

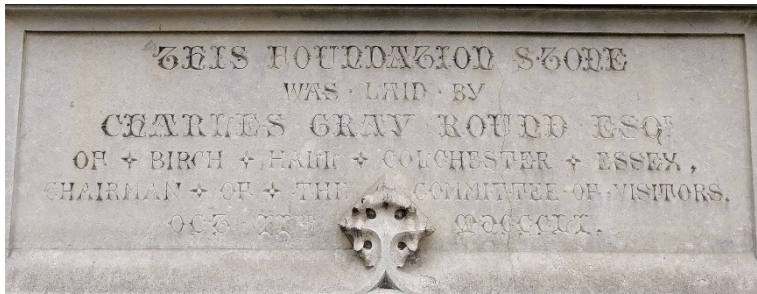
# News and Notes



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

**Issue 9, Autumn 2019**

**Editors: Claire Hilton, Lydia Thurston,  
Mutahira Qureshi**



# News and Notes

## History of Psychiatry Special Interest Group

Issue 9, Autumn 2019

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# Editorial

Mutahira Qureshi, co-editor

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Welcome to another edition of HoPSIG's *News and Notes*. There are now three of us editing it, Claire Hilton, Lydia Thurston and myself, Mutahira Qureshi. Lydia is on maternity leave. Congratulations, Lydia on Rohan's birth!

My understanding of the quest to discover psychiatry in history is perhaps akin to Edgar Allan Poe's monumental *The Pit and the Pendulum* situation,<sup>1</sup> where Poe's narrator is trapped in a dungeon with contracting walls. In the centre of the dungeon is a pit and hanging from the ceiling is a swinging pendulum which lowers itself with every swing and retains the potential to slice the narrator in its descent. The task of Poe's narrator is an impossible one: to escape the dungeon alive.<sup>2</sup>

The contracting dungeon walls, in this analogy, symbolize the limits of historical material available for our scrutiny that grow scarcer and more encoded in long lost volumes and languages the further we go back in time. The pendulum swinging from one extreme to the other symbolizes the waves in psychiatric practice over the course of history: from the strictly biological approach to the fully abstract one of free association. This is elucidated in Freud's case histories where he notes that what he writes 'should read like short stories and that, one might say, they lack the serious stamp of science'.<sup>3</sup> And in the midst of these two, as Poe's famous gothic imagination decrees, is the abyss of interpretation of historical material.

Perhaps Hieronymus Bosch's painting 'The Cure of Folly' illustrates this. The painting depicts, in Bosch's characteristic bizarre style, a red-robed surgeon performing what appears to be brain surgery with a scalpel, as a monk and a nun look on. And around the painting, inscribed in gold lettering is the following, in Flemish: 'Master cut the stone out quickly / my name is Lubbert Das'.

While tempting, it is simplistic to assume on face value that this evidences the historicity of psychosurgery. And if one is to avoid the slip into Poe's pit then any attempt at oversimplification and

over interpretation would be perverse.<sup>4</sup> And the answer to the question of whether Bosch's stone operation is based in reality or fantasy must be 'yes' to both.<sup>5</sup>

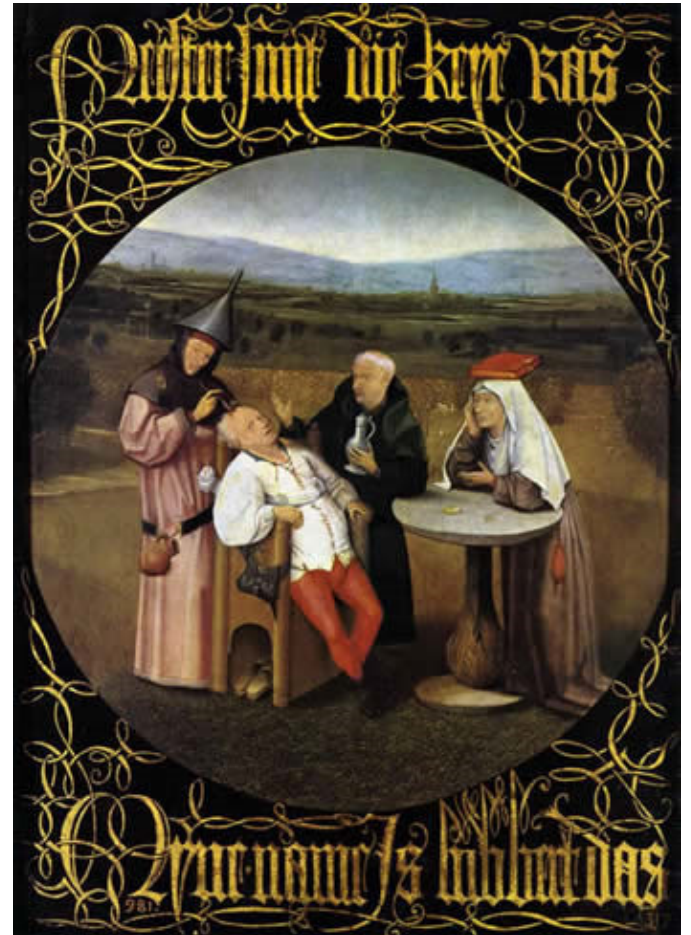


Figure 1 Hieronymus Bosch, *Cure of Folly (Stone Operation)*, ca. 1488 or later, oil on panel, Museo Nacional del Prado, Madrid

For while some medical texts from medieval times allude to the practice of invasive procedures like trepanning for neuropsychiatric manifestations, equally medical historians like William Schupbach completely dismiss the practice of such a procedure as depicted by Bosch. Others maintain that Bosch's rich extravaganza is an allegory of stupidity or 'folly' akin to the modern colloquialism 'having rocks in the head'. On the other hand, there have also been accounts that the visual extravaganza captured by Bosch reproduces a public entertainment spectacle put up by amateur theatres.

<sup>1</sup> Poe, Edgar Allan, and Alexander Scourby. *The Pit and the Pendulum*. Classic House Cassettes, 1977.

<sup>2</sup> Clark, David Lee. The Sources of Poe's the Pit and the Pendulum. *Modern Language Notes*, 1929, 44, 6, 349-356

<sup>3</sup> Freud, Sigmund. *The Complete Psychological Works of Sigmund Freud: Studies on Hysteria*. Vol. 2. London: Random House, 2001.

<sup>4</sup> Gibson, Walter S. *Hieronymus Bosch*. London: Thames & Hudson, 1973.

<sup>5</sup> Dixon, Laurinda. *Bosch*. London: Phaidon, 2003



Bosch paints with a flair of accuracy that inspires historical scrutiny for validity: red robed surgeon with a historically accurate scalpel in hand; wearing an inverted conical hat about to incise trans-cranially: while offering no explanations or embellishments or interpretations for this phenomenon to the beholder. While the former aspect is crucial to any historical writing; perhaps more well researched and historically-conscious interpretations and explanations could also be helpful.

In this issue we present a number of articles encompassed within the history of psychiatry: a walk through a reclaimed Victorian asylum, the eventful life of a young fevered political celebrity, the scrutiny for traces of madness within scripture, and Cade's inspired discovery of lithium as psychotherapeutic.

In terms of HoPSIG events and activities since the last issue, we hosted a seminar on aspects of the history of forensic psychiatry in March 2019. Dr Harvey Gordon spoke around the interface between adult and forensic psychiatry and Professor John Gunn about his 50-year experience as an academic forensic psychiatrist. This was followed by meticulously researched presentations looking at criminal lunacy and British asylums of the 19<sup>th</sup> century, and presentations by medical students.

HoPSIG also presented a session at the RCPsych International Congress 2019 in London. Professors Nicol Ferrier and Edgar Jones and Dr Claire Hilton spoke on the theme 'Want, disease, ignorance, squalor and idleness: Making it better? Episodes in psychiatric practice 1880–1980'. Thanks to all of you who attended. There was a great turnout. Claire Hilton's presentation has been summarised in a *BMJ* opinion piece, [Caring for people who are mentally ill—lessons from a tragic past](#). We have eagerly submitted our proposal for next year's Congress.

HoPSIG, together with RCPsych archives department, is also organising a witness seminar on psychiatric hospitals in the 1960s as a day event in October 2019. The seminar will be transcribed and annotated and made available online as a historical resource. In January 2020, we are linking with the Royal Society of Medicine for a conference [Mind, State and Society, 1960-2010](#). We have a **provisional** date for a conference in Newcastle upon Tyne, 17-18 September 2020, on the theme "Understanding death and mortality in the context of mental illness and institutionalisation during the 18th-20th centuries" – more information will follow.

Lastly, **please send us your articles and comments for the next newsletter**. Tell us about

any history projects you are doing, write a review on a relevant history book, film, or website; or send us pictures and articles about anything in the history of psychiatry which has caught your attention. The **copy date for the next issue is 31 January 2020**. We look forward to hearing from you. Please send your submissions to [claire.hilton6@gmail.com](mailto:claire.hilton6@gmail.com)

We hope you enjoy this issue!

