

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[92] Cherry, *Mental Health Care in Modern England*, p.238.
[93] Suzuki, "A Brain Hospital in Tokyo and Its Private and Public Patients, 1926-45," p.358.
[94] Scull, *Decarceration*, pp.81-82.
[95] Norris, *Mental Illness in London*, p.265.

the emergence of a core of chronic patients within this era.[96] However, in an influential paper of 1961, G.C. Tooth and Eileen M. Brooke proposed that, after a peak in 1954, there had been a 'small but steady reduction in the resident mental hospital population...in spite of a steadily increasing admission and readmission-rate'.[97]

Contrary to anticipated notions of a steady decline in length of psychiatric admissions, the present study revealed peaks and troughs around 1930. However, as outlined in the methodology chapter, Bethlem relocated in 1930, and efforts to discharge patients in preparation for the move would have had a distorting effect on length of stay and patient numbers at this juncture. Extending the survey of admission register data back to 1921 showed that mean length of admission began to decline in 1923, reaching its lowest level in 1925 for women and 1928 for men. Rates rose sharply thereafter, peaking in 1934 at 643 days (men) and 588 days (women), before falling to 116 days and 182 days respectively by 1944, yet, considerable variation was again observed in this area. To illustrate, from 1931-46, the average stay of 533 sampled female patients was 325 days, but with a standard deviation of 469 days. For the (308) males, the respective statistics were 447 and 863 days.

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[96] Bott, "Hospital and Society," pp.97-140.
[97] Tooth and Brooke, "Trends in the Mental Hospital Population and Their Effect on Future Planning," p.710.
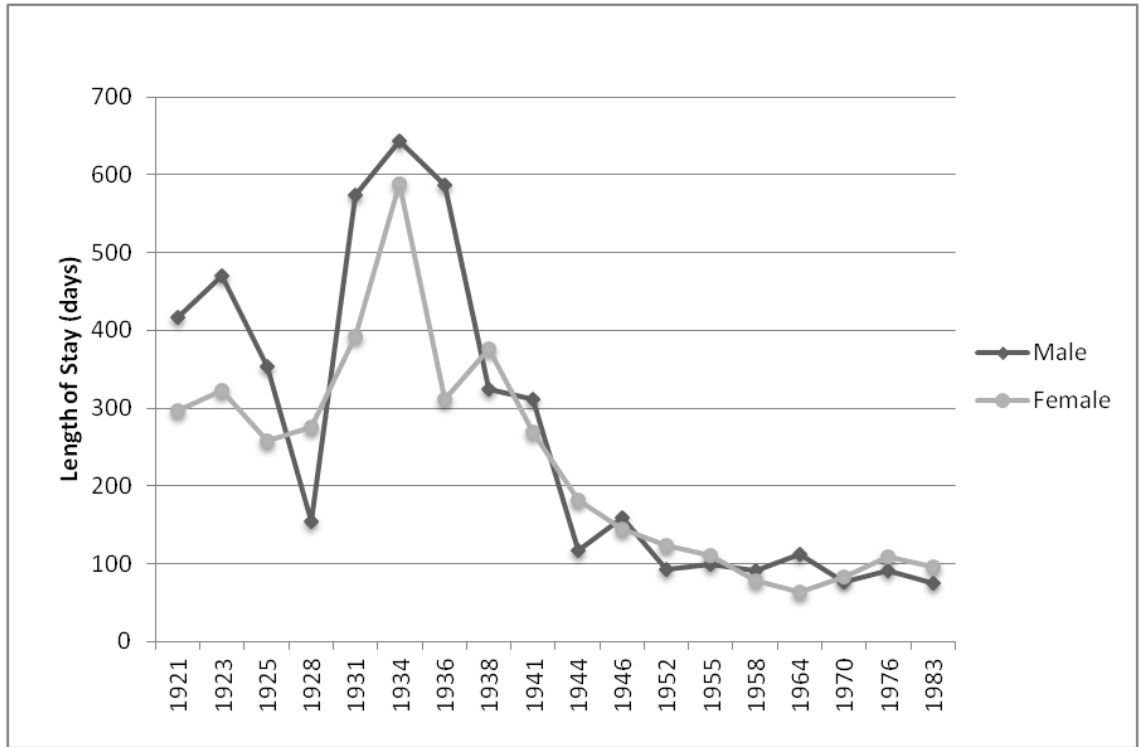
Figure 17: *Sampled Bethlem Inpatients, Mean Length of Stay, 1921-83.* Source: Admissions Database.
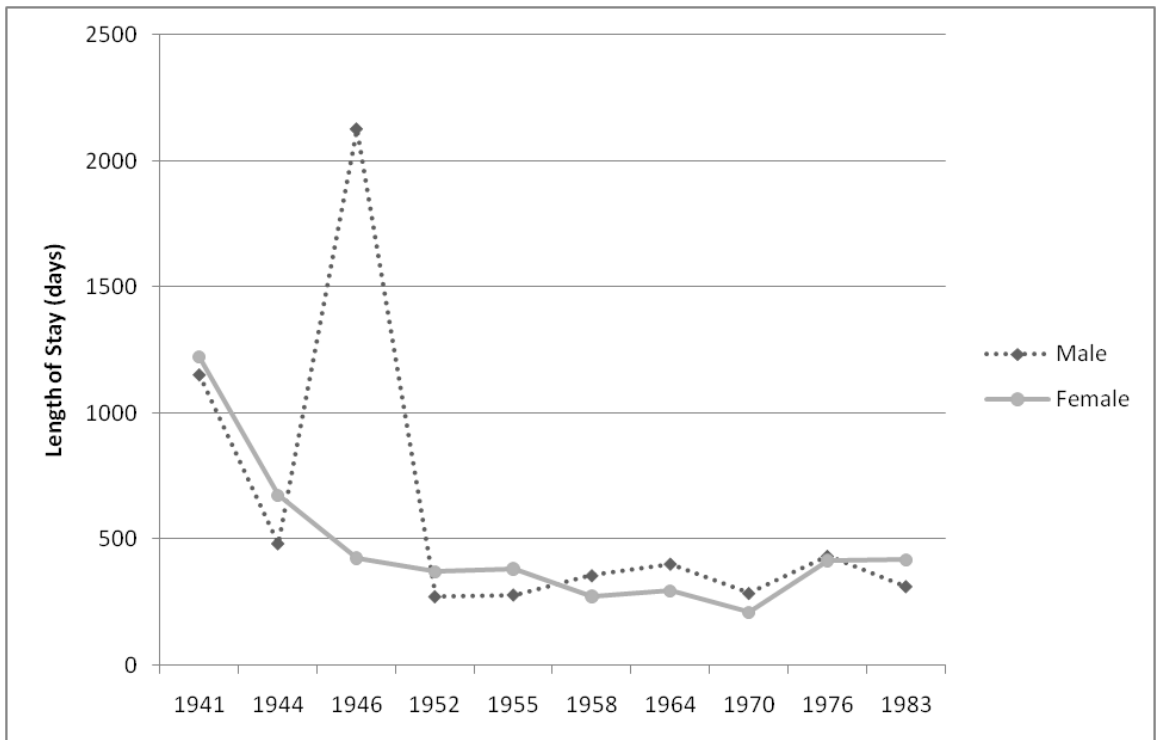
Figure 18: *Mean Stay, Longest Staying 10% of Sampled Patients, 1941-83.* Source: Admissions Database.

Before the NHS, few patients had more than one stay at Bethlem, unlike neighbouring hospitals, such as Colney Hatch, which reported a 31% readmission rate between 1895 and 1927, despite adopting 'curability' criteria specifying that patients should be admitted early in the course of their illness, be recoverable, and should not suffer from epilepsy or paralysis.[98] These stipulations were analogous to Bethlem's policy; yet, it was rare that admission to Bethlem would be the patient's first experience of mental illness, or that it would closely follow the onset of an attack. Rather, many sufferers continued to be supported by informal family or community networks in preference to incurring the stigma, expense, or upheaval, of institutional care. This meant that by the time of their arrival at Bethlem, many were in a state of severe or advanced mental distress, and not always responsive to treatment. Moreover, the increasing emphasis on self-referral and voluntary admission meant that the time of intervention was determined both by lay judgements of mental illness, and more practical (especially financial) concerns, as discussed below.

Economic pressures were acutely felt by the families of (unforeseen) long-term patients, such as 27 year-old electrician, PF. He was initially diagnosed with probable schizophrenia or manic depressive disorder, and admitted to Bethlem in 1934, on a voluntary, contributory, basis. Yet, four months into his stay, the physician superintendent wrote to his referring doctor, proposing that he now considered the case to be one of dementia praecox [primary dementia] and prone to drift into a chronic condition. As PF's father managed his son's expenses and liaised with the hospital over treatment decisions, his death in 1939 was thus a source of both emotional and economic upset. Financial responsibility subsequently passed onto his wife (the patient's mother) who successfully negotiated that PF be kept on at reduced fees as she could not afford the previous rate. However, in 1940, he was transferred under certification to City of London Mental Hospital, Dartford, after 'failing to respond adequately' to treatment and no longer fulfilling the conditions necessary for extension of stay at Bethlem.[99]

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[98] Hunter and Macalpine, *Psychiatry for the Poor*, pp.52-53.
[99] BRHAM, "Patient Correspondence Files, 1925-1947," ref. no. 762 (transferred October 1940).

Patient ID was 67 year-old retired sales manager, diagnosed with senile dementia. Married with six children, he had no family history of insanity, but suffered depression and anxiety consequent to acute influenza and lumbago. In addition to general confusion and agitation, his Urgency Certificate declared

> He has the delusion that he is bankrupt and penniless which I know to be untrue. He says he is dirty and in rags whereas he is clean and well-dressed... Sleepless and refusing food as believes he cannot afford it.

This theme continued into his admission, during which time he 'worried about his financial situation, afraid he will get into debt whilst in hospital, but grateful that it provides some probation from annoying people'.[100] In the event, ID died from pneumonia after eleven months at Bethlem, but his case illustrates the prominence of – real or imagined - monetary concerns to the hospital's purportedly affluent patients, and potential economic influences on duration of stay.

Postwar, inpatient stays grew shorter (figure 17) but readmissions increased rapidly, especially for anxiety and depression.[101] Analysis of the longest-staying 10% of inpatients between 1941 and 1983 (figure 18) highlighted two key trends; firstly, we observe a peak in the length of male admissions circa 1946. This may be a reflection of the small sample size and the requirement that only the severest male cases to be hospitalised at this time. These men were diagnosed with psychoneurosis and primary dementia, and they ranged in age from 19 to 48. Secondly, the most recent figures show that women have now overtaken men in average length of stay. This is arguably a more robust finding, taken from the entire year's admissions. Of the 35 longest-staying female patients, six were juveniles (under 20 years old) and a further eight were aged over 70. The latter group were mainly suffering from senile dementia, some with comorbid depression, whilst no diagnosis was available for the youngest patients. For the remaining age groups and where diagnosis was stated, schizophrenia and various forms of manic depression featured prominently.[102]

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[100] BRHAM, "Cwc: Departures and Deaths Patient Casebooks, 1923 -1953," ref. no. 106 (died January 1932).
[101] Andrews et al., *The History of Bethlem*, pp.652-653.
[102] BRHAM, "Ara: General Admission and Discharge Registers, 1931-1983."

Due consideration must be given to the impact of hospital policy in shaping length of admissions. As discussed in previous chapters, Bethlem governors originally stated that no patient should stay longer than 12 months. Whilst, in practice, this was not stringently enforced, the introduction of more effective physical treatments – notably ECT - from the 1940s gradually saw a diminution in patients staying more than six months. However, multiple admissions and transfers between wards and facilities within the Joint Hospital became more common, marking the start of the 'revolving door' phenomenon. With the creation of a 'Three Months Rule' in the early years of the Joint Hospital, any returning patients were classed as new admissions. For the same triennium (1949-51) there were 938 multiple discharges across a total of 7787 inpatients and outpatients (males: 375, females: 562). Moreover, 8.9% of males and 12.5% of females were discharged more than once in this period, and some had also received prior treatment on the Joint Hospital's child psychiatric ward. [103]

The hospital management was also quick to implicate changes in the type of patient and condition treated as key factors in this emerging trend. A prime target of managers' criticism was the Maudsley's Emergency Clinic. Likened to a general hospital casualty department, patients here required no referral, and 395 cases were seen in 1951 and 863 in 1953. Approximately 10% of these were referred to inpatient wards at the Joint Hospital.[104] However, such a service defied any control of numbers, backgrounds, or severity of disorders presented, to the detriment of the hospital's reported success rate. Joint Hospital physician, Edward Hare, thought the clinic attracted those poorer patients prone to mental illness.[105] In a similar vein, between 1970 and 1972, only 1182 of 1750 new outpatient appointments were kept, a finding that was blamed on the 'unreliability of drug dependent patients and the expectation of many new patients that they will be prescribed their drug of choice'.[106] Medical Committee minutes from 1957 further lamented the deleterious effects of current admission policy on record-keeping, observing thus:

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[103] BRHAM, "Triennial Statistical Report, Years 1949-1951," pp.33-34.
[104] BRHAM, "Triennial Statistical Report, Years 1958-1960," p.62.
[105] BRHAM, "Triennial Statistical Report, Years 1961-1963," p.9.
[106] BRHAM, "The Bethlem Royal and the Maudsley Hospital Report, 1970-75. Part I - Text," pp.59-63.

1. If a patient is not back from leave after 3 days, his discharge is notified immediately to the Board of Control. Often, however, he is readmitted within the next few days and so counts double;

2. When a patient is transferred from Bethlem to Maudsley and back again, he is counted as three admissions in the monthly return;

3. Whenever a patient is given leave longer than 72 hours, as perhaps at Christmas, he must be discharged and readmitted under the present regulations.[107]

Writing in 1959, R.W. Parnell suggested that length of stay data could provide key clinical and economic indicators of the scale of the problem of mental illness. Critically, he also highlighted the limitations of using patient discharge rates in isolation to substantiate claims of improved case management. Parnell investigated the factors influencing length of mental hospital stay in England and Wales, for patients admitted between 1953 and 1954. For this period, the median length of stay was around five months for schizophrenia, and six to eight weeks for manic depression, psychoneurosis, character, and behaviour disorders.[108]

Conversely, a sample of 100 Bethlem admissions from 1952, revealed the overall median length of stay to be 10 weeks for men, and 14 weeks for women. Amongst the longest staying 10% of patients, (table 12) the corresponding admission figures were 31 weeks (male) and 56 weeks (female) and their ages ranged from 20-60 and 13-49 respectively. Both male and female sub-groups featured undiagnosed patients, yet dual, and multiple, diagnoses were also apparent amongst the men. Whilst Parnell's study primarily concerned male schizophrenics, the present research indicated a female predominance amongst long-stay patients; a finding which, though based on a small sample, cannot, in this instance, be attributed to longevity effects. Although an inexact comparison, the above evidence suggests that admissions to 1950s Bethlem were somewhat longer than those at other comparable institutions, and that women stayed longer than men. Indeed, all but one of the six longest-staying patients in 1952 were female and, crucially, none were in the uppermost age bracket.

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[107] BRHAM, "Mcc: Medical Committee Documents and Minutes, 1955-1957," MCD.53/57: Letter to Secretary from J.G. Hamilton, 18/10/57.
[108] Parnell, "Length of Stay in Mental Hospitals," pp.1296, 1300.

Adm Length (days)	Gender	Age	Diagnosis
469	M	60	Cerebral Thrombosis
397	F	43	Schizo-affective State
392	F	13	Behavioural Disorder
391	F	39	Depression
351	F	16	None
323	F	49	Depression
280	M	40	Anxiety, Depression
219	M	64	None
213	M	35	Paranoid Personality, Hypochondria
187	M	20	Obsessional Neurosis, Hysteria, Immature Personality

Table 12: *Profile of Longest-Staying 10% of Sampled Bethlem Admissions, 1952.* Source: Admissions Database.

Early twentieth-century admission registers noted the date and circumstances (i.e. discharge, death or transfer) of a patient leaving hospital, together with a summary prognosis, broadly ranging from 'unchanged' to 'recovered'. Similar descriptions were applied in more recent hospital records, usually accompanied by patient destination and aftercare arrangements. The hospital boasted an impressive recovery rate, with, on average, 50% of patients 'recovered' and a further 32% 'improved' upon discharge between 1949 and 1969.[109] Voluntary patients were found to have had a better prognosis, with 77% of such cases discharged 'recovered' or 'improved' by 1947,[110] but this observation is inevitably complicated by the typically contrasting clinical pictures of the two groups. There were also higher recovery rates for women than men,[111] again alluding to the possibility that they were admitted on less serious grounds, or at an earlier phase in their illness.

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[109] BRHAM, "Triennial Statistical Reports, Years 1949-1969."
[110] BRHAM, "Bethlem Hospital Annual Reports, 1930-1947."
[111] Andrews et al., *The History of Bethlem*, p.704.

	Average % of Inpatient Discharges (both sexes)						
	1949-51	1952-54	1955-57	1958-60	1961-63	1964-66	1967-69
Recovered/Much Improved	47.5	48.4	49.4	50.9	54	50	41
Improved/Slightly Improved	30	30.8	29.8	30.3	31	34	40
No Change/Worse/Died	22.5	20.8	20.8	18.8	15	16	19
TOTAL DISCHARGES:	3245	3641	3942	4477	4609	4121	4007

Table 13: *Bethlem Royal Hospital, Inpatient Treatment Outcomes, 1949-69.* Source: BRHAM, "Triennial Statistical Reports, Years 1949-1969," eds. C.P. Blacker and A.T. Gore.

A sample of 40 patients admitted with 'recent melancholia' between 1931 and 1947 elicited an unexpectedly high death rate, given the somewhat prosaic image of this diagnosis and its prevalence amongst voluntary patient populations. Thus, 13 of 40 cases (10 male, 3 female) followed up died in hospital; of these, 5 (2 male, 3 female) committed suicide.[112] Novel forms of mental illness with relatively poor prognosis or high relapse rates attracted blame for declining overall recovery rates between 1967 and 1969 (Table 13). By the late 1960s, neurotics were singled out as having statistically worse treatment outcomes than schizophrenics, with just 2% of such inpatients deemed 'recovered' at discharge, compared to 10% for the latter group.[113] These findings lend support to the idea of an institution somewhat ill-unprepared for dealing with the uncharted territory of the varied and complex 'new' disorders presenting, or of the symptomatic and attitudinal challenges posed to conventional treatment methods.

Discussion

On reflection, the current findings underscore the need for a healthy scepticism in the process and, indeed, products, of psychiatric labelling. Changes in patients' moods and

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[112] BRHAM, "Cwc: Departures and Deaths Patient Casebooks, 1923 -1953."
[113] BRHAM, "Triennial Statistical Report, Years 1967-1969," p.2.

behaviour were variously associated with war, love, work, ageing and loneliness. The use of outwardly medical, but ultimately subjective, criteria to classify such vicissitudes of human feeling - and, by proxy, behaviour - represents an understandable, but self-defeating, concession to scientific hegemony. Moreover, this practice often has far-reaching (and under-recognised) implications for patients both during, and beyond, their psychiatric 'career'.

Ahead of reviewing the evidence presented here, it is helpful to consider more general explanations for the elevated interest in psychiatric epidemiology occurring from the 1950s. Although this was plausibly an economic move - the rhetoric of 'NHS resources' already permeating the literature[114] - commentaries were also imbued with contemporary social stereotypes, such as the 1950s housewife persona, and identification of lifestyle risks for mental illness. Empirically, this was a period of low female labour market participation, and the alienation and ennui amongst this population had already been implicated in the emergence of "suburban neurosis".[115] A recent essay by Rhodri Hayward[116] depicted such diagnostic stereotypes as a product of interwar social unease and professional disagreement, analogously to the competing visions of 'climacteric' insanity observed in the current study. Furthermore, oral histories conducted by Ali Haggett challenged the popular view that women felt oppressed or confined by domesticity, or that environmental factors could precipitate mental breakdown in the absence of previous psychiatric history.[117] Likewise, the current research highlighted the influences of family relationships and work/financial concerns - rather than domesticity per se - on mental illness. Additionally, Haggett's work reiterates the capacity of oral history to introduce new perspectives on accepted tropes within psychiatry.

In 1957, researchers such as Sidney Chave et al. were amongst the first to extend community-level studies into the remit of psychiatry, and, in so doing, began to frame mental illness as a legitimate public health concern. By centring their investigation on

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[114] Brooke, "Mental Health and the Population," pp.209-210.

[115] Stephen Taylor, "The Suburban Neurosis," *Lancet* 26 March (1938): pp.759-761.

[116] Hayward, "Desperate Housewives and Model Amoebae," p.45.

[117] Ali Haggett, "Housewives, Neuroses, and the Domestic Environment in Britain, 1945-1970," in *Health and the Modern Home*, ed. Mark Jackson (New York; London: Routledge, 2007), pp.91, 95-104.

the residents of a new housing estate, they also tapped into topical concerns relating to the stresses of urban living and the dissolution of conventional family networks.[118] Such a rendering of events serves to depict psychiatry as a recurrent beneficiary of developments elsewhere in medicine: thus, as mental health care arguably profited from the physical provenance and popularisation of occupational therapy,[119] here we again witness the belated infiltration of physiological ideas and methods into psychiatric treatment. David Armstrong argued that a postwar 'normalising' psychiatric gaze, and the extension/intrusion of psychiatry into the community, had fashioned the 'creation' of the neuroses.[120] Accordingly, the current research suggested a conceptual movement of madness away from bodily and institutional domains, to those of the life course and wider community, together with the rise of more contingent explanations, such as 'mental stress'. Bethlem's changing clinical and geographical remit saw the emergence of new diagnoses and services (especially following the creation of Joint Hospital) and liaison with other institutions, services, and professions. This extended reach and array of referring agents and opinion contributed to variable interpretations of causes and diagnoses and substantial contextual influence on labelling; areas which are summarised below.

The Subjective Science of Psychiatric Diagnosis

The practice of effectively coding both the individual and his illness ceased with the introduction of new classification schemes in the late 1940s. The concept of aetiology was gradually subsumed by overarching diagnostic categories, thereafter falling wholly within the medical purview, and blurring the already contested boundaries between origin and expression of mental disorder. Bethlem register entries from the 1950s to 1970s also indicated a perseverance of outdated terminology, and demonstrated reluctant or inaccurate use of the accompanying ICD codes. As indicated in chapter 4, such problems were compounded – if not caused - by the failure of medical training manuals to keep pace with taxonomical revisions, and their dissemination of unchanging and questionable characterisations of mental illness.

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[118] Martin, Brotherston, and Chave, "Incidence of Neurosis in a New Housing Estate," pp.196-202.
[119] Jones, "War and the Practice of Psychotherapy," p.500.
[120] Armstrong, *Political Anatomy of the Body*, pp.69-70.

Casenote follow-ups also revealed the continuation of older terminology and approaches, and the coexistence of ideas regarding mental illness causation. This affords a more nuanced picture than that available from purely statistical data. Yet, analysis and comparisons of diagnoses were beset by nosological inconsistencies, occurring both within, and between, the Lunacy Commissioners' codes and the later ICD. An apparent lag between the inception of classificatory revisions and psychiatrists' adoption and understanding of terminology, raises doubts over the reliability of diagnoses recorded. Such arguments are central to recent scholarship on the instability and confusion surrounding current psychiatric categories, notably 'depression'[121] and particular controversy over the delineation of 'personality disorder'.[122] Relatedly, there have been calls for the reinstatement of abandoned nomenclature, with the suggestion that ongoing scientific and theoretical advances may actually provide the justification required for such a move.[123]

The Prism of Gender

Although Bethlem register entries hinted at a diagnostic 'meeting of minds' in the experiences of male and female inpatients, casenote-level investigation uncovered greater gender disparities. This was most apparent in exploration of the climacteric aetiology, which, usually, was assigned to both men and women, but attracted differing attributions and treatment in casenotes. The identification and attribution of possible reasons for an attack of mental illness was, originally, a shared responsibility. Designation of a principal cause was based on medical opinion, but contributory or associated factors could reflect the views of other people who knew the patient. The discovery of broadly common aetiologies between men and women (namely, heredity, critical periods, and mental stress) challenges the adequacy of feminist theories – such as gender role transgression and patriarchal hegemony - in explaining these findings. On the other hand, women outnumbered men in instances of 'no factor assignable', raising the possibility that they were either subject to a lower admission threshold or that, once admitted, they were not a priority in terms of record-keeping.

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[121] Cole, McGuffin, and Farmer, "The Classification of Depression: Are We Still Confused?," p.85.
[122] Kendell, "The Distinction between Personality Disorder and Mental Illness," p.114.
[123] Fink et al., "Melancholia: Restoration in Psychiatric Classification Recommended," pp.89-92.

Additionally, a number of diagnostic anomalies warrant further discussion. The category 'psychoneurosis' was introduced in the aftermath of the 1930 Mental Treatment Act, encompassing the (often) milder afflictions of a cohort of voluntary patients. It wasn't until 1941 that any male patients were classed as psychoneurotic, at least five years after it was initially applied to women, who continued to account for the majority of this population. In contrast to prewar psychoneurosis, postwar Bethlem admissions for equivalent anxiety-related disorders rose fastest amongst men. Yet this pattern was inconsistent with that observed in local primary care, a 1964 survey of London GP practices reporting neurotic illness to be most prevalent among middle-aged females and an important cause of chronic illness.[124] It has been proposed that such an imbalance of 'milder' mental problems in women may be attributable to gender differences in the expression of distress, social assumptions of agency and rationality and to specific types of disorders experienced.[125] The disparity could also reflect gendered patterns of help-seeking behaviour, whilst it has elsewhere been argued that the changing role of women in industrialised society has similarly promoted mental illness.[126]

Postwar admission trends to Bethlem appeared to challenge gendered disease stereotypes, consistent with Elaine Showalter's[127] belief that a 'feminine' schizophrenia is a matter of cultural construct rather than 'statistical fact'. To avoid the pitfalls of generalising from the current data, it suffices to say that such an artificial gender divide, if discernable elsewhere, has not been found here. The present findings also raise questions about why melancholia or, later, depression, did not emerge as Showalter's prototypical 'female malady'. There are a number of possible explanations for why incidences peaked in the late 1950s to early 1960s and declined rapidly over the ensuing decade. Examples include changing interpretations of symptoms, expanded nomenclature, and the arrival of prominent new psychiatric drugs, coupled with efforts to manage milder conditions through community care. The very lack of a gender imbalance for depression may initially have stemmed from its diverse aetiology

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[124] Shepherd et al., "Minor Mental Illness in London: Some Aspects of a General Practice Survey," p.1363.

[125] Busfield, *Men, Women and Madness*, p.132.

[126] Walter R. Gove and Jeanette F. Tudor, "Adult Sex Roles and Mental Illness," *The American Journal of Sociology* 78, no. 4 (1979): p.831.

[127] Showalter, *The Female Malady*, p.204.

(organic or reactive forms) and, more recently, to the availability of convenient and nonstigmatised psycho-pharmaceuticals. Debates on the suitability of treatment (notably psychotherapy) by diagnostic group are advanced in the next two chapters.

A further key finding was the postwar ascent of affective psychosis found amongst female patients. 'Affective psychoses' were distinct from schizophrenic illnesses or paranoia, and primarily included the various forms of manic depression and 'involutional melancholia'.[128] The fact that the latter group initially featured 'climacteric insanity', 'climacteric melancholia' and 'menopausal melancholia' provides some clues as to why so many women received the affective psychosis label. Although these subtypes disappeared in later revisions of the ICD, the aforementioned shortcomings of training materials inevitably impeded the diagnostic process and prolonged outdated ideologies. However, an interviewee also attributed the greater expression, or recognition, of female mania, to sociocultural shifts.[129]

Socioeconomic Influences on Diagnosis and Treatment

A number of practical and institutional factors were also identified as instrumental in diagnosis. For example, dramatic changes observed in the length of Bethlem admissions circa 1925-1947 can be linked to features of both the hospital and wider social contexts. Potential influences included the economy, or the (in)ability of patients to contribute to their ongoing care. Financial hardship also featured in some casenotes from 1930s admissions, either in circumstances preceding hospitalisation, or as an issue in their continuing care.[130] A second factor is that of changing treatment methods and their efficacy. Bethlem's regime was somewhat dated in its reliance on physical therapies (ECT and insulin coma were still present in plans for buildings after 1947) but developments occurred in talking therapies, occupational treatments and the popularisation of social psychiatry, suggesting that the type of patient admitted was, to some extent, determined by clinical preference. Thirdly, reduced admission lengths may be a result of voluntary and outpatient services presenting more flexible modes of

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[128] World Health Organization, "Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death Based on the Recommendations of the Eighth Revision Conference, 1965, and Adopted by the Nineteenth World Health Assembly," p.145.
[129] Irene Heywood Jones, Interview by Author, 5th August 2010.
[130] BRHAM, "Cwc: Departures and Deaths Patient Casebooks, 1923 -1953," ref. nos 106, 762.

accessing mental health care. However, this in itself didn't necessarily correlate with length of admission; some of the longest-staying patients were found to be informal 'boarders' with no clinical diagnosis. Gauging an accurate impression of length of stay was also obscured by the previous practice of reclassifying patients (e.g. from certified to voluntary) midway through their hospital stay, and regarding this as new admission.

Certain diagnoses yielded surprisingly high mortality rates, as illustrated by a randomised follow-up of 40 melancholia cases in the 1930s and 40s, which revealed 13 deaths, of which five were suicides. Moreover, notwithstanding the small sample size, the discovery that all (3) of the female deaths were suicides alludes to possible gender differences in identification and treatment of this disorder. In the latter twentieth century, poor prognosis was observed for neurotics in particular, but figures were inevitably distorted by shifting terminology and policy 'goalposts'. Other commentators have used length of stay as a primary index for measuring recovery and prognosis, whilst conceding of the need to include additional markers of health post-discharge. Parnell's study showed that schizophrenic patients spent, on average, up to 3 months longer in hospital than those with other diagnoses, and that youth and student or professional backgrounds were also associated with extended admissions.[131] Analysis of contemporaneous Bethlem figures generated a different picture: median admission lengths were generally longer than those cited by Parnell, and the longest-staying patients covered a greater age and diagnostic spectrum. This reinforces the idea, introduced in chapter 4, that socioeconomic circumstances could be more influential than clinical features in shaping admission and treatment decisions. Thus, how long a patient stayed often reflected their financial situation or their ability to articulate their concerns and negotiate with hospital authorities; factors which, in turn, were intertwined with class and gender.

In summary, the current research has identified key patterns in the demographic composition of Bethlem's patients, diagnostic practices and treatment delivery. Moreover, the database exercise has furthered our understanding of how these characteristics evolved over the course of fifty years, against a broader backdrop of legal, social and scientific change. The picture which emerged from the present and

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[131] Parnell, "Length of Stay in Mental Hospitals," p.1300.

foregoing chapters, was of a postwar convergence, and, in some cases, reversal, of traditionally 'gendered' diagnoses, albeit one countered by a widening age disparity between male and female admissions, most prominent within the over-sixty age groups, where class differentials were observed both at Bethlem and on a national level.[132] The narrowing of conventional gender differences in diagnosis was particularly evident in 1983 statistics, wherein which men actually outnumbered women in admissions for anxiety-related disorders, whilst female rates of affective psychosis underwent a marked increase for the same period. Moreover, incidences of schizophrenia were more equally distributed between the sexes than popular accounts typically imply. Findings also suggested that new services – notably psychogeriatrics – seemed to serve an almost uniquely female clientele. Although one should not over-generalise from an individual case study, the present investigation of the gendered nature of admissions remains a valuable exercise in deconstructing and challenging accepted accounts of male/female disparity in psychiatric experience. Busfield contends that the growth of community care and concomitant reduction in specialist psychiatric input will make evaluations of gendered behaviour more salient in case identification.[133] Although such a view may seem anomalous in an era of encroaching medicalisation of psychiatry, it candidly reflects the inherent subjectivity of attitudes and attributional styles, which cannot be readily expunged from the diagnostic process.

Having sketched a social and clinical profile of Bethlem's inpatients, there now follows a qualitative exploration of therapies and services available to this population from the 1930s to the 1980s, which speaks to wider debates about the nature and efficacy of twentieth-century psychiatric treatment. The discussion begins with the evolution of physical and pharmaceutical methods, before proceeding to and exploration of the psychotherapies, in so doing testifying to the fluctuating fascinations with psyche and soma in the treatment of mental illness. The following chapter provides a background to the origins of key physical and drug-based approaches, and addresses the emergence, uptake and delivery of these services at Bethlem, Maudsley, and the latter-day Joint Hospital.

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[132] Logan, "Patients in Mental Hospitals," p.499.
[133] Busfield, *Men, Women and Madness*, p.117.

Chapter 6: Treating Brain and Mind

Introduction

The preceding chapters have utilised quantitative archival data to explore the changing clinical and sociodemographic profiles of Bethlem patients in the twentieth century, illustrated with excerpts from qualitative sources. This provided important insight into the types of patient treated and key features of their admissions and prognoses. However, to build on these statistical trends to glean a richer understanding of how patients were treated in this period, and to contrast and contextualise this with events elsewhere, the next two chapters draw on archived patient records, committee minutes and staff publications, supplemented by oral history interviews with former Bethlem employees. This is then viewed against a backdrop of wider historical and scientific literature and legal reform.

Although ministering to madness is now seldom considered in wholly biological or psychological terms, twentieth-century advances in treating brain and mind threatened to accentuate epistemological and practical divisions within psychiatry. Through evidence and evangelism, acceptance or obsolescence, new methods staked their claim in an increasingly crowded and dichotomised treatment market. The current discussion will both evaluate physical and pharmaceutical approaches to treating mental illness, whilst the following chapter will look at psychotherapeutic tradition and innovation. In allowing us to explore a greater depth of patient experience, the present chapter will also lay the foundation for the subsequent exploration of 'talking cures'. This arrangement is also apposite, in light of the suggestion that physical methods were pivotal in facilitating a departure from long-stay institutions and the emergence of care in the community.[1] Others, in turn, have viewed drug advances in particular as requisite precursors to the proliferation and popularisation of psychotherapy.[2] G.C. Tooth and Eileen M. Brooke proposed that the success of new physical treatments created therapeutic optimism,

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[1] William Sargant and Eliot Slater, *An Introduction to Physical Methods of Treatment in Psychiatry*, 4th ed. (Edinburgh E. & S. Livingstone 1963), pp.1-2.
[2] Alwyn Lishman, Interview by Author, January 26th 2011.

stimulated demand for mental health services and spurred an initial rise in hospital numbers. However, this trend peaked in 1954; thereafter, the combination of outpatient treatment, earlier and more effective hospital interventions, and active rehabilitation of long-stay patients, heralded a 'small but steady reduction in the resident mental hospital population', despite increased admissions and readmissions.[3] The availability of physical methods may also have served as a status symbol for hospitals; they embodied scientific authenticity, and represented a key facet of remaining in the 'vanguard of mental hospital design'.[4]

This chapter will situate methods, ideology and experiences within a broader historical and social and medical framework, and thereby tackle a number of key questions: First, what factors shaped patterns of uptake and usage of somatic treatments, and under what circumstances were they administered? More specifically, how did policy and/or contemporary education relate to ward-level practice, vis-à-vis ways in which treatments were used and the nature and chronicity of disorders which they were deemed to benefit? Finally, what, more recently, have been the effects of changing clientele and institutional regimes on such trends? In addressing these questions, this chapter will build on patterns of diagnosis and treatment explored in previous chapters and attempt to integrate these with the data on treatment decisions discussed here. This will then be compared to policy and practice at other institutions at the time.

To begin, there will be a summary of the provenance of physical interventions for mental disorders, detailing the circumstances in which key methods emerged and evolved, how they were later absorbed into early twentieth-century psychiatric education, and the impact this had on attitudes and practices in British mental hospitals. The focus will then shift to Bethlem as the case study institution, detailing the hospital's prewar use of key physical treatments, and, where applicable, contrasting this agenda with that of the early Maudsley Hospital. Consideration will then be given to the formative role of wartime experiences in fashioning new ideas and techniques, and ultimately explore changing

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[3] Tooth and Brooke, "Trends in the Mental Hospital Population and Their Effect on Future Planning," p.710.
[4] Jonathan Andrews et al., *The History of Bethlem* (London: Routledge, 1997), p.538.

responses to, and roles of, physical and pharmaceutical approaches in the postwar NHS and, more locally, the Joint Hospital.

Matter over Mind: Pre-existing Narratives

Chapter 5 explored ideas of hereditary and environmental influences on mental disorder, with the current findings suggesting both a gradual departure from single-cause aetiologies, and a reconfiguration of some former 'causes' as discrete diagnoses. This section will explore how such transitions shaped approaches to physical treatment. Mark Micale highlighted the persistence of theoretical and practical schisms within psychiatry, despite the efforts of some practitioners to treat both brain and mind.[5] Since the nineteenth century, moral treatment regimes had indeed prioritised psychic over bodily afflictions; yet, such approaches also endorsed a holistic regime for mental health, in which physical activity played a key role, alongside social and environmental factors. Writing in 1985, Karen Serrett asserted that these moral frameworks were gradually eclipsed by the rise of scientific psychiatry, which attributed mental illness to damaged brain material, with the seemingly necessary conclusion that such conditions were incurable, thus heralding a bleak vision of impending physical and social decline.[6] New interest in psychiatry after the Great War and the introduction of effective convulsive and surgical treatments from the 1930s contributed to ongoing reductionism of brain and behaviour. A key breakthrough had been Julius Wagner-Jauregg's (1917) malarial therapy for neurosyphilis (dementia paralytica) which was awarded the 1928 Nobel Prize for Medicine. Thereafter, according to Max Fink, 'the treatment of patients with one illness by inducing another became a paradigm in developing psychiatric treatments, leading to prolonged sleep therapy (1922), insulin coma (1933), convulsive therapy (1934), and leucotomy (1935).[7] This reiterates how fortuitous, chance discovery, was often the cornerstone of diagnostic and treatment shifts, rather than a linear trajectory of progress.

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[5] Micale, "The Psychiatric Body," pp. 323-324.
[6] Karen Diasio Serrett, *Philosophical and Historical Roots of Occupational Therapy* (New York: Haworth Press, 1985), pp.10-11.
[7] Max Fink, "Convulsive Therapy: A Review of the First 55 Years," *Journal of Affective Disorders* 63, no. 1-3 (2001): p. 2.

