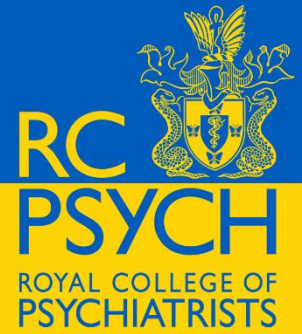


# News and Notes



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

**Issue 14, Spring 2022**



# News and Notes

## History of Psychiatry Special Interest Group

Issue 14,  
Spring 2022

### Editors for this issue:

**Lydia Thurston,**

**Nicol Ferrier,**

**Mutahira Qureshi**

### Cover image:

Pablo Picasso: Guernica

Guernica, oil on canvas by Pablo Picasso, 1937; in the Museo Nacional Centro de Arte Reina Sofía, Madrid. 3.49 × 7.77 m.

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# Editorial

## Learning from our past

**Lydia Thurston**

Co-editor

Welcome Readers to our Spring 2022 edition of News and Notes. Issue 14 is jam-packed with interesting reports, articles, and reviews, and is perhaps our fullest issue to date; evidence that more and more of you are discovering the fulfilment that can come from delving into our past. As I write this my thoughts are very much dominated by the current humanitarian crisis in Ukraine. The phrase 'history repeating itself' has been bandied about by the media in reference to both the pandemic and the war in Ukraine, but as historians we must remember that it's not history, but human behaviour and ideas that repeat themselves. It is not a simple case of taking ideas from the past to deal with the problems of today, but we can certainly learn from our history. As Graham Ash reflects in "the Chair's report", it seems inevitable that the current conflict will have a direct impact on the population we serve, and it is possible that an appreciation of history can help us to prepare for this.

In this issue, Jane Whittaker's article 'Covid-19 and Cholera: Do pandemics of the past have anything to teach psychiatrists of today?', similarly touches on the temptation to make comparisons in history and explores the lessons that we can learn from a cholera outbreak at Wakefield asylum in 1848. For those interested in the history of intellectual disability psychiatry, we have three fascinating articles for your attention. The first is Louise Westwood's piece on the Guardianship Society (established in the early 20th century to board 'the mentally and physically defective' with foster families), the second is Peter Carpenter's essay on the Bath Magdalen Hospital (the oldest charity in the UK dedicated to those

with intellectual disabilities), and the third is Alistair Robson's article on the history of 'West Syndrome'.

John Hall brings our attention to a gap in historical literature regarding the history of primary care mental health and sets the scene for a Witness Seminar on the history and development of primary care mental health, due to take place in June 2022. For further information and an opportunity to share information, please see our events page.

Other articles in this issue include Dick Mindham's insightful essay on the history of Yorkshire's contribution to psychiatry, and Ian Wheeler's absorbing account of Percy Walwyn; a psychiatric patient who had the potential to change the history of aeronautical engineering but was sadly disregarded on account of his mental illness.

We have six book reviews in this issue, including George Ikkos (former HoPSIG chair) and Paul St John Smith (EPSIG chair)'s review of 'Sedated: How Modern Capitalism Created our Mental Health Crisis' by James Davies. This key text argues neoliberalism as a cause of mental illness and suggests the over-medicalisation of psychiatry. Our reviewers discuss the importance of psychiatrists reflecting on the function of our specialty in society and encourage cautious evaluation of the author's evidence.

As well as our usual Chair, library, and archives reports, we are also including a report from the RCPsych Historian in Residence, Claire Hilton, who fills us in on what she has been up to in her role at the College. We hope this will be a regular feature. RCPsych librarian, Fiona Watson, also shares with us a report of her recent visit to the Bodleian library's exhibition based around Robert Burton's famous text, 'The Anatomy of Melancholy'.

As the world starts to emerge from the pandemic, we hope that there will be an opportunity for more face-to-face events. For starters, please come to HoPSIG's presentation at the RCPsych International



Congress in June. This year we will be discussing the introduction of physical methods of treatment in psychiatry in Britain and Europe, 1922-1944, and we would love to see you there!

Finally, we would like to thank everyone for their submissions to this issue, we really have enjoyed putting it together. If you're interested in contributing to the next issue of News and Notes in the Autumn, please send your articles, reviews, photos, ideas etc to: [nicol.ferrier@newcastle.ac.uk](mailto:nicol.ferrier@newcastle.ac.uk) by 31st August.

The HoPSIG Editorial Team: Lydia Thurston, Mutahira Qureshi, Nicol Ferrier.

## Next issue

Please send your articles, reviews, photos, ideas, requests for information etc by

**31 August 2022**

to

[nicol.ferrier@newcastle.ac.uk](mailto:nicol.ferrier@newcastle.ac.uk)

A note on the choice for this issue's cover image and other artwork:

We have selected two iconic artworks created in the wake of World War II to mark our support and sympathy for everyone affected by the devastating military action in Ukraine. For more information on the College's response to the conflict in Ukraine please visit the link [here](#).

On the title page is the famous masterpiece *Guernica* painted by Pablo Picasso in 1937 following the 1935 Nazi bombing of the town of Guernica in Spain. With its surrealism evocative of the pain and chaos of modern aerial warfare and the myriad of symbols overtly and covertly painted in canvas; *Guernica* is considered by many critics to be the most powerful anti-war painting in history. The original by Picasso is currently housed in Museo Reina Sofía in Madrid. A tapestry of this painting, copied from the original with Picasso's permission, woven at the atelier of French artist Jacqueline de la Baume Dürrbach, hangs in the headquarters of the United Nations in New York and periodically makes its rounds in many galleries across the world.

On the back cover you will find Paul Nash's piece *Follow the Führer Above the Clouds*, inspired by techniques of German surrealist Max Ernst, depicting a squadron of German aircraft flying over a sunlit cloudscape, accompanied by a huge flying shark. As with Picasso, Nash was repulsed by the horrors of aerial warfare that formed the hallmark of World War II and have continued to be the hallmark of all "postmodern" combats since. He tried to create a new powerful, surrealist form of propaganda. To Nash's disappointment the Ministry of Information declined to use his work for their campaign, but his poignant imagery makes Nash's *Follow the Führer* series a powerful statement against war.

## Check out our old newsletters at

<https://www.rcpsych.ac.uk/members/special-interest-groups/history-of-psychiatry/newsletters>

## Have a look at the RCPsych history, archives and library blog

<https://www.rcpsych.ac.uk/news-and-features/blogs/Search/>

# Chair's Report

Spring 2022

**Graham Ash**

Honorary Archivist and Interim Chair of HoPSIG

My first and pleasant duty is to thank George Ikkos, who stepped down as Chair last November, for his outstanding chairing of HoPSIG, and, personally, for his unwavering support over the last few years. He hands over our group in excellent health and has provided an exemplary model to follow. He has somehow, also found the time and vision to co-edit the book, '[Mind, State and Society](#)', with Nick Bouras. It is excellent and well deserved news that their contribution to the historical understanding of psychiatry in the UK in the mid and late 20th century has recently been recognised as one of the three most important new books of 2020-21 in the History of Science, Medicine, and Technology at the prestigious [Association of American Publishers](#) awards.

George has quietly shaped our activity, including his vision that history of psychiatry should contribute to the new [core curriculum](#) for MRCPsych and he has encouraged many members of our executive to develop their ideas into accomplished projects. I know that George will remain actively interested in the activities of the SIG, and we will continue to rely on him for his wisdom and good advice about strategy. As you will be aware a formal election is currently underway to decide our new chair. I expect that we will be able to announce the new appointment following our next executive meeting on 23rd March.

We have created a new post of Honorary secretary on the executive to reflect the increasing activity of our Chair and executive members. Tom Stephenson has very capably stepped into the role, and I am sure that he will enjoy and gain from the experience. Tom Burns and Nick Bouras, who I would like to thank for their immeasurable contributions, have recently stepped down to

take on significant new roles and we wish them both well in their future activity. This means we will be looking for new executive members so if you are interested, please do get in touch.

Our membership overall remains stable at around 2500. This is very good but there are some limitations as we know rather little about each other. We are now a well-established SIG and I wonder if we are approaching the stage where it would help to be more organised. The College has recently carried out its own membership survey and we may benefit from doing something similar of our own. It might be helpful to know how many of us are actively engaged in historical groups, research, or teaching, what are our interests and aspirations, level of expertise, where we are, and so on. I'd be very interested to hear your views on this.

I would appreciate your thoughts on how HoPSIG could support historical projects and education. The curriculum committee has accepted our evidence on the value of history which legitimises historical teaching within [core psychiatric education](#). We need to think how best this can be offered and what approaches and content are relevant. Our aspiration is for trainee psychiatrists to move beyond knowledge of historical chronology and facts towards historical awareness of the context of psychiatric care and the complexities of the relationship between psychiatry and wider society.

We are very fortunate that our executive member, Mohamed Ibrahim, had the inspiration to organize a joint online educational meeting between HoPSIG and the Medical Education team at East London Foundation Trust, which took place in January 2022. We have received very favourable feedback for this half-day event which was attended by two hundred plus participants. We are now in the early stages of setting up a similar event with another Trust and this joint model looks very promising for the future.

HoPSIG held a very successful day conference: 'Mind, State and Society: 2nd Conference on Social History of Psychiatry

and Mental Health in Britain 1960-2010,' in October 2021 in association with the Psychiatry Section at the Royal Society of Medicine. Claire Hilton, our Resident Historian, subsequently lead a highly informative webinar in the College members series on: 'Psychiatry, psychiatrists and Jewish identity in the UK, past and present'. Claire remains very active providing historical advice and insight within the College, and a reminder that the transcript of the witness seminar: '[Psychiatric Hospitals in the UK in the 1960s](#)', edited by Claire and Tom Stephenson is available on the College website.

Looking ahead, please join us the RCPsych International Congress 2022 at the Edinburgh International Conference Centre at 17.05-18.15 on Wednesday, 22 June 2022. We have an exciting session titled: 'The Shock of the New! The introduction of physical methods of treatment in psychiatry in Britain and Europe, 1922-1944'. Malarial therapy was introduced into Britain one hundred years ago this year and the subsequent development of physical treatments has become an emotive and contested history. We hope that this session will be enlightening.

Unfortunately, we continue to live in historic and challenging times. The escalation of the crisis in the Ukraine is of concern to us all and we will all hope that there will be a swift return to peaceful and harmonious relations in the region. As I write I have in mind the question of how we as historians and archivists should respond to historic times. Is history active? Or a passive bystander? If you have not read Samuel D. Kassow's, 'Who Will Write Our History?', the tragic story of the secret archivists of the Warsaw ghetto, then now may be a good time to do so.

Our interest in the history of psychiatry is so interlinked with social and political history that whatever happens in society should be of concern to us. It seems inevitable that the present conflict will impact on public mental

health and the practise of psychiatry, as we have seen with the societal repercussions of the pandemic. Will, for example, the currently rising price of crude oil affect the ability of mental health services to support service users in the community? How will the indirect impacts of the crisis affect the mental health of the UK population, let alone the wider traumas for those in the crisis zone?

It is vital that we record these consequences of the conflict and our responses to them. Our archivist, Frances Maunze responded rapidly to the pandemic, and has curated an archive of the College's digital response. As part of the 180<sup>th</sup> Anniversary Celebrations we put out a call for writing and creative responses to the pandemic. The remarkable winning entries are now readable as part of the [Future Archives](#) collection and an amazing [artwork](#) by Dr Anushree Chandan is featured on the cover of the most recent edition of BJPsych. We cannot foresee how events in the Ukraine will progress, but we will consider how HoPSIG should respond at our Exec meeting in March. In the meantime, please do consider what you can do to preserve any relevant documents, reflections, and objects in the days ahead.

I would like to conclude by commending our editorial team, Nicol, Lydia, and Mutahira, for their continuing success in producing such a high-quality newsletter. I hope that the present conflict will have abated by the time that you read our next edition.

# Historian in Residence

March 2022

**Claire Hilton**

Since this is the first ever historian in residence (HiR) report in News and Notes, I shall tell you a little about the post generally, and then something on recent activities.

The RCPsych HiR post was established in 2018. The role is voluntary, nominally ½ a day a week. As far as I know, the RCPsych is the only medical Royal College to have a HiR.

HiR schemes are uncommon in the UK, but well established in other countries, notably in Ireland, the USA and Canada. HiRs aim to achieve closer engagement between historians and public life, to help institutions develop understanding of the long-term context in which they function, and to provide background knowledge to help those grappling with complex policy issues. Historical analysis can help inform policy making by raising questions, contributing to debate, and stimulating thought about possible options to avoid reinventing the wheel and repeating past mistakes.

As well as history in policy and institutional perspectives, I also answer individuals' queries. Some people contact me directly and some questions arrive forwarded from the RCPsych. Questions come from doctors of all disciplines, journalists, film script writers, documentary producers, charities, genealogists, other researchers, and RCPsych staff seeking historical advice regarding college projects. Script writers are tricky: they usually accept suggestions, but at other times they reject the history for the drama, so it is lucky that they do not put me in the credits. Sometimes questions come from people who want to find out more about an ancestor who died in an asylum; they may be distressed, especially if they have just discovered that the ancestor died from "general paresis" due to syphilis. Explaining historical content, historical

method and where to find out more are all central to answering queries.

Questions are such that I often need to dispel myths about mental illnesses, treatments, and institutional healthcare provision in the past, and emphasise continuities and discontinuities of past with present. Because of the risks of misunderstandings associated with many people holding incorrect assumptions about psychiatric practices (such as about the use of electro-convulsive therapy past and present, or believing that no one was ever discharged from an "asylum") it is often easier to work face-to-face, one-to-one, usually online. As an example, one recent query was from a journalist perturbed that there were plans to tarmac over the cemetery of a former mental institution to create a carpark. His questions included about why the graves were unmarked, whether children would have been buried there, what could I tell him about abuse in that sort of institution which may have caused patients' deaths, and how could he find out more.

2020-2021 was very busy and great fun, collaborating, mainly behind the scenes, with others at the RCPsych for the 180th anniversary events—the "Future Archives" competition, the "free" history webinars, blogs, the "[Petition Group](#)" film, the Insight supplement, and other activities. At the moment, I am involved with planning "witness seminars", trying my hand at ghost-writing, aiming to keep up a flow of [blogs](#) on the RCPsych website and responding to queries as they arise. A project to label the portraits around the RCPsych with a suitable annotation is currently being discussed, although at the time of writing, in early March, more specific details are not available. If you are interested in working with me on the portraits project, please get in touch [claire.hilton6@gmail.com](mailto:claire.hilton6@gmail.com)



# Library report

**Fiona Watson**

Library and Archive Manager

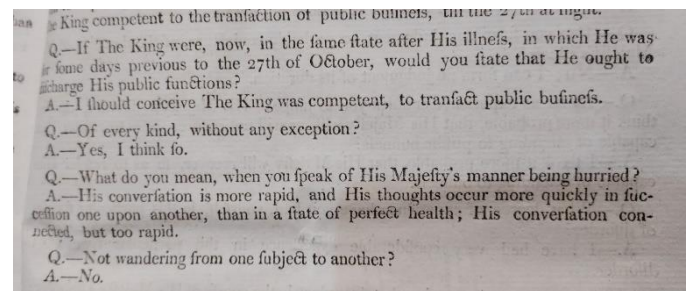
[infoservices@rcpsych.ac.uk](mailto:infoservices@rcpsych.ac.uk)

As of March 2022, the College Library is once again open to members for the first time after two long years. I am, of course, referring to the physical space, since use of online library services has been better than ever, and books have continued to be posted out to members. Nevertheless, it is an exciting time and I will see some of you back at Prescott Street in the coming months.

2022 also sees us still enjoying the echoes of the College's 180th anniversary, when for a whole year everyone had the history of the College and psychiatry at the forefront of their minds. One of the ways the College decided to mark the occasion was by adding to our rare book collection. Bernard Quaritch provided an excellent catalogue of rare books on medicine to help us make a selection. These included some fascinating volumes on infectious disease and vaccines, which discussed herd immunity and compulsory vaccines all the way back in 1782. Sadly, we have to narrow a collections policy to consider items so far outside the realms of mental health, no matter how topical they are!

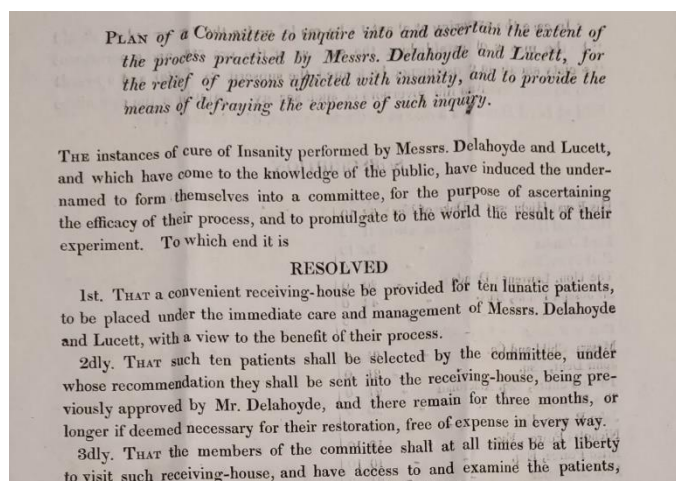
What we did select is equally fascinating. Focusing on the era shortly before the founding of the College in 1841 we chose three items, which have since been [added to the Archive](#) as they are more reports than books. The first item, also the earliest, is a "Report from the committee appointed to examine the physicians who have attended his Majesty during his illness; touching on the state of his majesty's health." Written in 1810 this contains a transcript of the examination of the doctors who attended and assessed George III's capacity to rule, leading to the Prince of Wales being made Regent early the following year. The five physicians being interviewed are Henry

Revell Reynolds, Matthew Baillie, William Heberden, Sir Henry Hallford, and Robert Darling Willis. They all agree that the King was, at that time, incapable of ruling but were confident of his recovery. Reynolds said: "his memory is as strong and correct as it ever was, his perceptions as acute, his judgement is perverted, and he has lost his discretion at present." He also asserts that "much the greater number" of people who suffered from the same unnamed disorder recovered.



Excerpt from Item 1: Report from the committee appointed to examine the physicians who have attended his Majesty during his illness.

The second and third acquisitions are related and concern an investigation in 1813 into a new cure for insanity being practiced by Messrs. Charles Delahoyde and James Lucett, two surgeons. The first item presents the Committee's plan for investigation and the second is the subsequent report. The investigation was led and partially financed by two of the Princes whose interest presumably stemmed from their father's condition and the overwhelming impact his mental health was having on the country at that time. The Committee planned to send Delahoyde and Lucett ten patients to undergo their new treatment and then assess the patients' condition and possible recovery. The nature of the treatment is not detailed in either item but [may have included some form of hydrotherapy](#). On the final page of the report Dr John Harness and the Princes attest that "the said process may be safely used, and without possibility of injury to the patients".



Excerpt from Item 2: Plan of a committee to inquire into and ascertain the extent of the process practised by Messrs. Delahoyde and Lucett.

The first pamphlet also includes brief information about three previous patients who underwent the treatment. Two were ex-military men: William Harrison and John Moon. The third was Elizabeth Lancaster, who, in 1813, was "now permitted to visit her home in Tooting for days together ... and is about to quit Sion Vale [asylum] altogether" despite having previously been a long-term inpatient. In the subsequent report we hear of only four patients who were given Delahoyde and Lucett's unknown treatment. All are said to have shown some improvement and in two cases this improvement was dramatic. Sadly, a miracle cure was not to be, the pair split soon after, probably over financial matters, since Lucett's wife wrote a letter on 18th May 1814 complaining that her husband was in the King's Bench for Delahoyde's debts. Lucett went on to try and make a career in mental health and asylums but was dogged by insolvency and allegations of quackery.

The College has also recently bought a first edition of the 1863 novel [Hard Cash](#) by Charles Reade, according to the bookseller's description, a "highly successful and immensely scurrilous best-seller exposing the abuses of the "trade in lunacy"," which "savagely burlesques" Dr John Conolly, Chairman of the RCPsych in one of its earlier iterations. I will not say more as HoPSIG interim Chair Dr Graham Ash is writing a

piece on the acquisition for the College's [History, Archives and Library blog](#).

If you'd like to have a closer look at those or any of our other rare books, please do get in touch at [infoservices@rcpsych.ac.uk](mailto:infoservices@rcpsych.ac.uk). As always, I would also urge anyone conducting any other research to give us a call as well. A short chat on Teams or Zoom sorting out how to access our databases or back issues of the early College journals can save you so much time wrestling with IT later on!

## References

Bernard Quaritch Ltd. (2021). Catalogue 1445: Medicine including The Alfred Swaine Taylor Collection [Sales catalogue]. London, England: Bernard Quaritch Ltd.

Bouchard, B. (2021, April). James Lucett (c. 1771 – 1851), self styled 'Professor for the cure of insane persons'. Epsom and Ewell History Explorer. <https://eehe.org.uk/?p=69614>

Reade, C. (1863). *Hard cash: a matter of fact romance*. Sampson, Low, Son & Marston.

# Archives report

## Francis Maunze

Archivist and Records Manager

### Past presidents' portraits

The "[Our history](#)" page on the College website, which was compiled as part of the 180th Anniversary celebrations, contains important resources of information on the history of the College and its predecessor bodies.

One of the resources which is being widely used is the page on [past presidents and chairmen](#) which contains portraits of past chairmen and presidents. For instance, the portrait of Dr Conolly Norman, medical Superintendent at the Richmond District Lunatic Asylum, and President of the Medico Psychological Association (1894) is being featured by the [Grangegorman Histories Project](#). Related to this project is "[The Golden Bandstand](#)" project which is using the portrait of Dr Joseph Lalor who was also a Resident Physician at the Richmond Lunatic Asylum for twenty-nine years. These two examples of the use of our archives collection underscores some of the benefits that can result from digitising some of our archives. The College needs to have a well-funded programme of digitising its archives as a way of promoting the collection, providing access to it, and ensuring long-term security through digital preservation.