## Hello again!

### From Prof George Ikkos, chair of HoPSIG

[ikkos@doctors.org.uk](mailto:ikkos@doctors.org.uk)

This is a propitious time to be involved in HoPSIG. 2021 will mark 50 years since the establishment of the College and the president has initiated preparations to publicise and reflect on this event. A sense of history is essential to the evolution of identity, and now that mental health has firmly established itself in the national conversation, it is especially important for us as psychiatrists. Is there something essential that is unique about our identity or is it change itself that marks it most? How can we learn from the past and contribute to the improvement of population and individual mental health in the future?

It is a propitious time also because we enjoy increasing support from the College. The response of the president Wendy Burn, registrar Adrian James and hon treasurer Jan Falkowski to our approaches has been consistently benign. The appointment of the first RCPsych historian has now been complimented by a new honorary archivist, Graham Ash. Graham has extensive experience and record of achievement in the history of psychiatry as medical humanities lead in the [Wittingham Lives](#) project and he will support Francis Maunze in enhancing the College archives and associated activities. Equally experienced is Peter Carpenter who as finance officer is leading the drafting of our annual plan. I am pleased to say that the College is reviewing its support for faculties, divisions and SIGs and along the way has relaxed the rules about engaging CALC in our events.

Looking to the future, I am delighted that Claire Hilton has agreed to continue as newsletter editor to support Lydia Thurston to further develop her valuable contribution and evolving skills as trainee editor. Lydia also chaired our well attended and high-quality contribution to the College International Congress at a session on 'Want, disease, ignorance, squalor and idleness: making it better? Episodes in psychiatric practice, 1880-1980'. Claire and Lydia have now been joined by our new trainee editor and executive committee member Mutahira Qureshi. Also new to the committee are trainees Thomas Stephenson who is co-leading with Claire Hilton the witness seminar on psychiatric hospitals in the 1960s, which will take place in October, and Mohamed Ibrahim who will lead on our next memoir competition under the umbrella of 'Archives of the Future'. A key objective will be the deposition of all

entries in the College archives to make them available for future generations of historians of psychiatry. Ibrahim will also take over from Andrew Howe the management of our Twitter account. We are indebted to Andrew Howe for establishing @rcpsychHoPSIG and building up to 782 followers. That's more than 15 times as many as @gikkos1! Trainee Kamran Mahmood has also agreed to join and I look forward to meeting him in due course; Matthew May too.

Finally, please mark 14 January 2020 in your diaries. Tom Burns is leading on behalf of the Royal Society of Medicine (RSM) Psychiatry Section and HoPSIG on the conference [Mind State and Society 1960-2010](#) to be held at the RSM. This will look in detail at aspect of the social history of psychiatry during this era and a high quality and diverse range of speakers has agreed to contribute. I look forward to seeing many of you there!

Have a great new academic year.

George

## Events, dates, website and information exchange

### Conference!

#### Mind State and Society 1960-2010

Tuesday 14 January 2020, for a detailed look at the history of psychiatry, mental health, and public mental health services in British society between 1960-2010: Royal Society of Medicine, Wimpole Street, London, W1G 0AE

### Next issue

Your articles, reviews, photos, ideas, requests for information etc please, by  
31 January 2020  
to [claire.hilton6@gmail.com](mailto:claire.hilton6@gmail.com)

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Have a look at the

**RCPsych history, archives and library blog**

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

### Information exchange

If you are interested the development of general hospital psychiatry in New South Wales, Dr Richard White would be keen to hear from you [richardtrathenwhite@icloud.com](mailto:richardtrathenwhite@icloud.com) (see page 21)

If you worked on a psychiatric 'observation ward' in a general hospital before the Mental health Act 1959, or heard accounts of them from people who did, Dr Colin Cowan would like to hear from you [cowan1605@gmail.com](mailto:cowan1605@gmail.com) (see pages 17-19)

# Articles

## Well and soundly built – establishing Herefordshire’s mental hospital at Burghill

Rhys Griffith

Senior Archivist, Herefordshire Archive and Records Centre (HARC),

[www.herefordshire.gov.uk/archives](http://www.herefordshire.gov.uk/archives)

St Mary’s Park is a secluded housing development on a wooded slope in the heart of the lush Herefordshire countryside. It lies roughly midway between the county town and the picturesque village of Burghill, four miles to its north west. Although access to the site is unimpeded, its layout and feel suggest a gated community. It incorporates a mix of housing representing two distinct periods of occupation. There are new properties, ranging from grand executive houses with manicured lawns to more modest terraced homes. Then there are the imposing red brick buildings, which clearly predate their less substantial neighbours. Their style is distinctively Victorian, and despite the residential setting, unquestionably institutional in origin. In particular, two great blocks set obliquely at the front of the site obviously served some former purpose. Rows of generously proportioned windows afford the fortunate occupants of these repurposed apartments delightful pastoral views and let in generous amounts of light. This was a feature that the original architects were specifically instructed to include. The advantages that now encourage enthusiastic estate agents to describe the development as *sought after* were once seen as essential elements in a therapeutic and curative process.

The Victorian structures are remnants, selected for adaptation, of a sprawling complex of buildings that was once known as the Burghill Mental Hospital and, before the introduction of more sensitive language, the Hereford County and City Lunatic Asylum. This was very much a local institution for a remote, lightly populated backwater, far from the centres of power and influence. And yet, the increasingly centralised nature of 19<sup>th</sup> century administration and social, economic and medical policy meant that

establishments like Burghill were typical of the national experience.

From the mid-19<sup>th</sup> century onwards, the capacity of the state to direct and regulate at a local level grew exponentially. New initiatives, such as public registration and the census, augmented the bureaucratic armoury. At the same time, efforts to address longstanding social problems in areas such as welfare and the penal system bound the nation ever more tightly to a single endeavour. Whilst the experience for those at the receiving end of a new punitive approach was invariably a harsh one, there were real improvements in key areas such as public health. Similarly, a growing interest in trying to understand mental illness combined with a merciful response to those afflicted with it influenced the emergence of the classic Victorian lunatic asylum. Burghill epitomised a new positive approach that was entirely at odds with the popular image of the gothic madhouse and an immeasurable improvement on the world it replaced.

### A first asylum

Before this change, provision for so called lunatics in the county, as in any part of kingdom, was at best arbitrary. The vast majority of those with mental illness were either cared for by their families or left at the mercy of society as wandering vagrants or prisoners. By the late 18<sup>th</sup> century private and, much less typically, charitable asylums began to emerge. Hereford’s own asylum, designed by John Nash no less, was opened in 1799 for both private and pauper patients. The original designs, housed with all the surviving records at Herefordshire Archive and Records Centre (HARC), betray the contemporary approach to the treatment of the 36 inmates, who were accommodated in rooms described as cells.<sup>1</sup>

There can be no clearer manifestation of the ills afflicting the early asylum regime than Hereford. Though notionally regulated by the local visiting committee of JPs, it became clear that abuses were rife. The establishment was run as a commercial enterprise with profit taking precedence over patient. The low point was reached in 1839 when the death of an inmate eventually led to a Parliamentary enquiry. Despite the scandal, the lack of any alternative allowed the notorious institution to continue operating until progress on a national level brought about its redundancy.

From the early years of the 19<sup>th</sup> century, a succession of enactments developed the notion of



state responsibility for the welfare of mentally ill people. The culmination was perhaps the legislative double act of 1845. The Lunacy Act and the Lunatic Asylums Act compelled local authorities to provide well regulated and suitably designed public asylums and a proper county based system of management that offered a safe setting for mentally ill patients and promoted their recovery where possible.

### A second asylum

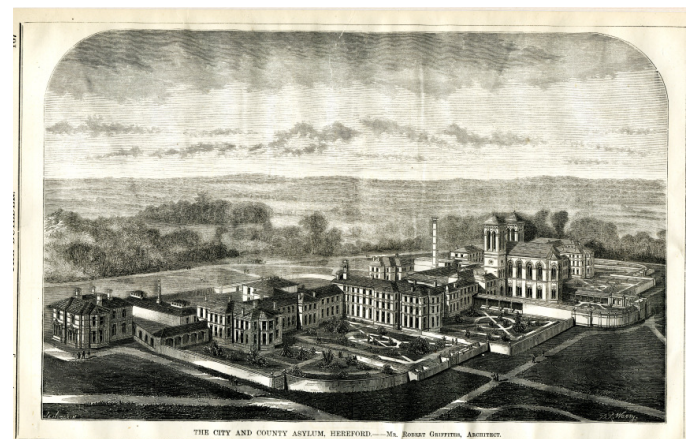
Dozens of petitions from Herefordshire parishes surviving among the archives of the Quarter Sessions at HARC attest to the reluctance of the local ratepayers to countenance a publicly funded solution.<sup>2</sup> They contain spurious references to the efficacy of independent asylums (foreshadowing more recent debates over the relative merits of private over state provision of services). These objections were in vain and the county duly followed the letter of the law by investing in a purpose-built facility for its most vulnerable citizens. The Act did not compel local authorities to establish individual asylums for every county. In order to minimise the financial impact on the county, therefore, the Justices formed a union with neighbouring Radnorshire and Monmouthshire and established a joint asylum in the countryside on the outskirts of Abergavenny.

