News and Notes

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

Issue 13, Autumn 2021

Cover image: Administrative Block at High Royds Hospital, 1995. One in a series of photographs taken by Norman Hodgson (technician in the Department of Psychiatry and Behavioural Sciences at the Leeds School of Medicine) to celebrate Professor RHS Mindham's 60th birthday. Published with owner's permission

Editors for this issue:

Lydia Thurston,

Mutahira Qureshi,

Nicol Ferrier

and

Claire Hilton

News and Notes

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The Witch Doctor or the God of the Cuckold, an amalgamate sorcerer, healer, and surgeon - as portrayed by a prehistoric artist in the Cave of Trois Frères, Ariège, France during what is known as the Age of the Reindeer. According to *The History of Psychiatry* by Alexander and Selesnick (1966) this is perhaps the first known depiction of a psychiatrist. Wikimedia Commons

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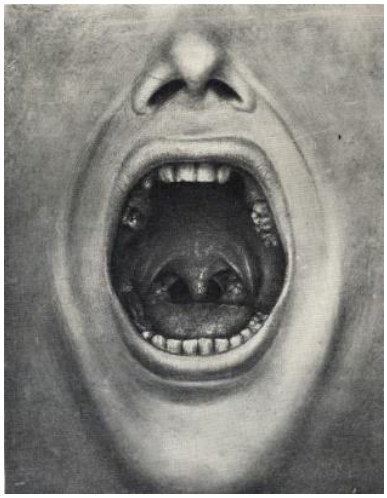
Editorial

Psychiatry and surgery, an unlikely friendship

Lydia Thurston
Co-editor

One hundred years ago, in 1921, the American Psychiatrist Dr Henry Aloysius Cotton (1876-1933), wrote his book entitled *The Defective Delinquent and Insane, The Relation of Focal Infections to their Causation, Treatment and Prevention*. This book was the result of Cotton's life work and dedication to the theory of focal infection in psychiatry. The theory of autointoxication as a cause of dementia praecox was not new, surfacing on the waves of developments in late 19th century bacteriology. Cotton's friend and supervisor Adolf Meyer wrote that Cotton had been '…determined to make a mark in psychiatry…' (1) and he achieved this by initiating research studies and experimental treatments, including treatment for general paresis of the insane. Cotton soon moved on to surgical techniques and believed that the cure for many psychiatric illnesses, including '…manias, melancholias, depressions…dementia praecox and the psycho-neuroses…' (2) lay in the surgical removal of organs with focal or chronic infections. This involved the removal of teeth, gallbladders, thyroids, tonsils, and parts of the colon amongst other organs. Cotton was initially assisted by his surgical colleague J.W. Draper but following Draper's death carried out most of the surgical procedures himself, apart from dental and gynaecological surgery. Success rates were allegedly over 80%, but with a mortality rate of 25-30% (3). In his book Cotton included detailed reports of 25 patients, many of whom appeared to make rapid recoveries following the removal of infected teeth or tonsils. He included only two deaths 'to show the necessity for early treatment and also the somatic pathology and cause of death'. (2)



Cotton thought that tooth decay might have a causal role in mental illness. Image taken from: Henry A Cotton. *The Defective Delinquent and Insane, The Relation of Focal Infections to their Causation, Treatment and Prevention*. Princeton: Princeton University Press; 1921. Public domain https://www.copyright.gov/circs/circ15a.pdf

Cotton's methods may seem barbaric to us today, but he was practising psychiatry at a time when scientific knowledge was accelerating rapidly. The evolving field of bacteriology created a sense of hope regarding the causes and potential treatments for a myriad of physical and mental illnesses. Penicillin would not be acknowledged by the medical community for another two decades, and surgery was a familiar friend, although it did not come without its own risks.

In this edition of News and Notes, we delve even further into the history of surgery's relationship with psychiatry with Eamonn Kinally's insight into the life, career and personality of the neurologist Walter Freeman, whose lobotomies followed Cotton's death by only a few years.

'Case 19 – Maniacal state in a married woman aet 28. No result from extraction of infected teeth, removal of infected tonsils or administration of anti-streptococus (sic) *and anti-colon bacillus serum. Large portion of infected colon removed with prompt recovery in 2 days'*

Excerpt from: Henry A. Cotton. *The Defective Delinquent and Insane, The Relation of Focal Infections to their Causation, Treatment and Prevention,* Princeton, Princeton University Press p. xii

Reflecting on the work of Cotton and Freeman allows us to appreciate the advancement of medical science and technology over the past century, and how much this has led to an overhaul of diagnostic terms and treatment within psychiatry. Organic conditions such as dementia paralytica, which would have filled asylums in the past, are thankfully now a rarity due to the technology of scientific investigations and the discovery of antibiotics. This is something which Professor RHS Mindham reminds us of in his *Reflections on a career in psychiatry* and his fascinating account of working in High Royds Hospital from 1977-2000. As science has advanced, diagnoses have changed or been expanded upon. Some diagnoses have thankfully been discredited and removed. John Bradley's fascinating but equally shocking personal memoir of *Conversion Therapy*, and his frank discussion about homosexuality's historic relationship with medicine and psychiatry, is an unadorned example of this. Some diagnoses are equally long forgotten or have been incorporated into our understanding of normal human emotions, as John Tobin reminds us in his fascinating article entitled *Nostalgia: The forgotten illness.* Thanks partly to the advent of psychopharmacotherapy, the treatment of mental illness has also transformed over the past century. As we have been learning over the past few issues of News and Notes, this evolution started with Chlorpromazine, and Mohamed Ibrahim will continue to tell the fascinating story of its development in the third article of this series.