Joanna Moncrieff surveyed articles published in *The Journal of Mental Science* between 1930 and 1960, and proposed that 'psychiatric research in the United Kingdom showed a prominent and continuous concern with physical treatments for mental illness, which substantially predated the introduction of modern psychiatric drugs'.[8] Concomitant legal reforms which replaced 'outdated' terminology further improved attitudes towards mental illness.[9] Psychiatric innovation was thus propelled by scientific optimism and a desire for closer allegiance with general medicine, which would benefit the professional and public reputation of the fledgling discipline. However, the use of physical means to treat mental problems was not met with unanimous support. Whilst an undeniably partial witness, Donald Winnicott asserted in 1947 that, in his application of the scientific method, the doctor 'serves the community by being part of a bulwark against superstition'. Additionally, he proposed that a reliance on physical interventions attracted the wrong sort of candidate to psychiatry, and that more detailed research was needed on the psychological effects of convulsive therapy.[10]

Having presented prominent existing narratives, case study investigation can now provide additional context and depth to understanding changing philosophies and practices of physical treatment in psychiatry.

Interwar Bethlem: Apparatus, Ambition, Advertising

In the realm of physical treatments, Bethlem has been regarded as non-controversial; a follower rather than a pioneer, with care and sedation remaining at the heart of the hospital's pre-1930s regime. Therapeutic changes were later made to appease patients and their relatives; a further suggestion of their formative influence as health care 'consumers'. Aside from cosmetic accoutrements and the provision of single rooms, this also entailed a move away from locked wards and coercion; Aubrey Lewis reportedly

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[8] Moncrieff, "An Investigation into the Precedents of Modern Drug Treatment in Psychiatry," p.479.
[9] Burns, *Psychiatry: A Very Short Introduction*, p.46.
[10] D. W. Winnicott, "Physical Therapy of Mental Disorder," *Br Med J* 1, no. 4506 (1947): pp.688-689.

declaring the inclusion of 'quiet rooms' for refractory patients in the new building to be 'an embarrassment'.[11]

Yet, like many of its contemporaries, early twentieth-century Bethlem greeted physical approaches with clear adulation, but knew little of their underlying mechanisms. The hospital subscribed to zeitgeist physical methods, such as electrotherapy, heliotherapy[12] and 'the barely palliative hydrotherapy'[13] and such apparatus was proudly depicted in its marketing materials of this era (figure 19). Existing at the margins of therapy and leisure, hydrotherapy (and the science of 'medical hydrology') reflected interwar efforts to 'assert the importance of the medical specialist able to draw together clinical experience and scientific knowledge to harness the healing properties of water and climate'. The twin effects of spa advertising and the hydrological treatment of neurasthenia and shell-shock,[14] served to popularise and legitimise this approach, thereby making it as a strategic feature for Bethlem's prospectus. The hospital's decision to style this facility as a 'treatment laboratory' also resonates with wider efforts to market itself as a research-led institution, as discussed in chapter 4.

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[11] Andrews et al., *The History of Bethlem*, pp. 688, 691-693.
[12] BRHAM, "Report of the Physician Superintendent for the Year 1931," p.12.
[13] Niall McCrae, "'A Violent Thunderstorm': Cardiazol Treatment in British Mental Hospitals," *History of Psychiatry* 17, no. 1 (2006): p.69.
[14] Jane M. Adams, "Healthy Places and Healthy Regimens: British Spas 1918-50," in *Environment, Health and History*, ed. Virginia Berridge and Martin Gorsky (New York: Palgrave Macmillan, 2012), pp.114, 120-121.
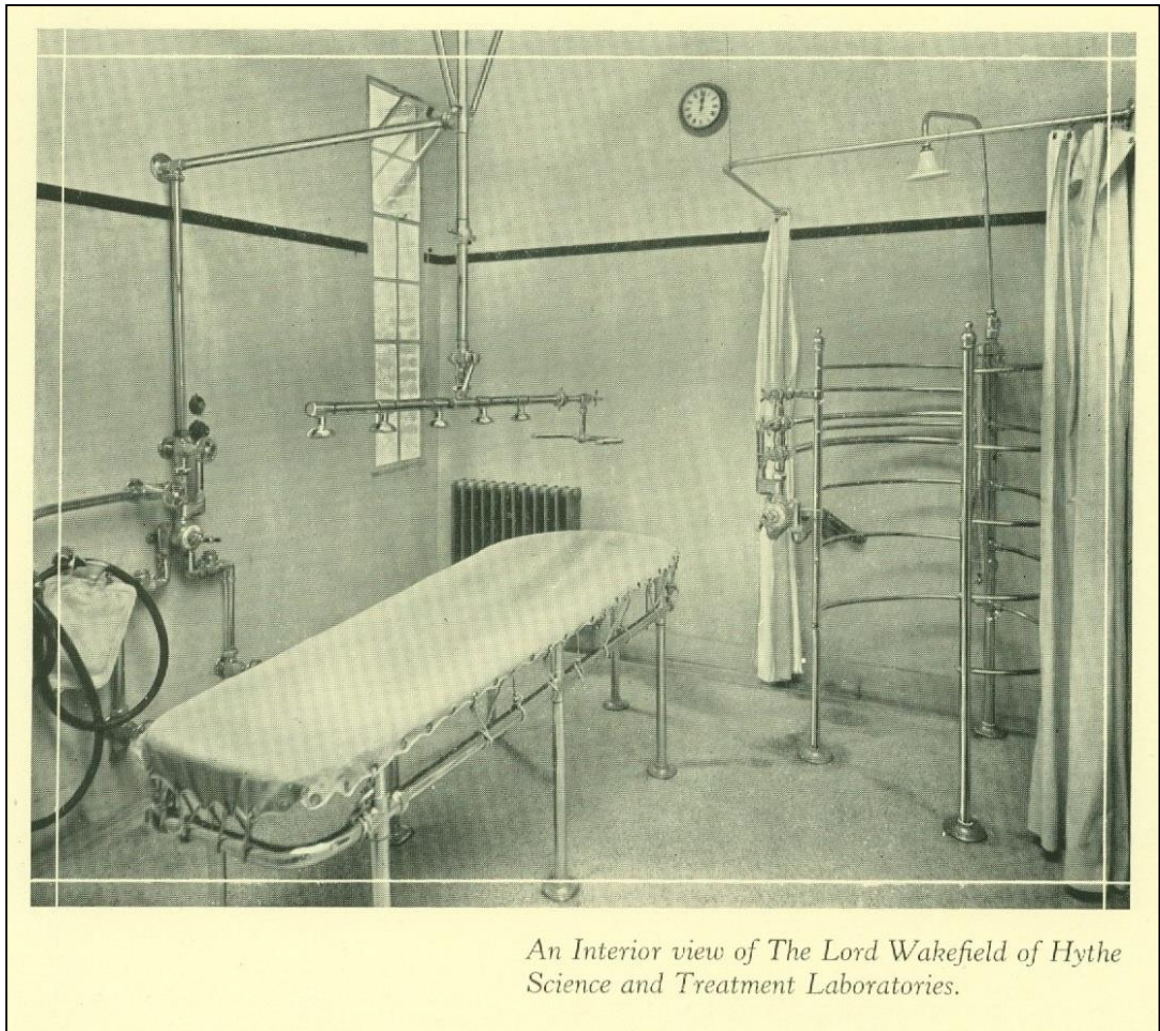
Figure 19: Lord Wakefield of Hythe Science and Treatment Laboratories, Bethlem Royal Hospital, *Souvenir Prospectus*, 1932, pp.8-9. Image credit: The Bethlem Art and History Collections Trust.

A number of patients had undergone assorted somatic interventions prior to their current admission. One such example was GB, a 47 year-old chronic melancholic, who, in her casenotes, was described as having a 'brilliant brain' but 'thoroughly irritable if someone else's brain does not work as quickly as her own'. Despite being of 'sunny disposition', she had suffered with insomnia, depression and indifference to food since the age of 17, and received the Weir Mitchell (Rest) Treatment for three months at another institution, after which 'she was advised to lead an outdoor life, so trained at a dairy'. Although this led to a career as a poultry and dairy farming assistant, GB's depression returned, and she spent a further three months at the Cassel Hospital before being admitted to Bethlem in 1931. On admission, she reported numerous physical complaints, but, there was 'little to find

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objectively'. Preoccupied with her lack of home and inability to have children, she was 'always willing to discuss her worries at great length, especially over what she will do when she leaves'. She subsequently acquired insight into her illness and relationship problems, but remained tearful, and was kept on prolonged bed rest, sleeping poorly. Upon hearing of possible job opportunity, GB became 'rather hypomanic, worries a lot', and was considered 'still rather pessimistic' after five months when transferred to the convalescent unit.[15]

However, Bethlem records also featured the use of insulin and Cardiazol-induced shock (later replaced by the more tolerable Triazol) and a gradual shift to electrical stimulation by 1940.[16] These approaches, and occasional leucotomies, were used to prevent the need to transfer Bethlem's 'presumably curable'[17] patients elsewhere; the (1950s) introduction of effective tranquillisers and anti-psychotics reduced such incidences of 'treatment failure'.[18] The social, scientific and, occasionally, economic rationales behind these methods, together with examples of their use at Bethlem, and, later, the Joint Hospital, will be discussed in later sections.

As the following excerpts suggest, treatment of physical complaints was a regular feature of 1930s patient casenotes, often to the virtual exclusion of any attention to mental diagnosis. Moreover, ambiguity resulted from the fact that the same methods could serve a variety of purposes. Thus, 59 year-old patient GB (introduced in chapter 4) was admitted voluntarily with recurrent melancholia and traumatic injury. His treatment regime included spoon-feeding and continuous baths, but without clear improvement; he remained depressed and self-accusatory to the point of his (self-requested) discharge after 162 days.[19] Yet, revisiting the case of GD, a 40-year old architect admitted following a suicide attempt, we learn that after repeated escape bids, he too was

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[15] BRHAM, "Cwc: Departures and Deaths Patient Casebooks, 1923 -1953," ref. no. 103 (discharged November 1931).
[16] BRHAM, "Report of the Physician Superintendent for the Year 1940," ed. J.G. Porter-Phillips, p.6.
[17] BRHAM, "Bethlem House Committee Minutes, 3rd October 1930."
[18] Felix Post, "Then and Now," *British Journal of Psychiatry* 133, no. 1 (1978): p.84.
[19] BRHAM, "Cwc: Departures and Deaths Patient Casebooks, 1923 -1953," ref. no. 84 (discharged June 1931).

...put on prolonged baths and kept in bed. Still troubled and depressed about his indecisions. Lacks insight into his condition, is suspicious, cannot understand why he is not allowed to go home and is essentially very dissatisfied. Solitary and uncommunicative.

Moreover, GD's casenotes showed a recurring focus on dental problems, and staff invoked causal links between tooth extraction and improvements in mood and behaviour, although a dentist had declared the conditions to be unrelated.[20] This exemplifies the perseverance of older constructions of mental illness, and the privileging of psychiatric opinion over other areas of expertise. A connection between infected teeth and mental disorder was central to the concept of 'focal sepsis', which was pioneered in early twentieth-century Britain by William Hunter[21] and in America by Henry Cotton. The latter reported patients' spontaneous recoveries following tooth extraction, but cautioned that

> Unfortunately, while the progressive men and leaders of the [dental] profession are familiar with dental sepsis, the rank and file are not sufficiently acquainted with the subject, and consequently the physician who attempts to rid his patient of oral sepsis must become acquainted with modern dental pathology and the interpretation of X-ray pictures of the teeth.[22]

Jones and Rahman suggested that the attraction of Cotton's model lay in its ability to disregard hereditary and psychogenic factors in mental illness. It won the support of Frederick Mott at the Maudsley for its potential in treating asylum-acquired infections; a theory supported by Mott's own discovery of a similar pathway for general paralysis of the insane (GPI).[23]

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[20] Ibid., ref. no. 184 (discharged June 1932).

[21] William Hunter, "Chronic Sepsis as a Cause of Mental Disorder," *BMJ* 2, no. 3487 (1927): pp.811-818.

[22] Henry A. Cotton, "The Relation of Chronic Sepsis to the So-Called Functional Mental Disorders," *British Journal of Psychiatry* 69, no. 287 (1923): pp.445-446.

[23] Jones and Rahman, "Framing Mental Illness, 1923-1939," pp.109-110.

Where sedative or other drug treatment was referenced, it was commonly as an afterthought to amelioration of actual or perceived bodily illness. A range of impressive-sounding interventions, including electrical treatment for headaches[24] and skin treatment with ultra-violet rays[25] were offered in response to patients' requests, and reportedly engendered psychological gains through improved self-confidence. Physiological tests could also form a key part of the diagnostic process. The (1931) admission of 48 year-old patient AV posed particular problems: although diagnosed with general paralysis of the insane (GPI), little was known of her family background, besides the fact that one sister had died in an asylum after maltreatment by her husband. Moreover, the patient herself had

> ...a most defective memory for the most recent events – she cannot remember for example how long she has been in the nursing home or perform even simple arithmetic. She believes she saw someone in a green dress crawl up her bed and steal her wedding ring when in the nursing home (whereas she'd given it to her husband the previous day for safekeeping). Disorientated and with no realisation of her mental deterioration. Husband reports that she informed him recently that she could see black people in her room; that she asserts a neighbour of theirs is dead (who is alive) and that another has "crooked legs"...Very difficult to manage – vindictive, irritable and nasty. Weeps frequently, believes husband admitted her so that he could have a rest. Resents nurses' attempts to get her out of bed. Sometimes 'childishly facile', displaying pleasure at the smallest flattery, at other times crying for hours at minor upsets. Neurological, motor and cerebro-spinal fluid tests conducted.[26]

The above evidence therefore implies a greater reliance on physical investigation in cases where an individual's medical history was incomplete, indicative of hereditary insanity, or if patient testimony was otherwise unobtainable.

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[24] BRHAM, "Cwc: Departures and Deaths Patient Casebooks, 1923 -1953," ref. no. 80 (discharged October 1932).
[25] Ibid., ref. no. 181 (discharged May 1932).
[26] Ibid., ref. no. 140 (discharged June 1931).

The discussion will now explore views of some leading physical treatments as expressed in contemporary training manuals, before using casenote evidence to demonstrate the ward-level practice of these methods. This will encompass the various shock treatments, surgical approaches, preliminary psychopharmaceuticals, and miscellaneous or 'combined' methods in use at this time.

Insulin Coma: Attitudes and Practices

Insulin coma treatment was formulated in 1933 by Viennese psychiatrist Manfred Sakel, and, according to Bethlem physician Brian Ackner, was the favoured treatment for schizophrenia in the early twentieth century. Patients were fasted and injected with sufficient insulin to induce hypoglycaemic coma. They were then aroused from this state after about half an hour, and the process repeated five or six times weekly, for a total of around 40 sessions. However, the method was inherently time-consuming, expensive and beset with complications.[27] The hospital was an early adopter of this method, embracing the practice in 1935, four years before its London County Council (LCC) approval for institutional use.[28] Despite apparent conviction that the method's efficacy outweighed the potential overdose risk to patients, the requisite nursing skill, and, later, difficulties in obtaining glucose and insulin, resulted in only a small number of patients actually receiving this treatment.[29] The clinical significance of the coma itself was also a matter of conjecture; critics countered that the accompanying nursing, medical and group support were of more importance, whilst H. Bourne's (1953) *Lancet* article[30] prominently debunked the contemporary belief that deep insulin coma cured schizophrenia. Usage of the method further declined with the introduction of phenothiazine drugs – notably chlorpromazine (Largactil) - but a 'modified' form, using smaller doses of insulin for its

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[27] Brian Ackner, *Handbook for Psychiatric Nurses*, 9th ed. (London: Bailliere, Tindall & Cox, 1964), pp.301-303.
[28] Andrews et al., *The History of Bethlem*, pp.688, 691-693.
[29] Ibid., p.692.
[30] H. Bourne, "The Insulin Myth," *Lancet* 265, no. Dec 12 (1953): p.1259.

sedative and appetite stimulant properties, achieved greater longevity in the treatment of some neurotic disorders.[31]

As part of the current research, an analysis was conducted of 40 Bethlem patients admitted with primary dementia between 1931 and 1947. This diagnosis was chosen because it was a clinical forebear of schizophrenia, suggesting that these patients would have been the likely recipients of insulin, or other physical therapies. In order to test this hypothesis, and to help identify any non-clinical influences on the usage of this method, equal numbers of male and female, and certified and voluntary, patients were sampled. Details were then recorded of any symptoms or treatments mentioned within clinical records, and these findings are tabulated below. Although insulin coma has been regarded as a leading treatment for primary dementia, this reading depicts it rather as just one of a wider range of therapeutic options for this condition. It is also of note, that some patients received more than one type of treatment; others, none.

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[31] Ackner, *Handbook for Psychiatric Nurses*, pp.602-603.

Treatment	Males (n=20)		Females (n=20)		TOTAL
	Vol	Cert	Vol	Cert	
Paraldehyde	1	6	5	8	20
Ammonium Bromide	7	4	4	3	18
Sulphanol	1	5	2	6	14
Medinal	6	1	4	1	12
ECT	1	3	4	2	10
Insulin			1	2	3
Leucotomy/Lobotomy	1	1			2
Cardiazol				1	1

Table 14: *Treatments Received, Sampled Primary Dementia Patients at Bethlem Royal Hospital, 1931-47*.
Source: CWC: Departures and Deaths Patient Casebooks, 1923 -1953.

Results indicated a general reliance on drugs until the 1940s, with paraldehyde, ammonium bromide and sulphanol amongst the most commonly-prescribed substances for these patients. All had sedative and hypnotic properties, had been employed at the hospital since the 1880s, and were considered safe and reliable. Another widely-used drug was sodium barbitone (Medinal), a long-acting barbiturate, which was inexpensive and easy to administer orally or intravenously, but carried a greater risk of accidental overdose.[32]

Insulin therapy was mentioned in three cases between 1938 and 1947, all involving female patients, two of whom were certified, and one who was voluntary. Only in the earliest case was insulin employed as a standalone treatment; by the late 1940s, it was administered in conjunction with ECT. Within the sampled records, no reference was found to ECT until 1941, when a two-month course of shocks was administered to a certified female patient shortly before she was reclassified to voluntary status. This finding could be interpreted as either evidence of the therapeutic efficacy of the method, or, more critically, as a sign that formally detained patients faced increased likelihood of undergoing physical procedures. From 1942 to 1947, 10 of the 14 primary dementia

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[32] Ibid., pp.277-278.

patients discharged had received ECT, usually in tandem with drugs. Of these patients, half were certified (three males, two females) and half were voluntary (one male, four females). However, one of the few patients deemed explicitly 'unsuitable' for ECT was a certified male, whose symptoms included restlessness, delusions, violence, and anorexia. His 'poor heredity' also precluded attempts at psychotherapy, leading to the suggestion of occupation as a last resort.[33] Only two references to psychosurgery were found, both for male patients (one certified, one voluntary) whilst the late 1940s saw the therapeutic application of hormonal extracts to one female patient within the sample. Gender differences observed in treatment allocation for supposedly comparable diagnoses/symptoms correspond with the climacteric findings, as presented in chapter 5.

Further insights can be gained by comparing the experiences and relative fortunes of two patients treated with insulin at Bethlem a decade apart. Within correspondence files of long-stay patients, one finds the case of a 27 year-old electrician, diagnosed with probable schizophrenia or manic depressive disorder, and treated once previously at the Maudsley. In July 1937, the physician superintendent, the patient and his father agreed on insulin treatment, but the patient was deemed 'too excitable' for the injections, and later dismissed as an unsuitable subject for this 'somewhat drastic' course of treatment.[34] However, less caution is applied when a 16 year old male was admitted as a temporary patient in the late 1940s. He was diagnosed as catatonic schizophrenic, but had been ill for only six months and had no previous psychiatric history. Nevertheless, it was quickly decided that he should undergo insulin coma treatment. He initially appeared to make rapid progress, having 'come out of his stuporose condition and is reading, talking and playing draughts' and was later declared 'very considerably improved'. These observations were used to justify continuation of treatment, and the patient had 57 comas within a three month period, by which time no further benefits were envisaged: 'He is no longer in a catatonic stupor but that's all one can say for him....He sits or lies about the place, sometimes lying full length on the table, occasionally answering questions but quite

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[33] BRHAM, "Cwc: Departures and Deaths Patient Casebooks, 1923 -1953," ref. no. 2112 (transferred August 1942).

[34] BRHAM, "Patient Correspondence Files, 1925-1947," ref. no. 762 (discharged October 1940).

beside the point'. It is tempting to surmise that - in this instance at least - a potentially hazardous method was implemented in response to the patient's legal, rather than clinical, status. He was readmitted as a voluntary patient but discharged a month later, with the parting verdict: 'There is no change. He still destroys his spectacles at regular intervals'.[35]

The above evidence offers insights into how two factors - changing ideas of 'risk', and the legal position of the patient - shaped treatment decisions at Bethlem. It may be concluded that clinicians gradually became less risk-adverse in administering insulin comas, but it is, nonetheless, difficult to discount the legal position of patients as a possible factor in determining types and immediacy of treatment given. Moreover, the introduction of a voluntary patient class in the 1930 Mental Treatment Act may, paradoxically, have served to accentuate the existing divide between patients. Thus, individuals not presenting 'informally' were thereafter increasingly prone to be viewed as challenging, and consequently, subjected to faster-acting (i.e. physical) safeguards. Gender divisions in case selection were not immediately apparent. However, women were more likely to be certified in the 1930s; the subsequent reversal of this trend could be viewed as an effect of the 1930 Act, given the escalation of female voluntary admissions for psychoneurosis.

Cardiazol Shock

In 1932, Ladislaus von Meduna of Budapest used autopsy evidence to posit the incompatibility of schizophrenia and epilepsy, and the potential for intravenously inducing fits using a camphor-based preparation. Despite Cardiazol being commonly viewed as a crude stepping-stone towards ECT, Niall McCrae proposed that, during the 1930s, it 'was the most widely used of the major somatic innovations in Britain's public mental hospitals, where its relative simplicity and safety gave it preference over the elaborate and hazardous insulin coma procedure'. [36] Writing in 1937, Alexander Kennedy concurred with the clinical antagonism of the two conditions, reporting that their coexistence was rare,

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[35] BRHAM, "Cwc: Departures and Deaths Patient Casebooks, 1923 -1953," ref. no. 3197 (discharged September 1947).
[36] McCrae, "'A Violent Thunderstorm'," p.68.

and, that in patients with both diagnoses, schizophrenic signs improved after they had experienced a seizure. He concluded that early and catatonic forms made the best recovery, but accepted that previous findings on the matter were ambiguous, due to different ways of describing the syndrome. His three case studies met the optimal clinical criteria, but were also uniformly female, single and in their early twenties, implying that there may have been additional determinants in the allocation of this treatment. [37] Moreover, optimal dosage was a matter of trial and error; spasms were dangerous and unpleasant, and repeated injections risked obliterating veins. Thus, a former nurse at Severalls recalled having to hold down patients to prevent broken bones,[38] and the fear evoked by the treatment was one factor in its withdrawal at Drayton's Hellesdon Hospital.[39]

In his (2010) account of three Danish hospitals, Jesper Vaczy Kragh described the markedly positive effect of Cardiazol on manic depressive patients, which, it was believed, outweighed the unpleasantness and fear associated with this method. However, Kragh proposed that some psychiatrists further exploited patients' fear of Cardiazol as a means of behavioural control.[40] A less awkward but equally effective alternative, branded 'Triazol', was introduced in 1938 by (future Maudsley psychiatrist) Willi Mayer-Gross and Alexander Walk,[41] after trials at Cane Hill Hospital.

Bethlem's *Case Book of Discharges and Deaths* recorded the case of a 27 year-old governess, DM, who was diagnosed with schizophrenia (catatonic stupor) in 1936 and certified. Cardiazol treatment was administered throughout her three year admission, with increasing dosage and number of shocks per session. Early indications were encouraging: 'There has been a very dramatic change since she started convulsive therapy. She spoke for a few minutes after the first; for some time longer after the

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[37] Alexander Kennedy, "Convulsion Therapy in Schizophrenia," *Journal of Mental Science* 83, no. 347 (1937): pp.622-623, 625-628.
[38] Gittins, *Madness in Its Place*, p.196.
[39] Cherry, *Mental Health Care in Modern England*, p.256.
[40] Jesper Vaczy Kragh, "Shock Therapy in Danish Psychiatry," *Medical History* 54, July (2010): p.352.
[41] W. Mayer-Gross and Alexander Walk, "Cyclohexyl-Ethyl-Triazol in the Convulsion Treatment of Schizophrenia," *Lancet* 231, no. 5989 (1938): pp.1324-1325.

third....In spite of sitting with her head in her lap for 2 years she now walks and stands erect', but on other occasions she suffered vomiting and diarrhoea or refused injections. The treatment was reinstated when she again 'verged towards stupor...has been impulsive and destructive. She destroyed a pillow and smashed a picture'. DM later improved sufficiently to be granted leave, but was still 'obstinate, difficult and impulsive' on her return, and received further Cardiazol injections against her wishes, and with no reported benefit other than a reduction in violent behaviour. Upon discharge two months later, she was 'slightly less manic' but 'not improved'.[42] This account supports the idea that 'shock' therapy could be a coercive device for use with challenging, legally detained patients. Similarly, Steven Cherry related the decision to administer 'novel and risky cardiazol therapy' to a schizophrenic patient in Norfolk, noting that 'her voluntary status did not prevent this essentially experimental treatment, but, in conjunction with her contacts with the outside world, limited it'.[43] Mounting evidence from Bethlem also corroborates the idea of a significant voice for (some) patients' families and friends in the shaping hospital treatment regimes.

 A further Bethlem patient to receive Cardiazol was HE, a female student, aged 20, diagnosed with primary dementia, attributed to 'insane heredity'. This was her second attack, with both instances linked to relationship break-ups:

> ...slept with an Indian 6 weeks ago....3 weeks ago became moody and depressed. Thought people were talking about her. Has wept, laughed, and sung. Goes into trances and makes strange movements. Talks rationally at times. At others talks religious rubbish – mixed up with chatter about black men. The family are very keen that she should be cured of her predilection for Indians!

Cardiazol treatment began a week into her admission, and she received a dozen injections over three week period, the final four after an apparent full recovery.

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[42] BRHAM, "Cwc: Departures and Deaths Patient Casebooks, 1923 -1953," ref. no. 1220 (transferred February 1939).
[43] Cherry, *Mental Health Care in Modern England*, p.184.

1/9/38 - She shows little change, often lying in bed happily with various expressions on her face, including serene contentment, wistful innocence, and tearfulness. Sometimes she is occupied with a jigsaw puzzle. At times she is liable to burst into song...It seems unpredictable whether she will answer a question rationally or whether the answer will betray some shallow delusion.

8/9/38 – she exhibits numerous delusions which are fleeting and her concentration is often fatuous and peculiar...She still thinks that she is Christ and in that capacity she could cure people here. 'Jesus wept, so I laugh' she said with a gay smile and then walked away. She is solitary and will sit for a long time with a vacant look on her face, often bursting into song.

19/10/38 – she is quiet and reserved, but otherwise completely normal. She appears happy, sociable and well-occupied.[44]

Even with allowances for cultural relativity of 1930s Britain, the religious and racial prejudices embedded in the above account convey a certain disregard and/or disrespect for the content of HE's speech and behaviour. She was not considered violent, yet, Cardiazol was, in this context, seen as a way of eliminating or suppressing socially inappropriate actions; one key respect in which the decision was thought to be beneficial to the patient's family.

Electroconvulsive Therapy

The inception of electroconvulsive therapy (ECT) was credited to Lucio Bini and Ugo Cerletti in 1930s Rome, and Lothar Kalinowsky proposed that, compared to Cardiazol injections, it offered instant results, less risk of side effects and potential economic gains.[45] However, there was disagreement over the optimum number and frequency of shocks,

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[44] BRHAM, "Cwc: Departures and Deaths Patient Casebooks, 1923 -1953," ref. no. 1586 (discharged November 1938).
[45] Kalinowsky, "Electric-Convulsion Therapy in Schizophrenia," p.1233.

and whether the intrinsic therapeutic element was the convulsion itself, or a procedural effect. Furthermore, the technique was originally intended for use on schizophrenic patients, but soon proved more beneficial in treating depressions, especially those of an endogenous or involutional nature.[46] Accordingly, this method featured prominently in the casenotes of middle-aged patients admitted with 'climacteric' disorders. For many, this was not their first attack of mental illness, their predisposition now supposedly exacerbated by the business or domestic strains characterising the later years of life.

Thus, a 59 year-old female was admitted voluntarily with her third attack of depression in early 1946. Previous episodes were attributed to 'insane heredity', but the latest was supposedly due to the continued strain of nursing her aged mother. She signed the ECT disclaimer form upon arrival at the hospital, and began treatment within a week, receiving 13 shocks over four weeks. She was variously described as 'Brighter and hopeful' and 'cheerful, active' before being discharged 'recovered' after a month.[47] Although treatment was clearly agreed beforehand, little consideration seems to have been given to the individual circumstances precipitating this depression, nor the environment to which the patient was so rapidly returning.

Another female of similar age had been recently discharged from Bethlem after six months, during which she was given ECT. Her family reported that:

> She was perfectly well until three days ago, when the friend with whom she was living died suddenly. She had to see to a lot of the formalities which proved too great a strain on her....she became unable to do anything and started to be unduly worried about things. Thinks everything is in a terrible muddle, especially money affairs and her clothes – the house is dirty etc. The symptoms are very similar to those of the first breakdown, but she is much less agitated.

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[46] Sargant and Slater, *An Introduction to Physical Methods of Treatment in Psychiatry*, pp.64-65.
[47] BRHAM, "Cwc: Departures and Deaths Patient Casebooks, 1923 -1953," ref. no. 2971 (discharged March 1946).

The casenotes once more recount apparent recovery within six weeks after a further course of ECT, and omit any detail of social or psychological support offered or arranged.[48] Patient backgrounds appear not to figure in the above cases. Rather, it seems that the model of illness operating was shaped by the convergence of faith in new technology, and (as discussed in chapter 5) wartime pressures on attitudes and resources for mental illness. Thus, for patients and professionals alike, ECT may have offered an efficient and acceptable mode of treatment, amidst challenging circumstances.

There were indications that ECT was also given to patients with primary dementia or schizophrenia. Moreover, responsiveness to this treatment could further shape diagnostic opinion, such that 'after 17 treatments...she does not speak or occupy herself at all. It is doubtful whether she is only hysterical or schizophrenic'.[49] The highest observed number of convulsions was 48, administered over nine months to a 22 year-old patient BE. Initially admitted on temporary status, her medical certificate declared her to be:

> Dreamy, preoccupied and retarded....virtually inaccessible. She has occasional impulsive outbursts against those attending her, and she is also occasionally faulty in habits. She needs constant care and supervision for her own welfare.

Although BE relapsed several times during her admission, it was maintained that 'with further treatment she always responds'; thus, doctors persevered with the shocks until the patient herself refused to continue. She was eventually discharged "relieved", having 'improved somewhat on her own' after the ECT course had ended.[50]

Even when matched for diagnosis and admission class, sampled female patients were more likely than males to receive ECT, or to have prior experience of this method. Moreover, the less frequent uses of ECT with male patients could often be linked to disciplinary motives. To illustrate, patient MF, a Royal Air Force scientific officer, was 'very

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[48] Ibid., ref. no. 3195 (discharged December 1946).
[49] Ibid., ref. no. 2543 (discharged May 1944).
[50] Ibid., ref. no. 2617 (discharged June 1945).

argumentative and anxious to go home...Has been impulsive and fights. Has had to be in QR [Quiet Room]. ECT started today'.[51] Another male schizophrenic, RD, was identified as a danger to others, and commenced a series of 14 ECT treatments in the early weeks of his 6-month admission.[52] These selected cases may be interpreted as suggestive of a more routine usage of electroshock on female patients, or a higher behavioural threshold for its implementation in males. As a rule, Bethlem casenotes tended to explicitly justify the more isolated uses of ECT on men, but, conversely, to emphasise the occasional withholding of the treatment from women.

Reasons for eschewing, or discontinuing ECT, included previous adverse reactions or lack or improvement following convulsions. The casenotes also provided some indication of the remaining treatment options in instances where ECT had failed or was deemed unsuitable. Thus, after receiving 40 electric shocks, it was declared of patient TB that: 'she is now a chronic schizophrenic; her people are not anxious for a prefrontal leucotomy until insulin has been tried. She may have to go elsewhere for this'.[53] Insulin was also proposed as the next method for patient ME, who appeared 'puzzled, dazed and...quite unable to give an account of himself'. As a former RAF officer, he had received ECT at a military hospital, where, following early improvements, he developed acute cardiac collapse.[54]

The above cases reinforce the notion of female mental disorder as being biologically-rooted and remedied. By contrast, the less frequent use of ECT with male patients appeared more closely linked to control needs, rather than curative aspirations, of hospital staff.

Psychiatric Drugs before the 'Psychopharmaceutical Revolution'

Drug use - whether for sleep promotion, pain relief or social control - was commonplace in mental institutions before the widespread introduction of new, and, arguably, more

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[51] Ibid., ref. no. 2537 (discharged May 1944).
[52] Ibid., ref. no. 2663 (discharged May 1945).
[53] Ibid., ref. no. 2594 (discharged December 1945).
[54] Ibid., ref. no. 2634 (discharged September 1944).

effective psychiatric medication from the 1950s. Indeed, Waddington proposed that, before 1948, all admissions – irrespective of diagnosis, behaviour, or legal status – received sedation, usually by sulphanol or paraldehyde, but he credited the 1950s arrival of drugs such as chlorpromazine with facilitating other developments, including ward unlocking, therapeutic communities and community care. Thus, whereas only 15% of patients in 1952 received drug therapy, this figure had risen to 40% by 1957.[55] Paraldehyde and the hypnotic chloral hydrate featured in 1930s Bethlem casenotes, but were being gradually superseded by short-term barbiturates such as Amytal or Medinal. These methods were all associated with unpleasant, if not dangerous, side-effects, but the barbiturates were comparatively cheaper, easier to administer, and carried less risk or overdose or contraindications.[56] An impression is formed of medication as a low-key feature of the everyday hospital regime, rather than a core focus of treatment. This idea is supported by Joanna Moncrieff's contention that use of the older drugs was prevalent, but 'excited little interest', unlike their replacements, which 'began to be regarded as having specific effects on different mental disorders.'[57]

A casenote follow-up was conducted to explore drug administration in cases of recent melancholia. Objectives were to identify named medicines and tonics, together with the characteristics and behaviours of patients to whom they were prescribed, and furthermore, to consider how the usage of these substances reflected contemporary textbook ideology. Recent melancholia was selected because it implied a mild, or transient, form of disorder, which would, latterly, be treated with psycho-pharmaceuticals. As in the previous analysis of primary dementia treatment, 40 patients with the specified diagnosis were sampled from 1930s-1940s admission registers. Equal numbers of male and female records were consulted, and, whilst this population largely comprised voluntary boarders, the sample also included seven certified patients (2 male, 5 female) and three temporary patients (2 male, 1 female).

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[55] Andrews et al., *The History of Bethlem*, pp.679, 699-700.
[56] Ackner, *Handbook for Psychiatric Nurses*, pp.277-278.
[57] Moncrieff, "An Investigation into the Precedents of Modern Drug Treatment in Psychiatry," pp.475-476.

Treatment	Males (n=20)			Females (n=20)			TOTAL
	Vol	Cert	Temp	Vol	Cert	Temp	
Paraldehyde	9	1	2	4	2	1	19
Ammonium Bromide	7	1	1	5	2		16
Medinal	2	1	1	8	1		13
Miscellaneous Tonics	2		2	2	2		8
Alcohol	4		2	1			7
ECT	4			2	2		8

Table 15: *Treatments Received, Sampled Recent Melancholia Patients at Bethlem Royal Hospital, 1931-47.*
Source: BRHAM, CWC: Departures and Deaths Patient Casebooks, 1923-1953

As indicated in table 15, the most commonly-used medications for the sampled patients in this period again included paraldehyde, ammonium bromide, and Medinal. The prevalence, apparent versatility, and simultaneous prescribing of these older drugs, are in all accordance with Moncrieff's description of their longstanding, but unremarkable, pre-1950s status.[58] Chemical sedation was often supplemented with alcohol (whiskey, brandy) or general tonics, such as Brand's Essence (chicken essence), Roboleine (a bone marrow extract) or Malt's Oil for restorative purposes, whilst Horlicks and Ovaltine also featured regularly on medicine charts.

From 1941, however, ECT was frequently administered instead of, or alongside, other drugs or tonics, and featured in eight of the 12 recent melancholia cases discharged after this date. This group comprised equal numbers of men and women, although the two certified cases were both female. Consequently, whilst one cannot disregard the possibility of age, class, or gender determinants of treatment allocation, the current small-scale survey produced no evidence to support this theory. However, casenote-level evidence revealed greater variation between male and female experiences and circumstances of ECT administration. There was also an unexpectedly high mortality rate amongst these patients, with 13 recorded deaths from the sample of 40, including five

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[58] Moncrieff, *The Myth of the Chemical Cure*, pp.41-42.

suicides; a finding initially somewhat incongruous with the clinical and legal profile of this group.

