

News and Notes



Newsletter of the Royal College of Psychiatrists' History of Psychiatry Special Interest Group

Issue 11, Autumn 2020

Cover photograph: Grotto at Claybury Asylum
(Sir Robert Armstrong-Jones Collection, RCPsych Archives)

Editors:

Claire Hilton

Lydia Thurston and

Mutahira Qureshi

News and Notes

**History of Psychiatry
Special Interest
Group**

**Issue 11, Autumn
2020**

Contents

Editorial , Lydia Thurston	3
Request for information: The evolution of primary care mental health provision since the late 1950s, Alan Cohen and Andre Tylee	4
HoPSIG chair's report , George Ikkos	5
Sort it out, don't throw it out , and archives update, Francis Maunze	6
Memoirs	
Contraptions for connections, John Bradley	7
Just bricks and mortar, David Dodwell	11
On the history of psychiatry	
The instructive case of James Tilley Matthews, Richard Mindham	16
Ernest Jones (1879-1958), Freud's collaborator and biographer, Fiona Subotsky	18
Chlorpromazine: The 'dying' history, Mohamed Ibrahim	19
Mental hospitals, trains, stations and a canal, Claire Hilton	21
Doing history	
<i>Learning from the Past: A Guide for the Curious Researcher</i> , Graham Ash	22
Tips on writing for <i>News and Notes</i> , Claire Hilton, Lydia Thurston, Mutahira Qureshi	23
Book reviews	
<i>Psychiatry: Past, Present, and Prospect</i> , review by George Ikkos	25
<i>Institutional Racism in Psychiatry and Clinical Psychology: Race Matters in Mental Health</i> , review by Ahmed Samei Huda	27
Forthcoming books by HoPSIG members	
<i>Poleaxed</i> , Peter Tyrer	28
<i>Civilian Lunatic Asylums during the First World War</i> , Claire Hilton	29
<i>Mind, State and Society: Social History of Psychiatry and Mental Health in Britain 1960-2010</i> , eds. George Ikkos and Nick Bouras	29
Interesting sources, websites etc	30
At the Science Museum, London	30
Dates for your diary	31

Editorial

A new sort of normal

Lydia Thurston, co-editor

Dear Readers, welcome to this Autumn 2020 edition of *News and Notes*. I hope that this edition provides you with some light relief after the last six months; there is no denying that we deserve some! COVID-19 has undoubtedly impacted us all, on both personal and professional levels. Personally, I experienced the first few months of the pandemic at home adapting to life as a new mother in lockdown, and professionally I have spent more recent months adapting to a workplace which is hugely different to the one I left in 2019. I am slowly adjusting to seeing patients virtually and am contemplating sitting a virtual CASC exam in January. In our Spring edition we echoed Hippocrates' mantra: 'Cito, Lange, Tarde!', let us hope that we can follow his last word of advice, and start to return to normal, or our 'new normal', soon.

The subject of returning to normal has made me think and reflect on other times in the history of our profession when we have faced great challenges. I thought it might be interesting to look back at the minutes of the seventy-ninth annual meeting of the Medico-Psychological Association of Great Britain and Ireland (MPA), in July 1920, one hundred years ago. At the time Britain was struggling in the aftermath of the First World War and a devastating influenza pandemic which lasted from 1918 to the Spring of 1920.

The annual meeting was set over two days at the town hall in Buxton, and the mental hospital in Cheddleton, Staffordshire. The first item on the agenda was the election of officers of the MPA council, which notably consisted entirely of men. There were 626 members recorded for the year 1920, a number which had not changed since 1919 despite the election of 21 new members, as 12 members had resigned and 9 had sadly died. During the Journal editors' report, there is mention that the Journal had begun to recover from the 'embarrassments imposed by war conditions'. There was talk of a new lease of life for the Journal in 1920, and a return to its pre-war standard. Post-graduate study was also a topic up for discussion. A special subcommittee had been formed, and having met twice already, they found the matter to be a 'very intricate one'. A paper, entitled 'The minimal requirements for a small clinical laboratory', was presented by W.G. Thomson, assistant medical

officer at the mental hospital in Cheddleton. The author put forward a case for asylums to set up their own in-house laboratories, in order to save time and money. He quoted Sir Robert Morant (British civil servant): '...the day of two hours to a round had gone and the days of two hours to a bed had come', highlighting an evolving paradigm shift to more patient-focused care. Thomson's laboratory had already been useful for tracing contacts during a small typhoid epidemic, as well as diagnosing dysentery, and cutting and staining sections from post-mortems. Study leave was suggested for psychiatrists to undertake short courses in bacteriology and pathological methods; hence avoiding the cost of employing a separate pathologist. The cost to establish the Cheddleton laboratory amounted to £115, excluding the cost of the microscope. An international delegate from Washington D.C, believed that simple asylum laboratories could be set-up for an even smaller cost if they were able to outsource more complex and specialist work to a central larger laboratory.

The minutes are well documented and lengthy. There is surprisingly little mention of the war, and no mention at all of the recent influenza pandemic. Instead there is an overriding sense of optimism and force of positive change, evidenced by the topics of discussion and the entertainment offered by the host. On the second day the members were treated to a garden party at the mental hospital in Cheddleton, hosted by the newly elected MPA president, Dr W.F. Menzies and his wife. The weather was 'beautifully fine' and members were able to admire the grounds, before being entertained by the hospital orchestra, conducted by Dr Menzies himself. The MPS's annual dinner took place the following evening at the Palace Hotel in Buxton. This was a well-attended and happy evening, with women notably being included in the guest list for the first time.

With that image of festivities in mind let us hope that we can similarly inject some optimism and hopefulness into our current situation. History teaches us that we are strong and resilient, and that we are able to adapt to new circumstances. Then, when we finally emerge from the end of the tunnel, we deserve to have a proper party!

Talking of celebrations, the College is approaching its 50th anniversary and 180 years since the foundation of the Association of Medical Officers of Asylums and Hospitals for the Insane, in 2021. HoPSIG's chair, George Ikkos, tells us more about how we plan to celebrate this.

In his article 'Just Bricks and Mortar: a personal journey through psychiatric buildings', David

Dodwell takes us on an architectural journey through various psychiatric hospitals and buildings throughout the country, with thoughts on how building layout can affect patient care, and comments on the impact that deinstitutionalisation had on chronic, long-term patients. Continuing with an architectural theme, Richard Mindham reveals the story of James Tilley Matthews, a patient who submitted plans for the design of the new Bethlem hospital in 1810. We are also treated to the first article in a series about the history of Chlorpromazine, the first antipsychotic, whose story is linked to the textile industry.

Ahmed Samei Huda reviews Suman Fernando's book *Institutional Racism in Psychiatry and Clinical Psychology: Race Matters in Mental Health*, which examines the deep roots of racism in the mental health system. The review is especially pertinent, given the recent acceleration of the Black Lives Matter Movement following the tragic death of George Floyd. It makes us question how racial prejudice has affected and still does affect psychiatric practice. This is a vitally important example of how studying the history of our profession can help to inform and improve patient care, specifically the care of black patients. We want to be part of continuing the discussion and welcome articles and book reviews about the history of all forms of prejudice in psychiatry. **As usual, please email your articles, reviews, photos, ideas, requests for information etc for the newsletter, to claire.hilton6@gmail.com by 31st January 2021.** We have written an article on tips for writing for the newsletter which we hope will be helpful. If you are thinking about starting your own historical research project, Graham Ash's review of the free online Futurelearn course on history research methods is worth looking at; and don't forget to tell us about your project too.

If you haven't already done so, please do read the fascinating transcript of the Witness Seminar held at the College in 2019 on Psychiatric Hospitals in the 1960s. It is available here: [Psychiatric Hospitals in the UK in the 1960s](#)

The eagle-eyed amongst you may have already noticed Claire Hilton's appearance in episode 2 of BBC Two's 'A House Through Time', a four-part series presented by historian David Olusoga. The programme follows the remarkable story of a sea-captain's house in Bristol from its construction to the present day, revealing links to the slave-trade, mentally ill inhabitants and war time tragedies. It is well worth a watch.

Finally, we hope that you enjoy this issue of *News and Notes*. We have received some excellent thought-provoking articles, and have enjoyed editing and putting them all together, a happy distraction in

these unprecedented times. Until next time; enjoy reading and stay safe everyone! #Blacklivesmatter.

Reference

Medico-Psychological Association of Great Britain and Ireland. Seventy-ninth annual meeting held at Buxton. *Journal of Mental Science* 1920: 66, 478-497. doi:10.1017/S0368315X00013815

Request for information

New research project:

Evolution of primary care mental health provision since the late 1950s

A new research project is looking at the evolution of primary care mental health provision since the late 1950s, around the time Michael Balint wrote *The Doctor, his Patient and the Illness*. The researchers are interested in any archive material, papers, articles, documents, or personal history and experience, that is relevant to the development of the way that general practitioners and their team provide mental health care to 90% of people with a mental health problem.

Please contact

Dr Alan Cohen doctoralancohen@me.com

or

Prof Andre Tylee andre.tylee@kcl.ac.uk

HOPSIG chair's report

George Ikkos

Covid-19 has caught the country off guard. We hail the heroic contribution of our psychiatry colleagues, other health professionals and ancillary staff. The virus has affected HoPSIG work too. If one is looking for a positive spin, the widespread realisation of the deadly impact of social inequalities, the high profile of mental health issues in relation to the pandemic and even, perhaps, the acceleration in the use of technology both in professional and clinical meetings, offer themselves for consideration. The latter has facilitated excellent attendance in both the April and July executive committee meetings! However, the College Microsoft Teams platform has not been particularly user friendly.

Our *News and Notes* editorial team have continued their excellent work and, even before the pandemic, had published a bumper issue of our newsletter. Another achievement has been our HoPSIG editorial in the *BJPsych*, led by Graham Ash and Claire Hilton, advocating an increased role for history of psychiatry in Post Graduate Medical Education and Continuing Professional Development, entitled "[History of psychiatry in the curriculum? History is part of life and life is part of history: why psychiatrists need to understand it better](#)". We hope that this will have both immediate and longer-term impact and we will continue working on its implications. Yet another important notable publication, edited by Claire Hilton and Tom Stephenson, is [Psychiatric Hospitals in the UK in the 1960s](#), the transcript of the Witness Seminar held at the College in October 2020. It is free to download. Do look up these publications if you have not done so already.

Our academic programme has sadly been thrown off course. We have had to postpone our September 2020 meeting in Newcastle on "Understanding death and mortality in the context of mental illness and institutionalisation during the 18th-20th

centuries", and are awaiting a new proposal from our partners there. We are currently reviewing the proposed Spring 2021 meeting in Manchester themed on Dr Samuel Gaskell of Lancaster Moor Hospital and/or the Gaskell family, and their contribution to mental health. Nicol Ferrier continues to lead on the Newcastle meeting and Graham Ash on the Manchester one.

As 2021 will mark 180 years since the foundation of the Association of Medical Officers of Asylums and Hospitals for the Insane and 50 years of the College, we believe that the history of psychiatry should figure prominently in College activities. Inevitably Covid-19 has encouraged us to stage webinars and Tom Stephenson and Claire Hilton will co-organise and host Tom Burns and Edward Shorter (Canadian Historian of Psychiatry) in a launch of the Witness Seminar report in January 2021. We are hoping that this will be the first of six webinars, one to be held every 2 months, including one on psychiatry and the Jewish community. Some of the proposed webinars are intended to share the work of contributors to *Mind, State and Society: Social History of Psychiatry and Mental Health in Britain 1960-2010* to be published by Cambridge University Press next year.

The Royal Society of Medicine (RSM) Psychiatry Section programme of activities on "Psychiatry in Dialogue with Neuroscience Medicine and Society" has been crucial to the preparation and formulation of the aforementioned manuscript. Through the Lambert Fund it will also secure free/open electronic access to the volume. To mark publication, the RSM Psychiatry Section will hold a meeting in association with HoPSIG on 9 June 2021, to follow-on from the first highly successful [meeting to discuss the book, held in January 2020](#).

Looking beyond these activities Nicol Ferrier is leading preparations for a witness seminar on "The rise and fall of academic departments of psychiatry in the UK". Though Covid-19 may have thrown our programme off course, it has spurred us to broaden and expand our activities too. We are pushing ahead in new directions.

Stop press!

College Archives Project

Sort it out, don't throw it out!

Please consider donating your personal archives to the College Archives rather than throwing them out.

The College has an archives collection development policy. Its main purpose is to collect, maintain, document and preserve the history of the College.

The policy also allows the archivist to collect personal papers of officers, fellows and members of the College. These papers usually supplement and compliment institutional records collected from the various departments, committees, faculties and other bodies of the College.

The papers which are more likely to contain information of archival value include:

- diaries, memoirs, biographies
- official correspondence, committee, faculty, section, group and division minutes, reports and files
- correspondence with colleagues, professional organisations, government bodies
- audio-visual records such as photographs, oral history tapes and transcripts, 35mm slides, videos, and other unpublished psychiatry teaching material
- material relating to service development ideas/projects and challenges in your locality
- items relating to clinical practice before 1971, i.e. at the time of the Royal Medico-Psychological Association or earlier

To protect the confidentiality of your archival donation we can specify a closure period so that your material will be stored safely but not made accessible to researchers during that time.