### Newsletters

Newsletters of Faculties, Special Interest Groups and Divisions and Devolved Nations are another popular resource that is being used by researchers who use our [online archives catalogue](#). A few years ago, the Archives carried out a project of digitising all old paper newsletters. The digital copies were later uploaded onto the online catalogue. College Members, staff, and researchers can now access and download copies of these newsletters without contacting the Archivist. For example, if one does a search using the word "old age psychiatry newsletters" they will see all the old newsletters published by the Faculty of Old Age Psychiatry.

### Upgrading the archives catalogue software

The College Archives is currently involved in upgrading the online catalogue from the Adlib software to a new software called Axiell Collections. The new software has a lot of benefits which make searching the online catalogue much simpler for Members and researchers. It also has features that can be used to manage exhibition materials and records. The software will eventually result in the modernisation and use of international standards in the management of our archives collection by the end of the year.



# "Who is not a fool who is free from melancholy?"

The Anatomy of Melancholy at 400 years

Fiona Watson

Library and Archive Manager

One of the jewels of the College's rare book collection is a first edition of *The Anatomy of Melancholy*. Published in 1621, this book has just celebrated its 400<sup>th</sup> birthday at a time when its subject feels as close to our hearts as it did to Robert Burton and his readers centuries ago.

Burton was a clergyman and Fellow of the university of Oxford as well as a voracious reader, book collector and librarian. He suffered from 'melancholy' and wrote the book to occupy his troubled mind; "this I aimed at ... to ease my mind by writing; for I had gravidum cor, foctum caput [a heavy heart, a full head]."

It is a fascinating, lengthy, and rather bizarre volume covering the nature of melancholy, its symptoms, and possible cures. Filled with quotes from classical and contemporary authors, it can sometimes feel to modern readers more like an encyclopaedia or commonplace book than a traditional monograph. C.S. Lewis bought a copy of *The Anatomy* in 1918 aged 19 while he was recovering from wounds sustained during WW1. He called it "a gossipy, formless book which can be opened anywhere" and it was one of his favourite titles to read while eating. Other famous fans include John Keats, Samuel Johnson, William Osler and Philip Pullman. In short, even if you haven't read *The Anatomy* yourself, you can guarantee it has had an impact on many authors you love and Western literature as a whole. *The Anatomy* was one of [only 588 new books](#) or editions published in 1621 in English, but its popularity was undeniable and near instantaneous despite the comparative lack

of competition. Burton managed to publish a further five editions in his lifetime as he added to the text, and these quickly became large and ornate books as the *Anatomy* became more and more popular. From the second edition onwards, it included a large ornate title page, which can be seen in fig.1.

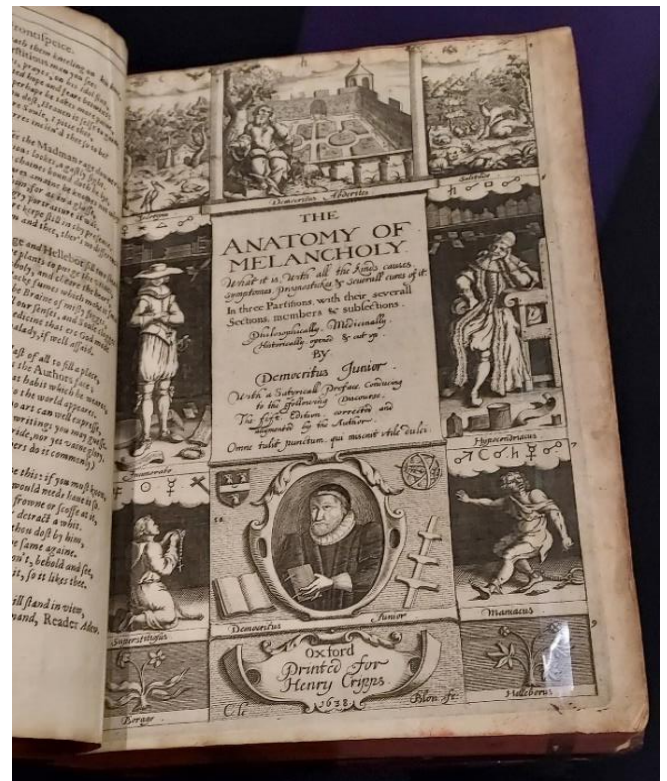


Fig. 1. Image from the 'Melancholy: A New Anatomy' exhibition, photographed by Fiona Watson.

In testament to its history and ongoing influence, the Bodleian library hosted a fantastic exhibition [Melancholy: A New Anatomy](#) around Burton's masterpiece, which ran from September 2021 to March 2022. The exhibition uses "the lens of art, poetry, and historical records [to] examine the afterlife of some of Burton's key ideas" and as with any great exhibition, the themes pulled from the *Anatomy* are a wonderful excuse to interact with some of the treasures the library holds.

You can see gorgeous Buddhist (see fig. 2), Hebrew and Arabic manuscripts that touch on mental health, as well as priceless manuscript copies of more modern works such as Wilfred Owen's *Dolce et Decorum est Pro Patria Mori*. There is also a lovely little book of songs designed to combat melancholy, which you can see in fig. 4.





Fig. 2. Image from the 'Melancholy: A New Anatomy' exhibition, taken by Fiona Watson.

One could argue that melancholy was more central to medicine in Burton's time than mental health is today. Despite the efforts of scholars such as Vesalius challenging physicians to investigate for themselves and challenge the accepted wisdom of the ancients, in the 17<sup>th</sup> century the Galenic philosophy of medicine was still in ascendancy. Most people are familiar with the idea of the four humours: Blood, Phlegm, Yellow Bile and Black Bile. Black Bile translates to *melaina chole* in Greek or, in the modern anglicised version: melancholy. It was believed that these four humours needed to remain in balance to ensure health. However, it was not just the humours that required balance, there were also the six 'non-naturals', which included: air, motion and rest, sleep, food and drink and emotions.

Burton investigates the relationship between melancholy and all these non-naturals in *The Anatomy*, and it is here that the book resonates heavily with modern medicine. Burton discusses what melancholy people should eat and how much they should sleep. He also recommends exercise and spending time somewhere with cleaner air.

These topics would hardly be out of place in a modern book on mental health or wellbeing, but others are less familiar. At the time of writing, medicine and astrology were still utterly entangled and Burton believed no physician could practise without consulting the stars.

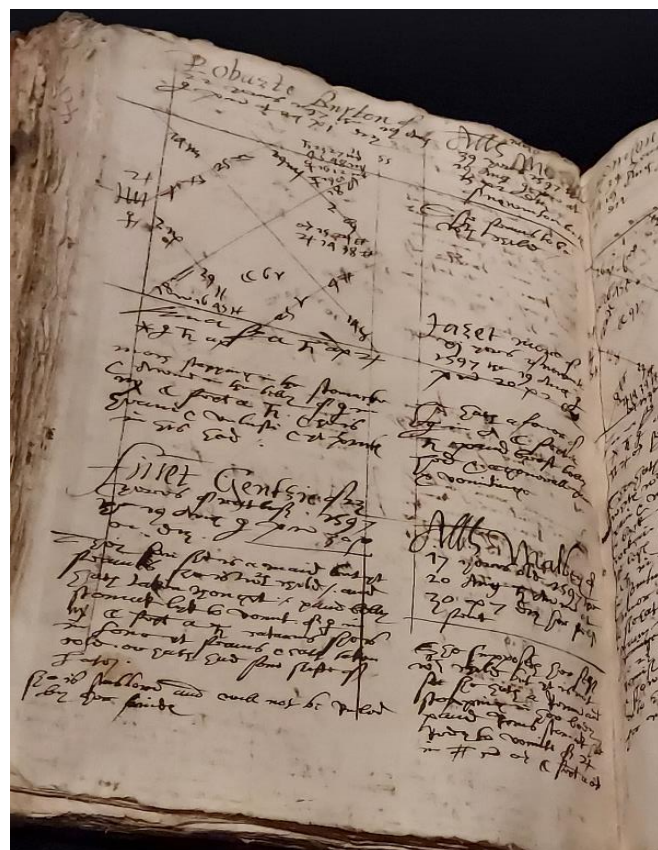


Fig. 3. Image from the 'Melancholy: A New Anatomy' exhibition, photographed by Fiona Watson.

In fig. 3, we can see the horoscope drawn up for Robert Burton, likely the same Burton who wrote *The Anatomy*, when he consulted the professional astrologer Simon Forman about his melancholy. These charts were very common at this time; divided into twelve areas they depicted the celestial bodies as they moved through the twelve houses. There were [three different kinds of charts](#) that could be drawn up: birth charts that depicted the skies at the moment of birth, 'electional' charts, which aimed to help people decide the best time to do things or make decisions, and event/horary horoscopes, which were calculated in the moment of asking a particular question or at the beginning of an event to determine outcome. In the top right of fig. 3 we can see the signs for Mercury and Venus and over on the middle-left Jupiter and Scorpio. Unsurprisingly, given that Burton was a clergyman, there is also quite a focus on religion and spirituality. Burton states:

*It is a disease of the soul on which I aim to treat, and as much appertaining to a divine [clergyman] as a physician, and who knows what an agreement there is betwixt these*

*two professions? A good divine either is or ought to be a good physician, a spiritual physician.*

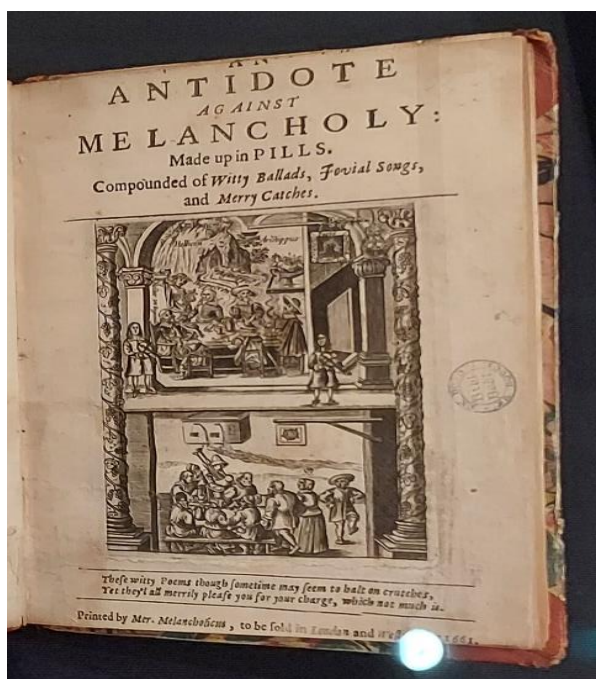


Fig. 4. Image from the 'Melancholy: A New Anatomy' exhibition, photographed by Fiona Watson.



Fig. 5. Image from the 'Melancholy: A New Anatomy' exhibition, photographed by Fiona Watson.

There is a section in the Anatomy regarding 'spirits, bad angels, or devils, and how they cause melancholy.' Burton tells us they might trigger delusions, including those relating to religion, such as an excessive melancholic conviction that one would be damned.

Unfortunately the exhibition at the Bodleian Library closed on the 20th March, but information about the main themes of the exhibition can still be found online.

You can find more information here: [Melancholy: A New Anatomy | Visit the Bodleian Libraries \(ox.ac.uk\)](https://visit.bodleian.ox.ac.uk/event/melancholy-new-anatomy#:~:text=Melancholy%3A%20A%20New%20Anatomy%20exhibition%20trail%20This%20exhibition,therapy%20and%20social%20contact%20for%20good%20mental%20health)

If you would like to view the first edition at the College, get in touch at [infoservices@rcpsych.ac.uk](mailto:infoservices@rcpsych.ac.uk)

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# Covid-19 and Cholera: Do pandemics of the past have anything to teach psychiatrists of today?

Jane Whittaker

## Have we been living in unprecedented times?

After all, there have been pandemics for as long as humans have lived close to each other. Pandemics shaped our world; the Justinian plague in the Western Roman Empire contributed to its downfall and the Black Death in Medieval Europe completely restructured the economic shape of 14<sup>th</sup> century society.<sup>1</sup> Arguably, Covid-19 and its variants are unlikely to cause the catastrophic shifts associated with these two pandemics, but perhaps that is hubris.<sup>2</sup> We certainly seem to be beset by compulsive comparisons of our current Covid-19 pandemic to pandemics of the past. The influenza pandemic of 1918 to 1921 seems to be particularly prominent, perhaps driven in part by the literary symmetry of the span of a century. That virus killed an estimated 100 million people worldwide.<sup>3</sup> So, do historical comparisons have any place in our current pandemic? And if they do, what can we, as psychiatrists, learn from them? In

this discussion I will argue that history has a lot to teach us and use the story of the cholera outbreak at the Wakefield Lunatic Asylum in 1848-9 as a case history.

## Cholera and asylums, Covid-19, and care homes?

Cholera in the 19th century shows how the balance of a previously endemic infection in a relatively small local population was altered, probably by imposed British colonial infrastructure projects in then Imperial India, like railways, followed by international trade facilitating global spread to industrial populations living in urban squalor. The initial failure of 19th century international agreement about quarantine, was primarily due to a British preoccupation with blocking attempts by European powers at containment that could have impacted on trade. A failure to reach a shared coherent European and British plan delayed action and cost lives. Ultimately it took most of the 19<sup>th</sup> century to agree an international strategy.<sup>4</sup>

Cholera ravaged the world between 1817 and 1870. A major outbreak in the early 1830's killed millions in Asia, and an estimated 55,000 in Britain. The 1849 outbreak killed around 33,000 in Britain.<sup>5</sup> Several other infectious diseases claimed more lives than cholera in the awful conditions of the expanding industrial towns; typhus and infantile diarrhoea contributed to a fall in life expectancy in urban populations, not recovered until the early 20th century. Tuberculosis even evoked its own fashion trends. Charlotte Bronte, despite seeing four of her sisters, possibly her brother and probably her mother die of the disease, wrote "Consumption, I am aware, is a flattering malady".<sup>6</sup> But cholera terrified

<sup>1</sup> Wagner, D.M., Klunk, J., Harbeck, M. et al (2014), Yesinia pestis and the Plague of Justinian 541-543 AD: A genomic analysis. *Lancet Infectious Diseases* 14, PP 319-326, also plague cycle book

<sup>2</sup> Kenny, Charles (2021) "The Plague Cycle: The Unending War Between Humanity and Infectious Disease". Scribner, Simon & Schuster, New York.

<sup>3</sup> Honigsbaum, M. "The Pandemic Century: A History of Global Contagion from the Spanish Flu to Covid-19" (Penguin, Random House, London, 2020)

<sup>4</sup> Chakrabarti, P. "Medicine and Empire, 1600-1960" (Basingstoke: Palgrave Macmillan, 2014),

<sup>5</sup> Chakrabarti, P (2014) *ibid*, see also Rosenberg, Charles, E. (1962/ 1987) 'The Cholera Years: The United States in 1832, 1849 and 1866 (with a new afterword)'. The University of Chicago Press Ltd, London. (Kindle edition) for a perspective on cholera in 19<sup>th</sup> century United States.

<sup>6</sup> Day, Carolyn, (2017) Dying to be Beautiful: Fragile fashionistas and Consumptive Dress in England, 1780-1820. *Journal for Eighteenth Century Studies*, 40 (4), pp 603-620 doi: 10.1111/1754-0208.12512



people, it struck indiscriminately, killed rapidly and with a typical marked dehydration and bluish pallor. A fragmented and a largely unregulated medical profession had diverse views about causation and treatment.<sup>7</sup>

Pre-nineteenth century ideas about animalistic transmission gave way to anti-contagionist theories before germ theory became incontrovertibly established by Koch describing the vibrio cholera bacterium in 1883.<sup>8</sup> Miasmatic theory was both widely held and politically expedient. If foul air and rotting matter, particularly because of squalid living conditions, caused cholera, then the solution was sanitary intervention, not quarantine or interruption in trade. Edwin Chadwick was the architect of the 1848 Sanitary Report that forced local authorities to supply clean water and proper drainage and saved many lives. It was also a result of politically expedient compromise.<sup>9</sup> William Farr, the father of modern medical statistics, wanted causes of death recorded to reflect not only the proximal illness, but distal factors like starvation.<sup>10</sup> In 1977 the then Labour government commissioned what came to be called 'The Black report' after its chairman, Sir Douglas Black, then President of the Royal College of Physicians. The brief was to look at differences in health outcomes across society; its findings were, just like Farr's, that the greater your social disadvantage, the worse your health outcomes. Quietly published over an August Bank Holiday in 1980 by a newly elected Conservative government it failed to quickly disappear. A decade later George Davy

Smith and colleagues showed that the health gaps between the most and least socially disadvantaged in our society had continued to widen. The recently released Marmot Report "Fair Society, Healthy Lives" makes the same points.<sup>11</sup> Chadwick's position was to avoid intervention in areas that impacted on free trade, like wages, working conditions, food quality and manufacturing costs. After all, the economy needed to be protected and cholera spread was slowed by action based on miasma theory; ensuring clean water and better residential conditions did indeed halt the spread; proving that, sometimes even the wrong theory can generate good ideas. Many 19<sup>th</sup> century medical treatments were ineffective at best, deadly at worst, and treatments suggested by doctors for cholera were no exception.<sup>12</sup>

Wakefield Pauper Lunatic Asylum, serving West Yorkshire, had opened in 1818. Samuel Tuke from The York Retreat had consulted on the design, build, as well as treatment regime. Its original physical structure therefore aimed to be light, airy, and welcoming, and its therapeutic aspirations sat within the Quaker-inspired moral treatment of the first half of the 19<sup>th</sup> century. However, the asylum rapidly expanded from 150 patients to 620 in the late 1840's. The asylum had largely been spared the effects of the first major wave of cholera in 1830's; there were no admissions from the local area whilst cholera was in the district. However, on 17<sup>th</sup> September 1848, Elizabeth Fenton was admitted to Wakefield from the local Gomersal Workhouse. Described as suffering from epilepsy and

<sup>7</sup> See Jewson ND. The disappearance of the sick-man from medical cosmology, 1770–1870, *Sociology*, 1976, vol. 10 (pg. 225–44) for a classic exploration of the changes in medicine,

<sup>8</sup> Ackerknecht, E.H (2009) 'Anticontagionism between 1821 and 1867: The Fielding H. Garrison Lecture', *International Journal of Epidemiology*, 38, no. 1 (February 1) pp. 7–21.  
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<https://www.lshtm.ac.uk/aboutus/introducing/history/frieze/william-farr> for a more heroic interpretation of their work.

. The recently released Marmot Report "Fair Society, Healthy Lives" (2022) makes the same points

<sup>12</sup> Burch, D. "Taking the Medicine: A short history of medicine's beautiful idea, and our difficulty swallowing it." (Vintage Books London, 2010)



prone to intermittent episodes of violence Elizabeth had no symptoms of cholera when admitted, but rapidly became ill. The asylum was aware of cholera cases in the workhouse and Elizabeth had shared bed space with fellow workhouse inmates who succumbed to cholera in the days immediately after her transfer. Elizabeth ultimately survived her brush with cholera but in almost four months between her admission and the end of the outbreak 106 patients and two staff members had died of it and many others were taken ill. As Chris Wilson has pointed out it is impossible to not be reminded of the discharges of vulnerable patients from hospitals into care homes at the start of 2020 and the catastrophic swathe of deaths that followed.<sup>13</sup>

In response to the outbreak, Dr Thomas Giordano Wright (1808-1898) was commissioned by the Lunacy Commission to write a report into the outbreak. Already a Medical Officer at the asylum, he undertook a systematic survey of the deaths in the asylum and conditions of the patients living there. Wright's 1850 report makes for difficult reading, but he writes with care and compassion. The first section is, in effect, a rapid response preliminary report and tracks the deaths in the days after Elizabeth's admission. The second section of the report is Wright's painstaking analysis of the 106 patient deaths attributed to cholera in the asylum during the outbreak. The story of the two staff who died, one a hospital clerk, the other Mrs Reynolds, one of the senior nurses who volunteered to care for cholera patients

is explained by Wright in a later footnote in his report.<sup>14</sup>

Wright found that prior to the cholera outbreak more deaths than expected had occurred in the asylum. He attributed these deaths to the rapid increase in numbers of admissions, including patients who had been waiting, in his opinion, far too long for a bed in other, often poorer, conditions. He explores the impact of diet, location, weather, patient physical condition and psychiatric diagnosis on mortality rates prior to and during the outbreak. As the asylum expanded, demand for its services increased. Cholera arrived as the numbers of newly arrived, vulnerable people were admitted. But the distribution of cholera cases did not fit neatly into any pattern of who arrived and when. His conclusions include the hesitant suggestion that maybe miasma theory cannot explain cholera, proposing the idea that cholera is in fact a contagion, even if the means of infection is not clear, writing that 'our persuasion being contrary to the doctrine of many influential writers on cholera has not been adopted without careful enquiry and reflection'.<sup>15</sup>

Robert Boyd summarised treatment interventions for cholera in asylums in the wake of the cholera outbreak of the 1830's and 1840's in the first volume of *The Asylum Journal*, the forerunner of our *British Journal of Psychiatry*.<sup>16</sup> His lengthy paper is, in effect, an early form of systematic review, describing the range of attempts to treat patients. Counter-intuitively he describes purging patients with emetics and giving

<sup>13</sup> Wilson, Chris (2020) The eerily similar pandemic we could have learned from but didn't. *The Conversation*, <https://theconversation.com/the-eerily-similar-pandemic-we-could-have-learned-from-but-didnt-138072>