Psychosurgical Influences and Practice

Prominent within this category, the prefrontal leucotomy procedure was pioneered by Egas Moniz in Lisbon in 1936. The idea was inspired by observation of the diminution of anxiety and concern (later termed 'frontal lobe syndrome') resulting from natural damage to this region of the human brain. Following experiments on apes,[59] Moniz proposed that severing white fibres beneath the cortex in the frontal lobes would reduce tension in psychiatric patients, without detriment to other mental faculties, and was, therefore, felt to offer most benefit in cases of 'worry, fear, tension and depression'.[60] This process achieved its apotheosis in the decades preceding the introduction of tranquillizers and anti-depressant drugs, by which time growing awareness of post-operative personality changes, together with high-profile abuses of the procedure had cast it in increasingly unfavourable light.[61]

Although interwar Bethlem was not a leading proponent of psychosurgery, records indicated that such methods were 'occasionally' used as a means of preventing the need to transfer Bethlem's 'presumably curable' patients elsewhere after a year's admission.[62] However, lacking requisite expertise, procedures usually either took place elsewhere, or, later, a fee was levied for a visiting surgeon. Andrews et al. noted that although Bethlem Governors were reluctant to sanction the use of leucotomy, the first such operation had actually been conducted at the hospital in 1944, some two years before official approval and insurance cover were granted. The patient in question was an 'obsessional and suicidal' female, whose condition had proved unresponsive to other interventions

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[59] There is disagreement over whether Moniz's theories and experiments predated, or were inspired by, John Fulton and Carlyle Jacobsen's paper at the 1935 International Congress of Neurology (London). For a full account, see: G.E. Berrios, "The Origins of Psychosurgery: Shaw, Burckhardt and Moniz," *History of Psychiatry* 8, no. 29 (1997): pp.72-73.
[60] Ackner, *Handbook for Psychiatric Nurses*, pp.304-305.
[61] J.D. Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (Cambridge: Cambridge University Press, 1998), pp.10-15.
[62] BRHAM, "Bethlem House Committee Minutes, 3rd October 1930."

throughout the course of her two-year admission. Her 'dramatic' improvement contributed to another four operations being carried out the following year, all on schizophrenic patients.[63] With the creation of the Joint Hospital, those cases not amenable to a new generation of neuroleptic drugs came under the auspices of the Guy's-Maudsley Neurosurgical Unit, which is discussed later in this chapter.

Miscellaneous and Combined Methods

McCrae described how 1930s practitioners sought to maximise the therapeutic potential of insulin and Cardiazol, by administering the methods simultaneously.[64] Likewise, a number of practices featured in early twentieth-century casenotes are not readily accommodated within standard categories, but, nevertheless, warrant inclusion for what they reveal about the trajectory of psychiatric opinion. In the triennium 1949-1951, 3.5% of all inpatients were treated by 'drug abreaction' (table 16), a technique based on the principle that hypnotic or stimulant medication could aid the free expression of suppressed material; the method could thus be employed in both diagnosis and treatment. William Sargant was a key proponent of this method, and documented its use with Joint Hospital patients. Crucially, rather than confining his research to the uncovering of forgotten memories, Sargant also considered the broader meanings and contexts of 'abreaction'. In so doing, he drew upon animal models and processes of religious conversion, to demonstrate how 'increasing nervous excitement... may be a means of disrupting habits of acquired behaviour and thought resistant to rational argument'.[65] Sargant's work is suggestive of diverse influences on psychiatric treatment models, and of finding inspiration in non-clinical domains (a process which, reciprocally, also served to demonstrate the universality of his claims).

In cases of reactive depression, it was thought that abreaction could 'break up "dynamic stereotypy" of thought and behaviour and help towards the solution of outstanding

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[63] Andrews et al., *The History of Bethlem*, pp.694-695.
[64] McCrae, "'A Violent Thunderstorm'," pp.68-69.
[65] William Sargant, "Some Cultural Group Abreactive Techniques and Their Relation to Modern Treatments," *Proceedings of the Royal Society of Medicine* May; 42(5) (1949): pp.367, 369.

conflicts'.[66] On the other hand, patient histories from Sutton Emergency Hospital

indicated that the technique could also aggravate chronic constitutional hysterics and

severe obsessives, whilst endogenous depressives were generally considered too retarded

to abreact at all.[67] In this sense, the clinical suitability criteria overlapped with those of

psychotherapy more generally, and, for some patients, abreaction could become an entry

point to such services. By 1973, familiarity with abreaction procedures was considered a

necessary skill for an envisaged new generation of Joint Hospital 'nurse-therapists'; a role

intended to ease the pressures resulting from a shortage of psychiatric personnel.[68]

Whilst abreaction proved useful in treating wartime traumas, Ackner reported that its

peacetime usage declined, because 'if there is no circumscribed traumatic event to

abreact, the mere release of anxiety or aggressive feelings by these means is usually of

little value in chronic neurotic patients, and can sometimes be harmful'. Moreover, the

introduction of gaseous inhalations, and, later, intravenous barbiturates, such as

thiopentone (Pentothal) or sodium amylobarbitone (Sodium Amytal), failed to overcome

the basic problem of achieving patient cooperation.[69] Cherry reported that at St. Andrew's

Hospital, narco-analysis and abreaction were amongst 'older approaches' successfully

revisited in the early 1960s, but shortages of time and resources limited usage to fifty

patients a year.[70] 'Continuous narcosis' (also known as 'deep sleep treatment') could last

up to three months, and was often used in conjunction with ECT – 'electronarcosis'[71] - or

tranquillizers, such as somnifane or pentothal. It was practised at Bethlem until the early

fifties[72] and, according to Sargant and Slater, was of particular benefit in manic states

causing physical exhaustion, or when patients were unwilling to be put on more radical

forms of therapy, and was 'a measure which, when other forms of persuasion are

unavailing, will keep the agitated indecisive patient in hospital on a voluntary or non-

[66] Sargant, "Some Cultural Group Abreactive Techniques," p.372.

[67] H. J. Shorvon and William Sargant, "Excitatory Abreaction: With Special Reference to Its Mechanism and the Use of Ether," *British Journal of Psychiatry* 93, no. 393 (1947): pp.709-732.

[68] I. M. Marks, J. Connolly, and R. S. Hallam, "Psychiatric Nurse as Therapist," *BMJ* 3, no. 5872 (1973): p.156.

[69] Ackner, *Handbook for Psychiatric Nurses*, pp.286-287.

[70] Cherry, *Mental Health Care in Modern England*, p.259.

[71] J.J. Geoghegan, "Electronarcosis," *Canadian Medical Association Journal* 60 no. 6 (June) (1949): pp.561-566.

[72] BRHAM, "Triennial Statistical Report, Years 1949-1951," p.42.

statutory basis, and so avoid the blow to family and patient of compulsory detention'.[73] One also finds evidence of cases of insulin coma being combined with electroshock, to similar therapeutic ends.

In a 1952 discussion, Dr Gerald Garmany of Westminster Hospital questioned the need for abreaction in peacetime, and sought to distinguish the practice from religious conversion. Yet, he ultimately believed that, for *healthy* subjects, it represented 'a pleasant indulgence which can remain quite enjoyable if it is not exercised too frequently. For the emotionally disturbed it can be nothing else but a tiresome disability. Damping down the fire beneath a bursting boiler is a good deal safer than taking its top off'.[74]

In some instances, treatment methods clearly arose from comparable theories; elsewhere, from the serendipitous discovery of idiosyncratic interactions or side-effects. One may speculate that these represented a transitional stage in the genesis of new methods, whereby practitioners were simultaneously keen to embrace new technologies, but reluctant to either fully abandon established methods, or to overtly profess the shortcomings of the earlier approaches.

The Early Years of the Maudsley Hospital

As outlined previously, the founding aims of the Maudsley Hospital were the voluntary treatment of early and remediable mental disorders, and the creation of a postgraduate psychiatric training facility. McCrae suggested that the Maudsley Hospital was anomalous amongst its British contemporaries in aspiring to a 'progressive German model of a university-linked psychiatric clinic'.[75] When it returned to its LCC incarnation in 1920, Maudsley doctors drew on recent military experience, in addition to their heterogeneous clinical backgrounds.[76] The combined effects of the Maudsley's admission criteria and ongoing research agenda therefore resulted in a very different caseload to that at

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[73] Sargant and Slater, *An Introduction to Physical Methods of Treatment in Psychiatry*, p.139.
[74] "Discussion on Abreaction," *Proceedings of the Royal Society of Medicine* March; 46(3) (1953): pp.156-157.
[75] McCrae, "'A Violent Thunderstorm'," p.69.
[76] Jones, Rahman, and Woolven, "The Maudsley Hospital: Design and Strategic Direction, 1923-1939," pp.357-359.

Bethlem, and, likewise, disparate influences on treatment protocols. Notable areas of contrast were a greater emphasis on new and emerging expertise, and suitability of methods to short-term or outpatient treatment. However, it has also been proposed that funders' requirements intrinsically shaped the character and agenda of the fledgling hospital. During the 1930s, The Rockefeller Foundation financed neuropsychiatric facilities at the Maudsley, and provided personal funding for émigré German psychiatrists, including William Mayer-Gross, Eric Guttmann and Alfred Meyer,[77] who also expedited the spread of electroshock and insulin treatments to Britain.[78] Such methods appeared incompatible with this country's more cautious medical tradition, but there was growing awareness of the need to embrace effective defences against a rising stream of mental hospital admissions. Maudsley doctors Aubrey Lewis and Eliot Slater were also awarded Rockefeller grants for overseas research during their careers, which further facilitated the transmission of theory and practice. [79]

Wartime Influences

Although the onset of World War II temporarily curtailed record-keeping at Bethlem, the hospital is known to have incurred damage from V-1 rockets, and incurred staff shortages and rationing of both food and medicines.[80] Such privations nonetheless aided the emergence of more pragmatic forms of occupational and industrial therapy, which are discussed later in this section. Between 1939 and 1945, Maudsley employees were evacuated to Mill Hill Hospital and Belmont Hospital, Sutton,[81] and – serendipitously - contrasting approaches evolved between the two sites. At Mill Hill, staff, including Aubrey Lewis, Eric Guttmann and Maxwell Jones, focused their attention on the social and occupational treatment of both military personnel and civilians,[82] yet this was also

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[77] Edgar Jones and Shahina Rahman, "The Maudsley Hospital and the Rockefeller Foundation: The Impact of Philanthropy on Research and Training," *Journal of the History of Medicine and Allied Sciences* 64 (3) (2009): pp.19-20.
[78] Uwe Henrik Peters, "The Emigration of German Psychiatrists to Britain," in *150 Years of British Psychiatry. Volume 2: The Aftermath*, ed. H.L. Freeman and G.E. Berrios (London: The Athlone Press Ltd., 1996), p.567.
[79] Crammer, "Training and Education in British Psychiatry, 1770-1970," p.238.
[80] Andrews et al., *The History of Bethlem*, pp.567-570.
[81] Waddington, "Enemies Within," p.190.
[82] Jones, "War and the Practice of Psychotherapy," p.500.

reportedly one of the first British hospitals to use ECT.[83] Work undertaken at Mill Hill proved the foundation for a number of key ideas and practices, notably the concept of 'effort syndrome', and Maxwell Jones' 'therapeutic community' regime.[84] The psychological aspects of the latter approach will be explored in more detail in the following chapter, but growing acceptance and formalisation of the concept of mental gains from physical activity is germane to the current discussion. Mill Hill also served as a base for the (1943) documentary *Neuro Psychiatry*, a Ministry of Information-backed broadcast, which painted a progressive - and, arguably, unsubstantiated - picture of the efficacy and acceptability of psychiatric care in Britain. According to Edgar Jones, by careful selection of patients and treatments, the film apparently 'demonstrated that a state-funded health service could effectively address the psychological problems of both civilians and service personnel alike'.[85] Wartime concerns and an impending nationalised health service may have accentuated demands for public education on mental health; yet, in other respects, this film has lineage in the earlier twentieth-century marketing efforts of Bethlem and other mental institutions. In the interests of self-promotion, these materials also made bold therapeutic claims, rarely, if ever, featured actual patients, and delivered their messages through the best available contemporary media.

A more extensive range of somatic and surgical treatment was administered at Sutton, under the directorship of William Sargant and Eliot Slater. In a *British Medical Journal* paper of 1942, Sargant advocated the use of physical interventions for mental 'first-aid', in situations which offered limited scope for psychotherapy or environmental adjustment. He thus proposed that prophylactic sedation, continuous sleep treatment, modified insulin, or convulsion therapy, could all serve to 'bolster up the constitution so that unavoidable stresses are better tolerated by the individual'.[86] Wartime experiences at Sutton further underpinned the (1944) first edition of a textbook,[87] in which Sargant and

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[83] Kalinowsky, "Electric-Convulsion Therapy in Schizophrenia," pp.1232-1233.
[84] Jones, "War and the Practice of Psychotherapy," p.500.
[85] Jones, "Neuro Psychiatry 1943," p.30.
[86] William Sargant, "Physical Treatment of Acute War Neuroses," *British Medical Journal* 2, no. 4271 (1942): pp.574-576.
[87] William Walters Sargant and Eliot Slater, *An Introduction to Physical Methods of Treatment in Psychiatry*, 1st ed. (Edinburgh: E. & S. Livingstone, 1944).

Slater condemned the hesitancy and pessimism of conventional psychiatry and again encouraged timely and decisive action to forestall prolonged mental distress.[88] Jones believed that

> The making of *Neuro Psychiatry* stung Sargant into a competitive response. In 1944, he made a fifteen-minute documentary film of treatment at Sutton…Sargant's film was shown to invited audiences for educational purposes, a visual counterpart to his textbook, but unlike *Neuro Psychiatry* it never became part of a government propaganda program.[89]

Although archival records for this site were inaccessible, successive editions of Sargant and Slater's text granted the hospital a philosophical legacy. The discussion will now turn to examine how an apparently dissimilar selection of therapeutic approaches from Mill Hill and Sutton were absorbed into civilian practice after the merger of Bethlem and the Maudsley hospitals.

Postwar Developments

The Triennial Statistical Report 1949-51 provided a summary of 'special treatments' administered at the Joint Hospital in the years immediately following the (1948) merger of the two ostensibly disparate institutions, and gave a glimpse into emerging therapeutic directions. Ten types (forms) are listed, including multiple treatments for some inpatients (table 16).

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[88] William Sargant and Eliot Slater, *An Introduction to Physical Methods of Treatment in Psychiatry*, 5th ed. (Edinburgh: Churchill Livingstone, 1972), p.13.
[89] Jones, "Neuro Psychiatry 1943," pp.26-27.

Special Treatments (including multiple treatments)	Males (1,397)		Females (1,848)		Total (3,245)	
	No.	%	No.	%	No.	%
ECT and Electronarcosis	272	19.4	653	35.3	925	28.5
Special Drug Treatment	235	16.7	256	13.7	491	15.1
Deep Insulin	86	6.1	112	6.2	198	6.1
Modified Insulin	53	3.8	141	7.5	194	5.8
Drug Abreaction	43	3.1	71	3.8	114	3.5
Continuous Narcosis	10	0.7	25	1.4	35	1.1
Leucotomy	4	0.3	30	1.6	34	1.1
Hypnosis	8	0.6	17	0.9	25	0.8
Group Therapy	5	0.4	15	0.8	20	0.6
GPI Treatment (Syphilis)	10	0.7	3	0.2	13	0.4
Total Patient Treatments	726		1,323		2,049	
Total Patients Treated	619	44.3	1,055	57.1	1,674	51.6
Patients Receiving no Special Treatments	778	55.7	793	42.9	1,571	48.4
TOTALS:	1,397	*100*	1,848	*100*	3,245	*100*

Table 16: *Special Treatments, 3,245 Inpatient Discharges*. Source: BRHAM, "Triennial Statistical Report, Years 1949-1951," eds. C.P Blacker and A.T. Gore, p.42.

A Statistical Report covering the period 1949-1951 detailed treatments commonly used at the Joint Hospital. As shown in Table 17, from a total of 2,049 treatments administered in this triennium, the three most frequent were electro-convulsive therapy (925 cases, 28%), 'special drug treatment' (491 cases, 15.1%) and deep insulin (198 cases, 6.1%).[90] However, by the late 1960s, insulin coma and continuous narcosis had been abandoned completely, and there was declining usage of ECT and leucotomy.[91]

Of 3,245 admissions, 48.4% received no special treatments, yet all apparently underwent some form of psychotherapy, which will be explored further in the next chapter. As discussed previously, a consistent female bias was found in numbers of patients admitted to Bethlem and diagnoses of some disorders (e.g. neuroses). Similar disparities were

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[90] BRHAM, "Triennial Statistical Report, Years 1949-1951," pp.42-43.
[91] BRHAM, "Triennial Statistical Report, Years 1967-1969," pp.2, 26.

discovered in the application of special treatments, with more females than males receiving these methods (57.1/44.3%). Gender imbalances were also observed in the use of the convulsant drug Triazol, whilst ECT and its use with sedation, 'electronarcosis', were given to 35.3% of female inpatients from 1949-51, compared to just 19.4% of males.[92] Internal records offered no explicit justification for this discrepancy, although women's greater longevity made them more vulnerable to diagnosis of endogenous or involutional depressions, which were deemed responsive to shock therapies. 'Special drug treatment' was the second most prevalent technique at this time, whilst leucotomy was a matter of medical and moral controversy, and 'sparingly used'. [93]

We will now look more closely at how key somatic approaches evolved across the Joint Hospital in the postwar decades, addressing the clinical, legal and social remit of services, and, where possible, attempting to map developments onto the changing patient profile. The discussion will again utilise archival materials, staff publications, oral histories, and a range of scientific and educational literature.

Putting Patients to Work

Bethlem offered an extensive range of activities within occupational therapy, and this eclectic mix of pursuits – some of which were longstanding features of ward life – was conceptualised and delivered with therapeutic zeal. A holistic ethos, coupled with the global transmission of theory and methods, served as a foundation for early and little-known advances in occupational therapy at Bethlem. Thus, Aubrey Lewis spent a formative period in America, observing Adolf Meyer's 'psychobiological' approach, whereby mental illness resulted from a person's maladaptive interaction with their environment, with the prevention, treatment and aftercare of such disorders achieved through attention to these relationships. In a seminal philosophical paper of 1922, Meyer stressed the centrality of rhythm in human routines and everyday activities:

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[92] BRHAM, "Triennial Statistical Report, Years 1949-1951," p.42.
[93] Ibid.

Our organism must be able to balance even under difficulty. The only way to attain this balance is actual doing, actual practice, a program of wholesome living as the basis of wholesome feeling and thinking and fancy and interests'.[94]

The professional 'occupational therapist' role only emerged in the early twentieth century; previously, such responsibilities fell to matrons and craft instructresses. The first generation of occupational therapists were predominantly female, educated and middle-class, and pioneering developments in the field were largely focussed on correcting the deleterious effects of prolonged hospitalisation. However, concerns over the social propriety of structured occupation sometimes conflicted with these attempts, or limited interventions to the genteel handicrafts. Despite some tradition of engaging patients in work, the Bethlem Governors of the 1920s were unconvinced of the need, or acceptability, of this approach for their clientele.[95]

Patronage of prominent medical men became a vital factor in the growth of the discipline. So it was that Scotland, guided by the vision and expertise of Dr. David Henderson, boasted a series of national 'firsts' in the introduction of occupational therapy.[96] Additionally, personal experiences and social contacts were both instrumental in shaping the actions of therapeutic reformers.

Elizabeth Casson represents a key Bethlem link in the history of occupational therapy.[97] Having sought experience as a clinical assistant at 'one of the best mental hospitals', she was aghast at the 'atmosphere of bored idleness in the day rooms' and the stark contrast between the pomp and creativity of Christmas preparations and the everyday ennui.[98] The biography of her sister-in-law, actress Dame Sybil Thorndike Casson, confirms that this

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[94] Adolf Meyer, "The Philosophy of Occupational Therapy," *Archives of Occupational Therapy* 1 (1922): pp.1-10.

[95] Andrews et al., *The History of Bethlem*, pp.688-690.

[96] Catherine F. Paterson, "A Short History of Occupational Therapy in Psychiatry," in *Occupational Therapy and Mental Health*, ed. Jennifer Creek (London: Churchill Livingstone, 2002), pp.8-10.

[97] For further discussion, see: Jennifer Walke, "All Work and No Clay? The Origins, Development and Role of Occupational Therapy at Bethlem Royal Hospital," (Unpublished MA Thesis: University of Exeter, 2005).

[98] Ann A. Wilcock, *Occupation for Health. Volume 2: A Journey from Prescription to Self Health* (London: College of Occupational Therapists, 2002), p.120.

institution was indeed Bethlem.[99] Casson was one of the first female doctors to graduate from Bristol University in 1919, after which she chose to specialise in psychiatry. Her belief in the social causes of hardship, together with the value of participatory approaches to remediation, reflected both her time working as a housing officer for social reformer Octavia Hill, and her links to the Arts and Crafts Movement.[100] Thus, Casson's background in social welfare, arguably underscored her recognition of therapeutic deficits at interwar Bethlem, and prompted her eventual path into occupational therapy, leading, in 1929, to her founding of Britain's first training school for the specialism, in Bristol.

An occupational therapy service commenced at Bethlem in the 1930s; the presence of which was clearly considered a key attribute in hospital marketing:

> The *Occupational Therapy Department*, which is such a potent factor in the problem of treatment, is under the direction of a capable and experienced Director. In this department, activities are not only carried on in the pleasantly appointed room in a separate unit, but also in the wards, encouraging the creation of a healthy interest and outlet for those patients who may be self-absorbed and suffering from morbid ideas, and the instruction they receive in the arts and crafts, provides work and recreation for their future.[101]

Following Casson's departure, Bethlem's first full-time occupational therapist, Nora Pollard, was appointed in 1932, and the laundry block converted into art and craft workshops. In the image below, these strike a balance between discipline and domesticity; a tidy but welcoming environment, with homely furnishings and a selection of patients' creations prominently displayed. The emphasis once more seems to be on informality and inclusivity for a discerning clientele.

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[99] Elizabeth Sprigge, *Sybil Thorndike Casson* (London: Victor Gollancz Limited, 1971), pp.217-218.
[100] Catherine F. Paterson, *Opportunities Not Prescriptions: The Development of Occupational Therapy in Scotland, 1900-1960* (Aberdeen: Aberdeen History of Medicine Publications, 2010), pp.34-36.
[101] BRHAM, "Bethlem Royal Hospital: Prospectus, 1932," p.13.
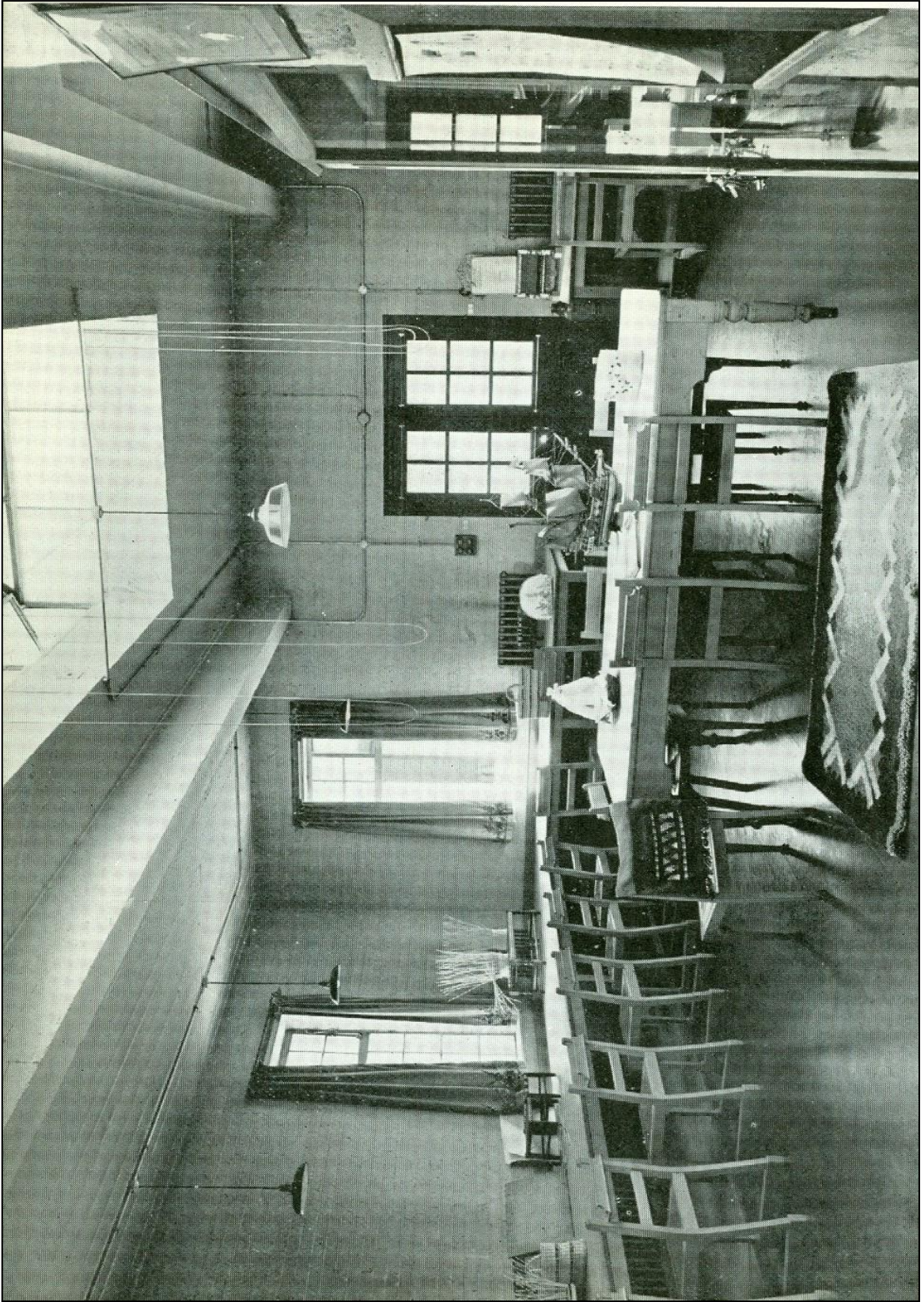
Figure 20: Arts and crafts department, Bethlem Royal Hospital, *Prospectus*, c.1930, p.16. Image credit: The Bethlem Art and History Collections Trust.

Wartime restrictions meant that therapists were obliged to find more realistic activities for their patients in place of the arts and crafts mainstay of earlier decades. Nevertheless, this change fostered an appreciation of how 'treatment' could serve additional economic and social benefits. By 1959, Bethlem was one of 58 hospitals in Britain routinely using what became known as 'industrial therapy'. Contributions from Joint Hospital staff also featured in the first edition of a seminal occupational therapy text,[102] implying that this approach was regularly used with patients of varying ages and diagnoses. The chapter provided case histories and summary guidelines for anxiety neuroses, reactive depression, obsessional neurosis, psychosomatic disorders, and psychopathic personalities, but noted that 'it is important to consider [patients] as persons as well as in terms of their diagnosis', and emphasised the need for collaboration with other hospital staff. For reactive depression, it was advised that

> Treatment consists of removing the cause, where possible...Occupational therapy should aim at diverting the patient from anxieties and assessing individual needs to ensure that the patient is better able to combat future difficulties...Instruction in simple cookery, dressmaking and home-nursing and assistance in make-up and hairdressing would help to increase confidence and self-respect in a woman patient, and for a man with a similar depression, home decorating, handyman's work and gardening, as well as self-valeting, might have a similar effect.[103]

Obsessional neurotic patients were further considered prime candidates for occupational therapy, given their 'neatness, orderliness, high moral standards...frequently high intelligence, coupled with their insight into the pathological nature of their symptoms and their desire to co-operate in the treatment'. Although it was here necessary to avoid situations involving unpredictability and decision-making, the authors believed that 'praise

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[102] E.M. Macdonald and H.M. Davidson, eds., *Occupational Therapy in Rehabilitation: A Handbook for Occupational Therapists, Students and Others Interested in This Aspect of Reablement*, 1st ed. (London: Ballière, Tindall and Cox, 1960), pp.124-143.
[103] Ibid., pp.124, 129-130.

and encouragement sincerely given and opportunities for constructive expression of compulsive drives will assist in the treatment.[104]

In its discussion of occupational therapy for psychopathic personalities, the book challenged prevalent popular and medical opinion on the treatability of such disorders. Whilst alert to the potential risks of 'inadequate' and 'aggressive' individuals, a conditioning approach was advocated,

> ...based upon the principle that if no yardstick of ethics exists whereby a patient can judge whether his behaviour is acceptable to society, certain indications such as the giving or withdrawing of privileges must be provided for him...The therapist, while being friendly, should show that she has a firm grasp on the situation and intends to control it...The patient should be told what is expected of him...and any wilful deviation should be corrected immediately.

There was acknowledgement of patients' common return to antisocial habits after discharge from a disciplined environment; a problem the authors linked to the high volume of court referrals, who attended 'for a period equal to that of a prison sentence, at the end of which they are free to leave'. Instead, it was suggested that, for psychopathic personalities, making freedom contingent on behaviour, could promote sustained improvements.[105]

Writing in the *Bethlem and Maudsley Gazette* in 1968, occupational therapist Miriam Plummer described the importance of 'working with a patient's residual abilities' throughout their admission, rather than seeking to diagnose or treat symptoms. She proposed that the profession required the sharing of scientific knowledge; establishment of effective interpersonal relationships with patients, good group leadership, and

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[104] Ibid., pp.131-133.
[105] Ibid., pp.134-136.

imaginative use of techniques and facilities.[106] Recruitment and resource shortages had
initially hampered implementation of 'a full programme...with a strong emphasis on
realistic rehabilitation and re-socialisation'.[107] However, by 1973, Bethlem's occupational
therapy department employed two senior staff, ten full-time occupational therapists, six
students, and six part-time technical instructors. The latter, provided by Kent Local
Education Authority, taught skills including pottery, cookery, dressmaking, woodwork,
typing, gardening, and grooming.[108]

Yet, as the following excerpts suggest, the concurrent existence of a day hospital offering
commercially-based industrial therapy reignited longstanding debate over recreational
versus vocational objectives, and threatened to limit occupational therapy's remit to
appeasement and diversion:

> Occupational therapy was quite a new development when I was there in '68. They
> had painting, needlework, pottery, social activities, a swimming pool, which was
> revolutionary… And then they had the big dance hall that they used for various
> things. And the sports as well; they had a gym.[109]

> The day hospital was fascinating. …we certainly had 'industrial therapy'; it was sort
> of like occupational therapy but with a commercial connection to it. They had a
> whole range of recipe cards that we had to put into packets. No, no, not just the
> women [laughs].[110]

Another interviewee described, in broader terms, the hospital's commitment to
community engagement:

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[106] M. Plummer, "Creative Aspects of Occupational Therapy," *Bethlem and Maudsley Gazette* Winter (1968): pp.20-21.
[107] Joan Clark and Olwen Owen, "Bethlem Community Centre," *Bethlem and Maudsley Gazette* June (1964): pp.64-65.
[108] BRHAM, "A Report in Connection with the Bethlem Royal Hospital Occupational Therapy Department, December 1973," ed. C.M. Carsley.
[109] Irene Heywood Jones, Interview by Author, 5th August 2010.
[110] Participant 04, Interview by Author, 30th September 2010.

Well, I know that they took care in the community very seriously... in December 1962, we went to a large green area in Bethlem, where, with a special, shiny spade, Mr Johnson [former House Governor, Kenneth Johnson] was asked by the architects and builders, to turn the first sod on the opening of the community centre....There was a shop, swimming pool, theatre, cinema, and so on. And clearly, they took it seriously, and they had a community *centre*. Basically, the same thing happened at the Maudsley, a few years later, but that was different. That brought patients in from the community, and also had sort of outreach services to community facilities. And, there was no doubt that grew, not only to quite large facilities, within both hospitals, but in the minds of the psychiatrists, it was quite a thing, to keep them out of hospital 'proper', with the aid to make regular connections with the hospital. And when they were there, to do things that were more like, you know, living in the community. So yes, I thought there was quite an emphasis on all that side of things.[111]

Although cognisant of the limitations of oral history recollection and interpretation, the above account enhances an emerging picture of Bethlem as a benign presence within its local environment; investing its energies in garnering acceptance and inclusion in an age of particular demonization of the psychiatric establishment. The hospital's development of occupational therapy also speaks to national level themes, through its incorporation of psychotherapeutic influences, and its sometimes contradictory concessions to both class/status (chapter 4) and the socioeconomic imperatives of work/productivity (chapter 5).

Shock Treatments in the Postwar Period

Until the late 1950s, insulin was used more often than ECT amongst sampled patients; thereafter, drug treatments – initially Largactil, later Chlorpromazine - predominated. Only four of 20 schizophrenic patients treated between 1952 and 1976 were offered ECT.

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[111] Leslie Paine, Interview by Author, January 25th 2011.

Rather than reflecting the prevalence of ECT usage, these small samples can provide context for qualitative case note discussion. A closer examination of these cases can also help elucidate the changing criteria for use of electroshock in the postwar decades. Admitted in 1955, JG was '...an unhappy looking girl...Stands and walks slightly stooped. Limbs tense. Shuffles hesitantly. Completely mute. Cooperates when requests repeated...Simple questions occasionally answered by almost imperceptible nod or shake of the head'. Her mother was also regarded as 'very disturbed, schizoid – probably schizophrenic. Very anxious and guilty. No insight into severity of [JG's] illness and makes possible plans for [her] future'. The patient had previously received 40 insulin comas without improvement, and deteriorated whilst on reserpine. Following ECT she was again worse – 'screaming, drooling and incontinent' but later became more quiet and docile with Largactil.[112]

A second case, EB, was admitted from the Maudsley Outpatients' Depatment, because of suicidal ruminations and depression. Like the previous patient, she had a family history of mental illness, and several of her relatives had also committed suicide. Although she had been given ECT shortly before her admission, Bethlem did not continue the course, but proceeded to observe little benefit from Chlorpromazine or weekly psychotherapy. Upon learning that the ward was closing, EB grew more disturbed, acting on her auditory hallucinations, attacking three nurses and attempting self-strangulation. During this period she received increasingly high doses of phenothiazines, before being transferred to Runwell Hospital. At this point, it was noted that 'the longer the patient has been in this hospital, the more the diagnosis of schizophrenia has been confirmed and she appears to be a long term inpatient psychiatric problem'.[113]

Patient HH, was a 32 year-old military office clerk, admitted with depression and anxiety, linked to fear of being considered homosexual. Some of his problems quickly abated, but he remained suspicious of people and, though offered ECT, he refused, asserting he was

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[112] BRHAM, "Bcs: Bethlem Case Summaries, 1952-1983," case no. D5478 (discharged January 1957).
[113] Ibid., case no. 687002 (discharged February 1970).

much better and could manage at home.[114] Finally, patient SJ had a long history of anxiety, depression and schizophrenia. She had relapsed after losing her job, and was experiencing depression, breathlessness, and severe agitation. She received a course of eight ECT treatments, but quickly relapsed when this was stopped, so was given 11 shocks at weekly intervals. Once again she became less depressed, and this time the improvement was maintained after cessation of ECT. However, the ECT was accompanied by a social rehabilitative effort, in which SJ was encouraged to gradually take longer walks on her own, to spend longer periods at home, and to attend occupational therapy independently, prior to her discharge to a local day hospital.[115]

Whilst cognisant that current findings may be an artefact of materials sampled, the above examples suggest that, from the 1950s, ECT was employed more sparingly, and as part of a broader regime (rather than, as 1940s casenotes implied, a therapeutic lynchpin). The approach had also begun to focus more specifically on acute depressive signs, rather than being less discriminately given to all patients with a schizophrenic or primary dementia diagnosis. Notably, one discharge summary also referred to use of the 'Total Push' programme, an early example of an integrated approach to psychiatric treatment for schizophrenia.[116]

Shifting public and scientific opinion towards shock therapies was reflected in contemporary practice at the Joint Hospital. Medical Committee minutes from 1950 reported the reallocation of beds to provide neurosis and senile units, but maintained that Bethlem's insulin unit should remain.[117] Bethlem formally abandoned the use of insulin coma in 1958, whilst the administration of modified insulin and continuous narcosis had 'almost ceased'. However, Brian Ackner, a Bethlem physician and author of a *Handbook for Psychiatric Nurses*[118] was instrumental in discrediting insulin treatment, which, in turn,

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[114] Ibid., case no. K7163 (discharged December 1958).
[115] Ibid., case no. G1240 (discharged September 1970).
[116] A. Myerson, "Theory and Principles of the "Total Push" Method in the Treatment of Chronic Schizophrenia," *The American Journal of Psychiatry* Vol 95, (1939): pp.1197-1204.
[117] BRHAM, "Mcc-01: Medical Committee Documents and Minutes, 1950," p.9.
[118] Ackner, *Handbook for Psychiatric Nurses*, p.293.

had implications for treatment and institutional design alike. Ackner instead favoured the use of ECT, and, in 1960, concluded that endogenous depressions benefited most from the technique, but that enduring depersonalisation symptoms were linked to longer hospital stays.[119] A retired Joint Hospital neuropsychiatrist witnessed the gradual demise of insulin coma therapy:

> That was hard to describe, the impact that had, because every mental hospital in England had insulin coma units, whole buildings devoted to it.... they were actively practising it when I first got there, in 1960; I think it had stopped by 1962 or 3...it was finished, but it was still used for the odd patient. But all over England, it took a while to die out; it was just a placebo effect.[120]

Bethlem's aforementioned Triennial Statistical Report was the first to show a downturn in cases receiving ECT.[121] Whilst the proliferation of pharmaceutical alternatives will be discussed later, use of ECT continued to evoke public outcry. In an attempt to allay some of the fears and misunderstanding surrounding psychiatric treatment, William Sargant acted as a consultant to the BBC documentary series 'The Hurt Mind' (1957). He explained and endorsed scientific advances in physical interventions, including ECT, leucotomy and drugs, whilst other episodes dealt with aspects of aetiology, psychological treatment and mental institutions. Recounting the experience in a subsequent *British Medical Journal* article, Sargant emphasised his sense of 'public responsibility', and his awareness of the 'tremendous power of television for good or evil in matters of medicine'.[122] He also cited statistics from the BBC-commissioned report[123] of audience responses, as evidence of the broadcast's role in augmenting public confidence in, and acceptance of, physical interventions. No corresponding effect was observed in respect of psychotherapy, which, Sargant felt, already enjoyed greater public favour as a result of film and radio

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[119] Brian Ackner and Q.A.F. Grant, "The Prognostic Significance of Depersonalization in Depressive Illnesses Treated with Electroconvulsive Therapy," *J. Neurol. Neurosurg. Psychiat.* 23 (1960): p.245.
[120] Alwyn Lishman, Interview by Author, January 26th 2011.
[121] BRHAM, "Triennial Statistical Report, Years 1958-1960," p.17.
[122] William Sargant, ""The Hurt Mind" " *British Medical Journal* 1 no. 5069 March 1 (1958): p.517.
[123] W.A. Belson, "The Hurt Mind: An Enquiry into Some of the Effects of Five Television Broadcasts About Mental Illness and Its Treatment," in *BBC Audience Research Report* (London BBC, 1957).

coverage.[124] Staff from the Maudsley Social Psychiatry Research Unit later conducted a content-analysis of 1,267 letters the BBC received from "Hurt Mind" viewers. In sum, 1,842 topics were identified, and grouped under broader headings. Thus, 554 letters concerned 'requests for advice about treatment', 526 'requests for further information', and 21 related to 'unorthodox methods of treatment'.[125] Whilst clearly indicative of popular interest in mental health, this was not necessarily a new phenomenon, but rather one which was belatedly achieving official acknowledgement.