Other essays in this edition include Nicol Ferrier and Ian Wheeler's article on the life and death of William Murdoch (1857-1917), and Rima Koli and Isabel Mark's fascinating commentary on Charles Darwin's chronic illness, and the myriad of 19th century treatments he underwent. Our Book Review for this edition is brought to us by Professor Mindham, who reviews Anthony Clare's new biography. In his final chair's report before stepping down from his position as chair at the end of the year, George Ikkos reflects on his time in the role, and details the many achievements of HoPSIG over the past 6 months.

As you know, the College has had a busy year celebrating its 180th anniversary. You can find out more about the history of the College, and catch up on any of the anniversary events you may have missed here: Celebrating 180 years of history | Royal College of Psychiatrists (rcpsych.ac.uk). The College's future archives competition, which was held as part of the 180th anniversary celebrations, has now closed, but you can read the winners' outstanding contributions here: Future archives | The Royal College of Psychiatrists (rcpsych.ac.uk), and they will be deposited in the College archives for future generations to read and learn about psychiatry in the present day.

As our working lives continue to adapt to a new hybrid model, unfortunately face to face events are mostly on hold over the next 6 months. However, as many of you may have discovered during lockdown, there is a wealth of online exhibitions and historical material available to keep you occupied. This includes *The Hidden Memories of Nottingham Healthcare* audio-visual exhibition which includes nineteen oral histories collected over the last year from former nurses, social workers and carers, all remembering the transition from mental hospitals to care in the community in the 1990s. The exhibition can be accessed here: https://www.mentalhealthcarememories.co.uk/ Turn to page 22 for more links to keep you occupied, including podcasts, a film and all of the old editions of News and Notes.

Finally, we are sad to say that after 13 editions of News and Notes, Claire Hilton has decided to take a step back from editing and this will be her last newsletter. Claire has been at the helm of the newsletter since 2016, and has played a key role in its lively transformation. Her knowledge and skill as a first-rate medical historian have been invaluable but so too has her unfailing enthusiasm and verve coupled with seemingly infinite amounts of patience. Luckily for us, Claire is continuing her post as Historian in Residence at the College as well as remaining an active member on the HoPSIG Executive Committee. We look forward to hearing about her research, and to attending some of the excellent HoPSIG meetings she has a reputation for organising. News and Notes will nevertheless still be in good hands, as Claire's position has been taken up by Nicol Ferrier, who will take the lead with myself and Mutahira continuing our roles. We will do our best to emulate Claire's work in producing the biannual Newsletter and will try not to pick her brains too often!

We have really enjoyed putting this edition together and are grateful to have received so many interesting, varied and high quality articles. As always, we look forward to receiving more! Please send your articles, reviews, photos, ideas, and requests for information etc. to: nicol.ferrier@newcastle.ac.uk by 31st January 2022.

Happy reading!

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

References

1. Meyer, A. (1934). In Memoriam: Henry A. Cotton. *American Journal of Psychiatry*. 90(4): 921-923.

2. Cotton, H. (1921). *The Defective Delinquent and Insane, The Relation of Focal Infections to their Causation, Treatment and Prevention*. Princeton. Princeton University Press. Available at: https://archive.org/details/defectivedelinqu00cottuoft/mode/2up Last accessed 03/09/21

3. Davidson, J. (2014). Bayard Holmes (1852-1924) and Henry Cotton (1869-1933): Surgeon-psychiatrists and their tragic quest to cure schizophrenia. *Journal of Medical Biography*, 0(0)1-9, doi:10.1177/0967772014552746

Next issue

Please send your articles, reviews, photos, ideas, requests for information etc by **31 January 2022** to nicol.ferrier@newcastle.ac.uk

Check out our old newsletters at

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

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

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

HoPSIG chair's report, autumn 2021

George Ikkos

Chair

Comings and Goings

Many thanks to our SIG administrator Catherine Langley who has served us so well and has now moved on. Welcome to new administrator Kelsey Hentschel. We look forward to working with her.

For matters relating to HoPSIG, please contact us via kelsey.hentschel@rcpsych.ac.uk

Congratulations to our Finance Officer Peter Carpenter on his assumption of the Chair of the Neurodevelopmental Psychiatry SIG. We are grateful that he will be seeing through his term as financial officer.