For assistance with the selection of material suitable for the Archives and for information on transfer arrangements, please contact:

Francis Maunze, College Archivist:
archives@rcpsych.ac.uk 0203 701 2539

or

Dr Claire Hilton, Historian in Residence:
claire.hilton6@gmail.com

or

Dr Graham Ash, Honorary Archivist:
gmash@btopenworld.com

Archives update

Sir Robert Armstrong-Jones (1857-1943)

In September 2019, Miranda Buckley donated the papers of her grandfather, Sir Robert Armstrong-Jones, to the College Archives. The donation was facilitated by Dr Claire Hilton, the Historian in Residence, who had been in possession of this unique collection of papers. The collection includes manuscripts, memorabilia, photographs, and printed material, some of which had appeared in very obscure journals.

Sir Robert Armstrong-Jones was the Medical Superintendent of the London County Asylum at Claybury from its opening in 1893 until his retirement in 1916. More information about both him and his papers can be obtained from the College's online catalogue *ref:* [GB 2087 RCPSYCH/Y/10](#)

'Our history' web page

As part of preparations for the College's 180th anniversary celebrations, to be held in 2021, we have updated the history page on the College website. Read about the College's long and storied past [here](#).

**Francis Maunze,
Archivist**

Memoirs

Contraptions for connections

John Bradley

Over the past 65 years (June 1953 to December 2018 when I relinquished my licence to practise) I have treasured a selection of remarks and observations, from my professional mentors and colleagues and from a number of patients, that have somehow stuck in my mind.

Experiences as a junior doctor

After spending five years at the Middlesex Hospital as a pre-clinical and clinical student, I qualified in May 1953 and took up my first job as a pre-registration house physician on 1st June under the then professor of medicine, Alan Kekwick. He immediately informed me that the following day he was going to be unavailable, except that he would telephone me every hour or two to see how things were going, but I would be in charge of half the professorial medical unit that day. It was Coronation Day. I was very conscious that there might be emergency admissions as the hospital was very near the coronation route in central London where crowds had gathered to catch a glimpse of the royal processions. Fortunately, the day passed without any serious incidents, particularly as the professor had somehow forgotten to telephone me quite as frequently as he said he would (and this was in the days before mobile phones). However, I learnt two valuable lessons—one was not to expect consultants always to keep their promises, the other, that ward sisters were the really important people. Casualty was in the very capable hands of its sister (accident and emergency consultants did not exist in those days) and ward sisters knew exactly what to do and the junior doctors were in many ways superfluous and only there to sign prescription forms.

After obtaining full registration in 1954 and after a stint as an ear-nose-and-throat house surgeon, I had to do my National Service in the Royal Air Force (RAF). After a brief period as a lone medical officer at a flying station in County Durham, I applied for a training post in neurology and psychiatry at the RAF headquarters hospital in Buckinghamshire. My commanding officer was Wing Commander Paddy O'Connor MD MRCP, who was a gentle, thoughtful and clever man who taught me a great deal about both neurology and psychiatry. Patients were, of course, national servicemen like myself (except that I went in with a commission) and were from all walks of life. Many were inadequately vetted as to their

suitability for service life and broke down very quickly on being exposed to RAF routine. Much of my job was involved in discharging them from the RAF, but a sizeable number developed psychotic illnesses which the RAF agreed to treat in the neuropsychiatric centre. The wing commander decided that I should become the medical officer in charge of the deep insulin coma unit as insulin coma was then being used for the treatment of schizophrenia. I learnt a lot about resuscitation from hypoglycaemic coma and its hazards (including death), and also how to cope with deluded and hallucinated young men requiring a lot of sedation with barbiturates, and evil smelling paraldehyde, as the phenothiazines were not then in general use. It was the wing commander who taught me how to treat deluded and hallucinated patients with his own form of psychotherapy. In his soothing Irish accent, he would assure them “‘tis but a trick of the nerves” which at least calmed them down, albeit temporarily, and it was certainly not as dangerous as insulin coma.

On leaving the RAF I obtained a post as a registrar in the psycho-endocrine research unit led by Professor Max Reiss at St Ebba's Hospital near Epsom. He was a large man of Czech origin with a slow avuncular air and a strong middle European accent. His main interest was an attempt to correlate subtle endocrinological abnormalities with a susceptibility to mental illness, in particular, poor development of the secondary sexual characteristics of both male and female patients. An abiding memory is of being with Max Reiss in a clinic and several other researchers (all, of course, in white coats) when he was interviewing a woman patient. Although a kindly man, his respect for patients' feelings when absorbed in his research was not very good, and this poor lady who he was about to examine was standing before him. He said without an explanation: “Please pull down your knickers”. She bridled with a sharp intake of breath and in order to reassure her he said: “I only want to see your pubic hair”.

I cannot remember the colour of the lady's underwear on that occasion but I do recollect when, as an undergraduate, I attended the clinic of the consultant neurosurgeon at the Middlesex, Miss Diana Beck, who was one of the few (if not the only) woman neurosurgeon who was practising at the time. She asked me to do a neurological examination on a woman who was complaining of headaches. I reported back to her that I could find no neurological abnormality and she sighed and said “I fear you are not going to be a very good doctor, you have missed the most important sign. She was wearing black underwear”. She then went on to say

you cannot trust a thing that any woman wearing black underwear will say to you.

Another consultant working in the psycho-endocrine unit at St Ebba's did not believe in wasting words. I remember him saying to a patient that he would prescribe some medication which would help him. The patient was not satisfied and then said: "What about my mind, doctor?" to which the doctor replied "Never mind your mind, just keep taking the pills".

Consultant posts, and some of the people I best remember

In 1964 I was offered an associate director post in a general hospital psychiatric unit in the United States (USA). Again, I learnt a great deal while there and it helped convince me that the National Health Service was a much better way of delivering healthcare than the way it was delivered in the USA. I did learn one cultural fact, that one should make sure how a patient's name is pronounced and make appropriate enquiries from the patient him or herself. I was in my consulting room when I was given the folder of a patient called Mrs De Pasquale. I thought I was being very clever and went out into the waiting room and asked for a Mrs De Pasquale in my best Italian accent. Nobody responded. I later discovered that she pronounced her name Deepaskwale.

In 1965 I was keen to return to England, partly to support my parents and partly because I felt very much that my future should lie in the UK. I was keen to work in London and applied and was appointed consultant at the 2,000 bedded Friern Hospital, originally Colney Hatch Lunatic Asylum, with appointments at two other north London hospitals, the Whittington and the Royal Northern. I had never worked in a mental hospital environment previously and was rather daunted to find that I was responsible for 500 inpatient beds quite apart from the outpatient clinics and liaison work but I was young and moderately ambitious and was pleased when I was offered a senior lectureship at the Royal Free Medical School to take on undergraduate teaching. I was later able to set up a professorial unit there with the late Professor Gerald Russell.

In addition to the consultants we had some trainee psychiatrists and staff grade doctors who were very experienced. I was extremely well supported by Dr Stephanie Felsenberg who had qualified in Vienna before the war and had come to this country to escape the Nazis. Initially her Austrian qualification had not been recognized and she had to work as a hospital ward cleaner. She taught me a great deal without being patronizing, even though she was old enough to be my mother. She was tough, but gentle. My enduring memory of her is of the way in which she would describe difficult or violent patients or

even irritating colleagues as "unappetitlich", which was the harshest word of opprobrium she ever used.

Apart from in the so-called "neurosis unit" in the hospital grounds, which had three consultants for 150 inpatient beds, there were only four consultants looking after the other 2,000 inpatients, and at that time the government was beginning to have doubts about the advisability of allowing such understaffed human warehouses to continue. This was reinforced by critical reports of such mental hospitals, and in particular, of Friern Hospital. After only a few months of my starting work there, the medical superintendent resigned. I was asked to take on the role of medical director in which I remained for 10 years. In a sense it was relatively easy because the government realised that these huge hospitals should be scaled down and at the same time many more consultants should be appointed.

The events that stick in my mind over this period were regular visits from the local member of parliament, Mrs Margaret Thatcher, who told me that they would joke in the House of Commons that the only reason she ever got elected was because there were so many lunatics in her constituency. She was determined (as I was) that the hospital service should be reformed and she managed to get me interviews with the then secretary of state Sir Keith Joseph, and by the time I left, the number of patients had halved and the number of consultants had risen to 23 with a professor and two senior lecturers.

I may have reported it elsewhere, but I was flattered and alarmed when I discovered that a patient who was on a long stay ward had told the nurse that I would have sexual relationships with her every other night. Fortunately, the matter never got to the General Medical Council as the nurse sensibly asked what occurred on the intervening nights and the patient replied that she kept those for the Duke of Edinburgh.

Apart from my inpatient work I was also looking after outpatient clinics. I think the patients that have stayed in my mind were those who had used some interesting malapropisms. There was a man who was seeking advice about his marital situation and after a lot of hesitation, he came out with it and said that he was "impudent". Another patient who had a series of depressive breakdowns and felt the stigma of mental illness very much, said that she felt like a "leopard". It was the poor lady who has provided me with the title of this essay who coined for me the most unforgettable phrase. She was deeply, if not psychotically, depressed and admitted to feeling suicidal because, as she said, "I've been using contraptions for connections." She was a good Catholic and felt she had committed an unforgiveable sin by using contraceptives.

Fortunately, she responded well to treatment, without losing her faith.

Sometime in the early 1970s I was asked to see a highly intelligent man in his seventies in his own home as he had been behaving strangely. His general practitioner telephoned and said that he was clearly deluded as he thought that he was the son of Lawrence of Arabia. I thought this must indeed be a delusion as, in so far as I knew, Lawrence fathered no children. Matters became clearer when I saw the gentleman who fortunately had a couple of friends looking after him as he was extremely excitable and overactive. He was able to tell me that he was the stepson of DH Lawrence. The poor man was becoming quite exhausted in a state of hypomania and I eventually managed to persuade him that he needed a bit of a rest in hospital. At last, after agreeing to this, he complimented me by saying "you and Dame Rebecca West would make a formidable team". This patient had impeccable literary connections, although it was not clear to me why I should be linked with that eminent author and outspoken feminist critic. It has since become for me a handy way of complimenting or insulting someone by substituting the name of my current like or dislike!

Another memorable patient was a devout Pentecostal woman who suffered recurrent bouts of what appeared to be manic psychosis. One of her delusional beliefs was that my then Australian registrar, also male, and I were the reincarnations of her two dead sisters, Ruby and Dora. One day in my role as Dora I found her lying on her bed talking incoherently. She would do this from time to time as part of her religious exercise of speaking in tongues, but when I interrupted her she returned to speaking ordinary English and shouted "piss off Dora". A few days after this encounter I was giving a seminar to some students and she walked into the room dressed in a white robe (she had said she was the bride of Christ). In a very dignified way, she pointed at the wall behind me and said "Mene mene tekel upharsin". From my education in the shadow of Canterbury Cathedral, I was able to recollect the meaning of this quotation from the prophet Daniel. She did not seem to be surprised when I said you must mean "I have been weighed in the balance and found wanting". She replied "Yes that's exactly what I do mean". She was of course, quoting the writing on the wall at Belshazzar's feast.

I am sure it is indeed beneficial to be cut down to size from time to time. For a number of years I served on the Parole Board where teams of three of us would hear appeals in various prisons in different parts of the country. The team usually consisted of a High Court or Circuit Judge, a psychiatrist and a lay person. We would travel and spend the night in a local hotel near the prison. One team, all of us with

the first name "John" were visiting a prison and checked into a hotel. I explained to the hotel receptionist that we were Lord Black, Sir John White (not their real names) and that I was Dr John Bradley. Yes, she said "We were expecting you, Mr Black, Mr White and Mr Bradley". In some ways this was in keeping with our normal Parole Board democratic policy where we did not use titles.

Some broader reflections

I have to admit that certain things that patients have told me have made me smile but I don't think I have ever wanted to laugh as I have always been far too conscious of the underlying sadness that lies beneath even the most manic façade. Any branch of medicine involves a practitioner in an attempt to relieve suffering, and hopefully, from time to time, one is successful in doing so, or at least ameliorating it, which I hope I have achieved, without causing harm. I am not by temperament a person who is easily carried away by enthusiasms, not for sport, religion or politics, and certainly not for the latest psychiatric treatment. My own personality assessment would be that I am a sceptical eclectic pragmatist, hopefully without being too pompous!

The last 65 years have witnessed many changes of emphasis in the treatment of patients suffering from psychiatric disorders, not least in a change of language in describing them such as mental health problems instead of mental illness, and learning disability instead of mental subnormality. Many of the more dangerous (and often ineffective) physical techniques have been abandoned and prolonged psychological therapies involving three to five sessions a week for several years have become unsustainable in terms of expense, and arguably of little benefit.

I am perhaps one of the few psychiatrists who have witnessed, and been involved with treating, schizophrenic patients with deep insulin coma with its rare but significant mortality and no benefit, in the early 1950s. I have seen the havoc caused by prolonged narcosis, the terrible side effects of excessive sedation with barbiturates and paraldehyde before the less toxic antipsychotic drugs came into use. They too had serious side effects, but at least they helped control the disastrous consequences of psychotic illness. Although lithium carbonate can be dangerous if not well monitored, the introduction of mood stabilisers has proved a boon, and even life saver, for those suffering from bipolar disorders. Electro-convulsive therapy is still in use, with refined techniques and equipment, and it can be a life saver in severe depression, but up to 40 years ago I saw it used indiscriminately, causing long term memory problems. Although in the early 1960s I witnessed a few patients with severe obsessional illness helped

by psychosurgery, I have also seen those whose lives have been ruined by personality changes or seizures.