However, prejudice and misinformation persisted, despite mainstream media and legal attempts to improve attitudes and dispel fears surrounding mental illness. An interviewee who had previously overseen ECT at the Joint Hospital recalled the professional ignorance and public opposition to the practice:

> None of us know how it worked; we still don't know. And it became a big worry to me, because sometimes, when you came into work in the morning, there'd be 50 people with placards, shouting 'he gives electric shocks to the brain!' And you had to walk through this chanting crowd to get into the hospital, and it's awful when the lay public gets a bit in their teeth like that. I think the public were good-hearted enough, but they were so vocal about it.[126]

Whilst such images threatened to incite public fear and hostility and towards psychiatry, nurses and clinicians also spoke of the profound impact ECT could have on hitherto intractable mental illness:

> I do think that there was a place for it, certainly, because I think that people do go into, such, you know, such, catatonia really, that you can't reach them, seemingly

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[124] Sargant, ""The Hurt Mind" ": p.517.

[125] G.M. Carstairs and J.K. Wing, "Attitudes of the General Public to Mental Illness," *British Medical Journal* 2, no. 5096 Sept 6 (1958): pp.594-595.

[126] Alwyn Lishman, Interview by Author, January 26th 2011.

you can't reach them. So, I think it helps, and I think it speeds up their recovery back into the world, really.[127]

ECT is a blunt treatment and can cause memory disturbance, there's something humiliating and *nasty* about giving patients shocks. But it could save lives, there's no doubt it could bring people out of profound depression fairly quickly, and it might be worthwhile taking the side-effects.[128]

Moreover, the realisation that this was their only means of relief, could lead to desperate bargaining with senior staff:

For some patients, it was the only thing that got them well. I had patients who followed me around – I remember one lady ...when she got these sudden depressions, nothing would get her well but that. And in the end, she begged me to take her into the Maudsley, and I took her with me, and for *years* I kept her going, in a way that nothing else could. Her life would have been ruined without ECT.[129]

Although opinion was divided as to gender differences in the efficacy of ECT, women were more commonly diagnosed with the conditions this method targeted, and oral history evidence confirms an almost uniquely female clientele.[130]

The localised protests described above were reflective of a wider hostility to shock treatments; sentiments which had diverse roots and manifestations. Eliot Slater reflected that opposition to ECT was

...ideologically-directed in the main; that is to say, it is by people who believe that psychic illness is the product of psychic causes, so that to intervene along a

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[127] Irene Heywood Jones, Interview by Author, 5th August 2010.
[128] Griffith Edwards, Interview by Author, 7th December 2010.
[129] Alwyn Lishman, Interview by Author, January 26th 2011.
[130] Irene Heywood Jones, Interview by Author, 5th August 2010.

physical line is a form of assault, and they are not going to believe it does any good.[131]

This 'ideology' was underpinned by multifaceted religious, academic, and professional opinions, and indeed represented a key impediment to wider acceptance of ECT. However, Fink suggested, such antagonism was also a product of earlier abuses and misuses of the technique, and ongoing variation in service provision and availability. Thus, although mid twentieth-century improvements in practice included the introduction of muscle relaxants, anaesthesia and oxygenation, these 'were not accepted as routine measures in developed countries until the mid-1950s, after 20 years of unmodified ECT'.[132] Although increasingly limited in the data it recorded, Bethlem's ECT treatment register for this period attested to the fact that preparatory muscle relaxants and anaesthesia (in the form of thiopentone, a short-acting barbiturate) were not commonly administered at the hospital before late 1949.[133]

In 1977, the Royal College of Psychiatrists published a *Memorandum on the Use of Electroconvulsive Therapy*, reviewing its clinical value, and advising on standards of administration and medico-legal issues. The College had reportedly been 'disturbed by poorly informed public comments on the effect and effectiveness of ECT, and in particular by the possible consequences of the action of certain pressure groups who have been campaigning against the use of ECT'. They also acknowledged professional disagreement about the optimal technique of administering the method.[134] Amongst their ten-point summary, the authors concluded:

> There is substantial and incontrovertible evidence that the ECT procedure is an effective treatment in severe depressive illness.

[131] Brian Barraclough, "Interview with Eliot Slater," in *Talking About Psychiatry*, ed. Greg Wilkinson (London: Gaskell, 1993), p.7.

[132] Max Fink, "Convulsive Therapy," in *A Century of Psychiatry*, ed. Hugh Freeman (London: Mosby, 2001), pp.229-232.

[133] BRHAM, "E.C.T. Treatment Register, 1949-1951."

[134] The Royal College of Psychiatrists, "Memorandum on the Use of Electroconvulsive Therapy " *British Journal of Psychiatry* 131, no. 3 (1977): pp.261-262, 264-265.

ECT is at least as effective as the most effective antidepressant medications, and exerts its effects more rapidly.

The main criteria for preferring ECT to other types of antidepressant therapy should not be the type of depression but severity of depression and the necessity for an immediate response.[135]

The College's subsequent survey report of 1981 painted a damning picture of deficits in ECT staffing, machinery, and the treatment environment, concluding that

If ECT is ever legislated against or falls into disuse it will not be because it is an ineffective or dangerous treatment; it will be because psychiatrists have failed to supervise and monitor its use adequately. It is not ECT which has brought psychiatry into disrepute. Psychiatry has done just that for ECT.[136]

The current findings, whilst only cameos of ECT administration at Bethlem, suggest that its increasing usage from the 1940s was at least in part attributable to patient demand, for whom it may have offered an efficient, economic and acceptable solution to mental distress.

Psychopharmacy

According to David Healy, 'the seeming discontinuity between the pre-1950s and the present regarding the availability of "antidepressants" is more apparent than real'.[137] He proposed that barbiturates and bromides had been in use since the 1860s, accounted for 40% of prescriptions by the 1930s, and, when used in hospital sedation, grounded the development of sleep therapy (narcosis). During the 1940s and '50s, it was observed that a barbiturate infusion (briefly) roused immobile patients, which, though creating

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[135] Ibid., p.266.
[136] Editorial, "E.C.T. In Britain: A Shameful State of Affairs," *Lancet* 318, no. 8257 (1981): p.1208.
[137] Healy, *The Creation of Psychopharmacology* p.63.

therapeutic optimism, also promoted longer-term tolerance and chronicity; problems subsequently addressed with ECT. Moreover, Healy reported that, before 1962, a range of tonics were administered, to increase appetite, and to promote sleep and convalescence. Some of these substances had antidepressant side-effects, and one, St. John's Wort, later became a leading complementary medicine. Likewise, stimulants – notably amphetamines - were accidentally discovered to be beneficial in the management of childhood hyperactivity, which, in turn, shaped theories of brain dysfunction and nosology. However, after 1962, regulatory changes curtailed advertising of non-specific, multipurpose tonics, instead creating a market for designated antidepressants, even though such Selective Serotonin Reuptake Inhibitors (SSRIs) had not been clinically tested on hospitalized patients.[138]

Institutional evidence supported the theory of early and quotidian psychiatric prescribing; in contrast, the use of physical procedures and hormones was explicitly recorded.[139] Well-documented successes of antibiotics like Penicillin offered hope for comparable advances in psychopharmacy.[140] Medications such as the antipsychotic chlorpromazine, tricyclic antidepressants, and the mood-stabiliser, Lithium provided a cost-effective means of alleviating suffering without lengthy hospitalisation or permanent surgery, and were marketed as having fewer contraindications than their predecessors.[141] However, these substances were not without their respective ethical concerns and unforeseen (especially neurological) side-effects. This prompted Phil Fennell to assert that

> The age of experimentation did not end with the dawning of psychopharmacy. As with psychosurgery, ECT and the physical treatments, the new drugs were pioneered on human subjects, many of them manifestly incapable of valid consent, and others clearly refusing.[142]

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[138] Ibid., pp.62-63, 66-67, 74.
[139] Moncrieff, "An Investigation into the Precedents of Modern Drug Treatment in Psychiatry," pp.481-482.
[140] Porter, *Madness: A Brief History*, pp.205-206.
[141] Burns, *Psychiatry: A Very Short Introduction*, pp.53-54.
[142] Fennell, *Treatment without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People since 1845* pp.157, 163.

Moreover, the escalating involvement of drug companies in shaping conceptions of mental disorder has attracted particular concern,[143] whilst Andrew Scull prominently criticised the efficacy, ethics, and professional acceptance of increased prescribing.[144] This was evident throughout the late 1950s, both in rising levels of prescribing to inpatients, and, significantly, the approximate 40% of outpatients who were already taking medication at their first hospital attendance.[145] Archival records suggested that caution was exerted in the prescription of drugs, but such controls were imposed on both financial and clinical grounds. Thus, in the late 1950s, the Joint Hospital's Medical Committee discussed ways of reducing drug expenditure. Chiefly, they recommended: 'tablet drugs to be prescribed where cheaper than capsules; use of non-proprietary equivalents for proprietary preparations and one brand only when a drug is manufactured under different names all selling at the same price'. A further memorandum by Dr W. Linford Rees, entitled 'Economy in Prescribing', declared that the newest tranquillising drugs were very expensive, of unknown efficacy and inclined to be prescribed by junior staff, often at the Emergency Clinic. Henceforth, it was stipulated that certain drugs could only be given on the authority of a consultant, and pharmacists were to submit twice-yearly statements on trends in expenditure and information regarding the cost of new preparations.[146] This evidence affords new insights into key determinants in clinical decision-making, and the routes through which drug company marketing directly infiltrated the hospital.

Restraint was less evident elsewhere. Interviewees described an upsurge in 'pill doctoring' amongst external psychiatrists, and the ensuing therapeutic complications this caused. Nurses also recalled particular branded drugs, including antipsychotics Largactil and Mellaril, antidepressant Tofranil (imipramine), the benzodiazepine tranquillizer Librium, and injections of Modecate (fluphenazine), a long-term antipsychotic. These substances were widely promoted within the hospital's *Gazette*, as illustrated below:

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[143] Moncrieff, *The Myth of the Chemical Cure*.
[144] Scull, *Decarceration*, pp.88-89.
[145] BRHAM, "Triennial Statistical Report, Years 1958-1960," p.5.
[146] BRHAM, "Mcc: Medical Committee Documents and Minutes, 1955-1957," GPM.89, MCD.13/58.

In the acute stage of schizophrenia, Melleril enables communication to be established with the patient.

Melleril ensures an emotionally adjusted, co-operative patient within the hospital — one who can benefit from rehabilitation programmes and who can be discharged on a maintenance dose for continued control. With Melleril the patient can adapt to his environment in the hospital, in the home and at work.

Melleril controls without excitation or undue sedation.

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helps the schizophrenic to find his identity and to come to terms with his environment

Available as tablets of 10, 25, 50 and 100 mg. Thioridazine Hydrochloride B.P., and as a syrup containing 25 mg. thioridazine in 5 ml.
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A name to conjure with.

'Largactil' has been a name to conjure with in psychiatric medicine for over sixteen years.
An influence of such magnitude and long duration can be explained by examining this legendary name.

'Largactil' was so named because of its LARGe variety of ACTIons; apart from being the first major tranquillizer, it acts in two other pharmacologically distinct ways – as a potentiator of central nervous depressants, including analgesics, narcotics and sedatives, and as an anti-emetic.

'Largactil' has achieved success in the fields of psychiatry, general medicine and anaesthetics in an ever-widening range of indications. These include major and minor psychoses; as an adjuvant to E.C.T.; drug withdrawal; senile dementia; the control of terminal pain and nausea and vomiting.

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'Largactil' is a trade mark of May & Baker Ltd for its preparations of chlorpromazine.

MA 8137

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Figure 21: Drug advertisements, *Bethlem and Maudsley Hospital Gazette*, 1970-1971. Image credit: The Bethlem Art and History Collections Trust.

The Largactil advert initially sought to establish a brand heritage, before outlining the drug's supposedly targeted scientific actions, yet (paradoxical) therapeutic versatility. A Melleril promotion of the same era took a somewhat different approach, its imagery and references to 'finding his identity' and 'enabling communication' more resonant of psychotherapeutic language.[147] Yet, the rhetoric of the 'co-operative patient' and 'continued control' promised solutions to the more practical concerns of ward management, and the timely resettlement of patients. Interestingly, when remembering the new medications, nurses often focused simply on their side-effects - or lack thereof - rather than any specific therapeutic gains:

> Certainly for depressive illness, anxiety, drugs were quite widely-used, yeah, I'm quite sure; major tranquillisers and antidepressants. And I know monoamine oxidise inhibitors....you had to be very careful with the diet....we were very conscious of that, and 'cos the major tranquillisers had side-effects, to give them Disipal to stop the neck rigidity and the Parkinsonian symptoms.[148]

Other respondents saw not only the characteristic clinical effects of the new preparations, but their role in promoting optimism and facilitating regime change within psychiatry:

> There had always been drug treatments, but they were crude in the extreme; people were sedated with bromides and walked about with drooping eyes. And, of course, the anti-convulsants had come in long before, for people with epilepsy. But what was new, were drugs which, quite demonstrably, alleviated mood and calmed agitation.... In other words, much more suitable drugs were the thing that caused the psychotherapeutics to follow the pharmacological revolution in psychiatry.... psychiatrists were desperate to get something really that helped.[149]

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[147] Allan Beveridge, "R. D. Laing Revisited," *Psychiatric Bulletin* 22, no. 7 (1998): p.452.
[148] Participant 03, Interview by Author, 9th September 2010.
[149] Alwyn Lishman, Interview by Author, January 26th 2011.

During the seventies, the beta-blocker Propranolol was used in conjunction with night sedation, whilst Valium usage rose dramatically. One interviewee noted the readiness with which this anti-anxiety medication was dispensed; a somewhat carefree attitude, and seemingly at odds with the Joint Hospital's earlier drug control policy:

> I can remember something that they were trialling, this Valium, people when they got panic attacks, they would have a Valium, they would have "right, you're allowed 5mg of Valium" and so they were, this idea of we'll make you feel calmer and then you'll be able to move on. So some people were popping the Valium quite commonly, and you wondered how they got over it.[150]

In 1967, Maudsley pharmacologist, Malcolm Lader, proposed that his profession's contributions had, hitherto, been less extensive in psychiatry than in general medicine, due to the recent arrival of prototypal psychotropic drugs (he cited chlorpromazine and imipramine), uncertainty over their effects, and a lack of effective, objective measurement criteria. Lader believed this situation would be improved through sustained clinical trials and collaboration between pharmacists and psychiatrists, few of whom had received training in both fields.[151] While the dual forces of medical science and new professional interests would indeed frame diagnostic and treatment approaches, the results would perhaps not be as harmonious as Lader anticipated.

Neuropsychiatry and Neurosurgery

The Maudsley had a particular bias towards 'interesting' cases for (neurosurgical) research, at the Institute of Psychiatry, and, from 1950, at the collaborative Guy's-Maudsley Neurosurgical Unit. Archival records suggest that this new facility quickly absorbed a significant proportion of Joint Hospital energies and fiscal resources: Greater outlay on x-ray plates, requests for a 'Schonander film changer' (£1,850) and 'a new device for classifying the different elements in the waves of electrical activity in the brain'

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[150] Irene Heywood Jones, Interview by Author, 5th August 2010.
[151] Malcolm H. Lader, "Clinical Pharmacology and Psychiatry," *Proceedings of the Royal Society of Medicine* 60, no. August (1967): pp.827, 830.

were amongst items approved by the Finance and General Purposes Committee in the mid fifties.[152] Interest and investment in this area belatedly led to the appointment of a neurologist, Alwyn Lishman, whose remit spanned any 'puzzling' cases at either Bethlem or Maudsley.[153] Professor Lishman also took the first British chair in neuropsychiatry at the Maudsley in the late 1970s, and published the standard textbook *Organic Psychiatry* (now in its 4th edition). His work made significant contributions in such fields as dementia,[154] alcoholic brain damage,[155] and the broader application of neuroimaging technology to understanding brain structure and function.[156]

There was also enhanced genetic and neuroscientific insight, with traditional post-mortem and neurophysiological approaches assisted by a range of new brain imaging techniques. Methods such as computerised axial tomography (CAT), magnetic resonance imaging (MRI) and positron-electron tomographic (PET) had a particular impact on treatment and prognosis for conditions including epilepsy, schizophrenia and psychogeriatric disorders.

In 1960, I. Pierce James published an article on 'Temporal Lobectomy for Psychomotor Epilepsy'. The paper followed up 72 Guy's-Maudsley Neurosurgical patients who had undergone this operation between one and six years previously. He outlined long-term social and personal benefits to be gleaned from the surgery, but also emphasised the need for sustained and coordinated aftercare to maximise improvements.[157] For one interviewee, employing neuroimaging in diagnosis held both clinical and attitudinal benefits for mental illness:

> Until people had shown that there were definite abnormalities on brain imaging in schizophrenia, you almost had a whole range...people thought in mystical terms

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[152] BRHAM, "Finance and General Purposes Committee, Presented Documents, 1954-60," (1960).
[153] Alwyn Lishman, Interview by Author, January 26th 2011.
[154] W. A. Lishman, "The Evolution of Research into the Dementias," *Dementia* 2, no. 4 (1991): pp.177-185.
[155] W. A. Lishman, "Alcohol and the Brain," *British Journal of Psychiatry* 156, no. 5 (1990): pp.635-644.
[156] W. Alwyn Lishman, "The Apparatus of Mind: Brain Structure and Function in Mental Disorder," *Psychosomatics* 24, no. 8 (1983): pp.699-720.
[157] I. Pierce James, "Temporal Lobectomy for Psychomotor Epilepsy," *Journal of Mental Science* 106, no. 443 (1960): pp.543-544.

about schizophrenia, they thought it was allied to being a saint, or something (which of course they often thought they were!) And people had all sorts of *wild* conceptions of schizophrenia, whereas now, we are pretty certain, that it is one of the most complex, and hard to unravel, brain diseases of all. That's a very new approach, and of course all of that evidence came *after* we'd found drugs that helped it. So we knew it should have been there, but with brain imaging, we can show it.[158]

Better long-term prognosis for schizophrenia could thus be attributed to earlier identification, improved treatment, and – last, but by no means least – some diminution of the stigma and misunderstanding associated with the disorder, due to its location as an 'organic' entity. Brain imaging techniques ultimately helped to formulate a theory of alcoholic dementia and to differentiate this from Alzheimer's disease; a crucial distinction, given the ambiguous symptoms but opposing prospects of the two conditions.[159]

Discussion

The foregoing discussion has argued that there were often ambiguous motives to a long tradition of somatic interventions at Bethlem. Current findings indicated that, during the 1930s and 1940s, Bethlem's flirtations with zeitgeist methods were more closely allied with image concerns than therapeutic efficacy; a trend later accentuated by wartime needs for fast-acting treatment and a desired alignment of psychiatric and general medical services. This lends weight to notions of health consumerism and an institutional marketplace (as examined in chapter 4) but fits equally with a wartime drive for efficiency and productivity, outlined in chapter 5. Consumerism thus becomes a prism through which to regard wider processes of social change, and though not embodying a *de facto* origin of physical therapies for mental illness, was a key factor underpinning their mid twentieth-century rise to prominence.

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[158] Alwyn Lishman, Interview by Author, January 26th 2011.
[159] W. A. Lishman, "Alcoholic Dementia: A Hypothesis," *Lancet* 327, no. 8491 (1986): pp.1184-1185.

Small-scale analysis of primary dementia and melancholia patients was inconclusive on links between gender or legal status and the likelihood of receiving physical interventions. However, on separate occasions, casenote evidence alluded to their use as a punitive device, or administered prior to reclassifying a patient to voluntary status, or, in the case of psychosurgery, used as an eleventh-hour measure to forestall the need to discharge or transfer 'presumably curable' clients. It is thus acknowledged that these are areas worth pursuing in future research. Interwar Maudsley was not scrutinised in such detail, but sources indicated that their treatment agenda was shaped by a convergence of clinical, professional and financial criteria. In later years, despite the introduction of effective and affordable drugs, the numbers of patients receiving ECT remained surprisingly high, with a marked female predominance. This finding corresponds with the claim by Andrews et al., that, aside from their benefits in augmenting the image of the psychiatrist as healer, shock and surgical methods moved the emphasis of 'active therapy' onto female patients;[160] a thesis which corresponds with current findings (Table 17) of a female predominance in use of ECT, insulin, and leucotomy in mid twentieth-century Bethlem. Throughout this era, however, it is noteworthy that female rates of melancholia also continued to surpass those of males. The sustained usage of shock treatments was a matter of scientific uncertainty and growing public opposition; yet, in casenotes and interview data, patients and staff alike acknowledged a need for the controversial ECT, and the relief it offered where other methods had failed.

From the 1950s, there was an escalating triumphalism in descriptions of somatic treatments, notably psychotropic mediation. Trevor Turner invoked psychopharmacological advances and the development of community-based support as contributory factors to declining mental hospital populations.[161] Scull, however, suggested that their success lay in 'facilitating the policy of early discharge, by reducing the incidence of florid symptoms...easing problems of community management...and persuading doctors with an exaggerated idea of the drugs' efficacy of the feasibility of such a

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[160] Andrews et al., *The History of Bethlem*, p.695.
[161] Turner, "The History of Deinstitutionalization and Reinstitutionalization," p.2.

policy'.[162] The localised significance of these changes is inconclusive: the most drastic fall in length of stay at Bethlem occurred from the mid 1930s (average 613 days) to the late 1940s (average 150 days); a period preceding the arrival of the new medications. Cherry was similarly dismissive of the significance of new drugs in the 'protracted and uneven decline' of St. Andrew's Hospital, and argued that pharmacology was not regarded as significant in analogous community care proposals for mentally handicapped or very elderly populations.[163]

Drug industry marketing may have loomed large within psychiatry, but ostensibly educational media messages also expounded on the virtues of scientific solutions to mental illness. Interwar drug use at Bethlem was quotidian and unexceptional; a secondary consideration to remediation of actual or perceived physical complaints. In the latter half of the twentieth century, one finds the expected dose of new drugs at the Joint Hospital, the direct marketing of which to hospital staff was explored through deconstruction of adverts published in Bethlem's in-house magazine in the early 1970s. Nurses' testimony, however, centred on the side-effects of these substances, rather than their (supposed) disease-specific actions. Hospital policy espoused caution and economy in the prescribing of drugs, and staff compared their regime favourably to that of neighbouring 'pill doctors'. However, on other occasions - albeit isolated - accounts paint a picture of over-zealous or inappropriate administration of psychopharmaceuticals. This could be attributed to the dual pressures of patient demand and a need for ward control, in a context of social permissiveness and understaffing.

Neuroimaging technology was demonstrably expensive, but delivered enhanced diagnoses and prospects for a less obvious spectrum of patients at Bethlem and Maudsley, including older people, schizophrenic, and epileptic, populations. Thus, its reach and benefits extended far beyond the confines of its home department.

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[162] Scull, *Decarceration*, pp.88-89.
[163] Cherry, *Mental Health Care in Modern England*, pp.274-275.

The current research employed a case study approach, and it is appreciated that one cannot generalise from such localised narratives. Nonetheless, the evidence provides valuable and detailed insight into how and why somatic treatments were used within twentieth-century British psychiatry. However, it was not possible to present a comprehensive account of physical and pharmaceutical developments in psychiatry, leading to inevitable omissions. The present selection was both chronologically-determined, and guided by emerging references to key methods, which were interpreted as an index of their bearing on contemporary hospital practice. In several cases, archival data were missing or inaccessible; this further restricted evaluation of treatments, to the particular detriment of our knowledge of Belmont Hospital, Sutton. Given the formative role of this site in the development of somatic treatments, and its connection to leading clinicians, it presents an important area for future research.

Some have argued that new physical and pharmaceutical methods facilitated the development of talking therapies and a departure from institutional care models.[164] The relative sequence and significance of such events remains hotly contested territory, yet psychotherapy gained prominence and acceptance in the twentieth century, and thus represents a critical next topic for the current enquiry.

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[164] Joan Busfield, *Managing Madness: Changing Ideas and Practice* (London: Hutchinson, 1986), pp.326-329.

Chapter 7: The Case of Psychotherapy

This chapter will first explore the provenance of talking treatments, their formalisation as psychotherapy, the subsequent diversification of approaches and their varying impact within Britain. Opinion remains divided as to the relative influences of key events and individuals in establishing and shaping the discipline of psychotherapy, and whilst only a brief overview of methods and theories will be possible, the aim is to identify the key differences between schools, to illustrate the existing debates within the field, and give examples of practices at other institutions. These accounts will be informed by new evidence of the twentieth-century emergence and refinement of psychotherapy at Bethlem, drawing on staff publications, educational materials, archived patient records and interviews with former staff members.

Previous chapters have already considered the backgrounds of twentieth-century Bethlem patients, the circumstances of their admissions, and facets of their inpatient care. The current chapter addresses popular understandings of, and rationales for, seeking psychological support, alongside the professional articulation and delivery of these services. Building on themes introduced in chapters 4 and 5, there will be further attention to clinical and personal determinants of (perceived) suitability for psychotherapy, and of the role of patients' attitudes, knowledge, and prior experiences in the materialisation and expansion of this field. Moreover, this chapter will reflect on the changes and continuities between orthodox and emergent approaches; consider the significance of key individuals in advancing new ideas, and explore the relationship between therapeutic community and anti-psychiatry beliefs.

Definitions and Origins

According to Edgar Jones, 'no satisfactory definition of psychotherapy exists, largely because of its broad clinical application and dissention within training organisations as to

its theoretical basis'.[1] However, such an absence further obfuscates an already opaque subject. Simply put, psychotherapy denotes any form of talking treatment, which may take place individually or on a group basis, and with varying requisite commitment and intensity. It is clearly demarcated from physical treatment, but there is a lack of consensus as to if, or when, the term should encompass Freudian psychoanalysis.[2] Further exploration of these issues will follow later in this chapter. First, the discussion will consider the circumstances in which psychotherapy evolved, and the influences which shaped it.

The term 'psychodynamic' may refer to 'the understanding and interpretation of psychiatric symptoms or abnormal behaviour in terms of unconscious mental mechanisms'.[3] Roy Porter viewed such approaches as a response to the pessimism of asylum psychiatry and the obduracy of its practitioners.[4] This context may indeed have been a spur to innovation, but recent scholarship by Sonu Shamdasani proposed that psychotherapy drew on disparate and contested legacies, and needed to sever prior associations with stage hypnotism and suggestion and differentiate itself through either the creation of a discrete, 'retroactive history', or by closer analogy with moral treatment.[5] This paradigm appealed to patients' supposed inner virtue, using shared, purposeful activity to promote self-esteem and self-mastery. It was felt that 'as indolence has a natural tendency to weaken the mind and induce ennui and discontent, every kind of rational and innocent employment is encouraged'.[6] By the start of the twentieth century, 'psychotherapy' was an accepted rubric for everything from 'mesmerism, hypnosis, suggestive therapy, moral therapy, Mind-Cure, mental healing, strengthening of the will, re-education, the cathartic method , rational persuasion, to general medical practice or the "art" of medicine'. It gained prominence and circulation through these

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[1] Jones, "War and the Practice of Psychotherapy," p.494.
[2] Charles Rycroft, *A Critical Dictionary of Psychoanalysis* (London: Penguin Books, 1995), pp.147-148.
[3] Ackner, *Handbook for Psychiatric Nurses*, p.354.
[4] Porter, *Madness: A Brief History*, p.187.
[5] Shamdasani, "'Psychotherapy': The Invention of a Word," pp.2-3, 8-10.
[6] Samuel Tuke, *Description of the Retreat* (London: Dawsons of Pall Mall Ltd, 1964), pp.156-157, 181.

associations, whilst remaining distinct from any specific figure or school. Furthermore, Shamdasani argued that Freud appropriated the domain of 'psychoanalysis' without ever specifying precisely how this differed from other forms of psychotherapy.[7] The current study presents a unique opportunity to chart the evolution of such approaches within an institutional setting, and to specifically examine the relationship between macro-level theory and individual patient encounters. Although the growth of psychotherapeutic services within a traditional psychiatric hospital may initially appear incongruous, this chapter posits that events and experiences of the early twentieth century provided fertile ground for the subsequent promotion and popularisation of these ideas, often aided by the work of individual proponents.

Development and Diversification of Psychotherapy in Britain

There now follows an overview of other prominent figures in early twentieth century psychotherapy, the organisations developed by their adherents, and the reception and impact of their teachings within Britain. Originally Sigmund Freud's protégé, Carl Jung actually achieved greater acclaim in these decades when he diverged from the psychoanalytic credo to develop his own 'analytical psychology'. Offering a less sexual and more idealistic description of the unconscious, he postulated the existence of different personality types, and the need for a healthy balance of 'extroversion' and 'introversion'. Central to his theory, was the idea that symptoms originated not in repressed memories, but rather a failure to cope with the present situation. Therapy was informal and conducted as a mutual conversational exchange, which included discussion of the patient's recent dreams.[8]

Developed in the 1920s, Melaine Klein's theory stressed the importance of resolution of ambivalence towards the mother (the breast) in ego development.[9] The Kleinian

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[7] Shamdasani, "'Psychotherapy': The Invention of a Word," pp.13-14.
[8] Edward Armstrong Bennet, *What Jung Really Said* (London: Macdonald, 1966), pp.144-146.
[9] Hanna Segal, *Introduction to the Work of Melanie Klein* (London: Karnac and the Institute of Psycho-Analysis, [1988] c1973), pp.24-27.

perspective also diverged from Freudian views, in considering the 'death instinct' a legitimate clinical concept, and aggression as the projection of these innate self-destructive tendencies.[10] Another of Freud's associates, Ernest Jones, was a leading British psychoanalyst, amidst a London scene that would later be coloured by the 'theoretical battles' waged between competing factions. Jones founded The London Psycho-Analytical Society in 1913, but a drift towards Jung amongst some members led to it disbanding. In 1919, it was re-established as the British Psychoanalytical Society, affiliated with the International Psycho-Analytical Association (IPA). However, there were ongoing disputes between proponents of leading child analysts Melanie Klein, Anna Freud, and those committed to neither viewpoint. Dissolution of the Society was averted only by the 'compromise solution' of allowing the factions – now known as the Contemporary Freudian Group, the Independent Group, and the Kleinian Group - to operate both joint and separate training programmes.[11]

An alleged 'credibility gap' in public and medical perceptions of psychotherapy resulted from the field's bewildering jargon and the intra-psychic accounts of European proponents presenting a challenge to the British empirical orthodoxy.[12] British psychiatrists and their patients were also reportedly less enthusiastic than their European and American counterparts about the new phenomenon,[13] whilst a 1920 *Lancet* article warned that psychotherapy, 'when unduly pushed or misapplied...may induce very disastrous consequences'. The author considered it a mere repackaging of commonsense, which neglected physical causes of neurosis, and likened the apparent benefits of 'personal intercourse of the physician with his patients' to those derived from moral treatment.[14] The 1927 edition of Henderson and Gillespie's *Text-Book of Psychiatry for Students and Practitioners* gave separate consideration to psychoanalytic theory, and to its therapeutic

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[10] Rycroft, *A Critical Dictionary of Psychoanalysis*, pp.90-91.

[11] Malcolm Pines, *Great Britain, Part 1* (American Mental Health Foundation, [cited 24/1/11)); available from http://americanmentalhealthfoundation.org/a.php?id=4.

[12] Jones, "War and the Practice of Psychotherapy," pp.505-507.

[13] Porter, *Madness: A Brief History*, pp.194-198.

[14] James Crichton-Browne, "Notes on Psychoanalysis and Psychotherapy," *Lancet*, no. June 12 (1920): pp.1296-1297.

value – the latter being 'much more dubious ground'. However, it was proposed that problems often stemmed from the misapplication of the technique to patients of inappropriate age, education, or diagnosis:

> There is no doubt that as a therapeutic weapon, psychoanalysis can be extremely dangerous, and that much harm has been done both to individual patients and to the general repute of psychoanalysis by injudicious practitioners of the method, who often disregard the limitations which Freud himself explicitly defined as early as 1904 – limitations which have not since been materially modified.[15]

Early twentieth-century medical textbooks acknowledged the role of psychotherapy in general practice, but poured scorn on the ongoing appropriation of this method by a clique of parvenu 'experts', and the consequent 'deskilling' of GPs. Thus, 'To-day, the practitioner has little confidence in his ability to deal with psychogenic factors, because he has been taught that only the very learned can practice psychotherapy'.[16] In contrast, a psychiatric training manual of the same era disputed the expectation, or desirability, of doctors acquiring expertise in mental disorders: 'no-one expects a general practitioner to be fully conversant with every speciality, nor does one expect from him a detailed argument in regards to prognosis and diagnosis, but the general practitioner should be familiar with the methods of examination, so as to be able to elicit the facts and present them systematically, even though he may not be able to interpret them correctly.[17] Moreover, W.H. Rivers posited that much of Freud's original theory had been irrevocably clouded by the ensuing furore:

> His views, or perhaps rather their applications, have stirred up such a bed of prejudice and misunderstanding, that their undoubted merits are in serious danger

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[15] Henderson and Gillespie, *A Text-Book of Psychiatry for Students and Practitioners* pp.456-458.

[16] D.M. Dunlop et al., eds., *Textbook of Medical Treatment* p.1014.

[17] D.K. Henderson and R.D. Gillespie, *A Text-Book of Psychiatry for Students and Practitioners*, 3rd ed. (London: Oxford University Press, 1932), p.67.

of being obscured, or even wholly lost to view, in the conflict produced by the extravagance of Freud's adherents and the rancour of their opponents.

Though largely dismissive of the theory of repression, or the efficacy of Freudian analysis as treatment, he conceded that it provided a 'constant working hypothesis to aid us in our attempts to discover the role of unconscious experience in the production of disease'.[18] In a more recent commentary, Dean Rapp argued that the British lay press were less hostile to Freud than the medicopsychological community, but that many favoured the more optimistic, less sexualised, Jungian framework, thereby facilitating the growth of 'an eclectic, diluted interpretation of Freudianism'.[19] The first research fellowships in psychotherapy were established at the Tavistock Clinic in 1936, and concerned psychosomatic disorders.[20] However, there were few consultant psychotherapists employed in London teaching hospitals until the 1960s and 70s, and postwar delays in the field's development have been attributed to resistance from the medical profession, and the 'ready ammunition' provided by the lack of scientific rationale for symptoms or treatments. Moreover, 'for the small number of demobilized psychiatrists whose interest had been captured by psychodynamic ideas during wartime, there were few training opportunities apart from the Institute of Psycho-Analysis'.

Writing in 2004, Edgar Jones proposed that the success and popularity of psychotherapy cannot be attributed solely to dissemination of Freudian ideas and opposition; rather, there existed a separate narrative of experimental military psychiatry, to which we shall now turn.

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[18] W.H.R. Rivers, "Freud's Psychology of the Unconscious," *Lancet* June 16th (1917): pp.912-914.

[19] Rapp, "The Early Discovery of Freud by the British General Educated Public, 1912-1919," p.217.

[20] The Tavistock and Portman NHS Foundation Trust, *Our History* (2011 [cited 25/10/11)); available from http://www.tavistockandportman.nhs.uk/ourhistory.

Wartime and Interwar Influences

It is widely believed that the psychological aftermath of the First World War prompted a reconceptualisation of the causes, classification, and management, of mental illness. Notable in this era, was the controversial and radical research conducted by Majors Wilfrid R. Bion and John Rickman, which implemented large, leaderless group approaches to treating the neurotic disorders of military personnel. These so-called 'Northfield Experiments' aimed to instil self-respect and responsibility in soldiers, in readiness for their return to frontline duties. The initial trials were short-lived and, ultimately, unsuccessful, but achieved their legacy in the group psychotherapy work continued by Major Michael Foulkes at the Maudsley and T.F. Main at the Cassel Hospital.[21]

The link between stress and emotional trauma later became a key focus of activity at the EMS hospital in Mill Hill. Maxwell Jones and Aubrey Lewis published a 1941 *Lancet* article on the topic of 'effort syndrome', advising that: 'The initial steps in psychological treatment have to take account of the belief or fear which most patients have that their hearts are damaged and that their life is therefore in danger...We have given the patient an explanation which is suited to his intelligence and general knowledge, and which he can accept without feeling resentful or ashamed of himself'. Of the 200 soldiers they studied, 'approximately equal numbers made an apparent recovery or were discharged, and the remaining 60% were returned to the Army for light duty'.[22]

Lewis conceded that war was bad for mental health, but invoked an amplified sense of 'corporate unity and usefulness' as a significant index in raising morale. Moreover, he suggested that 'the evil harvest may be reaped afterwards', with more profound psychological fallout observed in the months and years following the end of hostilities.[23] Peter Nolan further suggested that mental health nursing took on an 'exciting, liberal and progressive' form at Mill Hill, where recruits to the Royal Army Medical Corps (RAMC)

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[21] Jones, "War and the Practice of Psychotherapy," pp.496-497.
[22] Maxwell Jones and Aubrey Lewis, "Effort Syndrome," *Lancet*, no. June 28 (1941): pp.817-818.
[23] Lewis, "Mental Health in War-Time," p.27.

included Annie Altschul, later Head of the Joint Hospital's Nursing School. These recruits received intensive training in emergency nursing, and gained superior knowledge and leadership skills to those within the institutional milieu.[24]

Talking therapies therefore contributed to the rehabilitation of military personnel, and the elevation of psychiatry's professional and public standing. It has, nevertheless, been argued that morale-boosting accounts of swift recoveries created unrealistic expectations of what could be achieved with civilian patients in peacetime, amidst a backdrop of finite resources.[25] Thus, whilst psychotherapy was already well-established in private practice by the 1940s, cost, staffing and training limitations restricted parallel provisions within the NHS.