After 7 years at the helm, Claire Hilton has stood down as editor of HoPSIG News and Notes. She has continued advancing its quality throughout and has brought it to exemplary standard. She has been succeeded by Nicol Ferrier who no doubt will continue the same trajectory. Trainee editors Lydia Thurston and Mutahira Qureshi, who are making very active contributions including having edited the Spring 2021 issue, will continue in post.

At the end of the year, I will be standing down as HoPSIG Chair and the committee is making progress in agreeing an interim chair. It has been a pleasure and privilege to serve in this post and I look forward to remaining a member of the executive committee.

Trainees and others

An important recent contribution, spearheaded by Honorary Archivist Graham Ash, has been our feedback in August 2021 regarding the proposed revision of the postgraduate training curriculum. What we have seen so far falls short of what we, including trainees Rob Freudenthal and Tom Stephenson, advocated in our BJPsych editorial on behalf of the committee (1).

The key reason why I have greatly enjoyed my role as chair is the support of a talented, diverse, highly motivated, and hard-working executive committee including the many contributions of trainee members of the committee. I look forward to standing down on a high note because Mohamed Ibrahim, a trainee member of our committee, has secured a platform for HoPSIG to deliver a whole academic afternoon to over 200 trainees and trainers at the East London scheme on 5 January 2022. The title is **History of Psychiatry: Contemporary Relevance and Training Opportunities.** Claire Hilton, Nicol Ferrier and myself will be presenting along with the training members of the Committee (Ibrahim, Tom Stephenson, Lydia Thurston and Mutahira Qureshi) and the College Librarian Fiona Watson and Archivist Francis Maunze. We have developed content and format in a way which lends itself to repetition and calibration of the session for other similar fora. We are also hoping to record the whole event and make it available on open access.

Ibrahim has also worked actively with Francis, Graham and Claire and Fiona to organise and publicise the **Future Archives Competition**. This sought to document psychiatry in 2020-21 to coincide with the College's 180th anniversary. It has been an enormous success. High quality short essays, poems and diary extracts were submitted. The judging committee was chaired by RCPsych President Dr Adrian James, and included a journalist, an author/ psychiatrist and patient and carer representatives. All entries have been deposited in the College archives. Winning entries were presented on 12 July 2021 in a free webinar chaired by Adrian. They are available to view here: Future archives | The Royal College of Psychiatrists (rcpsych.ac.uk)

Activities, outcomes and future events

Covid-19 notwithstanding, this has been a very busy HoPSIG academic year. Claire led the development of the International Congress session on **"Learning from the**

Asylum Era: the patient voice was loud and clear but did we hear it?" This was chaired on 24 June by service user and new HoPSIG member Diane Goslar. It was an eye opener and a recording remains available for those registered at the International Congress this year.

Claire and Tom Stephenson also organised a joint webinar of HoPSIG and the Royal Society of Medicine Section of Psychiatry on **"The best and worst of role models: Learning from psychiatry in the long 1960s"**. This was an outcome of the witness seminar on **"Psychiatric Hospitals in the 1960s"** which they led in October 2019 and have documented in detail. The key speaker was Professor Edward Shorter, Professor of the History of Medicine and Professor of Psychiatry, Temerty Faculty of Medicine, University of Toronto, Canada, an award-winning writer on the history of psychiatry.

Claire and Tom Stephenson also contributed an excellent chapter in the recently published ***Mind, State and Society: Social History of Psychiatry and Mental Health in Britain 1960-2010*** (eds. Ikkos, G. and Bouras N. CUP, 2021) (#mindstatesociety). Claire also contributed a superb chapter on "Changing generations II: the challenges of ageism in mental health policy". Tom Burns and senior clinical psychologist John Hall contributed a chapter on "Critical friends: antipsychiatry and clinical psychology". Publication coincided with the College's 180th anniversary. Nick Bouras and I briefly introduced the book during the central event to celebrate the anniversary during this year's electronically held College International Congress. The book has been warmly endorsed by RCPsych President Dr Adrian James, Professor Sir Graham Thornicroft and Professor Linda Gask. It is available in print but, crucially, it is available electronically free in its entirety here: Mind state and society social history psychiatry and mental health Britain 19602010 | Mental health, psychiatry and clinical psychology | Cambridge University Press

Based on the book, HoPSIG and Royal Society of Medicine Psychiatry Section have also co-organised the second conference on **"Mind, state and society 1960-2010: History of psychiatry and mental health in Britain"** to be held on **Tue 5 Oct 2021 at the Royal Society of Medicine**. Further details may be found here: Mind, state and society 1960-2010: History of psychiatry and mental health in Britain (rsm.ac.uk)

Nicol continues to lead preparations for a Witness Seminar on "Enthusiasm and change: The development of the culture of academia in 1970s psychiatry", which is due to be held in May 2022 at the College.

180 years of RCPsych

1841 was the year of foundation of RCPsych's first predecessor organisation, the **Association of Medical Officers of Asylums and Hospitals for the Insane**. Directed by College Officers and led by Chief Executive Paul Rees and supported by Director of Communications Kim Catcheside, RCPsych continues to deliver a range of events to mark the 180th anniversary. Both in her capacity as Historian in Residence and as our representative, Claire has been a member of the core planning group. The group's outputs included the central event during the International Congress on 23 June 2021 when Nicol, Prof Eve Johnstone and Dr Aggrey Burke shared memories of their careers and changes in UK psychiatry during this period.