The social and clinical problems created by institutionalisation in the huge and understaffed mental hospitals became recognised in the early '60s, often accompanied by physical controls (in addition to use of drugs), such as padded rooms in Friern (and strait jackets at l'Hôpital Sainte-Anne, in Paris, where I worked for a month and where Professor Jean Delay discovered the effects of chlorpromazine). The gradual introduction of community care using day centres and multi-skilled professional care teams has been a significant advance, though lacking some of the more acceptable aspects of a psychiatric hospital, such as time and space, supported workshops, gardens and gardening, and access to extensive grounds, all of which could help recovery.

Quasi-psychotherapeutic techniques such as aversion therapy involving drugs or electric shocks for alcoholism or homosexuality have been abandoned as being useless and a series of mental health acts have attempted to preserve the rights of the individual. The efficacy of both group and individual psychotherapy for the treatment of depression, post-traumatic and other conditions, with time limited cognitive techniques is now well established, and the more intrusive use of sedative drugs, or even LSD (lysergic *acid* diethylamide), to open up traumatic memories by abreaction or narcoanalysis, are now rarely used for this purpose.

Unlike so many of my patients I have been very fortunate in avoiding serious illnesses, domestic unhappiness or unemployment. I have had an interesting and absorbing career which has taken me to Australia, New Zealand, the Far East, South Africa, the Caribbean and the United States, lecturing, performing medicolegal examinations, attending meetings or in an advisory role. I have met many interesting people, both in the medical field and in my medico-legal work over the last 30 years and made many good friends.

My work with the Mental Health Review Tribunal and the Parole Board has taken me to many parts of this country, and at the request of solicitors, visiting in their own homes, patients who were making personal injury claims. Although travelling has at times been tedious or tiring, it has rarely been too exhausting. However, one of my most uncomfortable journeys was visiting a patient living in Hull. It was mid-winter, the trains were delayed, cold and slow, and when at last I got home I was tired, hungry and not in the best of moods. The following day my instructing solicitor phoned to ask how I had found his client. All I could say was 'I've been to Hull and back on her account'!

Follow HoPSIG on twitter

@rcpsychHoPSIG



**Tweet us your opinions, views
or just say Hi!**

**Have a look at the RCPsych
history, archives and library
blog [here](#)**

Just bricks and mortar: a personal journey through psychiatric buildings

David Dodwell Locum Consultant
Psychiatrist, Cambridgeshire and
Peterborough NHS Foundation Trust, Cavell
Centre, Peterborough PE3 9GZ.

Having worked in psychiatry since 1979, I have been in a variety of buildings. Although *Not Just Bricks and Mortar*¹ emphasised the relative unimportance of buildings, they still have a role to play. Our physical environment is relevant to the patient-doctor relationship²⁻⁴, can be more or less satisfying for patients⁵, and conveys its own messages. At one time, the psychiatric archipelago was dominated by town and county asylums, a common feature becoming the descriptor of a 1961 address by a Minister of Health: the 'Watertower' speech⁶. The range of built environments I have worked in is also physical testimony to changes in healthcare fashion: I believe that the role of fashion is greatly underrated in healthcare although there are occasional references^{7,8}.

Withington, Manchester 1979

My psychiatric training started in a purpose-built District General Hospital [DGH] unit (one of those foreseen by Enoch Powell in 1961⁶) in Withington Hospital (then known as the University Hospital of South Manchester). Such units were seen as the cutting edge antidote to outmoded asylums, avoiding stigma for patients (who could now give the name of a hospital without it being immediately obvious they had a mental disorder: of course, this bypassed stigma, by patients identifying as generically ill, rather than overcoming it by patients being able to identify as mentally ill) and allowed psychiatrists to mingle easily with their physical health colleagues. The unit was connected to the rest of the hospital by an enormously long corridor, so integration was not so easy in practice. The unit was architecturally ugly, but to my inexperienced eye, served its purpose well. It had not acquired much in the way of chronic, long-stay patients (yes, they used to exist), but there were a few. Having bought into the idea of the DGH unit, I was appalled to hear a senior psychiatric trainee declare that one of the long-stay patients would be much better off in

an asylum with large grounds where he could safely tramp around all day.

According to Wikipedia, Withington started life as a workhouse, and at one point was the largest teaching hospital in Europe. The original site closed in 2002 (although a small new community hospital was built nearby). The psychiatric unit included an Alcohol Dependency Unit run by Brian Hore⁹, subsequently the [Brian Hore Unit](#),¹ which closed in 2016. The old purpose-built psychiatric unit is now the site of industrial offices (according to Google Maps).

Prestwich Hospital, Manchester 1981

Part of my rotation involved working in a former asylum: Prestwich Hospital, north Manchester (opened 1851; in 1903, probably the largest asylum in Europe). There were huge grounds, two large buildings, and a variety of lesser buildings. It was close to a main shopping street where patients were a familiar sight, identifiable by their ill-fitting suits (supplied by the hospital) and, often, by their Parkinsonian gait due to first generation antipsychotics. The main building nearest the road was a traditional symmetrical rectangular structure (with clocktower rather than watertower as central feature), originally one side for males and its mirror for females. The further building was architecturally unusual: an oval plan. From the outside it was striking, but I found the inside scary. The main corridor followed the oval plan and had no outside windows, so one could never see far. The view was further obstructed by heavy doors clankingly unlocked and re-locked by grim-faced nurses with large sets of heavy iron keys. The building was on a hill, so the floor kept changing height. I found the whole effect disorientating and oppressive. From what I can make out from Google, it is now completely demolished although there is a new-build secure unit on part of the site.

Rawnsley Building, Cheadle Royal Hospital, and High Elms (Manchester) 1985

My senior training included three different locations, all serving Central Manchester (to the south of the city centre and covering a fairly run-down, multicultural, inner-city locale). The Rawnsley Building was a purpose built out-patient and day hospital attached to a DGH, Manchester Royal Infirmary. It was colourful and included a [large mosaic wall created by patients](#) under the guidance of an artist¹⁰. It was situated in its catchment area

¹ Sadly, Brian Hore died on 26 July 2020.

and was within walking distance for many patients. It was the site of a trial where patients presenting acutely were randomly allocated to in-patient admission or day hospital care: to my surprise it was feasible to allocate non-detained patients: day hospital patients got better more slowly and initial carer burden was greater but at one year the day hospital outcome was better¹¹ and cheaper¹². Despite this evidence-based medicine, within 10 to 15 years virtually all working-age adult psychiatry day hospitals had closed.

In-patient care for this catchment area was provided in a ward rented from [Cheadle Royal Hospital](#) (opened 1849 as the Manchester Royal Hospital for the Insane, when the city-centre Manchester Lunatic Hospital was relocated; at the creation of the NHS it became private). It was about 10 miles away, accessible by one bus an hour which took about an hour to get there. The ward was dingy and run down (I was told that the private wards were like five star hotels) and our patients often spoke little English: many had uprooted themselves from their original country to the UK and then ended up uprooted from their community to this strange place. I think that this spectre of alienation affected my two consultants. Phil Thomas went on to become a chairman of the Critical Psychiatry Network and has published extensively on social and philosophical aspects of psychiatry including 'postpsychiatry'¹³. In her next job, Christine Dean worked in a similar inner city area in Birmingham and tried to treat people at home wherever possible¹⁴.

High Elms was an attempt to manage long-stay patients in a less institutional setting and with real-world activities. It was in the Central Manchester catchment area, and was based on an experiment in South Manchester, Douglas House¹⁵. As the new catchment area service was set up, some 'new long-stay patients' accumulated. A group of these long-stay patients were put into an ordinary house (with nursing staff) away from the hospital site on the basis that this would encourage normalisation and use of mainstream community facilities; they also did their own cooking and laundry rather than rely on institutional support. As Yogi Berra said, 'in theory there is no difference between theory and practice; in practice, there is'. High Elms was a large, rambling Victorian house in Victoria Park, a district originally of grand houses for rich merchants, but the area had become a run-down desert of dilapidated houses, whose occupants often did not connect with each other. Moreover, the nearest shops and facilities (e.g. Post Office, which was necessary at

the time to cash benefit payments) were a 20 to 30-minute walk. So there was no real community for these patients to integrate into, and limited community facilities for them to access. High-Elms is Grade II listed, disused and boarded up since 2013¹⁶.

Rubery Hill Hospital, Birmingham 1988

For a short time, I worked in [Rubery Hill Hospital](#), in south-west Birmingham. It opened in 1882 and cost £133,495 to build, to house up to 850 patients¹⁷. It was a large red-brick asylum with pavilion blocks linked by corridors, it had sizeable grounds including its own church. I recall a large quadrangular corridor, reminiscent of a cathedral cloister with the arches filled in, whose walls were decorated with colourful murals. A senior manager was desperate to sell the place off for a supermarket but his plans were frustrated when it was 'found' that the land included unmarked graves of former patients: it is likely that the boundaries of the long disused hospital cemetery had been forgotten. When I visited the site in 2010, there was a huge Morrison's supermarket and car park.

Garlands Hospital, Carlisle, 1991

I worked for a few months in [Garlands Hospital, Carlisle](#), another former asylum with additions of various ages. Some of the oldest buildings were separate blocks rather than a continuous building (like Prestwich and Rubery Hill). They were built of local red stone, which had acquired a venerable patina of green lichen creating an effect I considered subtle and beautiful. I thought the general effect was imposing but not overawing. The acute wards were in a purpose-built single storey complex, probably dating from the 1960s. It had a church and other buildings, including some conventional houses used as staff accommodation (I stayed in one). My recollection is that these buildings and their state of repair was superior to most hospitals of that era. I visited again in about 2015, the acute ward complex was still in operation and the corridors clean and well-kept. The grounds and old blocks had been sold: it seemed that the old blocks were being refurbished along with new build housing on the site.

Ipswich 1993

I moved to East Suffolk in 1993. At the time, there were two hospitals, the former Ipswich town asylum (St Clement's), and the former county asylum, St Audry's, in countryside 12 miles north-east of Ipswich. St Audry's was in the process of being closed and I never set foot in it. It was subsequently converted to upmarket residences.

St Clement's architecture was typical of an asylum: a fairly pleasant (red brick) frontage, bilaterally symmetrical (men on one side, women on the other) and extensive grounds to the rear. The original building, designed to house 200 patients, cost £18,950 in 1870¹⁸. I was told that a phalanx of men used to walk clockwise round the grounds, and phalanx of women anticlockwise, passing each other at the far end of the grounds. It had a range of additional buildings, including a 1960s house style building for the social work department and a similar one for the psychology department, a ward block (?1920s-30s), and various prefabs. Adult acute wards were some distance from each other: one in the main Victorian block, one in a prefab, and a Psychiatric Intensive Care Unit in a separate prefab. The two rehab wards were also separate, one in the main block and one in the ?1920s-30s block.

The main block housed a number of long-stay wards, whose patients were expected never to be discharged (some of them were told this was their home for life). As patients died, these wards were gradually closed; some of the younger long-stay patients were moved out, and new long-stay patients were placed out of hospital. At one edge of the hospital grounds, a new unit (Chilton Houses) was built in the late 1990s, to offer a long-term domestic type environment for patients who could not be discharged.



St Clement's Hospital.

https://commons.wikimedia.org/wiki/File:St_clements_hospital_oblique_10s07.JPG

Inevitably, there were discussions about closing the hospital. I have visited the site a few times. There is now a psychiatric unit on the DGH site and the grounds and old buildings (apart from prefab Health Authority buildings) have been sold off. There is extensive new housing round St Clement's perimeter road and on the grounds. My old office is now part of a posh flat. I read that Chilton Houses,

offering a home for life, closed in 2015, replaced by a unit which boasts of its short stay and fast turn-round¹⁹.

Peterborough 2001

Peterborough services in the last 20 years have been on a variety of sites. In 2001 there were two acute adult wards, each on a different DGH site (Peterborough District Hospital (PDH) and Edith Cavell Hospital (ECH), about 2 miles apart). Both were inappropriate in different ways. 'The Gables' at PDH was a former merchant's house. Visibility for nurses to observe was terrible, and although it had been a house, it did not have a homely feel. The second was on the first floor at ECH, on a 'Nightingale' ward, most patients sleeping in the long dormitory, with curtains round the beds just like in an old medical ward.

Also at PDH was a purpose-built rehabilitation unit with a ground floor ward and day hospital, and upstairs offices. It opened about 1999, the result of a generous gift by a Lincolnshire magnate, and named after his wife: the Lucille van Geest Centre. Also on this site was a 1960s house-style building (Little Gables) housing one Community Mental Health Team (CMHT), while a second was a few minutes away in a building which had been a workhouse (St Johns). The Child and Adolescent Mental Health team offices were in a converted 19th century house very close to the edge of the hospital site. A few minutes away, off-site, was another Victorian house which was used as offices and later became the Early Intervention in Psychosis team base. PDH was a convenient 10 to 15-minute walk from the central bus and railway stations. There was a further site (Gloucester Centre) three miles from PDH adjacent to an industrial park, consisting of one and two storey buildings, some brick and some flimsy prefabricated offices. This provided offices, and out-patient, day care, and in-patient wards for learning disability (LD) and for old age psychiatry.