Opened in 1851, the well-appointed new structure was designed to accommodate 254 patients. It rapidly became clear that the longstanding need for such a place of refuge had been underestimated and by 1864 the asylum had been enlarged to house a population of 480. Families and friends of individuals with mental illness were now able to submit their loved ones to the care of a trusted and well regulated institution. By 1868, the Herefordshire justices recognised that a shared provision could no longer meet this new and growing expectation and the decision was duly taken to invest in an asylum within the county.

### The third asylum, at Burghill

With classic Victorian energy and resolve, the Justices selected and acquired the Burghill site, commissioned the architect and oversaw the construction project to its conclusion within three years. The first patient was admitted, with no fanfare, on 1 February 1871. Meticulous, almost obsessive record keeping demanded by the Lunacy Act has ensured that a richly detailed archive of the asylum's management has survived at HARC. A key source for the early phase of the County and City Lunatic Asylum's history is the annual report to the committee of visitors compiled by the medical superintendent Dr Algernon Chapman.<sup>3</sup>

In the first report of 1872, Chapman gave a detailed description of the layout and pronounced it *well and soundly built*. The buildings, which were constructed using a pleasing brick design, had extensive and beautiful views and there was an ample water supply. Accommodation for 400 patients was divided by gender into four substantial wards on either side of a central axis. The day rooms and corridors were described as light and remarkably cheerful with airy dormitories. These opened onto regularly positioned exercise yards which formed a crucial part of the therapeutic regime. Similarly, workshops for the men and laundries for the women were designed not only so that patients could contribute to their own upkeep but in order that they might benefit psychologically from purposeful employment.



The completed Hereford City and County Lunatic Asylum in 1872. (HARC)



Staff and patients in the female corridor at the Hereford City and County Lunatic Asylum, c. 1900. (HARC)





Staff and patients in the female infirmary ward at the Hereford City and County Lunatic Asylum, c. 1900. (HARC)

Dr Chapman was a model superintendent of a Victorian asylum. He was a highly qualified and senior practitioner with a selfless commitment to the welfare of the patients in his care. Remarking on the typical response of local residents to the regular escorted walking parties of patients, he noted regretfully in his annual report: 'the belief which, I am sorry to say, is widely held that the Asylum is merely a place for shutting up and so getting rid of insane and troublesome people, and, ergo, if these people are to be met on the roads and have not been completely got rid of, the Asylum is failing in its duty.'

Until his retirement through nervous exhaustion in 1896, Chapman was served by a rigid staff structure. Perhaps second in rank, the chaplain played a key role by leading regular services in the asylum's chapel, where moral improvement was encouraged as a form of therapy. At Burghill, divine service was held three times a week and on Sundays more than half the population of the asylum typically attended. Less formally, the chaplain also strove to keep spirits up by regular contact with the patients and by arranging weekly entertainments, including balls and evening readings.

The housekeeper, who was the head of the female side with responsibility for welfare and cleanliness, supported this endeavour. Miss Cambridge was a proficient harmonium player and organised a choir of staff and patients. An assistant medical officer took the lead in medical procedures and was directly responsible for staff management and discipline. A clerk and steward oversaw the complex business of central administration – ensuring the effective use of supplies and maintaining the requisite medical and financial records. The workforce was further augmented by the farm bailiff and workers who ran, with the help of patients, the 100-acre land holding

on which the community relied for foodstuffs and income.

Of the whole hierarchy of staff, the attendants, who were near the bottom, had the most direct impact on the lives of the patients. In 1873 there were 9 male and 11 female attendants with a caring ratio of about 1:8. Financial rewards for those in the most direct influence on the lives of the patients were minimal and the working day could run from 6am-10pm. Exemplary standards of behaviour were also demanded as well as a range of special skills designed to support the patients and encourage recovery. Any form of cruelty was punished by instant dismissal and the use of physical restraint so rare as to feature in the annual report.

In the absence of effective medication, treatment was essentially limited to raising spirits and providing a secure, restorative and nurturing environment for the patients. Sedation, for example, was confined to the application of calming warm wet towels. There was a real attempt to identify different conditions and to treat them accordingly. The Victorian penchant for classification was given free rein at Burghill. Patients enduring conditions which ranged from mania to dementia and melancholia to moral insanity were enumerated carefully. Case books surviving at HARC chart the constant observation and treatment of each patient in unwavering and intimate detail.<sup>4</sup>

### Into the twentieth century

The public asylum at Burghill was emblematic of a national movement, an approach to mental health provision that endured for a century and a half. Expansion continued into the 20<sup>th</sup> century and the addition of the two new frontal wings in 1900 increased patient capacity by 150. A succession of Mental Health Acts and advances in psychiatry brought continuous change to the clinical and organisational regime. Nonetheless, the underlying ethos of the asylum as a place of refuge and recovery remained true. Just as national policy established the institutions, so it swept them away and in 1996 the patients were discharged for alternative provision.

In 1995, former patients at Burghill were interviewed for a volume of reminiscences called *Boots on, Out!* Without exception, they presented a positive image of the care they had received, notwithstanding their own difficult personal circumstances. Whatever the shortcomings that had by then come to be associated with institutional treatment, the staff at Burghill had made an earnest effort to heal those entrusted to their care. In doing so, they had also provided relief for family and friends and the

reassurance to society at large that those who were among its most vulnerable members could expect compassion from the state.

#### References

<sup>1</sup> Hereford Asylum building plans, 1798. HARC, Q/AL/157-161

<sup>2</sup> Petitions to the Justices against the establishment of a county lunatic asylum. HARC, Q/AL/196-8

<sup>3</sup> First Annual Report of the Committee of Visitors of the Hereford Lunatic Asylum, Burghill, 1872. HARC, BF53/1

<sup>4</sup> The main series of surviving case notes for male and female patients date from 1872-1919 and are now open for inspection. HARC, BJ10 passim

#### Further reading

Renton, C. *The Story of Herefordshire's Hospitals*, Logaston Press, 1999

Stevens, M. *Life in the Victorian Asylum*, Pen and Sword Books, 2014

## The Committee of the London County Council on a Hospital for the Insane

RHS Mindham

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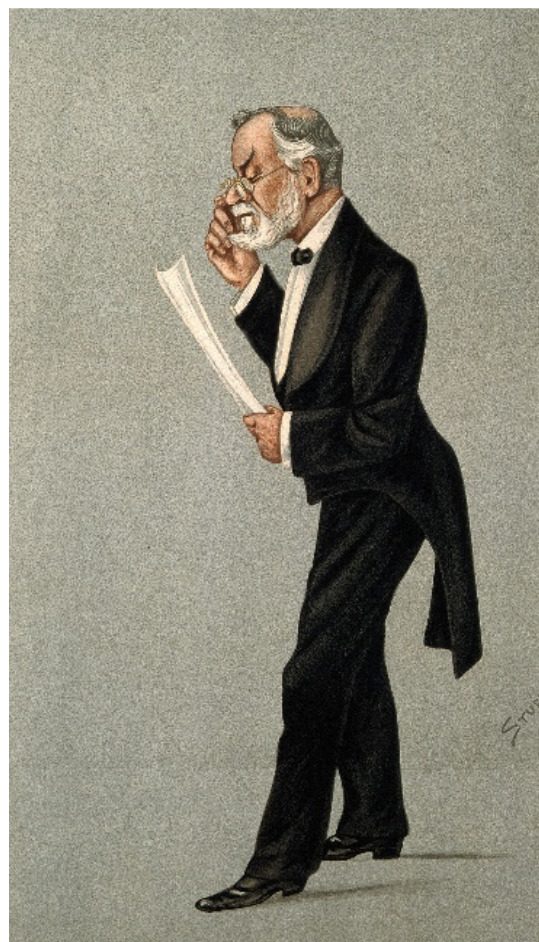
### The remit

The Committee on a Hospital for the Insane was constituted by the London County Council (LCC) on 11 April 1889.<sup>1</sup> Its task was: 'to enquire into, and report to the Council upon, the advantages which might be expected from the establishment, as a complement to the existing asylum system, a hospital with visiting medical staff, for the study and curative treatment of insanity.' The committee held its first meeting on 13 May 1889 when Mr Brudenell Carter, FRCS (Fig 1), was elected chairman. Members of the Committee were: Mr Carr-Gomm JP, Mr Burns, Captain James RE, Mr Hutton, Dr Longstaff FRCP, many of whom had served as chairmen of LCC and London hospital committees, and Mr Martineau JP, who was chairman of the LCC Asylums Committee.

### Procedure

The Committee drew up a list of eminent doctors who it wished to call to give evidence. The first three witnesses to be examined were Dr John Batty Tuke, formerly superintendent of the Fife and Kinross Asylum; Sir John Banks, Regius Professor of

Medicine in the University of Dublin and Sir James Crichton-Browne, Lord Chancellor's Visitor in Lunacy and formerly superintendent of the West Riding Pauper Lunatic Asylum at Wakefield. The Committee then drew up a list of questions which they wished subsequent witnesses to consider before giving evidence. These included the site, size and character of the hospital, links with general hospitals, medical and nursing staffing, admission policies, finance and payment of staff and the desirability of taking pupils. Although having female nursing staff managing male patients was considered, none of the witnesses called were women.



