RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

HOPSIG Newsletter

Issue 22, Summer 2026

Edited by

Mutahira Qureshi,
John Hall, Lydia Thurston,
Allan Beveridge,
& Nicol Ferrier

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Cover art: Vincent van Gogh, *Butterflies and Poppies*, Van Gogh Museum, Amsterdam, The Netherlands. Wikimedia Commons.

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Editorial page: Gustave Doré, *Summer*, Museum of Fine Arts Boston, Boston, MA. Wikimedia Commons.

End of each article in the newsletter: Adolphe Millot's illustrations titled *Papillions* for Le Larousse pour tous : Nouveau dictionnaire encyclopédique, vol.2. Extracted images via Wikimedia Commons

Page 7: Odilon Redon Evocation of Butterflies, Wikimedia Commons

Editorial

Nicol Ferrier, Editor, HoPSIG Newsletter

Welcome to the Spring 2026 edition of the HoPSIG Newsletter. We hope you enjoy some or all of it and find things of interest within it to stimulate or further enhance your interest (or intrigue) in our ever-fascinating subject. Please note the list of forthcoming meetings and we hope that some may be of interest to you.

As usual, we have six articles on a wide range of topics. Peter Carpenter, our co-Chair, has used his research on Kingsdown House Asylum to demonstrate a new twist on Mark Twain's famous proverb - there are lies, dammed lies, statistics and *asylum* statistics - and a reminder that ratios and percentages are made up of both a numerator and a denominator and that both are equally important. Peter also expands on the remarkable story of Louisa of the Haystacks he introduced at the HoPSIG autumn meeting in Bristol, 2025 with some interesting detective work. Andrew Larner gives an account of the Victorian alienist and Superintendent Joseph Wriggleworth who had a distinguished career not least in roles in the early forms of our College but also in the early developments of academic neurology. He must have utilized his well developed observational skills as following early retirement he became a renowned ornithologist. Interestingly John Cade, the father of lithium therapy, was also a distinguished ornithologist who ranked his bird watching research equally with his lithium work! Accounts of other alienists who had interesting hobbies welcome! Dr John Hall from Oxford is embarking on a major scholarly piece of research looking at the developments in psychiatric research and parallel changes in the delivery of Academic Psychiatry in the UK from 1952-72. As a prelude to this project, he gives us a snapshot of the situation in both these fields as it was early post war by describing a meeting convened in Oxford in 1952 to survey the field. Also from Oxford, Dr Jo Baskerville-Butler gives a very interesting account of the use of electrical machines giving patients shocks in the Warneford Hospital in the early nineteenth century. Plus ça change! Talking of which, we are delighted to publish the winning entry for this year's History of Psychiatry SIG Essay Prize, "Paradigms of the Past", Watching and Waiting: Observation as a Paradigm of Psychiatry's Past by Dr Gursharan Johal

who shows that while much changes in Psychiatry, some basics, in this case the importance and value of observation, stay the same.

In addition to two reviews of important books in our field, we publish reports from the Historian in Residence, the Hon. Archivist, HoPSIG's Co Chairs and an account of a fascinating meeting and exhibition to celebrate the 200th anniversary of the aforementioned Warneford Hospital. The Chairs report mentions that Dr Graham Ash is standing down as Chair (though continuing as Co-Chair). The Newsletter team would like to take this opportunity to thank Graham for his support, guidance and frequent reviewing! Claire Hilton, in the final paragraph of her Hon. Archivist's report mentions a statement she was asked to comment on - 'many of the founding fathers [of psychiatry] were racists and eugenicists.' I am sure Claire did a very good job of responding to this challenge but how would you respond? If anyone would like to pen an article (let's say 1000 words max) on this topic for the next Newsletter we would be pleased to publish a range of responses. There is no one answer!

Thanks are due to those who have done such an important job in reviewing articles for this issue and, finally, my thanks to the Editorial team for their help, especially Mutahira Qureshi who has, as always, done a great job in collating this issue and making it look so good. Mutahira has now got a consultant post. Lydia Thurston after many years of helpful work has also reached that status and is having to stand down because of pressures on her time.

Congratulations and thanks to both but therefore **the Newsletter Editorial team no longer has any trainee representative. If you are interested in this role, please contact me on i.n.ferrier@ncl.ac.uk**

I also look forward to receiving articles, meeting reports, book reviews etc for the next issue at the same email address by 31st October 2026.

Ode to Psyche

A note on the artwork in this issue

Mutahira Qureshi

The College's hundred years since the granting of the Royal Charter in 1926 felt an apt moment to return to one of the oldest symbols of psyche itself: the butterfly. The title of this piece is derived from John Keats' homonymous poem, which strikingly frames Psyche as an inner habitat. Keats imagines building a shrine (to her) "in some untrodden region of my mind," and tending it with "the wreath'd trellis of a working brain".

The Medico-Psychological Association (forerunner of the RCPsych) was also granted a coat of arms by the College of Arms at the time of the Royal Charter. The Arms contain the serpent-entwined rod of Asclepius, a universal symbol of medicine; surrounded by four butterflies of Psyche, to symbolise the healing of the mind. The crest is an ankh, the Egyptian hieroglyph for life. Two gold serpents, symbols of regeneration and renewal, support the arms on either side.

Royal Medico-Psychological Association coat of arms (1926) via HeraldryWiki

The butterfly's symbolic import in art dates to ancient times. It has been employed as a vivid sign of beauty and fragility, metamorphosis and transformation, and paradoxically both ephemerality and immortality. Or rather through death, apotheosis.

The symbolic entanglement of the butterfly with the psych disciplines is largely accepted to be rooted in the Greek myth of Psyche, frequently depicted with butterfly wings: a mortal woman who endures immense tribulations before achieving immortality. During these "labours" she attempts to end her life in despair more than once; and on these occasions she is rescued by timely intervention from the gods: a narrative that recognises mortal vulnerability as much as resilience. The ancient Greek word psyche (Ψυχή) carries the double meaning of "soul" and "butterfly."

It is curious, however, that other ancient civilizations without that linguistic bind also reach for the butterfly to think about mind and reality. In the *Zhuangzi* (c. 4th–3rd century BCE), the famous "butterfly dream" invokes the hard

problem of consciousness, the dream argument and metaphysics of reality Zhuang Zhou dreams he is a butterfly, wakes, and finds himself human, and yet cannot settle whether he is a man who dreamt he was a butterfly, or a butterfly dreaming he is a man. The passage does not (cannot) grant any stable vantage point "outside" experience from which to arbitrate what is real.

From there, the butterfly continues to flit across art. In Christianised medieval worlds it becomes associated with Resurrection, often via the parallel between entombment and chrysalis, and emergence into a "perfected" form. In Renaissance and Reformation era butterflies were recruited into visual contrasts: dark wings and red hues for demonic or fallen beings; lighter wings for sanctity and divine proximity. A vivid example is Pieter Bruegel the Elder's *The Fall of the Rebel Angels*, where fallen angels are curiously depicted with butterfly wings.

In the Baroque period, especially the Dutch Golden Age, butterflies frequently appear in still-life vanitas paintings, an allegorical art emphasising impermanence and the limits of worldly luxury. Here the butterfly sits close to the logic of *memento mori*. This is also the period when natural history and colonial travel intensified European collecting. The butterfly moved between painting, illustration, and the cabinet of curiosities in a limbo between scientific precision and aesthetics. The work of Maria Sibylla Merian is a particularly clear instance of that braid.

In the nineteenth century with its Industrial Revolution, the butterfly adopts a symbolic value as a harbinger of change; of hope and beauty; or the feared loss of it in the technological change. Redon's *Evocation of Butterflies* (top of this article) and Van Gogh's *Butterflies and Poppies* (cover art) are two such examples.

In postmodern and contemporary art, the butterfly returns, true to form, to its association with death and renewal. Frida Kahlo's *Self-Portrait with Thorn Necklace and Hummingbird* (1940) places butterflies in a charged symbolic field of pain, endurance, and self-fashioning. The contemporary British artist Damien Hirst returns to the butterfly in his works time and again, as a motif to explore the delicate tension between life and death- using actual butterflies for effect. Hirst cites the butterfly as a "universal trigger", where "everyone's frightened of glass, everyone's frightened of sharks, everyone loves butterflies". The universality of the butterfly is the universality of the psyche. For, as the solipsists say, only one's mind is sure to exist.

I hope that as you peruse this issue and encounter themes of relook, renewal, and resurrection, the flitting butterfly would continue to invoke the ephemeral yet eternal; unknown yet knowable paradox of the Psyche. And within it, recognise our own humbled and imperfect attempt— requiring continuous relook and renewal— to study it as psychiatry.

P.S. We apologize to our Historian in Residence, who must endure yet another compilation of "too many distracting… butterflies" which was (spoiler warning) his only "mild carp" with the anthology *Personally Speaking*, reviewed on page 60

This page: detail from Thomas Gainsborough, *The Painters Daughters Chasing Butterfly*. Collection of the National Gallery. Public Domain

Next page: Bruno Liljefors, *Redstarts and Butterflies. Five studies in one frame, Nationalmuseum*, Stockholm, Sweden. Image by Erik Cornelius, via Wikimedia Commons.

Page 24: Maria van Oosterwijck, *Vanitas-Stilleben (Vanities Stilllife)* Kunsthistorisches Museum Wien. Picture via Wikimedia Commons

Chair's report

Graham Ash and Peter Carpenter

ChairHOPSIG@gmail.com

The International Congress in June will see a seamless transition of HoPSIG executive. Congratulations to Peter Carpenter who becomes our Elected Chair and thanks to Graham Ash who is stepping down at the end of his tenure. Graham will continue as co-opted Co-chair and Tom Stephenson and Caroline Hayes will continue their great work as our Finance Officer and co-opted Hon. Secretary. I (GA) would like to take this opportunity to express my gratitude for the opportunity to chair HoPSIG over the last four years which has been a great and very enjoyable privilege. I would like to thank everyone involved with HoPSIG and the exec for your energy, enthusiasm, and expertise and support which have contributed to the vibrancy and continuing success of HoPSIG and I would like to wish Peter every success in his role as our new Chair.

The College has been celebrating the centenary of the granting of the Royal Charter to the Colleges predecessor association, the Royal Medico-Psychological Association on 13th March 1926. There have been a series of commemorative events and HoPSIG has supported an information-gathering event based on the Mass Observation studies which invited college members and staff to record their working day. We had 27 submissions which are being processed for archiving which will hopefully yield important material for archival researchers in the future.

We have had an exceptionally good response to our essay competition, 'Paradigms of the Past', which has now concluded. We will announce the winning entry at our Spring webinar on Wednesday 20th May.

It has been very pleasing to hear of so much external activity by members of the Exec. Congratulations firstly to Florian Ruths and colleagues for bringing to fruition a memorial plaque in remembrance of the early modern psychiatrist, Nathaniel Cotton. His grave has been restored and there will be a re-dedication ceremony on 1 June 2026 in St. Albans, Herts.

George Ikkos and co-editor, Thomas Becker, together with Nicol Ferrier and Marius Turda and other members of the executive have, remarkably quickly, written and edited a book, "Psychiatry after Kraepelin: Ambition Images Practices 1926-2026" based on the 'After Kraepelin' event at the RSM in April 2025. The printed book is in preparation and the e-book is at https://link.springer.com/book/10.1007/978-3-032-09475-9 . It may also be of interest that a digitized edition of Emil Kraeplin's writing and correspondence in German is now available online here, (and see below).

Claire Hilton and Gordon Bates have continued to contribute historical blogs to the Library and Archives blog and the *Cabinet of Curiosities* is becoming an established feature in the foyer at the College.

Peter Carpenter, and Graham Ash and Gordon Bates have had articles published in the Autumn 2025 edition of the BSHM on-line journal, Themes in the History of Medicine and Peter is the guest editor of the next edition.

We have met with Indira Vinjamuri, Associate Dean (Medical education) about historical input into Directly Observed Non-Clinical Skills (DONCS) which are under revision as part of the 2026 Curriculum review. This work is ongoing and further information will be available on the College website.

Artificial intelligence (AI) is a subject recently much discussed. Should HoPSIG take an interest in possible uses of AI in history? For example, the complete works of Emil Kraepelin are now available on line in German. If AI can make the text accessible to us, what advantage and disadvantages are there over 'human' translations. What about the use of AI to summarise historical literature? Perhaps we need to discuss more? Chris Moloney is leading a group to explore these issues.

The international Congress will be in Liverpool, Monday 15th to Thursday 18th of June. Claire Hilton, Hon. Archivist, Mandy Bryant, Archivist and Fiona Watson, Library and archives manager are hosting a session based on the Cabinet of Curiosities on Wednesday 17th June which will be a great opportunity to talk about HoPSIG. I hope that this session will be supported by members also the SIGs session on the final day, Thursday 18th.

As a final reflection, although our interests are primarily historical, we seem to be becoming more involved with the business of the College, where we are seen as a valuable resource for information to inform policy. Perhaps as a SIG we should now consider how we are best able to assist our policymakers to make historically informed decisions.

We hope you enjoy the HopSIG Spring meeting on 20 May and the planned Face to face meeting in Edinburgh on 14th November which will be joint with the Scottish Society for the History of Medicine (to be advertised on our website).

Thanks again to all for your tremendous involvement and support,

With Best wishes,

Graham Ash and Peter Carpenter, Co-chairs of HoPSIG

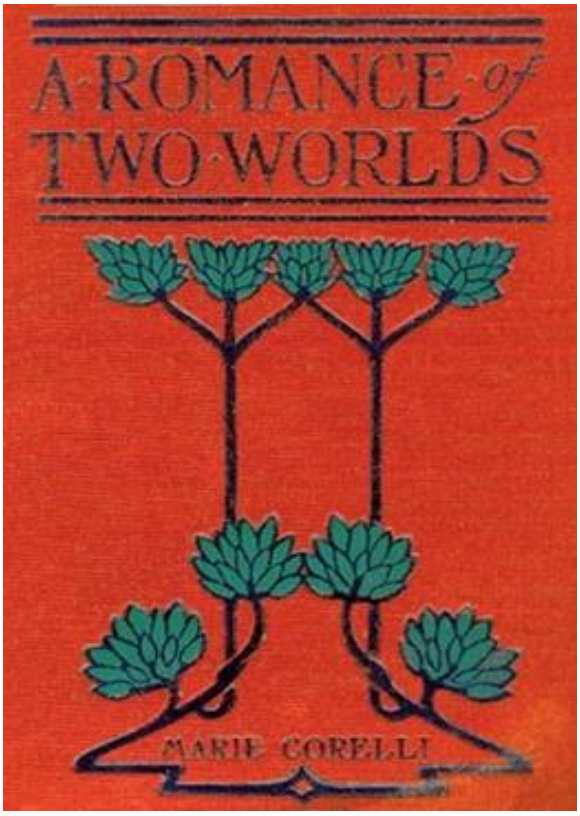
Historian in Residence Report Winter 2025

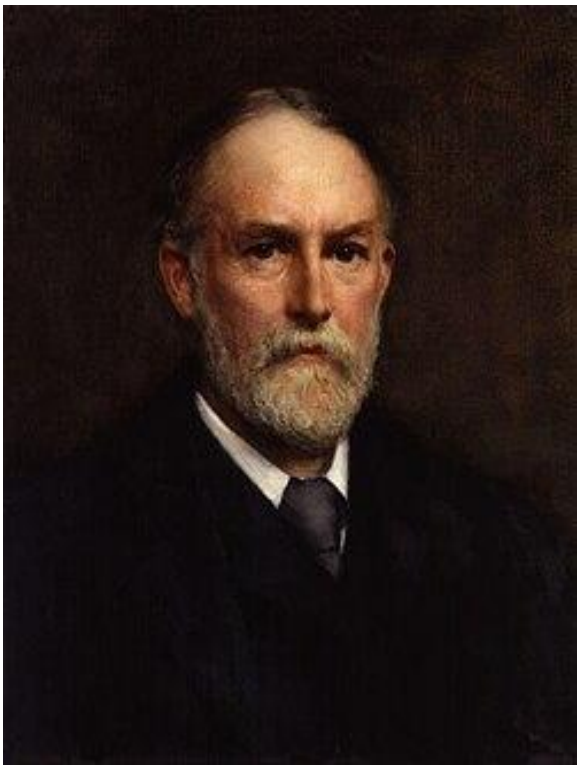
Gordon Bates

historian@rcpsych.ac.uk

The last six months have been busy with writing projects and research. There is always a long delay from submission to publications with book projects which is frustrating and only good if you prefer your gratification very delayed. I have written chapters for two multi-author collections likely to be published next year and I am tying up the loose ends on my own edited volume.