However inadequate the in-patient situation in 2001, it was an improvement on the previous arrangements for admissions. People who lived north of the river Nene (which runs through the centre of Peterborough) went 40-odd miles north to Rauceby Hospital near Sleaford, Lincolnshire, and those who lived south of the river went 50-odd miles south to Fulbourn (outside Cambridge).

A plan was formed to provide all general hospital services on one site, including a psychiatric in-patient unit. To this end, ECH was demolished and a new DGH (Peterborough City Hospital) and a

psychiatric unit (Cavell Centre) were built, the total site being known as the Edith Cavell Health Campus. The National Audit Office criticized the Private Finance Initiative funding for its poor value for money²⁰. The Cavell Centre provides in-patient care for adults, elderly, LD, and a clozapine clinic. The Gables was converted into luxury flats, the CMHT offices were demolished, as was the virtually brand-new Lucille van Geest Centre. The CMHTs moved to the Gloucester Centre site, but this has now been sold, and some services will relocate to the city centre town hall.

Some years ago I saw a sign to Rauceby while driving down the A15 and detoured to see if I could find the hospital. It was still there, boarded up and unused although there was some new housing nearby (presumably in part of the old grounds). In 2017 it was up for sale at £1million after Barratt Homes were refused permission to demolish most of it for housing²¹.



The Gables

https://commons.wikimedia.org/wiki/File:The_Gables,_Thorpe_Road,_Peterborough_-_geograph.org.uk_-_155843.jpg

Conclusions

What have I learnt?

1. Nothing is sacred and buildings can be demolished whether they are venerable, sturdy, and historical, or recent, purpose-built and state of the art.
2. It is possible to re-purpose hospital buildings into marketable accommodation.
3. It is helpful if wards (particularly acute wards) are accessible from the homes of patients to allow visits from family and easy home leave.
4. It is helpful if buildings that house people with long-term problems are near useful community facilities (such people may struggle to walk far or to use public transport).

5. Fashion and fads play a larger role in psychiatric service provision than we like to acknowledge.
6. The idea that institutional care impairs patients may be partly true²² but with thought such problems can be ameliorated through the physical environment²³ and staff awareness²⁴⁻²⁶.
7. It remains the case that some people develop severe, long-term impairments (negative symptoms) and I have seen this in people who never had a hospital admission.
8. It is possible to deny the existence of long-term or chronic conditions and focus on 'episodes' which respond to time-limited interventions, thereby denying services to some of the most needy (denying services to the 'incurable' is an old stratagem²⁷⁻²⁹).
9. Along with the denial of chronicity is an ideological imperative for 'stepping down'. This can be carried too far and if support and monitoring is withdrawn, failure will not be picked up. If the Peter principle is that employees are promoted to the level at which they are no longer competent, the equivalent is that patients are stepped down to the level of support inadequate for their needs.
10. It is possible to vilify public sector provision and maintain (with no evidence) that competition (which involves wasteful tendering and often a failure of accountability) is innately better than central control (which can, of course, have its own problems).

There were numerous factors in closure, the most consistent being their cost³⁰ and the wish to save money. Inquiries into maltreatment of patients in various hospitals³¹ facilitated closure. A common myth is that the reduction of in-patient beds was due to antipsychotic medication: the decrease antedated their introduction³², and a detailed case study of one catchment area hospital found no relation between in-patient numbers and antipsychotics, and explained it by changes in staff optimism, zeal, numbers, and policies³³. Although bed numbers have shrunk, admissions have increased³⁴.

Common themes are the triumph of ideology and narrative over facts and common sense, and the need for politicians and managers to do something, a doing which I suspect is primarily motivated by the doer's need for a sense of agency and desire for accolade, and subsequently dressed up in the fine clothes of altruism or economics.

References

1. Royal College of Psychiatrists. *Not just bricks and mortar. Report of the Royal College of Psychiatrists Working Party on the size, staffing, structure, siting and security of new acute adult psychiatric in-patient units*. London: Royal College of Psychiatrists, 1998. Council Report CR62.
2. Dijkstra K, Pieterse M, Pruyn A. Physical environmental stimuli that turn healthcare facilities into healing environments through psychologically mediated effects: systematic review. *Journal of Advanced Nursing* 2006;56:166-81.
3. Okken V, van Rompay T, Pruyn A. Exploring space in the consultation room: environmental influences during patient-physician interaction. *Journal of Health Communication* 2012;17:397-412.
4. von Sommaruga Howard T. The physical environment and use of space. In: Campling P, Davies S, Farquharson G, eds. *From Toxic Institutions to Therapeutic Environments. Residential settings in mental health services*. London: Gaskell, 2004. 69-78.
5. Wells-Thorpe J. Healing by design: feeling better? In: Kirklín D, Richardson R, eds. *The Healing Environment Without and Within*. London: Royal College of Physicians of London, 2003:11-23.
6. Powell JE. Address. *National Association of Mental Health Annual Conference*. Cane Hill Hospital, UK, 1961.
7. Metastasio A, Dodwell D. A translation of 'L'Elettroshock' by Cerletti & Bini, with an introduction. *European Journal of Psychiatry* 2013;27:231-9.
8. Marmor TR. Fads in medical care policy and politics: the rhetoric and reality of managerialism. In: Marmor TR, ed. *Fads, Fallacies and Foolishness in Medical Care Management and Policy*. Singapore: World Scientific Publishing, 2007:1-26.
9. Hore B. Doctor Brian Hore explains the history of the Brian Hore Unit; 2013: <https://www.youtube.com/watch?v=RR45laXwOws>
10. Bridges K, Brown L. Psychiatric patients work alongside artists on prizewinning project. *BMJ* 26 Aug 1989;299:532.
11. Creed F, Black D, Anthony P, Osborn M, Thomas P, Tomenson B. Randomised controlled trial of day patient versus inpatient psychiatric treatment. *BMJ* Apr 21 1990;300:1033-7.
12. Creed F, Mbaya P, Lancashire S, Tomenson B, Williams B, Holme S. Cost effectiveness of day and inpatient psychiatric treatment: results of a randomised controlled trial. *BMJ* May 10 1997;314:1381-5.
13. Bracken P, Thomas P. Postpsychiatry: a new direction for mental health. *BMJ* Mar 24 2001;322:724-7.
14. Dean C, Gadd EM. Home treatment for acute psychiatric illness. *BMJ* Nov 3 1990;301:1021-3.
15. Goldberg DP, Bridges K, Cooper W, Hyde C, Sterling C, Wyatt R. Douglas House: a new type of hostel ward for chronic psychotic patients. *British Journal of Psychiatry* 1985;147:383-8.
16. Vose J. Listed Building Consent application number 117961/LO/2017; 2017.
17. Tonks P, Smout L. Rubery Hill Hospital: a short history. Birmingham, UK. 1982.
18. Loynes G. St. Clement's Hospital. Ipswich. Centenary 1870-1970. *St Clements Rendezvous* 1970 (Souvenir Issue Centenary Celebration):3-12.
19. Norfolk and Suffolk NHS Foundation Trust. New-look recovery service helps service users live independently. 2017.
20. Comptroller and Auditor General. *Peterborough and Stamford Hospitals NHS Foundation Trust*. London: National Audit Office, House of Commons; 28 Nov 2012 2012. HC 658.
21. Davies E. [This creepy former psychiatric hospital could be yours for £1m](http://www.lincolnshirelive.co.uk). www.lincolnshirelive.co.uk
22. Goffman E. The medical model and mental hospitalization: some notes on the vicissitudes of the tinkering trade. *Asylums*. Harmondsworth, Middlesex: Penguin, 1968:281-326.
23. Barton R. *Institutional Neurosis. Third Edition*. Bristol: John Wright & Sons, 1976.
24. Lyth IM. The functioning of social systems as a defence against anxiety. A report on a study of the nursing service of a general hospital. *Containing Anxiety in Institutions. Selected Essays Volume I*. London: Free Association Books, 1988:43-83.
25. Watts D, Morgan G. Malignant alienation. Dangers for patients who are hard to like. *British Journal of Psychiatry* 1994;164(1):11-15.
26. Main T. The ailment. *British Journal of Medical Psychology* 1957;30:129-45.
27. Risse GB. Human bodies revealed: hospitals in post-revolutionary Paris. In: Risse GB, ed. *Mending Bodies, Saving Souls. A history of hospitals*. New York: Oxford University Press; 1999:289-338.
28. Gale C, Howard R. *Presumed Curable. An illustrated casebook of Victorian psychiatric patients in Bethlem Hospital*. Petersfield, Hampshire: Wrightson Biomedical, 2003.
29. Pancino C. Doctor and patient in the modern age: words, gazes and gestures. In: Malatesta M, ed. *Doctors and Patients. History, representation, communication from antiquity to the present*. San Francisco: University of California Medical Humanities Press; 2015:81-107.
30. Ceccherini-Nelli A, Priebe S. Economic factors and psychiatric hospital beds - an analysis of historical trends. *International Journal of Social Economics* 2007;34:788-810.
31. [Socialist Health Association. Official Inquiry Reports into National Health Service Mental Hospitals](http://www.socialisthealthassociation.org.uk).
32. Turner T. The history of deinstitutionalization and reinstitutionalization. *Psychiatry* 2004;3:1-4.
33. Shepherd M, Goodman N, Watt DC. Application of hospital statistics in the evaluation of pharmacotherapy in a psychiatric population. *Comprehensive Psychiatry* 1961;2:11-19.
34. Healy D, Savage M, Michael P, et al. Psychiatric bed utilization: 1896 and 1996 compared. *Psychological Medicine* 2001;31:779-90.

On the history of psychiatry

The instructive case of James Tilley Matthews

RHS Mindham

r.h.s.mindham@gmail.com

Only rarely does an individual patient become a subject for general consideration. James Tilley Matthews was a patient at Bethlem Hospital over two hundred years ago and his illness has continued to draw attention. His case was reported in a publication by Dr John Haslam, apothecary to Bethlem Hospital, in 1810¹ [Fig.1].

following a petition from the parish authorities, on 28 January 1797. At the time of his admission his relatives did not recognise his disorder nor his need for care. In May 1797 he appeared before Lord Kenyon in Lincoln's Inn Fields who considered him a 'maniac' and confirmed his detention. On 21 January 1798 he was moved to that part of the hospital which accommodated 'incurables.' At the time of his admission he sometimes behaved like an automaton; at other times he showed an elated mood claiming to be Emperor of the Whole World and in this belief issued proclamations to his subjects and dismissed those who threatened his authority.

Legal proceedings for his release

In 1809 his relatives considered him to be of sound mind '...and possessed the proper direction of his intellects'. They moved for a writ of Habeas Corpus with the purpose of effecting his discharge from hospital. The relatives engaged two doctors experienced in the field of insanity to support their application. Dr Henry Clutterbuck, of Blackfriars, saw him on four occasions before swearing an affidavit, in the third person, before the King's Bench; '...he verily believes him to be perfectly sane.' Dr George Birkbeck, of the City of London, saw the patient on six occasions and in his affidavit recorded '...he has attempted every mode of examination which he could devise' and came to the conclusion that the patient was not insane. Both doctors were aware that the staff of Bethlem, who were familiar with the case, regarded JTM as insane and that he had been for the whole of the thirteen years of his detention. It is noteworthy that Dr Clutterbuck spoke with Dr Thomas Monro [1759-1833], physician to Bethlem, who was of the opinion, based on several years of observation, that the patient was insane. On one occasion both Dr Clutterbuck and Dr Birkbeck examined the patient together in Dr Monro's presence, but Dr Birkbeck considered Dr Monro's reasoning to be unsound.

In response the hospital authorities gathered an impressive array of experts to counter the claims of the doctors engaged by the relatives. They were Dr Lucas Pepys, FRCP, Dr Robert Darling Willis, Dr Samuel Foat Simmons, physician to St Luke's Hospital, together with five doctors who worked in various roles for the Commission for Visiting Insane Patients: Dr Richard Budd, Dr Henry Ainsley, Dr James Howarth, Dr William Lambe, and Dr Richard Powell. On 29 November 1809 they formed the collective opinion that: '...the patient is in a most deranged state of intellect and wholly unfit to be at large.' They swore an affidavit to this effect on 30 November 1809. On considering the evidence the court directed that the patient be detained.