The Tradition of Talking Treatments at Bethlem and Maudsley

Waddington proposed that, from 1911-1914, Physician Superintendent William Henry Stoddart exerted an early Freudian influence at Bethlem, and endorsed the use of hypnosis as an aid to uncovering traumatic memories. Experiences in treating shell-shock inspired further psychological interest, reflected, at Bethlem, in the (1923) appointment of a consultant psychologist, William Brown, and the growing use of intelligence testing to aid psychiatric diagnosis.[26] Archival research initially produced little evidence of talking therapies in pre-war Bethlem: early twentieth-century records recounted the use of physical methods, implicitly bolstering this stance by cursory mention of patients who had previously and unsuccessfully been psychoanalysed elsewhere.[27] However, chapters 4 and 5 reported a more subtle infiltration of psychodynamic concepts, and tropes such as 'insight' into 1930s casenotes. This occurred concurrently with the wider development of psychoanalytic literature, and retains contemporary relevance as the basis for

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[24] Peter Nolan, "Mental Health Nursing in Great Britain," in *150 Years of British Psychiatry. Volume 2: The Aftermath*, ed. H.L. Freeman and G.E. Berrios (London: The Athlone Press Ltd., 1996), p.184.
[25] Jones, "War and the Practice of Psychotherapy," p.494.
[26] Jonathan Andrews et al., *The History of Bethlem* (London: Routledge, 1997), pp. 684-685.
[27] BRHAM, "Cwc: Departures and Deaths Patient Casebooks, 1923 -1953," ref. no. 721.

differentiating psychotic from non-psychotic states.[28] Use of this term at Bethlem was accompanied by a growing emphasis on individual attention and occupational pathways to mental and social rehabilitation.

Although these approaches ostensibly catered to the milder afflictions of voluntary admissions after the 1930 Mental Treatment Act, patient correspondence suggested that more chronic cases also benefited: In March 1940, nine years into what became a thirteen year admission for 'recurrent mania', patient AM penned a grateful and glowing account of his treatment to the Bethlem House Committee Chairman. Amongst the features he praised were: 'the extensive open-air treatment'; 'efficient and harmonious staff-patient relationships'; 'the numerous collective games such as cricket, football, billiards tournaments etc., to take one out of oneself', and 'the ability to give private treatment among such a mixed and large community'.[29] Substantial progress had apparently been made since the 1931 Report of the Commissioners of the Board of Control, which highlighted a critical lack of occupational therapy provision at Bethlem – a situation exacerbated during bad weather - and recommended the use of a dayroom and the appointment of a handicraft instructor.[30] The hospital's occupational therapy department opened the following year, offering 17 different classes, with 2 classes scheduled daily, typically catering for 19 to 25 female patients and 12 to 16 males. Physician Superintendent, J.G. Porter-Phillips, concluded that, 'from both attractive and effective treatment, and monetary points of view, this inauguration has been more than justified'.[31] Moreover, by 1950, Medical Committee documents discussed the establishment of a social club for patients, providing opportunities for recreation, education and, significantly, the acceptance of community-based roles and responsibilities. Emphasis was placed on making patients feel welcome and at ease, and thereby promoting identification

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[28] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: Dsm-5* (Arlington, VA: American Psychiatric Association, 2013).
[29] BRHAM, "Patient Correspondence Files, 1925-1947," ref. no. 195.
[30] Board of Control, "Report of the Commissioners of the Board of Control, 3rd February, 1931," pp.23, 25-26.
[31] BRHAM, "Report of the Physician Superintendent for the Year Ending 31st December, 1932," pp.11-12.

with, and contribution to, the wider group.[32] Although such measures were not part of a

formal treatment regime, in the absence of psychotherapeutic records for pre-NHS

hospital, they provide a preliminary indication of investment in forms of therapeutic

interaction.

In the interests of allowing 'an unprejudiced trial of every form of treatment offering a

reasonable prospect of benefit rather than harm', Medical Superintendent, Edward

Mapother, created a psychotherapeutic department at the Maudsley,[33] albeit employing a

'pragmatic interpretation' of psychoanalytic theory.[34] It has been proposed that plans for

this service were shaped both by European centres and London's Tavistock Clinic.

Founded in 1920 by Dr. Crichton-Miller, the latter institution was a cornerstone of the

British history of psychotherapy, pioneering treatment of the traumatic effects of shell-

shock, and promotion of the value of talking therapies for mental rehabilitation in both

military and civilian environments. However, in other respects, Mapother was 'no friend

to the Tavistock...and, as Professor of Psychiatry, blocked all attempts by the Tavistock to

secure University recognition as a specialized institute, though we were turning out

trained psychotherapists in increasing numbers'.[35] Despite these initial struggles, high-

profile figures within British psychiatry such as John Bowlby and Ronald (R.D.) Laing were

also associated with the Clinic, the latter having served as an army psychiatrist. The Clinic

fostered the 'object relations' school of psychotherapy, and, in the 1950s and 60s,

developed the concept of systemic family therapy.[36]

With diffuse and diverse influences, Clinical Director Aubrey Lewis maintained an

'epistemological scepticism' that, Rhodri Hayward suggested, had characterised the

interwar Maudsley, but, at times, exasperated colleagues. Thus, he failed to wholly align

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[32] BRHAM, "Mcc-01: Medical Committee Documents and Minutes, 1950," p.17: 'The Establishment of a Social Club for Patients', memo by Dr F.K. Taylor.

[33] Aubrey Lewis, "Edward Mapother and the Making of the Maudsley Hospital," *British Journal of Psychiatry* 115 (1969): p.1355.

[34] Hayward, "Germany and the Making of "English" Psychiatry," p.72.

[35] Henry Victor Dicks, *Fifty Years of the Tavistock Clinic* (London: Routledge and Kegan Paul, 1970), pp.60-61.

[36] The Tavistock and Portman NHS Foundation Trust, *Our History* ([cited).

himself with any particular school, and focused on exposing the shortcomings of existing theories rather than generating novel ideas.[37] In a 1957 address, 'Between Guesswork and Certainty in Psychiatry', Lewis postulated that divisions within the field were between those seeking general ('nomothetic') versus individual ('idiographic') theories, rather than adherents of specific schools. He acknowledged that both methods possessed intrinsic strengths, but believed psychiatric research to be overly individualist, to the detriment of understanding and predicting behaviour.[38]

Psychotherapeutic Education and Ethos

The discussion will now chart how emerging psychotherapeutic ideas were disseminated and applied, initially at the national level, then with a focus on Bethlem and the Maudsley. By 1939, there was growing recognition that alternative talking therapies were available to strictly Freudian analysis. President of the Royal Society of Medicine's Section of Psychiatry, T.A. Ross, advocated non-specialist interventions, and the potential for treating cases on general wards using 'simpler and shorter methods of psychotherapy'.[39] However, Ernest Jones conveyed an air of professional friction resulting from GPs' sense that analysts were encroaching on their territory. He further cautioned that the implicit attitudes of both doctor and patient could impede treatment, with neither wising to 'disturb the dark recesses of the unconscious'. Jones conceded that the psychoanalytic ideal of all doctors being analysed themselves was unrealistic, but believed 'it is imperative that they should all be alive to the importance of the mental process in all disease'.[40] Whilst psychoanalytic training had no fixed duration, it seldom took less than four years, and it was considered desirable for candidates to have two or three years prior experience in psychiatry. Aubrey Lewis noted that training varied in stringency and length between countries, but that the International Psychoanalytical Association was striving to

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[37] Hayward, "Germany and the Making of "English" Psychiatry," p.77.

[38] Aubrey J. Lewis, "Between Guesswork and Certainty in Psychiatry," in *The State of Psychiatry: Essays and Addresses* (London: Routledge and Kegan Paul, 1967), pp.206-207.

[39] T.A. Ross, "The Mental Factors in Medicine," *British Medical Journal* 2, no. 4047 (1938): p.211.

[40] Ernest Jones, "The Unconscious Mind and Medical Practice," *British Medical Journal* June 25 (1938): pp.1354-1359.

attain parity of standards and acceptance.[41] In 1939, a leading textbook proposed that 'the form of treatment should be suitable to the patient's intellectual ability and cultural status. The person of average intelligence can hardly understand analytical procedure....Thus analysis must be limited to those who are capable of going through a high school or university education'. Age, too was considered a limiting factor, with patients above the age of fifty not considered suitable subjects for psychotherapy.[42] Further rationales for this belief, and examples of its manifestations, are described later in this chapter.

It has been suggested that Bethlem failed to embrace psychotherapy and 'talking cures' as readily as its partner institution, but made tentative moves towards trying new ideas. Moreover, the fact that the hospital was split between two sites somewhat assuaged the friction caused by these differences of opinion, and allowed the Joint Hospital to remain a 'broad church able to incorporate treatments ranging from psychotherapy to neurosurgery'.[43] The arrival of the NHS removed some of the financial obstacles for patients seeking psychiatric treatment, but did less to diminish medical prejudices in psychotherapy case selection. Despite some misgivings, from 1949, it was claimed that all Joint Hospital inpatients received some form of psychotherapy.[44] This implied a discord between actions and intent, raising questions over the motives for endorsing the practice when only certain patients were thought likely to benefit. Had psychotherapy by this stage become a fashionable, but customary, feature of ward life rather than an approach conducted in a spirit of therapeutic intent and expectation? In other words, was it simply a prerequisite for a hospital of Bethlem's size and standing, regardless of therapeutic efficacy? A tentative explanation would be that psychotherapy served both social and therapeutic functions: thus, it could appeal to both the image-conscious and intellectually-

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[41] Lewis, "Psychiatric Education and Training," pp.155-156.
[42] D.M. Dunlop et al., eds., *Textbook of Medical Treatment* pp.1041-1042.
[43] Waddington, "Enemies Within," pp.191-192.
[44] BRHAM, "Triennial Statistical Report, Years 1949-1951," p.42.

inclined, and offered a further way of 'treating' milder (especially psychoneurotic) disorders before the expansion in psychiatric drug usage.

Discussions in 1956 also confirmed an earlier existence of psychotherapy at Bethlem than is widely assumed, but C.P. Blacker (consultant psychiatrist at the Maudsley Hospital and clinical teacher at the Institute of Psychiatry) justified exclusion of the field from his Triennial Statistical Report, 1949-51 on the grounds that: 'The figures …were so lamentably incomplete and (such as they were) threw such an unfavourable light on the results of psychotherapy as then practised in the Joint Hospital, that I thought it best to omit them completely'.[45] This rather denigrating exclusion encapsulated the low public profile of psychotherapy at the hospital in the mid twentieth century, whilst also perhaps alluding to its wider tradition of non-conformism to institutional orthodoxy; a theme further evidenced in subsequent developments. The aforementioned report detailed the slow uptake of group therapy in the postwar years: of a total 2,049 treatments given to Bethlem and Maudsley inpatients in the triennium 1949-51, this method amassed only 20 uses, 0.6% of the total. However, Blacker felt that this 'should not be taken as an index of the practice of group therapy in the Joint Hospital' because it was 'more applicable and systematically used by outpatients'.[46]

As previous chapters have demonstrated, specifics of patient class and age could guide treatment decisions at Bethlem. Records from the late 1960s implicitly reflected the belief that psychotherapy should remain the preserve of the social elite, whereas physical approaches, drugs, or no intervention, were more evenly distributed between social classes.[47] A more subtle age barrier was also in effect; psychotherapy patients were typically younger than the hospital's overall average, and the referral of an older patient from the day hospital was a noteworthy occurrence:

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[45] BRHAM, "Mcc: Medical Committee Documents and Minutes, 1955-1957."
[46] BRHAM, "Triennial Statistical Report, Years 1949-1951," pp.42-43.
[47] BRHAM, "Triennial Statistical Report, Years 1958-1960," p.17.

He has diffuse anxiety symptoms which are worst in the morning. His feelings of fear are intensified in any new situation where he feels something might go wrong..... He has had these symptoms all of his life and he is now 61 years old.... if he is sufficiently motivated he might be able to benefit from exploring things further in a psychotherapy group. However, most of our groups are composed of people in the age range 20-30 and not every therapist would be willing to take someone of (his) age.... it may be that the current arrangements are the best treatment that can be offered as I do not think that he would be considered suitable for behavioural treatment as his symptoms are too generalised and diffuse and long-standing. [48]

After the 1948 merger, decisions affecting treatment policy at the Joint Hospital had come under the aegis of the Medical Committee, whose archived minutes suggested that plans for psychotherapy services were an early priority. In May 1955, Dr. Robert Hobson submitted a 'Proposal for Institution of Group Methods of Treatment', namely Ward Groups, allowing 'coordination of the various aspects of hospital life, plus minimal psychotherapy, with the emphasis upon social rehabilitation' and Therapeutic Groups, 'for patients requiring psychotherapy of a more systematic, though not analytic, nature'. These two interventions were later approved for adoption. The following month, the Committee reviewed its outpatient psychotherapy policy, recommending that 'referrals should be made for a specific type of psychotherapy (e.g. group); certain types of chronically ill patients, e.g. severe character disorders, homosexuals, fetishists, should not be referred without special consideration of circumstances' and stressing that 'patients are basically the responsibility of the referring physician, except for the time in which they are in active psychotherapeutic treatment, when the consultant psychotherapist is in sole charge of the case'. Later that year, attention turned to matters of organising and financing psychotherapy: 'Long-term' treatment was defined as 'continuous psychotherapy given by one psychotherapist for a period longer than twelve weeks';

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[48] BRHAM, "Pct-07: Psychotherapy Assessment Reports, Oct 1979 – March 1981," case no. 802886.

'intensive' as meaning 'from three to seven sessions per week'. Bethlem already offered this service, conducted by Dr Hobson, and anticipated a growing waiting list, but concerns were voiced about the need for additional senior personnel to develop this area adequately.[49]

In light of Lewis' aforementioned reluctance to endorse any one school, there was a perhaps unsurprising lack of consensus on any single approach at the Joint Hospital, with the variety of psychotherapeutic services and practitioners defying attempts to identify a unitary theoretical underpinning. This resonates with a recent article by Catherine Fussinger, which sought to 'establish the proximity between [therapeutic community] initiatives taken in the 1950s by reformist psychiatrists and those launched by antipsychiatrists in the 1960s', and described the criticism such approaches evoked from psychoanalysts, given the latter's claim to a 'technical monopoly over the therapeutic use of interpersonal relationships'.[50] In so doing, she accentuated the contested roots of seemingly similar approaches, and the agency of key proponents; both ideas to be tested in the current chapter.

R.D. Laing was a prominent figure in the rise of such a therapeutic counter-culture. Laing's views were in opposition to mainstream psychology and psychiatry, but, crucially, 'well within the limits of contemporary liberal thinking'.[51] He acquired 'outrageous' celebrity, 'his views circulated widely…quoted as a contemporary sage, a seer for modern times'. Conversely, he never sought membership of a nascent coterie of new, fashionable therapies (e.g. Gestalt, transactional analysis) and attracted diverse and impassioned professional opposition.[52] A key point of departure from other theorists was Laing's

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[49] BRHAM, "Mcc: Medical Committee Documents and Minutes, 1955-1957."
[50] Catherine Fussinger, "'Therapeutic Community', Psychiatry's Reformers and Antipsychiatrists: Reconsidering Changes in the Field of Psychiatry after World War Ii," *History of Psychiatry* 22, no. 2 (2011): pp.152, 159.
[51] Brian Evans, "The Impact of the Ideas of R.D. Laing on UK Psychology Students," in *R.D. Laing: 50 Years since the Divided Self*, ed. Theodor Itten and Courtenay Young (Ross-on-Wye: PCCS Books, 2012), p.224.
[52] Zbigniew Kotowicz, *R.D. Laing and the Paths of Anti-Psychiatry* (London: Routledge, 1997), pp.89-93.

conceptualisation of madness as a journey of self-discovery, which could bring spiritual enlightenment.[53] Peter Sedgwick countered that

> …neither Freud, nor Jung, nor any Neo-Freudian or any neo-Jungian, nor for that matter any other existential analyst has taken the stance that psychosis is a higher form of sanity. Schizophrenia is breakdown, sheer affliction, for virtually all psychiatric schools; only for Laing does it mean also breakthrough and blessing.[54]

By contrast, Robert Hobson, the leader of Bethlem's therapeutic community, was an eminent Jungian and pioneer of the 'Conversational Model'.[55] He had originally qualified as a neurosurgeon, and wrote his M.D. thesis on 'Prognostic Factors in Electroconvulsive Therapy'.[56] This research was conducted at the Maudsley, under the guidance of Aubrey Lewis and Hans Eysenck, paving the way for Hobson's (1954) appointment as consultant physician at the Joint Hospital. His ostensibly disparate experience had, nevertheless, sparked a curiosity about the interplay of brain, mind and spirit, prompting him to train as a psychotherapist with the Jungian Society of Analytical Psychology (SAP) the same year. In subsequent articles, Hobson decried the lack of interest in group dynamics amongst his contemporary analysts,[57] outlined fundamental features and patterns of group processes, and the role of analysis in 'recognition and solution of resistances to the operation of integrating processes occurring in the group as a whole'.[58] He proceeded to bring anthropological, mythological and literary perspectives to topics including circumcision[59]

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[53] Allan Beveridge, "R. D. Laing Revisited," *Psychiatric Bulletin* 22, no. 7 (1998): p.452.

[54] Peter Sedgwick, "R.D. Laing: Self, Symptom and Society," in *R.D. Laing and Anti-Psychiatry*, ed. Robert Boyers and Robert Orrill (New York: Octagon Books, 1974), pp.38-39.

[55] David A. Shapiro, "Obituary: Dr Robert Hobson," *The Independent*, Monday, 29 November 1999.

[56] Robert F. Hobson, "Prognostic Factors in Electroconvulsive Therapy," *Journal of Neurology, Neurosurgery and Psychiatry* 16 (1953): pp.275-281.

[57] Robert F. Hobson, "Group Dynamics and Analytical Psychology," *Journal of Analytical Psychology* 9, no. 1 (1964): p.23.

[58] Robert F. Hobson, "An Approach to Group Analysis," *Journal of Analytical Psychology* 4, no. 2 (1959): pp.140-143, 151.

[59] Robert F. Hobson, "Psychological Aspects of Circumcision " *Journal of Analytical Psychology* 6, no. 1 (1961): pp.5-33.

and loneliness,[60] and was also noted for his innovative use of audio, and later video, recording, of sessions as a training aid. Elsewhere, the language and tone of psychotherapy reports variously invoked Freud, Klein or Bowlby, and specific illustrations of this will be provided later, in relation to patient casenotes. One longstanding Joint Hospital clinician recalled the diversity of opinion and advice available to staff:

> My learning stage interest was in combined methods...Aubrey's insistence was he didn't like people doing a psychoanalytic training until they'd got their psychiatric qualification. If you then wanted to find (one) he had Freudian psychotherapists, Jungian psychotherapists on the staff here.[61]

This view was echoed by one of his colleagues:

> We had a special psychotherapy unit, which was on Freudian and Jungian lines, and we had a whole corridor of marvellous psychotherapists, who were training people who wanted to specialise in psychotherapy. We had people like Michael Gelder and Isaac Marks –Isaac Marks was out at Bethlem – who were pioneers in behaviour therapy, and you could refer to them; they were only too keen to get people to add to the numbers that they were doing their trials on.... This is something I can't over-estimate too much, the luxury of working in a place, where every discipline in psychiatry was represented, and where, with a little bit of tact, you could get help from all avenues.[62]

Gelder and Marks published collaboratively throughout the 1960s and '70s in key areas including the classification, diagnosis and treatment of phobic disorders. In an age when behavioural therapy was growing in popularity, they undertook clinical trials of the relative benefits of this approach over individual or group psychotherapy. They reported

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[60] Robert F. Hobson, "Loneliness," *Journal of Analytical Psychology* 19, no. 1 (1974): pp.71-89.
[61] Griffith Edwards, Interview by Author, 7th December 2010.
[62] Alwyn Lishman, Interview by Author, January 26th 2011.

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that 'desensitization' elicited faster improvements in phobic symptoms than in a matched group of patients receiving psychotherapy, although the latter method resulted in continued and longer-term gains.[63] Likewise, a separate study found that agoraphobic patients receiving behavioural therapy showed temporary improvements in social relationships and ability to work, but warned that it 'cannot be recommended indiscriminately for all phobic patients', and instead represented 'an additional technique which can form part of general psychiatric management but not replace it'.[64] More recently, Marks turned his attention to the development of Internet-based screening[65] and self-help interventions[66] for common mental disorders.

Talking treatments were also an integral feature of day hospitals, which were provided at both sites of the Joint Hospital. 'Dayholme' at Bethlem opened in April 1956, and consisted of one large and two small converted sports pavilions at the northern end of the Monk's Orchard Road site. There was an average attendance of thirty-four patients, who typically used the service daily for two or three months. Treatments and occupational therapy were scheduled in the morning, whilst social activities organised by a patients' committee took place in the afternoon. Once a week, there was an evening 'Enterprise Club', attended by day or ex-patients, who could each invite one friend or relative. In 1957, the opening of new community centre at Bethlem provided additional space and resources for a greater range of occupational therapy activities.[67] At the Maudsley, two floors of a large Victorian house were given over to treatment and recreation for up to twenty-six day patients, who attended on weekdays between 8.30am and 5.30pm.[68] However, *The Bethlem Gazette* reported that hopes that its service would prove an 'acting

[63] M. G. Gelder, I. M. Marks, and H. H. Wolff, "Desensitization and Psychotherapy in the Treatment of Phobic States: A Controlled Inquiry," *British Journal of Psychiatry* 113, no. 494 (1967): pp.71-72.

[64] M. G. Gelder and I. M. Marks, "Severe Agoraphobia: A Controlled Prospective Trial of Behaviour Therapy," *British Journal of Psychiatry* 112, no. 484 (1966): pp.318-319.

[65] Tara Donker et al., "A Brief Web-Based Screening Questionnaire for Common Mental Disorders: Development and Validation," *Journal of Medical Internet Research* 11, no. 3 (2009).

[66] Tara Donker et al., "Implementation of Internet-Based Preventive Interventions for Depression and Anxiety: Role of Support? The Design of a Randomized Controlled Trial," *Trials* 10, no. 1 (2009).

[67] Andrews et al., *The History of Bethlem*, p.690.

[68] James Farndale, *The Day Hospital Movement in Great Britain* (Oxford: Pergamon Press, 1961), pp.203-205, 292.

and expanding unit from which future day hospitals could be patterned' were quickly dashed, and daily attendance rates fell from 39 to 21 patients within two years. A lack of awareness amongst senior staff as to the existence and whereabouts of the day hospital was implicated: some 75% of those questioned were unable to locate the facility[69] – a finding supported by nurses' testimony, which also displayed an intriguing ignorance of the day hospital amongst those working on the same site.[70] This speaks broadly to the marginalisation of (superficially) non-scientific approaches, in an era when psychiatry was seeking to align itself with general medicine. Yet, the day hospital remained a feature of hospital marketing activity, suggesting that its purpose lay more firmly in consumer/patient appeal than professional credibility.

The Maudsley shared a base with the Institute of Psychiatry, and swiftly became a nexus for cognitive behavioural therapy and group analysis. An active psychology department included Hans Eysenck and Hugh Freeman, whilst Maxwell Jones' theories on group dynamics and community psychiatry also attained wider acceptance.[71] One interviewee[72] recalled the dramatic results obtained though behavioural therapy for phobia[73] and how this method rapidly came to be viewed as a viable alternative to purely physical interventions. Viennese-trained S.H. Foulkes, Consultant Psychotherapist, later Emeritus Physician, and founder of the Group Analytic Society, outlined the principles and application of the group psychotherapy approach in a 1957 book.[74] However, rather than focus on the aforementioned, well-documented, Maudsley interests, the current discussion will cast new light on services either based at Bethlem, or those where there was prominent interchange of staff between Bethlem and Maudsley. In addressing postwar psychotherapies at the Joint Hospital, there will also be consideration of changing

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[69] Josephine Gifford, "Bethlem Notes. Dayholme: To Be Or..." *Bethlem and Maudsley Hospital Gazette* 4 (3) (1961): pp.146-147.
[70] Rhiannon Harlow Smith, Interview by Author, 2nd September 2010.
[71] Maxwell Jones, *Social Psychiatry in Practice* (Harmondsworth: Penguin Books Limited, 1968), p.173.
[72] Griffith Edwards, Interview by Author, 7th December 2010.
[73] H. L. Freeman and D. C. Kendrick, "A Case of Cat Phobia," *British Medical Journal* 2, no. 5197 (1960): pp.497-502.
[74] S. H. Foulkes and E.J. Anthony, *Group Psychotherapy: The Psycho-Analytic Approach* (Harmondsworth: Penguin, 1957).

demands for, and access to, treatment, together with the composite service provision that resulted from the amalgamation of interests and experience in the new 'Joint' Hospital.

New Services and Populations

Aubrey Lewis implemented a range of dedicated and often groundbreaking psychotherapies at the new Joint Hospital. These included an outpatient unit at the Maudsley, employing Freudian, Jungian and 'eclectic' therapies. It was initially considered the last resort for a highly disturbed minority, though there were hopes of offering a shorter form of the service to a wider selection of patients.[75] From the mid-1950s, Dr Carice Ellison ran a family planning clinic for female inpatients at the Joint Hospital. Initially an occasional service, it expanded to include sexual counselling, and to accept referrals from other psychiatrists, GPs and gynaecologists (the latter group acknowledging a role for pre and postoperative counselling for hysterectomy patients). Guidance on abortion changed after the Abortion Act (1967) allowing new emphasis on the patient's psychosexual life.[76] Moreover, increased public discussion of once taboo subjects (vasectomy, female sterilisation, menopause, infertility, adoption) also fostered misunderstanding and confusion on these matters, contributing to the average 64 new cases referred each year from 1970-1974. A designated Marital and Sexual Problems Clinic followed in 1974, to which 40 couples were referred during the inaugural year. It was led by Drs Patricia Gillian and Michael Crowe and offered separate interviews, physical examinations, sex education, desensitisation and conjoint psychotherapy.[77] Transitions in social mores were accompanied by a growing psychological literacy, here reflected in patients' prior knowledge and experiences of psychotherapy, and in the rising demand for such services. However, escalating referrals could not be sustained without a corresponding growth in psychotherapist numbers. Bethlem also hosted the Charles Hood

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[75] BRHAM, "Triennial Statistical Report, Years 1964-66," ed. E.H. Hare, pp.65-66.

[76] For discussion of illegitimacy rates in this era, see: Pat Thane and Tanya Evans, *Sinners? Scroungers? Saints? Unmarried motherhood in twentieth century England* (Oxford University Press, 2012). Also: Jane Lewis and John Welshman, "The Issue of Never-Married Motherhood in Britain, 1920–70," *Social History of Medicine* 10 (1997), pp.401-418.

[77] BRHAM, "The Bethlem Royal and the Maudsley Hospital Report, 1970-75. Part I - Text," p.55.

Unit, named after a nineteenth-century Bethlem physician, notable for his humane approach to patient care. This small, inpatient, facility was structured around Maxwell Jones' therapeutic community model, providing individual and group psychotherapy.[78]

The inadequacies of physical theories and growing recognition of the pathogenic nature of institutions themselves facilitated the inception of the therapeutic community. From his observations at Mill Hill's Effort Syndrome Unit, Jones conceptualised the condition as a maladaptive learned response, remediable through corrective education groups, and a regime of physical exercise and occupational therapy. Thus, 'a form of therapeutic community evolved from clinical practice'[79] and Jones' ideas on group dynamics and community psychiatry would attain wider acceptance after the war.[80] This approach hinged on 'social learning' principles, the idea that formerly-adequate patterns of behaviour must be unlearned – in an admittedly complicated and painful fashion – because they impeded the acquisition of new and more productive modes of behaviour.[81] Yet, there were also profound ideological challenges to the wider application of therapeutic communities. Maudsley consultant psychotherapist, Malcolm Pines, saw the therapeutic community movement as rooted in psychiatrists' experiences of working with large numbers of patients in military settings. He therefore argued that there appeared little scope for applying these concepts within teaching hospitals, and described 'very considerable and powerful social obstacles to be overcome before the [pyramidical] social structure can be altered'.[82] In his description of the Social Rehabilitation Unit at Belmont Hospital, Robert Rapoport proposed that the character of a therapeutic community was fundamentally based on three propositions: 'Everything is treatment; all treatment is rehabilitation; and all patients (once admitted) should get the same treatment'. Additionally, this Unit's prevailing ideology sought to foster democracy, reality

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[78] Ibid., pp.42-48.

[79] Jones, "War and the Practice of Psychotherapy," p.500.

[80] Jones, *Social Psychiatry in Practice*, p.173.

[81] Sanctuary Leadership Development Institute, *Maxwell Jones* ([cited).

[82] Malcolm Pines, "Therapeutic Communities in Teaching Hospitals," in *Therapeutic Communities: Reflections and Progress*, ed. R.D. Hinshelwood and Nick Manning (London: Routledge and Kegan Paul, 1979), p.26.

confrontation, permissiveness and communality.[83] A more recent definition is provided by Penelope Campling, who suggested that, in the UK, the term 'therapeutic community' denoted 'small cohesive communities where patients (often referred to as residents) have significant involvement in decision-making and the practicalities of running the unit'.[84] However, she differentiated the 'therapeutic community proper' from the 'therapeutic community approach', the latter being a phrase coined by former Maudsley Senior Registrar David Clark in his historical account of the reforming methods at Cambridge's Fulbourn Hospital.[85]

The Mill Hill legacy was further evident in a range of behavioural therapies – arguably the forerunners of contemporary CBT – which were offered at the Maudsley, often as part of funded research projects. The structured and quantifiable nature of these approaches made them easier to incorporate into outpatient or day patient regimes, and augmented the scientific credibility of the discipline in public and professional spheres. Having considered the range of services and facilities developed, we will now look in more detail at the work of Bethlem's (inpatient) therapeutic community and outpatient treatment units, and their connection to the new populations and demands the hospital was to satisfy in the latter twentieth century. There will be further exploration of the extent of change and continuity between novel approaches and older strategies, and on the centrality of charismatic leaders in advancing these ideas.

i) Inpatient Psychotherapy

The Charles Hood Unit opened at Bethlem in 1972, when Dr Robert Hobson closed the Tyson West Two inpatient unit at the hospital. Hitherto a general psychiatric ward, this building had, over previous decades, been incrementally requisitioned for psychotherapy purposes. The following discussion relates the circumstances precipitating the end of this service, and the emergence of the new Unit.

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[83] Rapoport, *Community as Doctor*, pp.52-54.
[84] Penelope Campling, "Therapeutic Communities," *Advances in Psychiatric Treatment* 7, no. 5 (2001): p.365.
[85] Clark, *The Story of a Mental Hospital*.

In a 1979 article, 'The Messianic Community', Hobson proposed that, despite achieving diverse popularity, the therapeutic community remained an amorphous and ill-defined concept; the resultant confusion sometimes to the detriment of patients and staff. He suggested that a lack of research was attributable to methodological difficulties and an absence of core underlying theory, concluding that 'we do not have anything approaching a psychology of personal relationships'. Drawing partly on his early Bethlem experiences, Hobson outlined his vision of a three-stage 'Therapeutic Community Disease', beginning with 'The Coming of the Messiah':

> A dedicated, enthusiastic leader brings a message of brotherhood in a new society. Usually, he is a sincere idealist with a fascinating charisma. Carrying the light of democracy into the darkness of a traditional mental hospital, he attracts a small body of followers, and, at the same time, arouses fierce opposition from the Establishment...Although he speaks of himself as 'just one member of a group', he becomes for his intimates virtually an incarnation of an archetypal figure – usually a Saviour Hero but sometimes a Great Mother. To others, he is a dangerous revolutionary or even the Devil...The leader and his colleagues collude in an idealization of himself and of the UNIT (now spelt in very large capital letters) which is often personified. The good UNIT is engaged in a battle with the powers of darkness: the 'badness' outside, which is embodied in the rest of the hospital, the traditional psychiatric establishment, or the world at large.

However, such an environment, he surmised, was beset by rumour, miscommunication, ritualised scapegoating, and a mounting 'persecutory anxiety' between individuals and groups. The second phase, 'The Enlightenment', occurred with the acknowledgment and attempted intellectualisation of such negative processes within the idealized community:

With dawning recognition that an egalitarian 'democratic' ideal has thinly disguised a destructive, albeit subtly concealed power-game, there is now a good deal of talk about the 'badness inside'. Debates occur about the definitions of 'role', 'status' and 'authority'....this rationalizing tendency often serves to exacerbate the persecutory situation.

If not promptly or constructively dealt with, Hobson asserted that the 'disease' could progress to a third stage, 'The Catastrophe', in which the unit could 'disintegrate and collapse'. He cited the 'serious psychological breakdowns' of prominent staff members, often consequent to the 'shattering' of the image of the Unit (the purported Brave New World) and illusion of themselves as leader. There were further risks of unresolved persecution and destructiveness causing 'acting out' (violence, suicide attempts, and secret sexual relationships) amongst patients and staff, and of the 'exclusive incestuous regression' of long-term community members.[86] The Bethlem unit indeed operated coterminously with the anti-psychiatry movement, but, whilst appearing to share some of its principles, did not explicitly identify with such activity. This serves to problematise the ideological position of the therapeutic community and, as per Fussinger's thesis,[87] points to under-recognised commonalities between outwardly opposing interests.

Hobson felt that 'the existence of Tyson West Two was maintained at a cost – a cost many of us are no longer willing, or indeed, able to pay'. Together with colleagues, he built the Charles Hood Unit on the principles of his 'Conversational Model, namely, the promotion of social learning, the centrality of language, and the ideal of 'aloneness-togetherness' – the ability to be both an individual with an identify, and a member of a community. Gone were the previous bold egalitarian claims, replaced by an emphasis on 'freedom and limits, authority and charisma, and the judicious selection of patients and staff'. The latter

[86] Robert F. Hobson, "The Messianic Community," in *Therapeutic Communities: Reflections and Progress*, ed. R.D. Hinshelwood and N.P. Manning (London: Routledge and Kegan Paul, 1979), pp.231-235.

[87] Fussinger, "'Therapeutic Community', Psychiatry's Reformers and Antipsychiatrists: Reconsidering Changes in the Field of Psychiatry after World War Ii," pp.159-160.

criterion included the refusal of certain severe or paranoid personality types, and sanctions against the 'useless language' of self-harm or suicide attempts.[88]

The new unit consisted of two parts: a nine-bedded hostel, with little supervision, and a day ward, offering individual and group psychotherapy. The 'therapeutic community' structure aimed to reduce dependence and institutionalisation, and encourage social interaction and caring. Hobson's unit served to provide experience and teaching in individual and group psychotherapy based on a psychoanalytic model, for both medical and non-medical staff. Furthermore, it allowed a special, intensive form of treatment for a group of very difficult patients, usually with long-standing personality disorders, for whom other methods of treatment had proved inappropriate or ineffective. Between November 1972 and April 1975, 31 patients were admitted (22 female; 9 male). Two thirds of these were aged 17-24, and most admissions (19) lasted 1-6 months.[89] These data therefore show a clear female predominance, akin to the prototypical female psychoneurotic admission some forty years earlier. As detailed below, the Unit had a rigorous selection procedure, involving a greater range of personal and professional backgrounds. It therefore appears less likely that the gender imbalance was still a corollary of professional attitudes. Rather, this effect could be due to females' greater willingness and capacity to commit to such treatment, or to comply with the Unit's exacting demands.

Drawing on oral histories and investigation of unit-level records, there will now be consideration of the various routes by which patients presented at the therapeutic community and what the treatment regime entailed, in terms of types and frequency of therapeutic activity. The Bethlem experience will be considered in the wider context of therapeutic communities, to identify contrasts and commonalities in ethos and practice. Although informants described the Unit as somewhat elitist and detached from wider Bethlem activities, it attracted residents from a variety of backgrounds. The only Charles Hood Unit records available were 15 patient case summaries from the year 1976-77. Of

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[88] Hobson, "The Messianic Community," pp.237-238, 240-241.
[89] BRHAM, "The Bethlem Royal and the Maudsley Hospital Report, 1970-75. Part I - Text," p.47.

these, five had been either transferred directly from inpatient wards, five were attending outpatient clinics, and one had been recently discharged from another institution. The remaining four self-referred through their GP or local services. Patients received a combination of group and individual therapy sessions several times a week, and were also expected to participate in a range of activities, including psychodrama, art therapy and social skills training. The ward was not locked, yet activities were all conducted on-site, and outside social interaction discouraged, arguably fostering a close-knit community ethos around a charismatic leader.

> The day really revolved around individual sessions with doctors, group sessions, they were very group-orientated, and obviously we spent a lot of time talking and doing activities. Occupational therapy was quite strong, one or two people were quite musical – there was a piano, I remember, and they used to play, and some people would sing occasionally and we used to have quizzes, but it was all kind of ....within the walls, really.[90]

Nurses also reported feeling privileged at having been chosen to work in the therapeutic community; one believed she was selected for being degree-educated[91] – a rarity amongst nurses of this generation – albeit this is not confirmed beyond anecdotal evidence. Moreover, the recollection that staff didn't wear uniform was also deemed by one to be another facet of the Unit's 'avant-garde' approach.[92] A recently-published account by a former Charles Hood Unit resident, Jackie Hopson, shed additional light on the operation of the Unit and the experiences of its residents.

> Winning a place in the Charles Hood Unit...was harder than getting into university and to me felt like a greater achievement. There were two long and demanding interviews, each time with a roomful of doctors, nurses and social workers. After

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[90] Participant 03, Interview by Author, 9th September 2010.
[91] Participant 04, Interview by Author, 30th September 2010.
[92] Irene Heywood Jones, Interview by Author, 5th August 2010.

the first interview, they sent me away with what seemed like an insuperable task: to finish university, get a job and survive for a few months....Some months and the second interview later, I was given a place.

Hopson lived in a large hostel (the former Hospital Steward's residence) called 'Winchelsea', and remembered the other occupants as being between 20 and 35 years old, and 'almost without exception, well-educated'. They shared responsibility for the running of the house, and, as members of the therapeutic community, participated in a full weekday timetable of (tape-recorded) groups, hostel meetings, and individual psychotherapy. Hopson emphasised the absence of psychotropic medication, but recalled that occupational therapy was provided four times a week, which included "social skills", psychodrama, and art therapy. Involvement in decision-making and the pervasive 'normality within our hospital experience' were fundamental, but the lack of hierarchy was felt to be

> ...both liberating and very frightening...sometimes we behaved like unruly children. One day in the pottery workshop, the OT potter having left briefly, we had fun throwing lumps of clay at each other and the ceiling. The OT leader returned to shout, "It's bloody bedlam in here!" which, of course, increased the hilarity.