One essay was for a book on the links between Victorian Art and Mental Illness titled *Creative Minds* edited by Rosemary Golding and to be published by Manchester University Press. I looked at the positive depiction of medical hypnotism found in Marie Corelli's *A Romance of Two Worlds* (1896). While it was incredibly popular at the time and was reprinted over twenty times, it is little known today: a strange hybrid of religion, romance and fantasy. Corelli envisaged hypnotism or mesmerism not only as a powerful therapeutic treatment for neurasthenia or depression but also a gateway to unlock one's creativity. There are striking parallels between this work of fiction and the ideas of one of Britain's leading psychologists of the time, Frederic Myers (1843-1901). His ideas of the subliminal self and unlocking its potential through dreams and hypnotism were highly influential in Britain and predate Freud's ideas of the unconscious. It is likely that his ideas were made more acceptable due to Corelli's fictional representation.

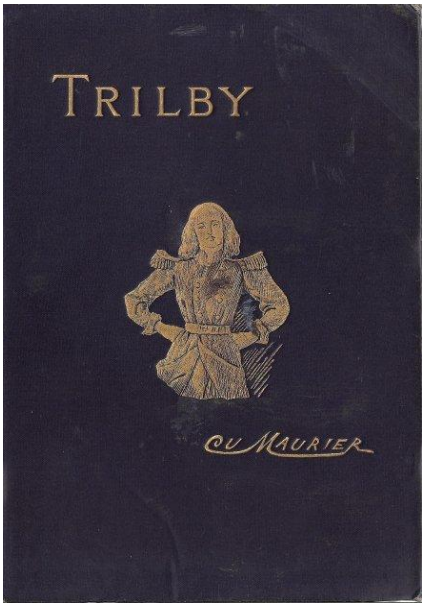




My other project was a slightly stranger commission. It is a chapter for the *Routledge Companion to Global Horror*. My PhD supervisor Roger Luckhurst writes on genre fiction like horror and is one of the editors. He asked me to offer a Medical Humanities perspective for

Horror Studies and as a secret horror buff I was glad too. It is very striking the way that new medical technologies are rapidly taken up and adapted and reworked by horror writers and film-makers. There is a long lineage stretching back to Mary Shelley's *Frankenstein* (1815) which repurposed Galvani's discovery of the effect of electricity on nerve and muscle cells to chilling effect.

I have been particularly interested in mind control and telepathy which are commonplace in supernatural horror. This emerged in the 1890s at the same time that medical hypnotism arrived in Britain from Europe. The original mind-controlling villain was Svengali, an Austrian Jew who hypnotised *Trilby* initially to cure her headache but then to become a great opera singer. This is another story of the late Victorian period where hypnotism is shown to liberate hidden talent but, in this case, it comes at a cost. Trilby is irrevocably tied to her hypnotiser, sickens and then dies when he does. This was one of many hypnotic fictions which emerged at this time and explored the physical and moral risks of hypnotism.



Hypnotism is important to psychiatrists and psychologists because it was the first step in all talking therapies. Both CBT and Freudian psychotherapy clearly emerge from hypnotism and suggestive therapy (Ellenberger, 1970). I will discuss my own book and my chapter on the story of medical hypnotism in Ireland in another report. Safe to say it has taken much of my time over the last couple of years.

There are also a couple of webinars coming up that I am also involved with which will have taken place before the newsletter is published. These are the Royal Charter Centenary Webinar on May 21st and a HOPSIG meeting the day before about Paradigms of the Past in which I will present my findings on 'Where did all the Catatonics go?'

Finally, I like to finish with some of the questions that I have received over the last few months as Historian in Residence. I have included my own and others original answers but additions or corrections are welcomed. I can also put interested readers in contact with the inquirer if they have shared interests.

Queries

Dear HiR,

My background is a psychiatric nurse. I am writing to you as my sister's mother in law died last year. Her name was Janie Thomas - www.theguardian.com/education/2024/nov/26/janie-thomas-obituary as she was a psychiatric social worker and worked closely with Donald Winnicott, and Clare was a close friend of hers. Most of that group of social workers, Janie, Clare Winnicott, Philidea Parsloe , and Olive Stevenson have long since died. My sister is still trying to clear Janies house- there are old papers - with comments by Donald Winnicot, Claire's cape and indeed a lot of things my sister Lyn has no idea if anything is of interest historically. Is it of historical interest at all?

Retired Psychiatric Nurse

Thanks for your query. I see from the obituary that Janie was president of the BASW 1984-6 and had an unusual and high-flying career.

My comments below are really a starting point which I hope will give you a sense of direction, as her archive seems likely to include historically valuable material. A summary of what would be available is essential, and please ask your sister not to bin things, especially related to her life-story, her career and the Winnicotts!

I am not a specialist in the social work field, but from delving into the history of psychiatry, the places I suggest contacting (no particular order) which may be able to advise you or offer a home to the material are as follows:

1. British Association of Social Workers Archives at the University of Warwick Modern Records Centre.

https://basw.co.uk/policy-and-practice/resources/records-british-association-social-workers

2. The Wellcome Collection, London, https://wellcomecollection.org/about-us which contains both Donald Winnicott's https://wellcomecollection.org/works/t7hj9d8b and Clare Winnicott's https://wellcomecollection.org/works/jhkxmm7n archives

3. LSE archives, in view of Janie's lecturing there and long academic careers. I see that her name is already mentioned in their archives catalogue https://archives.lse.ac.uk/search/all:records/0_50/all/score_desc/janie%20thomas

Claire Hilton (Honorary Archivist)

Dear Gordon,

I'm doing a bit of an art project at the moment where I'm carving the names of psychiatric inpatient wards in the UK in oak to make these sort of 'plaques' which I plan to place next to each other to make brief lines of text. Not exactly sure what will come of it. Many wards are named after flora (Oak, Elm, Heather, Cedar etc.), with a significant British figure emerging here or there (Orwell, Churchill, Bronte, Hepworth), like selected figures in vast British landscapes.

I was wondering, though, if you knew anything about the naming of wards in this country, or the history of how this has been thought through. If not,

perhaps you have an idea of someone else who might?

Adam Hines-Green (Artist in Residence RCPsych)

What an interesting question. I am no expert but my brief internet trawl revealed that “themed” ward names are quite common, particularly names linked to local place names, nature or eminent doctors. More recently there has been public involvement in the process, previously the decision was made by the hospital executive.

Going further back (before the NHS) many psychiatric hospitals and asylums depended upon wealthy benefactors whose names were also used for ward names.

I did not find anything more scholarly about the UK. With your permission I will ask the readership of the biannual newsletter.

Gordon Bates (HiR)

Archives Report, April 2026

Claire Hilton,
honorary.archivist@rcpsych.ac.uk

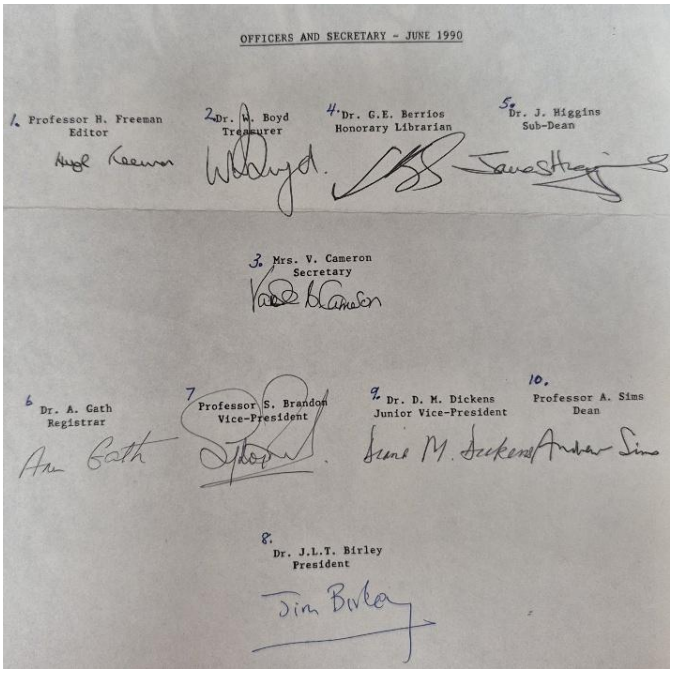
It has been a time of change in the RCPsych archives. Mandy Bryant is our new archivist, appointed in the wake of Francis Maunze's retirement. Mandy (archives@rcpsych.ac.uk) has joined us after working at Brunel University for many years and is collaborating with Fiona Watson (our librarian) and myself on several projects.

'Cabinet of curiosities – show and tell' at RCPsych International Congress, 2026

All three of us plan to be at Congress this year, presenting a fringe event (Wednesday 17 June, 1.40–2.40pm; room TBC). It will be a hands-on display of artefacts, archives, photographs and books which will introduce you to various aspects of the history of psychiatry and of the RCPsych. Please come! We look forward to telling you more about the objects and hearing your comments on them, and on any other psychiatric history-library-archives related matters.

One of the photos we found in the archives while preparing for Congress was from 1990:

Unusually, it was labelled:



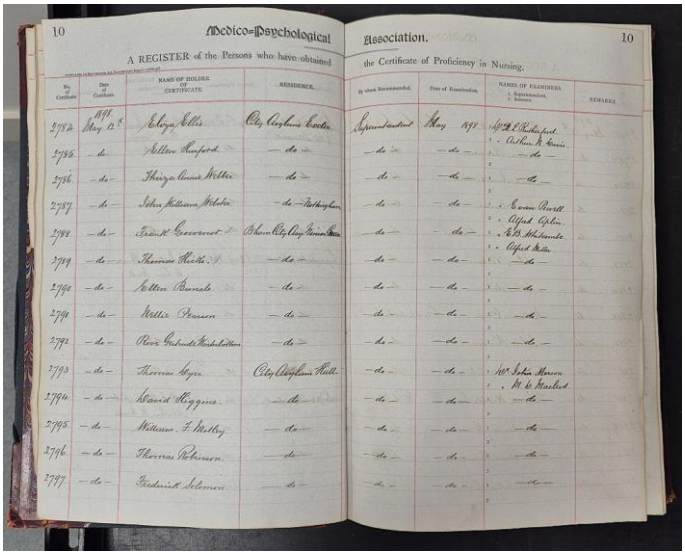
I noticed Dr Bill Boyd (born in 1930) in the photo. Since I had his email address from other history projects, I emailed him copies of both images. In his reply he wrote: 'Thank you so much for the photos...Happy reminders of College activities.'

Many of our photos need labelling.

Some will be on display at Congress – perhaps you will be able to help us?

Digitising archives

As part of celebrating the centenary of the Medico-Psychological Association (MPA) being granted the prefix 'Royal' in 1926, the College is having a fund-raising drive. The plan includes for some of the money gifted to be used for digitising archives to make them more widely available. Given that the RCPsych is an international organisation, and that we receive archive queries from around the world, this is an important matter. Also, those of you who have explored paper archives, whether searching on psychiatry or something else, will know that dates and spellings of names may be imprecise. This means that it is often easier to search the material yourself rather than having to be specific enough to send a request to an archivist. For example, the name Nellie Pearson is listed in 1898 in the register of people awarded the MPA's Certificate for Proficiency in Nursing. However, Nellie may be an abbreviation or diminutive of another name, Helen, Ellen, Adeline, Cornelia or Eleanor among them. The name Nellie may therefore not appear on official documents such as her birth and death certificates. That sort of discrepancy is challenging when trying to trace and understand the lives of our forebears, professional and otherwise. It is even more complicated for women because of name changes on marriage, but men also changed their names. Psychiatrist Robert Jones (1857-1943) was one who did so: he did not want to be confused with the orthopaedic surgeon Robert Jones (1857-1933), so he added a prefix to his name and became Robert Armstrong-Jones. The surname today is better known for its links to the British aristocracy.


10 Medico-Psychological Association. 10
A REGISTER of the Persons who have obtained the Certificate of Proficiency in Nursing.

Above: List of people who obtained the Certificate of Proficiency in Nursing, 1898, including Nellie Pearson.

Snapshot of psychiatry

Also, to celebrate the centenary, we have invited the College membership to help create a snapshot of psychiatry and psychiatrists in 2026. Harriet Stewart and Graham Ash wrote about this in their RCPsych blogs. So far, we have received photographs, a poem and many prose accounts of events. Some are very moving, and show a love of the work we do, but also point to the challenging conditions under which too many of our colleagues' work. We would still like to hear from you during the following weeks: **22–26 June**; **14–18 September**, and **7–11 December** 2026. The link to the submission portal can be found **here** (you will need to scroll down!). Please contribute to this exciting project. All contributions will be added to the RCPsych archives to be preserved for posterity. In another 100 years, someone may look at your account or photograph to find out something about what psychiatry and psychiatrists were really like in 2026.

Other activities

The Cabinet of Curiosities is still up and running, with blogs, and a photograph of each item displayed, on the RCPsych website. If you have something which you could lend to us to share in this way at the RCPsych, do let us know. We would love to hear from you.

Another project relates to obituaries. An article, Medical obituaries and compulsive reading, in *BJPsych Bulletin* discusses current thinking on creating obituaries and preserving the memory of our forebears. The RCPsych obituaries archive is fragmentary, to say the least. Other colleges, such as the Royal College of Physicians (RCP), have a well-established obituaries archive. As one historian of psychiatry told me recently, he regularly delves into the *RCP* collection to find out about *psychiatrists*. I think we should have our own comprehensive obituary archive, but please let me know what **you** think.

I also had the experience recently of being asked to comment on a BBC Radio 4 producer's statement: 'many of the founding fathers [of psychiatry] were racists and eugenicists.' Neither her question nor my answer will be broadcast so you will not hear the subsequent discussion! *How would you have responded?*

We look forward to seeing you at the International Congress in Liverpool.

Warneford 200: Commemorating 200 years of mental health care at the Warneford Hospital

Dr Joseph Baskerville-Butler, Dr Lydia Thurston

Dr Thurston is a specialty doctor in Psychiatry of Intellectual Disabilities, currently based in South Oxfordshire. She has been a co-editor of the HoPSIG newsletter since 2017.
Lydia.thurston@doctors.org.uk

Dr Baskerville-Butler is a higher trainee in Forensic Psychiatry, in the Thames Valley Deanery. In 2021, he co-curated the Bodleian Library's exhibit 'Melancholy: A New Anatomy'.

Joseph.B-Butler@oxfordhealth.nhs.uk

It is often said that the past is a foreign country, yet nowhere does that feel more tangible than within the storied halls and corridors of the Warneford Hospital. For two centuries people have passed through its doors, encountering the same varied manifestations of mental illness. Some arrive unwillingly. Care and treatment are offered. Many recover; most find succour and in time, all move on – one way or another. It is this unbroken thread that is being marked and explored in 'Warneford 200', an exciting, year-long programme to commemorate the hospital's bicentenary.

As two psychiatrists who are very familiar with its corridors, we have been fortunate enough to be involved in the project which includes a travelling and online exhibition, talks, creative projects, as well as a drama and documentary film[1].

Figure 1. 1831 engraving of the Warneford Hospital frontage. The pleasure gardens, modelled after Versailles, are visible in the foreground, used for female patients *"when they may be fit for a more extended range of liberty[6]".* Reproduced with permission from Oxfordshire Health Archives.

Why mark the two-hundredth anniversary of the Warneford? It is a good question, given the project's National Lottery Heritage grant funding. The Warneford is the oldest inpatient unit still in use across the entire NHS estate[2]. Its walls have witnessed the rise and fall of successive approaches to mental healthcare; from humoral medicine and moral treatment to shock therapy and psychosurgery, psychopharmacology, psychology, community care, the Mental Health Act and latterly the 'MDT'. Perhaps uniquely, this care has all been delivered within the same physical setting. Not only does this allow us to trace how contemporary mental health services evolved, but it also allows critical reflection upon them:

how else are we to improve services over the next two hundred years?

There is public interest. Discussions around the tensions between providing care, preserving autonomy, and balancing consent and dignity with safety and security are just as relevant in 2026 as they were in 1826. And unfortunately, ongoing stigma around severe mental illness still requires public engagement and the promotion of lived experience.

The Exhibition

The programme kicked off with the opening of the Warneford 200 Exhibition at the Museum of Oxford on 15th January 2026. The event was a gathering of all those who had been involved in and supported the project and was a chance to share reflections and discoveries. The evening started with a chance to look at the exhibition and to marvel at some of the artefacts on show. Our personal favourites were the menu (on the 20th of November 1949, the patients had for dinner: soup, roast sirloin, Yorkshire pudding and potatoes, followed by trifle and cream), cupping glasses for extracting blood and one of the first Electro-Convulsive Therapy machines. Audio guides captured the first-hand accounts of people admitted to the Warneford over the last forty years.