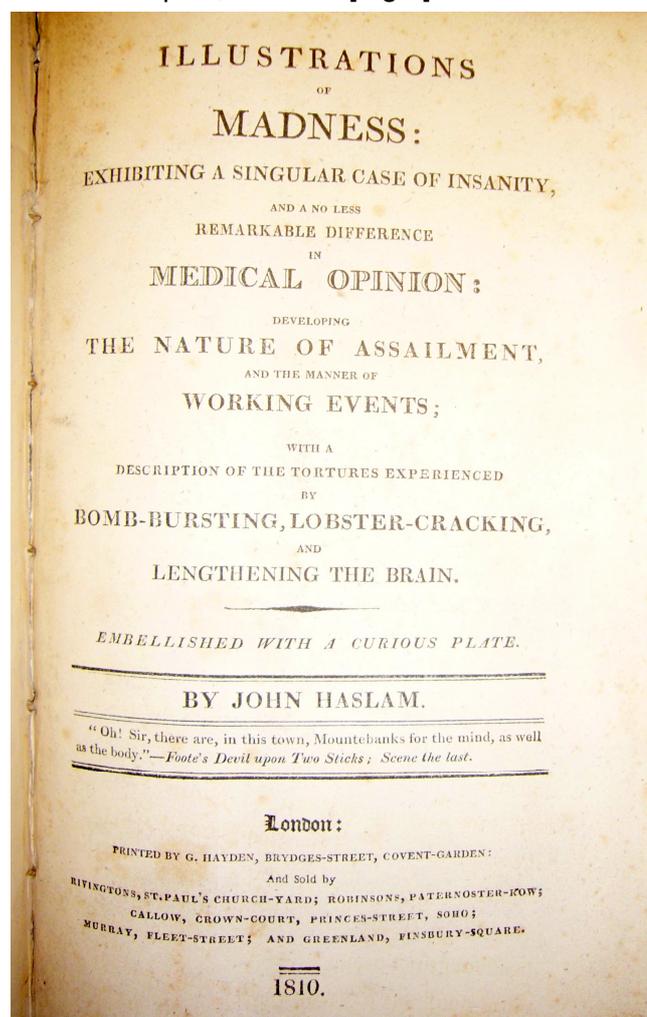


Fig 1. Title page *Illustrations of Madness*, 1810

Admission to Bethlem

James Tilley Matthews [JTM] was admitted to Bethlem Hospital, London from his address in Camberwell, by the magistrates at Bow Street,

Differences of opinion

Haslam drew attention to the remarkable difference of opinion between the medical examiners. He noted that the medical experts often examined the patient in the presence of others and commented that this may have created obscurity through excessive courtesy to those present. In passing, he noted deficiencies in the graduates of certain universities in professional matters as compared with physicians trained in London. He clearly regarded them as foreign universities with different standards; namely Leyden, Aberdeen, Saint Andrews and Glasgow!

Psychopathology

Haslam went on to describe the patient's mental state in some detail. JTM believed that he was being persecuted by a gang using 'pneumatic chemistry' to bring about his 'assailment' employing a machine described as an 'Air Loom'. The gang consisted of four men and three women, all spies, who lived in conditions of 'filth and promiscuous intercourse.' JTM described each of the gang in some detail commenting that some resembled prominent persons, who included John Smeaton, the engineer. The gang used a disgusting fluid consisting of bodily excretions, poisonous plants, toxic chemicals and 'Egyptian snuff' in his 'assailment'. The patient experienced: 'fluid-locking', 'cutting soul from sense', 'kiteing', 'thought-making', 'laugh-making', 'tying-down', 'lethargy-making', 'voice-sayings' and 'dream-making', among other experiences, all brought about, in his view, by a form of magnetism. Many of these phenomena are recognisable in current terms and might be regarded as first rank symptoms of schizophrenia, although we should be wary of attempting to make retrospective diagnoses.²

The Air Loom by which these effects were transmitted was illustrated by the patient and its features shown in some detail [Fig.2]. This was not simply a personal 'assailment' however, for the patient believed that Air Looms were concealed in every public building and were capable of putting ideas into the minds of prominent persons affecting peace, commerce, armaments and many other things. JTM had spent some time in France [1793-6], and had come to the view that there were plans to make Britain a republic, to weaken the Royal Navy and to give the French armies success.³ These influences were mediated through Air Looms situated near government offices. In his view his detention was allowing these plans to proceed. He believed that the Nore Mutiny of Easter 1797 was caused by this means and was part of a more general conspiracy.

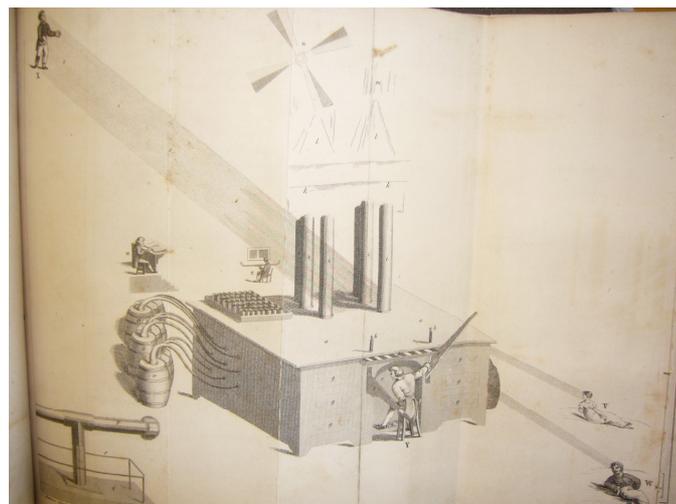


Fig 2 'Air Loom machine'. ([Wellcome Collection. Attribution 4.0 International \(CC BY 4.0\)](#))

Planning the new Bethlem

The legal proceedings described were not the only occasion on which JTM came to public attention. The buildings of Bethlem Hospital had been erected in 1676 to the designs of Robert Hooke, with some later additions. The hospital stood on the swampy ground of Moorfields just to the north of the wall of the City of London. The foundations were not good and the structure of the building was unsound. In 1810 the governors established an architectural competition for the design of a new hospital to be built at Saint George's Fields, Lambeth.⁴ The first premium was awarded to WC Lochner, the second to JA and GS Repton and the third to J Dotchen. JTM also submitted plans for the new hospital and such was the merit of his designs that the panel of judges, which included architects, awarded him a premium in recognition of his work.⁵ The Governors adopted none of the designs submitted but instructed the surveyor to the hospital, James Lewis, to prepare plans incorporating the best features of the plans submitted. The result was a building very like the one it replaced.

The moral

The case of JTM carries important lessons for clinical practice even after an interval of over two hundred years. Medical opinion was divided but may be, in part, attributed to deficiencies in the examination of the patient. The central skill of the psychiatrist in examination of the mental state was clearly less systematic than it later became. Careful exploration of the mental state in conditions of privacy was clearly required. Visiting doctors also failed to take heed of the opinion of those familiar with the case possibly suspecting that the hospital authorities wished to detain the patient for financial reasons. The extent of JTM's delusional ideas is extraordinary but familiar in character to experienced clinicians. The submission of plans for

the new hospital and the positive response of the judges clearly demonstrates that sound intellectual work can be performed in the presence of a sequestered delusional system. It is of some interest that both Dr Haslam and his senior colleague, Dr Monro, were dismissed from their posts at Bethlem in 1816 for overseeing malpractices at the hospital.⁶

I am grateful to the University of Glasgow for the use of their Library, for permission to use material from Haslam's book and for the kind assistance of the staff of Special Collections.

References

1. Haslam J. (1810) *Illustrations of Madness: exhibiting a Singular course of Insanity, and no less Differences in Medical Opinion: developing the Nature of Assailment, and the manner of Working Events; with a description of the tortures experienced by Bomb-bursting, Lobster-cracking and Lengthening of the Brain.* Covent Garden, London, G. Hayden. v-xi, 1-81.
2. Mellor CS. (1970) First-rank symptoms of schizophrenia. *British Journal of Psychiatry*, **117**: 15-23.
3. Porter R. (2004) *Madmen. A Social History of Madhouses, Mad-doctors and Lunatics.* Stroud, Tempus. 273.
4. Colvin H. (1995) *A Biographical Dictionary of British Architects, 1600-1840.* New Haven and London, Yale University Press. 614-616.
5. Porter R. (2004) *Ibid.* 236-239.
6. Hunter RA, MacAlpine I. (1963) *Three Hundred Years of Psychiatry 1535-1860.* London, Oxford University Press. 632.



Prompted by the 'blue plaque' illustrated in the last issue

Ernest Jones (1879-1958), Freud's collaborator and biographer

Fiona Subotsky

In 1903 Jones became resident medical officer at the North-Eastern Hospital for Children in London, but was forced to resign – ostensibly for taking absence without leave, having fallen out with the matron. Subsequently, despite brilliant academic qualifications and multiple applications, he was never again granted a substantive hospital clinical appointment in Britain, but had to make do with a variety of part-time appointments.

By 1906 he was working in a part-time post for the Education Department of the London County Council (LCC), with responsibilities in “mental deficiency” schools. One afternoon was spent assessing a number of children for their speech development, following which four children, one boy and three girls aged between 12 and 14 complained to the head teacher about the doctor's behaviour. She reported the matter to the LCC, and Dr Kerr, the LCC Medical Officer for Education, interviewed the girls with Jones present – most inappropriately in modern thinking. Dr Kerr concluded that the girls must have made it up between them. Nevertheless

one of the girl's parents took the matter to the police, whose further questioning of the girls and analysis of stains on a table-cloth led to Jones' arrest. Detailed reports of the subsequent hearings do not exist, but the girls' accounts were disbelieved, with laughter in court. Jones did not take the stand. The newspapers and medical journals rejoiced, and a party was held at the house of Sir Victor Horsley, the President of the Royal College of Surgeons of England, where funds raised to pay for the legal costs were formally presented to Jones. However, he does seem to have been moved to a different school area subsequently.

In 1908, Jones was again asked to resign from a hospital post, where he was formally a pathologist, for examining two female patients without a chaperone, and asking “certain questions” of one girl, aged 10, whose parents complained. Jones' own later account is that the girl had a hysterical paralysis whose sexual origin he was able to determine by his questioning.

He left for Canada, where rumours of inappropriately sexualised treatment continued. For example, he recommended masturbation, or going to prostitutes, and showed his patients obscene postcards. One of his patients accused him of having had sexual intercourse with her and threatened to shoot him. While he described her as “a severe hysteric” and “pronouncedly homosexual” nevertheless he gave her \$500 to prevent further scandal. In 1910 Jones had told Freud: “Now I have always been conscious of sexual attractions to patients; my wife was a patient of mine.”

Ernest Jones' later career with the psychoanalytic movement was an eminent one, much depended on by Sigmund Freud. He founded the British Psycho-Analytical Society and was Freud's official biographer, edited his works and helped many Jewish analysts, including Freud, escape from Nazi persecution.

Note:

Previously published as part of chapter, *With the benefits of hindsight: lessons from history*, 40-50. in *Abuse of the Doctor-Patient Relationship* eds. Fiona Subotsky, Susan Bewley, Michael Crowe, London: RCPsych, 2010.

Other references

Gabbard, G. O. (2002) *Boundary Violations and the Abuse of Power: Commentary on paper by Philip Kuhn.* *Studies in Gender and Sexuality* **3**, 379-388.

Kuhn, P. (2002) “Romancing with a wealth of detail”; narratives of Ernest Jones' 1906 trial for indecent assault. *Studies in Gender and Sexuality*, **3**, 344-378.

Maddox, B. (2006) *Freud's Wizard: The Enigma of Ernest Jones*, London: John Murray.

Chlorpromazine: The 'dying' history

Mohamed Ibrahim

Core Psychiatry Trainee, East London NHS Foundation Trust

This is the first article of a series telling the tale of the first antipsychotic: chlorpromazine. The advent of chlorpromazine, reserpine, and lithium in the 1950s ushered in what's been dubbed the "psychopharmacological revolution". Chlorpromazine was the first major "purpose specific" antipsychotic to enter the realm of psychiatric practice; that is to say, unlike other treatments at the time, it wasn't merely a sedative or a tranquillizer, but it treated psychotic symptoms specifically. Chlorpromazine has a fascinating story that trails from its origins in the thriving late 19th-century German textile industry and across different medical fields such as microbiology, treatment of malaria, surgery, and anaesthesia.

Modern pharmacology owes much of its progress and development to the science of synthetic chemistry. This newfound ability to synthesize molecules and manipulate them by adding or taking away chemical appendages was instrumental to the discovery of many molecules which revolutionized medicine in the early 20th century.

Chlorpromazine is a phenothiazine, a family of molecules that was first synthesized in Germany by textile manufacturers researching new dyes. A pivotal molecule, methylene blue, was developed by Heinrich Caro, a chemist working for the Badische Anilin und Soda Fabrik (BASF) company. August Bernthsen, another chemist, then synthesized the first phenothiazine while working on developing methylene blue derivatives.



Hauptlaboratorium der BASF in Ludwigshafen 1887

https://en.wikipedia.org/wiki/BASF#/media/File:Hauptlaborim_BASF_1887.JPG

Phenothiazines came into medical use through an unlikely interface between textile and histological

dyes. Phenothiazines were first developed as histological dyes by William Perkin in England. It was in this context that Paul Ehrlich noticed that some phenothiazines had antimicrobial properties, and he developed some compounds which were utilized in the treatment of sleeping sickness and syphilis. They had limited applicability, however, due to their toxicity.

Research into the phenothiazines' antimicrobial properties was accelerated by the geopolitics of World War One (WW1) and World War Two (WW2). During that time, the only known treatment for malaria was quinine, a compound extracted from the bark of the tropical cinchona tree, and it had no synthetic alternatives. During WWI, the allied powers embargoed quinine from the central powers, with the situation reversed in WWII as the axis powers embargoed the allies. This drove scientists on both sides to further research into the antimicrobial properties of the phenothiazines, in the hope of finding an alternative to quinine. As a part of this effort, the American chemist, Henry Gilman, and colleagues, synthesized a series of phenothiazine compounds in 1944. These molecules were found to have no anti-malarial effect, but were, picked up by French researchers at the pharmaceutical company Rhone-Poulenc, to study their anti-histaminic properties. It was notably this research effort that produced promethazine, an antihistamine still used in psychiatry for its sedative properties.