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<sup>16</sup> Boyd, R (1854) Observations on Cholera, *The Asylum Journal*, Volume 1, Issue 8, October 1854, pp. 115 – 125. DOI: <https://doi.org/10.1192/S251499030000104X>. Volume 1 was published in 1853-4, with Boyd's paper as well as summaries of reports from the Lunacy Commission giving guidance about cholera precautions in 'Circular of the Commissioners in Lunacy Suggesting Precautions against Cholera' (1854) *The Asylum Journal*, 1, (1) pp 14-15. <https://doi.org/10.1192/S2514990300000227>

them enemas. Patients are dosed with opium and calomel, essentially mercury salts. Physical interventions involving warmed air and turpentine rubs prove equally ineffective, and all treatments seemed to be accompanied by varying quantities of brandy. Some of these therapeutic strategies were discussed in detail in Wright's report. He too recognised that these interventions were often ineffective, but, like Boyd, reflected on the desperation of staff to try and help their patients. We may look back with the condescension of the present at these treatments but are they any less ill-informed than bleach drinking or internalising ultraviolet light.<sup>17</sup>

### **So, do historians have anything useful to say in a pandemic?**

Robert Peckham, writing from Hong Kong in early 2020 in the *Lancet* argued that historians should approach comparing past pandemics with Covid-19 with caution.<sup>18</sup> He pointed out that each pandemic has its own temporal and spatial specificity, even if there are underlying consistencies that can be extracted. The implication is that a failure to take heed of the past imputes blame, but equally that relying on the past to guide policy has risks. Dolan & Rutherford argue that history has influenced our pandemic management, using the 1918 -1921 Spanish Influenza pandemic as an example, and this has not always been helpful. However, they do identify the political motivations that have repeatedly been obstacles to effective interventions in the past and the present. Debates about the necessity of churches, schools, or bars to remain open has a weary familiarity. And, of course, the 1918

pandemic was driven by the rapid bringing together of huge numbers of young men, into military training camps, in cramped conditions, each with varying degrees of immunological naivety, further compromised by the squalid conditions on troop ships and a political imperative not to alarm a war-weary public by sharing information about the new, often fatal illness.<sup>19</sup>

By contrast, David Jones in 2020 in *The New England Journal of Medicine* argued that there are universal themes that historians should explore and share. He points out that the consistent themes are compelling, distressingly familiar, and can provide templates for action.<sup>20</sup> He alludes to Charles Rosenberg's classic three act analysis. Writing in 1989, with a focus on HIV/ AIDS as an exemplar Emerging Infectious Disease, (EID) and using Camus' "La Peste" as a template, Rosenberg sketched out three phases of pandemic behaviours in history.<sup>21</sup> He started with Act 1, "progressive revelation". Here, a population may be aware of a contagion, but do not acknowledge it, or dismiss it as irrelevant to their day-to-day lives as occurring elsewhere or to others. You could even call it denial. Politically there may be fears of over-reacting, damaging an economy or causing panic. Rosenberg's second act covered "managing randomness". Here people are striving to make meaning out of what is now becoming both tangibly real and terrifyingly indiscriminate. Even though the association between disadvantage and disease is amplified during pandemics, rich *and* poor can still be struck down. Rosenberg talked of this phase as the start of assigning blame and attempting to assert control. Here, fault

<sup>17</sup> BBC News Coronavirus: Trump's disinfectant and sunlight claims fact-checked By Reality Check team. Published 24 April 2020. <https://www.bbc.co.uk/news/world-us-canada-52399464>

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<sup>21</sup> Rosenberg, C.E. (1989) What is an epidemic? AIDS in Historical Perspective *Daedalus* (Spring) 118, (2) pp1-17 <https://pubmed.ncbi.nlm.nih.gov/11612464/> and Camus, A. (trans: Robin Buss) "The Plague" (1947 Penguin Modern Classics, Kindle edition, 2013) set in the 1930's French colonial Algerian town of Oran during an outbreak of what is assumed, but never stated, to be plague. Written in 1947 and positioned as an allegory of fascism it has become a startlingly prescient novel for our times. The last lines speak to the idea that even if the contagion (or political extremism) seems to have gone, it will always find a way to come back

lines in society are exposed. Blaming others, who are the most easily blamed – the poor, the othered, the undeserving – drives pointless and dangerous responses, be it cordoning off Chinese workers in 1920's San Francisco in the belief that they were the source of a plague outbreak or Presidential remarks about "China viruses".<sup>22</sup> Lastly, he explained that act 3 is about "negotiating a public response". Here, communities start to act, both selfishly and selflessly. Military metaphors are especially prominent and largely absurd. Public health concerns battle with political priorities, pleading for intervention as opposed to hoping that communities will follow guidance. Polarisation follows; economy or health, when perhaps one should go hand in hand with the other. Freedom of choice battles it out with community responsibilities. The political and social tone of a country colours its response, as well as its population's compliance. In 2020 China's and United States' approach to lockdowns, facemask wearing, and vaccination were startlingly different. This final phase slowly moves to an end as the disease becomes embedded in day-to-day life, as an endemic illness, just another disease we need to learn to live with, although the impact of endemicity looks hugely different depending on who you are and where you live. AIDS and, now Covid-19, are almost different diseases for those living in the global south. If anyone doubts this, I recommend casting your mind back to the scenes of hospitals running out of oxygen and funeral pyres of India in the Spring of 2021 and the inequities of global vaccine roll out.<sup>23</sup>

### **This is not a pandemic it's a syndemic**

Richard Horton, editor of the Lancet, took the idea of pandemics exposing societal fault lines even further in his editorial title asserting that "Covid-19 is not a pandemic" but was a syndemic. By this he meant that the impact of Covid-19 was the interaction

between a pathogen and societal and global inequalities. It could be argued that medical journals are no place to court political controversy and doctors are there to treat disease. Others may assert that doctors have a duty to advocate for their patients; as psychiatrists, our patients and their families are amongst the most vulnerable in society, to social disadvantage and to Covid-19. After all, the links between poor health and social disadvantage have been clearly known for nearly two centuries.

Pandemics affect those least equipped to deal with them. The global and local poor are most affected, the rich relatively spared, most likely to be able to work from home; take time off work if unwell; afford good nutrition and healthcare; and pay others to do their service tasks. Likewise, those with the highest burden of Non-Communicable Diseases (NCDs) are most vulnerable and as Horton points out NCD's disproportionately fall at younger ages on those who are poor, overcrowded, and have less access to decent quality nutrition – just like so many of our patients. Globally, vaccine access is determined by where a person lives, and their ability to use services, not by need.<sup>24</sup>

### **Conclusions**

History is not about predicting the future, but it can show us that the past has lessons it can teach us if only we can learn them. Pandemics amplify inequalities, locally and globally, where the poor, ill-equipped and vulnerable fare worst. Resources are not equitably shared, medical magic bullets like vaccination or sanitation are grossly unequally distributed, and this has consequences, just as the appearance of Omicron has shown us. Covid-19 has more in common with cholera than we might like to admit. It emerged in the context of humans disrupting a natural ecosystem and its global journey was facilitated by global transport infrastructure and a political resistance to disrupt economic activity. In

<sup>22</sup> Honigsbaum (2020) *ibid* and Viala-Gaudefroy, J and Lindaman, D. (2020/2021) Donald Trump's 'Chinese virus': the politics of naming. April 21, 2020, 5.17pm BST. The Conversation • Updated April 13, 2021, 2.24pm  
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<sup>23</sup> BBC News (2021) India coronavirus: Round-the-clock mass cremations  
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the 19<sup>th</sup> century impoverished slum dwellers in the new industrial towns bore the brunt of infection, as did those in institutions, including asylums and workhouses. Politically, intervention via sanitation resulted in huge benefits, but sidestepped the need to address working conditions, rates of pay and access to adequate nutrition. Transfers of vulnerable people into shared spaces with relatively poor understanding of transmission was demonstrated in Wakefield Asylums' 1848 outbreak, just like the rapid transfer of patients from hospital to care homes in 2020. Presciently, Dr Wright included suggestions for further action and advice for next time there was an outbreak. He included the imperative to try not to admit patients who were potentially infected to the asylum, to ensure high standards of cleanliness, to ensure that rooms and wards were well ventilated, and that patients with symptoms could be isolated. He notes the sacrifice made by staff caring for patients, including the death of one of the nurses and one of the hospital clerks.<sup>25</sup> You could be forgiven for having a sense of déjà vu.

### Acknowledgements

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# Community care of the Mentally Defective: The Guardianship Society, 1913-1930s

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Louise Westwood



Portrait of Grace Eyre Woodhead  
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At the end of the nineteenth century, the philanthropist Grace Eyre Woodhead (1864-1936) began providing holiday homes in Sussex for children from special schools in London.<sup>2</sup>

<sup>1</sup> Louise Westwood 'Avoiding the asylum: Pioneering Work in Mental Health Care, 1890-1939' unpublished D.Phil. thesis, University of Sussex 1999. 'Care in the Community of the Mentally Disordered: The Case of the Guardianship Society 1900-1939' *Social History of Medicine*, 2007 Vol.20, No1 pp.57-72  
For comments and/or questions email Louise on [obsessivebeek@yahoo.co.uk](mailto:obsessivebeek@yahoo.co.uk)

The 1913 Mental Deficiency (MD) Act categorised forms of mental defect and replaced the Lunacy Commission with a more powerful Board of Control (BoC). This act prompted Grace Woodhead to formalise her organisation and Dr Helen Boyle (1869-1957) was a founder member of this new 'Guardianship Society'.<sup>3</sup>

## The work of the Guardianship Society

The aims of the Society were to board out 'the mentally and physically defective with carefully selected families' and obtain training and employment where possible.<sup>4</sup> Foster carers did monthly reports and ensured medical treatment and supervision where necessary. In 1913 the Society received 133 cases, 86 were under 16 years of age. By 1926 the case load had risen to 618 with over 200 boarded out; cases now came from all over the country with fees paid by the local authorities.<sup>5</sup> The fees for foster homes varied and payment included board, lodging, washing and repair of clothing. In 1914 a mother and baby were boarded for ten shillings a week and a thirteen-year-old was boarded for six shillings a week. The boarding fee for one young woman was reduced from seven to one shilling because she was helping out in the guest house.<sup>6</sup> In 1915 the Society boarded out a young woman on the waiting list for Dr Helen Boyle's Lady Chichester Hospital. In 1916 an epileptic girl was sent to work with women farmers in Heathfield on the recommendation of Dr Boyle.<sup>7</sup> A youth who had been in an asylum for years was allowed out on licence in 1921 and the Society found him employment; he

<sup>2</sup> See entry in the Dictionary of National Biography

<sup>3</sup> East Sussex Record Office (ESRO) GUA 31/19 typescript notes on the origin of the society, undated circa 1925.

<sup>4</sup> Ibid, GUA 31.1 and GUA 9/1 Annual Report 1913.

<sup>5</sup> Ibid GUA 9, annual report 1926.

<sup>6</sup> Ibid GUA 2/1, Minute book

<sup>7</sup> Ibid, GUA 2/2, Executive committee minutes.

eventually became independent.<sup>8</sup> Two farms were acquired by the Society in the 1920s to provide care, work, and training for boys.<sup>9</sup>



Plaque for Dr Helen Boyle outside Lady Chichester Hospital.

Photograph courtesy of Dr Claire Hilton.

Married couples acted as foster parents and ran the farms. The boys stayed for two to three years before permanent placements were found. In 1929 Dungates farm had thirteen boys with six out on licence to local farmers and Tubwell had seven with one out on licence. The cost of living and training at Dungates in 1928 was 21 shillings a week. These examples illustrate the relationships between the Society, Dr Boyle's Lady Chichester Hospital, the asylums, local businesses, and the full range of cases that were being helped by the Society.

By 1931 the Society had six non-residential occupational training centres providing training and work skills for adolescents. The girls learned sewing, knitting, and cooking,

the boys were instructed in leather and woodwork. Portsmouth and Cardiff had training centres and Cardiff provided training for instructors. The Society sent a workshop teacher to Cardiff for three weeks at a cost of three guineas. His report stated that the workshops were of mixed sex but separated into age groups and the boys were doing domestic work alongside the girls.

A mental after-care committee was formed in 1925 in cooperation with Brighton Council and the Brighton Asylum. That year 45 cases were visited after discharge and three patients were placed in foster care. The precedent for this work was the national Mental After-Care Association which had been active since the 1870s helping those released from the asylums. By 1928 there were 228 patients on the after-care register. In 1926 Dr Harper Smith from the Brighton Asylum began a weekly clinic at the Society's offices. From 1930 Dr Boyle worked closely with Dr Harper Smith at the Royal Sussex County Hospital which had a 'nervous disorder' clinic that also assessed the mentally defective and epileptic.<sup>10</sup> With the addition of after-care and a clinic, the Society was now an all-encompassing mental welfare organisation. The Society became a model for interested authorities. The Star Cross institution near Exeter requested details of their funding arrangements. An ex-committee member started a similar organisation in Vancouver and a lady councillor from Perth Australia visited the Brighton Headquarters to discuss their work. The Society was highly praised at the International Congress of Mental Health in Washington, USA in 1930.<sup>11</sup> However, the work did not find approval in all quarters.

## Control and Resistance

International Relations in Psychiatry: Britain, Germany, and the United States to World War II (Rochester Press, 2010) L. Westwood 'Explorations of Scottish, German and American Psychiatry: The work of Helen Boyle and Isabel Hutton in the Treatment of Noncertifiable Mental Disorders in England 1899-1939'.

<sup>11</sup> ESRO, GUA 9/1 Annual Reports and GUA 11/1 newspaper cutting

<sup>8</sup> Ibid, GUA 1/1 General Committee Minutes, 10 October 1921.

<sup>9</sup> Ibid, GUA 32/8, 32/10, 32/13/1-10, 32/14/1-14. Dungates and Tubwell farms, medical journals, patient books and BoC reports.

<sup>10</sup> L. Westwood 'A Quiet Revolution in Brighton: Dr Helen Boyle's Pioneering Approach to Mental Health Care 1899-1939' *Journal of Social History of Medicine* 2001 Vol.14 No.3 pp439-457. Also, V. Roelcke, P. Weindling, and L. Westwood (eds)

The BoC ordered local authorities to form Mental Deficiency committees and voluntary associations under the 1913 Act, to deal with the perceived growth in Mental Deficiency.<sup>12</sup> These committees were meant to ascertain the mentally defectives in their area, find suitable accommodation, segregate the sexes, and provide supervision and treatment. Dorset, Devon, Staffordshire, Canterbury, Sussex, and Essex took up the challenge, but other local authorities ignored the directive.<sup>13</sup> The Board of Guardians administered the Poor Law and were meant to work with the new local committees and 'visit defectives under guardianship'.<sup>14</sup> The term 'guardianship' in this context refers to individuals who were living with relatives under supervision. Grace Woodhead's 'guardianship' was innovative because cases were placed in non-familial homes under foster care. The local committees were made up of lay volunteers with no medical training, but they used medical terminology as an empowerment mechanism.<sup>15</sup> The Society used local doctors, including Dr Boyle, to assess any general health problems in their 'charges'.<sup>16</sup>

The BoC compiled statistics on the mentally defective from the work of the local committees. In 1927 the BoC chastised the East Sussex Committee for not 'fully ascertaining the defectives in their area'.<sup>17</sup> Interestingly this was the area where the Society was most active. Annual reports and correspondence from the BoC provide an insight into the ideological clashes between the Board and the Society. The BoC was firmly committed to ascertainment, segregation and institutionalisation and the

Society was committed to non-institutional care in foster homes and small communal farms, workshop training and work placements, which ensured individuals had a considerable amount of freedom in the community.

The BoC had been complaining about some of the Society's procedures since 1914 stating they were in 'contravention of the Mental Deficiency Act'.<sup>18</sup> In 1920 the BoC demanded that the Society 'should confine their activities to the Southern counties in their immediate neighbourhood' and change their name to the Brighton Guardianship Society.<sup>19</sup> Dr Boyle had refused to have dealings with the BoC in relation to her hospital for early nervous disorders arguing that her cases were 'borderline' and not under their jurisdiction.<sup>20</sup> The Society's response to criticism by the BoC was that 'many of the Society's cases are borderline mental cases and there is no provision for the notification of such.'<sup>21</sup> This response was clearly straight from Dr Boyle who had no time for the vagaries of the BoC and the Society ignored their demands.

The Society was criticised by Brighton Council in 1932 for 'importing defectives into Brighton from other areas' because the practice was perceived as 'a grave menace to the amenities of the town as a health resort'.<sup>22</sup> Attention had been drawn to fostering in council homes because one family, who were claiming benefit through a means test, had added the payment for their boarders. The Town Clerk told the Society that they should cease boarding out their cases as this contravened the agreement not to sublet. However, the rent book contained

<sup>12</sup> Hereafter simply referred to as committees.

<sup>13</sup> K. Jones *A History of Mental Health Services* (Routledge) 1972

<sup>14</sup> ESRO, C/C/11.50/1 Sections (5) and (7) of the constitution of the East Sussex Voluntary Association of the Care of the Mentally Defective, 18<sup>th</sup> July 1916.

<sup>15</sup> P. Dale & J. Melling (eds) *Mental Illness and Learning Disability since 1850* (Routledge) 2006. P. Dale 'Tensions in the voluntary-statutory alliance: 'lay professionals' and the planning and delivery of mental deficiency services, 1917-45'

<sup>16</sup> The Society used this term rather than patients.

<sup>17</sup> ESRO, C/C/11/50/1, letters 17<sup>th</sup> & 18<sup>th</sup> October 1927.

<sup>18</sup> Ibid, report from BoC, 19<sup>th</sup> Sept.1914.

<sup>19</sup> Ibid, letter to the Society from the BoC 3<sup>rd</sup> Dec.1920.

<sup>20</sup> Dale & Melling (2006) L. Westwood 'Separatism and Exclusion: Women in Psychiatry, 1900-50'

<sup>21</sup> ESRO, memo to BoC, undated.

<sup>22</sup> Ibid, GUA 31/4 18 April 1932. C/C/1150/2, 4 May 1932



no restrictions on lodgers which had a long tradition in working class homes. The Society refused to provide the council with information on their foster carers and carried on boarding cases. The Society's annual report in 1932 discussed the urgent need for funds in a difficult economic climate and pointed out the considerable amount it was contributing to the local economy. Foster parents alone had been paid £23,000 for their services over several years.

The attitude of the BoC towards the Society was ambiguous to say the least, with one letter in 1920 stating that the work was a 'valuable experiment' which they would be glad to see extended to other parts of the country.<sup>23</sup> Nevertheless, the Board's funding tells a different story. In 1929 the Central Association for Mental Welfare (CAMW) obtained a grant of £2000. The Society complained to the BoC that the CAMW 'only do part of the work of the Society'.<sup>24</sup> Local committees favoured by the board received huge grants. In 1930 the Society received £345, Essex Association received £2,010 and Middlesex CAMW £5,730. Middlesex's grant then increased to £8,655 in 1932/3.<sup>25</sup> This funding strategy illustrates that the BoC had no inclination to support the Society's work.

## Conclusion

The BoC was responsible for care and control of the Mentally Defective. However, the 'control' element assumed far more importance at a time when there was increasing debate on eugenic concerns and sterilisation of the 'unfit'. Many BoC commissioners were former asylum superintendents and the medical commissioners had old psychiatric experience and were not open to new practices.<sup>26</sup> Grace Woodhead maintained an optimistic approach to mental deficiency believing that training and education were

essential at a time when most practitioners were pessimistic in outlook and custodial in approach. The care of the mentally deficient has been the subject of considerable research and it is generally agreed that there was less emphasis on improvement and an increasing discourse on containment, which can be seen in the BoC's approach which lacked empathy or innovation.<sup>27</sup> The 1959 Mental Health Act recommended the BoC be abolished because 'safeguards against abuse of the mentally ill would be better dealt with by local review and discharge rather than a central body'.<sup>28</sup> The BoC was dissolved in 1960, but the Guardianship Society continues its work supporting independence for people with learning disabilities in the 21<sup>st</sup> Century as The Grace Eyre Foundation ([www.grace-eyre.org](http://www.grace-eyre.org)) based in Brighton.

<sup>23</sup> Ibid. letter from the BoC 3 Dec 1920.

<sup>24</sup> Ibid, 1 Jan. 1930

<sup>25</sup> National Archive. MH58/70/95009/3/13A and ESRO, GUA Annual Report 1932.

<sup>26</sup> M. Thomson *The Problem of Mental Deficiency; Eugenics, Democracy and Social Policy in Britain 1870-1959* (Oxford, Clarendon Press) 1998.

<sup>27</sup> A. Digby & D. Wright (eds). *From Idiocy to Mental Deficiency: Historical perspectives on people with learning disabilities* (Routledge) 1996.

<sup>28</sup>

<https://discovery.nationalarchives.gov.uk/details/r/C621> Board of Control 1913-60.

# Care of the mentally ill; Yorkshire's special contribution

## RHS Mindham

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Over the last two hundred and fifty years there have been developments in the care of the mentally ill in Yorkshire which have been of national and in some cases international significance. Rollin and Reynolds went so far as to write of the 'Golden Triad of York, Wakefield and Leeds.'<sup>1</sup> There is considerable substance to their assertion. In the eighteenth-century asylums for the care of the mentally ill were established in many large towns in Britain financed from legacies or public subscription. [Norwich, 1713; Dublin 1746; St Luke's, London, 1751; Manchester, 1766; Montrose, 1782; and Liverpool, 1792.] Bethlem Royal Hospital had arisen from the monastery of St Mary of Bethlehem founded in 1247.<sup>2</sup> The York County Asylum was founded in 1774, financed by public subscription and opened in 1777.<sup>3</sup> It was accommodated in a splendid building designed by the prominent local architect, John Carr, in the style of a grand country house. This was quite different from the earliest asylums, and more were to follow in this style.

The establishment of the York County Asylum led to unexpected but important developments in York. A member of the Religious Society of Friends, died in the York Asylum in 1791 and was thought to have been neglected. Under the leadership of William Tuke, The Religious Society of Friends of York resolved to build their own asylum which would employ gentler methods of care than was then customary. The Retreat, designed and built by John Bevens, opened in 1796. [Fig.1].