The opening of the exhibition was followed by speeches from Dr Karl Marlowe (CMO of Oxford Health NHS Foundation Trust), and Dr Jane Freebody, a historian who has played an integral role not only in research for the project, but also in its organisation, management and fundraising. Also in attendance were Dr Tina Eyre from the Oxford University Museum of the History of Science, who provided curatorial input and Kati Lacey, who designed the exhibition banners. The speeches were followed by Pippa Breeze, who performed thought provoking and evocative poems about her lived experience of mental illness. The evening closed with a screening of the history of the Warneford film, specially commissioned to tell the Warneford's story. It includes excerpts from a play titled 'Within These Walls' by Janet Bolam, which has also been created in aid of the project and is based on case studies taken from the hospital archives.

Figure 2. The W200 launch was held on 15th January 2026. From left: Tina Everett, previous lead physiotherapist at the Warneford; Dr Joe Baskerville-Butler and Dr Lydia Thurston, authors of this article; Dr Jo Richards, Child and Adolescent Psychiatrist and W200 researcher and Professor John Hall, member of the W200 steering group. Author's own photo.

Two hundred years of Mental Health Care

About two miles away from the launch, up Headington hill, the Warneford Duty Doctor would have been sat fatigued in the Doctor's Mess, handing over to their night colleague. But before it was the doctor's mess, it was the

superintendent's office, and before this it was farmland. At that time (the early 1800s), most of Headington's income came from the limestone quarries that built the University of Oxford.

It was Headington stone, that in 1812 a committee of gentleman of the University decided to use again, this time to build the Oxford Lunatic Asylum[3], a place of "*relief*" for those of "*respectable and educated life*". The rural Headington site, overlooking the dreaming spires was chosen for its peace, quiet and separation from the city.

Hospitals then, as now, require capital investment and expertise. £20,000 was raised through public subscription and donation, with the University of Oxford donating around a third[4]. Much of that expertise was sourced, or given, by the Reverend Vaughan Thomas who was initially a subscriber, then a member, and then the chair of the Hospitals Management Committee[5].

Prior to the opening, he wrote to asylums and to experts across the country to inform the Warneford's design and practice, and he pored over plans. So much so that the archives are full of his handwritten letters and scrawls. He was particularly focussed on the Asylum's gardens, writing how to make the tree-lined arcades more like Versailles, how to place the viewing mound to command the most beautiful view, and the precise locations for the Grecian vases and classical sculpture[6]. Vaughan Thomas' intuition on the importance on the natural environment in insanity mimics modern research on the relationship between greenspaces and wellbeing.

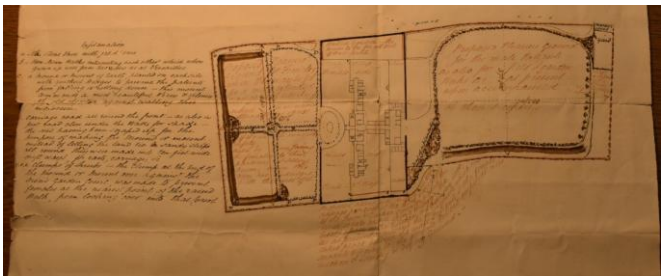


Figure 3. One of Vaughan Thomas' many handwritten notes, depicting his ideas and plans for the Warneford's grounds. The Warneford archives are full of similar notes. Author's own photograph

Through the asylum, Vaughan Thomas embarked on a long friendship with Reverend Samuel Warneford[7]. Warneford, rich through inheritance and his marriage to a wealthy landowning MPs daughter, and possibly because of his wife's insanity[8], donated £80,000 (£7 million today) to the asylum over many years. In 1832 he paid for the twelve-foot stone enclosing wall which, like the building and his statue in the hospital reception, still stands today. In 1847 he paid for the hospital's chapel and the endowment of a chaplain. The asylum was re-named in his honour in 1843.

Figure 4. An engraving of the marble statue of the Reverend Samuel Wilson Warneford. The original still sits at the hospital reception, keeping its long vigil over all who pass through its doors. From Source 7, Wellcome Collection, in the public domain.

People

In 1826, the Oxford Lunatic Asylum first opened its doors to patients. On the staff were a director, matron, two 'keepers' (providing day-to-day supervision of patients), three servants, two cooks, a laundry maid and three groundsmen. The management committee appointed Dr James Adey Ogle, the Aldrichian professor of Medicine at the University of Oxford, to oversee care.

At this time, the asylum was charitable but 'private' in the modern sense. There were three classes of accommodation. Patients paid for their room and care, which was informed by current medical practice and moral therapy; the progressive, activity-based management philosophy pioneered by the Tukes in York. Fees for poorer patients were subsidised by the fees of those wealthier and through public donation.

There were false starts. The first director was removed "*unfit for the situation… owing to the state of his mind*". The second fattened his own pigs on the Warneford's produce, displayed concerning bookkeeping and fed veal intended for patients to his dog. He was similarly let go[4].

Ogle then picked a young assistant apothecary from the nearby Radcliffe Infirmary, Frederick Wintle, to be the new director, who came to the Warneford alongside his wife Jane (who became the matron) in 1828[4]. The Wintles and Ogle oversaw the first stable phase of the Warneford's management, and as Wintle acquired more medical qualifications, Ogle withdrew from day-to-day medical responsibilities.

The Wintles' legacy remains relevant. He was a founding member and subsequently chair of the organisation that developed into the Royal College of Psychiatrists[9]; they give their name to one of the female inpatient wards at the Warneford and their great-great grandson, Professor John Hall was formerly the Warneford's lead psychologist and is now on the HOPSIG editorial board and the W200 Project's steering group.

Today and Tomorrow

Like all stories of the past, the Warneford's origins only exist as we interpret it. The interpretation is dependent on the questions we ask about the past, which in turn are shaped by our present. One of the aims of the W200 project is to ask new questions of the Warneford and to uncover new stories.

Wintle, and later Dr Allen were supported by their wives as matrons. Given how ineffective medical treatment was for insanity, perhaps it was the compassionate care of the nurses and keepers, the activities and the safety and security provided by the building itself that was more important in patients' recovery. The original rules for keepers (which are on display at the exhibition), if removed of their Christian overtones, are just as relevant now. The same cannot be said of the outdated medical treatments. What is distinctly missing is the accounts of patients, which W200 is rightfully foregrounding.

And so the work continues; both within the exhibition and at the Warneford itself. The archives, alongside other sources are still being systematically analysed by the exhibition team. The findings are being shared through short articles, published to the online exhibition whilst smaller discoveries and curiosities are posted on social media.

Current strands of research include the changing professions of patients over time; the treatments used across different epochs of the Warneford's history and the emergence of the other professions at the Warneford, such as social care and occupational therapy. Other work has explored the presence of students at the Warneford, which at numerous points in its history has been called an additional Oxford college[10]. Work is also underway examining the historical use of restrictive practices and the balancing of safety and security against iatrogenic harm.

The team continues to uncover individual stories, which demonstrate that those at the Warneford have always grappled with similar difficulties: The melancholic farmer and the 'go-fund-me' appeals in the local papers to support his admission in 1826; the suicidal mother of the child who had passed away, racked with guilt and nihilistic delusions in 1829, and the discharged patient who later murdered a mother and her four year old son in 1901.

The work continues at the Warneford itself. No longer deemed suitable to provide direct patient care, plans for the new Warneford Park hospital have been submitted to the Local authority. Within these proposals, the original Warneford is set to become a postgraduate Oxford College[2]; its Headington stone coming full circle, returning to the University. The Warneford thus begins a new chapter, handing over its duties to the new.

Figure 5. Photo of the Warneford Hospital, taken by the author at the conclusion of a busy summer on-call shift in 2021. Originally the frontage, this is now the rear of the hospital. Author's own photograph.

The Warneford 200 exhibition is travelling around Oxfordshire in 2026. You can find out more about the exhibition on the website, where The History of the Warneford film can also be viewed.

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7. Christian philanthropy exemplified in a memoir of the Rev. Samuel Wilson Warneford, LL.D., late Rector of Bourton-on-the-hill, and honorary canon of Gloucester and Bristol : wherein an attempt has been made to shew the diversities of its operations, but the sameness of its spirit; the varieties of its form, but the universality of its principle / by...Vaughan Thomas, available at https://wellcomecollection.org/works/jj5hz46j, accessed 9th April 2026.
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Timeless Bodies: Death, Grief, and Healing Across Cultures

29-30 June 2026, Manchester Museum

A two-day interdisciplinary workshop exploring how cultures across time have understood death, mourning, remembrance, and healing.

Bringing together archaeology, classics, Egyptology, museum practice, philosophy, psychotherapy, literature, and the arts, the event examines how historical conceptions of death and the afterlife, such as Iron Age funerary practices, Egyptian mortuary texts, Roman philosophical consolations, and modern literature and art, continue to shape contemporary understandings of grief, healing, and remembrance.

Talks and roundtables will focus on the following themes:

- Death, the body, and the afterlife
- Mourning, ritual, and remembrance
- Healing through museums, literature, and art

Funded by University of Manchester CIDRAL Events Grant Scheme 2025/2026, the workshop will be in person at the Manchester Museum.

Free to attend | Limited places | Registration required

For a full programme or to register interest please email Dr Allegra Hahn at allegra.hahn@manchester.ac.uk

MANCHESTER 1824
The University of Manchester

MANCHESTER MUSEUM

‘Cabinet of curiosities – show and tell’ at RCPsych International Congress, Liverpool, June 2026

Claire Hilton, Mandy Bryant and Fiona Watson will be presenting a fringe event on Wednesday 17 June, 1.40–2.40pm (room TBC). It will be a hands-on display of artefacts, archives, photographs and books which will introduce various aspects of the history of psychiatry and of the RCPsych.

Please come!

This page: Sarah Paxton Ball Dodson *Honey of the Hymettus*, source photograph by Bonham Gallery made available under the Creative Commons CC0 1.0 Universal Public Domain Dedication

Page 52: Richard Dadd, *Contradiction: Oberon and Titania*, Private collection. Wikimedia Commons. Richard Dadd painted this during his confinement at the Bethlem hospital for the hospital's first resident Physician-Superintendent, William Charles Hood.

How good was your asylum at curing you?

How good were the 1844 Statistics?

Peter Carpenter

One hurdle historians of lunatic asylums have is the dearth of material available before 1844. The Royal College of Physicians were meant to supervise the licensed houses around London but left little record of their actions; the provincial houses were supervised by local Quarter Session magistrates who also left few records. The 1828 Madhouses Act moved the supervision of metropolitan madhouses to a new body – the Metropolitan Commissioners in Lunacy [MCiL], and in 1842 The Inquiry Act charged them to inspect public asylums and licensed houses throughout England and Wales Their massive 1844 report on the state of care of Lunatics (Metropolitan Commissioners in Lunacy, 1844a) gives a mass of detail – giving details on all licenced houses and the state of care in them alongside the care in Public Asylums and workhouses. Alongside this they published the first detailed national statistical report on the operation of the asylums of England and the two they discovered in Wales (Metropolitan Commissioners in Lunacy, 1844b). This is a goldmine for researchers as the first detailed and relatively accurate survey of the country. Their report triggered the 1845 Lunacy Act which changed the MCiL into the Lunacy Commission who would regulate, inspect and report on all premises in England and Wales for the next 68 years – their annual reports an important primary source of material.

The statistical tables are a fertile source of data for researchers, including cure rates and causes of insanity and of death. However, inspection of the data for one provincial asylum reveals how erroneous this data can be.

The MCiL statistical report includes returns by all asylums on their 'cure' rates over the preceding years. Recovery rates would be an important statistic for the Commissioners in Lunacy as it monitored their capability to cure the national problem of lunacy. With so many patients getting stuck and swelling asylum numbers this preoccupation was inevitable.

The 1844 statistical returns show, for example, that the cure rate at Bedfordshire County Lunatic Asylum had varied from 9.25% to 25.5% in the last five years. Gloucestershire's statistics were between 20% and 36% and the private asylum I have been researching, Kingsdown House in Box, Wiltshire (Figure 1) had a declared cure rate between 11% and 24%.

Figure 1: Modern Kingsdown House (Author's picture)

The cure rate was calculated as the number discharged cured in a year divided by the average number of resident patients for that year. This was an easy statistic to calculate but was fundamentally flawed as an indicator of the chances of cure for a patient in that asylum. If an asylum was full of long stay patients the denominator in this calculation swelled with inactive patients, reducing the statistic. The Commissioners did not use the alternative statistic of number cured divided by number admitted. Bethlem ignored the Commissioners and used this latter calculation to claim a cure rate of 54% - putting it in a champion league compared to the cure rates reported by others.

The Wiltshire Magistrates kept an admissions register for Kingsdown House Asylum that covers 1828 until its closure in 1946. This includes the dates of admission and discharge and condition at discharge. The register is accurate in its names and dates and outcomes when compared with other sources if we ignore the 1844 report. The register of about 2000 patients has now been transcribed by this author into a spreadsheet to enable further analyses based on individual pathways.

Kingsdown House asylum housed about 50–60 patients before it admitted an additional 60 paupers in 1836 from various poor law unions. The 1834 Poor Law encouraged pauper lunatics to be placed in asylums, and the unions seemed prepared to have contracts with asylums at a distance – for a time Kingsdown took patients from the North Devon unions, over 100 miles away. From 1836 to 1845 Kingsdown held over 130 inpatients, and there were several mass transfers of pauper patients as poor law unions contracted with Kingsdown or removed their patients to other asylums. As a result, many were transferred before they could be 'cured', pushing down the potential results.

	MCiL report				**Register - cure rate as % of those discharged in year**					
Year	Av. No. pts	Declared Cure rate %	Stated No. disch cured	Calc Cure rate %	No. Paupers Disch.	Cure rate paup.%	No. Private Disch.	Cure rate Priv.%	Total No. Disch.	Calc Disch Cure rate
1837	137	**14%**			29	34%	10	40%	39	**36%**
1838	137	**14%**			24	29%	12	17%	36	**25%**
1839	138	**13%**	13	**9%**	21	29%	13	46%	34	**35%**
1840	135	**20%**	20	**15%**	38	13%	20	40%	58	**22%**
1841	139	**11%**	11	**8%**	16	31%	9	44%	25	**36%**
1842	134	**24%**	24	**18%**	39	41%	12	25%	51	**37%**
1843	137	**21%**	21	**15%**	36	33%	8	25%	44	**32%**
Total		**Av. 17%**		**Av. 13%**	**203**	**Av. 30%**	**84**	**Av. 35%**	**287**	**Av. 31%**

Table 1: Data from Metropolitan Commissioners 1844 statistical report for Kingsdown House, compared with the data from Admission register

To compare the cure rate obtained from the Admission Register I have tabulated the cure rate by year of discharge to compare them with the Commissioners' declared rates (Table 1). I have separated the discharges for pauper and private cases for information as well as giving the overall figures to compare with the MCiL data.

Unfortunately the cure rate declared for Kingsdown on page 196 of the Statistical Report is wrong – a prior table gives the numbers discharged cured and it is clear that numbers given as the percentage rate cured are simply the total number of people discharged cured each year and not this number divided by the average number of residents – if this is calculated correctly the rate is lowered by about a quarter. This is an obvious mistake that suggests the Commissioners did not check the figures for consistency before publishing. In addition, the date of opening is given as 1841, though data is given for 1837 onwards and discharge statistics are bizarre as they overestimate the numbers cured and ignore transfers despite these being specifically included in the rubric of the table. (Table 2 shows the discrepancy and Figure 2 the breakdown of type of discharge by year using the MCiL categories)

State at discharge	No. in MCiL Report	No. Calculated from Register
Discharged Cured	89	67
Disch not cured incl transfer	14	69
Died	72	76
Total	175	212

Table 2: Outcomes stated in Metropolitan Commissioners' Report vs that calculated from Admission register.