Around the same time, there was ongoing research on the role of antihistamines in the prevention and treatment of surgical shock. Henri-Marie Laborit (1914-95), a French military surgeon working at the Sidi-Abdalla Naval Hospital near Bizerte, Tunisia, was interested in finding pharmacological alternatives to prevent surgical shock. His research included different substances including promethazine and an arrow poison with antinicotinic properties known as "curare". Laborit's work was ground-breaking in many ways. One of Laborit's early successes was his "lytic cocktail" a mix of promethazine and dolantin (an opioid derivative). It was a significant landmark in anaesthesia history as it opened the door for further research into "cocktail" preparations used in induction of general anaesthesia. Laborit was aware of potential psychiatric applications of his lytic cocktail, and hoped that it would be tried for treatment of agitated patients with psychiatric illnesses. Indeed, he recalled, in an interview recounted by Judith Swazey, that "I asked an army psychiatrist to watch me operate on some of my tense, anxious Mediterranean-type patients. After surgery, he agreed with me that the patients were remarkably calm and relaxed. But I guess he didn't

think any more about his observations, as they might apply to psychiatric patients.”

Rhone-Poulenc, capitulating on Laborit's research's momentum, extended research into anti-shock properties of different phenothiazine-based antihistamines. It was in this context that Simone Courvoisier studied the properties of different phenothiazine-based antihistamine molecules and their derivatives, initially synthesized by the chemist Paul Charpentier. A molecule coded RP-4560 produced unexpected results when she tried it on rats. She found that it resulted in inhibition of conditioned reflexes (i.e. reflexes learned through classical Pavlovian conditioning) without affecting their strength or consciousness. In the case of “Courvoisier's rats”, they were initially conditioned to climb a rope when exposed to a bell ringing, with the bell associated with an electric shock. Rats exposed to RP-4560 at certain levels lost that reflex without their motor power being affected. Courvoisier described this as “forgetfulness of motive”. Despite being oblivious to its significance at the time, it was reproduced during much subsequent research with antipsychotics.

The forgetfulness of motive phenomenon was later important to the understanding of both the pathophysiology of schizophrenia, in terms of the dopamine hypothesis, and the pharmacodynamics of antipsychotics, in term of their anti-dopaminergic properties. Shitij Kapur (2003), for example, explained psychotic symptoms as a manifestation of “aberrant salience” attribution to otherwise insignificant events and stimuli, due to malfunction of brain dopaminergic activity. According to the aberrant salience model, forgetfulness of motive can be explained by the bell sound being an event which was salience-laden as it was initially associated with an electric shock. Thus the effect of chlorpromazine on Courvoisier's rats could be understood as blanket dampening of all attributed salience due to the drug's anti-dopaminergic properties.

RP-4560 was a chlorinated variant of promazine and was thus called chlorpromazine. Chlorpromazine was also effective in prolonging sleep induced by barbiturates. It was a success and was selected for wider research. Laborit, now working at the physiology laboratory at the Val-de-Grace Military Hospital in Paris, received a sample of chlorpromazine to research its role as an agent to prevent surgical shock. Following initial trials on animals, Laborit tried chlorpromazine on his patients as an anaesthetic “booster”. It was a hit! Not only had chlorpromazine helped during and following their surgery due to its anti-shock properties, but for patients given it pre-operatively, it helped the patient to be markedly more relaxed prior to their operations whereas they'd be expected to be highly anxious.

In December 1951, chlorpromazine was manufactured and promoted by Rhone-Poulenc in France, and, by November 1952, it was available on prescription there. It was promoted for a wide range of indications: anti-shock, anti-convulsion, anti-emetic, anti-oedema and as a hypnotic. This was suggested by its trade name, “Largactil”, meaning “broad activity”. Laborit championed the case of chlorpromazine, and advocated for its use in other specialities beyond surgery and anaesthesia, such as cardiology, in burns and of course in psychiatry. Laborit's zeal for chlorpromazine was so great that it was later dubbed “Laborit's Drug”.



Largactil: anaesthesia, psychiatry, nausea and vomiting, pain. [Wellcome Collection](#). Attribution 4.0 International (CC BY 4.0)

Next time, we'll find how Laborit, over lunch with his somewhat hesitant neuropsychiatry colleagues, contributed to changing the face of psychopharmacology and modern psychiatry.

References

- Ban, TA. Fifty years chlorpromazine: a historical perspective. *Neuropsychiatr Dis Treat.* 2007;3:495-500. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2655089/>
- Kapur, S. Psychosis as a state of aberrant salience: a framework linking biology, phenomenology, and pharmacology in schizophrenia. *Am J Psychiatry.* 2003;160:13-23. doi:10.1176/appi.ajp.160.1.13
- López-Muñoz, F., Alamo, C., Cuenca, E., Shen, W., Clervoy, P., & Rubio, G. History of the discovery and clinical introduction of chlorpromazine. *Annals of Clinical Psychiatry.* 2005;17:113-135. <https://doi.org/10.1080/10401230591002002>
- Swazey, JP. *Chlorpromazine in Psychiatry: A Study of Therapeutic Innovation.* Boston: MIT Press, 1974

Mental hospitals, trains, stations and a canal

Claire Hilton

Googling “Napsbury Hospital railway siding” led to a surprising find: a model railway ‘00’ gauge, 7 plank mineral wagon, bearing the name of the hospital. Who, barring psychiatrists, railway enthusiasts and historians would want one of those? But there it was. I purchased one of the tiny, 1:76 scale models. The original full-size version was probably used to transport coal, building materials and other heavy goods to the hospital.

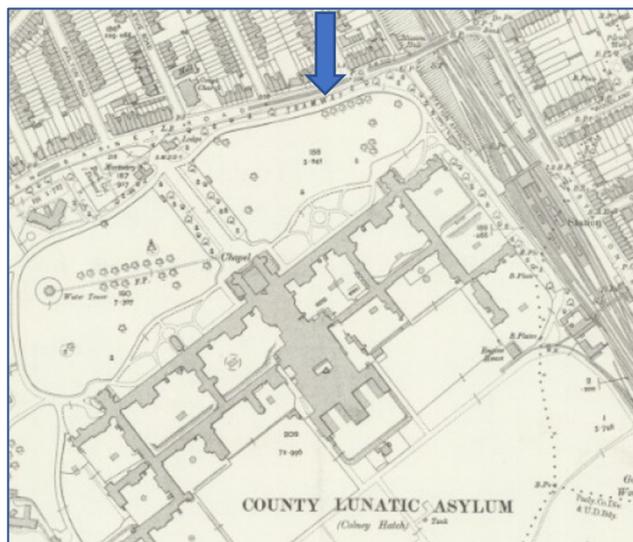


Located rurally, the hospitals needed good transport links, especially for heavy goods and for staff and visitors. Some had their own railway sidings – such as Napsbury, Calderstones and Horton. A road in the new housing estate of Napsbury Park, is called ‘Siding Way’.



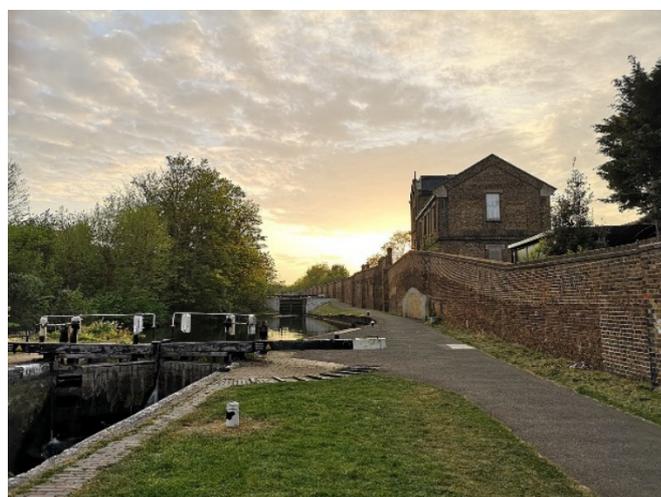
Other mental hospitals used a public railway station nearby, such as Colney Hatch Station (now New Southgate) on the Great Northern Railway mainline. Colney Hatch Station was constructed at the same

time (c.1850) as the Second Middlesex County Pauper Lunatic Asylum, also called “Colney Hatch”. The asylum had its own tramway into the grounds.



Colney Hatch: Hertfordshire XLVI.13, 1914
<https://maps.nls.uk/os/> Tramway indicated with blue arrow.

The first Middlesex County Lunatic Asylum at Hanwell had a different access route for its heavy goods: by barge along the Grand Union Canal to its own dock.



Smeashy, [Hanwell flight of locks and brick boundary wall](#) CC BY-SA 4.0

Doing history

***Learning from the past: A guide for the curious researcher*¹: An online course review**

<https://www.futurelearn.com/courses/learning-from-the-past>

Graham Ash, Honorary Archivist, RCPsych

"All beginnings are hard", opens the novel *In the Beginning* by the American author Chaim Potok; it has been equally true for this review, as it is for starting historical research. One of the aims of HoPSIG is, of course, to encourage psychiatrists to do so. History can be approached in many ways and at different levels. For most of us non-historians, there is the immediate issue of how to avoid our tendency to Whiggish accounts of the inexorable progression towards perfection of psychiatric services, which sharply contrast with the predominant themes of academic historians. Starting from the vantage point of service user perspectives, most such histories show psychiatry as a malign, or at best, potentially malign force for social control. A medical historian once confided to me that, as psychiatrists, our inescapable closeness to our subject makes us unable to write the history of psychiatric services and our profession. So, how do we get onto the same wavelength as academic historians in terms of current themes, discourses, methodologies, and philosophies? *Learning from the Past: A Guide for the Curious Researcher* might serve well as a starting point to understanding contemporary research methods in history, and regardless of whether you have previously taken a course in this!

FutureLearn provides Massive Open Online courses (MOOCs) in partnership with several prestigious UK and overseas universities. MOOCs combine e-learning and social media. This gives a livelier feel than conventional e-learning, with opportunity for discussion with tutors and other participants as you go along. A team of historians, curators, archivists, and librarians teach the course by text, images, and videos. Pitched at the potential historical researcher, perhaps at Masters or final year undergraduate level, it provides a useful introduction although it is not a substitute for an established research methods programme such as the Oxford diploma in Local History.

In its approach, the course demonstrates the greater overlap between academic disciplines in the humanities than in the sciences. It primarily uses material from modern history and contains some distressing content. The material is presented in steps, with opportunities for focused discussion after each, and numerous links to reference material and digital tools. A particularly strong feature is the use of video interviews with historians who talk about their own research and preferred methodologies. Several areas of historical research that are novel and relevant to the history of psychiatry are introduced, including political ideology, the use of corpus linguistics to analyze literary or historical texts, and research using geospatial data and digital archives. More familiar methodologies such as oral history and the use of maps and images are also discussed. The course does not cover a specific area of history, although many such courses are offered on the same learning platform. Another strong point is a series of activities designed to help thinking about and constructing a research question, supported on-line by the educators and other course participants.

Although stated as four hours study per week over three weeks, be prepared to spend considerably longer if you wish to go into any depth. I found the course enjoyable, stimulating, and rewarding. It should be a great help if you are thinking of starting your own research project, although still find a supervisor for it! It is free and is available on a rolling programme. It can be accessed at <https://www.futurelearn.com/courses/learning-from-the-past>

Reference

1. *Learning from the Past: A Guide for the Curious Researcher*. Ian Cooke, Dean Blackburn, Alex Henry, and Maiken Umbach. University of Nottingham, British Library, University of Birmingham. April 2020.

Tips on writing for *News and Notes*

Claire Hilton, Lydia Thurston and Mutahira Qureshi

These brief notes are based on our recent experience of editing the newsletter. Sometimes the articles we receive are not up to the standard required for publication.

The newsletter is not peer reviewed, but we still cast a critical and knowledgeable eye over each submission, considering its historical content and readability. If in doubt, we ask for expert help in assessing it. We include all sorts of material, aiming to raise interest in the history of psychiatry, particularly for our readership across the “psy” disciplines. However, other people, including journalists, archivists and historians, also dip in. We want the articles to be an informative, educational, relevant, and light read.

Some articles we receive employ good historical methodology and are eloquently written. Some are philosophical, or memoir-based, or coincide with anniversaries, or incorporate history from other angles—such as the wedding cakes in [issue 10](#). Some are more a list of facts with little context or explanation, which we include because they may be useful for others wanting to delve deeper, or because they can provide source material for historical introductions for clinical research projects.

So far, we have not rejected any articles, but many have been returned to authors with suggestions for revision without which we will not publish them. The articles we publish remain on the College website long-term, and can be accessed easily by those who search your name online. Therefore, we would be doing you, our contributing authors, a disservice if we did not aim for a high standard.

We particularly like receiving articles from colleagues in the early stages of their careers and from non-psychiatrists.

If you would like some brief guidance on historical methodology, it can be found [here](#).

Below are some suggestions which may help you with the style of writing historical articles, which is different from the style required for scientific papers.

Start with an introduction

Set the context and explain the purpose of what you are writing, e.g.