Fig. 1. Architects drawing of The Retreat at York<sup>4</sup>  
Permission given to use this illustration by The University of Glasgow, Archives and Special Collections.

In 1813, Samuel Tuke, grandson of the founder of the Retreat, published a report on the work of the asylum in its first fifteen years.<sup>4</sup> He describes the events leading to the establishment of the asylum, details of funding, the regimen of care employed, an analysis of the types and numbers of patients treated, factors influencing progress and outcome and accounts of problems which had arisen. This is a truly remarkable book and was enormously influential in disseminating Quaker ideas of how people should behave towards each other irrespective of sex, social class, or mental illness. Tuke's account shows that details of the social background of patients were routinely sought, together with the family history and occupation. Observations of the mental state of patients at various stages of their illnesses were recorded together with the outcome of care. This information enabled Tuke to categorise patients in the diagnostic terms of the day and to make observations on the management of patients. Somewhat surprisingly Tuke was a layman with no training in medicine. The physical health of patients was dealt with by a visiting physician, but the hospital was run by a lay committee. The Retreat had broken away from the methods of management of insanity then widely employed by doctors which had proved to be so unsatisfactory. Many hospitals were established and conducted on the lines of The Retreat, but its early influence came in part from Tuke being invited to advise on the design of the new West Riding [WR] Asylum for pauper lunatics

at Wakefield.

The County Asylums Act of 1808 which permitted local authorities to use public funds to provide care for the insane led to the building of a number of asylums around England. At their meeting in October 1814 the Visiting Magistrates of the West Riding of Yorkshire resolved to build an asylum for the County, they established an architectural competition, and asked Samuel Tuke to advise on accommodation for the asylum. Tuke's recommendations were furnished to architectural practices which expressed interest in the project. Tuke's advice was subsequently published by the architects and became widely known.<sup>5</sup> The architects, Watson and Pritchett of York were judged to have presented the best proposals and were engaged to oversee the building of the asylum. In their design the architects came under several important influences. In 1787, the philosopher, Jeremy Bentham, had proposed a principle of building which he recommended for institutions such as factories, prisons, schools, and hospitals, where the inmates and staff required supervision. Bentham called his principle 'the panopticon' and believed that its adoption would lead to the better conduct of institutions to the benefit of inmates. This principle had been employed by James Bevens in the small 'Lunatic House' at Guy's Hospital, opened in 1797 but had been used by the Scottish architect, William Stark, for his much larger cross-shaped asylum in Glasgow in 1810. Watson and Pritchett proposed an H-shaped building with wards in the vertical elements, staff accommodation in the horizontal, with observation towers at the inter-sections.<sup>6</sup> Extension of the hospital could be achieved by adding extra wards blocks on each side using the same system of observation. The architects used the layout of the gallery ward which had been introduced by Robert Hooke at the Moorfields Bethlem Hospital in 1676. The towers contained a spiral staircase which had a crow's nest look-out at each level giving an unobstructed view of each ward allowing senior staff to observe the wards without themselves being seen. The asylum opened in 1818. [Fig.2]. A number of asylums employing the panopticon principle were built around Great Britain.

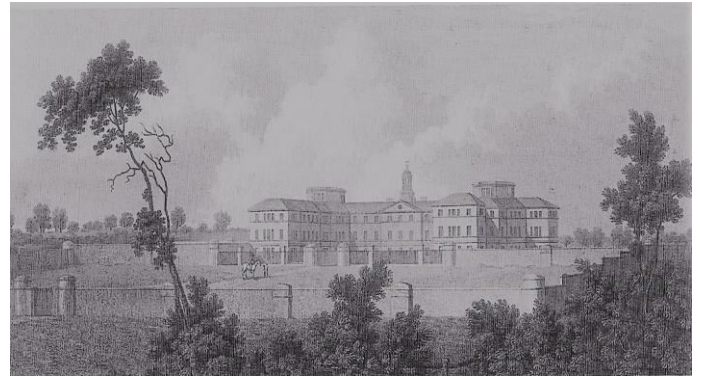


Fig. 2. Engraving of the West Riding Asylum for pauper lunatics, Wakefield, by John Landseer, c1818. Reproduced with permission from The West Yorkshire Archive Service.

The WR Asylum was not only innovative in its design but was able to appoint very able staff. The first Medical Superintendent was Sir William Ellis [1818-31] who later became the first superintendent of the Hanwell Asylum, Middlesex, then the largest in the country. Dr. CC Corsellis, [1831-53], oversaw a major expansion in the hospital's work and in 1841 was a founding member of The Association of Medical Officers of Asylums and Hospitals for the Insane, a fore-runner of the RCPsych. Henry Maudsley, [1857-8], who came from a farming family in the west of Yorkshire and had qualified in medicine at University College Hospital, worked there in his first post in psychiatry.<sup>7</sup> He was later to establish the Maudsley Hospital which became a leading centre of treatment, training, and research in psychiatry. Sir James Crichton-Browne, [1866-1876], promoted teaching and research at the asylum at a time when research in medicine was still in its infancy. He made arrangements for Sir David Ferrier to conduct research into the localisation of brain function which in turn led to the hospital reports becoming the neurological journal, *Brain*. Professor Bevan-Lewis, who conducted research into the pathology of mental illness, and was a teacher at the Leeds School of Medicine, became the first professor of mental diseases in an English medical school shortly after the Yorkshire College, a constituent part of the federal Victoria University, became an independent university in 1904. Professor J Shaw Bolton recounted the history of the hospital in his Presidential Address to the Royal Medico-Psychological Association in 1928. John



Hughlings Jackson and Charles Darwin took note of the work carried out there. The arrangement that the medical superintendent of the WR Asylum would hold a senior appointment in the University of Leeds continued until the establishment of the full-time Nuffield Chair of Psychiatry in 1946. The early date of the asylum, development of teaching and research and association with the University of Leeds led to many of its trainees moving to senior posts in other asylums as they were opened. An increase in the population of the County due to industrialisation led to an increase in demand for places in mental hospitals. At this time the WR included the cities of Leeds, Wakefield, Sheffield, and Bradford as well as several large industrial towns.<sup>8</sup> Three further large asylums were built to serve the WR. A similar pattern was seen in the East and North Ridings of the County.

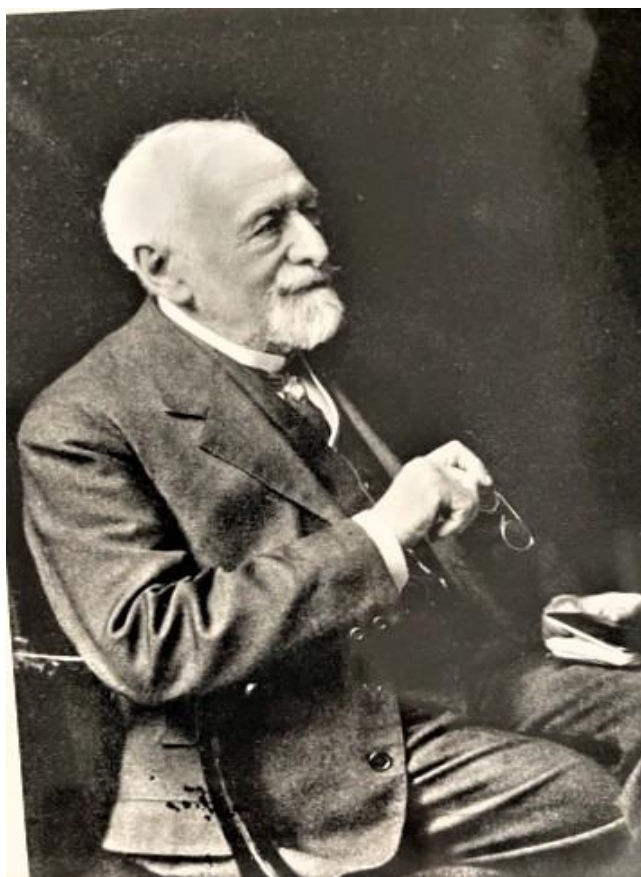


Fig. 3. Photograph of Sir Clifford Allbutt. Reproduced with permission from The University of Leeds, Special Collections and Galleries Research Centre.

The introduction of teaching in mental illness to medical undergraduates in the Leeds School of Medicine was in part due to the influence of Sir Clifford Allbutt. [1836-1925].

<sup>9</sup> [Fig.3.] He was born in Dewsbury, attended St Peter's School, York, qualified in medicine at Cambridge University and St George's Hospital, London in 1859 and returned to Yorkshire to work as a physician in Leeds. He became enormously influential. Among other things he promoted the use of the clinical thermometer and the ophthalmoscope in clinical practice. He had a sustained interest in mental illness and served as visiting physician to the WR Asylums, served on the Board of Management of the Wakefield Asylum and was on the building committee for the construction of the WR Asylum at Menston. He gave evidence to the London County Council Committee of 1890 established to consider the establishment of a 'hospital' for the insane to work alongside the existing asylum system.<sup>10</sup> He introduced teaching in mental illness to the undergraduate curriculum in Leeds and enjoyed a personal friendship with Crichton-Browne. After almost thirty years in Leeds in 1889 he became a Commissioner in Lunacy and moved to London where he also engaged in medical practice. In 1892 he was appointed Regius Professor of Physic in the University of Cambridge. Throughout his career he showed concern for improvements in the care of the mentally ill and remained a friend to the emerging speciality of psychiatry.

One might ask how did these developments come about and why did they occur in Yorkshire? During the eighteenth century a groundswell of public concern over the care of the insane had emerged. In Norwich, then one of the largest cities in England, Mary Chapman established a small charitable asylum for the insane as early as 1713. Thomas Guy included care for the insane in his new hospital founded in 1721. There was dissatisfaction with the existing arrangements leading to a number of initiatives around the country such as the work of Andrew Duncan, in Edinburgh and John Storer in Nottingham, both physicians, to establish asylums for the insane in their own cities. The recurring mental illnesses suffered by King George III brought the care of the insane to public attention and during the century many towns and cities erected asylums for the care of the insane by public subscription. The developments in York can be seen as part of these trends but there



was also a distinct contribution to the understanding of the needs of the mentally ill. The regimen of care at The Retreat was not based on theoretical understanding of mental illness but rather on an empathic understanding of the distress caused to patients and to their relatives and of methods of reducing it. Samuel Tuke did not claim to have found solutions to the cure of mental illness; indeed, he repeatedly states that cures for mental illness were not available. The approach adopted at The Retreat was a system of care rather than of curative treatment. The Retreat was run by a lay committee, but the role of the medical attendant was greatly valued. This is shown in Tuke's warm remarks about the Retreat's first medical attendant, Dr Fowler, at the time of his death. Tuke not only contributed to the design of the WR Asylum but much of the approach to care at The Retreat was incorporated in the instructions to the staff of the WR Asylum.

The work of the WR Asylum was seminal in many ways but most importantly it developed a programme of research into mental illness, initially in the field of

neuropathology, and recognised a need for the training of doctors to specialise in the care of the insane. Allbutt and others saw the need for all doctors to have instruction in the care of the insane. Amongst these influences it is clear that the care of the mentally ill was not solely the province of doctors nor was it understandable simply in medical terms. At the end of the nineteenth century the need was for truly effective treatments for the mentally ill.

### *Acknowledgements*

*I am grateful to: The University of Glasgow, Archives and Special Collections, for permission to use an illustration from Samuel Tuke's Book, The West Yorkshire Archive Service for permission to use the engraving of the Wakefield Asylum by John Landseer, c1818, and The University of Leeds, Special Collections and Galleries Research Centre, for permission to use the photograph of Sir Clifford Allbutt.*

<sup>1</sup>Rollin HR, Reynolds EH, [2018]. Yorkshire's influence on the understanding and treatment of mental diseases in Victorian Britain: the golden triad of York, Wakefield, and Leeds. *Journal of the History of the Neurosciences*, **27**: 72-84.

<sup>2</sup>Taylor, J, [1991], *Hospital and Asylum Architecture in England 1840-1914*. London. Mansell.

<sup>3</sup>Colvin H, [1995], *A Biographical Dictionary of British Architects, 1600-1840*. New Haven and London, Yale University Press.

<sup>4</sup>Tuke, Samuel, [1813], *Description of the Retreat, an institution near York, for Insane Persons of the Society of Friends. Containing an account of its Origin and Founders, the Modes of Treatment, and a statement of Cases*. York, William Alexander.

<sup>5</sup>Tuke Samuel, [1815], *Practical Hints on the construction and Economy of Pauper Lunatic Asylums; including instructions to the architects who offered plans for the Wakefield Asylum and a*

*sketch of the most appropriate design*. York, William Alexander.

<sup>6</sup>Ashworth AL, [1975], *Stanley Royd Hospital, Wakefield. One Hundred and Fifty Years. A History*. Wakefield, Wakefield Area Health Authority.

<sup>7</sup>Lewis A, [1951], The twenty-fifth Maudsley Lecture. Henry Maudsley-his work and influence. *Journal of Mental Science*, **97**: 259-277.

<sup>8</sup>Roberts JM, [1986], Madhouse to Modestate-Psychiatry in West Yorkshire, 1750-1986. The University of Leeds Review, **30**: 163-183.

<sup>9</sup> Anning ST, [1980], *The History of Medicine in Leeds*. Leeds, WS Maney & Son Ltd.

<sup>10</sup>Brudenell Carter R, [1890], *The Report of the Committee of the London County Council on a Hospital for the Insane*. London, LCC.

# 'West's Syndrome' in Warwick Asylum in 1853 – a case study

**Alastair Robson**

Dr Henry Parsey was appointed the first Medical Superintendent to the Hatton asylum, (or more correctly Warwick County Lunatic Asylum), which opened on 29<sup>th</sup> June 1852. For the previous four years he had been Assistant Physician to Sir John Bucknill at the Exminster asylum (Devon County Lunatic Asylum), and when a medical student at King's College, London, he had attended Dr John Conolly's lectures on insanity at the Hanwell asylum (Middlesex County Asylum).<sup>1</sup>

The County Record Office at Warwick holds an extensive archive of the asylum's records from its inception to its closure on 31<sup>st</sup> July 1995. A review of the clinical records for its first five years of activity revealed that of the 399 admissions, (which included two patients brought to the asylum, bound hand, and foot; one at the bottom of a cart), twenty-seven patients had an admitting diagnosis of epilepsy and learning or behavioural difficulties. Whilst not insane, epileptics were considered to be 'proper objects for admission', 'where the fits produce imbecility of mind as well as of body'.<sup>2</sup>

This explains why, of those twenty-seven, four were children under the age of sixteen. The youngest was a 4-year-old boy named George Keeley, whose parents found his behaviour so unmanageable that the only way he could be controlled at home was by being shut up in a cupboard (he quickly improved on admission, becoming 'tolerably

affectionate', but died in a 'prolonged fit' a year later). The next youngest was a boy aged 7, James Saunders, who was brought to the asylum by his father, and from the notes made by Dr Parsey, one senses his admission was driven more by parental concern rather than by exasperation:

*James Saunders, male, aged 7, admitted 24<sup>th</sup> October 1853. The child is sent here as an idiot. He was from birth sickly and for many months not expected to live. He has been deficient in intelligence, and for the last two years subject to epileptic fits. He does not appear devoid of general intelligence; is extremely distressed at being left here by his father.*

After a month's observation, Dr Parsey recorded:

*November 29<sup>th</sup>. Has since being here greatly improved in bodily health and gained flesh. He has had no severe epileptic fit; but many times in the day momentarily loses his intelligence, his arms spread wide and are joined by a slight convulsion which to a less extent affects his body but he never falls, the muscles of the face and eyelids are similarly convulsed and the eyeballs turned upwards: the convulsion which lasts only a few seconds suddenly stops and he immediately returns to consciousness with a rather surprised look.*

In general matters he displays sufficient quickness and aptitude but does not seem to possess the faculty of continued application. When asked if he can read replies in the affirmative and repeats 'ABC' which constitutes the whole of his aptitude – occasionally asks when shall he go home but soon makes himself happy here.

Compare the above description with this, written a few years earlier, in respect of another young boy, also named James:

<sup>1</sup> Robson A 'Unrecognised by the World at Large': a biography of Dr Henry Parsey, Physician to the Hatton Asylum, Warwick Matador Press Kibworth Beauchamp Leicestershire 2017.

<sup>2</sup> General Rules for the Government of All the District Lunatic Asylums of Ireland 1843; Lunacy Act of 1845 [8 & 9 Vict. c. 126].

*The child [James Edwin] is now near a year old; was a remarkably fine, healthy child when born, and continued to thrive till he was four months old. It was at this time that I first observed slight bobbings of the head forward...these bobbings increased in frequency, and at length became so frequent and powerful, as to cause a complete heaving of the head forward toward his knees, and then immediately relaxing into the upright position... these bowings and relaxings would be repeated alternately at intervals of a few seconds, and repeated from ten to twenty times or more times at each attack, which attack would not continue more than two or three minutes; he sometimes has two, three, or more attacks in the day; they come on whether sitting or lying... all of a sudden down goes his head and upwards his knees;...independent of this affection [he] is a fine grown child, but he neither possesses the intellectual vivacity or the power of moving his limbs, of a child of his age; he never cries at the time of the attacks, or smiles or takes any notice, but looks placid....*<sup>3</sup>

This report was written by his father, Dr William West, and published in *The Lancet* on 13<sup>th</sup> February 1841; James's first birthday. William West was a surgeon-apothecary in Tonbridge, Kent, who had qualified MRCS (member of the Royal College of Surgeons) from Guy's Hospital in 1815, (where he would have been a contemporary of John Keats, who qualified LSA (licentiate of the Society of Apothecaries) the following year).<sup>4</sup> Strictly speaking, William was not entitled to the title 'Dr', although he is referred to as such throughout the medical literature.<sup>5</sup>

William West sought advice for his son from Sir Charles Clarke of Queen Charlotte's

Hospital, a highly esteemed specialist in women's and children's diseases who would, it was said, go out of his way to attend the families of unknown doctors.<sup>6</sup> He claimed to have seen four similar children; he called the condition 'salaam convulsions' – 'salaam attacks' is a synonym still used today – but Dr West's letter to *The Lancet* was the first published account of the condition.

Both reports describe seizures which, given the caveats surrounding retrospective diagnosis, are probably in keeping with what we now recognise as 'infantile spasms'. Whilst Dr Parsey recognised that James Saunders was epileptic, it is unlikely he would have seen infantile spasms *per se* before; it remains a rare neurological disorder (2-3 per 10,000 live births), with an onset before the infant's first birthday, as was the case with James West.<sup>7</sup> Although James Saunders' age of onset, according to Dr Parsey's history, was very much later than is usual, his asylum admission papers state he had suffered from epilepsy for 'seven years', which is more in keeping with the diagnosis.

No further investigation nor treatment was possible in the 1850s, but today our understanding of the condition, if not complete, is better – the triad of infantile spasms, progressive mental retardation and a diagnostic EEG waveform pattern known as 'hypsarrythmia' is known as 'West's Syndrome', but it took some time: the characteristic 'hypsarrythmia' on EEG wouldn't be recognised as such until 1951, and specific treatment would have to wait until 1958, when ACTH was found to be an effective anticonvulsant (very much by chance).

What became of the two boys? James West, on his father's death in 1848, entered Park House in Highgate, the first asylum in England for children with learning disabilities

<sup>3</sup> West WJ. *On a peculiar form of infantile convulsions*. *Lancet* (1841) 35: 724–725.

<sup>4</sup> Regarded then (colloquially) as the 'Licence to kill'.

<sup>5</sup> Eling P et al. *The mystery of the Doctor's son, or the riddle of West syndrome*. *Neurology* (2002) Mar 26; 58(6): 953-955.

<sup>6</sup> *Inspiring Physicians*. RCPLond Munk's Roll 1782–1857 vol IV p12.

<sup>7</sup> *West syndrome* gpnotebook.com

(one of its founders was John Conolly), and then in 1854 he went to the newly built Earlswood Idiot Asylum in Redhill, Surrey, whose first Medical Superintendent was Dr John Langdon Down; here James remained until his death from tuberculosis (TB) on September 27th, 1860, aged 20. TB was the commonest cause of death of children at Earlswood, possibly because they slept in dormitories of about fifteen beds. He was buried in the cemetery of Tonbridge parish church, adjacent to his father's grave.

As regards James Saunders, Dr Parsey's recorded in his case notes every three months or so that James continued 'in good bodily health, with no change in character of his epileptic fits nor mental state', until entries ceased in September 1855: presumably James gave Dr Parsey no further cause for concern. One hopes James managed to continue to 'make himself happy' in the institution. It would be reasonable to assume that in the fullness of time James entered 'Highfield', the Idiot Asylum, which Dr Parsey had pressed the asylum's Visitors to build to provide more appropriate accommodation, separate from the main asylum, and rudimentary schooling, especially for the young intellectually disabled. But this was not the case: James's name does not appear in the register of residents transferred to Highfield when it opened in 1871. The only further record of his life is an entry in the asylum's burial register which reveals that James died on 29<sup>th</sup> June 1859, aged twelve, and was buried in the asylum's burial ground.

(Although there is a plan in the asylum's archive marking individual graves, the burial ground has since been deconsecrated, and is now parkland for recreation and dog-walkers from the housing estate which has replaced much of the asylum). His cause of death is not recorded, but it too was probably due to TB. (Of the twenty-eight admissions in 1852-1857 under the age of 21, ten died in the asylum before the age of 30; nine - if one includes James - from 'phthisis' (pulmonary TB) or 'pneumonia'; the other being George Keeley, from a 'prolonged fit'.)

Eponymous fame came to Dr West and Dr Down: for William West, when a French neurologist, Dr Henri Gastaut, (he of 'Lennox-Gastaut Syndrome', a close relative of infantile spasms), in 1960 suggested the use of 'West's Syndrome' for the triad described above, and for John Langdon Down, 'Down's Syndrome' would come to supersede the term 'mongolism' (his earlier term for the clinical features of trisomy 21, which he first described in 1866).