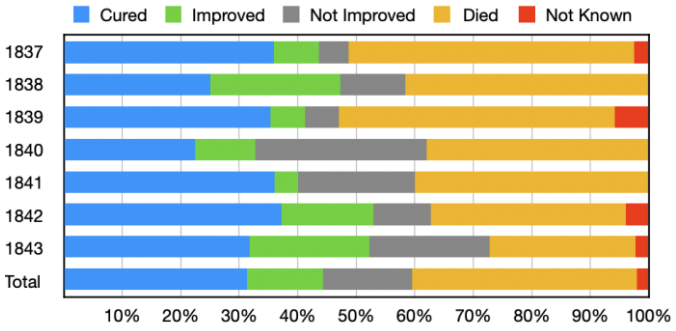

Figure 2: Ratio of outcomes for patients DISCHARGED in each year, using Admission Register data and MCiL categories

The MCiL report showed an annual cure rate of 11-24% between 1837 and 1843 – off putting for any relative seeking a place to cure their loved one. The real figure using their data was even worse at 8–18%. But calculating by patients shows that any patient leaving in these years had a chance of leaving cured varying from 22-37%. The prospects for patients entering in the same years (Figure 3) was similar for leaving cured but better for dying, probably as many of the paupers admitted *en masse* in 1836 died over the next few years. The presence of long stay inpatients ensured the MCiL cure rates were low and in this asylum there were many long stay patients – for the patients resident on 1

January 1840 only 20% had been in for under a year and 20% over 5 years.

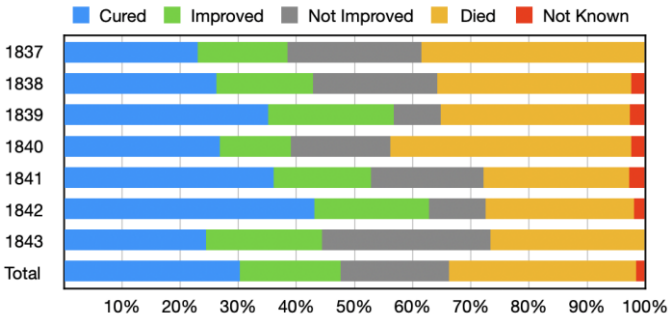

Figure 3: Ratio of outcomes of patients ADMITTED in each year, using Admission Register data and MCiL categories

I feel this is worth publishing as a case study of how comments about cure rates based on the 1844 method of calculation grossly underestimates the cure rate for any patient admitted if an asylum contains chronic patients and also as it shows that the data was not checked at the time.

Asylums such as Kingsdown were achieving decent cure rates before modern medicines arrived. But it has to be said that what was considered cure was more generous in that time. The MCiL did not bother themselves to define the terms, when publishing their returns but Thurnam who tried to regularise asylum statistics, defined the term in his 1841 work:

- *[Recovered:] applied only to those cases where the patient has been so far restored as to appear fully capable of performing, with propriety, the duties belonging to his station in the world; though it is not pretended but that sometimes, perhaps, upon a minute examination, traces of mental disorder might still be detected. [or in case of imbeciles, has returned to state they were before over-come by illness; also called recovered if discharged when with friends on successful convalescence (Thurnam, 1841)*

Thurnam was more pessimistic, using the term recovery rather than cure, but his concept was based on return to prior social functioning rather than elimination of symptomatology. He did not present this as a new concept and this definition would seem to reflect the practice of the time.

Anyone using the MCiL 1844 statistics should check the data used for internal consistency and estimate the number of chronic patients when looking at the declared cure rates.

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Psychiatric research in Britain in 1952

John Hall

John Hall is a clinical psychologist by background, and is Visiting Professor of Mental Health at the Centre for Medical Humanities, Oxford Brookes University. He is a Mental Health Associate of the College, and a member of the HoPSIG committee.

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Introduction

In March 1952 the first national conference to consider the state of psychiatric research in Britain was held at Magdalen College Oxford. Surprisingly, there was no chapter on research in the second volume of Hugh Freeman's and German Berrios' review of 150 years of British psychiatry, to partner John Crammer's comprehensive chapter on training and education (Crammer 1996): little has been written about the general histories of psychiatric and mental health research in Britain. The Oxford conference proceedings, published in January 1953 as *Prospects in Psychiatric Research*, give a snapshot of both the objectives of psychiatric research, and the state of psychiatric research structures, practice and methodology at that date (Tanner 1953). This article reviews the book in the context in which the conference took place.

The context

The central focus of research in the network of asylums that developed during the nineteenth century was the study of mental disease based on the organs and fluids of the body, collected from patients during life and dissected after death (Wallis 2017). This also meant that the asylum pathological laboratory was the primary site for research, with earlier meanings of the term 'research' in this field encompassing what would now be considered as routine data collection and case studies.

Two Individuals of the late nineteenth century are the most prominent examples of this form of research. In his nine years as Medical Superintendent of the Wakefield Asylum from 1866 James Crichton Browne (1840-1938) created the first centre of psychiatric and neurological research and treatment in Britain. From 1895 Frederick Mott (1853-1926) was Director of the central London County Council (LCC) Pathological Laboratories at Claybury Hospital in Essex, and he was the driving force behind the negotiations to set up the Maudsley Hospital in 1908, along the lines of the German University clinics. Hugh Freeman commented that "in 1900, there were some psychiatric research activities in Europe, but very few in the UK" (Freeman 2010). In what has been termed the 'pre-modern era of psychopharmacology' a wide range of medicinal agents had been developed for day-to-day use in asylums, with the early use of opium and camphor, for example, and later paraldehyde from 1882, and the barbiturates from 1903. But in accounts of their use "a desperate clutching for effective remedies ... is palpable" (Mitchell & Hidzi-Pavlovic 2014: 338).

The First World War had a major impact on British psychiatry, both by exposing psychiatrists to the psychological consequences of intensive warfare (Shephard 2000), and by the major disruption to the civilian mental hospital system as many of them were converted to military hospitals. The Maudsley Hospital eventually opened for civilian psychiatric purposes in 1923, with Mott

as director of the research laboratories (succeeded by Frederick Golla in 1923) and Edward Mapother as the first medical superintendent. The hospital had the explicit purpose of concentrating on neurosis, and on early and 'mild' forms of psychosis, so crucially was able to select a varied range of patients for both research and training (Jones et al. 2007, Jones & Rahman 2008). In 1933 conditions became so difficult for Jewish psychiatrists in Nazi Germany that emigration became the only option for them (Peters 1996). With the support of the Rockefeller Foundation Mapother was able to offer three research fellowships to Willi Mayer-Gross, Erich Guttmann and Alfred Meyer.

In WWII, as in WWI, psychiatrists were recruited to the services. Alongside their clinical work, they - with psychologists - became heavily involved in the selection of both recruits and officers, and a wide range of research projects were conducted in the armed forces during the war (Privy Council 1947). On the outbreak of war, the Maudsley staff were evacuated to two different temporary sites, at Mill Hill School in north London, and at Belmont Hospital in Surrey, with their research programmes.

There were a number of developments in research methodology. Many formal measures of educational and intellectual ability had been designed by the 1930s, such as the non-verbal Progressive Matrices test, developed by John Raven while working with Lionel Penrose on the genetics of mental deficiency. A number of new statistical techniques had been developed, as illustrated by a series of papers on medical statistics in 1937 by Bradford Hill, published as *Principles of Medical Statistics* (Bradford Hill 1937).

An example of a classic research study after WWII is the systematic follow-up of 330 leucotomies by Erwin Stengel at Graylingwell Hospital (Stengel 1950). In 1953 the young psychiatrist Harold Bourne conducted a critical analysis of the literature on the effectiveness of insulin, showing how inadequate that evidence was (Bourne 1953).

In 1927 the Royal Medico-Psychological Association (RMPA – predecessor of the Royal College of Psychiatrists) set up a Research and Clinical Committee, chaired for most of this period by Golla. The minutes of the Committee (held in the archives of the RCPsych) illustrate both ongoing concerns of the committee, and significant key events. The adequacy of schemes of psychiatric diagnosis was a constant issue, drafting and approving the definitions of the classification of mental disorders to produce the *Statistical Tables of the Association.*

There were ongoing, and sometimes testy, discussions with the Medical Research Council (MRC) both about promises of a grant, and the general level of support by the MRC for psychiatric research. Two detailed RMPA memoranda are of particular interest, one in 1937 by Norman Glaister pleading for the creation of a committee to co-ordinate research between 'physiological' and 'psychological' research workers and to confer with clinical workers. In 1938 Edwin Goodall from Cardiff prepared a paper on the *Need for the establishment of psychiatric Clinics with Research Departments in University Centres.* In 1950 the government had published a memorandum on research in hospitals (Ministry of Health 1950), and this led from 1952 to ongoing discussions about the need for co-ordinating regional research committees.

The state of psychiatric research knowledge in 1944 was summarised by a special issue of the *Journal of Mental Science* (Fleming 1944): GWHT Fleming noted a similar review by Henry Devine fifteen years earlier, with a second edition only 4 years later (Devine 1929, 1933). Apart from articles on specific

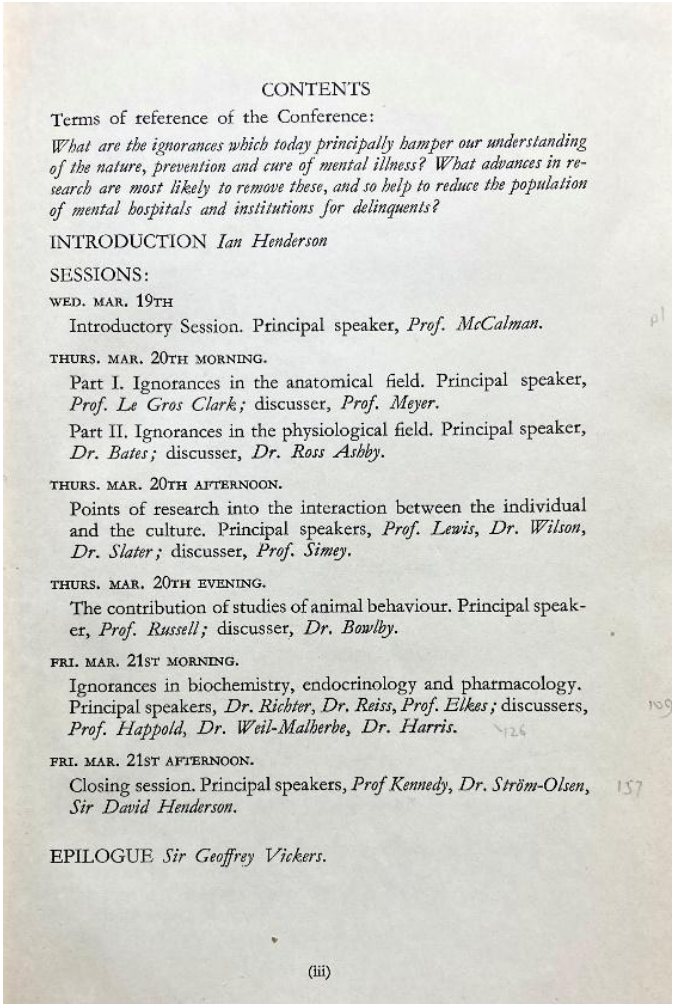
diagnoses, the emphasis in the issue was mostly on biological topics, such as vitamin deficiency, neuro-endocrine relationships, and neuropathology.

On the 5th July 1948 the NHS came into being. It had not been a foregone conclusion that the mental hospitals would enter the NHS on the same basis as the general hospitals. However, in the same year the British Postgraduate Medical Federation was formed, as a federation of a number of postgraduate medical schools each linked to an appropriate hospital for major branches of medicine. So the new Institute of Psychiatry (IoP) came into being in Camberwell, linked with the Maudsley and the former charitable Bethlem Royal Hospital in Beckenham, both already recognised schools of London University. The two initial chairs of psychiatry and neuropathology at the IoP were supplemented in the period under review by a chair in physiology in 1952.

The 1952 Oxford Conference

The conference was sponsored by the Mental Health Research Fund (MHRF), inaugurated in 1949 with the objectives of promoting, financing and encouraging research on mental health and disease. The conference was the first major project of the Fund, as they recognised that 'stimulation of research is a notoriously chancey business', and they wished to obtain a clear view of the field, 'with the help of those most intimately engaged in it'.

The aims of the conference were to consider 'the ignorances which to-day principally hamper our understanding of the nature, prevention and of mental illness' and to consider what advances in research would be most likely to remove those 'ignorances'. Some 50 doctors and scientists were invited to attend, with the invitation strategy being to gather one or two distinguished representatives from each discipline, rather than to sample according to the numbers working in each field. The conference was organised by the MHRF Research Committee, with Sir Geoffrey Vickers as chairman and James Tanner as secretary. Derek Richter at Cardiff, was one of the co-founders of the Fund, and he must also have been involved in selecting those to be invited: the prestige of the well-networked Sir Geoffrey could have been a factor in people accepting the invitation, along with the seductive attraction of three nights of Magdalen College dinners!



CONTENTS

Terms of reference of the Conference:

What are the ignorances which today principally hamper our understanding of the nature, prevention and cure of mental illness? What advances in research are most likely to remove these, and so help to reduce the population of mental hospitals and institutions for delinquents?

INTRODUCTION *Ian Henderson*

SESSIONS:

WED. MAR. 19TH

Introductory Session. Principal speaker, *Prof. McCalman.*

THURS. MAR. 20TH MORNING.

Part I. Ignorances in the anatomical field. Principal speaker, *Prof. Le Gros Clark;* discusser, *Prof. Meyer.*

Part II. Ignorances in the physiological field. Principal speaker, *Dr. Bates;* discusser, *Dr. Ross Ashby.*

THURS. MAR. 20TH AFTERNOON.

Points of research into the interaction between the individual and the culture. Principal speakers, *Prof. Lewis, Dr. Wilson, Dr. Slater;* discusser, *Prof. Simey.*

THURS. MAR. 20TH EVENING.

The contribution of studies of animal behaviour. Principal speaker, *Prof. Russell;* discusser, *Dr. Bowlby.*

FRI. MAR. 21ST MORNING.

Ignorances in biochemistry, endocrinology and pharmacology. Principal speakers, *Dr. Richter, Dr. Reiss, Prof. Elkes;* discussers, *Prof. Happold, Dr. Weil-Malherbe, Dr. Harris.*

FRI. MAR. 21ST AFTERNOON.

Closing session. Principal speakers, *Prof Kennedy, Dr. Ström-Olsen, Sir David Henderson.*

EPILOGUE *Sir Geoffrey Vickers.*

(iii)

Figure 1: Conference programme and principal speakers and discussers (from Tanner 1953: iii)

The conference was attended by 47 men and two women (Mildred Creak at Great Ormond Street Hospital, and Margaret Jackson, *Lancet* Assistant Editor). They included eight professors of psychiatry: Edward Anderson at Manchester, Joel Elkes as professor of experimental psychiatry at Birmingham, Sir David Henderson at Edinburgh, Alexander Kennedy as professor of psychological medicine at Newcastle (Durham University), Aubrey Lewis at London, Douglas McCalman at Leeds, William Millar at Aberdeen, and T Ferguson Rodger at Glasgow. There were then no professors in Wales or Northern Ireland. The seven directors of research or of research units were Ross Ashby at Barnwood House Gloucester, Mayer-Gross at Crichton Royal Dumfries, Max Reiss at Bristol Mental Hospitals, Derek Richter at Whitchurch Hospital Cardiff, Martin Roth at Graylingwell Hospital Chichester, Grey Walter at the Burden Neurological Institute Bristol, and Hans Weil-Malherbe at Runwell Hospital Wickford. There were five senior research staff in non-psychiatric departments at the Institute of Psychiatry, three professors of psychology, and three overseas members – Dr J Groen from Amsterdam, Dr OL Peterson from the Rockefeller Foundation, and Professor RN Sanford from Berkeley California. Others of note included John Bowlby from the Tavistock Clinic, Desmond Curran from St George's Hospital London, Maxwell Jones from Belmont Hospital, and Elliot Slater from the National Hospital Queen Square London. Twelve of those attending had been authors or joint authors in the 1944 Fleming volume.

The research units represented included both established hospital units and MRC units. The longest-established hospital unit represented at the conference was at Cardiff City Mental Hospital, where the first medical superintendent, Edwin Goodall, had established a research laboratory in 1906, and which Richter headed from 1947. The charitable 'registered' hospital Barnwood House near Gloucester was linked from 1939 with the privately endowed Burden Neurological Institute at nearby Stoke Gifford: the first published report on the use of ECT on patients in England was a collaboration there between Fleming, Golla (now retired from the Maudsley) and W Grey Walter (Fleming et al. 1939). At the Crichton Royal Hospital near Dumfries, originally a Scottish charitable hospital, Mayer-Gross was Director of Clinical Research, working alongside John Raven. Runwell Hospital at Wickford had opened in 1937, the last major psychiatric hospital to be built in Britain: the medical superintendent was the Norwegian R Ström-Olsen, and the director of research there from 1950 was John Corsellis, who while holding the chair of neuropathology at the IoP did most of his work at Runwell,

A Clinical Research Department was started at Graylingwell Hospital Chichester in 1947 by Joshua Carse (Research Report 1971): the first director was Stengel, followed as director in 1950 by Roth, and during this period the unit was taken over by the MRC. Lewis was director of the MRC Occupational Psychiatry Research Unit set up in 1948 at the IoP, later known as the Unit for Research in Occupational Adaptation before adopting its final and best-known title as the Social Psychiatry Unit in 1958 (see Shepherd & Davies 1968).