Robert Brudenell Carter, by Sir Leslie Ward, 1892 CC by 4.0 licence: Credit: Wellcome Collection

The committee interviewed sixteen eminent doctors in all, most connected with medical schools and universities. They included physicians and surgeons many with an interest in neurology, but only two had held appointments in the field of insanity. They all believed that the care of the mentally ill had not progressed as a result of scientific advances to the same degree as in medicine as a whole. They were unanimous in the view that a hospital for the mentally ill which had the structure of a general hospital and a wide range of expertise among its staff would promote an increase in knowledge of mental disease. Dr David Ferrier's comments were especially pertinent: 'We have learnt a good

deal...of the objective functions of the brain...but as regards the subjective functions of the brain – the psychological aspects of cerebral activity – I think...we are practically in total ignorance.'

### **Definition of mental illness**

Before proceeding further, the Committee reached a consensus as to the nature of mental illness. They were aware that many believed that insanity was the result of supernatural forces. The Committee regarded mental illness as part of the province of medicine and that suffers should be investigated and treated accordingly. They believed that many mental illnesses were due to diseases of the brain, some of which had been identified, and that new methods of investigation would reveal pathological changes in the brain which would lead to new methods of treatment and prevention. They noted that some toxic processes could produce mental derangement which may be temporary, but that long-term exposure to the toxin might result in permanent damage. These considerations led the Committee to the view that a pathologist had a particularly important rôle to play in both clinical management and research. This view of the scope of mental illness meant that only the most severe conditions were considered and that the morbidity of less severe conditions was not recognised. The Committee were aware of the relationship between some forms of insanity and physical illness which required medical evaluation and treatment.

### **Stasis in the care of the mentally ill**

The Committee felt that the geographical isolation of asylums, the large number of patients attended by assistant medical officers and the administrative burden borne by medical superintendents had contributed to a lack of progress in the field. Patients had been deprived of the advantages of the approach to care adopted in general hospitals. However, the Committee recognised the important contribution of 'moral treatment' to the care of patients ('moral' in this context meaning mental or psychological, following the practices of Samuel Tuke at The Retreat in York) as well as contributions to the understanding of mental illness from research in certain centres.

The Committee then drew up three questions which were sent to the medical superintendents of all asylums in England and Wales and to the medical directors of observation units attached to poor law hospitals in London. In essence, the three questions were: are present arrangements for research into mental illness adequate; are there deficiencies which might be remedied by a hospital for the insane; would you be willing to give evidence to the Committee in person? Of the 65 who replied three quarters were dissatisfied with current arrangements but only one third gave unqualified

approval to the proposals. The opinions expressed reflected the view that most asylums provided good care of patients who were suffering from mental illnesses for which there was no cure; moral treatment was the best that was available. Many respondents did not believe that visiting doctors were likely to contribute very much to what was already being done. As an alternative, improvements in the rates of recovery might be made by increasing staffing levels in asylums. Some of the reports were delivered with striking eloquence.

### **Out-patient clinics**

Consideration was given to the desirability of establishing outpatient clinics in the hope of reaching patients in the earlier stages of illness when they might be expected to be more responsive to treatment. Patients might also be supervised once they had been discharged from hospital. In considering this the Committee seemed to be wary of trespassing on the territory of other doctors, especially general practitioners. The place of medication in treatment which might be employed in outpatient work was uncertain although there had been some modest advances in the use of medication in neurology which might be extended to mental illness. Medication in asylums was largely used to treat physical conditions or used a non-specific way.

### **Research**

The proposed hospital was to be a centre for increasing understanding of mental illness through research. The Committee noted the need, in promoting research, for large numbers of patients to be brought together, for systematic collection of data, for the analysis of information and for the study of experimental treatments, and for the results to be promulgated through learned journals and scientific meetings. These activities would be an integral part of the work of the proposed hospital.

### **Teaching**

The Committee considered the needs to teach both undergraduate medical students and trainees in the field of mental illness. The Lunacy Act placed specific responsibilities on doctors in the detention of patients by virtue of mental illness. The General Medical Council (GMC), established in 1858, had the task of overseeing the training of doctors to ensure that it prepared them for the responsibilities placed upon them. The Committee regarded the present arrangements for teaching undergraduates about mental illness and the supervision of their training by the GMC as unsatisfactory. They noted the need to provide both theoretical and practical teaching to undergraduates and to trainees in the speciality.



## Costs

Estimates of the likely cost of the hospital were obtained from Mr BB Rawlings, Secretary of the National Hospital for the Paralysed and Epileptic. In his opinion, based on detailed calculations, the hospital would cost around £62 per bed per year, before medical staff costs, which compared with about £30 in a county asylum. There was consideration of whether medical staff should be paid, at what level and whether they should be resident or part-time. Members felt that a generous salary should be offered for a pathologist, to ensure the appointment of a candidate of the right calibre.

## Recommendations

Having completed its review the Committee unanimously recommended that a hospital for the mentally ill of one hundred beds be established in London by the LCC under the supervision of a subcommittee of the LCC Asylums Committee. The hospital would provide treatment for acutely ill patients and would be concerned in the furtherance of knowledge of mental illness by research and in the teaching of medical students and of trainees in the speciality.

Many currents are evident in the proceedings of the Committee. Professional interests were at stake in many areas. There was a strong representation of neurologists among those interviewed who saw that their speciality had benefited from scientific advances and that similar approaches might be used in mental illness. They may have overestimated what had been achieved in their own speciality. The report repeatedly touches on the changing interface between psychiatry and neurology, a relationship which has never been fully resolved. Medical superintendents were defensive, seeing their rôle being to care for incurable patients humanely. There was some concern that changes might be recommended by a committee which did not fully understand the needs of mentally ill people. An important issue was the nature of contracts of employment of doctors; should they be full-time and require residence or part-time and allow private practice? The Committee were, however, convinced throughout their deliberations of the need to further the investigation and treatment of mental illness by any means possible and to improve arrangements for the teaching of the subject.

## The legacy

The Committee's proceedings were no less than a review of the state of psychiatry in the British Isles and reflected similar problems in medicine at large. It was a turning point in the development of psychiatry in which there was to be a move from asylum-based practice to early treatment of acute patients, the development of outpatient work and the

recognition of the morbidity of the neuroses. Sir Henry Burdett, author of the definitive work on the design of hospitals and asylums, thought the report sufficiently important to include it in its entirety as an appendix to his book.<sup>1</sup> Many years passed before the Committee's recommendations were acted upon. A hospital for acute psychiatric admissions (later to become Pinderfields General Hospital) was opened adjacent to the West Riding Asylum in 1900, and many asylums early in the 20<sup>th</sup> century, built detached acute wards or 'neurosis units'. In London, the Maudsley Hospital was completed in 1915 but did not come into its intended use until 1923 on account of the First World War. The widespread provision of psychiatric services in general hospitals came much later.<sup>2</sup>

*I am grateful to the Royal College of Physicians and Surgeons of Glasgow for the use of their library and to the library staff for their kind assistance.*

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# Lithium: celebrating a bicentenary

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Soranus of Ephesus recommended the consumption of natural mineral waters for mania as far back as the 2nd century AD.<sup>1</sup> Yet, as 2019 passes, there appears to have been little celebration of the 200<sup>th</sup> anniversary of the discovery of lithium, by Johan August Arfwedson despite the fact that in 2018 at least 12 national guidelines, and the global World Federation of Societies of Biological Psychiatry guideline, cited lithium as the recommended pharmacological treatment for bipolar disorder (BD);<sup>2</sup> and given that BD types I and II have a collective lifetime prevalence of 2.3%.<sup>3</sup>

The following selected resources provide enjoyable historical insights into the discovery of lithium, its usefulness in psychiatry, opposition to its use and eventual acceptance. Reading these would be an apt act of celebration.

Weeks and Larson's (1937)<sup>4</sup> paper on Johan August Arfwedson (1792-1841), a Swedish scientist, and his services to chemistry details how Arfwedson, with support from Jöns Jacob Berzelius, deduced that something was missing when trying to account for the results of his chemical analyses of the mineral petalite, which led to the discovery of lithium.

John Cade's seminal paper (1949)<sup>5</sup> gives an account not just of methodical observation and deduction, but intriguingly states that his starting point was an investigation of the toxicity of urea, for which lithium urate was found to be the most practical medium. Then to further ascertain the effects of lithium, lithium carbonate was used. Noting the effect of lithium on the activity and responsiveness of guinea pigs, experimentation then moved on to study the effects of lithium with patients. Sadly, Cade is no longer with us. In this auspicious period, it would have been a privilege to delve into how his original investigation developed and ask his opinion of the tribulations and successes of lithium in psychiatry.

A contemporary paper detailing concerns about the toxicity of lithium chloride when used as a substitute for sodium chloride gave a flavour of the issues surrounding lithium, as well as a further example of the style of scientific papers of the time (1949).<sup>6</sup>

An account of the bumpy road of lithium in psychiatry by Shorter (2009)<sup>7</sup> details that in the 1960s its usefulness was opposed in strong terms by two

leading psychiatrists from the Maudsley Hospital and that it was only as late as 1970 that the Food and Drugs Administration of the USA finally approved lithium. Lithium has also had renowned advocates, for example, Poul Christian Baastrup and Mogens Schou (to name just two) who supported its use as a prophylactic agent against manic-depression and recurrent depressive disorder.<sup>8,9</sup>

A recommended tome providing a scientific, clinical and historical perspective from leading proponents of lithium is the dedicated *Lithium in Neuropsychiatry: The Comprehensive Guide*<sup>10</sup>.