And did Dr Parsey achieve similar fame? Unfortunately, not, despite his being much respected by the medical profession during his lifetime. Following his death in 1884, his obituarist in *The Lancet* regretted that his reputation had been 'unrecognised by the world at large'; which remains the case today.



# From poor law lunacy to primary care mental health: a gap in the historical literature

**John Hall**

PhD FBPsS

Visiting Professor of Mental Health and Senior Research Associate in the Centre for Medical Humanities, Oxford Brookes University: formerly Head Clinical Psychologist for Oxfordshire NHS Mental Healthcare Trust and Senior Clinical Lecturer in Clinical Psychology, Department of Psychiatry, Oxford University.

## Introduction

This article reviews the ways in which general practitioners were involved in 'lunacy' in the nineteenth century, and how from c.1900 some began to be engaged in more psychological aspects of their practice. After World War I (WWI) a number of service developments took place, and with the advent of the NHS a steadily increasing body of epidemiological evidence and innovations in general practice psychiatry led to major developments within primary care, to the point where a concept of primary care mental health was emerging.

Research in the broad field of the history of mental health and psychiatry in Britain has been dominated by ideas formulated and practices directed by successive generations of mad-doctors, alienists, and psychiatrists. Until around 30 years ago much of the history was also written by them, until the advent of medical historians such as Roy Porter. These histories have unsurprisingly privileged the role of psychiatrists and have ignored the role of the proto-general practitioners (GPs).

The overall historical development of general practice in Britain has been fully covered by Digby (1999) and by Loudon, Horder & Webster (1999) - Loudon himself being a former GP - and more controversially by Honigsbaum (1979), with a continuing stream of more recent articles (e.g., Kmietowicz 2006). There is virtually no reference in these books to the role of general practice in the care of the mentally ill.

Likewise in the many histories of psychiatry in Britain little reference is made to the role of general practice. As Turner et al. (2015) note in their witness-seminar based review, until the past 20 or 30 years the dominant themes in this British historiography have typically been the run-down of the large mental-hospitals, the transition to community-based practice, and the rise of psychopharmacology, without any consideration of the role of primary care as a major theme. Surprisingly, in a chapter titled 'Clinical perspectives on community and primary care psychiatry and mental health services' in the recent historical volume edited by George Ikkos and Nick Bouras, less than a page is devoted to primary care psychiatry (Turner 2021). The comprehensive *Primary Care Mental Health*, edited by Linda Gask and colleagues (2018) similarly has half a page on the history of the field. So, is there a history of psychiatry in general practice, or a history of primary care mental health?

## Early patterns of practice

There are arguments as to when a medical role that can be described as 'general practitioner' emerged. Before the slow growth of the public asylum system from the early nineteenth century, several groups of doctors were involved with the melancholy, the distracted and disturbed, in their day-to-day practice. The higher-status physicians had a financial interest in maintaining as wide a span of practice as possible and some would develop an interest in lunacy. Apothecaries and surgeon-apothecaries saw the paying middling classes, and they could be paid by

the parish Overseers of the Poor for medical services to paupers. Private madhouses were well-established by the beginning of the eighteenth century, some owned by doctors but many by lay-people (Parry-Jones 1972). There were a few charitable asylums, such as St Lukes Hospital in London. Peter Carpenter has identified a number of doctors caring for single lunatics in their own homes in the Bristol area, including Samuel Hitch, previously a GP, who sent out the invitation for the meeting at Gloucester which set up the Association of Medical Officers of Asylums and Hospitals for the Insane in 1841 (Carpenter 2021). Published case-books of surgeon-apothecaries, such as those of Robert Storrs working in Doncaster from 1824, make clear reference to, for example, mania and delusions (Tooth 2007).

A key turning point was the 1834 Poor Law Amendment Act, which was intended to address the worst aspects of the old system. The Act created 'Unions' or groups of parishes, managed by a Board of Guardians who were required to build a workhouse and to appoint a specified group of officers, crucially the master of the workhouse, a medical officer, and one (or more) relieving officers. It was the job of the medical officers and relieving officers to ascertain those people who might need relief and to be admitted to the workhouse or to the asylum, so 'harmless' lunatics (including those then classified as 'idiots') were admitted to the workhouses, including many older people. If a workhouse inmate became so disturbed that they were unmanageable, the workhouse master could initiate a transfer to an asylum. The records of Poor Law Unions, such as Henley-on-Thames (Richmond 2008), show how paupers 'of weak mind', 'partially insane' and 'idiotic' were routinely admitted to the workhouse. Peter Bartlett (1999) has made clear the close interaction between the Poor Law and Lunacy systems, with a workhouse as an important route to admission to an asylum. So the Union medical officers, mostly part-time appointees from local surgeon-

apothecaries were, with the relieving officers, the gatekeepers to the workhouses, the private madhouses and the few asylums that then existed, and were involved in the long-term care of people deemed mad.

In 1845 the Lunatic Asylums Act required the erection of an asylum at public expense by all English and Welsh counties and boroughs, and similar Acts were passed for Scotland and Ireland. The rapid growth of the asylum system meant that many of the new asylum doctors were surgeon-apothecaries. But what did any of these doctors, in general practice, as poor law doctors, or as asylum doctors, know about lunacy? The first comprehensive text on the topic was the 1858 *Manual of Psychological Medicine* by Bucknill and Tuke. The medical faculty at University College London offered teaching on mental disorder from 1865, Edinburgh University from 1869, and part-time lecturers in mental pathology or mental diseases began to be appointed at medical schools from around 1870. Not until 1885 did the GMC say that teaching on the topic was even desirable, and it was only compulsory in 1893 (Crammer 1996). Until the beginning of the twentieth century there could thus have been no expectation that a doctor had formal knowledge about lunacy, so their expertise in distinguishing between different presenting conditions would have been limited, with wide discrepancies in the threshold levels of disturbance seen as warranting admittance to the workhouse or asylum.

During the nineteenth century routine general practice was of "a ritualistic nature ... The patient was in the doctors' surgery for between three and five minutes ... Most patients were content with a standard bottle of medicine" (Digby, p. 199). Rhodri Hayward's 2014 book *The Transformation of the Psyche in British Primary Care 1880-1970* explores how at least a few GPs became interested in psychological aspects of their patients' problems towards the end of the century. Thomas Mitchell, a GP at a village

near Tonbridge, was from 1906 treating patients through hypnotic techniques, and Charles Tuckey, a London GP, became convinced of the benefits of hypnotic suggestion and in 1911 published an article on the topic in *The Practitioner*. In 1906 the *Medical Society for the Study of Suggestive Therapeutics* was founded, with Tuckey among the founding members. Unsurprisingly a number of those interested in hypnosis became interested in psychoanalysis as it was introduced to Britain. Four of the original fifteen members of the London Psychoanalytic Circle in 1913 were medically qualified, the secretary being Douglas Bryan, a Leicestershire GP, with Thomas Mitchell also a member (Hayward 2014). In WWI large numbers of soldiers were evacuated from the front-line with nervous and mental shock, and alongside the well-known military hospitals such as Craiglockhart Hospital at Edinburgh, RAMC regimental doctors encountered these patients and continued to see them in general practice after the war (Shephard 2002).

The period from 1920 is important for the development of a number of new health and mental health policies and agencies, not least the creation of a Ministry of Health in 1919. The 1920 Dawson Report made a number of recommendations about the alignment of preventative and curative medicine, to be brought together by general practitioners in health centres. The Dawson model of health centres was slow to develop; the Pioneer Health Centre of the 1926 'Peckham Experiment' is probably the best-known example, which focused on a model of family health and was seen as providing evidence for 'suburban neurosis' (Hayward 2014). Among the most prominent new agencies was the Tavistock Clinic founded by Hugh Crichton-Miller, a former GP who had run a nursing home before WWI, which became home to an eclectic group of psychodynamic practitioners. Another innovation was the introduction into Britain of the American mental hygiene movement, which emphasized early intervention, prevention,

and the promotion of mental health (Toms 2013).

GPs would have seen many patients with mental health problems, termed 'nerves' or neurasthenia, and each year most would carry out medical examinations for certification under the 1930 Mental Treatment Act. However, there were no major developments in the medical treatment of mental disorder available to GPs. Laudanum was still widely used for nervous conditions, and morphine and codeine were also widely used. The bromides had been long known as sedatives and hypnotics in hospital settings, and by the 1930s they had migrated into secondary care settings: one estimate was that 4 out of 10 scripts in general practice were for bromides (Glatt 1962). If a GP was fortunate there might be a psychiatric out-patient clinic in the nearest town - there were 162 such clinics in Britain in 1935 (Andrews et al. 1997).

### **Enter the NHS**

Charles Webster details the discussions regarding the shape of primary care leading up to the new NHS system in July 1948, and the immediate consequence of a 'deluge of demand' (Webster 1988). An independent review of the state of British general practice (Collings (1950) was alarming in its description of poor premises and equipment, and of over-worked practitioners poorly informed about the most effective treatments. This was one trigger to a British Medical Association (BMA) report on general practice, leading to the College of General Practitioners being formed in 1952 (Fry et al. 1983).

An important development was the introduction of training seminars for GPs by Michael Balint, a Hungarian psychoanalyst working from the Tavistock Clinic, with his wife. The seminars combined a Tavistock-inspired approach to psychodynamic therapy and a group therapy approach, and by 1962 there were eight courses in London and

eleven others elsewhere in England. His 1956 book *The Doctor, His patient, and their Illness* remains a classic training text.

The scale of mental disorder within general practice was supported by the epidemiological evidence that was slowly being collected. Arthur Watts, a Leicestershire GP, wrote *Psychiatry and General Practice* (1952) with his wife (the first book to bear that title), and one of his studies showed that 30% of his patient list manifested some kind of psychological distress. John Fry, working in Beckenham, was another pioneer of research into the conditions that GPs encountered, and he estimated that 10% of his patients manifested some form of neurosis (Fry 1954). Surveys conducted into the mental health of residents in 'New towns' showed evidence of both primary care consultations and similar levels of psychiatric referrals (Brotherston & Chave 1957). The most influential early work on the epidemiology of mental illness in general practice was carried out by Michael Shepherd and his colleagues from the General Practice Research Unit set up at the Institute of Psychiatry in the late 1950s. His 1966 *Psychiatric Illness in General Practice* was a landmark, insisting that mental health services could only be enhanced by better training and better support for GPs.

The beginnings of deinstitutionalisation from the late 1950s, and 'community care' of the discharged patients placed new demands on general practice. From 1953 chlorpromazine treatment in psychiatry spread rapidly and the drug was soon translated into general practice, with tricyclic antidepressants introduced from 1958. While GPs were encouraged not to initiate the prescription of these drugs, GPs were in practice involved in repeat prescriptions, and reviews suggested there was a risk of over-prescribing in primary care (Parish 1971).

Another development was the deployment of hospital mental health nurses to the community who already knew the discharged patients. The first published example was a

1954 project in Croydon with patients from Warlingham Park Hospital. This new role of community psychiatric nurses (CPN) developed rapidly from the 1960s, with CPNs usually assigned to sectors of the catchment area of the hospital they served, thus linking with the GPs of discharged patients (Hunter 1974).

Major developments in general practice were limited by the method of funding. The 1966 'Family Doctors Charter' introduced a new form of GP contract that permitted payment for associated staff, changing the face of primary care by allowing the employment of practice nurses and reception staff, and by stimulating the development of group practices. The range of visiting staff increased, with the two most important new groups for mental health care being clinical psychologists and counsellors. The demand for clinical psychology services grew significantly with the advent of behaviour therapy from the early 1960s. While many GPs were keen to employ counsellors, standards of training were highly variable before the British Association of Counsellors, formed in 1970, brought about more consistent standards of practice.

In 1972 the College of General Practitioners became a Royal College, and one of their first major reports, *The Future General Practitioner: Learning and Teaching*, set out a direction of development for the profession. A 1972 joint review by the BMA, Royal College of Psychiatrists, and the Society of Medical Officers of Health, explored what mental health services might look like after the 1974 re-organisation of the NHS. Their report contains a chapter on *The General Practitioner and the Mental Health Service*. The Department of Health and Social Security *Better Services for the Mentally Ill* 1975 White Paper was the first comprehensive policy on mental illness services, but the section on primary care, using a rhetoric of the 'primary care team', is less than one page and mentions only health visitors, home nurses,



and the possibility of an attached social worker, in addition to GPs.

David Goldberg and Peter Huxley's *Mental illness in the community's* (1980) was a key publication, not only adding to the epidemiological base for community mental health, but crucially introducing the concept and powerful analytic tool of filter theory, seeing the transitions, or pathways of care, from the community to different levels of psychiatric care as mediated by a sequence of decisions by patient, GP, and psychiatrist.

## Summary

From the early twentieth century up to World War II there are clear signs of GPs becoming interested in psychological problems, with new mental health movements and agencies emerging which reflected increasing concern about how to bring general practice, public health and psychiatry closer together. From the 1950s, with the foundation of the College of General Practitioners, the early epidemiological surveys, and the first Balint groups, a new phase began in the understanding of the presentation of mental health concerns in primary care in Britain. The complementary moves over the same period from the mental hospitals to new District General Hospitals units, the growth of outpatient clinics, the availability of new drugs, and the first attachments of other mental health professionals, revised the boundaries and interfaces between specialist and community services and led to new understandings of how people moved through them (Hilton & Stephenson 2020).

A number of key events and publications from the 1980s have led to a situation where

exploring the 'history of psychiatry in general practice' is no longer adequate<sup>1</sup>. Conventional histories of psychiatry have not yet recognised the significance of primary care for the management of both presenting complaints and of long-term or continuing health care problems. The 2009 and 2018 editions of *Primary Care Mental Health* demonstrate the movement to a coherent model of primary care mental health that now deserves its own critical history.

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Note: The archives of the Royal College of General Practitioners hold a number of papers of individuals (including those of John Fry and CAH Watts) and working parties (including the working party on psychiatry and the general practitioner), and the BMA archives hold the papers of the BMA Psychological Medicine Group 1937 to 1971, but neither of these have been accessible during lockdown.

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period, and some provisional emergent themes (such as the shift in diagnostic and formulation approaches best illustrated by ICPC-3), which will be summarised in a succeeding article, linked to a witness seminar on the **History of Primary Care Mental Health** being organised by Alan Cohen, Lydia Thurston and André Tylee, due to take place in June 2022.

<sup>1</sup> In July 2020, during the COVID lockdown, I conducted telephone interviews with seven individuals who were closely involved in the development of primary care mental health from the late 1970s. These interviews identified a number of key events (such as GP Fund-holding from 1991) and publications (such as the 2009 first edition of Linda Gask and Helen Lester's *Primary Care Mental Health*) from that

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# Percy Walwyn: Prophet Without Honour

Ian Wheeler

Ian Wheeler is the author of *Fair Mile Hospital: A Victorian Asylum* (History Press, 2015)

Email: [ian@cholsey.com](mailto:ian@cholsey.com)

In fields of technical endeavour, I have long been fascinated by the might-have-beens, should-have-beens and the unfortunate geniuses who were overshadowed or suppressed by corporate might, jealous rivalry or, on occasion, simply being too far ahead of their time. The latter is *part* of the true tale of Percival Walwyn, who in 1949 proposed a development in aviation technology that nobody else appeared to think of until nearly forty years later.

Based on sketchy evidence, Percy Walwyn was born in 1902, *possibly* in Worcestershire and, again, *possibly* with family connections in Much Marcle, Herefordshire. He clearly had a technical bent and rose to become Chief Designer for the Brough motorcycle concern of Nottingham, at the time makers of highly advanced and prestigious machines. By now, the reader is perhaps wondering why a motorbike designer should feature in the pages of *News & Notes*. The answer is that he was a psychiatric patient.

Owing to 100-year rules applicable to the records, it's not yet possible to find out when Percy became ill but by 1949, he was a patient at Fair Mile Hospital—until the days of the NHS known as the Berkshire Mental Hospital—in the village of Cholsey, near Wallingford in that county. The jet engine was still quite a novelty at that time but, as seen in the accompanying drawings, Percy's imagination was fired and in that year he produced technical sketches of a device for directing a jet's thrust as a means of aiding control of an aircraft, including details such as hydraulic actuators and the pilot's controls. These he submitted to the Air Ministry in London and, based on

unvarnished memories passed down within my family, the following episode unfolded.

The Air Ministry was clearly intrigued by the drawings and despatched a car full of boffins and officials to the address inscribed on the pages: Fair Mile Hospital, Wallingford.



Fair Mile Hospital, originally The Moultsford Asylum and known up to 1948 as The Berkshire Mental Hospital.

At the reception desk they encountered my grandfather, Leslie Talbot, and asked to see Mr Percival Walwyn.

Leslie was a little taken aback but replied that there was no Percival Walwyn at Fair Mile—unless they meant Percy, who was one of the patients!

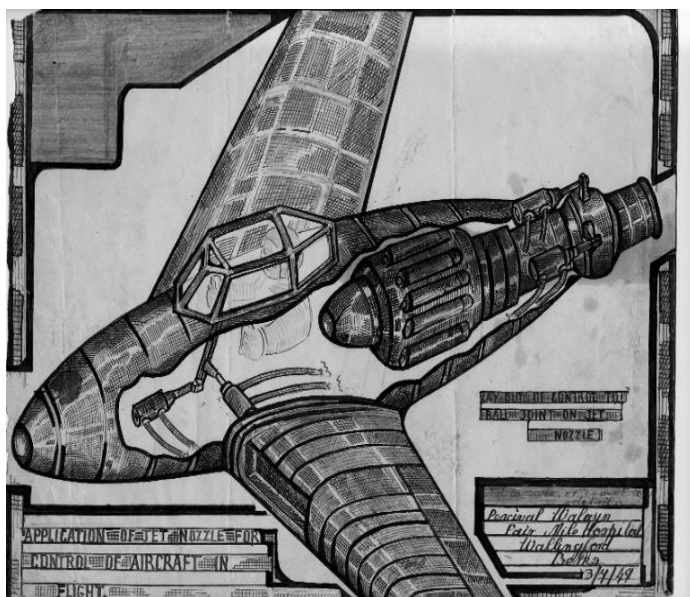
At this point we are forced to ponder whether the Air Ministry was aware that Fair Mile was a mental institution, but it appears not. One imagines that there was a certain amount of harrumphing and shuffling of feet, but it is known that the Ministry party turned on its heels, piled back into the car and retreated to London in embarrassment, never to be seen in Cholsey again. Poor Percy.

Seen from a modern, technical perspective, Percy's ideas were considerably ahead of the materials- and engine technology of the day. Granted, the sketches depicted something closer to plumbing and agricultural machinery than cutting-edge aviation design, but the essential idea that Percy had conceived, which we now call *thrust vectoring*, has since become accepted in some of the most advanced fighter aircraft in the world: the Bristol (later Rolls-Royce) *Pegasus* jet engine that lifted the Harrier 'jump jet' had a somewhat different take on thrust vectoring and design studies for it did not begin until 1956, seven years after the









Exterior design of Walwyn's jet-propelled swept-wing aircraft, with a cut-out around his exhaust-swivelling apparatus and even a rudimentary sketch of a pilot in the cockpit.

Some say that genius and madness are close relations. I am sad that Percy's vision was not appreciated in his lifetime. Available information suggests that he died in 1957, drowned in the river Thames while out fishing. His casting technique involved pirouetting on the spot with his rod held out, so that centrifugal force would carry hook, float and line far out into the stream. Perhaps this 'engineering principle' made him so giddy that he fell into the water. He was still a Fair Mile patient, and the Hospital authorities were never able to decide whether it had been an accident or suicide.

I wonder what became of the men from the Ministry.

#### **Author's Note:**

Accompanying images were originally in the Talbot/Wheeler family connection but are now held at the National Aerospace Library, Farnborough, Hants., which has kindly given permission for them to be reproduced here.

Those wishing to enquire further about the Walwyn drawings should contact:  
 Tony Pilmer, Librarian & Archivist,  
 The Royal Aeronautical Society,  
 National Aerospace Library,  
 The Hub, Fowler Avenue,  
 IQ Farnborough,  
 Farnborough, GU14 7JP, UK.  
 E: [tony.pilmer@aerosociety.com](mailto:tony.pilmer@aerosociety.com)

T: +44 (0)1252 701060

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 views or just say Hi!

# The Bath Magdalen Hospital – early care for the ‘Idiot’

Peter Carpenter



The Hospital seal [from impression given to author]  
The edge reads Sancta Maria Magdalena Sigillum Magistri Hospitii: Saint Mary Magdalen Seal of the Master of the Hospital

On the old Wells Road out of Bath, now a quiet cul-de-sac called the Holloway, lies the Magdalen Chapel - the oldest in Bath. Tourists visit rarely and usually pay more attention to the Judas Tree by the Chapel than the cottage they pass next to the churchyard – however this cottage was The Magdalen Hospital which has claim to be the oldest charity in the United Kingdom dedicated to the care of people with intellectual disability.

It was reputed to have been founded by Aethelstan,<sup>1</sup> but the earliest surviving deed is dated 1186 when Walter Hosat donated his house, adjoining chapel of Mary Magdalen and land to the Priory of Bath. This

was at a time when the Bath waters were famed for curing leprosy – Bath’s founding legend was of King Bladud curing his pigs’ and his own leprosy in the waters there. The Magdalen Leper Hospital operated with its master and brothers, but leprosy diminished after the Black Death (for reasons still argued over) and the poorly endowed hospital decayed until in 1486 only 2 or 3 ‘poor people’ lodged there. In this year the Prior of Bath, Cantlow, took over the Hospital and in 1491 rebuilt the Chapel. He probably also rebuilt the hospital building as an attached almshouse for the poor and infirm.

The Hospital was probably saved in the Dissolution because in 1536 Henry VIII granted the mastership to a Simon Sheppard ignoring the Priory’s ownership. In the later disputes it was then decreed that the state could not take the hospital’s lands whilst the master still used them to maintain inmates. It appears the hospital became a state sinecure, with the master renting out the main buildings and lands whilst keeping a small cottage on the end of the property for the inmates, as shown by Stukeley in 1723.