Her sense of privilege at having been selected to engage in a 'rather experimental form of treatment' in many ways paralleled the testimony of Unit nurses. Hopson's predominant memory, however, was of being 'considered as human beings with futures that we might realise, rather than psychiatric dregs to be confined, drugged and, at all costs, to be kept away from the "healthy" population outside'.[93] These experiences reflected Unit ideals of

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[93] Jackie Hopson, *One Good Year: Being an in-Patient in the Charles Hood Unit, Bethlem Royal Hospital, 1974 -1975* [Blog] (Bethlem Royal Hospital Archives and Museum, 12/09/11 [cited 19/09/12)); available from http://bethlemheritage.wordpress.com/2011/09/01/first-person-narratives-3-one-good-year-part-1/.

openness, autonomy, and the creation of 'situations in which genuine meetings are likely to occur'.[94]

When considered in the wider therapeutic community context, the Charles Hood Unit was atypical in some respects. Particular variability was noted in the ethos, methods and clientele of other units, and admission criteria elsewhere reflected a growing adherence to diagnostic, rather than social, profiles. For instance, the therapeutic community at Belmont Hospital originally accepted '...people whom nobody else could understand or manage; at first it took men who had been unable to find or stay in work, but later it took those formally diagnosed as "psychopaths"'.[95] Contrasts were also observed in other aspects of ward life. In describing the (1958) creation of a therapeutic community – The Adrian Ward - at Fulbourn Hospital, Clark recalled initial resistance from prospective patients and nurses. The latter group feared boredom and faced marginalisation from colleagues in the wider hospital, who 'disapproved of all the freedom and of the long sessions of discussion between the doctor and the nurses'. He saw this as totemic of more diffuse problems of favouritism and envy affecting patients and staff. Although essentially self-governing, this unit encouraged a greater degree of social interaction than was apparent at the Charles Hood Unit. Thus, patients at Fulbourn

> ...arranged a number of outings, set up a welcoming committee to help patients newly transferred from the Admissions Villa, and made several trips to the admissions villa to improve relations...Some patients gave singing, piano, and painting sessions on the long-stay wards.[96]

In assessing the clinical composition of therapeutic community clientele, archival investigation showed that the majority of Charles Hood Unit patients attending from 1976

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[94] Hobson, "The Messianic Community," pp.239, 242.

[95] D. H. Clark, "The Therapeutic Community—Concept, Practice and Future," *British Journal of Psychiatry* 111, no. 479 (1965): p.950.

[96] Clark, *The Story of a Mental Hospital*, pp.166-168.

to 1977 had been diagnosed with some form of personality disorder, as defined by ICD criteria. There were also a number of cases of confirmed or suspected schizophrenia within this group, reflecting diagnostic trends reported in chapter 5. However, it is unclear whether standardised labels and codes were routinely applied to patients who had not had prior contact with psychiatric services. The tendency for self/GP referrals to feature longstanding, but vaguely defined symptoms – typically an inability to cope with domestic or workplace stresses – contrasted sharply with the degree of disorder amongst the Maudsley transfer patients, suggesting a correlation between illness severity and mode of admission. Although none of these individuals received compulsory treatment, this trend was reminiscent of the clinical dichotomy observed between voluntary and certified admissions to Bethlem in the early twentieth century.

Furthermore, there were many incidences of dual or multiple diagnoses, and the emergence of 'new' conditions – for example, anorexia nervosa, or drug dependency– which would soon become the focus of specialist treatment facilities. As discussed in chapter 5, this was one consequence of a mid twentieth-century taxonomical transition, whereby a number of former aetiologies were reconceptualised as discrete mental disorders. Despite allegedly accepting the most challenging patients, individuals could be excluded from the programme if their behaviour or attitudes were felt to compromise the wider progress of the Unit or abuse the support offered there, as typified by a patient who repeatedly self-harmed, despite having agreed to refrain from doing so.[97] In such situations, patients were transferred to a more closely supervised environment, in the hope that it could better contain their problems. Some were permitted to continue attending therapy sessions from their new base, if future benefits were envisaged. However, others, such as patient JK, were summarily discharged to outpatient care and 'medical model' drug treatments.

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[97] BRHAM, "Chd: Charles Hood Unit Inpatient and Outpatient Case Summaries,1976 - 1977," case no. 742740.

She began to say that it was not sufficient just to be understood, something must be done, something "physical", "breaking the rules", something with rather primitive concrete qualities. She became aware that when things (i.e. interpretations) were given to her, she was involuntarily spoiling them – "I keep getting in my own way...I can't help biting the hand that feeds me". An interpretation would be twisted so that its meaning was vicious and destructive. In a similar way, attempts at reparations turned into poisonous destructive remarks about Dr C...It was impossible to deal more directly with her aggressive impulses which...in reality were too strong to be contained. She consequently took to acting out, which relived some of her tensions but left the sessions empty and useless. Limits were then placed on her acting out with the clear sanction of discharge. She was unable to refrain from damaging herself and so destroyed her treatment.[98]

Many patients had hitherto received various forms of treatment, or, on arrival, were taking antidepressants or other prescriptions (e.g. methadone) which they were allowed to continue. Prior impressions and experiences of psychotherapy varied widely among the clientele, some regarding it as a last-ditch solution after the failure of drug-based interventions, whilst another harboured an 'expectation of having therapy performed upon him, like an operation by an expert which would eradicate his distressing fantasies'.[99] The promise of therapy as an escape was evident in the case of 18 year-old ND, a former Maudsley inpatient, who

...was always a difficult patient because of the negative stance he adopted. All treatment he insisted was completely useless, he would sit in treatment sessions with eyes closed and in a position of exaggerated relaxation. He said that he needed psychoanalysis, by which he meant he needed a chance to live fully in his world of dreams and fantasies so that he became more and more cut off from the real world, except, possibly, the television. This destructive part of him eventually

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[98] Ibid., case no. 757045.

[99] BRHAM, "Pcs: Psychotherapy Department Outpatient Case Summaries, 1974 -1986," case no. 750119.

led to his discharge. He missed more and more of the group sessions and when limits were set with the sanction of discharge, immediately broke the limits.[100]

Hobson elaborated further on the concepts of freedom and boundaries, reasserting the need for clear rules and penalties for both residents and staff. He decried any former 'pretence' that the (Tyson West Two) therapeutic community was an 'egalitarian society', instead proposing that authority was

> ...vested in the whole staff-patient group...there is a curious kind of 'equal asymmetry'...We need more courage to act responsibly, openly, and directly, in deciding to exclude or remove some patients and some staff, not waiting for them to be extruded as scapegoats. Ideally, they choose to leave.[101]

One may speculate that psychotherapy's countercultural cachet was shaped by prominent anti-psychiatry rhetoric, and patients' expectations may have been coloured by these more radical ideas and approaches, as demonstrated in the (1973) case of GH.

> He has developed a lack of interest in his life, in his studies, in everything generally which mattered to him before. This feeling came both gradually and abruptly. The abrupt change was the result of taking LSD. He has taken it over the year at fairly frequent intervals. At first he felt no special effect. Then he had the usual experiences, but on one occasion he had a very dramatic experience. He felt everything became disintegrated, then there was an experience of the world being different, especially a new meaning to death etc....He could only find interest in such subjects as Laing and Kelly construct theory. Asked if he would have sought

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[100] BRHAM, "Chd: Charles Hood Unit Inpatient and Outpatient Case Summaries,1976 - 1977," case no. 750428.
[101] Hobson, "The Messianic Community," pp.240-241.

treatment if it were not for the LSD experience, he said he would not have done so. What he wants from therapy is to become interested again.[102]

A generally high level of intelligence and education was reported amongst the residents, and academic stresses were frequently implicated in case histories, thus:

> She first got depressed at the age of 18. At that time she was due to take her 'A' levels and was extremely frightened of failing and thereby disappointing her parents...who had very high expectations of her ....Her wish was to rebel....handed in a blank paper at the examination and became more depressed afterwards.[103]

For the above patient, this episode signalled the onset of a psychiatric career, later beset by bereavement, consistent fear of (divine or parental) retribution, and identity crises; problems which were unsuccessfully treated with ECT before her psychotherapy commenced. In a separate case, it was felt that a patient's obsessions and bodily fixations originated in perceived abandonment and 'family pressure to achieve', such that:

> 'As this material emerged, she got very in touch with her inner despair, and how her life had been a "performance" for others' benefits, which conceals desperate feelings of unhappiness and rejection'.[104]

A number of additional recurring issues and therapeutic interpretations were found within Unit records. The concept of 'transference' is fundamental to therapy, and has been defined as 'the process by which a patient displaces on to his analyst feelings, ideas, etc., which derive from previous figures in his life'.[105] This was considered vital in either individual or group sessions, as a means to making the unconscious accessible to both

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[102] BRHAM, "Pct-03: Psychotherapy Assessment Files, September 1973 – January 1976," case no. 731689.
[103] Ibid., case MM, no number given. Letter from Heinz Wolff, 4/3/75.
[104] BRHAM, "Pcs: Psychotherapy Department Outpatient Case Summaries, 1974 -1986," case no. 692679.
[105] Rycroft, *A Critical Dictionary of Psychoanalysis*, p.185.

physician and patient, and thereby enabling the patient to be 'convinced and corrected'.[106] However, time constraints and negative transferences could also adversely affect the therapeutic relationship, as demonstrated in the case of DH. She entered the Unit aged 18, following two years of difficulty with school work due to anxiety and unhappiness, closely related to family relationships.

> In her first individual session, she discovered that she would only be seeing Dr C for 3 months. Her understandable bitterness about this dominated the entire three months, particularly as she felt rejected by her earlier out-patient therapist, Dr S. Accordingly, from the very beginning, Dr C was seen in the transference as two objects similar to her parents...She was able to see a real person who was distinct from these two images and who became the object of undeclared yet obvious feelings of love...She saw him for 8 sessions and was too hurt to come to the final 4. She discharged herself on the day Dr C left the Unit and has not taken up our offer of further help.[107]

Intellectualisation or demonstrations of psychological literacy were viewed as defence mechanisms, intended to control or neutralise social interaction. Thus, 21 year-old JC, was diagnosed with 'narcissistic, schizoid and obsessional disorder of personality development, and...Rigid controls (including the abuse of food and drugs) against primitive anxieties about absence of identity'. During bi-weekly 50-minute sessions, he

> Spent a lot of time neutralising areas of difficulty by intellectualising. It became clear that he read a lot of psychological literature and spends hours thinking of his "complex". He initially controlled the interviews and the therapist...Attempts to look for transferences are neutralised by him, jumping at therapist's ideas and

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[106] Foulkes and Anthony, *Group Psychotherapy: The Psycho-Analytic Approach*, pp.14-15.
[107] BRHAM, "Chd: Charles Hood Unit Inpatient and Outpatient Case Summaries,1976 - 1977," case no. 765045.

then he subtly changes them to his own preconceived notions, e.g. therapist represents father.[108]

It was likewise noted that 40 year-old designer, MF, '...has made little use of group activities during his stay, finding such structure very threatening. Individual therapy he found only slightly less so – constant intellectualisation and attempts to gain control of the situation'.[109] Professional opposition to such behaviour could also have stemmed from the threat it represented to their status; a fear which may, paradoxically, have been accentuated by the 'flattened hierarchy' of the therapeutic community.

Records indicated that patients often struggled to cope with the termination of therapy, whether attending on a residential or outpatient basis. Thus, for patient JB, who attended both individual and group psychotherapy, the final three months of treatment were specifically devoted to 'working on the problem of termination of therapeutic relationship'.[110] In a move which was seen as symbolically as well as practically important, others chose to set their own completion date. Fears of ending the therapeutic alliance were conceptualised in terms of attachment and loss, thereby alluding to failures of early (emotional) development. This was exemplified by the case of 26 year-old patient AF, who, it was observed

> Cannot conceptualise therapist leaving or new person coming. She hints at irrational thoughts but cannot put them into words. It is as though she functions like the very young infant who cannot differentiate between self and mother...In the session she apparently experiences some sort of realism (?the mother infant relationship) but the therapist is constantly aware that she may be thinking in a delusional manner – the very border of psychosis and neurosis.[111]

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[108] Ibid., case no. 751875.
[109] Ibid., case no. 752705.
[110] BRHAM, "Pcs: Psychotherapy Department Outpatient Case Summaries, 1974 -1986," case no. 720467.
[111] BRHAM, "Chd: Charles Hood Unit Inpatient and Outpatient Case Summaries,1976 - 1977," case no. 751261

Moreover, the 'separation hypothesis' stipulated that a mother's presence was required for healthy ego development, and that her absence during the child's early years could limit his capacity for affective relationships. Rapoport, an anthropologist, tested this thesis against the clinical and sociological features of therapeutic community residents at Belmont Hospital. He reported that patients who had experienced significant separation from either parent before the age of ten had ego weaknesses proportionate to the degree of separation, but concluded that 'this experience does not exhaust the possibilities for developing weak egos, nor does it assure this outcome'.[112] Other Bethlem staff invoked Donald Winnicott's theories in discussion of the necessity of 'good-enough mothering' in facilitating healthy mourning in response to loss, and in reducing the likelihood of depression.[113]

The current case study findings echo previous accounts of the downfall of therapeutic communities. Rapoport suggested that a major shortcoming of this approach was the lack of attention given to the aftercare of patients,[114] whilst Campling argued that a late twentieth-century decline in therapeutic communities was jointly attributable to NHS reforms and a shift in the prevailing social philosophy towards encouragement of individualism at the expense of collectivism.[115] Hobson's unit also proved short-lived, though his idea of a readily teachable 'dialogue between persons'[116] was articulated in the 'Conversational Model' of psychotherapy, which gained longstanding currency through the work of subsequent analysts. Thus, a 1986 paper by Frank Margison and David A. Shapiro concluded that 'the Conversational Model entails specifiable therapist behaviours which can be readily taught to trainee psychiatrists, and that the clinical effectiveness of

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[112] Rapoport, *Community as Doctor*, pp.312, 315.
[113] J. R. Pedder, "Failure to Mourn, and Melancholia," *British Journal of Psychiatry* 141, no. 4 (1982): p.329.
[114] Rapoport, *Community as Doctor*, p.3.
[115] Campling, "Therapeutic Communities," p.366.
[116] Robert F. Hobson, *Forms of Feeling: The Heart of Psychotherapy* (London: Tavistock, 1985), p.182.

an eight-session implementation of the model bears comparison with that of a similar package based on empirically grounded cognitive and behavioural principles'.[117]

Pines proposed that specific reasons for the demise of the Charles Hood Unit included 'a lack of internal support from the rest of the hospital, the expense of running a small unit with a relatively high staff ratio, and the competition of other items in the budget for priority'. However, he emphasised that the major challenge to the operation of this facility was its paradoxical selection procedure, whereby patients had to 'both warrant the offer of inpatient treatment for a considerable length of time (up to and sometimes over a year) and yet were thought to be able to maintain a considerable degree of autonomy within that setting'.[118] This arguably reinforced a Bethlem tradition of marketing to a privileged elite, contrary to Hobson's professed resistance to external hospital influences. Unit-level records supported the notion of a therapeutic community 'in, but not of' its parent institution, yet spoke to a more self-imposed exclusion; at odds with comparable units, where mixing and integration of patients was positively encouraged. This highlighted certain aspects of variability between communities, as therapeutic community advocates imposed their own values and experiences on Maxwell Jones' ideas, once more attesting to the theme of charismatic leadership. Oral histories reinforced the notion of an arduous selection procedure for all those connected to the Charles Hood Unit; a process seemingly designed to protect and nurture a core unit identity, and one which generated dual senses of privilege and marginalisation. Accordingly, this unit, and, to an extent, the broader therapeutic community movement, may be seen to have sowed the seeds of its own destruction.

ii) Outpatient Psychotherapy

The Joint Hospital's Outpatient Psychotherapy Unit was based at the Maudsley, but with interchange of staff with Bethlem. The number of referrals rose greatly in the 1960s, from

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[117] Frank Margison and David A. Shapiro, "Hobson's Conversational Model of Psychotherapy - Training and Evaluation: Discussion Paper," *Journal of the Royal Society of Medicine* 79, no. August (1986): p.471.
[118] Pines, "Therapeutic Communities in Teaching Hospitals," p.28.

167 in 1962 to 245 in 1966, but growth couldn't be sustained without a corresponding rise in number of psychotherapists. In the mid 1970s, the unit was staffed by four part-time consultant psychotherapists, one senior registrar, three registrars, five senior tutors in psychotherapy and various research assistants. According to Bethlem records, the caseload comprised a high proportion of severely disturbed, often schizoid personalities, presenting difficulties with interpersonal relationships or with psychosomatic or sexual problems. The Hospital Report noted that 82% fell into one or more of these categories, whilst the remainder included schizophrenics and those with affective disorders and borderline states. The majority were relatively young (17-44 years, mean age 30) but with an equal balance of men and women. Treatment typically ranged from three months to over three years, and casenote evidence showed that patients frequently changed from group to individual therapy. Additionally, the service collaborated with St. Francis' Hospital Dulwich and the Charles Hood Unit;[119] a rare instance of cooperation between the therapeutic community and other institutions, possibly heeding wider demands for a broadening therapeutic purview and greater continuity of care.

Inspection of outpatient casenotes can once more further understanding of the prevailing theoretical influences and attitudes, social and clinical composition of clientele and interpretation/handling of issues presented. This will be considered alongside the publications of a number of practitioners involved in the operation of this service. Requisite levels of income and intelligence were specified for successful analysis, alongside the incompatibility of certain disorders, behaviours or personalities. These restrictions were in accordance with original Freudian doctrines, which specified the exclusion of 'psychoses, states of confusion and deeply-rooted (toxic) depression', and rejected the use of psychotherapy for 'the speedy removal of (hysterical) symptoms'. However, an individual's perceived suitability for such treatment could also be determined by non-clinical factors. In accordance with prevailing psychiatric opinion, younger patients were preferred, on the grounds that:

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[119] BRHAM, "The Bethlem Royal and the Maudsley Hospital Report, 1970-75. Part I - Text," p.42.

> Near or above the fifties the elasticity of the mental processes, on which the
> treatment depends, is as a rule lacking – old people are no longer educable – and,
> on the other hand, the mass of material to be dealt with would prolong the
> duration of the treatment indefinitely.[120]

At Bethlem, intellect-based exemptions were further defended by the claim that 'those of a lesser ability develop less subtle conditions than those who can understand analytical procedures'.[121] Yet, such views were at odds with the approach of Murray Jackson and colleagues elsewhere in the Joint Hospital. An influential thinker, Jackson was notable for his use of (Jungian) psychotherapy with psychotic patients; his work on a 'therapeutic milieu' ward at the Maudsley was outlined in a 1992 paper.[122] He was an early advocate of extending the clinical remit of psychotherapy, by combining it with neurobiology and other approaches within general clinical psychiatry, and a proponent of training nurses in psychodynamics. Despite these ambitions, the Maudsley ward closed upon Jackson's retirement in 1987 and was not replaced.[123] This reinforces the argument that key charismatic individuals were central to the creation and development of psychotherapy; services, which otherwise lacked professional consensus, or, by definition, a conventional evidence base.

Rejection of chronic or criminal cases for psychotherapy was a manifest, but inconsistent, policy at the Joint Hospital. Class-related findings were elicited from psychotherapy casenotes, notably within patient backgrounds, reasons for seeking treatment and professional interpretation of symptoms.[124] Thus, a patient in the mid 1970s was

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[120] Sigmund Freud, *Collected Papers. Vol. 1, Early Papers: On the History of the Psycho-Analytic Movement* (London: The Hogarth Press and the Institute of Psycho-analysis, 1924), pp.257-259.
[121] D.M. Dunlop et al., eds., *Textbook of Medical Treatment* p.1041.
[122] M Jackson and R Cawley, "Psychodynamics and Psychotherapy on an Acute Psychiatric Ward. The Story of an Experimental Unit," *British Journal of Psychiatry* 160, no. 1 (1992): pp.41-50.
[123] Murray Jackson, *Unimaginable Storms: A Search for Meaning in Psychosis* (London: Karnac Books, 1994), pp. xix,185.
[124] BRHAM, "Pct: Psychotherapy Outpatient Case Assessments, 1964 -1986."

described as 'pleasantly bland, but essentially uncommitted…. I have no doubt that she found herself bored by the group's moderately intellectual tenor and desire to explore feelings'.[125] Another female was similarly dismissed as being 'of lowish intelligence which made it difficult for her to understand the innuendos of the group'.[126] However, as the following excerpt suggests, their male counterparts also found themselves recipients of such prejudices; yet, this was accompanied by an apparent openness to some social mixing:

> A rather pale-looking young man dressed in working-class clothing….I had the feeling that he might not have been in touch with what was going on and that he might have felt out of place with three middle-class, rather articulate persons, but it quickly emerged that he had in fact been following everything that was said and was able to identify himself with other person's problems….He has the capacity to relate and to identify to persons of both sexes and should be placed in a group which would not be overwhelmingly middle-class or over articulate.[127]

This belies an idea about the link between 'class' and intelligence which informed the treatment. In other cases, the choice to undergo therapy may have been viewed as an extension of an implausible masquerade, to be gradually dismantled in the group environment:

> In many ways, it is surprising that this highly schizoid young man, given to pathological lying, coped with a group at all. His outside life is so restricted and peculiar…. as far as one could gather, he spent much of his day hanging around the British Museum reading room, or London University, adopting the posture of

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[125] BRHAM, "Pcs: Psychotherapy Department Outpatient Case Summaries, 1974 -1986," case no. 712615.

[126] Ibid., case no. 720770.

[127] BRHAM, "Pct-05: Psychotherapy Assessment Files, June 1977 – Sept 1978," case no. 772653.

someone very involved in a variety of vague and esoteric subjects, about which he knew practically nothing.[128]

Gender differences were observed in other aspects of psychotherapy. Whilst familial or marital discord was widely manifest, females were more likely to be viewed as suffering under the weight of parental expectation, and substance abuse or aggression were more frequently invoked for men. Homosexuality (latent or overt) was another recurring theme, implicitly linked to loneliness, and, as illustrated below, often interpreted as a defence mechanism:

> I was impressed by the fact that he is keen on psychotherapy but at the same time the complete absence of any interest in girls certainly makes a prognosis as to a change in his sexual orientation rather doubtful. It is obvious that there are many reasons for his homosexuality: in his childhood particularly, the fact that he has never felt that his father had any interest in him whatsoever. He is thus continuously looking for love from a male figure. His relationship to women was no doubt also adversely affected by the fact that his own mother left when he was only a few weeks old and he and his brother were sent to a home.[129]

> His homosexuality and his lack of significant relationships in his life seem to me to have been a way out of his loneliness and at the same time to have threatened him whenever they had become too intimate.[130]

> He feels insufficiently masculine and is unsure as to whether he wishes to follow a homosexual rather than a heterosexual orientation....He is afraid that if he becomes more masculine he will behave just like his father, that is become violent

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[128] BRHAM, "Pcs: Psychotherapy Department Outpatient Case Summaries, 1974 -1986." case no. 711194

[129] BRHAM, "Pct-01: Psychotherapy Assessment Files, 1964-1969," case no. S2444.

[130] BRHAM, "Pct-03: Psychotherapy Assessment Files, September 1973 – January 1976," case no. 742949.

and alcoholic. I pressed him strongly on his motivation for insight and working through as opposed to support and symptomatic relief.[131]

Presented herself as a tall, slender woman in jeans and just a touch of the masculine in her dress, but not in her manners or expression... Had psychotherapy previously but 'quite useless' as she didn't mention that she knew she was a lesbian... Her need to idealise her father perplexed her for she knew at some level that he was no saint....The first seven years of her life were dreadful, marked by terrible emotional upheavals centred around his (previous) wife and children... I even wondered if her lesbian orientation didn't have the aim of defending her from negative feelings towards him.[132]

Furthermore, efforts were made to assuage a female divorcee's concerns that her new partner's homosexuality could prove an obstacle to wedded bliss:

...there is a man who lives in the same building as her who is a homosexual and an alcoholic ....who she finally started an affair with... She gradually found him a very kind, shy and lonely man, whose homosexuality and alcoholism were due to his loneliness. He became extremely fond of her and stopped drinking and seeing boyfriends. Now he has asked her to marry him. He is quite highly placed in the city and has money.....some sort of director in a business firm.[133]

The pathological stance taken towards homosexuality is less surprising in view of the fact that it remained an ICD diagnosis until 1992,[134] somewhat lagging behind the tides of social change. Parallel research into potential biological determinants of homosexuality

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[131] BRHAM, "Pct-05: Psychotherapy Assessment Files, June 1977 – Sept 1978," case no. 770163.

[132] BRHAM, "Pct-09: Psychotherapy Assessment Reports, June 1982 – December 1983," case no. 822498.

[133] BRHAM, "Pct-03: Psychotherapy Assessment Files, September 1973 – January 1976," case JL, no number given. Letter from J.H. Rey, 23/21/75.

[134] George Mendelson, "Homosexuality and Psychiatric Nosology," *Australian and New Zealand Journal of Psychiatry* 37, no. 6 (2003): p.678.

was also being undertaken at the Joint Hospital. Thus, in a 1962 *Lancet* article, Eliot Slater

reported that, amongst 401 males admitted to Bethlem or Maudsley Hospitals with ICD

diagnosis "320.6 – pathological personality, sexual deviation, homosexuality", mean

maternal age and birth order were both more significant than expected, showing 'a shift

from the standard of the general population towards the distribution shown by

mongols'.[135] In her discussion of Severalls Hospital, Diana Gittins also alleged that 'a

persistent lack of clarity as to what mental illnesses were meant that moral judgements

frequently determined diagnosis', with homosexuals, transvestites, and young women

with illegitimate children considered most vulnerable to such apparent illness. This

uncertainty was compounded by the availability of 'aversion therapy' - employing graphic

imagery and electric shocks – as (what Gittins termed) 'psychiatry's new toy' for treating

homosexuality in the 1950s and '60s.[136] The 1960s 'sexual revolution' had another,

somewhat different, ramification at Severalls, where it reportedly elevated concerns from

staff about female inpatients becoming pregnant; conversely, 'a blind eye was turned

towards homosexual relationships between patients'.[137]

Bethlem's assessment reports of this era also frequently featured comments on clients'

physical appearance, as follows:

> She also has fantasies of getting pregnant without having even been kissed by a
>
> boy! Together with this, she dresses in the opposite way to these fears. She wore
>
> make-up, long hair falling on her face, knee high black boots, and a mini skirt which
>
> was no screen for anything. Nobody could fail to see that there is conflict![138]

> The patient is a tall, slim girl with a punk appearance – wearing a mini-skirt,
>
> coloured tights, having dyed blonde hair with extensive dark roots showing and

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[135] Eliot Slater, "Birth Order and Maternal Age of Homosexuals," *Lancet* 279, no. 7220 (1962): pp.69-70.
[136] Gittins, *Madness in Its Place*, chapter 7: 'The Space and Pace of Treatments'.
[137] Ibid., pp.104-105.
[138] BRHAM, "Pct-01: Psychotherapy Assessment Files, 1964-1969," case ND, no number given. Report by H. Rey, 18/13/69.

wearing very bright make-up. She thus portrays a clownish appearance as if making a mockery of herself.[139]

However, such comments should be viewed in their appropriate context, namely, as a personal 'aide-memoire'; a technique potentially encouraged in training. As it did not serve as a clinical record, there would have been scant expectation of other doctors (or researchers) ever accessing this information.

The analysts themselves were usually, though not always, male, and tended towards a certain infantilisation of their female clientele, as illustrated by reference to a 30 year-old woman as a 'girl'. Moreover, it wasn't until the 1980s that the unit saw the hitherto inconceivable acceptance of a deaf patient.[140] Therapy was, nevertheless, generally conducted as a dialectic process, and patients' attitudes, expectations and prior experiences all reciprocally influenced consultations. Examples included clients questioning theory and methods employed,[141] seeking types of therapy not offered at Bethlem,[142] or dismissing treatment on the basis of unfavourable hearsay.[143]

Aubrey Lewis retired in 1966, and was replaced by Denis Hill, a key proponent of psychotherapy, which he considered an essential and versatile therapeutic tool. This approach flourished throughout Bethlem during his tenure, and the proliferation of ill-defined, ward-based groups had reached 220 per week by 1984, despite – in a reversal of previous circumstances - some opposition from patients themselves.[144] By the early 1970s, Heinz Wolff observed that psychosomatic medicine was no longer confined to the

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[139] BRHAM, "Pct-07: Psychotherapy Assessment Reports, Oct 1979 – March 1981," case no. 801840.
[140] BRHAM, "Pct-09: Psychotherapy Assessment Reports, June 1982 – December 1983," case no. 821633.
[141] BRHAM, "Pct-05: Psychotherapy Assessment Files, June 1977 – Sept 1978," case no. 730217.
[142] BRHAM, "Pct-03: Psychotherapy Assessment Files, September 1973 – January 1976," case no. 753346.
[143] BRHAM, "Pcs: Psychotherapy Department Outpatient Case Summaries, 1974 -1986," case no. 750199.
[144] Andrews et al., *The History of Bethlem*, p.687.

study of a small number of so-called 'psychosomatic disorders' but had found wider application in clinical practice.[145]

Discussion

The preceding investigation has demonstrated how, from informal beginnings, Bethlem's range of talking treatments expanded throughout the twentieth century, and this case study has been contextualised by reference to national milestones in the establishment of psychotherapy. Although constrained by the availability and reliability of evidence, the current combination of oral history and archival materials has shown the significance of institutional contexts in the diffusion of psychotherapeutic policy and practice. In particular, the Bethlem evidence has identified historical precedents of health consumerism, thereby presenting a revised account of the ethos and operation of twentieth-century institutional psychiatry. As with other developments at the hospital, what were later termed 'talking therapies' were offered on the basis anticipated demand rather than efficacy, and patients increasingly brought their own prior beliefs and knowledge to such encounters. At the local level, this augments the prototypical image of the educated, middle-class (especially voluntary) Bethlem admission. However, this enhanced appreciation of how people sought and applied new approaches to mental wellbeing also lends support to this being part of a wider shift, thereby reinforcing Thomson's contention that there was a need instead to 'bring together high and low psychological cultures'.[146]

Edgar Jones believed that many psychotherapeutic developments were direct descendants of wartime experience and innovation, and that 'having established their pedigree in the army, groups became an accepted form of treatment in the NHS'.[147] Whilst such factors were certainly a spur to the method's popularisation and acceptance

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[145] Heinz Wolff, "Basic Psychosomatic Concepts," *Postgraduate Medical Journal* 47, no. August (1971): pp.525-532.
[146] Thomson, *Psychological Subjects*, p.1.
[147] Jones, "War and the Practice of Psychotherapy," p.509.

in peacetime, at Bethlem, the ascent – and ultimate demise, – of a therapeutic community appeared more closely linked to the efforts of an inspirational unit leader, Dr Robert Hobson. This has parallels with the lifecycle(s) of units elsewhere, which were contingent on the enthusiasm and beliefs of key charismatic individuals, sometimes to the near exclusion of wider contact or influences. Thus, although the nuanced experiences of particular services were grounded in local institutional conditions, common threads identified can inform national level debate on this issue.

The territorial antagonism between psychotherapeutic services (markedly therapeutic communities) and orthodox psychiatry was perhaps unsurprising in light of the contrasting heritage of the disciplines, and the suggestion that the former evolved in response to the shortcomings of the latter. In his 1956 RMPA Presidential Address, T.P. Rees, Medical Superintendent of Warlingham Park Hospital, argued that the concepts of the open door and the therapeutic community were not new, but rather 'an indication of a return to what was best during the era of "the moral treatment of the insane"'.[148] Rees further emphasised the risk of institutionalisation from overly comfortable mental hospitals, and their '...unfortunate tendency...to boast of their high rate of turnover, and it is assumed that the higher the turnover, the better the hospital, and the greater the credit due to the doctors'.[149]

The Bethlem case study illustrates this changing trajectory of professional opinion, but also suggests that the evolution of psychotherapeutic approaches at the hospital was shaped by a wider array of influences and interests, than the purely local, thus emphasising the need for additional research to reappraise the processes of postwar psychiatric reform. Patients' attitudes and awareness arguably stimulated demand, and helped fashion the range of therapies and services available at Bethlem from the 1950s, yet other forces appear to have been operating in tandem to restrict this growth and,

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[148] T. P. Rees, "Back to Moral Treatment and Community Care," *British Journal of Psychiatry* 103, no. 431 (1957): p.306.
[149] Ibid., p.311.

eventually, bring about the cessation of once-popular services. Even when pioneering facilities such as day hospitals were implemented, there was apparently little attempt to promote their existence or benefits to other staff (and, hence, little hope of their being integrated into 'mainstream' psychiatric treatment). In the case of psychotherapy services, it is unclear whether the key obstacle was that of casual disregard, or of overt opposition to non-medical approaches. Although the official agenda at the Joint Hospital supposedly encompassed a diversity of theory and practice, one interviewee suggested that this alone was insufficient to moderate the personal antipathy of some of his colleagues: 'You had to be careful on his firm not to mention Freud. Because it wasn't just that he wasn't an analyst, he held Freud and all his works in disdain. A reasonable attitude, but a bit blinkered'.[150]

Key areas for speculation are the markedly 'closed' nature of the Charles Hood unit and the purportedly long tradition of psychotherapy at Bethlem, in contrast to the dearth of available records. Possible explanations for this again include psychotherapy's non-medical status, inter-professional rivalries, or social class of patients. Nursing staff recalled the stereotype of therapeutic community residents as 'neurotic skivers', and cast doubt over the legitimacy of their symptoms, depicting them as 'a younger, trendier group, more like 20s and 30s and 'kicking off' …not quite sure what the criteria was to get in there'.[151] Although this image supports the idea of patients' agency in service development, one is left with the overwhelming impression that a (partly self-imposed) culture of separation may have contributed to early developments in psychotherapy not featuring prominently in Bethlem's archive, whilst subsequent incarnations increasingly fell foul of demands of economy and evidence.

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[150] Griffith Edwards, Interview by Author, 7th December 2010.
[151] Irene Heywood Jones, Interview by Author, 5th August 2010.

Chapter 8: Discussion

The last two decades have seen renewed attention to the twentieth-century history of the psychiatric hospital. This interest has moved beyond decarceration or humanitarian narratives, to look afresh at the asylum as the location of novel treatment regimes. While some have linked a traditionally narrow focus in psychiatric historiography to the formation of imposing, isolated, and inhumane institutional tropes,[1] other, more recent, scholarship has demonstrated the value and versatility of case studies to informing wider concerns within psychiatry. Thus, Edgar Jones and colleagues in their 2010 study shed new light on the Maudsley Hospital's contributions to fields such as psychotherapy[2] and the conceptualisation and treatment of wartime trauma.[3] They also utilised admissions data to reveal a contrast between the institution's intended and actual patient profiles,[4] whilst a further paper explored the role of funding bodies[5] in shaping hospital protocol. Institutional case studies have also served to challenge widely-accepted narratives of the processes and determinants of therapeutic change. For example, Cherry stated that, 'for all the emphasis on war as a catalyst for psychiatric treatments and the impact of the 1930 Mental Treatment Act, the inter-war St. Andrew's Hospital provided a more relaxed but not dissimilar environment from the Edwardian asylum'.[6] Similarly, Pamela Michael asserted that, although the First World War was widely deemed a 'watershed' in the treatment of mental illness, any resulting paradigm shift was not immediately apparent in admissions, theories, or therapies at Denbigh. Instead, 'the overwhelming focus of both staff and official visitors was on the material fabric of the asylum and the physical health of its patients'.[7]

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[1] Cherry, *Mental Health Care in Modern England*, p.305.
[2] Jones, "War and the Practice of Psychotherapy," pp.493-510.
[3] Edgar Jones, "Shell Shock at Maghull and the Maudsley: Models of Psychological Medicine in the UK," *Journal of the History of Medicine and Allied Sciences,* 65, no. 3 (2010): pp.368-385.
[4] Jones and Rahman, "Framing Mental Illness, 1923-1939," pp.107-125.
[5] Jones and Rahman, "The Maudsley Hospital and the Rockefeller Foundation," pp.273-299.
[6] Cherry, *Mental Health Care in Modern England*, p.312.
[7] Michael, *Care and Treatment of the Mentally Ill in North Wales, 1800-2000*, pp.111-112, 121.

The present research sought to analyse the changing nature of institutional care for psychiatric patients in mid twentieth-century Britain, though a case study of Bethlem Royal Hospital. Secondary objectives were: to explore the role of legislative frameworks in shaping the institution, through analysis of the composition of patients, in terms of admission patterns; to investigate changing definitions of mental illness, with respect to diagnosis and social factors; and to examine the impact on service organisation and treatment of scientific developments in the theory and practice of psychiatry. These secondary objectives led to the identification of four key themes, which permeated the research and are outlined below. Present findings will now be discussed in terms of their local (institutional) and national level significance.

Local Contributions

In addressing events of the twentieth century, this research is situated at a nexus between traditional, Bedlam-esque, depictions[8] and Bethlem's modern-day presence at the international forefront of psychiatric treatment and research. Secondly, the themes and debates which have emerged as significant from this study are germane to wider concerns within the chronologically recent, but conceptually distant, history of psychiatry. According to Andrews, 'Bethlem rigidly excluded children and adolescents until 1948. Equally, an effort was made to discourage those over 60, in the belief that a cure was unlikely....The creation of an adolescent unit and a psychogeriatric unit ...did not materially change the emphasis...it was not until the 1960s that there was a real shift'.[9] However, there had hitherto been limited analysis of how, for example, patients' social class, age, or gender, affected their propensity to mental disorder, and the nature of treatment they experienced, despite the publication of psychiatric epidemiological surveys from the 1950s.[10] The present study brings new sources to bear on the analysis of backgrounds of patients admitted to the hospital between 1930 and 1983, their diagnoses, and the treatment they received, thereby building on the foundations of the

[8] Allderidge, "Bedlam: Fact or Fantasy?," p.18.
[9] Jonathan Andrews et al., *The History of Bethlem* (London: Routledge, 1997), p.658.
[10] Carstairs et al., "Changing Population of Mental Hospitals," pp.187-190.

twentieth-century history of the institution already established by Jonathan Andrews[11] and Keir Waddington.[12] Exclusive access to closed records allowed fresh insights into the emergence and operation of new services and approaches and the changing patient profile; findings which were informed by a wider scientific and medical literature, and later complemented, and augmented, by the first-hand testimony of retired Bethlem nurses, psychiatrists, and administrators. Moreover, the creation of an admissions database facilitated the casenote follow-up of specific patient populations, thereby providing a richer, extended view of individual journeys through the hospital system. Besides introducing new voices to the existing institutional literature, the current evidence provided an examination of top-down effects on hospital practice, in such areas as the impact of key legislation on admissions patterns; the ward-level usage of psychiatric drugs in the early twentieth century, or the acceptance and implementation of new diagnostic criteria. These aspects are explored in more detail below.