- I am writing this because....
- This is important because....
- I am trying to...

Say something about what was known before you started your research, e.g.

- Others have written on....
- I have found no other analyses of...
- Historical understanding of...is limited:...

Some people like to **explain the format** of the rest of the article, e.g.

- In this paper I will discuss...Then I'll explore...Then etc

Explain the terminology you use:

Terminology about mental illness has changed over the years. Its meaning today may not be the same as it was in the past, e.g. “mania” a century ago could mean any overactivity, including that in delirium, and “melancholia” could mean a state of withdrawal from social contact for an assortment of reasons. In 2008, Professor James Williamson illustrated changing usage when he recalled being a medical student in 1942 on a ward with 30-40 patients who had post-encephalitic Parkinson’s disease:

the other clinical clerk and I—it was Christmas time—we said we must put on some sort of show for these poor patients because they were all perfectly mentally clear, but most of them were pretty severely disabled. So we put on a sort of pantomime for them...and we were looking around for a very exotic disease that nobody would ever have heard of so we looked up the text book of neurology and here was a chapter on Alzheimer’s, pre-senile dementia and so we used this as an exotic condition that nobody would ever know anything about.¹

Using terminology which was official and accepted in the period about which you are writing is often appropriate, but some words may be offensive today. Regarding the history of psychiatry, lunatic, imbecile, asylum and “a dement”, are examples. The same principles apply to terms about ethnicity, religion, age and other designations linked to today’s concepts of “protected characteristics” under the Equality Act 2010. It is a courtesy to readers to make it clear why you are using obsolete language, either

by explaining, or, at a minimum, putting the term in quotation marks.

Main body of the article

History needs to be contextualised. Events do not occur in a vacuum. Consider what was going on in the wider world which may have brought about, shaped or affected the central theme of your article. Always consider **why** things happened, not just what happened and when.

Do not criticise through the eyes of hindsight. Criticise or compliment from inside the time period you are studying, not through today's retrospectoscope!

For example, if critiquing Henry Maudsley when he made racist or sexist comments² consider aspects such as:

- Were they mainstream or extremist in the context of the time?
- Did his colleagues and others agree with him?
- What effect did they have (if any)?
- Did they change later? In what way, how and why?

Base your conclusions on evidence, not on speculation.

Writing style

Write chronologically, as a story.

Write in the past tense about the past, and try to write in the active voice, not passive. The active voice usually takes fewer words and indicates who did the act, which in history, is often what the reader wants to know.

If your article is getting lengthy (for *News and Notes*, that means over 1,500 words) **review your use of adjectives**: frequently, they add little to the meaning.

Keep sentences short. Recent submissions have included sentences of over 70 words, which are far too long.

Introduce your characters as people, using first name plus surname, when mentioned the first time.

Define abbreviations.

Keep capitals to a minimum, and be consistent.

Quotation marks: be consistent, i.e. use either double or single quotation marks, not both (except for quotes within quotes).

Quotes

Please double check all quotes from the original as we receive many submissions with inaccuracies. *Don't* just assume that your typing skills have automatically got it right. If you are not *absolutely* certain of the wording, then paraphrase without quotation marks. Misquoting comes across as slapdash, and raises questions about the author's ability to attend to detail more generally.

Lengthy, indented quotes require neither italics nor quotation marks.

Relating past to present

History does not repeat itself because the context changes with time and place, but people's behaviours and ideas recur. We therefore cannot 'lift' solutions from the past to deal with concerns today, but we can learn from the past. Historical analyses can inform decision making by giving fresh insight into current problems, generating a broader range of questions about the issues and adding to the evaluation of possible solutions. ***If you relate past to present, do so cautiously.***

Retrospective diagnosis

It is instinctive for clinicians to try to make a retrospective diagnosis based on historical material, but is it valid? For many mental disorders, diagnostic classification remains a changing feast: what is compatible with standard classifications today, might be outdated tomorrow. How meaningful it is to speculate on past diagnoses and to "translate" them into modern terminology is debated by historians of medicine.

German Berrios, psychiatrist and historian, particularly of psychopathology, wrote: "The adjective 'mental' and the noun 'illness' refer to constructs and not to qualities or objects existing *sub specie aeternitatis*"³ and:

When talking about classifications, we should take the word seriously. They are more than lists, glossaries, or inventories. Instead, they are structured and commonly hierarchical clusters of objects having a relationship with one another. The more one thinks about their application to mental disorders the more one realizes that the problem here is not only our lack of knowledge about taxonomy but the possibility that psychiatric objects may not be susceptible to classification at all.⁴

Referencing

Please check references for accuracy and make sure that they are consistent in style.

Illustrations

Please state the source and permission to reproduce each illustration.

Other points

Please read through your submission before submitting it.

If it is over 1,500 words, why not split it in two?

We hope that these notes are useful and can help you structure future articles.

We look forward to reading them.

Happy writing!

**Your articles, reviews, photos,
ideas, requests for information
etc please,**

by

31 January 2021

to claire.hilton6@gmail.com

Notes and references

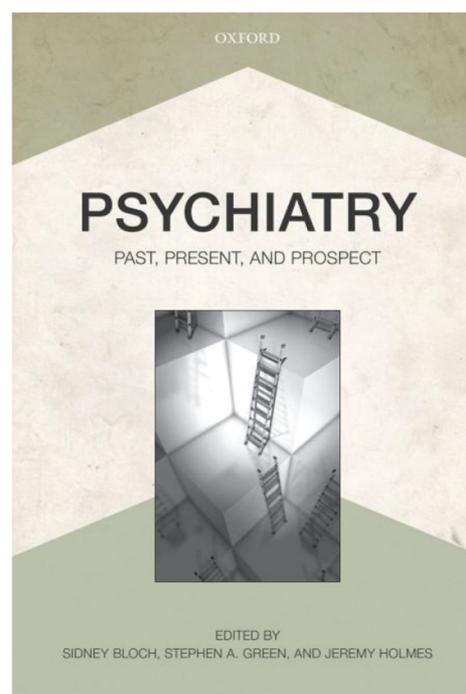
1. Guthrie Trust Witness Seminar, *The Development of Old Age Psychiatry from the 1960s until 1989* www.gla.ac.uk/media/media_196526_en.pdf University of Glasgow, 2009, 36.
2. e.g. Henry Maudsley, *The Physiology and Pathology of Mind*. Macmillan, 1868, 54.
3. In its essential or universal form or nature; what is universally and eternally true, without any reference to or dependence upon the temporal portions of reality.
4. German Berrios, "Defining and classifying mental illness" 180-195. In: *Psychiatry: Past, Present, and Prospect*, ed. Sidney Bloch, Stephen Green and Jeremy Holmes. Oxford University Press, 2014, 180, 193.

Book reviews and forthcoming books by HoPSIG members

Ideology of psychiatry:

Psychiatry: Past, Present, and Prospect eds. Sidney Bloch, Stephen Green and Jeremy Holmes. OUP, 2014.

A critique by George Ikkos, consultant liaison psychiatrist and chair of HoPSIG



Download free at <https://pingpdf.com/pdf-47990.html>

The editors of *Psychiatry: Past, Present and Prospect* (PPPP) invited a stellar group of psychiatrists to write about their specific area of expertise and, in part through their personal experiences and contribution, to offer an overview of psychiatry since 1950. Regardless of the argument advanced in this brief note, which is intended as a critique, it is a stubbornly good book. The praise offered by Elaine Murphy in her book review is well deserved.¹

Let it be remarked in passing that this is very much an Anglo-Saxon psychiatry rather than a "psychiatry", but we will not dwell on this further. This and other critiques aside, the hope is that anyone

reading this note who has not read PPPP already, will turn to it now. However, it is just as much an exercise in the ideology of psychiatry as a chronicle of our specialty's life during these years. Written by those who have dominated the field (25 men and 2 women) it is a "victors' history". This is so, even though it is painfully honest. Murphy captures the candour of the contributors when she agonisingly exclaims "Have we really changed the prospects for our patients' lives so little in 50 years? Has so much neuroscientific research, psychopharmacology, sociology and changing political environments produced so little? I fear so". It may be a victors' history but not a triumphalist one.

PPPP achievement

PPPP opens with chapters on "Psychiatry and neuroscience", "The past, present and future of psychiatric genetics" and "Fifty years of applied clinical research: schizophrenia". Chapters on the "History and development of social psychiatry" (Ch 6), "50 years of mental health legislation: paternalism, bound and unbound" (Ch 8), "The ethical dimension in psychiatry" (Ch 9) and others follow. These include chapters on sub-specialties e.g., "From alienist to collaborator: the twisting road to consultation-liaison psychiatry" (Ch 11) and specific topics e.g. "Trauma and psychiatry" (Ch 15).

Before focusing on critique, it is important to emphasise how rich the chapters are in detail and sophistication. This of course would be expected of one written by Michael Rutter who in chapter 12 on "Child and adolescent psychopathology: past scientific achievements" gives a masterly account of the field and its significance, including psychiatric genetics. German Berrios' chapter on "Defining and classifying mental illness" (Ch 10), equally unsurprisingly, is a highly intelligent appraisal of relevant issues and acknowledgement of persisting serious conceptual and practical diagnostic difficulties. In their chapter on "The forensic psychiatric specialty: from birth to the subliming" Paul Mullen and Danny Sullivan match Rutter and Berrios in sophistication and add an element of sarcasm, as perhaps only seasoned forensic psychiatrists can do. These are just examples.

PPPP ideology

PPPP paints a vivid canvas. There is no lack of acknowledgment of our clinical and scientific uncertainties. Nevertheless, it demonstrates a somewhat limited degree of self-awareness. The fact of the complete absence of contributions other than from practitioners in Anglo-Saxon countries, and of the marginalisation of female authorship, both being unremarked upon in the preface, is a case in point. Although marginalisation of women might not have troubled the editors, it roused Dr Gianetta

Rands sufficiently to directly reproach Oxford University Press for gender bias in their publication. They responded in masterly fashion by inviting her to edit *Women's Voices in Psychiatry*,² a collection of essays written mainly by women psychiatrists.

It is not just non-Anglo-Saxons and women who have been excluded from PPPP. Readers might ask why potential authors who are not psychiatrists, let alone anti-psychiatrists, who were so much part of the intellectual landscape and practice of psychiatry during these years, were not invited to contribute. Are they not part of what psychiatry has been, is and might become in the future? What has psychiatry been for them and what might become of their hopes or grievances? And what about the diversity of psychiatrist colleagues, many of whom make unheralded but significant contributions to quality and standards of this specialty? What has been the experience and practice of those, many who have toiled on the clinical coalface?

The strongest clue to the ideological nature of PPPP may be found in the arrangement of chapters. For example, chapter 1 is on "Psychiatry and neuroscience". Whilst such priority complies with arrangements one might expect in undergraduate or post-graduate medical textbooks, it is not clear why it should be so in a historical volume, especially one where, in the preface, the editors state that they "wanted to face up to the negative side". Tellingly, they see "perennial indecisiveness about the profession's boundaries" as a negative, even as Berrios, Mullen and Sullivan demonstrate its necessity. Indeed, some of us think this is what makes the specialty both fascinating and appropriately flexible given the complexity of the brain and, more generally, the human. It would have made more sense to place Berrios' chapter on the conundrums relating to "Defining and classifying mental illness" at the forefront and not at number 10. Also, given the importance of transference/countertransference for clinical practice,³ and the fact that psychodynamic practice is the one form of therapeutics which has been maintained throughout that period and continues to mount a comeback, it would have been appropriate to place Jeremy Holmes' finely judged "Psychodynamic psychiatry—rise, decline, revival" (Ch 21) in an earlier spot.

Conclusion

In their preface, Bloch, Green and Holmes ask: "would it not be to the advantage of trainees to hear directly from the 'elders' of the profession—their observations, feelings and fantasies about psychiatry from graduation as psychiatrists through to retirement?" Yes, undoubtedly so and I urge trainees to read it. After all, leaving aside the limited progress in terms of the PPPP authors' motivating

ambitions, psychiatry has evolved and is a fascinating and professionally rewarding specialty as it is. We have a lot to offer and make a positive difference to patients and their families. However, having read PPPP, I suggest readers follow-up with *A Sociology of Mental Health and Illness*⁴ and *Lost in Dialogue: anthropology, psychopathology and care*⁵ to get a sense of what is missing, yet needs to be understood. Doing so would be consistent with the editors' own preface which concludes:

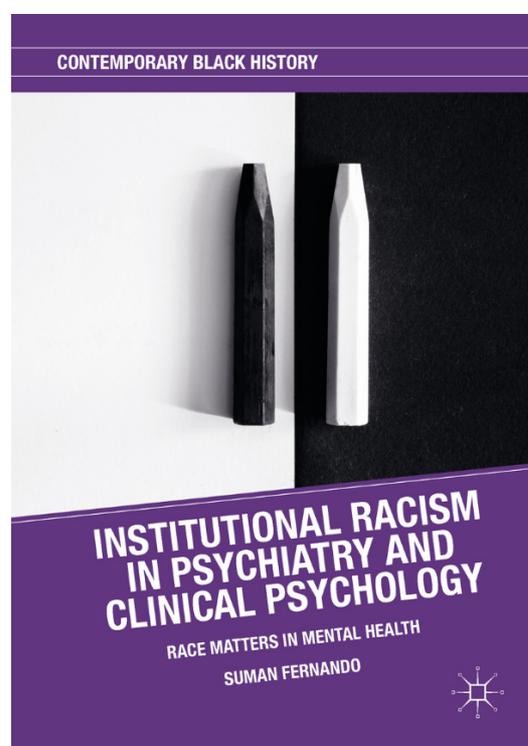
Another striking change has been in the arena of therapeutics. In our psychiatric infancy treatments were broad-brush and non-specific: neuroleptics for psychosis; antidepressants for mood disorders; psychoanalysis for the neuroses; and abstinence for addicts. Since then scientific advances and the influence of the multibillion-dollar pharmaceutical industry have contributed to a proliferation of diagnoses and attempts to find specific medications or psychotherapies to treat them. This trend leaves us wondering if something has been lost and in need of recovery. There is an urgent need for a whole-person medicine that engages patients not in terms of quasi-mechanistic dysfunction, but rather at the level of personal experiences, and agency.