1723 View of Bath by Stukeley. St Magdalen Chapel is in forefront, the farmhouse to left and the Hospital (later rebuilt by Duel Taylor] to right with man standing in front. The building attached to the chapel may have been the hospital when rebuilt in 1491.

It is not clear when the Hospital moved from caring for the infirm or ‘lazars’ to ‘idiots’. Lepers were one of the groups routinely excluded from medieval hospitals which also included pregnant women, the mentally ill and epileptics so a dearth of lepers could easily have seen it move to other people excluded from the other Bath Hospitals. The Bath Corporation record of grants to the ‘almsfolk’ of the Magdalen changes to being to the ‘Hospital’ in 1594 and to the ‘Guide’ at

the Magdalen in 1612. Guide was a term then used for a carer or keeper. The evidence of the 17<sup>th</sup> century is that inmates were not given regular money as happened in other hospital charities in Bath, but a person was paid to care for them, suggesting they were not just 'poorfolk'. In addition, the master charged an entry fee. No other hospital in Bath charged for entrance (it was later abolished in 1833 as uncharitable) and this must have encouraged friends to pay for the admission of people who needed care but who might live a long time – the disabled. The Bath Corporation accounts pay for clothing for *Thorne's daughter placed up at the Maudlins* in 1656 and a monument in the chapel dated 1662 notes the woman with 'innocence' was buried in the churchyard to lie with 'Innocents' which was then a common term for 'Idiots'.

Anthony Wood, the Oxford antiquary, and historian, visited Bath in June 1678:

*In the middle part of this hollow way on the right hand stands a little old decrepit hospitall built originally for lunaticks. At this time there are but two; lately four; and formerlie there have been six lunaticks.... The two lunaticks that are now there (of which one is a female) are kept by an old man who is a cobbler and keeper thereof, and hath paid yearlie to him for their diet and lodging £13.<sup>2</sup>*

He must have visited the hospital to know these personal details. It is possible that the female was 'Thorne's Daughter.' He probably used the term 'Lunatick' to cover any mental disability.

In 1700 friends advertise a reward for a missing man:

*Missing from St Mary Magdalen's Hospital near Bath ... Oliver Cambridge, a short thick man, brown hair'd, a reddish beard, goeth bending forward with his knees, the forefinger of his left hand*

*crooked. Whoever gives notice of him ... shall have a Guinea Reward and reasonable charges.<sup>3</sup>*

It is interesting that they only describe him by his physical characteristics and make no mention of any mental features. However clearly money had been paid to put him there and his friends wanted their monies worth.

In the 1734 enquiry into Somerset charities, the master David Thomas stated that

*There is a nurse that makes it her whole business to attend the poor persons at the hospital; they have constantly their bellies full of wholesome dyet; they are not troublesome to any of the Town and they have things befitting persons in their circumstances.<sup>4</sup>*

He is clear – the important things are that they were fed well and do not trouble others, at a time when Bath was renowned for its beggars.

Bath had tourists and the Magdalen Chapel was notably old as well as on the old road out of Bath to Wells. It is therefore interesting to see how little it features in personal accounts of Bath, with only Wood's account known. However, it does appear in guidebooks.

The first extensive guide to Bath was published in 1743, aimed at the new horde of wealthy visitors. It is the first to mention the hospital and to call the inmates 'Idiots':

*St Mary Magdalen's Hospital is a poor Cottage ... built for the Reception of Idiots, but there are few maintained therein; the Nurse's Stipend for the Support of herself, and the People under her Care amounting to no more than £15 a Year: ... whoever enters it will see enough to cure his Pride, and excite his Gratitude for the Blessings he enjoys.<sup>5</sup>*

It is clear that tourists could enter and see the inmates. The nurse is clear on how little



she gets, so one presumes donations were always welcomed by her. Had Anthony Wood made a donation 70 years earlier?

A smaller guide book of 1755 is dismissive:

*St Mary Magdalen's Chapel is situated under Beachen-Cliff, and is now called the Maudlin's. Here is a Hospital for Idiots; but it makes so indifferent a Figure, as to be scarce worth Notice...*<sup>6</sup>

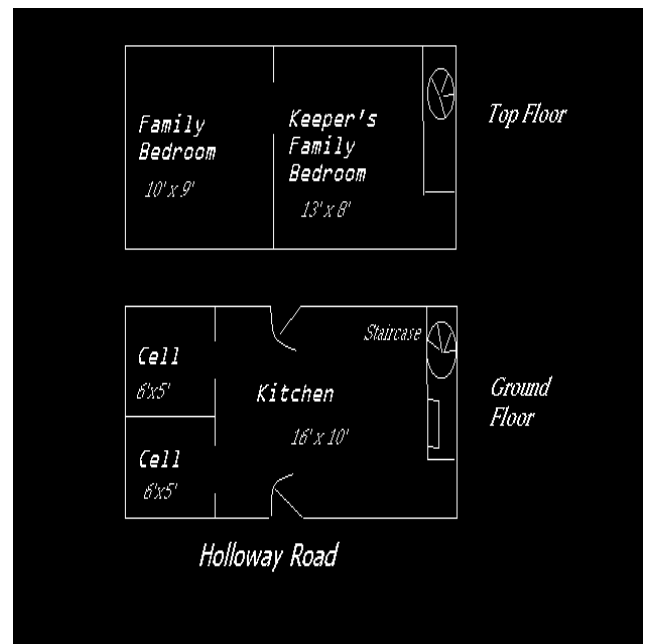
In 1761 the rector and master Duel Taylor rebuilt the collapsing hospital cottage. This is the building we currently see with a plaque above the door stating it was rebuilt in 1761. During renovations in the 1960's a larger plaque was found indoors, sited to be seen as one entered the building, commemorating Duel Taylor's work and calling the place a 'morotrophium' – an invented latin word derived from the Greek word *moros* meaning foolish or stupid, (and from which the word 'Moron' was derived in 1910).



Duel Taylor's 1761 Hospital in modern times



*The commemorative interior plaque: It can be translated as: In the year of Salvation 1761 not long after the inauguration of our most auspicious George III; this Home for Idiots, founded 270 years ago by John Cantlow, Prior of Bath, almost collapsed with age, rebuilt by Duel Taylor, Rector of Bath and Master of this Hospital.*



A rough plan of Duel's morotrophium

In 1806 the one remaining inmate died, and the local paper commented:

The poor inoffensive idiot whom the passenger may have seen for



nearly half a century past sitting at the door of the Magdalen Hospital in Holloway, died last week, aged 92. He has been for some years the only patient supported in that institution and we doubt not that the intention of the benevolent founder will be fulfilled by the speedy appointment of some other proper object to fill the vacancy.<sup>7</sup>

A later report to the Charity inquiry notes that the man died aged 95, after 75 years in the house'.<sup>8</sup> So he was in the house from about 1730, was there when all the guidebooks were written and when Duel Taylor rebuilt it. He must have become a recognised character in Bath. He belies the idea that life was always short in Georgian England if you were disabled.

No one was admitted after the admission fee was declared illegal in 1833. The charity was dormant until in 1891 it was merged with the *Bath Idiot and Imbecile Institution* [founded April 1846, but that is another story] as a new educational charity for 'Imbeciles' – the Magdalen Hospital School. The school eventually closed but the Magdalen charity still exists and gives grants to local children with special educational needs.

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<sup>2</sup> A Clark (Ed.), *The Life and Times of Anthony Wood, antiquary, of Oxford, 1632 - 1695, described by Himself*. Volume II 1664 - 1681. Oxford Historical Society xxi (1892) p409-10.

<sup>3</sup> *London Gazette* 15th - 18th Jan 1699/1700 number 3567 page 2 *Advertisements*.

<sup>4</sup> Bath Record Office: *Enquiry into Somerset Charities*. 1734-5. Volume 1 page 80-85.

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<sup>5</sup> J Wood *An Essay towards a Description of the City of Bath*. (First edition Bath: W Frederick, 1743) Part 2, page 66, Repeated on page 306 of Second edition 1749.

<sup>6</sup> Anon., *The Bath and Bristol Guide or the Tradesman's and Traveller's Pocket Companion*. 3rd edition (Bath: Boddely, 1755) page 16 - entry repeated over the many reprints and related guides until 1762.

<sup>7</sup> *Bath Journal* Monday 28 July 1806 page 3e.

<sup>8</sup> *Sixth report of the Commissioners of Inquiry concerning certain Charities in England and Wales* (British Parliamentary Paper 1822 (12) IX 1) page 737

# "Money from Misery?"

Book review of James Davies,  
**Sedated: How Modern Capitalism  
Created our Mental Health Crisis**

Atlantic Books, Main edition, March 3,  
2022.

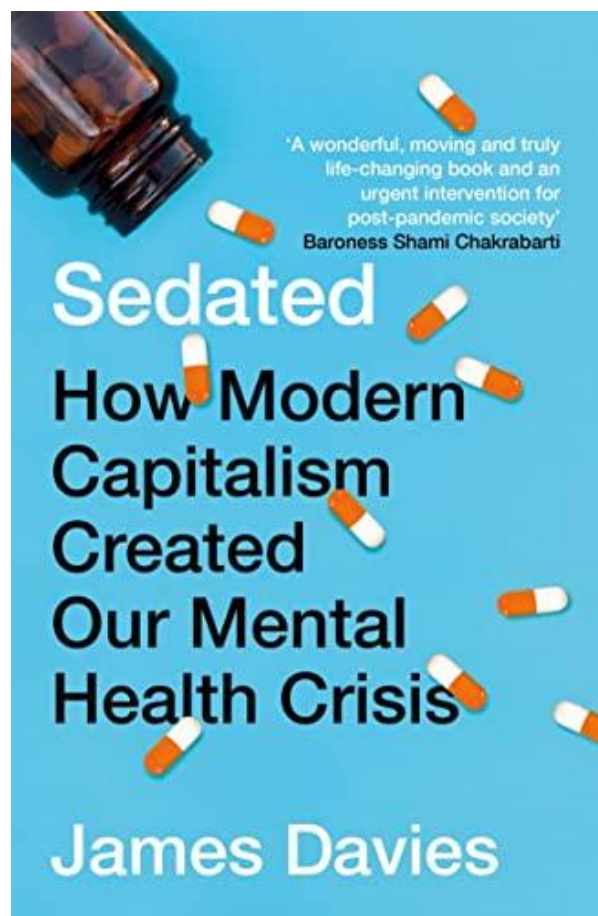
ISBN 9781786499875 £10.99  
(paperback)

**George Ikkos**

Immediate Past Chair, RCPsych HoPSIG

**Paul St John Smith**

Chair RCPsych Evolutionary Psychiatry SIG



James Davies is Associate Professor in Medical Anthropology and Mental Health at the University of Roehampton, a qualified psychotherapist who has worked in the NHS, and a co-founder of the Council for Evidence-Based Psychiatry (CEP). His clearly written and

engaging book is addressed to a broad public. Though he offers significant international perspective, the focus is on British society since Margaret Thatcher's neoliberal reforms, beginning in the 1980's. Along with many commentators Davies perceives an essential continuity with Tony Blair's succeeding Labour governments, especially in health policies. Labour governments' injection of cash in the NHS, which undoubtedly made a positive difference, is nevertheless consistent with Davies' thesis (1). Since 2010, things have only got worse (2).

## **Neoliberalism as a Nosogenic Agent in Mental Health**

As Davies reminds us, at the heart of neoliberal reforms has been a profound move away from communal values and towards unbridled individualism. Margaret Thatcher and her ministers viewed the state as the enemy and sought to diminish it, despite being at its helm. Their emphasis has been to reduce regulations and taxation to free individual initiative and reap the rewards of creative enterprise, or so they have argued. An often-observed outcome has been the staggering increase in social inequality. *"While in the late 1970's the top 5 percent of British households had an income four times higher than the poorest 5 per cent, that gap would gradually widen over the subsequent decades to reach the ten times difference we endure today"* (p. 307). This, as Wilkinson and Pickett (3) originally demonstrated and Davies updates, has been seriously deleterious to numerous social outcomes, including mental health.

The author being an anthropologist, it should not surprise us that one of the strengths of the book is interviews with a variety of stakeholders in different fields and at different levels of seniority, including those on the frontlines. For example, through an interview with Margaret Thatcher's fawning biographer Charles Moore [Ch. 9] he establishes that she wanted to change the personal values of people even more than to change the economy. She had hostility towards collectivism which she famously turned against trade unions. Self-

defeatingly, one key consequence has been to depress salaries which, in turn, has meant that large swathes of the population have not had the cash to purchase the commodities on the sale of which entrepreneurs depend for making profit. The neoliberal solution to this conundrum has been a massive increase in debt. Debt is both a risk factor and outcome of ill mental health. The debt “solution” ultimately resulted in the mortgage default crisis and the international financial collapse in 2008 from which we have not recovered since.

If the above is a previously told story, the contribution of Davies includes detailing some of the day-to-day consequences. For example, in a very disturbing chapter [Ch. 4] he reports on how the unemployed in Britain are compelled to attend courses provided by a multitude of private contractors to the state as part of its workfare programmes. There they are told that they can all achieve anything they want and that if they do not it is their fault. Failure to attend or even the temerity to object to this traumatising ideological nonsense risks suspension of their benefits. It is not too farfetched to state that this is brainwashing on behalf of the neoliberal state the scale of which would be familiar to its now demised communist opponents. The impact on their mental health is predictably detrimental. Similar processes occur in the workplace where the increasing mental distress generated by the rigidly regimented working environment is attributed by “workplace wellbeing” contractors to the employees’ personal failures. In the process all these providers make a handsome profit.

### **Neoliberalism and Mental Health Services**

Over the years, because of the reforms there has been increasing mental distress leading to increasing public interest in mental health. At the heart of Davies’ protest is how the “mental health” discourse and systems have failed to recognise and appropriately address the fact that the marked increase in individual distress is secondary to social and political choices. Instead, they have pathologised (medicalised) it through individualisation of psychopathology.

The charge is that services have gone to great lengths to place themselves directly at the service of neoliberal values rather than challenge them for the mental hardship they cause. Persuasive evidence is the development of the NHS IAPT psychological therapy services (Ch. 5). An explicit rationale for their funding has been that they would help return people to work. This trumped considerations such as mental health needs and client preferences with respect to treatment and evaluation. Davies offers evidence that they provide an unreasonably narrow range of treatments that in practice have been found to be (largely) ineffective and not contribute to higher rates of return to employment. Most damningly he reminds us of evidence that the statistical returns that these services provide to the service purchasing funders have been doctored. Most alarmingly, but perhaps predictably, the performance targets and obvious inadequacy of the system in the face of diverse and serious client distress cause high rates of mental ill health in IAPT staff!

Of course, the target driven culture is not unique to IAPT but widespread, beginning at school. It is a key contributor to the increasing prevalence of mental ill-health. In many areas, including mental health services, it is also a cause of deterioration in performance (4).

### **Neoliberalism      Psychiatry      and Psychopharmacology**

A central target of Davies’ criticism is psychiatry, which he identifies with psychopharmacology. He reads the history of psychiatry as showing that, repeatedly, it announces grand solutions with fanfare, only for these to be found wanting, even harmful in the long term. Past examples have included the touting of asylums as therapeutic environments in the 19th century, and psychosurgery and insulin coma for schizophrenia in the 20th. Could it be that even allowing for some short-term positive effects, the overall effect of psychotropic medication will be ultimately assessed as negative in the future? After all Tomas Insel, former Director of the National Institute of Mental Health, and strong advocate for biological psychiatry at the

time has turned sour on outcomes (p. 61). Robin Murray, Professor of Psychiatric Research at the Institute of Psychiatry, Psychiatry and Neuroscience, has counselled caution too (5, 6).

As such criticisms will likely raise hackles in some readers of this newsletter, it is important to highlight that Davies, in brief asides, explicitly disavows the reduction of mental distress simply to social determinants (p. 319). Furthermore, he accepts that some “drug use for short-term stabilisation of the most severe forms of distress” (p. 72). Interestingly he also makes no criticism of ECT.

A list of some of his key criticisms includes the following:

The neoliberal reforms have led to increasing prevalence of phenomena that meet diagnostic criteria for “mental disorder”. However, because the increase is due to social change rather than the spread of some “disease”, it is inappropriate to situate the locus of disturbance in the individual. This misplacement serves the interest of the neoliberal system and removes or blunts opportunities for protest to rectify the prevailing disturbance at its social roots: i.e., the population is “Sedated” as per the book’s title.

Considering the above, the massive increase in prescription of antidepressants (in the UK from less than 24/1000 to almost 60/1000 between 1991 and 2014) (p. 49) has not best served the interests of the patients, but of neoliberal capital. This latter includes the pharmaceutical industry which has reaped enormous gains.

A telling example he offers in support of this case comes from India. Genetic advances led to overwhelming corporate control of farming through the issuing of exclusive patents for genetically modified seeds and, consequently, farmer destitution because of power imbalance. As a result, there was a marked increase of farmer suicides. The government’s response has been to promote diagnostic vigilance for depression and advocate increase in antidepressant prescribing! (p. 232)

Though psychotropic medication may sometimes be helpful in severe short-term depression and psychosis, it may be ineffective or harmful in the longer term argues Davies (Ch. 2).

In support of ineffectiveness, Davies emphasises that the same countries that have experienced the explosion in antidepressant prescribing have also experienced a parallel leap in disability claims for mental illness. He explains that if antidepressants were effective, one would expect to have seen a reduction in disability. This is a reasonable argument as, even if one counters that there have been improved detection levels, the parallel rise does little to reassure about the effectiveness of ensuing treatment.

The response of psychiatrists to antidepressant withdrawal phenomena which were described decades ago has been slow, evasive, and inadequate. He suggests that too often withdrawal has been mislabelled as discontinuation syndrome or relapse or simply, not recognised at all. We will not discuss this important contentious area further here but note the reasonable concern.

He also cites research on outcomes in schizophrenia and antipsychotic prescribing which suggest that these medicines do more harm than good when continued long term (see 7 and 8 for updates on Harrow’s and Whitaker’s theses; also, note responses in same journal). We will discuss this issue below.

## **Psychiatric Evidence**

How might psychiatrists respond to the above? With great interest! It is important that in view of appalling elements in our history we reflect broadly on the function of our specialty in our society generally. Davies’ evidence concurs with our experience that the changes we associate with neoliberal society have caused misery and mental ill health and that the excessive attribution of disturbance to the individual serves the system better than the patient. Indeed, we would go as far as to interpret the recent history of psychiatry and mental health in Britain (9) as convincingly showing that, whatever benefit it may have brought to patients (and it has brought some),



it is better designed to serve the interests of capital than the patients themselves.

And how might psychiatrists evaluate the evidence? With a clear mind. Davies marshals enough evidence to raise concerns. Such concerns are unlikely to go away, not least in relation to psychotropic medication, because we have failed so far to define the specific nature and boundaries of mental illness. Have we really made progress in this respect since 1799 when James Sims' defined madness as 'the thinking, and therefore speaking and acting differently from the bulk of mankind, where that difference does not arise from superior knowledge, ignorance, or prejudice' (quoted by Shorter in 10)?

Having said that, the author is somewhat careless and selective with the facts in support of his thesis. For example, however well this might fit with his condemnation of antidepressants, to our knowledge thalidomide (pp. 191-3) was never marketed as an antidepressant. As another example, although the concerns about long term use of antipsychotics do have foundations in evidence, other more reassuring evidence is passed over in silence (11, 12). Such silence may serve well the purpose of simplicity in a polemical work aimed at the general reading public but undermines the author's credibility in medical discourse and health policy decision making.

One of the weaknesses of "Sedated" is that although it includes a helpful interview with a psychiatrist, the well-known critic of the diagnosis and pharmacological treatment of ADHD Professor Sam Timimi, this provides too-narrow a perspective from the clinical point of view. For example, having agreed that psychotropic medication is necessary in acute psychosis, including but not limited in response to violent conduct and associated risk, and having agreed that ideally medication use must be kept to a minimum, such a colleague would have highlighted experience where termination has taken place, either against medical advice or in concordance between patient and psychiatrist, where the results have been

catastrophic. This is a tragedy for the patient and loved ones and sometimes others too. In such cases, all too often recriminations begin even sometimes by patients who take legal action after they have stopped medication against advice! But they are not alone: family, GP's, the press, and politicians are all too ready to heap blame on psychiatrist or social worker, especially when there has been fatality (13). The very clear clinical problem here is that we do not have robust criteria on which to base decisions to reduce or stop medication. It is important that the profession recognise the legitimacy of concerns over long term use of medication, without rushing to any premature and ill-considered wave of medication discontinuation. There is a need for well-designed research to address issues of effectiveness, safety, withdrawal, and harm in relation to these.

### **Psychiatric Solutions**

The book's limitations notwithstanding, to the extent that the argument is valid, what is the solution? We concur that any complacency about the rise of psychopharmacology is counterproductive, including to the reputation of our profession. Reassuringly, the recent acceptance and embrace of need for action in relation to the social determinants of mental ill health (14) is most welcome. For this to be effective the profession needs to abandon "aspirations" to "political neutrality". Science and politics are not divorced. Without necessarily being "party political" we must make political points. Davies suggests that a solution might be grassroot organisation and protest, inspired by the "me too" and "black matters matter" movements. We concur and the profession must not keep aloof but actively seek to work together with the service user movement in genuine partnership whenever possible (15). Early and persistent familiarity with the field of "mad studies" will help in this (16). Equally importantly, we have previously argued that psychiatrists need to recognise that "affect\*", not the brain" is the object of special medical clinical expertise of psychiatrists (17,18).