The six sessions of the conference were structured around five themes, with principal speakers for each session. There were sessions on: anatomy; physiology; biochemistry, endocrinology and pharmacology; the interaction between the individual and culture; and on the contribution of studies of animal behaviour (see Appendix for details of all

speakers and discussants). While there was little direct discussion of psychotropic drugs, the session on biochemistry, endocrinology and pharmacology had as principal speakers Richter and Reiss, with Elkes talking on the effect of drugs on the CNS. The session on 'the individual and culture' is in some ways the most interesting as the most discursive, with the principal speakers including Lewis, Alexander Wilson from the Tavistock Clinic, Slater & Bowlby. Kennedy and Ström-Olsen were the two principal speakers for the closing session: Kennedy welcomed the exchange of views "far into the night". Ström-Olsen spoke of the need for multi-disciplinary research set-ups and team-work; and the last word was by Henderson, who said it was the best conference he had ever attended!

An Epilogue by Vickers was a plea for co-ordination and integration of research, alongside proposals for long-term studies of normal families. He suggested goals for research: quicker and more certain cures for the major psychoses, and to improve the 'threshold of the bearable'. And he spoke of the new scarcely recognised science of 'public mental health'.

A close reading of the published text, however, tells another story:

"There is a very large group of psychiatrists whose thoughts and endeavours seldom or never turn to research at all" (McCalman, p.3)

"it is usually doubtful when a patient recovers or gets worse ... whether the change in his condition is attributable to social and cultural influences, or to the special therapy" (Lewis, p.54)

"a brief remark about the training of full-time medical research workers. In the present set-up in the NHS this is quite farcical" (Ström-Olsen p.167)

"As far as diagnosis is concerned, we are only just extracting ourselves from the age of superstition and witchcraft" (Kennedy p.161)

"the work does not at present attract enough suitable men (*sic*). In those choices which are seen to have determined a man's career the scales are unduly weighed against research; in particular, against research bearing on mental health" (Vickers p.178).

So alongside the reports of the research being undertaken, and visions for the future, the realities of the state of psychiatric research in Britain at that time was revealed. The research community was in a parlous state. Few psychiatrists were interested in research anyway. Existing research methodologies were unable to identify causation. Training in research was totally inadequate. Almost all treatment methods were empirical and palliative.

Conclusions and the legacy

This review of the Oxford Conference, and of preceding and contemporaneous developments, demonstrates the significance of the period c.1952-1955 as a baseline for understanding the major changes in structures and methods of psychiatric research up to c.1970, including the creation of new chairs in psychiatry both in established universities and the new medical schools, the founding of the new journal *Psychological Medicine* in 1969 explicitly concentrating on 'original, high-quality research' – and the formation of the Royal College of Psychiatrists in 1971.

In 1952 there were few university departments of psychiatry. Most of the existing research units had no link to university medical schools. Most clinicians had no interest in conducting research - maybe because of work overload. The pinnacle of a professional career was still to be the medical superintendent of a mental hospital, so research was not valued for career

advancement. There was little research funding available, and there was little opportunity for trainees to gain research skills. The mental hospital was still unchallenged as the site for most psychiatric research, with the pathology laboratory still seen as the focus for most of that work: when the MRC took responsibility for Richter's Centre in 1957 it was moved to Carshalton to be close to the large group of mental hospitals in the Epsom area (Reynolds 2015).

The people attending the Conference are of interest. Alongside the already leading figures of Sir David Henderson, Aubrey Lewis and Willi Mayer-Gross, were a number of younger researchers - Tanner was 32 and Martin Roth was 35. Alongside the original group of three German psychiatrists (Guttmann, Mayer-Gross and Meyer), the assimilation of Stengel (who was not present at the conference), Reiss, and Weil-Malherbe into senior posts indicates their importance in improving research standards. The Russian-Lithuanian Joel Elkes was a pioneer in his uniquely titled post, and with his wife conducted a methodologically innovative study on the effectiveness of chlorpromazine (Elkes & Elkes 1954): his move to the USA in 1957 was a loss to the British research community. Richter himself deserves to be better remembered: he was the driving force in the creation of the MHRF (Reynolds 2015). The growing body of senior appointments and grant-supported researchers at the IoP, with the steady growth of associated trainees, would lead to the Maudsley diaspora of a new generation of research psychiatrists and clinical psychologists.

And fundamental assumptions were about to be challenged. In 1953 chlorpromazine was introduced clinically, with a new hope of therapeutic advances – with the associated funding from drug companies of numerous clinical trials. In 1954 the *Royal Commission on the Law Relating to Mental Illness and Mental Deficiency* (the Percy Commission) was set up, which would lead to the liberating 1959 Mental Health Act.

The seventh edition of Henderson & Gillespie's *Textbook of Psychiatry* was published in 1950. First published in 1927, the text was still heavily dependent on case studies: even in the last 1969 tenth edition there were 37 case studies, some 2 pages long. In 1954, the first edition of the 650 page *Clinical Psychiatry* by Mayer-Gross, Slater and Roth appeared: all three authors were present at the Oxford Conference, when writing was already under way. The introduction made it explicit that the book was laid 'on the ground of the natural sciences.' There were 32 pages of references, the great majority to journal articles. It could not be clearer – a new era of psychiatric text books had dawned. *Mayer-Gross, Slater & Roth* was to be the British psychiatrists' bible for decades to come.

And in 1955 the maximum number of psychiatric inpatients in England and Wales was about to be reached before the unforeseen reduction in patient numbers. The shape of mental health services was about to change, and psychiatric research would become less neuropathological, both more social and biological, and more methodologically rigorous.

Notes

Thanks to Claire Hilton for her comments on an earlier draft, and to Mandy Bryant for access to RCPsych Archives.

This article is part of a longer study, with part II in preparation, which covers the period from c.1952/54 to c.1970/71. If any reader has reflections or comments on the issues and people involved,

please contact me on: joni_hall@btinternet.com.

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Appendix: Principal speakers and discussers at 1952 MHRF Oxford Conference

This list gives the dates, post at date of conference, and later posts and achievements, for each person

Ian Henderson d1986: Chairman, Mental Health Research Fund: stockbroker, co-founder with Derek Richter of MHRF 1949, active as Trustee of MHRF for 37 years.

Douglas McCalman 1903-1957: Professor of Psychiatry Leeds 1948-1957.

(Sir) Wilfred Le Gros Clark 1895-1971: Professor of Anatomy Oxford University 1934. Primatologist and evolutionary theorist: co-prover of the forgery of Piltdown man. FRS

Alfred Meyer 1895-1990: Professor of Neuropathology IoP. Pioneer in pathology of epilepsy.

John A V Bates 1918-1993: External Staff MRC staff at Neurological Research Unit at National Hospital Queen Square 1946-1978. Pioneer in Neurophysiology.

William Ross Ashby 1903-1972: Director of Research Barnwood House Gloucester 1947-1959, Professor of Biophysics University of Illinois 1960-1970. Pioneer in Cybernetics

(Sir) Aubrey Lewis 1900-1975: Professor of Psychiatry IoP 1946-1996. Central figure from 1936 in the development of the role of the Maudsley and then IoP.

Alexander T M Wilson 1906-1978: Chairman Management Committee of Tavistock Clinic 1949-1958. Psychiatrist. Unilever 1958-1970, Professor of Organisational Behaviour London Graduate School of Business Studies 1970-1974.

Eliot T O Slater 1904-1983: Physician in Psychological Medicine National Hospital Queen Square 1946-1964, Director MRC Psychiatric Genetics Unit 1964-1969. Co-author *Clinical Psychiatry* with W Mayer-Gross & M Roth.

Thomas Simey (Lord Simey) 1906-1969: Professor of Social Science Liverpool University 1939-1969, Pioneer in social policy.

Roger Russell 1914-1998: Professor of Psychology UCL 1950-1957, Professorial posts at Indiana University and University of California 1957-1972, Vice-Chancellor Flinders University South Australia 1972. Pioneer in psychopharmacology.

John Bowlby 1907-1990: Consultant Psychiatrist Tavistock Clinic 1945-1972, author *Maternal Care and Mental Health* 1951. Pioneer in attachment theory

Derek Richter 1907-1995: Director of Neuropsychiatric Research Centre Whitchurch Hospital Cardiff 1947-1960, Director MRC Neuropsychiatric Unit

Carshalton 1960-1971. co-founder with Ian Henderson of MHRF 1949. Pioneer in Neurochemistry.

Max Reiss 1900-1970: Director of Research Department Bristol Mental Hospitals 1946-1957, Director of Neuroendocrine Research Unit Willowbrook New York USA 1957-1970. Pioneer in Neuroendocrinology.

Joel Elkes 1913-2015: Professor of Experimental Psychiatry Birmingham University 1950-1957, Director of Neuropharmacology Research Centre NIMH Washington DC 1957-1963, Professor of Psychiatry John Hopkins University Baltimore 1963-1974. Pioneer in Neuropharmacology.

Frank Happold 1902-1991: Professor of Biochemistry Leeds University.

Hans Weil-Malherbe 1905-1904: Director of Research Runwell Hospital 1947-1958, Chief of Section of Neurochemistry Special Mental Health Division NIMH Washington DC USA 1958-1975. Biochemist.

Geoffrey Harris 1913-1971: Senior Lecturer IoP up to 1962, Professor of Anatomy Oxford University *and* Honorary Director MRC Neuroendocrinology Unit Oxford 1962-1971. FRS.

Alexander Kennedy 1909-1960: Professor of Psychological Medicine Durham University 1949-1957, Professor of Psychological Medicine Edinburgh University 1957-1960.

Rolf Ström-Olsen 1902-1986: Physician Superintendent Runwell Hospital,

Sir David Henderson 1884-1965: Physician Superintendent Royal Edinburgh Hospital *and* Professor of Psychiatry Edinburgh University 1932-1955, President RMPA 1946, co-author *A Textbook of Psychiatry* 1927 (1o editions).

Sir Geoffrey Vickers VC 1894-1982: Chairman of MHRF Research Committee 1951-1967. Member of MRC 1951-1960. Solicitor, Social Systems practitioner.

James Tanner 1920-2010: Secretary of MHRF Research Committee, and Lecturer in Physiology St Thomas's Hospital 1948-1956, Professor of Child Health and Growth at Institute of Child Health London 1966. Pioneer in Human Development. Editor *Prospects in Psychiatric Research 1953*.

Watching and Waiting: Observation as a Paradigm of Psychiatry's Past

Winner of the History of Psychiatry SIG Essay Prize 2026: "Paradigms of the Past".

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Gursh Johal is a Specialty Doctor in General Adult Psychiatry based in Greater Manchester. She also works as a clinical researcher with several universities, with a research focus on suicide research methodology and psychological autopsy. Please note, the author has a diagnosis of dyslexia. Contact email: gurshjohal89@doctors.org.uk

In psychiatry, observation is an essential part of "how things are done". In ward offices, names sit beside intervals: fifteen minutes, thirty minutes, constant. During handover, someone might mention that a patient will need "closer observation overnight." Such phrases pass without comment. They feel routine, practical, and necessary. Early in my psychiatry training, I remember noticing how much of ward life involved simply watching. Not just the formal observation levels, but the quieter, continuous noticing: who had withdrawn from ward life, who had become unsettled, who seemed slightly different from the day before. No one ever really explained this directly. It was just understood that observing in this way was part of the job.

When we consider the paradigms of psychiatry's past, we often picture diagnostic systems, treatments, or institutions that have come and gone. These are frequently considered the most visible markers of change in psychiatry. Less often considered are the everyday practices that have persisted across these paradigm shifts. Observation is one of them. It has not belonged solely to one particular era, but has travelled through them, changing in meaning and emphasis but remaining central to how mental health care is delivered. Consequently, observation can be viewed as a paradigm in itself - not a diagnostic framework or a treatment, but a way of organising attention and deciding what matters and why. It is difficult to imagine psychiatric care without it. We observe for agitation, withdrawal, changes in sleep, affect, eye contact, movement, gait, and engagement. We then adjust observation levels in response to clinical instinct as much as evidence. All of this feels like common sense, but it is shaped by history. The act of watching has been present throughout the development of psychiatry.

In nineteenth-century asylums, observation was central to daily life. Casebooks recorded sleep, appetite, posture, restlessness, and conversation in careful meticulous detail (Scull, 2015; Porter, 2002). In many ways, asylums ran on this kind of scrutiny. It maintained order and control. Historical accounts suggest that little went unnoticed. Wards were structured around observation and surveillance (Goffman, 1961). If patients could be seen, they could be managed. However, observation was never a neutral objective act. What was seen always

required interpretation. Restlessness might signal distress, agitation, or illness. Withdrawal might suggest sadness, anger, or deterioration. Across eras, the meaning of behaviour has been heavily moulded by the assumptions of psychiatry at the time. Watching did not reveal; it depended on how clinicians made sense of what they were seeing.

The early twentieth century introduced a shift in how psychiatry observed. With the rise of psychoanalytic approaches, attention turned inward. Distress was increasingly understood in terms of subconscious conflict, symbolic meaning, and internal narratives. The therapeutic encounter became less about monitoring behaviour and more about listening to what patients said. At first glance, this might appear as a departure from observation as a central focus. The emphasis moved from visible behaviour to inner experience. However, despite this, watching did not disappear as a fundamental tool. Psychoanalytic practice depended not only on words, but on the careful noticing of pauses, facial expressions, gestures, and body language. The analyst observed as much as they listened. Consequently, observation persevered but became much more subtle. Behaviour was no longer simply recorded; it was interpreted symbolically. Observation remained central to the encounter. In this way, even a new paradigm that appeared to prioritise the unseen did not abandon the act of watching. It reframed it.

Later in the twentieth century, psychiatry moved further towards a medical and diagnostic framework. Observation did not disappear. Instead, its role and emphasis shifted once again. Watching became less about maintaining order, or psychoanalytical interpretation, and more about gathering clinical information. Observing behaviour was still central, but it was now analysed through diagnostic approaches. Agitation, slowed movement, incongruency of affect, - these became signs to be read rather than disruptions to be contained or manifestations to psychoanalyse. Nursing notes, ward rounds, and clinical summaries relied heavily on what staff had seen. Change and recovery were tracked through small observations over time.

This shift is perhaps most clearly reflected in the mental state examination, still one of psychiatry's core clinical tools. The mental state examination is built largely on observation: appearance, behaviour, speech, affect (Sims, 2002). In many ways, this is psychiatry's bread and butter. Before investigations, before rating scales, before formulations, the clinician watches. In this context, observation became clinical evidence. The act of observation itself remained, but its meaning moved from supervision to assessment. Behaviour was no longer only a matter of keeping order; it was now a source of clinical knowledge.

The latter half of the twentieth century also brought structural transformation: the gradual dismantling of the asylum and the move towards community-based care. As long-stay institutions closed and patients were treated increasingly in outpatient settings and their own homes, the architecture of observation changed. The ward no longer provided constant visibility and monitoring. Clinicians could not watch continuously. Instead, observation became episodic. In community psychiatry, watching took on a different form and relied on scheduled appointments, home visits, and reports from family members. The question was no longer what could be seen within a contained environment, but what might

be inferred from fragments: a missed appointment, a change in presentation, an uncollected prescription, a relative expressing concern. Observation became more dispersed and dependent on collaborating networks. But even as the setting changed, the underlying assumption endured: deterioration would reveal itself in these snapshots of behaviour, as part of a greater pattern. Collecting such snapshots and fragments required new observational structures such as documentation systems, multidisciplinary communication, and legal thresholds for intervention. In this way, the move to community care did not replace observation as a paradigm. It forced it to adapt (Scull, 2015; Rose, 1998).

Observation has also functioned as a response to uncertainty. In the absence of biomarkers, imaging, or definitive tests, psychiatry has long relied on careful watching as a way of knowing. When clinicians are unsure, they stay close, observe, and wait. Across eras, watching has often been the default response when understanding is incomplete or muddled. Contemporary research continues to support the importance of this attentiveness. Studies of suicide and self-harm have shown that subtle behavioural changes often precede crisis. These early shifts are not always captured through structured tools and frameworks but are frequently noticed by staff and surrounding networks. Studies that analyse suicide in mental health settings have repeatedly highlighted the role of clinical concern and observable change in the period before death (Appleby et al., 2017). Therefore, modern evidence does not replace observation; it quietly reinforces its continuing relevance.