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# John Tom: Sir William Courtenay, the Peasants' Saviour, and the Kent Lunatic Asylum

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Kent County Lunatic Asylum

The Kent County Lunatic Asylum at Barming, Maidstone opened in 1833. Its most colourful patient was admitted in the same year. Case number 107 reads:

28 October 1833. Committed under a warrant of the Secretary of State. His real name is John Nichols Tom of Truro in Cornwall, a Maltster by trade fond of cricket and sailing...his mind has not been quite sound for many years. He would pursue some amusement for a time with great ardour and then suddenly give it up without any assignable cause....Present Conduct: labours under delusions regarding his person and property - fancies himself Sir Wm. Courtenay. Believes P. Castle in Devonshire belongs to him and that he is heir to the Honeywood Estate. Supposes he has been at Jerusalem and other places which he never visited and calls himself a 'Knight of Malta'. His ideas are very deranged on many subjects and he betrays his insanity in his conduct as well as his conversation wearing a beard and dressing unlike any one else.

John Tom was born in 1799 in St. Columb Major, Cornwall. His first school was run by a pastor, along

strict religious lines. At 18 he became a solicitor's clerk, at 21 he had a successful career as a clerk to wine merchants. He later managed a malting business, and at 25 married a market gardener's daughter with a good dowry. He began to visit London and joined the Spencerian Society. He was said to have admired Richard Brothers, a religious prophet (1757-1824) who claimed to be the 'Revealed Prince of the Hebrews, God Almighty's Nephew'. Brothers was later arrested and declared mad. He also admired William 'Longbeard' FitzOsbert who raised an agitation in Kent against the poll tax in the time of Richard I styling himself 'Saviour and Apostle of the Poor'.

When Tom was 28 his mother developed 'symptoms of insanity' was admitted to St Lawrence Bodmin Lunatic Asylum where she soon died. After his mother's death, his business premises burnt down, for which he was falsely blamed, but subsequently received the insurance.

At age 30 Tom began to have fits of melancholy and acted eccentrically. The melancholy was so severe that he had blood let and his head shaved. His business was closed due to his mental state. Shortly afterwards, however, he wrote a letter saying 'great events were germinating in the womb of time' in which he would play a part and predicted a seat in Parliament.



John Tom. Photograph by author, with permission from owner

'England had never been so near revolution since 1688' following the slump of 1830: the Enclosure Acts, the fall in wheat prices after the Napoleonic Wars and the consequent return to the gold standard raised inflation. An agrarian revolt took place over much of England in 1830, starting in Kent with the destruction of threshing machines (farm labours expected the new machinery would leave them out of work) and rick burnings. Small farmers and



radicalised middle classes joined the landless labourers urging the end of the tithes system.

It was into this political context that Tom appeared. After several exploits he arrived in Canterbury in September 1832, giving his name as Count Moses Rothschild. A large powerful man with black beard, dressed in robes of antique splendour, his appearance immediately attracted attention. He stayed at the local inn appearing once a week to attend church. He never conversed but casually revealed wealth.

In December 1832, he put himself forward for election as Sir William Percy Honeywood Courtenay, Knight of Malta for the parliamentary seat of Canterbury, as a Tory radical, 'to end tithes, end taxes on working class and shopkeepers, on knowledge, and primogeniture, chartered and corporate bodies, sinecures and slavery.' Demagogic and of striking appearance, he demonstrated his physical prowess at gatherings, by leaping onto the table at the Guildhall, and declaimed against the House of Commons. He proclaimed universal suffrage, harangued the crowds from the balcony of the Rose Inn, and his coach was pulled by enthusiastic followers. *The Times* said he was mad. After losing the election, he began a campaign for election to a county seat, but made the mistake of appearing aged and infirm and was exposed, obtaining only 3 votes.

Returning to Canterbury he started a newspaper, *The Lion* in which he supported the small farmer against inflationary rents and tithes, attacked Unitarians, atheists, agnostics and Tom Paine, and began to enunciate his religious principles and loyalty to the throne. The first issue of *The Lion* gives a fantastic autobiography and the titles of King of Jerusalem, Prince of Arabia, King of the Gypsies.

Trying to defend smugglers, he was charged with perjury. At the hearing he was silent but grimaced at witnesses, smiled ingratiatingly at the judge, or threw up his eyes, an effect 'indescribably ludicrous'. When found guilty he delivered a logical speech but ended with the declaration 'Kent! Your God will see me done justice to!' Sentenced to 5 months in Maidstone prison, to be followed by 7 years transportation, his wife managed his transfer to the Kent County Asylum, pleading his insanity.

After a year in the asylum his local supporters wrote to Dr Poynder, the superintendent, to obtain his release, but received the reply that although he had 'conducted himself peaceably and conformed to the rules of the institution....at the time of the perjury was decidedly of unsound mind. He would now harm no-one but I cannot answer for the conduct of others who might be excited by his unsound and extravagant opinion...and...delusions respecting his personal property'.

Eventually his family persuaded the Home Secretary, Lord Russell, and others to exert pressure on the asylum to release him to the care of his father. Tom persisted in denying his father's identity repeating his claim to the Honeywood Estate. He came to stay with a local farmer, Mr Francis, at Boughton in October 1837. Francis, who was described as 'someone of small understanding but of great vanity', narrow and religiose, was overwhelmed by Tom's aristocratic aspirations. Tom immediately began to associate with the inhabitants of Boughton.

In January 1838, wearing a brace of pistols, he began his rides through Kent, and Francis turned him out. He made the acquaintance of the Culvers of Bossenden Farm near Faversham, an elderly couple with a 40-year-old daughter, who quickly became Tom's disciple. Tom began to put forward religious claims, including his own divinity, to use apocalyptic messages to arouse crowds, and at dusk to fire his pistols into the air loaded with iron filings. He held frequent meetings and addressed his sermons to labourers to include pointed reference to exploitation. At one meeting he divided bread (and cheese and beer) and set a loaf on a pole as a standard. He formed a small army of agrarian labourers, led by *The Lion* banner, who marched around the Faversham area.

Meanwhile, the local Justices of the Peace had heard of these activities and sent local constables, the Mears brothers, to arrest Tom at Bossenden Farm. In the presence of his followers, Tom shot Nicholas Mears, then as he lay wounded, stabbed him with his sword. As they reacted with horror Tom again preached at them. The military were called out from Canterbury. A major, 5 officers and 100 men surrounded Tom and his band in Bossenden Wood. Tom opened fire, killing a Lieutenant Bartlett. Tom's band charged at the troops who returned fire at short range, killing Tom and 7 others.



Hernhill Churchyard

An inquest on Tom's death reached a verdict of 'justifiable homicide'. He was buried in Hernhill churchyard in an unmarked grave lest he be exhumed by followers, six of whom are also buried there.

### **What are the clinical implications of John Tom's case?**

Tom's Cornish accent in Kent must have emphasised his outlandishness. There is a possible family history, although his mother's mental illness diagnosis was not stated. There was a strong religious influence of his school, although in the context of Cornish nonconformity, such establishments were not uncommon. Tom's heroes were a contemporaneous religious lunatic, who had achieved great following; and a historical figure who greatly resembled Tom in stature and beard and had led a peasants' revolt in Kent. Both proclaimed their divinity.

In his early 30s significant life events included the fire at his business premises and wrongful accusation of fraud. These were followed (within 2 years) by attacks of melancholia severe enough to be labelled 'insanity', to prevent him working and to require treatment.

During recovery from the last of these melancholic attacks he manifested expansive ideas and subjective mental excitement: then followed a brief normal interlude and finally his strange behaviour. His mental state in London and Canterbury seems dominated by expansiveness, energy, suggestibility and the development of grandiose delusions. His form of thought was normal, as instanced by his ability to write coherent newspaper articles. His state in court was not disinhibited although it was eccentric, and communicated enough affect to arouse people. His charisma impressed a gullible population, but he was not able to refrain from expressing his claims sufficiently to avoid his convictions. *The Times* and the prison authority thought him mad.

During his time in the Kent asylum he showed reasonable behaviour but maintained his delusions. Released into the right social context, his delusional beliefs expanded, he became grandiose, violent, overactive and callous within a brief time.

Possible psychiatric diagnoses are: personality disorder, schizophrenia, affective disorder or frontal lobe syndromes, although GPI was unlikely because of the long course, as was a brain tumour, because of his fluctuating, rather than deteriorating, state. The only evidence for schizophrenia were the chronic delusions, becoming encapsulated then less systematised but there is no evidence of hallucinosis, and good evidence of organized thought rather than disrupted thinking. Tom's

personality in his 20s seemed mature, respectable, syntonetic and well-integrated, not the sort of psychopathic personality that could callously kill a man and joke about it afterwards. The likely diagnosis is therefore bipolar affective disorder, manifesting as depressive bouts, a brief mixed state and mania.