### **Conclusion**

There has been excessive medicalisation of psychiatry since DSMIII in the 1970's, and the technological progress that led to the "decade of the brain" in the 1990's. The overwhelming focus of billions of pounds of research funding by the National Institute of Mental Health (NIMH) on narrowly conceived biological research which continues to this day has damaged the reputation of the profession, even if it has raised expectations in some. To balance our attention with increased emphasis on psychosocial factors is not anti-biological. Evolutionary theory and research have compelling arguments that social aspects of our lives are still pivotal to the causes of mental disorders, as well as wellbeing and failure of organisations or psychiatrists to address or to work with social components of a patient's problems massively reduces the effectiveness and worth of psychiatry (19).

Finally, though "Sedated" may do a service to the profession, despite, or perhaps because of the enthusiastic response it has received more widely, selective presentation of evidence and lack of nuance at times diminishes its service to the general public. After all, the increase in prescription of antidepressants may not only be the result of the processes outlined by Davies, but also for reasonably straight forward medical factors, such as the relative safety of SSRI's compared to TCA antidepressants in overdose (20). Still, even if one accepts this and other psychiatric objections, much remains of relevance to psychiatric thinking and practice. Both hit and miss.

\*NB: Affect here does not specifically refer to affective disorder nor to affect as it is defined in the psychiatric literature on phenomenology and mental state examination (see Thompson, E. Primordial Dynamism: Emotion and Valence, Ch. 12 in *Mind in Life: Biology, Phenomenology and the Life Sciences*, Harvard UP, Mass, 2010; and Bennett, M. R., Hacker, P.M.S. (2007) *Emotion*, Ch. 7 in *Philosophical Foundations of Neuroscience*, Blackwell, London). Rather, it is defined as feelings, emotions and agitations and its impacts of thoughts, behaviour and relationships (17, 18).

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**Conflicts of Interest:** none declared

## The Authors

George Ikkos is a Consultant Liaison Psychiatrist at the Royal National Orthopaedic Hospital, immediate past Chair of the Royal College of Psychiatrists History of Psychiatry

Special Interest Group (HoPSIG), former President of the Royal Society of Medicine Pain Medicine and Psychiatry Sections and joint editor of the online Open Access book Ikkos, G., Bouras, N. (2021) *Mind State and Society: Social History of Psychiatry and Mental Health in Britain 1960-2010*, Royal College of Psychiatrists and Cambridge University Press, <https://doi.org/10.1017/9781911623793>

Paul St John Smith is a retired Consultant Psychiatrist, Chair of the Royal College of Psychiatrists Evolutionary Psychiatry Special Interest Group (EPSIG) and joint editor of *Abed, R., St John Smith, P., (2022) Evolution and Psychiatry*, Royal College of Psychiatrists and Cambridge University Press, in press.

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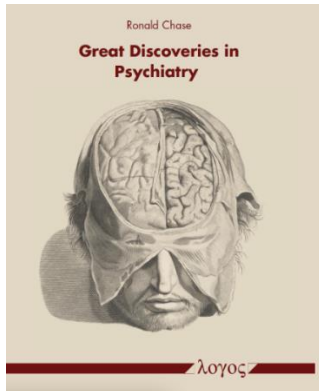
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# Great Discoveries in Psychiatry by Ronald Chase

Tom Burns



I'm sure anyone interested in the history of psychiatry will enjoy this book. I certainly did. It has fifteen chapters, each telling in engaging detail the events and people involved in most of the landmark discoveries in our

discipline. This is robust narrative history, with each discovery presented within its relevant context (both professional and social) but paying close attention to the personalities and quirks of the key individuals before rounding up with Chase's 'perspective' on its impact. I particularly valued realising how my own understanding of several of these events had often become distorted over the years (a bit like errors accumulated by bored monks transcribing medieval manuscripts). I had, for example, totally muddled key stages in the discovery of chlorpromazine and its testing by Laborit, Delay and Deniker.

The book covers all the anticipated discoveries: antipsychotics, ECT, antidepressants, Lithium, autism and modern genetics. Chase is scholarly and thorough, without being prolix or pedantic. The odd 'folksy' turn of phrase attests to his commitment to widening public awareness of these important events but doesn't jar or get in the way of clear descriptions of complex issues.

Chase is clearly of a 'biological' disposition when it comes to his assessment of psychiatry's progress. Personally, I was a bit disappointed that there were only two chapters dealing with psychological or social advances (Moral therapy and Freudian psychotherapy). I thought he was a bit

ungenerous to Freud; like him or loath him he made a massive difference. I wondered also if the development of the Therapeutic Community by Tom Main and Maxwell Jones in WWII might have warranted a chapter, given its persisting impact on institutional care and the stimulus it gave to multidisciplinary working.

A particularly enjoyable feature of this book are the wonderful (and well chosen) photographs that pepper the chapters. My favourite is the comfortable, smiling face of 82-year-old Donald Triplett, retired bank worker and keen golfer. It was Triplett, as a mute five-year-old, who sparked Kanner's investigations into autism. The photograph of Eduard Pernkopf's inauguration as dean of the University of Vienna's Medical School in 1939, flanked with swastika banners and with the whole lecture hall standing to give the Nazi salute, is truly chilling. It gives substance to the unvoiced, but unavoidable, evidence in this book of the massive contribution of the German Jewish diaspora to psychiatry.

I have one major criticism of this excellent book. Chapters one to eleven do deliver exactly what the title promises, but not the last four. I mentioned Chase's biological bent earlier and I think it lies at the root of this enthusiastic foray into current neuroscience developments, and some well-trodden thoughts about the diagnostic difficulties posed by schizophrenia, in chapters twelve to fifteen.

Historians are at their best in interpreting the past, not the present. I think it is a pity Chase did not stop at chapter eleven, with the discovery of the antidepressants. The great thing about the past is that one can draw some relatively confident conclusions about the subsequent impact and current importance of the events related. Endophenotypes and saccadic eye movements are undoubtedly interesting in their own right, but there is precious little evidence yet of them changing psychiatry. As someone who has spent 40 years in clinical practice, constantly in the shadow of some hyped 'revolutionary neuroscience



discovery' that will 'change everything", I'd rather wait and see.

Overall, this is a book to really enjoy for those already interested, as I guess most reading this review are. The style is engaging and allows for different levels of familiarity with the material, and individual chapters are brief and vivid. I fear, sadly, that the unfortunate choice of cover may limit the number of casual browsers who pick it up and buy it. This is a pity as there is so much to learn in it and I'm sure they would enjoy it.

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# Psychiatrist in the Chair: The Official Biography of Anthony Clare

Brendan Kelly and Muiris Houston, 2020, Merrion Press, pp. 292.

## Graham Ash

*\*Richard Mindham's review of AC's biography, 'Psychiatrist in the Chair' appeared in the Autumn Newsletter 2021.*

Anthony Clare was so ubiquitous a figure when I was training that I am sure that I once heard him speak at a conference in Dublin, but equally I cannot be sure whether this memory is but a figment of my own imagination. He was the ever-present public face of psychiatry in the UK and Ireland in the late twentieth-century. He came to prominence following the publication of his best-selling book, 'Psychiatry in Dissent' in 1976, and through his writing and broadcasting remained a high-profile media figure until his celebrated radio show, 'In the Psychiatrist's Chair' ended in 2001. His career took dramatic and unexpected turns, and he played a significant role in the foundation of the College and later in medical education in Britain and Ireland. In the recent history of psychiatry in the UK, he remains an esteemed yet enigmatic figure.

This is the first biographical account of Anthony Clare's life and eminent career to be published. Or perhaps careers as he had several, a talented student and debater, then clinical psychiatrist, academic and scientist, writer and broadcaster and would-be politician, as well as husband to his wife Jane and father to their seven children. Brendan Kelly and Muiris Houston, his biographers, are distinguished in their fields of academic psychiatry and medical journalism. They ask: 'Who was Anthony Clare? What drove him? And what is to be learned from his life, his career, and his

unique, sometimes controversial legacy to our understanding of the mind?'

Their fascinating, yet sometimes frustrating biography synthesises Clare's own writings, academic and journalistic, public, and family records, and specially conducted interviews with Jane and close family members, friends and colleagues, former patients, even public figures who were amongst his broadcast interviewees. Their response and account of Clare's life is certainly based on extensive research. However, in the face of so much primary information the biographical narrative sometimes loses its coherence although containing considerable material of interest to historians. There is a chronology and comprehensive bibliography of Clare's academic and journalistic work together with 300-plus endnotes.

His biographers acknowledge the help and support of Clare's family which has given them access to much interesting reflection and anecdote. I am not sure whether this gives rise to the sub-title, an 'Official Biography'. Kelly and Houston have not allowed themselves to conjecture on Clare's life and career. Instead, they maintain a respectful distance whilst presenting a remarkably forthright and 'scientific' account which focuses on their subject's undoubtedly eminent qualities, only rarely allowing a critical voice to emerge. Their collation of evidence about Clare's life and works is nevertheless so rigorous and meticulous that this biography stands as an indispensable resource.

Several chapters are written thematically, on Clare's writing of 'Psychiatry in Dissent', on his celebrated career in radio and television broadcasting, and on his return to Dublin from London in 1989. I feel these are amongst the more successful sections of the biography. I found the discussion of his return to Ireland particularly interesting. His unanticipated decision is framed by his biographers as fitting into a pattern of deference to the significant women in his life and primarily in accord with his wife's longstanding wish to return home. I would nevertheless have liked to have read more

about other factors in his decision. Clare held ambitions to help improve psychiatric training and services in Ireland and he had an active interest in entering politics in Ireland, although he was ultimately unsuccessful in this venture. The possibility of unhappiness in his academic department at Barts is raised but perhaps underplayed, as is his reaction to wider political events in Britain and the major NHS re-organisations that were impending.

There is much material that helps to explore and understand Clare's motivations, one of the aims of this work. The politician, Anne Widdecombe appeared 'In the Psychiatrist's Chair' in 1997, recalling that she saw Clare as being primarily interested in other peoples' motivations. Commentary in greater depth on the drivers of Clare's success nevertheless does not strike me as a particular strength of this biography. I can only attribute this surprising paradox to the great difficulty of describing and defining a figure so celebrated and successful in many different fields. Readers will need to work hard and come to their own conclusions.

To conclude, had he come to prominence in recent times, Anthony Clare would surely have been awarded a distinguished Professorship in Public Engagement and Psychiatry. He would have been relieved of the need to teach, research, lead a university department and do clinical work on top of his prolific media presence. Perhaps this would also have saved him from the sense of dismay he experienced at the end of his amazing career. Unfortunately, we will never know. As Professor Anthony Mann said of him (p.212) -

'Tony's talents were in the media, lecturing, writing and broadcasting - and he was brilliant at all of that.'

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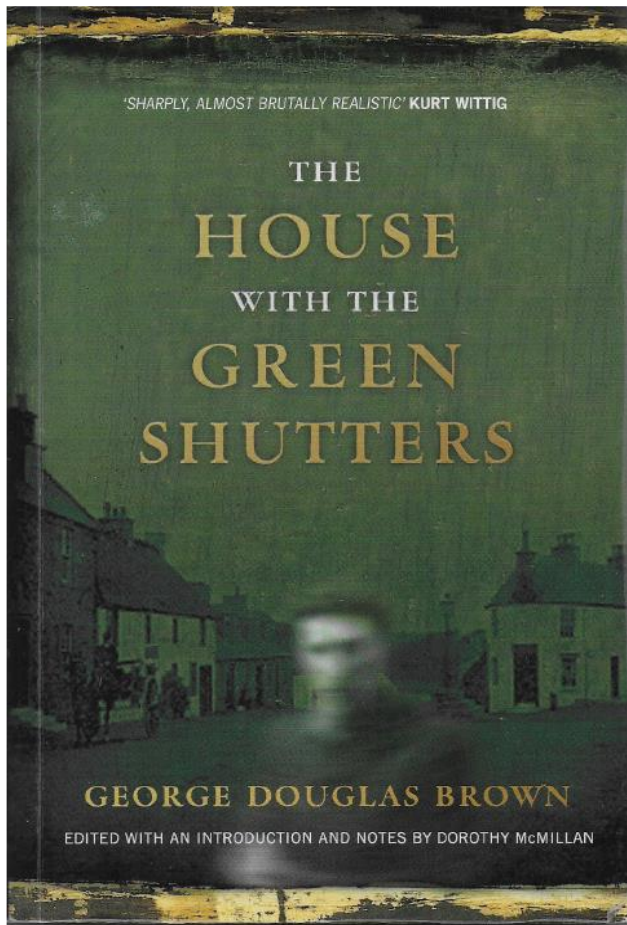


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views or just say Hi!**

# The House with the Green Shutters by George Douglas Brown

First published in 1901; this edition, Edinburgh, Polygon edited by Dorothy McMillan with introductory notes, 2020. ISBN 978 84697 5387.

**R.H.S. Mindham**



This book is well known in Scottish literary circles having been a set book for courses and examinations in schools and colleges. It belongs to the 'kaleyard' school of literature,

which was active in the late nineteenth century onwards and is defined by the Oxford Dictionary as: 'writers of fiction describing, with unsparing use of the vernacular, common life in Scotland'. There were contemporary parallels in the artistic world in which the Glasgow Boys<sup>1</sup> and the Scottish Colourists<sup>2</sup> depicted ordinary life, often in the open air.

The story is set in rural Ayrshire in the fictitious small town of Barbie on the brink of industrialisation. The author presents a grim psychological drama. There is extensive use of an Ayrshire dialect which requires many readers to use the glossary. The central figure in the story is John Gourlay, the owner of a haulage business which provides local delivery services and has a monopoly on the carriage of stone from the local quarry. He is proud of his success and ability to dominate the inhabitants of the town, with no consideration for the welfare or feelings of others. His success is represented by his ownership of 'the house with the green shutters' which is allegedly the best house in the town, set in a prominent position. He is also proud of his horses and carts which are the basis of his business. He dominates his poor wife, his sickly daughter, and his feckless son.

A group of the male townsfolk known as 'The Bodies' meet in the main street and taverns where they discuss local events in detail. Their judgements are not generous. Members include the Provost, the Deacon, the Minister, the doctor, farmers, shopkeepers, and tradesmen. There are distinct, if unstable, hierarchies in the group. The Minister frequently repeats his advice: 'At the Day of Judgement, my friends, every herring must hang by his own tail.' The Bodies have been compared with the chorus in a Greek play but in some respects, they are like a therapeutic group in that their

<sup>1</sup> The Glasgow Boys were a circle of influential modern artists and designers working in Glasgow in the late 19th century. [The Glasgow Boys | National Galleries of Scotland](#)

<sup>2</sup> The Scottish Colourists were a group of four Scottish painters active in the early twentieth century: They were influenced French artists' bold use of colour and free brushwork. [Scottish Colourists | National Galleries of Scotland](#)



discussions also reflect interactions between them.

James Wilson is a newcomer to the town and is the son of the area's mole catcher. From this modest background he establishes a retail emporium and a haulage business in competition with Gourlay. Wilson recognises opportunities arising from the development of coal mining and the railways which have escaped Gourlay. He also has a highly competent and feisty wife who greatly supports his business initiatives. He competes successfully with Gourlay and then overwhelms him. This rivalry is played out in competition between their sons. Both are sent by their fathers to the local academic fee-paying school where young Wilson thrives and young Gourlay falters. Ritual corporal punishment is part of the educational regimen. The problem is compounded when Gourlay sends his son to the university in Edinburgh in the hope that his modest abilities will fit him to become a minister of the church. Gourlay junior is not successful in Edinburgh and is expelled from the university. His problems are intensified by alcohol and money lenders.

When Gourlay junior returns home he has to face the wrath of his father. A serious row breaks out leading to violence in which Gourlay junior strikes his father with the poker. Gourlay falls and sustains a fatal injury. In the horror which follows, Gourlay junior, his sister and his mother all commit suicide by poisoning. They are discovered by the postman.

The personalities of the characters and their emotional experiences are described in vivid detail. Many of the defence mechanisms described in psychoanalysis are displayed in individuals and among The Bodies. Gourlay experiences extremes of emotion and at times has paranoid ideas and hallucinations, whilst Gourlay junior experiences acute intoxication and delirium tremens.

The author, George Douglas Brown, was the illegitimate son of a farmer. He showed

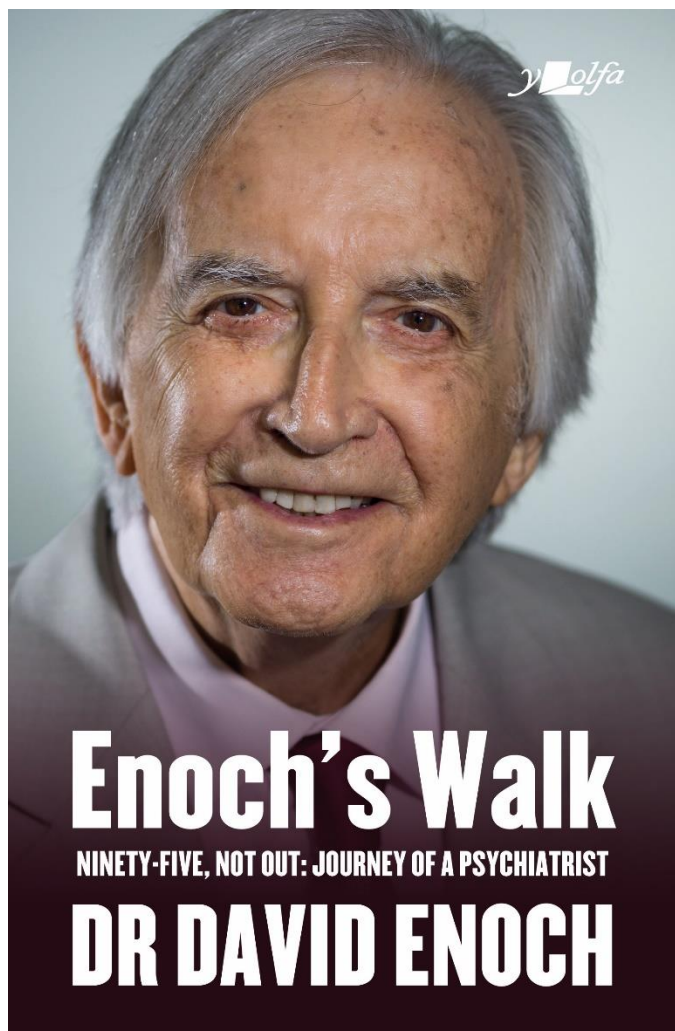
academic abilities at an early age which took him to the universities of both Glasgow and Oxford, although sadly died at the young age of thirty-two, meaning that he didn't go on to write more books. The book is brilliantly written and deserves to be read beyond Scotland.

# Enoch's Walk: Ninety-Five, Not out: Journey of a Psychiatrist by David Enoch

Y Lolfa: Talybont, 2021

**Claire Hilton**

Historian in Residence, RCPsych  
[claire.hilton6@gmail.com](mailto:claire.hilton6@gmail.com)



For glimpses into the worlds of coal mining in South Wales, military service in India (1945-8), psychiatric hospitals, clinical work, mind, brain, consciousness, God, Christianity and much more between 1926 and 2021, one has to look no further than *Enoch's Walk: Ninety-Five, Not out: Journey of a*

*Psychiatrist*. At 95 years of age, with two books published since 2020 (this one, and *Uncommon Psychiatric Syndromes* [5<sup>th</sup> edition]<sup>1</sup>), and two more planned, David Enoch is certainly "Not out". Yet he candidly expresses thoughts about "being out" one day, as well as his emotions associated with life's good times and with struggles, losses, and errors. Fortunately for me, David wrote the book in his second language, English, rather than his first, which is Welsh. Fortunately, too, it costs £14.99—and I'd like him to tell me the secret of how he managed to get an attractively colour-illustrated 368-page book published to retail at that price!

David had a humble start in life in a Welsh mining village. His father hewed coal underground, and survived dangers in the mines, but succumbed to pneumoconiosis caused by the deadly dust. The family was close knit and devoutly Christian. David writes about his faith as much as his psychiatry. Both are integral to his identity, and his career as a lay preacher, ministering to people's spiritual needs, has been even longer than his career in psychiatry.

When David started in psychiatry in the mid-1950s, the Lunacy Act 1890 (amended 1930) was still law, neuroleptic and antidepressant medications were new, there was little coordinated post-graduate training, and pre-RCPsych, there was no membership examination. He vividly describes the psychiatric environments in which he practiced, from Victorian "bins" in England and Wales, to a purpose built psychiatric "Professorial Unit" in Liverpool in the 1970s, and psychiatric hospitals, some behind the times, and others, such as at Runwell, with a strong research ethic. From 1963 until 1974 he was consultant at Shelton Hospital, Shropshire:

an old mental asylum stuck firmly in the practices of the 1930s and '40s. It was, for all intents and purposes, a town within a town. Within its high walls was the main hospital building, a modern building for occupational therapy, a farm, a cricket pitch,

a church, shops, an entertainment hall, and immaculately kept grounds. At weekends, dances were held at the hall for patients, and various celebratory activities took place throughout the year, such as at Christmas time.

As a young consultant, David had to put his hand to what today are considered specialties within psychiatry, including forensic psychiatry, and liaison psychiatry when general hospitals were located often miles from the psychiatric hospitals. His patients were all ages, from children to advanced years. His many case studies are fascinating, informative, and hopefully sufficiently anonymised. He presents some where he made clinical errors. We can all learn from these, on specific points as well as on the broader art and value of being reflective about our own working practices.

An innovative leader, he also had a hand in the development of psychogeriatrics. He chaired a group of geriatricians and psychiatrists in 1968-70 which devised a scheme for creating and providing comprehensive, dedicated community and hospital integrated psychiatric services for older people.<sup>2</sup> In 1972, before the RCPsych old age psychiatry "Group" (now Faculty) began, his report led to the British Geriatrics Society approaching the RCPsych about improving psychiatric-geriatric collaboration.