Another notable output is the ongoing monthly series of free webinars, with registrant numbers above 1000 on one occasion and above 700 on others. The webinars include:

Petition and Plotting: the early days of the College

Where were all the women? (The story of how men fought to keep women out of medicine and how women eventually overcame the barriers)

Dr Helen Boyle (1869-1957): The first woman president of the Royal Medico Psychological Association

Campaigning to improve Mental Health Services

How the patient voice has grown in making decisions about care

Changing views of what constitutes a mental illness over the last 180 years

Open Access recording of the webinars may be found on**:** Free webinars for members |

Royal College of Psychiatrists (rcpsych.ac.uk)

It has been a privilege to chair the last two of the above. Claire will be contributing to the October webinar on "Psychiatry, psychiatrists and Jewish identity in the UK, past and present". Other planned free webinars include "The impact of war on Psychiatry in UK, planning after a prolonged crisis" (Sept), "Psychiatry and sexuality" (Nov), and "How will current psychiatric practice be seen in the future?" (Dec). You may access up to date details about upcoming events in this series of events through this link:

https://www.rcpsych.ac.uk/events/free-webinars/free-webinars-for-members

Thank you

This is my last report for News and Notes in my current role. As the above amply demonstrates, I have been fortunate to chair HoPSIG at a most propitious time. I wish my successor an equally good time and have every expectation that our group, now numbering approximately 2500 members, will continue to flourish.

Reference

1. Ash G, Hilton C, Freudenthal R, Stephenson T, Ikkos G. History of psychiatry in the curriculum? History is part of life and life is part of history: why psychiatrists need to understand it better. *Br J Psychiatry*. 2020 Oct;217(4):535-536. doi: 10.1192/bjp.2020.64. PMID: 32241320

Archives report

Francis Maunze
Archivist and Records Manager

Future Archives Competition
The Future Archives Competition which was organised as part of the celebrations for the College's 180th Anniversary was a resounding success. A total of sixty-two entries were submitted by fifty-three entrants. The entrants were drawn from psychiatrists of all grades, medical students, patients and carers, a mental health pharmacist, international fellows, and retired psychiatrists. The four winning entries were from a service user and psychiatrists. The results of the competition were publicised through webinars that were chaired by the President of the College, and can be viewed here.

Collecting archives
The Archives continue to appeal for donations of historical papers from members especially those from the South Asian region as the College was celebrating its second South Asian History Month during July. We also participated in an appeal for donations for archival materials by the South West Division. The Division is organising an online exhibition as a way of celebrating the College's anniversary.

The **Archives Collection Development Policy** was reviewed so that mental health service users, carers and qualifying members of the public can be allowed to donate historical materials to the College Archives.

The Archives is also reaching out to other institutions such as the Royal College of Physicians of Edinburgh and the National Health Service (NHS) that have been involved in projects aimed at collecting Covid-19 related archival materials. The NHS has a project called "NHS Voices of Covid-19" whose objective is to organise interviews that will be deposited with the British Library's wider Covid-19 collecting initiative. The Royal College of Physicians of Edinburgh's project called "Uncovering the Covid-19 Archive" has enabled their Archives to collect materials like diaries, photographs and written experiences from medical practitioners. The aim of their project is to ensure that future generations, historians, and researchers will be able to access the voices of these workers and be able to understand their experiences during the pandemic. We hope that through collaboration with these organisations we will be able to develop our own collection of Covid-19 related material.

Library report

Fiona Watson

Library and Archive Manager

infoservices@rcpsych.ac.uk

I spent yesterday at Prescot Street for the first time in at least a month and it was a very odd experience. The College is currently undergoing renovations, so if I want to visit the half of the book collection that lives in the basement (those books too old to be clinically useful but not old enough to yet be interesting) I have to have an escort and a hard hat!

Most of my time is still spent working from home and, if anything, this makes me more accessible to the majority of members who use the library. One of the consequences of Covid-19 that I did not expect, was the rise in requests for help with systematic reviews and these now take up a significant proportion of my time. Health libraries are noticing this increased interest all across the UK and not solely for topics relating to the pandemic. Systematic reviews are always fascinating projects to work on and I very much enjoy the chance to meet and work with the teams as they build their proposals. Given the significant workload systematic reviews generate, over and above a more run of the mill literature review, we have a clear policy on which parts the library supports. If you're interested, we will help