At the local level, the combination of admissions data and qualitative evidence provided a detailed and contextualised account of Bethlem inpatients and their experiences from the 1930s to the 1980s. Four national-level themes also emerged from the case study evidence. The first of these, the appearance of a consumerist model of mental health, was evidenced chiefly through hospital marketing materials, and, reciprocally, the beliefs, experiences, and preferences of patients and their families as documented in casenotes and correspondence files. A second key theme was a mid twentieth-century transition from aetiological to diagnostic frameworks of mental illness. Although this was partly a consequence of new, outwardly scientific, systems such as the ICD and DSM, the ensuing proliferation of new 'disorders', and the medicalisation of former causal factors, were to contribute to shifts in service provision and the profile of psychiatric admissions. Thirdly, gender-specific attributions and treatment observed in interwar records often arose from practitioner attitudes and social pressures. Yet, in subsequent decades, there was greater evidence of a 'meeting of minds' in the experiences of male and female patients. Finally,

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[11] Andrews et al., *The History of Bethlem*, especially chapters 33-34.
[12] Waddington, "Enemies Within," pp.185-202.

the aforementioned changes in patients' backgrounds, knowledge, and expectations, were also intertwined with the expansion and diversification of psychotherapy and psychodynamic approaches. These key themes are interwoven throughout the four results chapters and provide the framework for the forthcoming discussion. There will now be reflection of the ramifications of current findings for the larger historiography.

Consumerism and the Hospital Marketplace

Although recognising that literature on health consumerism is contested, the current research indicated that, broadly construed, this was an impetus to localised changes, which were often resonant with transitions in psychiatric provision on a national scale. The findings thereby accentuate the influence of this previously underestimated factor in underpinning developments in twentieth-century institutional care.

The study commenced by considering the 1930 Mental Health Act, which endorsed voluntary and outpatient psychiatric treatment, and ended with the 1983 Mental Health Act, which placed legal controls on the application of certain therapies, and introduced the Mental Health Act Commission to monitor standards of care. However, 1930 was also significant from a localised perspective, marking the year in which Bethlem relocated from on overcrowded London site, to genteel, purpose-built accommodation in rural Kent. The hospital had welcomed its first 'informal' admissions in 1882, whilst, in 1915, the newly-completed Maudsley Hospital was awarded Parliamentary dispensation to defray the costs of treating voluntary patients.[13] Bethlem's Resident Physician Superintendent, George Henry Savage, viewed these changes as necessary for financial and professional betterment when other institutions had already done likewise in an attempt to court a superior class of patient. He was, therefore, dismissive of any impact of the new clause on existing hospital practices. Moreover, records suggested the hospital governors opposed the Act's introduction of a 'temporary' admission class (permitting detention without certification for up to six months) regarding it as at best unnecessary, and at worst, a

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[13] Jones, Rahman, and Woolven, "The Maudsley Hospital: Design and Strategic Direction, 1923-1939," p.363.

therapeutic impediment, contributing to an increase in recorded patient mortality rates.[14] While it may be argued that the Act signalled the recognition of new patterns of asylum utilisation already underway in the non-statutory sector, the current evidence indicates that the legislation was neither as innovative nor widely embraced at a practical level as official accounts may have alleged. Although the 1930 Act cannot, therefore, be credited with introducing the practices of voluntary or outpatient treatment to Bethlem, it presaged a steady rise in the number of informal patients, and, by 1939, Andrews et al. reported that over 75% of cases were admitted this way.[15]

The Bethlem data challenged the novelty and impact of legislative reform, and the significance of patients' legal status. As shown in chapters 4 and 5, a patient's negotiating power in hospital decision-making appeared to be influenced more by their financial circumstances or their ability to express their concerns; variables which were further framed by an individual's social class and gender. Institutional histories have generated a similar picture with regard to the sometimes peripheral role of legal status. Steven Cherry depicted the 1930 Act as an extension of earlier policy innovation in Norfolk, which had included the (1923) renaming of the institution as 'St. Andrew's Hospital', the introduction of a parole system, and provisional attempts at outpatient services. Although noting that the Act 'suggested a degree of empowerment for some patients and the possibilities of greater cooperation between doctors and patients in the quest for cure' he also believed that voluntary status conferred few guarantees regarding treatment or discharge: whilst, on paper, informal patients were entitled to discharge themselves at 72 hours' notice, choosing to exercise this right could lead to certification and readmission. He also reported 'little success' in the usage of 'temporary' patient status; a finding supported by the current study.[16]

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[14] BRHAM, "Report of the Physician Superintendent for the Year Ending 31st December 1930," p.8.
[15] Andrews et al., *The History of Bethlem*, p.655.
[16] Cherry, *Mental Health Care in Modern England*, p.172.

The year after the 1930 legislation, the Lunacy Commissioners' Schedules were amended, with the addition of a class of 'psychoneuroses', exclusively for the assorted hysterias, obsessions, and phobias, of a new generation of voluntary patients. For David Armstrong, the arrival of this category 'formalised an increasing concern of general medicine with the mind. The mind in all its detail had become important – not the diseased mind of the mad or insane, but the ordinary mind or everyone'. Whereas the former concept of 'neurasthenia' had been attributed expressly to over-exertion, the neuroses recognised more generalised stress, 'which might appear in anyone'.[17] The 1930 Act also accrued greater influence through its secondary effect on therapeutic directions at Bethlem. Thus, the opening up of voluntary and outpatient treatment options stimulated a requirement for brief and 'acceptable' forms of therapy to address new social and clinical demands. Such pressures interacted with mounting scientific and professional concerns from the mid twentieth century, which are explored further later in this section. Michael noted that, post-1930, institutional provision within north Wales was unchanged, but saw greater significance in the Act's promotion of 'a much wider cultural shift....encompassing the attitudes of the general public, a commitment to reform at the local level, and the willingness of GPs to alter their procedures and strategies for patient care'. She also linked the mid twentieth-century rise in voluntary admissions to the availability of surgical and shock treatments, which shortened hospital stays, and aligned mental hospital experiences to those of general hospitals, thereby sustaining the practice of leucotomy until 1966;[18] trends which find tentative support in chapter 6 of the present study.

Further mid twentieth-century legislation provided a top-down influence on the nature of psychiatric treatment and populations. Nearly half of the beds inherited by the National Health Service (NHS) were in mental, or mental deficiency, hospitals, yet blueprints for the NHS had omitted plans for mental health. The eventual NHS Act was also significant in providing the underlying impetus for Bethlem's merger with the Maudsley Hospital, and the consequent acquisition of teaching status granted the Joint Hospital some autonomy

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[17] Armstrong, *Political Anatomy of the Body*, pp.22-23.
[18] Michael, *Care and Treatment of the Mentally Ill in North Wales, 1800-2000*, pp.126, 169.

from external policy directives. According to Kathleen Jones, the 1959 Mental Health Act was a 'considerable legislative advance', which freed mental hospitals and most of their patients from separate, and stigmatising, designations.[19] For Michael, it 'implied a movement towards decentralisation and more emphasis on local authority and community-based provision'.[20] However, as others have pointed out, the Act removed the legal barriers to community care, but didn't legislate for, or fund, it.[21] The Act drew on the principles of the 1954 Royal (Percy) Commission, whose 'brave, comprehensive and forward-looking' report of 1957 was enshrined within law just two years later. Joint Hospital Medical Committee minutes documented internal discussion of the likely effects of the 1957 Report, with particular reference to terminological shifts and changes to certification rules these suggested. It was felt that difficulties could arise from the lack of any precise definition of 'psychopathic', but, for severely sub-normal patients, there were perceived benefits from the easing of the need for statutory admission, the granting of discharge powers to family members, and the enhanced potential for community care or flexibility of transfers between institutions.[22] In acceding greater agency to the patient's family, this legislation represents another example of formalising existing practices at Bethlem, namely the processes of negotiation and collaboration elicited from patient correspondence files of the first half of the twentieth century (see chapters 4 and 5).

Akihito Suzuki previously argued that nineteenth-century Bethlem physician, Charles Hood, urged the 'disfranchisement of the family as a proper component of psychiatric discourse', believing them to be unaware of, or actively suppressing, key information about their relative's illness.[23] The present study reveals something of the twentieth-century dynamics of these relationships, at a time when patient and family preferences

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[19] Jones, *Asylums and After*, p.157.
[20] Michael, *Care and Treatment of the Mentally Ill in North Wales, 1800-2000*, p.189.
[21] Freeman, "Psychiatry in the National Health Service, 1948-1998," p.5.
[22] BRHAM, "Mcc: Medical Committee Documents and Minutes, 1955-1957," MCD.61/57 - Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (Percy Report) - Memo by House Governor and Secretary.
[23] Suzuki, "Framing Psychiatric Subjectivity: Doctor, Patient and Record-Keeping at Bethlem in the Nineteenth Century," pp.128-129.

were further informed by new ideas and circumstances. In so doing, these findings build on Mathew Thomson's account of the evolution of popular psychology during the interwar period; techniques and literature that served to provide a 'language and topography of self to access hidden levels and harness them towards ethical, social, and sometimes spiritual, ends'. This, he proposed, evolved in conjunction with a questioning of orthodox and expert discourses, and prompted a contentious (re)defining of the boundaries of health and illness.[24] For example, chapter 4 of the current study highlighted the primacy of religion in some patients' histories, the antagonism of such beliefs with modern concepts of selfhood, and the ways in which faith-based views and behaviours were professionally interpreted and accommodated. Prior psychotherapeutic experiences, awareness, and preferences, were also repeatedly evidenced from casenote investigation. Moreover, as reported in chapters 5 and 7, Bethlem's outreach activity and moves towards multidisciplinary working from the mid twentieth century were important conduits through which external voices began to permeate the hospital culture, to sharpen the focus on key populations, and to shape the experiences of patients and staff. However, as detailed in chapter 4, such moves inevitably resulted in a wider spectrum of professionals – all with subjective knowledge of, and attitudes towards, mental illness – becoming additional 'gatekeepers' to psychiatric services.

Chapter 6 explored the lineage, uptake, and usage of key physical and pharmaceutical treatments, and the circumstances under which they were administered. It also addressed the interaction of policy and educational messages in treatment decisions, together with the perceived nature and chronicity of their 'target' disorders, and considered the influences of changing clientele and hospital regimes on favoured treatment practices. The research reaffirmed the accepted notion of differing therapeutic traditions and agendas between Bethlem and the Maudsley Hospital, and of continuing role disparities after the merger.[25] At the latter institution, treatment decisions were determined chiefly by research and educational demands, and the civilian hospital retained interests in the

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[24] Thomson, *Psychological Subjects*, pp.8-10, 51-52.
[25] Russell, *Scenes from Bedlam*, p.196.

research and treatment of wartime traumas.[26] By contrast, at Bethlem – at least during the first half of the twentieth century – the adoption of new techniques and apparatus appeared more closely linked to status concerns and the (perceived) demands of the target clientele. Thus, it subscribed to a variety of zeitgeist physical treatments, often, seemingly, more in the spirit of self-promotion than therapeutic rigour,[27] and in 1930s brochures, occasional images of 'scientific' apparatus were interspersed between glossy (albeit deserted) vistas of the hospital environment.[28] This evidence provisionally supports the idea that, in tandem with wider social and medical trends, features of 'consumerism' became a critical factor in the development of twentieth-century psychiatric treatment and practice.

Although not atypical in its ignorance of the workings of methods it endorsed, some approaches and equipment retained a presence at the hospital long after they had been physically and conceptually abandoned by institutions elsewhere. To illustrate, Medical Committee minutes of 1950 documented the reallocation of beds for new facilities, but ruled that insulin coma wards should remain despite the method's declining application and scientific credibility.[29] Approval for the practice was formally withdrawn over the following decade, and, by 1964, a nursing textbook attributed any supposed 'successes' instead to concomitant 'intensive nursing and medical care, and group resocializing effects'.[30] This reversal of opinion alludes to a mid twentieth-century privileging of tradition and perceived demand over scientific evidence; principles which were relegated in subsequent decades, amidst practical and ideological challenges. Further evidence to this effect is provided in chapter 6.

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[26] Jones, "Shell Shock at Maghull and the Maudsley: Models of Psychological Medicine in the UK," pp.394-395.
[27] BRHAM, "Report of the Physician Superintendent for the Year 1931," p.12.
[28] BRHAM, "Bethlem Royal Hospital: Prospectus, 1932," pp.8-9.
[29] BRHAM, "Mcc-01: Medical Committee Documents and Minutes, 1950," p.9.
[30] Ackner, *Handbook for Psychiatric Nurses*, p.302.

The identification of quotidian but unassuming pre-1950s psychotropic drug usage at Bethlem supports a previous investigation by Joanna Moncrieff. This contrasts with the well-documented 'heroic' use of surgery and shock treatments, including insulin coma therapy, Cardiazol and leucotomy.[31] The latter methods were rarely employed at Bethlem, and, of the few cases identified, no clear link was found to gender or legal status, although neither can be entirely discounted as a determinant of treatment approaches, given the low number involved. Comparison of cases treated by insulin a decade apart suggested that physicians grew less cautious in administering comas to patients, but achieved no sustained therapeutic benefit in either instance. An (albeit isolated) account[32] of treatment by Cardiazol shock also reinforced Jesper Vaczy Kragh's assertion that psychiatrists exploited patients' fears of this method for the purpose of controlling behaviour.[33] Conversely, Edward Mapother reportedly refused to sanction the use of Cardiazol, insulin, or lobotomy at the Maudsley, 'driven by the knowledge that patients would vote with their feet'[34] and, moreover, 'feared to risk the lives of voluntary [patients], especially with our fierce local Coroner waiting to pounce on us at the slightest provocation'.[35] In this context, the decision to administer physical methods is thereby framed as a dialectic process, involving clinical, legal, and reputational concerns.

Aetiology to Diagnosis

As shown in chapter 5, a move from anecdotal observation to systematic classification saw Bethlem's 1907 introduction of the Lunacy Commissioners' coding schemes, which reported in great detail the proven, or suspected, aetiology (causes) of insanity. This was accorded separate status to 'form of disorder' (diagnosis), and such decisions continued to draw on both medical and lay opinion, in seeking to establish a comprehensive medical history of the patient and, where possible, their relatives. Regular attributions of heredity,

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[31] Moncrieff, "An Investigation into the Precedents of Modern Drug Treatment in Psychiatry," p.481.
[32] BRHAM, "Cwc: Departures and Deaths Patient Casebooks, 1923 -1953," ref. no.1220.
[33] Kragh, "Shock Therapy in Danish Psychiatry," p.352.
[34] Jones, Rahman, and Woolven, "The Maudsley Hospital: Design and Strategic Direction, 1923-1939," p.378.
[35] William Sargant, *The Unquiet Mind : The Autobiography of a Physician in Psychological Medicine* (London: Heinemann, 1967), p.53.

or critical periods (puberty, climacteric, senility) within this category, initially suggested a persistence of deterministic theories of mental illness, a notion reinforced by the close attention to familial patterns of mental or nervous distress. Yet, this was increasingly counterbalanced by the presence of 'mental stress' or 'no factor assignable' as aetiologies, implying a gradual ascent of more contingent explanations throughout the first half of the twentieth century.

The Lunacy Commissioners' schedules remained in use until the late 1940s, at which point the new Joint Hospital made the gradual transition towards the World Health Organisation's *International Classification of Diseases* (ICD) framework. A departure from basic cause-effect dichotomies, and increasing recognition of multiple and varied causes of mental distress, were thus accompanied by efforts to describe and codify an array of additional disorders. The emergence of 'new' diagnoses - notably depression and personality disorders - was greeted, on occasion, by confusion, disregard, or resistance, towards changing nomenclature, and calls for the reinstatement of older terminology.[36] Moreover, the later twentieth-century proliferation of psychiatric conditions resulted in several former aetiological factors being reframed as diagnoses, arguably conflating source and symptom of problems such as alcoholism. This resonated with wider dissent, and questions regarding the reliability[37] of psychiatric labels and national variation[38] in diagnostic practice. Chapter 5 demonstrated how Bethlem's acknowledgment of the influence of environmental factors on even 'predisposed' constitutions, also contributed to the departure from wholly hereditarian explanations of causality, and the replacement of 'critical periods' with an extended range of age-specific diagnoses. This chimes with both the gradual departure from single-cause aetiologies observed within Bethlem casenotes from the 1940s, and subsequent attempts to integrate physical and

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[36] Parker et al., "Issues for Dsm-5: Whither Melancholia? The Case for Its Classification as a Distinct Mood Disorder," pp.745-746.

[37] N. Kreitman, "The Reliability of Psychiatric Diagnosis," *British Journal of Psychiatry* 107, no. 450 (1961): pp.876-886.

[38] J. R. M. Copeland et al., "Differences in Usage of Diagnostic Labels Amongst Psychiatrists in the British Isles," *British Journal of Psychiatry* 118, no. 547 (1971): pp.629-640.

psychological interventions, as described later in this chapter. William Ray Arney and Bernard J. Bergen suggested that, by the mid twentieth century, 'medical discourse was expanding to become something more than strictly medical'. They showed how, by the 1980s, the trajectory of textbook advice on the origins and treatment of alcoholism had arrived at a model which encompassed biophysical, psychological, and sociological considerations.[39]

Similarly, therapist and writer, Darian Leader, asserted that a 'commodification of the psyche' has been reflected in the explosion of psychiatric diagnoses, rising from between one and two dozen in the early twentieth century, to over 360 by the early 1990s. Observable, superficial states such as shyness are now pathologised as defining disorders, some of these conditions created and advertised by drug companies seeking to secure niche markets for their products.[40] Likewise, the publication of the DSM-5 has reignited debate on the 'ever-widening net of "mental disorder" that (it) seeks to cast over unhappiness, personal misfortune and troubling conduct'.[41]

Whilst not a comprehensive survey, the medical and psychiatric texts consulted in the current study variously presented ambiguous impressions of the causes and manifestations of key mental disorders, which were reaffirmed in casenote evidence. That is to say, they appeared over-determined by contemporary social and gender norms, which may thus have elevated the risk of (what are now considered) harmful or inappropriate therapeutic interventions. Such shortcomings would, arguably, acquire a new significance, as GPs' psychiatric caseloads increased, and they necessarily took on the mantle of providing appropriate support or referrals. Two articles provided some

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[39] William Ray Arney and Bernard J. Bergen, "The Anomaly, the Chronic Patient and the Play of Medical Power," *Sociology of Health & Illness* 5, no. 1 (1983): pp.9-11.

[40] Darian Leader, "A Quick Fix for the Soul," *Guardian*, Tuesday September 9 2008.

[41] Mark Rapley, Joanna Moncrieff, and Jacqui Dillon, "Carving Nature at Its Joints? D.S.M. And the Medicalization of Everyday Life," in *De-Medicalizing Misery: Psychiatry, Psychology and the Human Condition*, ed. Mark Rapley, Joanna Moncrieff, and Jacqui Dillon (Basingstoke: Palgrave Macmillan, 2011), pp.2-4.

indication of the scale and nature of this problem: a 1962 *Lancet* paper[42] estimated that 30-90% of 'organic' complaints under the care of GPs had a psychiatric component, and a (1964) general practice survey of psychiatric morbidity in Greater London suggested the existence of vulnerable subgroups (especially middle-aged females) 'suffering from minor disorders which are inadequately represented in hospital practice'.[43] The first trend may reflect female bias in both referral for, and recognition of, mental disorder, and is congruent with patterns of voluntary admission to Bethlem (chapters 4 and 5). However, institutional heritage and new diagnostic criteria also served to augment this trend. The latter finding speaks to shifting postwar priorities for limited psychiatric beds, with the emphasis increasingly on the violent (male) patient, whose symptoms defied community management, and again resonates with the findings of the current study.

As discussed in chapter 4, diagnostic shifts also entailed the refocusing of interest on particular age groups. One manifestation of this was the emergence of the new field of psychogeriatrics in mid twentieth-century Bethlem. Claire Hilton proposed that, notwithstanding neuropathological concerns, mental problems affecting older people were, traditionally, a neglected and largely unattractive research prospect.[44] Research in this field was impeded by a belief in the incurability of such disorders, coupled with pervasive negative stereotypes of this population; a situation which, Pat Thane proposed, did not significantly alter until the 1960s.[45] In this context, Bethlem's (1948) inception of a psychogeriatric unit, under the directorship of Felix Post, was a pioneering venture, but oral history evidence[46] indicated that the service lacked a therapeutic culture, retained gender and class imbalances, and that, elsewhere in the hospital, age was still deemed a barrier to treatment.[47] In 1970, the admission age was increased from 60 to 70 years; a move which precipitated an overall decline in numbers, and strengthened the ward's

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[42] Tredgold, "The Integration of Psychiatric Teaching into the Curriculum," p.1345.

[43] Shepherd et al., "Minor Mental Illness in London: Some Aspects of a General Practice Survey," pp.1362-1363.

[44] Hilton, "The Origins of Old Age Psychiatry in Britain in the 1940s," pp.267-270.

[45] Thane, *Old Age in English History*, pp.450-451.

[46] Rhiannon Harlow Smith, Interview by Author, 2nd September 2010.

[47] BRHAM, "Pct-07: Psychotherapy Assessment Reports, Oct 1979 – March 1981."

female predominance. The existence of the Unit ultimately assisted the reconceptualisation of older patients as a group with discrete, but remediable, disorders, and thereby challenged their devalued status within the medical and public imagination.

Data presented in chapter 4 showed that although the mean age of sampled patients remained fairly constant between the 1930s and 1980s, this concealed greater variation between men and women, and a postwar increase in the number of admissions at either end of the age spectrum (namely, under 20 and over 70 years). This was, at least in part, a reflection of new services arriving from the 1940s, which prioritised the clinical needs of these age groups. By the mid twentieth century, Bethlem, and St. Ebba's Hospital, Epsom, were the first units nationally to make discrete provision for adolescent patients, whilst the emerging specialisms of addictions treatment also routinely attracted a twenty-something, male, clientele. Thus, these new services both directly and indirectly contributed to the growing proportions of the oldest and youngest populations at the hospital, even if this was not evidenced in an official change of policy.

Research priorities appeared increasingly instrumental to age-related service development at Bethlem. This builds on the contention of Bonnie Evans et al. that the arrival and ascent of mental hygiene and child guidance concerns in the late 1920s provided the 'intellectual context' for developments in child psychiatry, marking a departure from organic explanations, towards new interest in the social roots of childhood mental illness, and the therapeutic application of behaviourist concepts.[48] At the time of the merger, it was noted that the Joint Hospital's various 'special activities' - e.g. child, adolescent, geriatric, and neurosurgical units – influenced both the type of patient admitted, and the possibility of their being retained in hospital for 'longer than the customary period'. Patients transferred from other mental hospitals were also 'admitted largely in connection with research projects'.[49] This signalled a general departure from the

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[48] Bonnie Evans, Shahina Rahman, and Edgar Jones, "Managing the `Unmanageable': Interwar Child Psychiatry at the Maudsley Hospital, London," *History of Psychiatry* 19, no. 4 (2008): p.472.
[49] BRHAM, "Triennial Statistical Report, Years 1949-1951," pp.4-5.

prioritisation of localised services, towards a geographically wider remit of specialist investigation and intervention; a further encroachment into the mental health marketplace. The emergence of these services also speaks more broadly to Armstrong's theory that categorisation legitimised new modes of surveillance and social intervention; by establishing 'new zones of visibility it thereby created the space for the observing gaze of new disciplines'.[50] Within the current study, a transition from aetiological to diagnostic frameworks, a departure from hereditarianism, and an expansion of new 'conditions', all reinforce subjective influences and value judgement, and support Mark Micale[51] and R.E. Kendell[52] in their rejection of any essentialism in psychiatric diagnosis.

Gender

Findings presented in chapter 5 showed a predominance of voluntary, psychoneurotic, female admissions to 1930s and 1940s Bethlem. This appeared to be a corollary of both hospital marketing and national legislation, and would, in turn, also shape therapeutic provision at the hospital, as outlined below. The study therefore enhances prior knowledge of gendered experience at the hospital beyond the level of admission trend disparities. Current results accord with Joan Busfield's suggestion that, following the 1930 Act, increased attention to common nervous complaints contributed to rising numbers of female psychiatric patients.[53] Thus, rather than making support more accessible to established psychiatric populations, she argued that voluntary and outpatient treatment chiefly benefited the newly-recognised, milder disorders; a group within which women were disproportionately represented.

Melancholia and primary dementia were shown to be the leading diagnoses of sampled Bethlem inpatients between 1931 and 1947, with psychoneurosis the third most common

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[50] Armstrong, *Political Anatomy of the Body*, p.54.
[51] Micale, "On the "Disappearance" of Hysteria: A Study in the Clinical Deconstruction of a Diagnosis," pp.496-526.
[52] Kendell, "The Distinction between Personality Disorder and Mental Illness," pp.110-115.
[53] Busfield, *Men, Women and Madness*, p.134.

diagnosis for females, and applied more than five times as regularly to them as to male admissions. Whilst the current results therefore corresponded with previous accounts of a widening gender imbalance in mental hospital populations in this era, one may also argue that specifics of Bethlem tradition, location, and marketing, further inflated the quantity of (mainly female) voluntary patients presenting with such problems.

A further striking finding in chapter 5 was the convergence, and, in some cases, reversal, of traditionally gendered patterns of psychiatric diagnosis in the postwar decades. Examples of this included the narrowing of the divide between male and female rates of schizophrenia; men outnumbering women in admissions for anxiety and nervous complaints; and affective psychosis becoming the most common diagnosis amongst the sampled female patients. Possible explanations for this trend include a sociocultural shift towards the recognition and acceptance of male emotional distress, but also more liberated forms of female expression; what one interviewee described as being 'allowed to "get out the box"...be their own personality'.[54] Pragmatically, it could be argued that the effects of aforementioned classificatory changes were disproportionately felt by women, given that the 'affective psychosis' category featured a number of exclusively female subtypes. More broadly, Armstrong suggested that attempts to delineate brain from mind, and psychoses from neuroses, were hampered by a 'normalisation' culture, and the amalgamation of disparate patient groups and practices within postwar psychiatry.[55] At Bethlem, the coincidence of these phenomena with institutional reorganisation and the emergence of new treatment specialisms, effectively concealed, though not conquered, such effects; attention increasingly focusing instead on the diversification of therapies and services.

Compared to other physical approaches, electroconvulsive therapy (ECT) attained relative longevity and wide application within the hospital. First mentioned in casenotes of the early 1940s, it was, thereafter, administered with increasing regularity to a range of

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[54] Irene Heywood Jones, Interview by Author, 5th August 2010.
[55] Armstrong, *Political Anatomy of the Body*, pp.67-68.

clinical populations, often in conjunction with drugs. However, interview and archival evidence presented in chapter 6 alluded to a female predominance within patients receiving this treatment; this was again in accordance with well-documented wider trends.[56] However, one cannot rule out the possibility that this was an artefact of women's greater propensity to be viewed as suffering from the (neurotic) conditions considered remediable by this method; an indirect consequence of the shifting trajectory of diagnostic opinion, and one reinforced by social norms and textbook examples alike. It is appreciated that this area would benefit from additional research, using a larger population. Brief admissions to Bethlem were increasingly structured around a course of ECT, often at the (usually female) patient's request, and even when symptoms were of a reactive nature. It was suggested that, for both patients and practitioners, this technique promised efficient and acceptable results; demands which were accentuated under wartime conditions. In her description of a north Wales asylum, Michael maintained that ECT and leucotomy 'both shortened hospital stays and made the institution look less custodial and much more like a general hospital. These 'drastic' treatments thus actually persuaded more patients to seek help voluntarily'.[57] Her theory provides one plausible explanation for the growing demand for ECT amongst informal patients in 1940s Bethlem, and foreshadows the objectives of the 1954 Percy Commission in aligning treatments of mental and physical illnesses. Psychiatric historiography has thus demonstrated the significance of sustaining an aspirational public perception of the asylum, and underscored the existence of a complex relationship between the use of convulsive treatments and the legal status of patients who received them.

Psychiatry's use of ECT has attracted fear and controversy; attitudes which were affirmed by former Bethlem employees who were involved it its administration. However, an important counter-narrative also emerged, in that several interviewees recalled the rapid improvement of some patients following such treatment,[58] and the hope it embodied for

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[56] See, for example: Busfield, *Men, Women and Madness*, p.239.
[57] Michael, *Care and Treatment of the Mentally Ill in North Wales, 1800-2000*, p.169.
[58] Griffith Edwards, Interview by Author, 7th December 2010.

individuals for whom other methods had failed.[59] The latter view reinforces Max Fink's

claim of electroshock's versatility and efficacy,[60] such that 'patients undergoing ECT have

proved to be its best advocates'.[61] Although legal status did not appear to have

determined the allocation of this method in diagnostically-matched Bethlem patients,

casenotes highlighted a tendency for certified or temporary patients to receive ECT prior

to being reclassified to voluntary boarders. This finding poses a number of potential

explanations: given the waning proportion of formally-detained patients after the 1930

Mental Treatment Act, one may hypothesise that certified status became - rightly or

wrongly - conflated with severity of illness, hastening the application of physical methods

with this patient group. This therefore represents an avenue for future enquiry utilising a

larger dataset.

Popular historical literature has emphasised the benefits of new medications in

humanising hospital wards, shortening hospital stays, and moderating symptoms insofar

that patients could engage in occupational therapy or community-based services.[62] Such

hypotheses are, however, not borne out within the present results (chapter 6). Firstly, the

arrival of occupational and industrial therapies at Bethlem occurred in the early twentieth

century, meaning that these practices were unlikely to have had lineage in novel chemical

controls. In their accounts of the new drugs, former nurses also highlighted the absence of

side effects associated with these substances, rather than any 'positive' effects on

outward symptoms.[63] This was a particularly interesting finding, which runs contra to the

rhetoric of drug advertising that infiltrated the hospital's *Gazette* from the 1970s.

Moreover, both interview and archival data alluded to a culture of diligence and economy

in prescribing; a finding at odds with received notions of immediate clinical impact or

profligacy of prescribing,[64] but one which further substantiates David Healy's claim that

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[59] Alwyn Lishman, Interview by Author, January 26th 2011.
[60] Fink, "Convulsive Therapy: A Review of the First 55 Years," p.7.
[61] Max Fink, *Electroshock: Healing Mental Illness* (Oxford; New York: Oxford University Press, 2002), p.5.
[62] Burns, *Psychiatry: A Very Short Introduction*, pp.53-54.
[63] Participant 03, Interview by Author, 9th September 2010.
[64] BRHAM, "Mcc: Medical Committee Documents and Minutes, 1955-1957," GPM.89, MCD.13/58.

the 'psychopharmacological revolution' of the 1950s 'largely bypassed' Bethlem.[65] Finally, the largest fall in length of stay amongst sampled patients also occurred prior to the introduction of these substances. Although based on a relatively small number of patients, these Bethlem data may be interpreted as supporting sociological perspectives, whose adherents[66] challenged the widespread notion that new drugs facilitated symptom management, and thereby hastened the transition towards non-institutional care and encouraging the growth of talking therapies.

Psychotherapy

Chapter 7 explored the origins and development of psychotherapy services within twentieth-century Britain, and further illustrated this through reference to the articulation and application of such approaches at Bethlem in this period. Roy Porter saw psychodynamic approaches as an antidote to the pessimism of asylum psychiatry and the inflexibility of its practitioners.[67] They boasted clear advantages for wealthy, educated patients, and a burgeoning class of private therapists, and proved instrumental in the early twentieth-century rehabilitation of military personnel. The latter experiences also served to augment psychiatry's professional and public status (yet, by some accounts, also generated undue optimism for its peacetime application).[68]

The current study uncovered a longstanding but informal history of talking cures at Bethlem. However, as shown in chapter 7, a convergence of factors in the 1930s prompted renewed attention to the therapeutic values of social interaction and a more personalised care regime. Thomson also posited lesser-known contemporaneous excitement over popular or 'practical' psychology,[69] which may have shaped attitudes to admission and treatment amongst Bethlem's largely middle-class clientele. Thus, a new

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[65] David Healy, "The History of British Psychopharmacology," in *150 Years of British Psychiatry. Volume 2: The Aftermath*, ed. H.L. Freeman and G.E. Berrios (London: The Athlone Press Ltd., 1996), pp.61, 74.
[66] Scull, *Decarceration*, pp.88-89.
[67] Porter, *Madness: A Brief History*, p.187.
[68] Jones, "War and the Practice of Psychotherapy," p.494.
[69] Thomson, *Psychological Subjects*, pp.7-8.

generation of voluntary patients admitted following the Mental Treatment Act of 1930, brought with them differing clinical requirements and, significantly, expectations, than those admitted compulsorily. Typically, they presented with milder, psychoneurotic disorders, and required – or sought – shorter admissions, but long-stay, chronic patients also benefited from the individualised approach of the nurse-patient relationship that was a consequence of the shift towards individualised treatment. This era also witnessed the introduction of an occupational therapy service at the hospital, arguably building on the philosophical foundations of moral therapy, which promoted self-regulation of conduct and appeals to patients' presumed inner virtue. Experiences during the two World Wars served to heighten public and professional awareness and acceptance of psychotherapy, and the NHS subsequently removed some of the financial hurdles to its peacetime delivery. Bold claims that all Joint Hospital inpatients would receive some form of psychotherapy[70] implied a somewhat indiscriminate and overzealous embracing of this nascent approach, and belied the relatively slow uptake of group methods in the years following the merger.[71] Indeed, such statements seem to reflect therapeutic aspiration over actuality, and may be viewed as part of the hospital's continuing forays into self-promotion. They also endorse Nikolas Rose's account of the 'spectacular expansion of the psychotherapeutic domain since the end of World War II' and the application of its mechanisms and vocabularies 'to all the multifarious problems of life.[72] Similarly, an implicit consumerism within these Bethlem records paralleled the hospital's approach to physical therapies (notably ECT) and foreshadowed Leader's (2008) proposal that, within an outcome-based society, psychotherapy is increasingly viewed as 'a set of techniques which can be applied to a human being….a business transaction with a buyer, a seller and a product'.[73]

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[70] BRHAM, "Triennial Statistical Report, Years 1949-1951," p.42.
[71] Ibid., pp.42-43.
[72] Rose, *Governing the Soul: The Shaping of the Private Self*, pp.213-214.
[73] Leader, "A Quick Fix for the Soul."

Writing in 1963, William Sargant and Eliot Slater believed that the wider application of psychological and social therapies, combined with expansion in the range and flexibility of physical methods, had led to traditional, dichotomised prescribing, being 'turned topsy-turvey'. Thus, treatment of neuroses could now accommodate various forms of psychotherapy, physical methods, and behavioural therapy based on conditioning theory. It was felt that 'in the grave psychiatric states, schizophrenia, depression, and the more recalcitrant and incapacitating forms of anxiety and obsessional neurosis, the first attack has had to be given over to the somatic methods...once they have played their part, re-training and rehabilitation techniques come into their own at a later stage'. The authors also proposed that the convergence of psychological and physical methods 'upon the same processes, mechanisms and functions' should be accompanied by 'an open-minded attitude on the part of the therapist (which) will contribute towards that synthesis of view-points and practice for which we must hope'.[74] However, this stance was a contrast to the undercurrents of professional antagonism (notably concerning psychotherapy) and the marginalisation of non-medical services - such as the therapeutic community and day hospital - observed within the current investigation.

As mentioned previously, it was felt that the 1930 legislation had 'inspired a new attitude towards receiving hospital treatment, rendering it more convenient, less stigmatised, and more scientifically credible' in general society. Yet, Michael also contended that the expectations of voluntary patients were a significant impetus to further policy change, in such areas as ward unlocking, a heightened therapeutic focus, and the provision of amenities.[75] Despite contrasting institutional settings and traditions, the findings from this study are broadly in line with this analysis.

Interviewees reported that Aubrey Lewis promoted a therapeutic eclecticism across the Joint Hospital, but that friction also arose between proponents of opposing professional backgrounds, with particular disdain sometimes levelled at Freudian theorists.

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[74] Sargant and Slater, *An Introduction to Physical Methods of Treatment in Psychiatry*, pp.305-306.
[75] Michael, *Care and Treatment of the Mentally Ill in North Wales, 1800-2000*, pp.177-178, 185.

Anecdotally, some recalled Bethlem being perceived as inferior to the Maudsley, and a suitable 'backwater' for low priority treatments or populations, thus: 'I suppose everyone said that they were equal, but they weren't. In terms of prestige, centrality, to the mission, they [Bethlem] were extra beds, extra bed space'.[76] Another alluded to the existence of entrenched institutional biases at the start of his tenure:

> When I was told I'd got the job ....the Board of Governors – they said there were one or two conditions. One was that I would live in the House Governor's residence, on the Bethlem Estate....The second one was, that they were still, as a Board, very disappointed in the cooperation between the Bethlem and Maudsley, and although Mr [Kenneth] Johnson had been a very good House Governor, he was born and bred LCC man, to whom Maudsley was the great hospital, and Bethlem was a rather old-fashioned country estate. For example, he went to the Maudsley fairly early every morning – he lived in the house – but he spent maybe an hour or so there every morning, and then went straight to the Maudsley, leaving his deputy at Bethlem all the time, to run it. And they didn't quibble over that; I don't know if they knew it happened. They did think that the two hospitals were not gelling as one, even after fifteen years.[77]

The veracity of such statements is a matter of conjecture; less contested, is the finding that some psychiatrists were granted relative space and freedom at Bethlem to develop services in 'less desirable' fields such as addictions treatment and psychogeriatrics. This was, therefore, a local circumstance with far-reaching implications for the wider landscape of psychiatric knowledge, methods, and patient populations.