The other lesson of the story for psychiatrists, lies in the interaction of the sick individual with his conflict-ridden society. Tom was thrown like a lump of yeast into a vat which was at the right temperature and had the right ingredients for an explosive fermentation. He was loaded with a hotchpotch of religious, patriotic and radical ideas which makes for populism and fascism. Many of those who were attracted to him had their own personality deficiencies that were sublimated by Tom's demagoguery. It culminated in the shocking murder of Mears which resulted in the sudden cohesion of an exhausted demoralised band, causing them to charge 100 militiamen. As a psychiatrist therefore I can approve of the clinical judgement of Dr Poynder, who said that Tom might be in remission but he could not speak for the susceptibilities of others.

It remains to point out that we now have insecure unemployment, the collapse of an industrial base, a government which favours the already privileged, populist civil riots, a disestablished working class, and our welfare institutions are being demolished.

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# Observation Wards: the alternative setting for emergency admissions under the Lunacy Act

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While investigating the history of locked doors in British psychiatric hospitals I came across fleeting references to observation wards. They appeared to be places to which psychiatric patients were admitted, which functioned outside the mental hospitals before the Mental Health Act 1959. I had worked in psychiatric hospitals since 1985 but never heard the term nor seen anything written about them. Consulting Kathleen Jones' *History of the Mental Health Services* also revealed nothing. So I began research into this, starting with PubMed and EBCSO and moved on to university library collections, Hansard and online newspaper archives and then Bath, Bristol and Somerset archives of local authority committee reports for public service institutions between 1930 and 1960, chosen for convenience of access.

## The Lunacy Act

The story of the observation wards is intimately linked to the Lunacy Act 1890. While the provisions in that Act for admissions to mental hospitals are well known, there was also Section 20 which allowed for a detention for up to three days in a workhouse of an 'alleged lunatic' where it appeared to the relieving officer (responsible for controlling access to facilities and relief under the Poor Law) or a police officer that this was necessary for their welfare or public safety. The Act also allowed the doctor in charge to extend the detention by a further 14 days. Nathan Raw, physician of Mill Road Infirmary in Liverpool, wrote in 1902 about the use of Section 20 in the workhouse and his experience of discharging nearly one third home recovered.<sup>1</sup> Additionally, a magistrate could detain there under Sections 19 and 21 for up to fourteen days for assessment where there might be a case for certification.

The settings within the workhouse or the workhouse infirmary where such people were brought became known as observation wards and there are numerous newspaper reports from the 1890s regarding them.<sup>2,3</sup> By this time workhouses were no longer full of unemployed workers and their families

but were effectively state hospitals for the aged, sick and infirm. Observation wards in the workhouse infirmary had a specific remit for the emergency care of the mentally disordered. The 'observation' aspect was to allow for a doctor and magistrate to review them for certification to a mental hospital, the only means of admission, as no form of voluntary or informal admission was permitted. While some had purpose built mental wards such as Lewisham Infirmary or Smithdown Road in Liverpool, this was probably rare and most would have either been very small rooms or mixed with other workhouse infirmary patients. Their depiction by HG Wells in his novel *Christina Alberta's Father*,<sup>4</sup> comments by Public Health doctor Letitia Fairfield (Fig 1)<sup>5</sup> and observations by Donal Early on conditions in Stapleton Road in Bristol in the 1940s<sup>6</sup> suggest they were often grim.



Fig 1: Letitia Fairfield (1885-1978), public health physician and campaigner for social reform. In RAF uniform. Chief Medical Officer to the women's branch of the RAF, 1918  
<https://wellcomeimages.org/indexplus/image/L0034544.html> (CC by 4.0 licence)

## Observation wards in London and beyond

Medical writing focused on the observation wards began in the 1930s, mainly in London. A service reorganisation took place following the 1929 Local Government Act whereby the management of workhouses and their infirmaries were transferred from the Poor Law Board of Guardians to the county council. London County Council (corresponding to Inner London) had about 20 observation wards, many of which were small and unfit for purpose and a plan was made to consolidate this to six larger ones although this was delayed by the Second World War. It was council policy for admissions to go to the observation ward first rather than to a mental



hospital and up to 7000 admissions took place annually. The largest and best connected of these was at St Francis Hospital in East Dulwich, by then mainly a geriatric hospital. The medical officers were not psychiatrists but nevertheless made the recommendations to the visiting magistrate about certification to mental hospital. By 1937 there were weekly visits by Professor Edward Mapother as medical superintendent of the Maudsley, and Maudsley trainees eventually worked there and covered out of hours. St Francis continued as one of the six consolidated observation wards until 1967. There were five separate studies of the unit, the first of which in 1937 by Pentreath and Cunningham Dax, medical officers in the unit, gives a very detailed account of the clinical work.<sup>7</sup> Most of the admissions were initiated by the relieving officer, acting at the request of general practitioners. Half of their intake, often in severe self-neglect, had organic mental disorders including senile dementia, epilepsy and alcoholism, with delirium commonly resulting in death on the unit. The commonest diagnoses made were 51% organic (of which 20% senile changes), 17% schizophrenia and 16% depression. Within the 17 days of detention 25% were discharged home, and 43% went on to mental hospital, 18% to general hospitals and 3% to mental after-care convalescent homes.

All the St Francis authors, from the 1930s to 1950s, were enthusiastic about the role of the observation ward as a short term treatment unit, seeing it as a place where recovery could take place without going to the distant mental hospitals, with laboratories for physical investigations nearby and family able to visit, see the social worker and receive psychological support.<sup>14</sup> These writers acknowledged that this was an exemplary unit and other facilities were far less well provided for.<sup>7</sup> A critical 1935 Board of Control report about conditions nationally recommended that their function be only short term holding to allow certification. A *Lancet* editorial in response pointed out that they could be useful as reception units, providing intermediate care with trained (i.e. with mental hospital experience) medical and nursing staff and integration into the local medical system.<sup>8</sup>

Information about observation wards and the use of Section 20 outside London is harder to find, despite affirmation in a 1945 Parliamentary debate that there were 600 observation wards nationally.<sup>9</sup> An exception to this is Donal Early's annual survey of Stapleton Hospital in Bristol between 1946 and 1960 which included the observation ward.<sup>3</sup> There is evidence that in some authorities outside London the Duly Authorised Officers (DAO), as relieving officers were called after 1948, admitted more readily into mental hospitals.<sup>10</sup> Local archives tell part of the story and there were 212 Section 20

detentions in Bristol in 1945 and 70 in Somerset in 1958, far fewer relative to the population than in London.

### The NHS era

1948 led to most of the workhouses and infirmaries becoming hospitals and being absorbed into the NHS. Thus the observation wards were now part of general hospitals but still received direct admissions through the DAO and the police. Nationally around 16% of admissions to mental hospitals came from observation wards in 1953.<sup>11</sup> At the same time the mental hospitals were developing separate admission units intended to deal with early cases and by 1945 60 out of 101 hospitals had one.<sup>9</sup> As the NHS developed, specific hospitals were designated for Section 20 admissions. By 1954 there were 140 designated, half of which were in mental hospitals, so clearly there had been a substantial closure or repurposing of the observation wards. Domiciliary or outpatient psychiatric consultation was becoming more available to GPs leading to more direct admissions to mental hospital and fewer coming via the DAO.<sup>3</sup> Furthermore, a slow movement towards general hospital psychiatric treatment units was underway with 82 in existence in 1960, mostly developed from observation wards.<sup>12</sup>

The 1959 Act brought informal admission and the end of Section 20 detentions. Detention became a medical affair with psychiatrists taking the lead and no further role for the DAO acting independently in admissions although the police could still use three-day detention orders under Section 136. The St Francis unit, which had been taking a mixture of informal and detained patients under the 1959 Act, stopped being an observation ward in 1967 and became a catchment area admission and treatment ward.<sup>13</sup>

### Conclusion

And so this component of service provision for mental disorder disappeared. Conditions for patients in the poorly resourced ones were undoubtedly miserable and they must have been challenging for staff, with a vast range of conditions, high levels of serious physical illness, frequent deaths and acutely disturbed and aggressive behaviour to be managed in an isolated service. A product of Poor Law provision and enshrined in the Lunacy Act, their role in emergency provision was eventually eclipsed by the psychiatric admission wards, much as the Board of Control would have wanted in the 1930s.

**As the observation ward era came to a close around 55 years ago it is possible that some readers may have worked in them or heard accounts as trainees from senior psychiatrists. If so, I would be extremely interested in hearing about these experiences.**

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## The Scholar's Melancholy

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The French king Charles VI (1368-1422) suffered from severe mental illness that plagued him from his early twenties until his death, earning him the nickname 'le fol' (the mad). One of Charles' contemporaries, Pope Pius II, mentioned in his memoirs that Charles believed he was made of glass. He wore padded clothes to protect his brittle limbs and forbade others from touching him. Charles suffered from the 'glass delusion' a condition which was relatively common in Europe during the late Middle Ages and the early Renaissance. European literature from the 1500s-1700s had a plethora of reports of 'glass-men' both real and fictional. People whom we know about suffering from this delusion belonged almost exclusively to the upper rungs of society; nobles, merchants, scholars and artisans. Indeed, this disorder is referred to as 'the scholar's melancholy'.