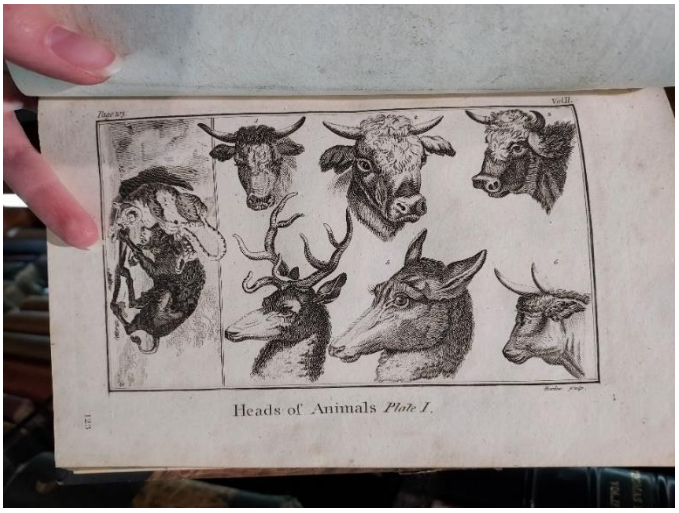
you develop you search strategies, run the searches for you on the databases the College has access to and export the results.

This rush of interest has spiked its own wave of librarians looking to improve their searching skills so that they know they are giving the best advice possible. We are all investigating the new software that has been developed, such as Covidence and Rayyan, to help people process the huge numbers of articles these reviews generate. If we find them useful then we can recommend them in turn to library users.

Many members I speak to find the databases we use for systematic reviews overly complex and counter-intuitive. Librarians like myself are well aware of this and I have invested a lot of time this year working with colleagues in the NHS to push the providers into making changes and simplifying access. If there is something you think could be made better, please do get in touch and let us know.

On the more historical side of things, I am slowly working my way through reclassifying the antiquarian book collection. In the past these books were classified using an in-house system, presumably created by one of my predecessors. However, all the modern books are classified using the most popular medical classification scheme: Wessex, and it make sense to bring them all under the same roof. The joy of this for me is the chance to get up close and personal with the collection!

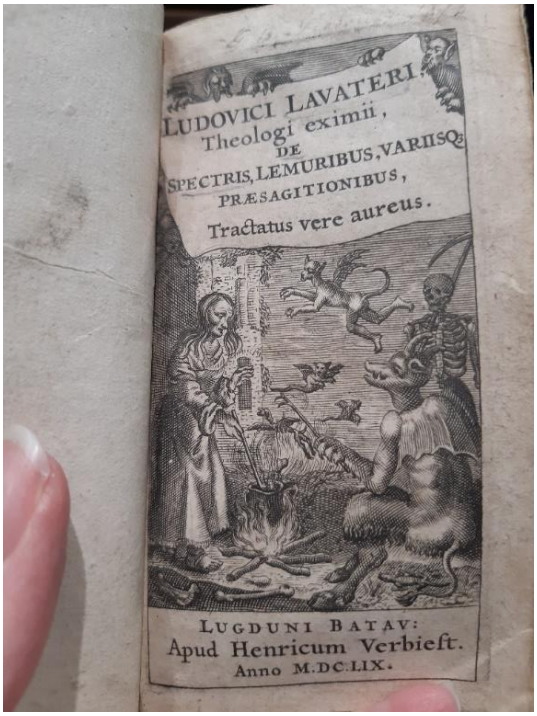
I have now worked my way through topics such as sleep, dreams, the brain, philosophy and anatomy, all of which are easier to classify. But it isn't always quite so simple, some books do not fit neatly into modern medical boxes. We have an aggravating number of books on phrenology and physiognomy and, as you can imagine, no obvious place for them.



Then there are the books on the occult:

- *Sorcellerie, Magnétisme, Morphinisme: Délire des Grandeurs, par Paul Regnard.*

- *De Occulta Philosophia Libri Tres.*



The ones that have you stretching the boundaries of what a category was likely intended for:

- *An Essay on the Disorders of People of Fashion.*

- *On the [Hand]writing of the Insane, with Illustrations.*

And the truly random:

- *The Psychic Life of Insects.*

I expect at some point I will need an expert to help me translate some of the disorders into their equivalent modern diagnoses:

- *Etudes Cliniques sur la Grande Hystérie ou Hystéro-Épilepsie.*

- *Spasm in Chronic Nerve Disease: being the Gulstonian Lectures delivered at the Royal College of Physicians of London, March 1886*.

We hope to welcome small numbers of members back to the College soon and in larger numbers once the renovations are complete in December. So, if any of those titles or images spark a desire in you to see the book in all its glory, please do get in touch.

We are also always looking for people to contribute the History, Archive and Library blog, you can see some recent entries here:

Detail (rcpsych.ac.uk)

I particularly recommend Claire's recent additions covering her asylum explorations.

Follow HoPSIG on twitter

@rcpsychHoPSIG

Tweet us your opinions, views or just say Hi!

The History of Psychiatry Special Interest Group (HoPSIG): a narrative on the evolution of the current Group

Francis Maunze
Archivist and Records Manager

This piece is the story of the two History of Psychiatry Special Interest Groups, and of the Friends of the College Archives group, that existed between them. Those that are familiar with the history of Special Interest Groups of the College, know that there was a History of Psychiatry Special Interest Group that existed in the past, and that the current Group is a reincarnation of this first Group. However, few people are aware of the Friends of the College Archives (FOCA), a group that existed between the first and the current History of Psychiatry Special Interest Groups. One of the objectives of FOCA was to continue providing a forum for members that were interested in the history of psychiatry. This piece will attempt to highlight the main achievements attained by these three groups.