The Monks Orchard Road site also hosted the Charles Hood Unit therapeutic community, discussion of which can inform national debates about psychotherapeutic innovation and diversification, but also the apparent marginalisation of emerging services within the more

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[76] Griffith Edwards, Interview by Author, 7th December 2010.
[77] Leslie Paine, Interview by Author, January 25th 2011.

traditional sphere of institutional care. Thus, chapter 7 depicted this as a service which existed, to all intents and purposes, 'in', but not 'of', the wider hospital. Patients ('residents') and staff alike related a sense of privilege at having been selected for the Unit, but scant documentary evidence of its operation was available. Diversification of psychotherapeutic services ostensibly reflected social and legislative shifts, especially those attitudes and strictures pertaining to marriage and sexuality. However, data from both the oral history and documentary research conducted for this study attested to the continued peripheral status of non-medical services, such as the day hospital and therapeutic community; a finding substantiated by the purported contrasts between such approaches and institutional orthodoxy. Although this broadly illustrates localised obstacles between therapeutic innovation and implementation, chapter 7 also described how, reciprocally, the therapeutic community sought to distance itself from the life of the wider hospital. This was unsurprising, in light of Robert Hobson's dichotomised vision of 'the good UNIT' and the 'badness outside'[78] and paralleled experiences documented elsewhere. Thus, in his account of Social Rehabilitation Unit at Belmont (now Henderson) Hospital, Robert N. Rapoport declared that 'experimentation with therapeutic milieux has taken different forms', but, equally, acknowledged that 'the Unit's ideas are based in large part on a reaction against the 'evils' of custodial hospital....Many of the staff's ideas are derived from attempts to avoid some of the problems of the conventional mental hospital system'.[79]

Conclusions

The present study has thus employed novel sources and perspectives to ask new questions about the recent existence of Bethlem Royal Hospital, and to juxtapose the character and experiences of its patients with those of institutions elsewhere. It was acknowledged that research adopting a case study approach could lack representative value and that caution should be applied in extrapolating conclusions. Yet, it was felt that

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[78] Hobson, "The Messianic Community," p.232.
[79] Rapoport, *Community as Doctor*, pp.268-270.

such limitations were offset by the chance to observe recent change in an institution close to the cutting edge of psychiatric theory and practice. Bethlem remained atypical in both its patient intake and administrative arrangements throughout the twentieth century. Measures to widen access to the hospital were countered by a more dogmatic desire to uphold institutional standing, thus: 'the reputation of a hospital in the outside world depends not only on the amenities it provides, and on the qualities of its medical and nursing staff; it also depends on the behaviour and demeanour of the patients'.[80] The study therefore presented a vital opportunity to examine how marketing, social status, and other non-clinical factors contributed to twentieth-century institutional practice and psychiatric inpatient experiences. In this way, the evidence extends prior institutional historiography, and provides a prism through which to develop ideas of health consumerism, lay psychology, and an emerging medical marketplace.

In sum, the Bethlem evidence provided here explores a new phase in the hospital's history, and reinforces the value of institutional case studies as the starting point for analysis of both the new psychiatric services and populations that emerged in the twentieth century. The four interlinked themes evolving from the case study evidence represented a distillation of some of the macroscopic concerns of British psychiatry. Bethlem's self-promotional activity occurred in tandem with a gradual infiltration of popular, or non-medical, beliefs and knowledge into hospital decision-making. Secondly, chapters 4 and 5 examined the localised interpretation of national policy – either reinforcing or challenging hospital tradition - and the protracted transition to new diagnostic schemes, often resulting in the rejection, ignorance, or misuse of new terminology. A third theme, the issue of gender, was consistently apparent. It was noted that a convergence of internal and external forces precipitated Bethlem's early twentieth-century focus on the voluntary, psychoneurotic, female admission; a trend which, in turn, guided hospital practice. The study further identified gendered determinants of diagnosis and treatment, especially with the arrival of new labels, and the transformation of former

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[80] BRHAM, "Triennial Statistical Report, Years 1949-1951," p.8.

aetiologies into discrete mental disorders. This theme also overlapped with the growth of psychotherapeutic services and clientele (chapter 7) and the particular antagonism and achievements resulting from the coexistence of disparate services at the Bethlem site.

Reflections on Use of Archival Data

Casenote evidence can inform both institutional-level debates, and broader concerns within psychiatric historiography. Thus, Trevor Turner's analysis of casebooks from Ticehurst House Asylum, 1845-1890, provided a 'historical control sample' for exploring the genesis of ideas and practices, and the application of Victorian-era diagnostic schemata.[81] Likewise, a recent conference paper successfully mobilised nineteenth-century Bethlem casenote evidence to elicit an increasingly nuanced picture of asylum life, which provided a contrast to accepted professionalisation narratives. Dominant themes included the renegotiation of traditional boundaries of madness, occurring within the patient-practitioner dynamic, or between ostensibly opposing professional interests.[82] Retrospective scrutiny of psychiatric patient records nevertheless remains a matter of ethical and academic controversy. Jonathan Andrews cautioned that, historically, only the testimony of the most educated, eminent or vociferous cases was likely to be retained or published. Moreover, such writings, he claimed, presented only 'a fraction of patients' total output during their confinement. What does survive, furthermore, must be interpreted against the criteria for interception and selection'.[83]

The current study explored practical, subjective, and ethical restrictions in the use of (especially recent) hospital archives, and, where possible, outlined compensatory strategies. Omissions, inaccuracies, and inconsistencies were encountered in admissions registers throughout the timeframe in question, whilst data for certain periods were

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[81] Turner, "A Diagnostic Analysis of the Casebooks of Ticehurst House Asylum, 1845-1890," pp.15-16.
[82] Sarah Chaney, "'"The Single Swallow Does Not Make a Summer": Motive Power and the Individual Patient in Late Nineteenth-Century Asylum Case Histories'" (paper presented at the Biography and its Place in the History of Psychology and Psychiatry Symposium, UCL Centre for the History of Medicine, 20th June 2011).
[83] Andrews, "Case Notes, Case Histories, and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century," p.269.

unavailable. Acting on the advice of the archivist, sampling strategies were devised in order to avoid or assuage these issues, but, in some areas, record-keeping customs defied attempts to elucidate demographic trends. Thus, prewar admission registers provided only a rough index of the true occupational profile of Bethlem patients, because they often omitted the employment status of females, or substituted that of their husband (as 'head of household'). Additionally, fluctuations in hospital policy regarding reclassification or maximum length of stay created ambiguity over the reasoning behind such decisions, challenged the accuracy and validity of records, and sometime prevented longitudinal insights into patients' progress.

For the purposes of the current study, previously unseen records encompassed a range of medical and lay contributions, thereby filling in the contours of a patient's life prior to admission, and, in some cases, salvaging the 'black box' of events unfolding within the hospital walls. Furthermore, the notes gave additional context to the circumstances in which key treatments were suggested or rejected, their clinical effects, and, occasionally, patients' attitudes towards these measures. In most instances, the inclusion of drug charts within casenotes also provided the only means of investigating prescribing patterns in the prewar decades. Crucially, however, the Bethlem records denied any real access to the patient's perspective. As is discussed below, new strategies are clearly required if recent generations of psychiatric patient testimony are not to be lost to posterity.

Reflections on Use of Interview Data

Oral histories were intended to complement the main corpus of documentary research, yet, a shortage of available pre-1983 Joint Hospital staff, and delays in recruitment and arranging appointments, served to limit the total number of respondents. A greater quantity and occupational variety of interviewees may, thus, have produced additional insights into life at the hospital, and, reciprocally, generated further lines of archival enquiry. Nevertheless, the shared professional backgrounds of the 5 psychiatric nurses

belied greater heterogeneity in their individual experiences, opinions on care regimes, and perceptions of their roles at Bethlem.

Future Research Directions

The limits to generalisation from case study evidence discussed in the Methods chapter pose new questions regarding contemporaneous trends in public asylums in areas such as voluntary admissions and the arrival and implementation of new approaches. Such scholarship could offer new insights into the roles of varied administrative structures in ward-level decision-making and the specific impact of institutional context and management on patients' experiences. There is, however, an overarching need to strike an effective balance between focusing on the sequelae of legal and scientific change, and those specific to the immediate environment. Existing institutional histories have thus described the localised emergence of new theories, methods, and patient groups, yet such discussions remain frequently underpinned by personal narratives or - for the twentieth century – chiefly concerned with either the rhetoric of drug revolution or decarceration. Nevertheless, Barbara Taylor's recent account of life as an inpatient during the twilight years of Friern Hospital, provided a timely opportunity to open up debate and reappraisal of the value of asylum care in this era.[84]

The current research has shed new light on a lively and significant era in Bethlem's recent history. In some areas, regrettably, it was beyond the scope of the project to offer more than a succinct overview of particular themes or services; elsewhere, historical lacunae have resulted from the loss, physical deterioration, or inaccessibility of key archives and resources. Future research ventures would be contingent upon ethical approvals for access to patient-identifiable data. With this criterion satisfied, further investigation of the twin wartime personas (Mill Hill and Sutton) of the Maudsley Hospital would serve to enhance current understandings of the inception and articulation of new ideas and approaches immediately prior to the formation of the Joint Hospital. Furthermore, it is

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[84] Taylor, "The Demise of the Asylum in Late Twentieth-Century Britain: A Personal History," pp.193-215.

important to discover whether the community links in mid twentieth-century Bethlem - both *within* the hospital itself, and, externally, to neighbouring educational or penal facilities - were also observed at institutions elsewhere, and to exploit deinstitutionalisation narratives as a catalyst to, rather than a curtailment of, continued exploration of psychiatric care.

Psychotherapy represents another sphere of interest, given its growing and diverse relevance over the past century, and apparent popular appeal, but professional marginalisation, at Bethlem. The small number of psychotherapy records available presented a tantalising glimpse into the theoretical bases and practical delivery of such services, yet raised further questions regarding their status and acceptance within the wider hospital, and revealed little of their longer-term efficacy. Continuing an established tradition within psychiatry, the recent publication of patients' experiences – here, in collaboration with her psychiatrist – can help to demystify therapeutic principles and practices, and further legitimise the voice of the patient within the professional domain.[85]

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[85] Jackie Hopson and Jeremy Holmes, "Through the Wasteland: Chronic Depression," *BMJ* 342:d93 (2011).

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Appendices

SCHEDULE
OF
FORMS OF INSANITY
as at the time of record.

(FORMS 1B AND 2B OF RULES OF COMMISSIONERS IN LUNACY.)

I. Congenital or Infantile mental deficiency (Idiocy or Imbecility) occurring as early in life as it can be observed.

Symbols to be
entered in the
Registers.

        Intellectual—

I.   1. *a.*   With Epilepsy.
I.   1. *b.*   Without Epilepsy.
I.   2.   Moral.

II.   Insanity occurring later in life.

Symbols to be
entered in the
Registers.

II.   1. Insanity with Epilepsy.
II.   2. General Paralysis of the Insane.
II.   3. Insanity with the grosser brain lesions.
II.   4. Acute Delirium (Acute delirious mania).
II.   5. Confusional Insanity.
II.   6. Stupor.
II.   7. Primary Dementia.

        Mania—

II.   8. *a.*   Recent.
II.   8. *b.*   Chronic.
II.   8. *c.*   Recurrent.

        Melancholia—

II.   9. *a.*   Recent.
II.   9. *b.*   Chronic.
II.   9. *c.*   Recurrent.

II.   10. Alternating Insanity.

        Delusional Insanity—

II.   11. *a.*   Systematised.
II.   11. *b.*   Non-Systematised.

Volitional Insanity—
II. 12. *a.*   Impulse.
II. 12. *b.*   Obsession.
II. 12. *c.*   Doubt.

II. 13.   Moral Insanity.

Dementia—
II. 14. *a.*   Senile.
II. 14. *b.*   Secondary or Terminal.

SCHEDULE OF CAUSES AND ASSOCIATED FACTORS OF INSANITY.

To be returned as Principal Causes, or as Contributory or Associated Factors, with Symbols for purposes of Tabulation.

(FORMS 1B. AND 2.A. OF RULES OF COMMISSIONERS IN LUNACY.)

Symbols to be entered in the Registers.

HEREDITY (excluding Cousins, Nephews, Nieces and off-spring)—
    Insane Heredity ... ... A. 1.
    Epileptic Heredity ... ... A. 2.
    Neurotic Heredity [including only Hysteria, Neurasthenia, Spasmodic
    (idiopathic) Asthma and Chorea] ... ... A. 3.
    Eccentricity (in marked degree) ... ... A. 4.
    Alcoholism ... ... A. 5.

MENTAL INSTABILITY as revealed by—
    Moral Deficiency ... ... B. 1.
    Congenital Mental Deficiency, not amounting to Imbecility ... B. 2.
    Eccentricity ... ... B. 3.

DEPRIVATION OF SPECIAL SENSE—
    Smell and Taste (either or both) ... ... C. 1.
    Hearing ... ... C. 2.
    Sight ... ... C. 3.

CRITICAL PERIODS—
    Puberty and Adolescence ... ... D. 1.
    Climacteric .... D. 2.
    Senility ... ... D. 3.

CHILD BEARING—
    Pregnancy ... ... E. 1.
    Puerperal state (nor septic) ... ... E. 2.
    Lactation ... ... E. 3.

MENTAL STRESS—
    Sudden Mental Stress ... ... F. 1.
    Prolonged Mental Stress ... ... F. 2.

PHYSIOLOGICAL DEFECTS AND ERRORS—
    Malnutrition in early life (signs of Rickets, &c.) ... ... G. 1.
    Privation and Starvation ... ... G. 2.
    Over-exertion (physical) ... ... G. 3.
    Masturbation ... ... G. 4.
    Sexual excess ... ... G. 5.

Symbols to be
entered in the
Registers.

TOXIC—

  Alcohol … … … … … … … H. 1.

  Drug Habit (morphia, cocaine, &c.) … … … … H. 2.

  Lead and other such poisons … … … … … H. 3.

  Tuberculosis … … … … … … … H. 4.

  Influenza … … … … … … … H. 5.

  Puerperal sepsis … … … … … … H. 6.

  Other specific Fevers … … … … … … H. 7.

  Syphilis, acquired} {all patients believed to have suffered}.. H. 8.

  Syphilis, congenital} {at any time in their lives from Syphilis}. H. 9.
         {to be entered.}

  Other Toxins … … … … … … … H. 10.

TRAUMATIC—

  Injuries … … … … … … … I. 1.

  Operations … … … … … … … I. 2.

  Sunstroke … … … … … … … I. 3.

DISEASES OF THE NERVOUS SYSTEM—

  Lesions of the Brain … … … … … … K. 1.

  Lesions of the Spinal Cord and Nerves … … … K. 2.

  Epilepsy … … … … … … … K. 3.

  Other defined}   {Limited to Hysteria, Neurasthenia,}
    Neuroses}   {Spasmodic Asthma, Chorea}… … K. 4.

  Other Neuroses, which occurred in Infancy or Childhood
    (limited to Convulsions and Night-terrors) … … K. 5.

OTHER BODILY AFFECTIONS

  Haemopoietic System (Anaemia, &c.) … … … L. 1.

  Cardio-Vascular degeneration … … … … … L. 2.

  Valvular Heart Disease … … … … … L. 3.

  Respiratory System (excluding Tuberculosis) … … L. 4.

  Gastro-intestinal System … … … … … L. 5.

  Renal and Vesical System … … … … … L. 6.

  Generative System (excluding Syphilis) … … … L. 7.

  Other General Affections not above included (*e.g.*, Diabetes,
    Myxoedema, &c.) … … … … … L. 8.

Instances in which NO PRINCIPAL FACTOR could with certainty
be assigned, but in which one or more Factors were ascertained,
and were returned as Contributory or Associated … … … M.

NO FACTOR ASSIGNABLE, notwithstanding full
history and observation … … … … … … N.

NO FACTOR ASCERTAINED, history defective … … … O.

Data Coding and Formulae

Data Entry and Coding		
Category	**Description**	
1931 Register		
Reference Number	Numeric	
Admisson Date	Numeric - dd/mm/yyyy	
Sex	Male = M, Female = F	
Admission Class	Private = P, Rate-Aided = R	
Admission Status	Voluntary =V, Temporary = T, Certified = C	
Marital Status	Single = S, Married = M, Widowed = W, Unknown = U	
Occupation	Industry class	
	Schedule Group and (sub)divisions	
Previous Certification	No of occasions (0=None)	
Age	Numeric - Years	
Attack Type	Congenital = C, First = F, Not First = N, Unknown = U	
Previous Admissions	No of occasions (0=None)	
Present Attack Duration	Numeric - Y/M/D	
Aetiological Factors	Schedule Codes	
Form of Illness	Schedule Codes	
Mode of Leaving	Discharge = DI, Transfer = T, Death = DE, Reclassified = R	
Departure Date	Numeric - dd/mm/yyyy	
Length of Stay	DATEDIF(Adm Date, Dep Date, "d")	
1983 Register		
No. in register	Numeric	
Admission date	Numeric - dd/mm/yyyy	
Sex	Male = M, Female = F	
Ward	Abbreviated title*	
Date of Birth	Numeric - dd/mm/yyyy	
Age on admission	DATEDIF(Date of birth, Adm Date, "y")	
Discharge date	Numeric - dd/mm/yyyy	
Length of Stay	DATEDIF(Adm Date, Discharge Date, "d")	
	*Ward titles:	CHU = Charles Hood Unit (Psychotherapy)
		FM1 = Fitzmary 1 (includes Mother & Baby Unit)
		FM2 = Fitzmary 2
		GH1 = Gresham 1 (Psychogeriatric)
		GH2 = Gresham 2 (Psychogeriatric)
		HLH = Hilda Lewis House (Mentally-handicapped children's unit)
		ISU = (? - Part of TW1)
		M&B = Mother and Baby Unit
		TE1 = Tyson East 1 (Adolescents)
		TE2 = Tyson East 2 (Adolescents)
		TW1 = Tyson West 1 (General)
		TW2 = Tyson West 2 (General and Behvioural Therapy)
		WH1 = Witley 1 (General and Alcohol and Behavioural Therapy)
		WH2 = Witley 2 (Drug Unit - oral)
		WH3 = Witley 3 (Drug Unit - injectors)

Postwar Diagnoses: Coding Framework

PSYCHOSES			
1	Dementia	Alzheimer's Disease	Senile Dementia
		Multi-Infarct Dementia	Pre-Senile Dementia
2	Toxic Psychosis	Delirium Tremens	Drug/Alcohol Hallucinosis
3	Schizophrenia	Catatonia/Stupor	Paraphrenia
		Hebephrenia	Residual Schizophrenia
		Paranoid Schizophrenia	Schizo-affective State/Disorder
4	Other Organic Psychosis	Confusional State	Huntington's Chorea
		General Paralysis of the Insane (GPI)	Korsakov's Syndrome
		Puerperal Psychosis	
5	Affective Psychosis	Depressive Psychosis	Mixed Affective Disorder/Disturbance
		Hypomania	Psychotic Depression
		Manic Depression (all types)	
6	Paranoid States	Morbid/Chronic Jealousy	
7	Other/Unspecified Non-Organic Psychosis	Brief Psychotic Episode	Psychogenic Psychosis
		Childhood Psychosis	
NEUROSES, PERSONALITY DISORDERS AND NON-PSYCHOTIC MENTAL DISORDERS			
8	Depression	Affective Disorder/Illness	Melancholia
		Depressive Illness	Neurotic Depression
		Endogenous/Chronic Depression	Reactive/Agitated Depression
9	Neurotic and Anxiety Disorders	Anxiety	Neurasthenia
		Eating Disorders	Neurotic Breakdown
		Hypochondria	Obsessive Compulsive Disorder (OCD)
		Hysteria	Phobia
10	Personality Disorder	Affective	Immature
		Anankastic	Impulsive/Aggressive
		Asocial	Inadequate
		Asthenic	Obsessional
		Borderline Personality	Paranoid
		Cyclothymic	Psychopathic
		Dependent	Schizoid
		Dysthymic	Sociopathic
		Histrionic	Unspecified
		Hysterical	
11	Sexual Deviation	Exhibitionism	Hypersexuality
		Homosexuality	Masochism
12	Drug/Alcohol Use or Dependency	Drug/Alcohol Dependency (Syndrome)	Drug/Alcohol Addiction
		Habitual Excessive Drinking	Drug/Alcohol Withdrawal
13	Non-Psychotic Mental Disorder of Organic Origin	Puerperal/Post Partum Depression	Traumatic Brain Injury
		Post-Operative Conditions	Arteriosclerotic Personality Change
14	Childhood/Adolescent Behaviour Disorder		
15	Other/Unspecified Neurosis or Non-Psychotic Mental Disorder (incl. stress)	Grief Reaction	Unspecified Adjustment Reaction
		Transient Situational Disturbance/Crisis	
MENTAL OR NEUROLOGICAL RETARDATION			
16	Mental Retardation	Borderline Intelligence	Educational/Mental Subnormality
		Intellectual Handicap	
17	Neurological Disorder	Epilepsy	Parkinson's Disease
		Frontal Lobe Syndrome	

Admissions Database: Pre-1947

Ref No.	Adm Date	Sex	Adm Class	Adm Status	Marital Status	Occupation Industry	Code	Previous Certif.	Age (yrs) Present	Age (yrs) 1st Attack	Attack Type	Previous Adms	Present Attack Duration Years	Months	Days	Aetiological Factors Principal	Associated		Form of Illness	Mode of Leaving	Departure Date	Length of Stay (d)
86	03/01/1931	M	P	C	M	Clergyman	Ca1	0	59	59	F	0	0	6	5	B3			11b	DE	12/01/1940	3296
84	02/01/1931	M	P	V	M	Traveller	Ea2	0	59	56	N	0	1	6	0	I1			9c	DI	13/06/1931	162
87	06/01/1931	M	P	V	M	Civil Servant	Aa4	0	58	58	F	0	0	6	0	F2			9a	DI	11/11/1937	2501
98	24/01/1931	M	P	C	S	Engineer	Cf1	0	18	18	F	0	0	0	3	F2	D1		7	R	24/04/1931	90
99	03/02/1931	M	P	V	M	Army	Ba1	0	41	37	F	0	3	6	0	F1	B3		11a	DE	01/03/1932	392
100	10/02/1931	M	P	V	M	Traveller	Ea2	0	47	45	N	0	2	0	9	F2			9c	DI	14/05/1931	93
105	18/02/1931	M	P	V	M	Accountant	Ea1	0	34	26	N	2	0	4	15	F2	B3		12b	DI	02/04/1931	43
106	18/02/1931	M	P	C	M	Retired	Ya1	0	67	67	F	0	0	2	0	L1	D3		14a	DE	17/01/1932	333
109	27/02/1931	M	P	C	M	Hotel manager	Vd2	1	55	51	N	1	0	1	0	D2	F2		9b	DI	24/04/1931	56
114	07/03/1931	M	P	V	S	Civil servant	Aa4	0	35	16	N	0	2	0	0	D3	F2		7	DI	29/08/1931	175
115	10/03/1931	M	P	V	S	Clerk	Eb1	0	22	20	F	0	2	0	0	D2	L1		7	DI	20/03/1935	1471
117	12/03/1931	M	P	V	S		nil	0	30	25	F	0	6	0	0	A3	F2		7	DI	29/03/1944	4766
119	13/03/1931	M	P	V	M	Engineer	Cf1	0	48	27	N	0	0	1	0	D2	F2	D3	9c	DI	29/04/1931	47
128	24/03/1931	M	P	V	W	Retired	Ya1	0	67	67	N	0	0	2	0	H1	A3		14b	DI	31/05/1931	68
131	30/03/1931	M	P	V	S		nil	0	65	56	N	3	0	1	0	D3	F2	D3	9c	DI	23/02/1943	4348
80	07/04/1931	M	P	V	M	Retired	Ya1	1	58	44	N	3	0	6	0	D2	F2		9c	DI	08/10/1932	550
137	11/04/1931	M	P	V	M	Medical Practitioner	Cc1	0	36	23	N	1	0	0	1	A3	F2		7	DI	28/10/1931	200
138	13/04/1931	M	P	V	S	Farmer	Ga1	0	18	18	F	0	1	0	0	A1	D1		7	DI	11/10/1932	547
139	15/04/1931	M	P	C	W		Ge1	0	53	52	F	0	1	0	0	H1	D2		14b	DI	08/06/1935	1515
142	20/04/1931	M	P	V	S	Traveller	Ea2	0	20	16	N	0	0	4	0	A3	D1		7	DI	16/03/1932	331

Admissions Database: 1952-1983

The information available from postwar admission registers was more limited, and the worksheet was amended to reflect this:

Register No.	Adm. Date	Sex	Age on Adm	Diagnosis	Discharge Date	Length of Stay (d)
D5353	27/12/1952	F	14	Organic brain damage	01/04/1953	95
D170	30/01/1952	F	64	Depression, obsession	02/05/1952	93
D1531	08/10/1952	F	42	Alcoholic/toxic Hallucinosis	24/10/1952	16
D5112	12/04/1952	F	13		12/08/1952	122
D7078	20/08/1952	F	34	Depression, obsession	29/12/1952	131
B6426	17/03/1952	F	35	Depression, phobia	29/05/1952	73
D7131	11/08/1952	F	32	Post-natal depression	15/08/1952	4
D895	19/06/1952	F	23	Anxiety, depression	03/01/1953	198
D328	13/03/1952	F	61	Hypochondria, Anxiety	31/07/1952	140
D7159	02/10/1952	F	32	Hysteria, depression, hypothyroidism	18/07/1953	289
D7032	18/02/1952	F	70	Senile Dementia, Psychosis	30/09/1952	225
C2623	06/10/1952	F	37		05/12/1952	60
D623	03/06/1952	F	30	Depression	14/06/1952	11
D5209	17/06/1952	F	13	Hysteria	27/09/1952	102
C487	16/04/1952	F	15		21/08/1952	127
D144	07/02/1952	F	64	Bromide intoxication	06/03/1952	28
C3727	19/01/1952	F	63	Hysteria, hyponchondria, depression	21/06/1952	154
D1433	19/11/1952	F	51	Depression, hypochondria	27/03/1953	128
D1040	25/07/1952	F	65	Depression	21/10/1952	88
C742	12/06/1952	F	69	Depression	30/08/1952	79
D1599	13/09/1952	F	16	Behavioural disorder, anxiety	08/12/1952	86
D1956	22/11/1952	F	30	Depression	13/03/1953	111

Occupational Codes: Pre-1934

No occupational schedule was located for pre-1934 admission registers. Instead, the framework below was devised by manually recording combinations of codes and job titles featured in registers in this era.

Group	Division	Sub-Div	Sample Occupations
A	a	1	Telephone operator, telegraphist
		2	Post Office clerk
		3	
		4	Civil servant, Inland Revenue, GPO sorter
	b	1	Police inspector
		2	LCC District officer, MP
B	a	1	Army (incl. retired), Lieutenant, Colonel
		2	Navy (incl. retired)
	b	1	Life Guards (trooper), RA Private
		2	Petty Officer RNAS, RNVR Messenger
	c	1	
		2	
C	a	1	Holy orders, minister, clergyman
		2	Missionary, deacon(ess), Salvation Army officer
		3	Nun, church worker, Sister of Mercy/Charity
	b	1	Barrister, solicitor
		2	Actuary
	c	1	Doctor, physician, surgeon, medical practitioner, health visitor
		2	Nurse
		3	Doctor of medicine, med. practitioner, med. student (also Ya5)
	d	1	Teacher, governess, school mistress, tutor
	e	1	Researcher, author, writer, librarian, journalist, astronomer
	f	1	Surveyor, engineer
	g	1	Artist, architect's asistant, draughtsman
		2	Photographer
		3	Singer, musician, organist, music teacher
		4	Actress, entertainer
		5	Piano tuner
D	a	1	Pantryman, waiter/waitress
		2	Servant, mother's help, lady's companion, maid, cook
	b	1	
		2	Gardener
	c	1	
		2	
		3	Laundry proprietor
E	a	1	Accountant, director, (estate) agent, merchant, auctioneer/valuer
		2	Traveller
	b	1	Bank clerk, typist, book-keeper
	c	1	Stockbroker, banker
	d	1	Insurance, shipping clerk
F	a	1	Stationmaster, railway wagon inspector, railway servant
		6	Packer
	b	1	
		2	
		3	Motor driver
	c	1	Merchant service
		2	Ship's steward
	d	1	
		2	Draughtsman, wharfinger
G	a	1	Farmer
		2	Gardener, florist's assistant
		3	Planter
	e	1	
I	a	1	
	b	1	Coal merchant

Group	Division	Sub-Div	Sample Occupations
K	a		
	b		
	c	1	Moulder, fire-brick manufacturer
		6	Pattern maker, machine belt splicer
	d	1	Electrical engineer
L	a	1	Jeweller, optician
M	a	1	Builder
		3	Carpenter
		6	Decorator
		7	Plumber
		9	Builder's merchant
	b	1	
		2	Surveyor
N	a	1	
		2	Wood carver, designer
		3	House furnisher, furniture dealer
	b	1	Box-maker
P	a	1	Chemist (dispensing), pharmacist
		2	Chemist
Q	a	1	Furrier
R	a	1	
		2	Printer's head reader, Compositor
		5	Music publisher
	b	1	
S	a	1	
	b	1	
	c	1	Draper
T	a	1	Tailor
		2	Milliner
		3	Dressmaker
		4	Embroidress
		7	Dress designer
		8	Hosier
V	a	1	Dairyman
		2	Butcher, meat salesman
		3	Baker
		4	Confectioner's assistant
		5	Grocer, tea dealer
		6	
		7	Caterer, provisions dealer
	b	1	
		2	Tobacconist
W	a	1	Sanitary inspector
	b	1	
X	d	1	Shop assistant, shop-keeper, showroom assistant
		4	Works manager
	e	3	
Y	a	1	Retired (all occupations)
		2	
		4	Nil, none
		5	School boy/girl, student, scholar
		6	Housewife, housekeeper

Occupational Codes: 1934-1947

Only one photocopied version of the subsequent 'Schedule of Occupations of Patients Admitted' was available. The physical size and resolution of this document made it impractical to reproduce in its entirety; an outline of industry groups is thus provided below.

CODE	OCCUPATION
A	Fishermen
B	Agricultural Occupations
C	Mining and Quarrying Occupations
D	Workers in the Treatment of Non-Metalliferous Mine and Quarry Products
E	Makers of Bricks, Pottery and Glass
F	Workers in Chemical Processes; Makers of Paints, Oils, etc.
G	Metal Workers (Not Electro-Plate or Precious Metals)
H	Workers in Precious Metals and Electro-Plate
I	Electrical Apparatus Makers and Fitters (Not Elsewhere Enumerated) and Electricians
K	Makers of Watches, Clocks, and Scientific Instruments
L	Workers in Skins and Leather, and Makers of Leather and Leather Substitute Goods
M	Textile Workers
N	Makers of Textile Goods and Articles of Dress
O	Makers of Foods, Drinks, and Tobacco
P	Workers in Wood and Furniture
Q	Makers and Workers in Paper and Cardboard; Bookbinders etc.
R	Printers and Photographers
S	Builders, Bricklayers, Stone and Slate Workers; Contractors
T	Painters and Decorators
U	Workers in Other Materials
V	Workers in Mixed or Undefined Materials (Not Elsewhere Enumerated)
W	Transport and Communication
X	Commercial, Finance and Insurance Occupations (Excluding Clerks)
Y	Public Administration and Defence (Excluding Professional Men, Clerical Staff, and Typists).
Z	Professional Occupations (Excluding Clerical Staff)
AA	Persons Professionally Engaged in Entertainments and Sport
BB	Persons Engaged in Personal Service (Including Institutions, Clubs, Hotels, etc.)
CC	Clerks, Draughtsmen and Typists
DD	Warehousemen, Storekeepers, and Packers
EE	Stationary Engine Drivers, Dynamo and Motor Attendants
FF	Other and Undefined Workers
GG	Retired, or Not Gainfully Occupied

Study Information Sheet

Study Information Sheet – Psychiatric Patients and Their Treatment at Bethlem Royal Hospital, 1930-1983

Miss Jennifer Walke
Centre for History in Public Health, Public Health and Policy, London School of Hygiene and Tropical Medicine, 15-17 Tavistock Place, London, WC1H 9SH
Jennifer.Walke@lshtm.ac.uk 020 7299 4757

I am conducting research on the twentieth century history of Bethlem Royal Hospital. The study will use archival sources and interviews to explore the development of psychiatric services and life at the hospital between 1930 and 1983. You are one of a group of key individuals being asked to take part in the research. Before you decide whether or not you wish to take part please read the following and contact me if you would like to discuss it further.

- **What is the purpose of the study?**

The study will address the impact of wartime experiences and the inception of the NHS on British mental health services, before considering the relationship between Bethlem and features of the wider social, legal, economic and medical climate. I will then look at the aftermath of Bethlem's merger with the Maudsley Hospital in 1948, and initial treatment priorities, efficacy and service expansion amidst major changes in clientele and resources.

- **Why is this important?**

During the twentieth century, there were many significant developments within psychiatry, with ongoing historical debate as to the causes of these changes. As Britain's oldest and arguably foremost psychiatric hospital, Bethlem represents an ideal case study for addressing questions arising from this flux of ideas and practices. The study can provide important historical context to today's mental health services and policies.

- **Why have I been chosen?**

I am keen to hear the experiences of people who were involved in Bethlem's administration and development during the mid to late 20th century.

- **Do I have to take part?**

No. It is completely up to you. Should you agree to help, you are free to withdraw from the study at any time, without having to give a reason. If you do decide to take part, please keep this information sheet.

- **What will the study involve?**

The study will involve one interview conducted by Jennifer Walke, a researcher with a particular interest in the history of psychiatry. The interview will take place at a time and location convenient to you and a list of discussion topics will be provided in advance. The interview may last up to 2 hours and will be recorded so as not miss anything important.

- **What are the risks and benefits of taking part?**

Participation is voluntary, and can be at a time and place to suit you. You will be given written information about the research and have a chance to ask questions before signing the consent form. To further reduce potential distress or intrusion, can choose how your interview data are used.

You will be able to share your personal views and experiences of working at Bethlem, and in doing so help us understand more about how the hospital developed during the last century.

- **What if there is a problem?**

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. If you have a concern about any aspect of this study, you should ask to speak to the researcher using the contact details at the top of this sheet.

If you remain unhappy and wish to complain formally, you can do this through the London School of Hygiene and Tropical Medicine. Please contact:
Patricia Henley, Clinical Trials QA Manager, LSHTM, Keppel Street, London WC1E 7HT.
Tel: 020 7927 2434   Email: patricia.henley@lshtm.ac.uk

- **Will my taking part in this study be kept confidential?**

No quotes or other information arising from your participation in this study will be included in any reports, even anonymously, without your agreement. If you would like this interview to be on a confidential basis, for background only, then please indicate this on the attached form. All interviews will be anonymised for publication if the interviewee wishes. Data will be kept in a locked filing cabinet and if material is held on a computer, this will be password protected.

- **What will happen to the results of the study?**

Interview data will initially contribute to an educational project, and may later be written up for publication in academic and professional journals.

- **Who is funding the research?**

- **Who has reviewed the study?**

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by the London-Surrey Borders Research Ethics Committee.

The research has also been formally reviewed by The London School of Hygiene and Tropical Medicine Ethics Committee (no.5518)

Thank you for reading this form. Please do not hesitate to contact me if you require any further information regarding the study.

Interview Consent Form

Interview Consent Form – Psychiatric Patients and Their Treatment at Bethlem Royal Hospital, 1930-1983

Miss Jennifer Walke
Centre for History in Public Health, Public Health and Policy, London School of Hygiene and Tropical Medicine, 15-17 Tavistock Place, London, WC1H 9SH
Jennifer.Walke@lshtm.ac.uk 020 7299 4757

Please Initial Box

I confirm that I have read, and that I understand, the Participant Information Sheet, dated August 2009 (Version 4). I have had the opportunity to consider the information, ask questions about the study, and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw at any time from the interview, without giving any reason.	
I consent to the interview being audio-taped.	
I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from LSHTM, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	
I agree to take part in the study and hereby assign copyright of my contribution for research purposes to the Centre for History in Public Health at LSHTM.	

Name:

Signature:

Date:

Please tick one only:

I permit the use of my name with quotations from the interview   [   ]

I wish to be consulted before publication of named quotes   [   ]

I wish quotes to be used anonymously and in such a way that I cannot be identified   [   ]

I do not want to be quoted at all, even anonymously   [   ]

Interview Topic Guide

- Introduction

- **Personal and Professional Background**
    - Formative influences and training (where/when/what?)
    - What attracted them to BRH/intended role? (reputation, career prospects)

- **Workplace Issues**
    - Duties, working conditions and pay
    - Staff morale
    - Multidisciplinary working, liaison with other factions of Joint Hospital
    - Interaction between psychiatrists and social workers/other external agencies

- **Patient Welfare (non-clinical)**
    - Living conditions, ward unlocking, physical restraint
    - Occupational therapy, recreation and sport
    - Visitors and/or parole
    - Work placements and training opportunities

- **Treatment, Diagnoses and Research**
    - Emerging treatment specialisms and new patient groups (neurosis, addiction etc)
        - BRH old/incurable stereotype
        - Age and gender of admissions
        - Outcomes/prognosis for newer caseload – 'revolving door' process
    - Physical and drug therapies
        - Adoption/popularity of approaches > research/education
        - Interplay of old and newer methods– theoretical shifts or consensus?
    - Psychotherapy and therapeutic communities – new clientele
    - Day hospital and outpatient services
    - How successful were attempts at service integration?

- **External Influences**
    - Political and legislative impact:
        - Mental health care within NHS – intended/actual beds, funds, etc.
        - Hospital Plan 1962 – Hospital closures, community care etc
        - 1974 Local Government Act, 1975 '*Better Services for the Mentally Ill*'
        - Mental Health Act 1983 – esp. patients' rights
    - Economic factors
    - Social attitudes
        - Anti-psychiatry, public attitudes to mental illness
            - Acceptability of receiving treatment
            - Local reputation of hospital, community links

- **Evolution of the Joint Hospital**
    - Main differences observed over course of career
    - Impressions of BRH today
    - Biggest challenges faced by the contemporary hospital

- Thanks and debrief