Across the Rhine, and much later, lived a blue-blooded glass-woman, the celibate Bavarian princess Alexandra Amalie Prinzessin von Bayern

(1826-1875). One day in 1840, the quirky princess seemed odder than her usual self, walking sideways and tiptoeing, as if literally treading on eggshells. She later explained to her concerned – and slightly irritated – retinue that she'd swallowed a glass grand piano as a child and that it dwelt within her till that day. She was afraid to move too violently lest it shatter within her.



Charles VI of France. attributed to Mazarine Master - De Vecchi-Cerchiari, *I tempi dell'arte*, volume 2, Bompiani, Milano 1999. Copyright: Public Domain

Another case was reported by two 16<sup>th</sup> century royal court physicians from France and Spain. The patient in question, an anonymous French prince, thought that he was made of glass. He slept in a barn, like china stowed in hay in shipping crates. He was however, cured, when his extra savvy physician arranged for a fire to be set to his hay bed that sent the prince bolting for dear life and right back into sanity.

Some of those affected believed that certain parts of their anatomy were made of glass rather than their whole body. The body part most commonly implicated was the 'derrière', the glutes. An eclectic mix of English, Dutch and French writers from that period mentioned different cases of men with the delusion of glass buttocks. Their reports were succinct, factual and without much detail. Thomas Walkington, in *The Optick Glasse of Humors*, mentioned a 'ridiculous fool' from Venice who was deluded, believing his shoulders and buttocks were made of glass. He wouldn't sit down fearing he'd shatter his 'crackling hinder-part'.

The most colorful account of a patient with a 'vitreous clunibus' was that of a French glass-maker from the Paris suburb of St. Germaine who always wore a miniature cushion around his buttocks even when he was standing. Unwittingly taking a lesson from the French prince's physician, the glazier was cured after his physician gave him a thrashing, telling him that if his rear was really made of glass why was it hurting so much?

European literature from the period has several examples of glass-men in fiction, which indicate that the glass delusion wasn't uncommon and that many educated men across Europe had come across it in one way or the other. The delusion however might

have been overrepresented in the literature, because it was reported to exist almost entirely among the scholars and nobles rather than as part of day-to-day life of the common folk.

A notorious literary glass-man was the protagonist in Miguel de Cervantes' 17<sup>th</sup> century novella *El Licenciado Vidriera* – The Glassy [or fragile] Lawyer – Tomás Rodaja. After eating a quince that his lover had laced with what she thought was an aphrodisiac, Tomás became gravely ill. As he recovered, he became deluded, believing that his whole body was made of glass. He avoided any physical contact, walked only in the middle of the street, wouldn't wear shoes or any 'bounding' clothes, ate only fruits offered to him in a 'urinal pouch stuck on the end of a stick' and would only sleep either in the outdoors or stowed in a hayloft. This sharpened Tomás' wits and he became something of a local sage, growing in fame so much that the king himself sought his counsel. In a remarkable scene in the novel he travelled to appear before the king in a carriage full of hay. Tomás' delusion gradually wore off, but he found to his dismay that there were swarms of people still on his tail, all seeking the wisdom of the fragile oracle. He eventually joined the infantry and went to Flanders where he died in some obscure battle.



Miguel de Cervantes. Attributed to Juan Martínez de Jáuregui y Aguilar. The Bridgeman Art Library, Object 119216 Copyright: Public Domain

Another reference to the glass delusion can be found in Tomkis' play *Lingua*, a 17<sup>th</sup> century comedy about the five senses vying for supremacy over the human body. Tactus, the sense of touch is seen to be possessed with a similar delusion. Tactus folds his robe and sits upon it, musing that 'For this is true Man's life is wondrous brittle.' He then tells Olfactus (sense of smell) 'Touch me not lest thou chance to break my life'. He was also frightened of loud noises, saying 'Speak not so lowd, the sound's enough to crack me'. Olfactus then jeers him 'Why? Art thou hatching eggs th'art feard to break them?' The scene closes by the ailing Tactus pleading Olfactus 'Go to the City make a Case fit for me: Stuff it with wool, then come again and fetch' much to the amusement of the entertained Olfactus who exits the stage as Tactus continues to wail his misfortune.

Despite being relatively common in the late Middle Ages and early Renaissance, the glass delusion almost vanished later. One uncorroborated case of the glass delusion was a mere hand-written footnote on a 19<sup>th</sup> century copy of de Cervantes' *El Licenciado Vidriera*. This note said that the anonymous owner of the copy had known of a similar patient at an asylum near Paris. Delusional content themes seem to have some kind of persistence across the ages. One encounters accounts of persecutory delusions and delusions of grandeur since times of antiquity. Therefore, a delusion that appears suddenly for a mere 200 years before whisking away again is a curious phenomenon. That period witnessed great transformations and changes, the discovery and colonization of the New World, the Protestant reformation and rise of secularism and the scientific method. It was a time of great doubt and uncertainty. And as people witnessed the indubitable truths and principles which defined them for over a millennium undone, they wondered what safety there was; any new principle was equally, if not far more, fragile. It's easy to envisage how this angst could be interpreted as a sense of fragility of the self and what defines it.

From a psychiatric perspective, the glass delusion can be understood as either an exaggerated mood symptom, overvalued idea or delusion in someone with a depressive disorder. Most of the glass-men appear to have been depressed. This argument is lent further strength when one examines a related condition which was present around the same historical period called 'urinal melancholy'. The word 'urinal' at that time could refer to a glass-made flask. People with this sort of melancholy believed that they were glass urinals, and their psychopathology had strong nihilistic and guilt-related overtones, with beliefs that they were evil, useless, and so vile and unworthy that they were but urinals. This can be explained as a mood-congruent overvalued idea or delusion in a patient who suffers from severe depression. And let us not forget the anonymous French prince's confession under duress, who when battering against the burning hayloft door, pleaded with his draconian physician to release him from the blaze, gave us his view of what a glass delusion was about: 'I don't think I am a glass vase but just the most miserable of all men; especially if you will let this fire put an end to my life.'

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# A letter from Sydney

Richard White

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Members of HoPSIG may be interested to learn about aspects of the history of psychiatry in New South Wales (NSW).

It is hardly surprising that history of psychiatry in NSW—like the histories of the other five Australian colonies, which federated into the Commonwealth of Australia in 1901—differs from the history of psychiatry in Great Britain. After all, NSW was established as a penal colony that was close to a world apart in its governance, geography, climate and cultural circumstances from its ‘Mother Country’—as Australians used to call Britain. Moreover, the Great Southern Land had been inhabited for over 60,000 years when Europeans arrived to colonise it in 1788. It is a sad part of our historical narrative that the newcomers have yet to correct injustices done to our First Nations. Other parts of our history are much happier. After decades of difficulty, NSW and the other Australian colonies prospered during the gold rush and pastoral boom of the 1850s and had good fortunes during the twentieth century.

Our first crude lunatic asylum was built in 1811 at Castle Hill near Sydney. After that year our asylum systems followed trajectories like those in the UK and in the USA. By the 1880s our asylums, and our standards of psychiatry, matched those in Britain. In NSW we had two outstanding Inspectors-General of Mental Hospitals, Frederic Norton Manning (1868-98) and Eric Sinclair (1898-1925), both of whom should be remembered and celebrated by our profession. There are other pleasing chapters in a long and complex narrative concerning psychiatry in Australia. However, to be brief, between 1900 and 1950 our asylums suffered the same overcrowding and neglect as bedevilled their equivalents in the USA and in the UK.

Until the 1960s Australia derived much of its theory and practice of psychiatry from the UK. Our first three professors of psychiatry at the University of Sydney were from the UK: Sir John Macpherson (Scottish, 1923-26); William Siegfried Dawson (English, 1926-52), and William Trethowan (1956-62). Trethowan made great contributions to psychiatry in NSW during his six years, as did the English-born foundation professor of psychiatry at the University of New South Wales (1962), Leslie Kiloh.

Davidson Maddison was our first Australian-born Professor (1962). Until the 1960s most of our leading psychiatrists had their earliest psychiatric training in the UK. The influence from the UK is still evident in Australia, but American ideas, especially those concerning community psychiatry, psychotherapy, and liaison psychiatry, became a larger part of the mix after the 1950s.

The Royal Australian and New Zealand College of Psychiatrists was created in 1963, but without its royal prefix until 1977.