In today's psychiatric practice, observation has taken on another layer of meaning. It is now closely tied to the management of risk. Observation levels are increased when patients are considered high risk or unpredictable. Staff remain physically present, sometimes continuously. Notes record whether someone is "settled," "visible on the ward," or "safe with support." Watching becomes a way of preventing harm to the patient and to others. This reflects a broader shift in psychiatric culture. In systems shaped by responsibility and accountability, the act of watching now signals vigilance and demonstrates care. Sociological accounts of professional practice suggest that such changes are not unusual; practices evolve and take on new meanings while retaining familiar forms (Abbott, 1988; Rose, 1998).

Looking across these different periods, observation emerges as one of psychiatry's most consistent practices. What has changed is not the watching itself, but what clinicians believe they are looking for. In one era, it was behaviour and order. In another, psychodynamic turbulence, or in another, symptoms and diagnosis. In the present, risk and safety. Each period has interpreted observation through its own priorities. If we think of paradigms not only as theories or diagnostic systems, but as ways of working and thinking that shape what clinicians attend to, then observation stands out as one of psychiatry's most enduring inheritances from the past. Across changing diagnoses, institutions, and treatments, the habit of watching has remained. Long before psychiatry developed classifications or assessment tools, it developed a way of paying attention. In that sense, observation may be one of the field's oldest technologies: a way of gathering information, detecting change, and responding to distress. But at its core it reflects a central belief that care

begins with noticing. Before psychiatry learned how to treat, it learned how to watch.

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Louisa ‘Maid of the Haystack’ and her move to Guy’s in 1788

Peter Carpenter

At the HoPSIG autumn 2025 meeting I spoke about ‘Louisa of the Haystack’, a name given to a mysterious woman who arrived in Flax Bourton near Bristol in about 1776 and lived in a haystack there before spending 19 years in asylums. She has been the inspiration of numerous books, novels, poems, portraits, research articles and blogs as well as at last one play, and still invokes curiosity. The most detailed academic article is the most recent - that of Smith(1). When I spoke, I threw down the challenge of finding out when she moved to Guy’s Hospital. My research since then has found out that past writers have all assumed it was several years after the correct date and she spent more time at Guy’s than in care in Bristol.

Figure 1. Louisa, known as 'maid of the haystack'. Engraving by G. Scott, 1805, after W. Palmer, (1763-1790). Source: Wellcome Collection 877i Public Domain.

Background:

In 1776:

> *a young woman stopped at a small village near Bristol and begged the refreshment of a little milk. There was something so attractive in her whole appearance as to engage the attention of all around her. She was extremely young, and strikingly beautiful: her manners graceful and elegant, and her countenance interesting to the last degree. She was alone — a stranger — and in extreme distress; yet she uttered no complaints, and used no arts to excite compassion, her whole deportment and conversation bore visible marks of superior breeding, yet there was a wildness, an incoherence, and want of consistency in all she said and did. All day she wandered about in search of a place to lay her wretched head, and at night actually took up her abode under an old haystack(2)*

As a mysterious woman who did not say where she was from, she eventually attracted a lot of curious visitors including people sent by Queen Caroline. Eventually some claimed she was the illegitimate daughter of Francis I, Emperor of Austria, confined but then escaping at the cost of a major head

wound. Others blamed a cruel violation by an unknown man for her mental state. She was supported by the local residents who also protected her, but she was placed in the Lunatic wards at St Peter's Hospital in Bristol – the Bristol Workhouse. She then either escaped or was discharged, and returned to live in her haystack, where she then met the local notable Hannah More, the religious writer, teacher and playwright. Hannah publicised her case in the London based, *St James Chronicle* (2), from which the above quote is taken, and appealed for funds for Louisa, seemingly with little success despite much interest. She then funded Louisa's admission to a private asylum in Bristol.

At this time there were only two near Bristol: Joseph Mason's Asylum at Fishponds, located next to her father's school where she grew up, and now managed not by the famous mad-doctor, but by Mason's daughter and her husband who was a grocer. The other was the newly opened Asylum at Hanham Grange, just east of Bristol, operated by the retired Wesleyan minister and ex-schoolmaster Richard Henderson who was friends with John Wesley. Hannah was a friend of both John Wesley and Richard and paid the £50 per annum to place Louisa there in December 1781. John Wesley was interested in insanity and visited Henderson when in Bristol, and in his journal charts the decline of Louisa. Hannah More's diary and letters record progress as she visited as Louisa's 'friend', in other words, funder. The last comment by Wesley is in 1784:

6. March 1784 — I spent a few melancholy minutes at Mr. Henderson's with the lost Louisa. She is now in a far more deplorable case than ever. She used to be mild, though silly: But now she is quite furious. I doubt the poor machine cannot [sic] be repaired in this life. (3)

The move to Guy's:

Every history of Louisa relates that Louisa was eventually transferred by Hannah More to the (Incurable) Lunatic Ward at Guy's Hospital where she died on 19th December 1800. The probable reason for the move was her difficulty paying Henderson's fee, though she had it reduced to £30 and got friends to help, but also as she saw no chance of recovery in a woman who did not recognise her and could not justify the fee of a private asylum. Unfortunately, as a chronic patient the only options were to admit Louisa back to St Peter's Hospital as a pauper, but she was not a Bristol pauper, or to the incurable lunatic wards in London at Bethlem, St Luke's Hospital for Lunatics, or Guy's Hospital.

Bethlem's ward for chronic patients had high competition for its places and was usually filled by patients moving from their acute wards. The biographer of Hannah More, Anne Stott, suggests that Louisa was first placed in St Luke's, as Hannah describes being upset by visiting there (4). St Luke's' registers survive and do not record any admission of Louisa. Hannah probably described visiting St Luke's when she was scouting out the possible placements for Lousia. She transferred Louisa from Hanham direct to the lunatic ward at Guy's. Hannah did not have to pay for Louisa in Guy's but she still paid them £10 a year for clothing and comforts for Louisa.

Up to now no one has found when she moved and most assume it was in the

1790s, after Richard moved his asylum to Clevehill in Downend in 1789 and probably when he died in 1792. The archives of Guy's are held at the London Archives. The admission registers for this period do not incorporate the lunatic admissions but some contain a separate loose sheet of the lunatic ward patients, listing the patients at the time. There are two lists covering this period. The list in the 1795-1802 register (5), headed 'Lunaticks in Guys Hospital 3 Nov 1795', states:

[Admitted] [20 or 30] August 1788; [name] Louiza; [Parish] dead; [on security of] Sir Charles Middleton, Hartford St, Middx & Hannah More, Bristol, spinster [nominated by] W Snell esq. Died 19 December 1800.

The prior admission register for 1789-95 also has a sheet for lunatics that appears to include Louisa but the entry is so water damaged it is illegible. The previous register's list ends with a lunatic admitted in June 1788.

Comments:

This date of admission of August 1788 is several years earlier than any writer has suggested. However, Smith notes that in September 1788 Hannah wrote that she was arranging for Louisa to be moved to a hospital. In fact, the arrangement was complete. Apart from the cost of her placement, Louisa's move was encouraged by the impending end of the lease on Hanham Grange and the asylum moving to new premises, rather than Richard's death. The exact date would have been determined by when a place at Guy's became available. Louisa spent the majority of her time in the asylum at Guy's and not at Hanham, spending seven years at Hanham Grange and twelve at Guy's.

We have no record of the treatment she received at Guy's. Wakefield described it as the best planned ward of any he had seen, describing the restraints used and design of beds for wet patients (6).

Henderson seems to have been very benevolent in his approach. Wesley talks of how Henderson governed his patients by love and not fear, and it is worth noting that Louisa did not have her head shaved as part of treatment as many recommended. Her old head injury was first discovered in 1785 after her hair was cut close. Wesley notes Henderson restored her physical health and gave her a small room for herself. She does not appear to have been forced to wear clothes, but was allowed to cover herself with a blanket. No visitor talks of mechanical restraint as might be used elsewhere to stop her removing her clothes. We also know that Henderson's son John mixed with the patients and taught some Astrology and Numerology – not obvious therapeutic studies for the insane but the poet William Gilbert gained his lifelong interest in Astrology when he was there (7).

Hannah More spent a sizeable proportion of her early income caring for Louisa. We can speculate what compelled her to support this attractive vulnerable and mysterious woman. Hannah would become famous for her *Cheap Repository Tracts*, preaching Christian virtues to the poor; caring for Louisa was in keeping with her personality, and in her letters, she clearly feels for Louisa's decline. She visited little when Louisa was in Guy's, seemingly as it distressed her and as Louisa did not recognise her. Whether her experiences affected her views on Insanity and Asylums has yet to be studied.

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Joseph Wiglesworth (1854-1919): from asylum medicine to ornithology

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Joseph Wiglesworth (Figure 1) followed the standard path of career advancement in asylum medicine in the late nineteenth and early twentieth centuries. But his later career diverged into another discipline, one which might perhaps be more related to asylum medicine than at first appears: ornithology.

After studying medicine and undertaking resident posts in Liverpool and London in the late 1870s, Wiglesworth was appointed Assistant Medical Officer (AMO) at Rainhill Asylum, the Third Lancashire County Asylum, located in Prescot, a few miles outside Liverpool. In addition to his clinical duties at Rainhill, he had the opportunity to perform many post-mortem examinations, his pathological studies resulting in many publications, most appearing in the *Journal of Mental Science* (forerunner of the *British Journal of Psychiatry*). These papers indicate his awareness of current developments, such as the doctrine of cerebral localisation as pioneered by the neurologists John Hughlings Jackson (1835-1911) and David Ferrier (1843-1928), with attempts at clinico-pathological correlation. Wiglesworth was also a frequent contributor to meetings at the Liverpool Medical Institution and to its house journal, the *Liverpool Medico-Chirurgical Journal*. He also contributed to Hack Tuke's *A dictionary of psychological medicine* of 1892.

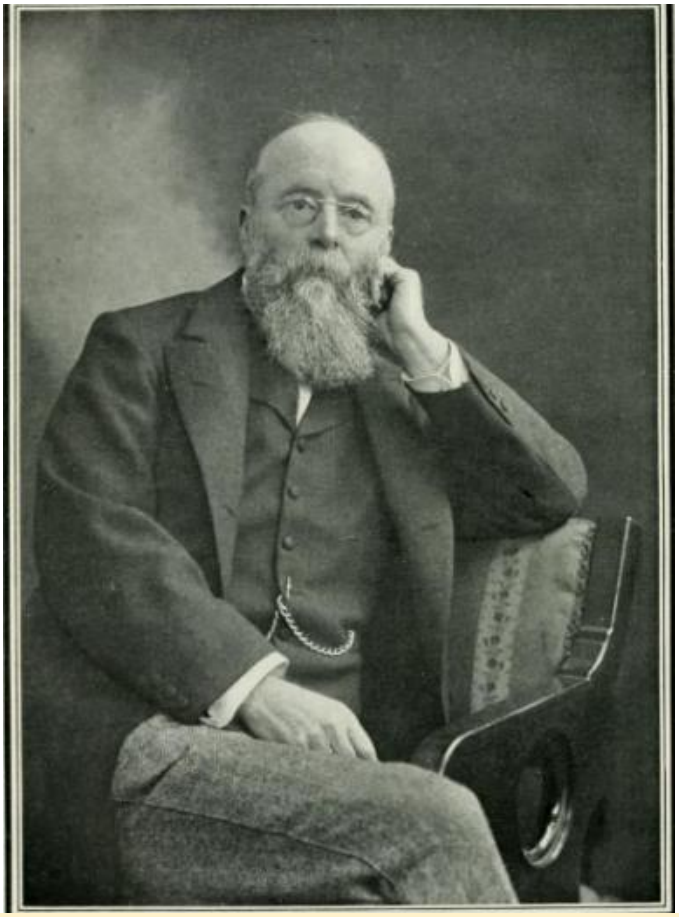

Figure 1: Joseph Wiglesworth (1854-1919)

Aside from his publications, Wiglesworth may be encountered, with greater immediacy, in his entries in the surviving case books of Rainhill Asylum which have been noted to be "in almost perfect copperplate, always concise and to the point" (Barnes, *Psychiatric Bulletin* 1995;19:767).

Wiglesworth was appointed Superintendent of Rainhill Asylum (Figure 2) in 1889 and shortly thereafter Lecturer on Mental Diseases in University College, Liverpool. During his long incumbency at Rainhill, he became increasingly involved with the work of the Medico-Psychological Association (MPA; forerunner of the Royal College of Psychiatrists), of which he had been a member since 1883, firstly as Honorary Secretary (1890) and then President (1902). At the MPA Annual Meeting held in Liverpool on 24th July 1902, he delivered his Presidential Lecture on the subject of "Heredity and evolution".

Figure 2: Rainhill Asylum (image from *Psychiatric Bulletin* 1993;17:113)

Wiglesworth's investigative work in asylum medicine had clear overlap with the developing specialty of neurology. He became a member of the Neurological Society of London, the first dedicated neurological society in the United Kingdom, in 1888 and presented to this body on two occasions, also publishing in the Society's official journal, *Brain: a journal of neurology*. Wiglesworth also facilitated notable developments in neurology through appointments made at Rainhill Asylum during his Superintendency. In 1892, Alfred Walter Campbell (1868-1937) arrived as pathologist. In his 13 years in post, before returning to his native Australia in 1905, Campbell wrote many papers, his seminal contribution being his description of cortical cytoarchitectonics, resulting in his monograph, *Histological studies on the localisation of cerebral function*, published in 1905. Wiglesworth must also have been involved in the appointment of Henry Head (1861-1940) as a Clinical Assistant at Rainhill in November 1894. Still at an early stage of what was to become an illustrious career in neurology, including the editorship of *Brain*, Head later collaborated with Campbell in one of the classic papers in the history of neurology, the mapping of sensory dermatomes based on the distribution of herpes zoster skin lesions (*Brain* 1900;23:353-523).

Wiglesworth's retirement from Rainhill in 1912 at the age of 58 was considered to be early by some commentators and was ascribed to a dramatic incident in late 1894 when he was assaulted by a patient. The details vouchsafed in the retrospective accounts differ, but it seems that Wiglesworth was stabbed in the neck, severing an artery, the haemorrhage from which he controlled with digital pressure until a surgeon could be summoned from Liverpool to attend him. Whether this event was indeed instrumental in determining Wiglesworth's retirement, some 18 years later, is moot, but with the benefit of hindsight we might ponder as to whether he suffered from PTSD, if such retrospective diagnosis is permitted.

Wiglesworth's retirement to Winscombe in Somerset allowed more time to pursue his interests in ornithology which had already been apparent during his Rainhill days. A member of the Liverpool Biological Society, founded in 1886, Wiglesworth became President (1899-1900) and spoke on the many varieties of "Flightless birds" in his Presidential Lecture. However, Wiglesworth was no mere armchair taxonomist, rather he was an active observer of the outdoor world, keen to see birds in their natural habitats. To this end, he visited

Shetland in June 1895 and in May 1899, observing a colony of fulmars on the cliffs of Hermaness on the island of Unst. These findings were reported to the Liverpool Biological Society in 1900, likewise his journey to the remote Outer Hebridean island of St Kilda in the summer of 1902, then still inhabited. These ornithological observations were not only presented to and published by the Liverpool Biological Society but also were subsequently published as a book (Figure 3) which was reviewed in *Nature*.