Special Interest Groups were established within the College to facilitate the exchange of information, to promote discussion and to generate interest in a particular field of psychiatry. The History of Psychiatry Group was one of the first Groups to be established in 1988 alongside that on Philosophy in Psychiatry and Computers in Psychiatry.

History of Psychiatry Special Interest Group 1988–2003

As a way of facilitating the exchange of information and to promote discussion on the history of psychiatry, the Group established links with other similar organisations here in the United Kingdom and in Europe. The first links to be established were with the Library of the College, and the History Section of the World Psychiatric Association. Contacts were also established with other historical societies like the History Section of the German and Italian Psychiatric Societies, the Wernicke Society in Germany, and the European Society for the History of Psychiatry.

The Group organised meetings and conferences. For instance, by the end of 1989 the Group had held three symposia, one at Robinson College, Cambridge, on Henry Maudsley. This was later featured in the October edition of *British Medical Journal*. The other was a Cambridge meeting on the *History of Physical Treatments in Psychiatry*, whose proceedings also appeared in a supplement of the *Journal of Psychopharmacology*. The third was the October meeting on the *History of Psychiatric Symptoms*.

In 1991, members of the Group participated in the 150th Anniversary celebrations of the founding of the College. The Group was responsible for organising two successful historical meetings. One was a special session on "*The Current State of Psychiatric Historiography*", held at the anniversary meeting. The meeting was chaired by Dr Henry Rollin, and among the speakers there were luminaries such as Professors Raquel Alvarez from Spain, Otto Marx from Germany, George Mora from the USA, and Dr Roy Porter of London.

The other event was a celebratory gathering at Gloucester organised with the South-West Division of the College. This took place on 27 July 1991, exactly 150 years after the famous meeting held on the same day in 1841. The speakers at this meeting were Professors Janice Morgan, Sims, and Parry-Jones, and Drs Bailey, Porter, Heaton-Ward, John Langley and Rollin.

The Group contributed immensely to the publication of *150 Years of British Psychiatry* which was published as part of the anniversary celebrations and was edited by Drs German Berrios and Hugh Freeman. Members contributed to chapters on the analysis of the evolution of psychiatry in the

UK as seen through the privileged window of the College and its predecessor bodies.

In 1993 the Group organised a meeting to commemorate the centenary of Hack Tuke's famous *Dictionary of Psychological Medicine*. The College Archives has in its collection an album with Portraits of Contributors to Tuke's Dictionary of Psychological Medicine, 1892 . The commemoration took place at the Swansea Annual General Meeting held on 16 April 1993. The session was called "Tuke's Dictionary and 19th century psychiatry".

In 1995 the Group continued its successful liaison with professional historians via seminars, joint meetings and publications. This led to the holding of the joint symposium at the Welcome Trust on "*Voices from the past"* which was attended by some 150 delegates, and a series of other meetings. Members of the Group also attended the 3rd Triennial Conference of the European Association for the History of Psychiatry held in Munich, Germany in September of the same year.

From 2000 the Group stopped submitting annual reports to Council. In February 2002 Council noted the Group no longer seemed to be active, and in 2003 Council accepted the proposal from the Executive and Finance Committee that the Group should be discontinued.

Friends of the College Archives (FOCA) (2007-2015)

Between 2003 and 2007 there existed no body in the College that provided a forum for members that had an interest in the history of psychiatry. The situation changed when Dr Fiona Subotsky, Honorary Treasurer of the College from 1999 to 2006, was appointed the first Honorary Archivist in 2007. Her role was to promote the history of the College and its archival holdings and to work closely with the Archivist. She was also tasked with the responsibility of building links with individuals and organisations interested in the history of psychiatry. To succeed in carrying out her responsibilities she established Friends of the College Archives (FOCA), a group whose objectives were to support the Archivist in the preservation, promotion and use of the College's archival heritage, and the promotion of interest in the history of psychiatry.

The day to day running of the group was done mainly by the Archivist and the Honorary Archivist, hence its scope of proposed activities was modest. The proposed activities included just one meeting a year at the College, usually in connection with a display or presentation, a history session at the annual meeting, an annual visit/outing to a site of historical interest such as an old asylum, encouragement of history projects relating to psychiatry, and a newsletter by post or email three times a year.

The achievements of the group included:

- the organisation of history of psychiatry sessions at annual meetings. The first session was presented at the 2009 Annual Meeting in Liverpool. It was called "From Shell Shock to Secure Psychiatry in Merseyside" Professor Edgar Jones` presented 'Shell Shock: the work of Maghull in World War I' and Dr Caroline Mulligan on 'Ashworth Hospital Now'.
- the organisation of an exhibition called 'Ten Nineteenth Century Presidents and their Asylums' for the 2008 Annual Meeting
- creating a poster on Dr Helen Boyle, first woman President of the Royal Medico-Psychological Association, which was displayed at the College's 2012 International Congress held in Brighton.