Teaching medical students and junior doctors was another passion. He was clinical tutor at Shelton, where he introduced regular teaching sessions for junior doctors. He was senior clinical lecturer at Liverpool

University while being the only consultant psychiatrist at Liverpool Royal Infirmary. His radio broadcasting was an extension of his teaching and preaching, as were his schemes, described with their pitfalls and successes, of working with church leaders and members to give them pastoral care skills to offer emotional support to others in their community. The opportunities and challenges he describes may resonate with psychiatrists who are involved with faith communities today.

David is a seasoned author of books on various aspects of psychiatry and Christianity. His most well-known psychiatric text is *Uncommon Psychiatric Syndromes*. It stemmed from a fascination about Capgras syndrome after he presented a patient with the condition to his consultant while a junior doctor. The first edition, published in 1967<sup>3</sup> when he was four years into his busy first consultant post, included contributions from two other psychiatrists in the Midlands, Professor William Trethowan and Dr John Barker – the latter's curious biographical study is due out later this year.<sup>4</sup>

David's very readable memoir avoids technicalities, gives many insights into psychiatry and religion, tackles controversial issues and is personal and compassionate. It conveys something of his great energy and perseverance and his love of life, his family, his faith, psychiatry, and his country—Wales. I warmly recommend it to entertain and inform, and for you to marvel at.

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<sup>1</sup> David Enoch, Basant K. Puri, Hadrian Ball. *Uncommon Psychiatric Syndromes* (5<sup>th</sup> ed). London, Routledge, 2020.

<sup>2</sup> M David Enoch, John Howells. *The Organisation of Psychogeriatrics*. Ipswich: Society of Clinical Psychiatrists, 1971.

<sup>3</sup> M David Enoch, WH Trethowan, JC Barker. *Some Uncommon Psychiatric Syndromes* (1<sup>st</sup> ed). Bristol: John Wright and Sons, 1967.

<sup>4</sup> Sam Knight. *The Premonitions Bureau: A True Story*. London: Faber and Faber (due out May 2022).

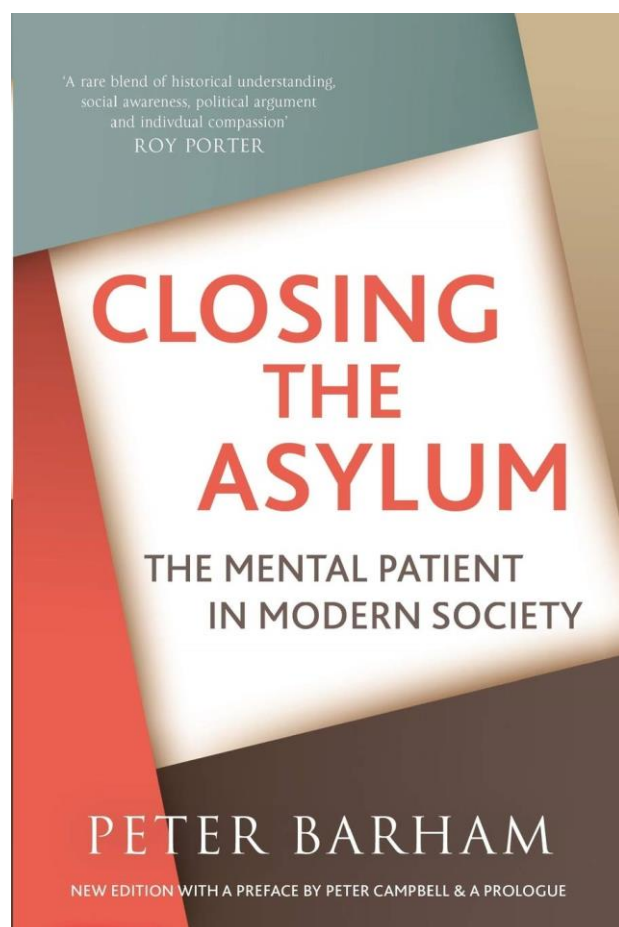
# Peter Barham, Closing the Asylum: The Mental Patient in Modern Society

New edition, London: Process Press Ltd, 3rd Edition, 2020. Pp. 226. ISBN 1899209212 £12.99 (paperback)

**Mutahira M Qureshi**

Co-Editor  
[mutahira.qureshi@kcl.ac.uk](mailto:mutahira.qureshi@kcl.ac.uk)

*A reflection*



Barham's book *Closing the Asylum* is a third edition of his original published by Penguin in 1992, where he provides an analysis of the process of asylum closure in Britain (c. 1950-1990) and its aftermath, on people's experience of mental illness, both individual

patients and society. The 2020 reprint was spurred on by the COVID-19 pandemic, which perhaps, better than anything in recent years, is bringing to the fore inequalities of health care, and the still great vastly indefinable divide between physical and mental health and the poorly understood twilight zone where they meet and traverse into each other's demarcated space. The new edition also contains a welcome accompaniment in the form of a preface written by Peter Campbell, a well-known and life-long mental health advocate and campaigner, born out of his own lived experience of mental illness. Although first published in 1992, *Closing the Asylum* is perhaps one of those books that is worthy of the description usually reserved for timeless historical works dubbed "as relevant now as in that time", earned equally from their superior writing and the resistance of their subject matter to fundamental change.

Peter Barham is a psychologist and a historian. In *Closing the Asylum* he delivers a complex and deeply explorative therapy in the guise of a history book. As a young psychiatrist, born post 1990 after the events of the asylum exodus in the UK that form the core of the book, I found Barham's book both humbling and difficult to read. I started off with a general desire to like the book, and I found myself disliking it instead; and in this dislike I found a genuine appreciation for the work. Perhaps this is why I liken it to therapy, as I was reminded of the words of my psychotherapy supervisor when I ran into a difficult patch with my first ever psychotherapy patient, that therapy is never supposed to be easy. It is supposed to be helpful, or that is the hope, but it is not supposed to be easy for either parties: the patient or the therapist. And for this reason, I believe that Barham's book should be read by all mental health professionals and policy makers attempting to delve into the complex phenomenon that is the care for those who suffer from mental illnesses.

The pièce de resistance of the book is the chapter where Barham explores the views of mental health service patients and takes us



into their world of hardships, some of which, sadly, are exacerbated by being in care. There is a patient who is refused a simple job at a bakery that he is more than qualified to do, there are former patients who are forcibly evicted from their hard-fought for home, and there is a patient who would rather suffer than come into the "system". These stories bring out Barham's true merit as the *vox sola*; a neo-revolutionary working to bring the narrative of the patients to light.

There has been a long tradition, perhaps dating to the earliest of civilisations, where mentally ill people had things done to them or for them, they had interventions imposed and the management of their illness unilaterally controlled by the rest of society. They were the Other, those less capable of managing their lives without support, or intrusion, depending on the perspective. It was difficult to read how these interventions impacted on those intended to benefit from them. Barham then ties this into the wider philosophical underpinnings of society's attitudes and perceptions towards mental illness that breed the hierarchical-paternalistic behaviour of institutions. He builds a rich and compelling narrative, with accomplished historian Roy Porter, sociologist Kathleen Jones, and anthropologist Elizabeth Bott being some of his most cited sources.

Ultimately, the point that Barham aims to make through the process of the book, is that community care was the beacon of hope that was supposed to empower mentally unwell people and bring them out of the asylum wherein they were otherwise doomed to disappear. However, things have clearly not gone to plan and the core features of the asylum era, in particular the stigma of mental illness and the perceived helplessness and limited control on their affairs felt by the sufferers is still very much the same. These changes, as Barham argues, do not take place in vacuum and the philosophical and unconscious mechanisms at a cultural and societal level all serve to bring this about. On this basis, considering

Barham's own vast experience straddling both the fields of history and psychology, and the research that has gone into bringing *Closing the Asylum* together I think that this work will remain a very important piece in the narrative of western psychiatric history for a long time to come.

However, Barham departs from a neutral detached narrator in this book and, whether driven by his passion or compassion, while on the one hand describing vivid and unforgettable characters in the shape of mental health patients, he inevitably falls in the trap that he wants society to eventually escape: the trap of us and them; the Other. In his narrative the Others are doctors and policy makers. Right at the very beginning Barham dubs the Others, in as condescending a tone as he believes doctors do their patients, "the misguided elite". Unfortunately, this tone continues unfettered throughout the book, where Barham comes very close to dismissing the clinical and scientific advances in the field of psychiatric research, almost praising the resolve of countries that refused to move away from asylum-practice, and at one point makes a very bold claim that outcomes of severe mental illnesses are better in the Third World. The last resonated deeply with me since I have had the opportunity of practicing psychiatry in Barham's Third World, more as boots-on-the-ground rather than the man-in-the-high-castle vantage of Barham's statement, and I can say for sure that this is remarkably different to the truth. As a matter of fact, when I moved to the UK to train in psychiatry, I found that none of my colleagues had ever seen the classic catatonic schizophrenia, those classic Kraepelinian 'Anglepoise sign' and 'psychological pillow' because it would be very unlikely for anyone in the UK to be left untreated or without care for long enough to worsen to that point. I suppose it is similar to the recent questions posed as a result of the sentiments aroused by the COVID vaccines: it is easier to forget the morbidity and the mortality before vaccines existed the further, we are removed from that period temporally.

In Barham's narrative doctors are blundering, superior, obtuse, and "duplicitous". While I can agree with his sentiment of holding the "powers" to accountability, I worry about the general public that has access to Barham's book. He is quick to repeatedly identify Edward Hare and John Wing as "prominent psychiatrists" when quoting some of their controversial beliefs, for example, but fails to identify Henry Maudsley as a psychiatrist when quoting some of his psychiatric reforms, instead identifying him as a "prominent observer". I believe this omission, and others like it, to be very unconscious but very significant for readers among the general public. To me, knowing all of them to be psychiatrists I can see Barham's attempt to be holistic and balanced. But these subtle omissions to someone who is unfamiliar with these personalities can further reinforce the other stereotype: of doctors and policy makers being on the wrong side always and in everything. There is also very little discussion in the book about other facets of culture and society that have shaped these attitudes, including marked risk aversion, the newly emerging litigation culture breeding defensive-practice, and the nature of evidence-based practice and empiricism that forms the very bedrock of the medical profession. I believe that all of these contribute to shaping the current medical and law-making practice resulting in the creation of rigid frameworks. I believe that human beings are rarely inherently callous or evil and those doctors and officials who set out to end the asylum era with medication and community treatment were largely driven by a spirit of care and reform based on the existing social and scientific evidence at the time. And they are still majorly— at least in my experience— motivated by the same.

I also think that despite its high merit, Barham's book is incomplete. He takes us on

this journey of incredible introspection— certainly for a psychiatrist, if not for society in general—and there are periods of stark embarrassment at some of the glaring shortcomings and blunders of my predecessors that make me want to do better. However, he stops short and ends the book there. There is no moment when it comes together for the reader. I came to expect from Barham's research that he would conclude with proposing a solution, or a template for change. However, the absence of it leaves the book feeling like a scathing opinion-piece which critiques but does not internally evolve into a practical solution. I sincerely hope that Barham will follow-up and come up with plans based on his own clinical and academic experience and his knowledge of the lived experiences of patients, with a roadmap to help work with the Others in coming up with something that would redress the failures of our current system. I, for one, would look forward to that immensely.

I will close this reflection by once again bringing to the fore that *Closing the Asylum* is an incredibly important historical work for those seeking insight into why the current mental health system, despite being a springboard leap away from the asylum-era has ended up losing its footing, and as with Icarus's wings, instead of soaring, has fallen flat and come undone.

# Histories of Psychiatry – a New YouTube Channel

**Graeme Yorston**

Visiting Professor at University of Chester  
[g.yorston@nhs.net](mailto:g.yorston@nhs.net)

In November 2021 I posted my first YouTube video on the History of Tourette's Syndrome. I was very nervous about doing it, worrying that it might undermine my professional standing or land me in expensive copyright infringement litigation.

I was very new to social media and if it had not been for the encouragement of my son who has his own YouTube fitness channel, I don't think I would have been brave enough to embark on this project.

I have been interested in the history of psychiatry since starting as a trainee in Fife in 1992. I was lucky to work with Allan Beveridge and others, in a department that was interested in the historical underpinnings of its subject matter, and I soon embarked on my first paper - The Life of Leopoldo Fregoli (1). It would be easy to dash off a paper on this topic now, but back in the 1990s there was no Wikipedia, there were no remote library search options, there wasn't even an internet!

The information revolution has certainly made it easier to carry out research into the history of psychiatry, but books and archives that have not been digitised remain an invaluable source of information and anybody who wants to carry out academically sound research in this field has to be prepared to spend time with the primary sources. This was exemplified recently when researching a video on the history of mental illness in Ancient Egypt. When I went to the primary sources, it became clear that many of the papers written by psychiatrists about mental illness in Egyptian were rather... presentist – a

withering critical term used by historians for enthusiastic but amateur efforts in their field.

My aim with the channel is to present regular videos on a variety of topics relating to the history of mental health for a general educated viewership but which have academic integrity. I have tried to make them accessible to a lay audience whilst having enough information to also appeal to psychiatrists and other health professionals. There is so much misinformation about mental health issues in the public view, maintaining myths that should have been exploded long ago, and contributing to the continuing stigmatisation of mental illness, that one of my key aims is to adopt an evidence-based approach to exploring these issues.

Currently on the channel, apart from Tourette, you can find histories on (Mad) Hatters, Louis Wain (and his cats), the Duchess of Argyll (brought back into limelight by the BBC period drama), Glyndwr Michael (the man who never was), and an exploration of madness in Viking sagas (werewolves included). Projects in the pipeline include Rosemary Kennedy's lobotomy, Agatha Christie's fugue, Harriet Tubman's narcolepsy, and as with the Vikings, an exploration of mental illness in Ancient Egypt.

I have a genuine passion for history and a desire to share that with people and I would welcome suggestions for new topics. If anyone is interested in collaborating on future videos, please let me know.

The link to the channel is:

<https://www.youtube.com/channel/UCGextEiemQgyDI3QsCXGkRQ>

- (1) Yorston, G. (1995). The life of Leopoldo Fregoli. *Psychiatric Bulletin*, 19(12), 764-766.  
<https://www.cambridge.org/core/journals/psychiatric-bulletin/article/life-of-leopoldo-fregoli/BDFA6DA56C3BBDE41EA5B5A10F1FCDDA>

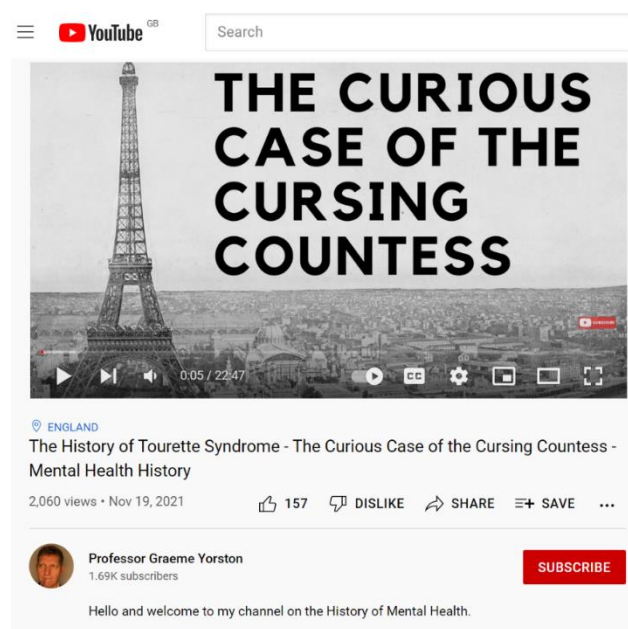
# A professor takes to YouTube and there is science with Skald poetry... and Odin!

A review of the YouTube channel  
Mental Health Histories

**Mutahira M Qureshi**

Co-Editor

[mutahira.qureshi@kcl.ac.uk](mailto:mutahira.qureshi@kcl.ac.uk)



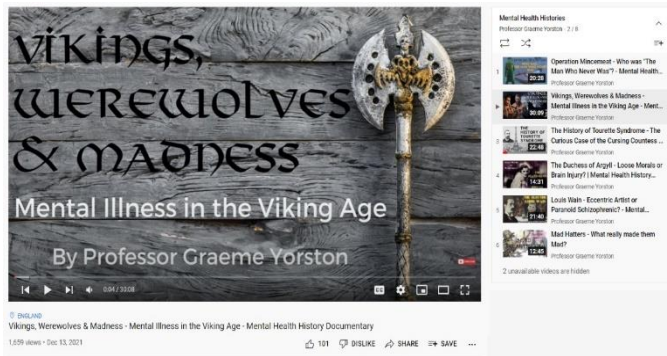
Yorston's YouTube channel with an opening frame of his first uploaded video

Video essays are an evolutionary form of academic writing that, like digital art, are here to stay. Video platforms like YouTube and Vimeo have sprawled beyond purely entertainment and educational videos and given rise to a spectrum on which the video essay genre lies somewhere in the middle, although skewed more on the side of latter than the former. I consider myself a fan (or critic, depending on perspective!) of this format and currently subscribe to several such YouTube channels, albeit most of them dealing in medieval history or quantum physics—my two great and incommensurate loves! And I believe it will not be long before

the video essay category might be considered worthy of entering the realm of grey literature (there is already a peer-reviewed journal in existence that reviews scholarly videographic works(!), although at present only limited to cinematographic pieces).

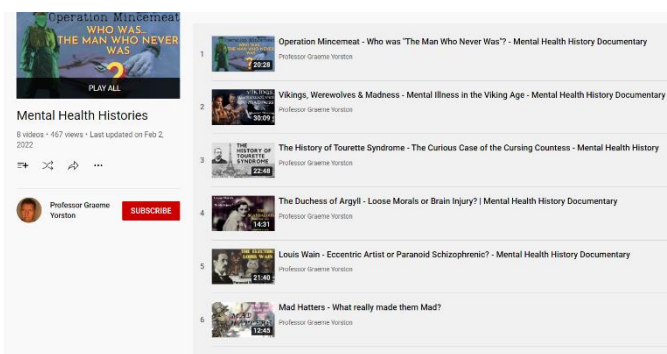
Professor Yorston's channel was recommended to me to potentially review in my capacity as an editor of this newsletter. I set off to do this as a professional obligation, but it took two seconds of opening jaunty vintage music accompanying a pencil sketch of Paris reminiscent of the 19<sup>th</sup> century École des Beaux-Arts style, announcing the rather literary title, "the Curious Case of the Cursing Countess" that immediately told me that this was a video essay done right. This was further confirmed when at some point in the Tourette video Professor Yorston shows us the painting of a French noblewoman as he starts to talk about the case but then immediately declares that the picture is not an actual portrait of this Countess because none exist. At several points he makes well-timed jokes. In his Viking video he takes timely intermissions with great pieces of neopagan ritualistic music (I recognised some from bands Warduna and Danheim but I am quite tempted to request a full playlist for that video!), some footage from TV series *Vikings* and *The Last Kingdom*, and recites passages from well-known Norse sagas in deep voice, creating an atmosphere of the Norsemen invoking Odin right before their infamous routs. He keeps well away from the problematic practice of retrospective diagnosing, presents technical information in a way that can be understood by non-medics, and ends both videos with a full list of his academic sources and his recommendations for further reading.





Although this still picture does not convey it, but this video starts with the blow of a war horn!

A video essay by its definition (although none fully exists) is meant to advance a scholarly argument (in this case exploration of historical subject matter from a modern scientific perspective), while typically not meant to educate they do serve that purpose, and their presentation is expected to be highly immersive and atmospheric (specific to their subject). A case in point is *Every Frame a Painting* series from which this genre derives its core features. And that is precisely the point: every frame must be art, while you discuss your factual science. This is what separates this from other short video formats like vlog, opinion, commentary, docuseries, or whiteboard. I believe Professor Yorston has fully grasped this and executed it to near perfection.



A full playlist of Mental Health Histories as of 15 February 2022

Needless to add at this point that I went on to watch the only two videos which were uploaded at the time in one sitting (each about half hour long) and ended up liking and subscribing—which ultimately is a

YouTube presenter's hope with each viewership. This is not just my view, if the appreciative comments to his videos are any proof. And even though he might not be able to keep this up once his subscribers number in the tens of thousands (he has already garnered a following of 1.7k since starting out in November 2021), but for now Professor Yorston replies to each comment, answers questions leading from his videos, and takes requests for his next. I would certainly be recommending this channel to my history-loving friends and family, and I am clearly using my position as the co-editor to spread the word to the lovers of medical/psychiatric history that form the readership of *News and Notes*. If you ever read a history book and imagined a background soundtrack playing to the intense scene captured in an ancient chronicle, accompanied by vivid visual imagery; as you skimmed through the footnotes and references, then this channel is most definitely for you.

## Dates for your diary etc.

Join us at the **RCPsych International Congress 2022** at the **Edinburgh International Conference Centre** at **17.05-18.15 on Wednesday, 22 June 2022**. We have an exciting session titled: 'The Shock of the New! The introduction of physical methods of treatment in psychiatry in Britain and Europe, 1922-1944'

Follow the Fuhrer Above the Clouds  
Paul Nash  
Date: 1942  
Style: Expressionism, Surrealism  
Theme: WWII  
Genre: landscape  
Media: paper, pencil, collage, watercolor  
Location: Imperial War Museum, London, UK

Public domain  
Added: 2 Jan, 2020 by xennex  
Accessed from Wikiart on 27 MAR 2022.  
<https://www.wikiart.org/en/paul-nash/follow-the-fuhrer-above-the-clouds-1942>

### Next issue

Please send your articles, reviews, photos, ideas, requests for information etc by **31 August 2022**, to [nicol.ferrier@newcastle.ac.uk](mailto:nicol.ferrier@newcastle.ac.uk)

A **Witness Seminar on the History and Development of Primary Care Mental Health** is due to be held on **17<sup>th</sup> June 2022**. If you are interested in attending (virtually), or have any documents which you think may be of interest to the organisers, please contact Lydia Thurston at [Lydia.thurston@doctors.org.uk](mailto:Lydia.thurston@doctors.org.uk)