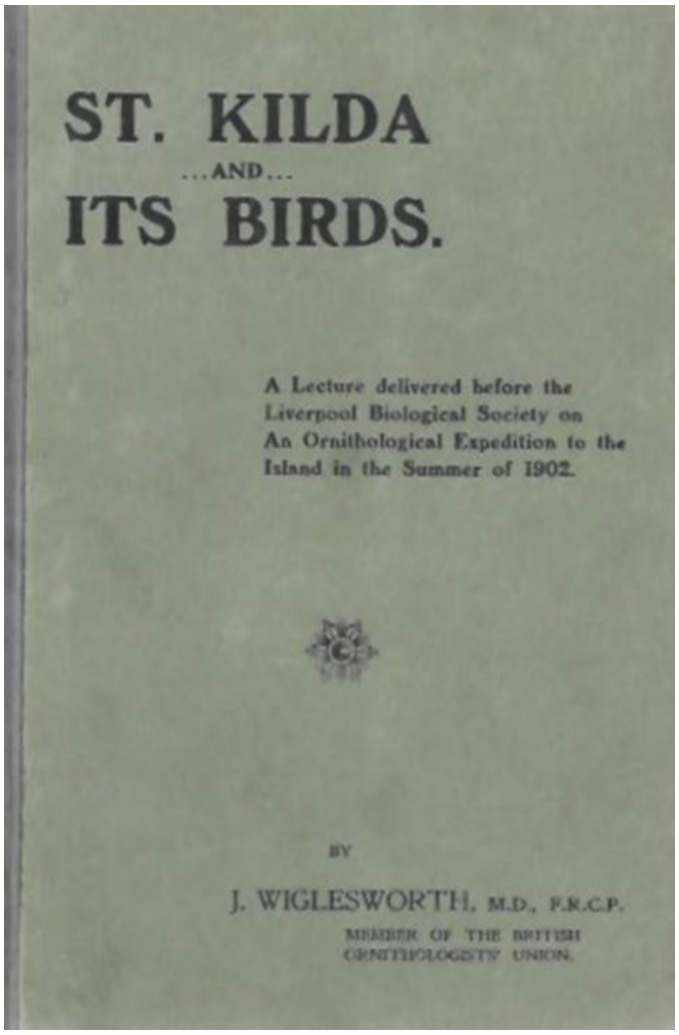

Figure 3: Wiglesworth's Lecture on the Birds of St Kilda, published 1903

One of Wiglesworth's retirement goals was to document fully the birds of Somerset, to which end he was president and recorder of the Ornithological Section of the Somerset Archaeological and Natural History Society. On one birding mission in May 1919, in pursuit of the nest of a kestrel or a peregrine falcon on the cliffs above Porlock Bay, he went missing. His body was found on the shore below the cliffs two days later at low tide. The coroner found that death was caused by fracture of the skull and not by drowning.

What common grounds might be traced between the study of psychiatry and of ornithology? Aside from individual interest, we suggest the following might be shared attributes. Both require careful and patient observation as a prelude to either diagnosis or identification. The differentiation of types or species, of illness or of bird, may be challenging, since these may appear very similar, with overlapping features, and naming may often be based on initially limited or restricted information, hence the possibility of misdiagnosis or misidentification. With a diagnosis or identification made, there is then the question of classification, in the hope of promoting an understanding of the interrelationships of the different types/species identified, through a process of ordering or categorisation. This might facilitate future recognition of forms previously described, and also recognition of deviations from the known, such that unusual or novel forms are recognised as such.

Similar arguments might also be applied to botany, a subject routinely studied in the medical curricula of the nineteenth century, in which connection Wiglesworth's cultivation of "a very complete garden of British plants which were arranged according to their natural orders" whilst at Rainhill is of note. Likewise, other facets of natural history. For instance, James Cunningham Howden (1830-1897), Medical Superintendent at Montrose Royal

Asylum, was a keen geologist and conchologist who donated a large collection of fossils and shells to his local museum.
It would be interesting to learn of other psychiatrists who harboured such interests in natural history in addition to their professional work in psychiatry.
Did they perhaps find a restorative power in the natural world, that might be helpful not only to themselves but also to their patients?

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Medical electricity at the early Warneford; where the Galvanic met the Galenic

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Elizabeth Whale, born in 1804 at the height of the Industrial Revolution, entered domestic service in Oxfordshire aged sixteen. She was one of hundreds of thousands of young women, daughters of agricultural labourers and rural workers – who left home to sustain the households of a rapidly expanding, newly affluent class, their fortunes built on rapid technological change. Elizabeth worked hard and completed eight years of *"praiseworthy conduct[1]"* before her admission to the Warneford Hospital (then the Oxford Lunatic Asylum) in 1829.

Her ninth year had not been so praiseworthy. Elizabeth had become pregnant. She was unmarried, and she was unwilling to reveal the father. She gave birth on the 10th March 1829, losing a *"great quantity of blood[1]",* but alive. Her child was not to be so lucky; within weeks Elizabeth's baby had died.

Racked by loss, guilt, midst postnatal complications and scandal, Elizabeth descended into a *"wretched desponding state[1]".* At a time of little formalised support, away from her home and family, Elizabeth attempted to *"destroy herself[1]"* by hanging.

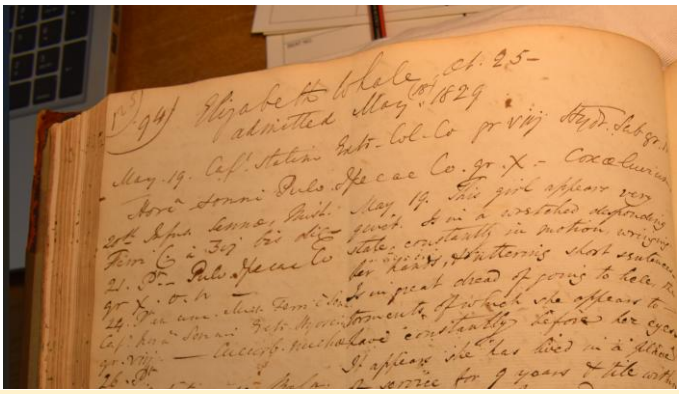

Figure 1. The first page of Elizabeth Whale's case notes, detailing her mental state on admission to the Warneford. She was the 94th patient admitted to the asylum. Author's own photo.

She was admitted to the Warneford on the 18th May 1829, a Monday. Frederick Wintle, then an apothecary, wrote of her arrival; *"wringing her hands and uttering short sentences. Is in great dread of going to hell, the torments of which she appears to have constantly before her eyes[1]".* Elizabeth neither slept nor ate. Wintle examined, recording only a *"rather full[1]"* pulse and that there had *"not been any appearance of the menses[1]".*

Why, in her otherwise scant medical records, was such prominence given to her menstrual cycle? Elizabeth was unknowingly witnessing the final gasps of humoral medicine, the ancient Hippocratic theory which held that health (and ill-health) were dictated by the balance of four vital fluids. Of these, black bile or 'melancholy' was implicated in disorders of the mind. Doctors could speak to, look at and examine patients not to come to a differential diagnosis but to the patient's underlying humoral state[2].

Hippocratic theory dictated that the woman had a wetter constitution, which meant excess blood needed to be

drained from the system. Thankfully, this generally occurred naturally through menstruation but if not, a physician might have recourse to bleeding.

The theory persisted, only in a slightly modified form, to the early nineteenth century. James Cowles Prichard, eminent physician of the day, wrote that if the "*uterus does not assume its proper action at the time when it comes to… all the evils follow"* and "*no other part was more assailed…than the nervous fabric[3]".* Thus for women admitted to the Warneford, menstruation was desirable. So desirable that whenever a female patient at the Warneford menstruated, the fact was carefully underlined, as if especially important.

In the absence of her period, Elizabeth was cupped. A scarificator nicked the superficial blood vessels around her neck and a warm cupping glass was applied. As the air cooled and contracted, blood filled the glass. 177ml of blood was removed. 300mls more was taken two weeks later.
This did not seem to help. On the 27th May 1829, Elizabeth attempted to "*destroy herself in various ways[1]*". She secreted a pair of scissors. She was *"confined by means of the waistcoat[1]",* but managed to grab the nurse's key chain and wrap it tightly around her neck. She was again secured in the waistcoat and spend the night "*endeavouring to break free and imploring those who approached to loose it[1]".* On the 29th, Elizabeth dashed her head through a pane of glass, with the aim of escaping to drown herself in a river, to "*escape the fires of hell[1]".* She complained of smelling sulphur.

Due to her agitation, combined with a flushed face and a hot head, her scalp was shaven and she was put into the dripping shower bath. This formed another popular treatment modality; warm and cold baths, dripping showers, douches and jugs of water thrown into patients' faces were employed to either soothe agitated patients or stimulate those more melancholic and withdrawn. Elizabeth, owing to her delusional fears of the fires of hell, *"[begged] to be allowed to remain in for a longer time[1]".* Additionally, Elizabeth was "*very willing to work any employment connected with water such as washing and she appears quite comfortable when bathing[1]".* Following the bath, a draught of opium and antimony was given to sedate and "*purge[1]"* which resulted in *"considerable prostration[1]".*

By September 23rd, due to the ongoing lack of menstruation, Dr James Ogle (The non-resident physician overseeing the Warneford's medical care) ordered the "*electric shocks[1]".*

This seems extreme to our modern perspective, but the medical, scientific and cultural establishment of the early 19th century had become increasingly obsessed with the power and potential of electricity. This new technology, lauded as a "*panacea[4]"* with the power of reversing death itself began two hundred years prior with the invention of the first electrical generators. These used static electricity; an insulating cloth was held against a spinning glass sphere; electrons were transferred from glass to cloth and a charge built up in the glass sphere. The resultant "*electric fire[4]"* could be discharged at will.

The harnessing of this mysterious power, its striking effects and apparent potential captured mid-eighteenth-century imaginations. Shocking one another became a popular Georgian parlour game[5]. Physicians were particularly intrigued and applied it indiscriminately to people experiencing wide varieties of

ailments, including lunacy and obstructed menses[6]. John Wesley was an especially enthusiastic advocate for its use in mental illness, writing; "*there is no remedy in nature, for nervous disorders of every kind comparable to the proper and constant use of the electrical machine[6]".*

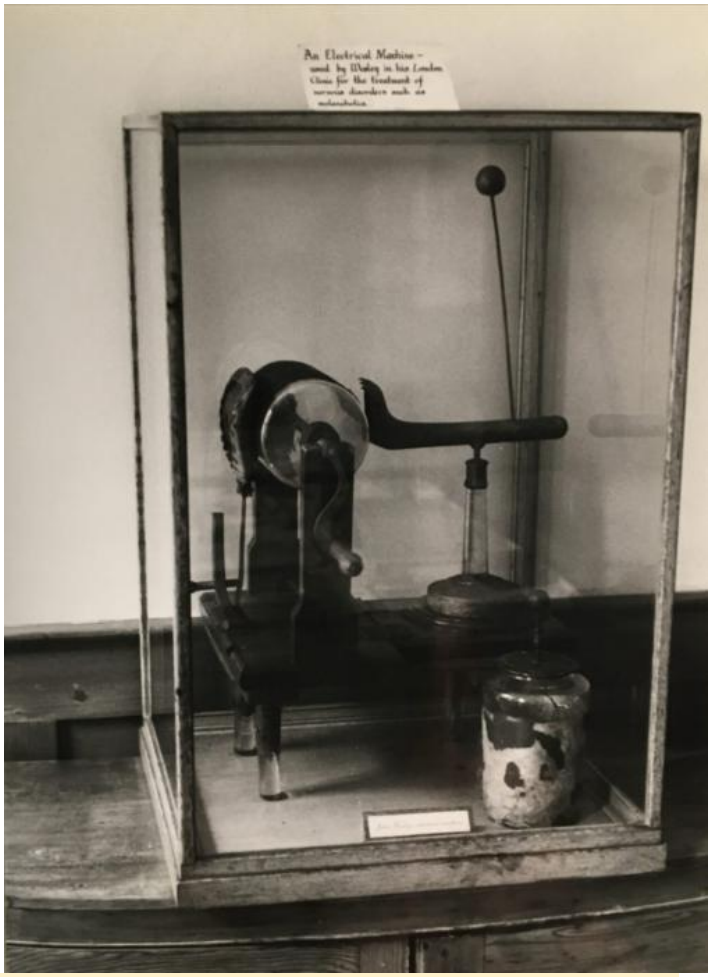

Figure 2. John Wesley's Electrical Machine. The crank to rotate and charge the glass sphere is visible. This was used by Wesley at his London home for the treatment of nervous disorders. Reproduced with the permission of the Trustees of Wesley's Chapel, City Road'.

Electrotherapy developed further in the 1780's following the experiments of Luigi Galvani, who found that a dissected frog's leg twitched when attached to both a brass hook and iron railing. Whilst he had inadvertently created a battery, Galvani incorrectly attributed the movement to 'Animal Electricity'; an innate force that powered all living things.

Galvani was succeeded by his nephew, Giovanni Aldini, also a physician, who took things further. In 1802, in front of a packed crowd at Newgate prison, Aldini applied conductors to the *"ear and to the rectum[7]"* of the newly executed corpse of George Foster. Aldini, upon applying electricity, wrote that *"such violent muscular contractions were excited, as almost to give the appearance of reanimation[7]".* The Newgate Calendar reported "*the jaws…began to quiver and the adjoining muscles were horribly contorted and one eye was actually opened[8]".* One spectator "*died of fright[8]*". Fifteen years later, Mary Shelley published Frankenstein.

Galvanic focus turned from the dead to the living and the early case reports suggest that it found some use in cases of poisoning,[9,10] rheumatism[11] and drowning[12]. As a means of facilitating muscle contraction, galvanism was employed in uterine haemorrhage and arrested labour[13]. In these cases, practitioners were warned to consider the "*painful sensations"* which *"disturb the emotions considerably[13]".*
Aldini turned to the torpor of melancholy and in 1802, "*galvanised"* the deeply melancholic Louis Lanzarini. Watched over by the professors and medical students of St Ursula Public Hospital, Aldini applied electricity across Lanzarini's hands. Soon after the shocks were administered, *"A change was soon observed in the patient's countenance, and his whole demeanour seemed to indicate that the degree of his melancholy was somewhat lessened[14]*".

Figure 3. Giovanni Aldini's illustrations of conductor placement for galvanic therapy. The voltaic pile battery, with stacking alternating discs is visible. Taken from source 13, reproduced from Wellcome Collection, in public domain.

It is in this context, on the 27th October 1829, under the gas lamps of the Warneford's wards where the Galenic met the Galvanic. The nurse applied one conductor to the bottom of Elizabeth's back and another to her "*pubis*[1]". The conductors were connected to a voltaic pile; alternating discs of copper and zinc separated by salt-water soaked cloth. The more discs stacked, the greater the potential difference and the more powerful the shock. Electrons, released by zinc followed their path of least resistance; through Elizabeth.

Elizabeth had "*several sharp shocks through the pubis every day*[1]*".* Wintle recorded an accelerated pulse that "*soon subsided*[1]", but no improvement in her condition. They noted she was "*not so susceptible of electricity as persons in good health for a shock which was very severe to the nurse did not affect her*[1]*".* By the eighteenth day of electricity, the shocks appeared to have more of an effect and by day twenty two, Elizabeth was "*as susceptible of the electric shock as any other person*[1]". Her clinical condition? "*There is not any appearance of the menses but she is more cheerful*[1]*"* wrote Wintle.

The treatment ended on the 9th December 1829, after forty-three days. Elizabeth was "*working well*[1]*"* around the hospital. There had been no further attempts at "*destruction*[1]*".* Her maintenance therapy included keeping her bowels open through occasional purges. Still focussed on menstruation, despite her clinical improvement, the medical team prescribed Hellebore to "*stimulate the uterus to action*[1]*"* and employed the vapour bath, to *"relax the vessels of the uterus*[1]*"*. Neither worked, but Elizabeth continued to improve, assisting daily in the kitchen. By February 1st 1830, Elizabeth appeared "*very well*[1]*"* and Wintle wrote to her father to "*fetch her home*[1]*".* She left two days later.

In the first ten years of the Warneford's existence nine patients were "*electrified".* Elizabeth was the first, and the only discharged "cured". Seven of these were women and, in these cases, electricity was invariably used to precipitate menstruation. Often, the only mention is "*electricitas region hypogastrium",* in the corner of the page. Patients' diagnoses are not reported, and often the sparse notes prohibit even a guess.

It is hard to believe that electricity played any part in Elizabeth's recovery. Patients have always recovered and deteriorated, independently of medical input. Without controls or comparison, how could Wintle and Ogle know whether their treatments 'worked'? It is understood how interventions persisted: They had powerful theoretical backing, were widely accepted across the profession, practitioners were unknowingly subject to confirmation and attributional biases, and treatment failures could always be rationalised. This may explain why Wintle and Ogle persisted in promoting Elizabeth's menstruation, despite her clear clinical improvement. It is only with the advent of epidemiology did Medicine acquire the tools to evaluate its efficacy.

Even without data, the use of electricity in the asylum waned, or never caught on initially. The 1847 Report of the Commissioners of Lunacy makes scant reference to electricity; only Dr Bucknill of the Devon County Asylum reported finding electricity "*beneficial in some cases, when used moderately so as to not produce fear or pain*[15]*".* Wintle, now physician of the Warneford does not mention electricity at all in his accounts of treatment. An advert for a galvanic medical device in 1871 lists many indications, but mental illnesses are not amongst them[4].

It is tempting to deem doctors as deluded as their patients. But this judgement is lazy and reductive. The Warneford of the 1820's operated in an entirely different medico-cultural context to our own, a context which we cannot project backwards. Wintle and Ogle recorded what they considered important, not what we prioritise today. They were answering their own concerns, not ours.