There is, of course, much more to tell about the history of psychiatry in Australia. Members and fellows of the Royal College of Psychiatrists who are interested in the history of ‘madness’ in Australia may wish to read three recent books that deal with different periods in Australian psychiatry:

- Jamie Dunk. *Bedlam at Botany Bay*. Sydney: NewSouth Publishing, 2019
- Sarah Luke. *Callan Park Hospital for the Insane*. Kew, Victoria: Australian Scholarly Publishing, 2018
- Ann Westmore and Greg De Moore. *Finding Sanity: John Cade, lithium and the taming of bipolar disorder*. Sydney: Allen and Unwin, 2016

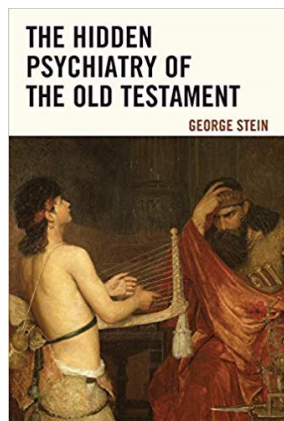
## On a personal note:

In 1968 and 1969 I had some of my earliest training in psychiatry in England, mainly at Netherne Hospital and Friern Hospital. After 38 years in liaison psychiatry at the Royal Prince Alfred Hospital in Sydney I retired in 2013. There was a lot in between. I am (hopefully) nearing completion of a PhD dissertation at the School for the History and Philosophy of Science at the University of Sydney, where I am also an honorary associate in the discipline of psychiatry at its Central Clinical School. My dissertation concerns the development of general hospital psychiatry in New South Wales. I would be keen to correspond with anyone who is interested in this topic. My email address is [richardtrathenwhite@icloud.com](mailto:richardtrathenwhite@icloud.com)

## Book Review

### *The Hidden Psychiatry of the Old Testament* by George Stein (Hamilton Books, 2018) pp. 599

Reviewer: Harvey Gordon, forensic psychiatrist



George Stein has written an interesting and well-researched work on psychiatry in the Old Testament. This follows a series of articles previously published in the *British Journal of Psychiatry*. In so doing he has walked into a minefield, or indeed two.

Psychiatrists have long sought to elucidate the historical roots of our theory and practice (e.g. Tuke, 1882). However, some historians of psychiatry have claimed that psychiatrists are unqualified as historians and that they have distorted its history (Scull, 1991). More specifically, an unresolved debate, more akin to a full-blown argument, has raged over whether it is legitimate to compare psychiatric diseases now with those from the past. That mental disorders occurred in antiquity is widely accepted (e.g. Okasha, 2004). One prominent view is that mental disorders have core symptoms, the nature of which remain generally unchanged over time and culture, even if their content may vary (Turner, 2006). Edward Hare in 1988 postulated that schizophrenia was in fact a recent disease unknown before the nineteenth century (Hare, 1988). Stein would certainly challenge that view, as would other authors of eminence (Turner, 1992). There are problems with retrospective diagnoses of schizophrenia, including imprecise definition, use of current concepts imposed on earlier times, interpretation of ancient texts and cultural variables (Fraguas, 2009). But at what point in the past is it retrospective: last month, prior to the last revision of ICD or DSM, the nineteenth century, the Middle Ages, biblical times or even prior to that? This

reviewer suspects schizophrenia existed in ancient times, and dare not guess whether it afflicted Neanderthal man or even chimpanzees.

If Stein survives that minefield he has another to negotiate. The Old Testament, as with the New Testament and the Koran, is a sacred document (Barton, 2019). The Old and New Testaments are indeed a compilation of documents by several authors. They are revered by many. Two thousand or more years since they were written, they retain an enduring historical memory and contemporary relevance even to those with no faith. Though comprehending them accurately requires them to be seen in the context of the times when they were written, they have nonetheless been interpreted and reinterpreted and faced the inevitable challenge of relevance as societies change over time. When Stein diagnoses mental disorder in biblical figures such as King Saul, Job and Ezekiel, is he being irreverent? I don't think so, but some may think otherwise. We can perceive the awe of the Old Testament even with a scientific or medical mindset. These great books survive even when subject to critical analysis, indeed not only survive but are potentially enriched. There is not only mental disorder portrayed in the Old Testament but also manifestations of human and even divine evil. Satan must come in here somewhere maybe. The Old Testament is no anachronism.

If Stein and his book are not blown to smithereens by the mines, this work ought to be considered a valuable contribution to both the study of the Old Testament and to the history of psychiatry. This applies whether parts of the Old Testament are real or fictional.

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## Book Review

### *The Five Giants: A Biography of the Welfare State* by Nicholas Timmins, 3<sup>rd</sup> ed., (William Collins, 2017) pp. 819

#### A history and appreciation of the Welfare State: review by George Ikkos

'In every country it is unfortunate not to be rich; in England it is a horrible misfortune to be poor.'

Alexis de Tocqueville, *Voyages en Angleterre et en Irlande en 1835*.

Even as its definition and nature have changed, poverty has been a persistent feature of UK society. A self-confessed product of the Welfare State (WS), former *Financial Times* public policy editor Nicholas Timmins tells us he started writing *Five Giants* in anger in 1989 when the social security policies of Margaret Thatcher's government had started causing previously unknown levels of homelessness to young people. As I re-read the 3<sup>rd</sup> edition in 2019, unprecedented numbers of young and old have been relying on food banks.

The *Five Giants* in the title of this *Biography of the Welfare State* are William Beveridge's want, disease, ignorance, squalor and idleness. His 1942 *Social Insurance and Allied Services* ('The Beveridge Report') set out the enduring post-war architecture of the British WS with education, health, housing, social insurance and social security policies. Timmins writes with elegance and authority attracting enthusiastic praise from across the political spectrum. Sharp characterisations of personalities add depth to interest; politicians' witticisms about each other add humour to information (e.g. Labour's Alan Johnson on his joint endeavour with fellow minister Charles Clarke 'a charm offensive – I was the charm, Charles was the offensive').

In 2001 when I first read the second edition on its publication, I was shocked to learn that the origins of the WS lie not in Christian charity or Socialist agitation but in nationalism, empire and war. National models vary, starting from Bismarck's during his 19<sup>th</sup> century pursuit of German unification. When propaganda copies of the Beveridge report were dropped in occupied France, Hitler feared it would be perceived as 'stealing National Socialist policies' and ordered their destruction wherever

found. Post-war, right wing libertarians<sup>1</sup> proclaimed welfare as a totalitarian threat too!

In Britain the first national welfare provisions were made during the Boer War (1899-1902) after almost 50% of potential recruits were found unfit for service. Two world wars brought major advances. In the aftermath of WWII political parties shared rhetorics of national solidarity and the WS was enlisted in the anti-communist battle for minds. Now that the West has won the Cold War, the WS has come 'under fire' and had to undergo 'renewal'. In 2008, just before the neoliberal crisis, at a time of unprecedented national wealth, the 'citadel on the hill' still survived. Annual expenditure was £500 billion, still taking 2/3 of all government expenditure, or very roughly a quarter of the country's income, as it had since the 1980s. It has suffered since.

The WS was created by 'liberal elites'. Lloyd George, a Liberal war minister and later prime minister, implemented transformational changes during and after WWI. The patrician Sir William Beveridge had been a head of the London School of Economics and later a Liberal MP. In popular imagination the WS is associated with Labour, because of Aneurin Bevan's remarkable alliance with the Royal Colleges to overcome GP and BMA resistance to establish the NHS in 1948. It is hard now to grasp the scale of improvements brought by its spread of specialist expertise nationwide. Bevan, the son of a Welsh miner who went down the mines aged 13, was never a disciplined character; often a divisive figure both within his party and outside. However, he acted creatively and decisively and emerges with enormous credit. A passionate advocate for the poor, he considered his greatest achievement having established remarkably high building standards and space provision for council housing as housing minister (since watered down by successive Conservative and Labour ministers aiming for economies of scale).

'The unnerving discovery that every Minister of Health makes...is that the only subject he is ever destined to discuss with the medical profession is money' proclaimed Enoch Powell, later notorious for his 'Rivers of Blood' speech. Together with Labour's Bevan and Kenneth Robinson, he is identified as one of the three most effective 20<sup>th</sup> century health ministers. A hard-nosed monetarist he resigned his junior Treasury post in the late 1950s protesting at allegedly excessive spending. In contrast, as health minister he successfully increased expenditure in his department, albeit also increasing prescription charges. His 1962 *Hospital Plan for England and*



*Wales* was ground-breaking, proposing a District General Hospital for each 125,000 population. In mental health he is remembered for his 1961 'Water Tower' speech demanding reduction of asylum beds from 150,000 to 75,000 (or fewer if possible) as part of his hospital plan! In 1948 asylum beds absorbed almost 50% of NHS expenditure. Today mental health (still the biggest single budget line) is down to only about 10%.

Timmins paints his magnificent panorama on a huge canvas. References to the discovery of Largactil, asylum scandals and subsequent community care tragedies, the promise of Prozac, the DSPD travesty (Dangerous and Severe Personality Disorder diagnosis), street homelessness, prison trans-institutionalisation and IAPT (Improving Access to Psychological Therapies) mark the interface of policy and politics with psychiatry's history. The alarm raised by repeated re-disorganisations from constant administrative reforms, especially in the decades surrounding the millennium is acknowledged. The emergent picture is coloured more with frustration than fulfilment of our community care aspirations.

**Acknowledgment:** I am grateful to Professor Tom Burns for detailed editorial advice.

#### Reference

<sup>1</sup> Both 'libertarians' and 'liberals' privilege individual liberty in society; however, the former accord it absolute primacy, whereas the latter balance it with the aim of improving the weakest in society (see: Ikkos, G., Boardman, J., Zigmond, A. (2006) Talking liberties: John Rawls' theory of justice and psychiatric practice, *Advances in Psychiatric Treatment*, 12, 202-213, <https://doi.org/10.1192/apt.12.3.202> )

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