As interest in the activities of the group increased, it was decided that it was time to re-establish the History of Psychiatry Special Interest Group, and on 8 January 2015 a meeting was held at the College to discuss preparations. Then on 20 March 2015 an inaugural meeting was held where FOCA was transformed into the History of Psychiatry Special Interest Group (HoPSIG). For almost seven years FOCA had managed to provide a forum for those interested in the history of the College and psychiatry, thus bridging the

gap between the two History of Psychiatry SIGs

Proposal for a Special Interest Group in the History of Psychiatry

Dr Fiona Subotsky, Honorary Archivist Royal College of Psychiatrists

We are proposing a **Special Interest Group in the History of Psychiatry**, with strong links with the College Archive Department. Members would be directly involved in planning and engaging in history related activities such as the newsletter, displays, talks, meetings etc., building on the activities of the Friends of the College Archive.

Background

The Friends of the College Archives group, organised by Fiona Subotsky (Honorary Archivist) and Francis Maunze (College Archivist) has occupied a similar role since 2008. Activities have included:

- Supporting the launch of Thomas Bewley's book: *From Madness to Mental Illness* on the history of the College
- Production of the FOCA Newsletter 3 times per year Organising history sessions at the Annual International Congresses
- Organising and contributing to displays and exhibitions on the history of psychiatry and the Royal College of Psychiatrists and its predecessor bodies.
- Suggesting speakers for the Special Lecture series

Currently

Now the College has moved to Prescot Street and the antiquarian books are on display, there has been a renewed interest in the history of the College and of psychiatry, for instance about 150 people attended the recent talk on *Jack the Ripper's Psychiatrist: Dr Lyttelton Stuart Forbes Winslow* and a similar number attended Baroness Murphy's lecture on *A Capital Business: Managing the City's Unwanted.*

To form a Special Interest Group the College requires the support of 120 members.

Above: Poster on the establishment of HoPSIG

History of Psychiatry Special Interest Group (2015–present)

Like the first SIG, this Group has also been involved in organising meetings, seminars, and RCPsych International Congress sessions. The Group also circulates an e-Newsletter twice a year. The Group held its first witness seminar in October 2019.

From last year, members of the Group have been involved in organising various activities to commemorate the 180th anniversary of the College this year, just as members of the first Group did in 1991 when the College celebrated its 150th anniversary. The activities for this year's historic occasion included a "Future Archives" competition, publishing of a learned book, and taking part in the organisation of a webinar series. Further information about the Group can be found here.

References

Royal College of Psychiatrists Annual Reports

German E Berrios and Hugh Freeman (eds.) *150 Years of British Psychiatry 1841–1991*. Gaskell/Royal College of Psychiatrists, 1991.

Programme: The South-Western Division and the History of Psychiatry Special Interest Group: A Special Meeting to celebrate 150 years of British Psychiatry and the 150th Anniversary of the Foundation of the Association of Medical Officers of Hospitals for the Insane, Saturday 27 July 1991, Wotton House, Horton Road, Gloucester (Donated to RCPsych Archives by Dr Peter Carpenter).

Nostalgia: the forgotten illness

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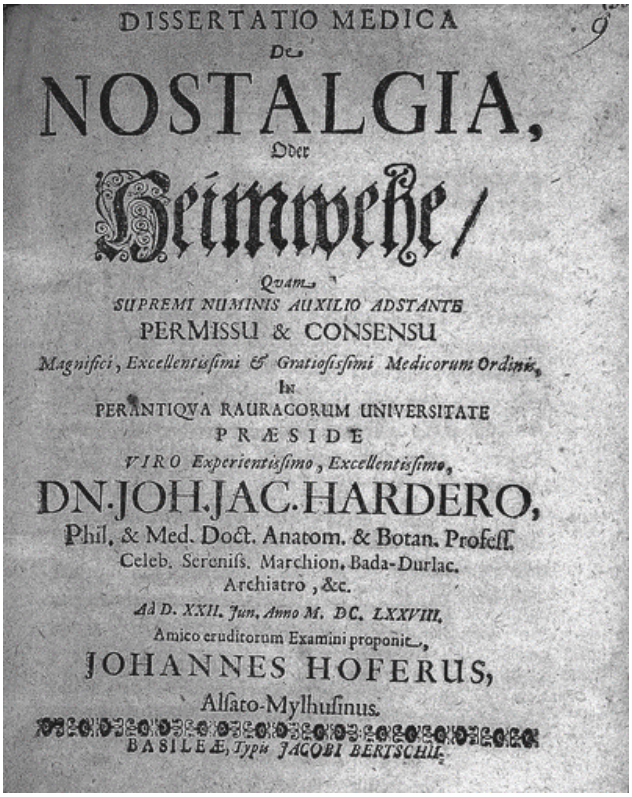
The term Nostalgia originated in Switzerland during the seventeenth century. In 1688, the Swiss physician Johannes Hofer described how some Swiss mercenaries who had served in France, developed chronic tiredness, symptoms of dejection, melancholy, disturbed sleep, weakness, anxiety, loss of appetite, cardiac palpitations, stupor and fever. Nostalgia was thought to develop in the long periods between battles, rather than as a consequence of battle, and to be related to homesickness and a fear of never seeing their homeland again. The term was derived from the Greek, nostos (return to the native land) and algos (pain or grief). In extreme cases Nostalgia could lead to death. The actual details of how death occurred as proposed by the concept eludes us, though physicians over the next two hundred years mentioned this outcome when describing the illness. No doubt some of the deaths were as a result of suicide or starvation, but how death occurred in other cases is not understood.