Over the following two hundred years, the world was transformed by electricity. But for all the modern neuroscience, neuroimaging, biomarkers, advances in data and its analysis; medicine still contains profound uncertainties and will therefore always be drawn to the dominant innovation of the age. In 1826 it was electricity whilst in 2026 it is artificial intelligence, biotechnology, and virtual reality. In two hundred years, will our practice be judged in a similar way to how we might judge Wintle? We have not relinquished our use of electricity, after all.

Five months after discharge, Wintle saw Elizabeth out in Oxford, "*looking quite well and very sane*[1]*"*. She asked for a job. Wintle wrote that he may *"employ her in the kitchen*[1]*".* Whether she credited the Warneford for her recovery, or whether stigma, scandal and trauma left her with few alternatives, goes unrecorded. Whether she was employed or not, is also unsatisfyingly unrecorded. History and science preserve what is important. Of electricity at the Warneford, and of Elizabeth Whale, we have only this glimpse.

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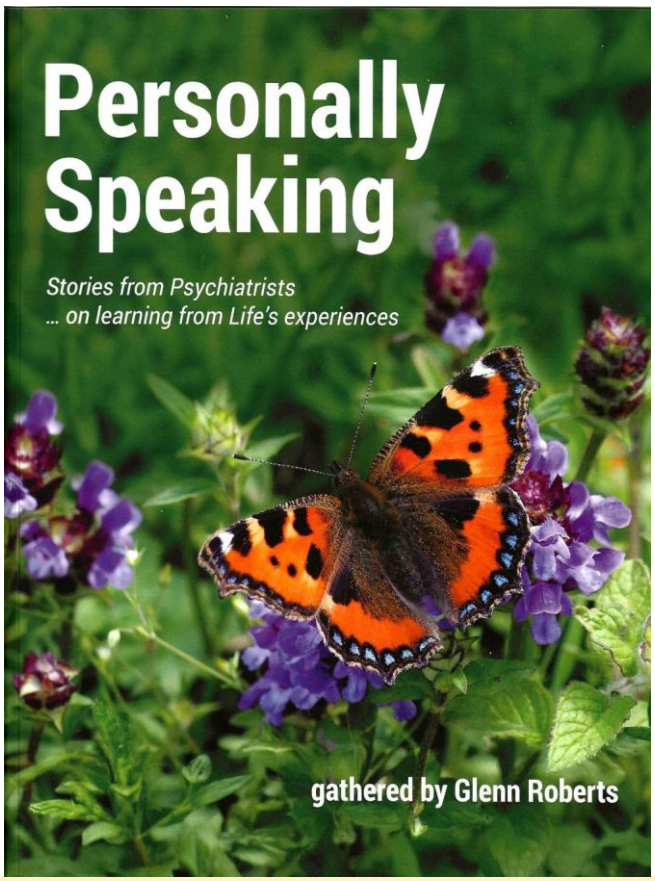
Detail from Winslow Homer *Butterflies* (1878), New Britain Museum of American Art, New Britain, CT. Wikimedia Commons.

Review of *Personally Speaking: Stories from Psychiatrists...on learning from Life's experiences* (2025) Edited by Glenn Robert

Gordon Bates



For further information and access to print and digital copy see personally-speaking.com

In 1834, the unpublished author and playwright Claude Bernard (1813-1878) went to Paris looking for an editor and publisher for his work. He had read the Romantic authors like Victor Hugo and was influenced by the philosophy of René Descartes' emphasis on establishing certainty and rejecting dogma through radical scepticism or 'methodological doubt'. The critic Saint-Marc Giradin gave the young man some kindly advice, suggesting he relinquish his literary leanings and try medicine instead.
This switch from potential man of letters to physician was to have profound implications not only for Bernard but the whole of Western Medicine. Bernard would become a revered physiologist and the figurehead of the experimental and scientific turn of nineteenth-century European Medicine. He recommended experimentation and evidence over received wisdom and anecdote. He saw the patient as part of the scientific process, an object for study in order to understand the laws of physiology. He recommended that the physician develop emotional distance to protect scientific clarity. Bernard became relentless in his pursuit of empirical knowledge. He became a vivisectionist, using animals to reveal how the digestive system functioned. According to popular legend, he even experimented on the family dog while his family was away, causing his wife to leave him soon after.

This story may be known to some but feel strangely familiar to many. It is a Promethean tale of how the unfettered scientific pursuit of knowledge is alluringly rewarding and productive yet leads inevitably to the loss of humanity. It is the mad scientist archetype that started with Mary Shelley's *Frankenstein*. The narrative also implies that there is a binary between clinical warmth and scientific rigour; between patient subjectivity and medical objectivity; between story-telling and scientific fact.

As I read *Personally Speaking*, this foundation myth for modern Medicine

came back to me, repeatedly. Glenn Roberts has assembled 20 senior psychiatrists who have personal and clinical stories to tell. What unites these tales is that all writers present their stories in opposition to the simplistic, harmful binary of the Bernard tale. The separation between doctor and human is not inevitable.

Some of the tales are highly intimate, revealing and moving; some are elegantly written; all are worth reading. The book is aimed at practitioners, trainees and students and has clear messages about the power of story-telling and careful listening; the importance of kindness; learning from our patients; and the role that personal tragedy can have in making better doctors. The book is designed to be read easily: the font is large; the chapters are relatively short; there are poems and there are relevant pictures. Perhaps my only mild carp is that there are too many distracting photographs of butterflies, there to symbolise both the 'psyche' and transformation.

The seniority and experience of the individual writers and their willingness to expose some of the most personally challenging moments of their lives suggests that they believe in the importance of these messages. I was unaware that Dinesh Bhugra had been writing a regular column for the Journal of the Royal Society of Medicine called 'Letters to a Young Doctor'. This title captures the essence of what I think is attempted with the book. Bughra suggests that he might be perceived as a grumpy old man, frustrated that his hard-won knowledge and insight might be lost by the next generation of doctors. However, that was not my impression.

Despite the multiple challenges faced by the profession today, from health disinformation to potential redundancy due to Artificial Intelligence, these stories sing with the importance of human connection. Sometimes the significant other is the therapist, the wise trainer or the colleague. Sometimes it is the patient or one's faith offering guidance or direction. Sometimes the only critical resource that is required is the time needed for reflection.

When I spoke to my son Kingsley, who is a resident doctor (though not a psychiatrist), about the book and its lessons. He did not think it trivial or solipsistic. He told me it sounded very contemporary and relevant. He said that he thought my research into Victorian medical hypnotism was more distant and disconnected from day to day medical practice. I politely disagreed. The story of Victorian medical hypnotism concerns the first time doctors considered the powerful impact of the patient on the doctor as well as the doctor on the patient. This was the first time that the curative but non-physical aspects of the doctor/patient relationship were considered and the importance of the human connection in enhancing expectation and thereby recovery. Sigmund Freud learned how to induce hypnosis under Jean-Martin Charcot at the Salpêtrière. He quickly gave it up in his psychological work. He was so concerned by the power of the doctor/patient connection and of the doctor's suggestion, even outside of the trance state, that he wanted to negate it by sitting out of the patient's line of sight. In Recommendations to Physicians Practicing Psychoanalysis (1924) he suggested that 'the doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him.'

A discussion of the so-called opaque screen was an important part of my

training supervision in the 1990s and not only during my psychotherapy placement. Mostly it was viewed as an ideal that aided impartiality and kept relationships professional. It is only more recently that I have started to bring my 'self' into my work and feel comfortable about it. Perhaps, as the French philosopher Michel Foucault saw it, these detached and emotionally neutral clinical relationships represent a knowledge and power bias in favour of the physician (The Birth of the Clinic, 1973).

Ironically, I have found that in giving up the power that comes with impersonal, clinical objectivity and becoming a fellow human in the room, I can enhance my own power to heal and enjoy the consultation more. In conclusion, I think this is an important if unusual book that positively represents contemporary and personal practice and deserves to be read by all psychiatrists.

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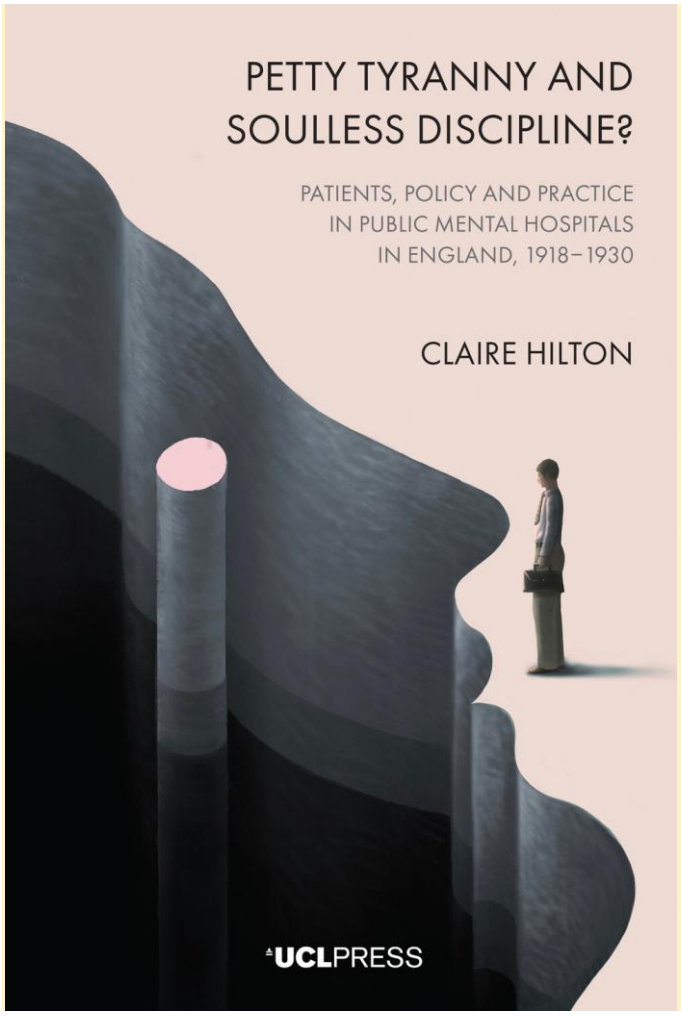
Psychiatry's then and now

Reflection on Claire Hilton (2025) *PETTY TYRANNY AND SOULLESS DISCIPLINE? Patients, Policy and Public Mental Health in England 1918-1930*, UCL Press (open access)

George Ikkos

The author: George Ikkos is Consultant Liaison Psychiatrist at the Royal National Orthopaedic Hospital UK, Clinical Fellow of the International Neuropsychoanalysis Association, Honorary Fellow of the Royal College of Psychiatrists (RCPsych) and immediate past Chair of the RCPsych History of Psychiatry Special Interest Group. Co-edited with Nick Bouras, "Mind State and Society: a Social History of Psychiatry and Mental Health in Britain 1960-2010" (RCPsych/ Cambridge University Press, 2021) was joint Silver Award in the Society of American Publishers PROSE Awards 2022 in the category of History of Science, Medicine and Technology (available open access https://doi.org/10.1017/9781911623793). Their co-authored Metacommunity: the current status of psychiatry and mental healthcare and implications for the future was "Editor's choice" for 2024 (available open access BJPsych International. 2024;21(3):70-73. https://doi.org/10.1192/bji.2024.15). Co-edited with Thomas Becker, *"Psychiatry after Kraepelin: Ambition Images Practices 1926-2026"* (Springer Nature) is also recently been published to mark the centenary of Kraepelin's death and is available open access https://link.springer.com/book/10.1007/978-3-032-09475-9



Claire Hilton is the founding co-chair of the *History of Psychiatry Special Interest Group (HoPSIG)* and the first *Historian in Residence* of the Royal College of Psychiatrists (RCPsych).

A former Consultant Old Age Psychiatrist and current Research Fellow at Birkbeck, University of London, this is Hilton's third book. With a primary focus on England, chronologically and thematically it forms a sequel to her second one on "Civilian Lunatic Asylums During the First World War: a Study of Austerity on London's Fringe" (1). In common with this previous, it is written with strong values of kindness, compassion, care and integrity. In her detailed examination, she employs a wide range of previous scholarship, service user and advocates testimony, press, policy and fiction writings, and her own original research. This last extends to interviewing our contemporary descendants of the

patients back then. The book is illustrated with a number of photographs, some of her own.

In her introduction, Hilton sets out the "historical context and methodological considerations". The chapters that follow are: "Outside to inside: public experience and understanding, and into the mental hospital"; "Certified under the Lunacy Act: patients' daily life in the hospital"; "Challenges for the mental hospital doctors: medical knowledge and treating patients" and "Regulatory culture: structure and staff". Perhaps reflecting her moral priorities, the longest chapter is the one on daily life in the hospital. Inter alia she offers multiple examples of abuse, discriminatory language and the awful conditions for the "inmates". For example, patients had to queue for bath and share consecutively one towel for 5. This meant that those at the back of the queue did not dry at all. In a later chapter, the failure of regulators to act with curiosity, integrity and courage is particularly notable, something familiar to us too. The epilogue "Then and now" reflects in detail on significant similarities of problems that the author finds in mental health services decades distant from each other. This is a notable strength of the volume.

Her comparison begins with the assumption (p.3) and concludes with the observation that provision of good mental health care is a "wicked problem": "Wicked problems are associated with confusing information; with individuals, groups and decision makers championing conflicting values; with baffling ramifications; and often, proposed solutions do not cure them… Wicked problems are hard to solve and require a multi-faceted process spanning far wider than professional groupings. No one group is to blame. Stakeholders across society need to work collaboratively, creatively and honestly" (p. 239). Based on this she takes aim at Michel Foucault and Andrew Scull who she associates with peddling "single issue mythologies" (p. 10).

Hilton's is a historicist account. The past is back there to be found and she is committed to describe it as "objectively as possible" (p. 10). This leads her not to examine the very concept of mental illness but to allow the term to stand as it emerges from its use at the time. Thus, she reads history with the grain, but in a nuanced way, it must be said. Though she does well to challenge Whig "progressivism" and she makes a quick early reference to the work of the Sociologist Graham Scambler (p. 3), her methodology may be relevant to why she does not address in a more fine grained way some root causes of so many similarities across a whole century.

Others take a more dialectical approaches to history (2-4). The least we can say, is that the current disastrous situation and accelerating prevalence of mental health problems in the Western world (5,6, 7) is not inconsistent with Foucault's (8, 9) and Scull's (10) theses (see also 7). One does not have to agree entirely with their writing to find that such failure might even be significantly explained by them. In my reading, neither Foucault nor Scull has suggested that psychiatrists have been entirely to blame. Foucault seems to blame instrumental Reason in particular, while Scull blames Capitalism. They both suggested, however, that psychiatrists exercised agency and fulfilled functions and ambitions within the broader systems of thought and political economy. In her study, Hilton herself finds that some doctors are to blame, others not, yet others passionate advocates for change and improvement. Be that as it may, I think the over-

biologisation of psychiatry in recent decades has made the profession blameworthy as a whole for our predicament now, but not alone so. Here, as highlighted by Hilton, health services regulators appear especially culpable too, though, presumably, they are no less well-meaning than psychiatrists. But what are their ideologies, motivations, actions and rewards and what functions do professional groups have and how do they fulfil them within the broader political economy and social sphere? The same may be asked of medicine and the healthcare and pharmaceutic industries more broadly, too (11-13).

Hilton writes clearly and in detail, digresses repeatedly from England to comparisons with other countries, both within the UK and beyond, and addresses matters from a range of perspectives (service user, charitable, public, parliamentary, law/ human rights, professional, patient, administrative etc). "Petty Tyranny and Soulless Discipline?" may be of particular benefit to undergraduate medical students or undergraduate or postgraduate students in the humanities seeking deeper acquaintance with the era or preparing essays or dissertations in the field but others too. Her book ends in 1930 with the arrival of new mental health law. The next equally significant change in this took place in 1959. I hope that she will write the history of mental health and services in the three decades 1930-1960, which include war as well and peace. This would create a notable historical trilogy and update Kathleen Jones's pioneering one (14), but with more specific focus on the half century 1910-1960.

Note: an abbreviated version of this text has been published as book review on the website of the British Society for the History of Medicine (accessed 17/11/25) https://bshm.org.uk/wp-content/uploads/2025/11/Petty-tyrany-for-website.pdf

Conflict of Interest: I succeeded Claire Hilton as Chair the Executive Committee of The Royal College of Psychiatrists History of Psychiatry Special Interest Group. We both remain members of its executive committee and have collaborated there and beyond.

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