References

1. Murphy, E. Book Review: "Psychiatry: Past, Present and Prospect, Edited by Sidney Bloch, Stephen Green and Jeremy Holmes, Oxford University Press, 2014." *BJPsych Bulletin* 39 (2015): 104. doi: 10.1192/pb.bp.114.048413.
2. Rands, G. ed. *Women's Voices in Psychiatry: A Collection of Essays*. Oxford, Oxford University Press, 2018.
3. Gabbard, GO. *Countertransference Issues in Psychiatric Treatment* (vol 18 in *Review of Psychiatry* series). Washington DC: American Psychiatric Press, 1999.
4. Rogers, A., Pilgrim, D. *A Sociology of Mental Health and Illness*, 6th edition. New York, Open University Press, 2021.
5. Stanghellini, G. *Lost in Dialogue: Anthropology, Psychopathology and Care*. Oxford, Oxford University Press, 2017.

***Institutional Racism in Psychiatry and Clinical Psychology: Race Matters in Mental Health* by Suman Fernando, Palgrave Macmillan, 2017. Paperback, 232 pgs, £49.99**

Reviewed by Ahmed Samei Huda, Consultant psychiatrist, Tameside and Glossop EIT, Pennine Care NHS Foundation Trust



The recent *Watchmen* TV series, opened with black people in the United States in the early 1920s being shot, bombed from the air and rounded up by white people. The natural assumption is that this was fictional, but it was based on real historical events—the Tulsa Race Massacre of 1921—which is largely airbrushed from the historical consciousness of many people. I had a jarring experience reading Suman Fernando's book when it mentioned race riots in Glasgow in 1919. This is my home city, but I had never heard of them. At school, when I was young, many decades ago, this was not taught to us. Scotland, as victim of the English, continues to this day as the main theme of historical education, not Scots as perpetrators of racist violence, so the Broomielaw Race Riot is not mentioned.

These palimpsests about violent racist acts carried out in Western countries may be regarded as the version of *His-story* that is convenient whereas Fernando's book is more *My-story* that I identify with—that my parents lived through and I continue to do so. The book combines several elements: a more straightforward historical narrative; sociological analysis of race, ethnicity and culture; and a reportage of events that the author witnessed, lived through or had reported to him.

I should mention that I am no expert on the history and nature of race or racism, how it affects psychiatry and clinical psychology or the academic terminology. Fernando's historical narrative identifies the beginning of the modern forms of the "psy professions" occurring during the Enlightenment Period in European countries and their New World Colonies. It makes a link between that period's economic drivers of colonial exploitation and slavery, and the societally convenient development of theories justifying racial and cultural superiority of white people over others.

This "race thinking", according to Fernando, became embedded in psychological theories, such as instinct and intelligence, and sociological theories of cultural superiority. Prominent psychiatrists were also infected by "race thinking" such as Emil Kraepelin, Carl Jung and Sir Aubrey Lewis. Jung comes in for particular criticism for appropriating ideas from Eastern cultures whilst simultaneously making racist statements about the negative effects on white Americans from mixing with black people. Karl Jaspers escapes from this section of the book despite racist comments in *General Psychopathology*.

Drapetomania—the fictitious mental illness said to cause Black slaves to want to escape in the pre-Civil War United States—is described as a construct created by psychiatrists but my understanding is that it was coined by a non-psychiatric doctor. The thorny issue of high rates of schizophrenia diagnosed in the Black community is explained as a racialised diagnosis imposed by white psychiatrists and associated with stereotypes of dangerousness and drug misuse in a context of dysfunctional families. My own view is that experiences of racism and socioeconomic deprivation contribute to high rates of psychosis in Black people and that white and Asian psychiatrists (including myself) miss the mood symptoms and tend to misdiagnose mood psychosis as schizophrenia.

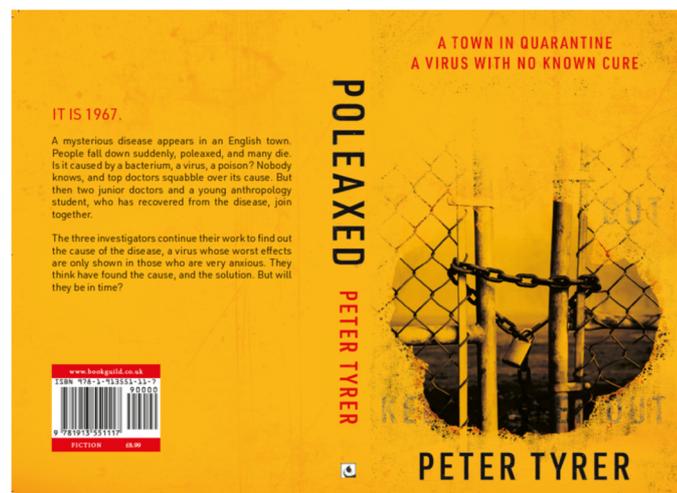
The book includes a useful summary of the sociology of race with definitions of terms such as "race" and "institutional racism" with a further argument by the author that psychiatry and clinical psychology are institutionally racist. The author describes, from his own and other's experiences,

how racism, or problematic attitudes on race, have had a negative impact on both patients and professionals from ethnic minorities.

The themes of the book are very important—how "race thinking" and prejudice have affected both psychiatry and clinical psychology, and the development of their theories and their practices. This type of book reinforces the importance of history of psychiatry so that we can learn from the past to improve practice in the present. The book helps in this regard but it is priced for libraries rather than individuals. In the training curriculum for future psychiatrists, it is important that they learn the history of psychiatry's troubled relationship with racial prejudice affecting its concepts and actions; the contents of this book would make a good basis for this.

Forthcoming books by HoPSIG members

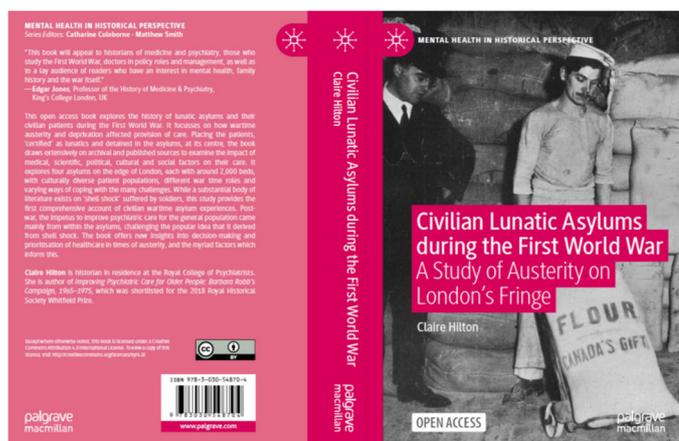
Poleaxed by Peter Tyrer



Peter Tyrer wrote:

The action in this novel takes place in 1967. At this time I was working at Goodmayes Hospital in Essex and then at St John's Hospital at Stone in Buckinghamshire, both representative mental hospitals of the period. They feature in several chapters. The new Poleaxe Syndrome in the novel is very odd and requires knowledge of both mental and physical health; the disconnect between medicine and psychiatry at that time is highlighted in the novel and it needs a patient with the syndrome to join the dots. The antediluvian attitudes of the medical establishment to psychiatry are illustrated frequently, and with some amusement.

***Civilian Lunatic Asylums During the First World War*, by Claire Hilton**



From back cover:

This open access book explores the history of lunatic asylums and their civilian patients during the First World War. It focusses on how wartime austerity and deprivation affected provision of care. Placing the patients, 'certified' as lunatics and detained in the asylums, at its centre, the book draws extensively on archival and published sources to examine the impact of medical, scientific, political, cultural and social factors on their care. It explores four asylums on the edge of London, each with around 2,000 beds, with culturally diverse patient populations, different war time roles and varying ways of coping with the many challenges. While a substantial body of literature exists on 'shell shock' suffered by soldiers, this study provides the first comprehensive account of civilian wartime asylum experiences. Post-war, the impetus to improve psychiatric care for the general population came mainly from within the asylums, challenging the popular idea that it derived from shell shock. The book offers new insights into decision-making and prioritisation of healthcare in times of austerity, and the myriad factors which inform this.

Mind, State and Society: Social History of Psychiatry and Mental Health in Britain 1960-2010

eds. George Ikkos and Nick Bouras, Cambridge University Press, 2021

George Ikkos wrote:

In this issue I critique Sidney Bloch, Stephen Green and Jeremy Holmes', in many ways excellent, *Psychiatry: Past, Present, and Prospect*.

Our book, *Mind, State and Society: Social History of Psychiatry and Mental Health in Britain 1960-2010* offers a response to complement that volume. Distinguished contributors from psychiatry, psychology and other mental health professions, as well as service users, historians, social scientists and politicians, help us place psychiatry and mental health services in their national and international social context during the half-century 1960-2010, and assess the mutual impact.

We aim that this social historical account, whose publication coincides with 50 years since the foundation of the College, will have significant philosophical, training and policy implications. The first section looks at the social and institutional context during the 1960s and 70s; the second, at the social, policy and scientific cogwheels which built the motor of change during subsequent decades; the third, at clinical and social outcomes; and the final section explores specific topics such as interfaces with work, sexuality, religion, the military etc.

Interesting sources, websites etc

[Psychiatric Hospitals in the UK in the 1960s](#)
RCPsych witness seminar, **free download**



<https://montagulomax.org/> A Victorian GP with a dark secret, who spearheaded lunacy reform

<https://www.nuffieldtrust.org.uk/health-and-social-care-explained/nhs-reform-timeline/> An interactive timeline which brings 70 years of reform and change in the National Health Service to life, charting the evolution of this public institution from its inception in the post-war years through to the present day. A very useful resource.

<https://www.nrscotland.gov.uk/research/learning/exhibitions/exhibition-resources> New on-line exhibition: History of forensic psychiatry: Prisoners or Patients? Criminal Insanity in Victorian Scotland

Oyedeji Ayonrinde (2020) 'Brain fag': a syndrome associated with 'overstudy' and mental exhaustion in 19th century Britain, *International Review of Psychiatry*, 32:5-6, 520-535, doi:10.1080/09540261.2020.1775428

Oyedeji Ayonrinde (2020) Cannabis and psychosis: Revisiting a nineteenth century study of 'Indian Hemp and Insanity' in Colonial British India. *Psychological Medicine*, 50:7, 1164-1172. doi:10.1017/S0033291719001077

J Rehling, and J Moncrieff (2020) The functions of an asylum: An analysis of male and female admissions to Essex County Asylum in 1904. *Psychological Medicine*, 1-7. doi:10.1017/S0033291719004021

At the Science Museum, London.....

“Alarm whistle for use by warders at Winson Green Mental Hospital, 1890-1914.”



Image:

<https://collection.sciencemuseumgroup.org.uk/objects/co134214/alarm-whistle-for-use-by-psychiatric-warders-alarm-whistle> Science Museum Group Collection © The Board of Trustees of the Science Museum

[Creative Commons Attribution-NonCommercial-ShareAlike 4.0 Licence](#)

Science Museum item caption:

“Warders at Winson Green Mental Hospital used this alarm whistle. It is representative of the level of institutional security within psychiatric hospitals around the early 20th century. Whistles such as this were part of control measures to curb patients’ disruptive or aggressive behaviour. They were also for the warder to call assistance. It was made of German silver by J. Hudson and Company in Birmingham.”

Dates for your diary etc

For next issue of *News and Notes*

Your articles, reviews, photos, ideas, requests for information etc please, by

31 January 2021

to claire.hilton6@gmail.com

Follow HoPSIG on twitter

@rcpsychHoPSIG



Tweet us your opinions, views or just say Hi!

Have a look at the RCPsych history, archives and library blog [here](#)

Look out for the RCPsych's forthcoming competition

Future Archives

Opens January 2021, to write about your experience of today's psychiatry, so that historians of the future will have an understanding of the discipline through the eyes of those involved – patients, carers, nurses, doctors, psychologists, social workers, researchers, policy makers etc....

This is part of the celebration of the 180th anniversary of the founding of the Association of Medical Officers of Asylums and Hospitals for the Insane, and the 50th anniversary of the RCPsych, in 2021.

A series of webinars on the history of psychiatry and what we can learn from the past is also being planned for these anniversaries (dates to be confirmed)

Also

RSM history event 9 June 2021 (face to face or webinar style)

Another witness seminar, probably late 2021