Theories abounded as to why some individuals were susceptible to suffering from Nostalgia and others not. Hofer believed that the sufferer's imaginative reconstruction of their home overwhelmed them to the point that their bodily energy and vital spirits were diverted from their necessary, life-sustaining functions (1). The Swiss physician Johann Jakob Scheuchzer (1672-1733) suggested in 1705 that Nostalgia was caused by the increased atmospheric pressure that the Swiss soldiers allegedly experienced as they descended from the mountains to the plains (2). He developed this theory associated with his concerns that the high rate of Nostalgia diagnosed among Swiss mercenaries might make them look weak and militarily unreliable.


DISSERTATIO MEDICA
De
NOSTALGIA,
Oder
Heimwehe/
Quam
SUPREMI NUMINIS AUXILIO ADSTANTE
PERMISSU & CONSENSU
Magnifici, Excellentissimi & Gratiosissimi Medicorum Ordinis,
In
PERANTIQUA RAURACORUM UNIVERSITATE
PRÆSIDE
VIRO Experientissimo, Excellentissimo,
DN. JOH. JAC. HARDERO,
Phil. & Med. Doct. Anatom. & Botan. Profess.
Celeb. Sereniss. Marchion. Bada-Durlac.
Archiatro, &c.
Ad D. XXII. Jun. Anno M. DC. LXXVIII.
Amico eruditorum Examini proponit,
JOHANNES HOFERUS,
Alsato-Mylhusinus.
BASILEÆ, Typis JACOBI BERTSCHII.

Johannes Hofer (1688) *Dissertatio Medica de Nostalgia, oder Heimwehe.* J Bertsch, Basle. https://wellcomecollection.org/works/txcb9pv7 (Public domain)

There was a recognition that, in many ways, Nostalgia was related to melancholia and loss of hope of ever returning to their home country, family and friends. Treatment included purges, which were considered to improve digestion thereby freeing up vital spirits, and chronic cases were sent home, which was noticed to effect a cure. There was a German equivalent of Nostalgia at the same time, called Heimweh, (3) and the concept in relation to soldiers became accepted across Europe, particularly among Napoleon's levée en masse (conscripted soldiers).

Between 1792 and 1815 France was continually at war. A total of four and a half million men served in the French army

during that time. For the French it was "la nostalgie" and "la maladie du pays". It was considered to drain men of their strength and their will to live and was associated with suicide (4). It was so frequent during the French revolutionary wars that it was considered a threat to the French nation.

French physicians reported that Nostalgia was associated with marked isolation. Silence was such a key characteristic of the illness that when a soldier was being very vocal about their homesickness, it was considered that he was more likely to be malingering. The impact of malingering and desertion upon troop numbers led the French military in 1793 to cancel all convalescent leave in the Army of the North, with the exception of sufferers of Nostalgia (5). A medical report in 1803 claimed that between 1793 and 1794 one twentieth of the French army suffered from Nostalgia. The condition was so lethal among the Bretons, that in the army of the Moselle, doctors granted them permission to visit home (6). In 1793, Jourdan le Cointe, a French doctor, warned that if Nostalgia reached epidemic levels, then severe physical punishment should be carried out upon the sufferers, including using a red-hot iron applied to the abdomen. Le Cointe related that an outbreak of Nostalgia among Russian soldiers marching towards Germany in 1733 led to their General threatening to bury alive any person who came down with this illness. He subsequently acted upon his threat (7).

The military doctors with the French armies believed that they could cure Nostalgia by imbuing the victims with a greater sense of national attachment and patriotism. They would do this by creating a sense of loyalty to the nation, la patrie, as opposed to the victims' home locality, le pays. They would reinforce a soldier's nationalistic fervour and get him to view positively his connection to the idea of France, as opposed to local loyalties such as to Brittany or Languedoc. They noted that many of the conscripts who suffered from Nostalgia came from rural communities as opposed to cities and that French was often not their native tongue. Nostalgia was, in this way, conflated with a lack of patriotic and revolutionary vigour. The medical profession could be thought of as acting as state agents by infusing patriotism into those suffering from Nostalgia and by increasing the morale of the army. This conflation of Nostalgia and lack of patriotism continued into the second half of the nineteenth century. After the defeat of the Paris Communards in 1871, many of the Communards were exiled to New Caledonia in the Pacific Ocean. When they complained that Nostalgia was decimating their numbers, the penal authorities denied their claim and said that their rebellious actions in Paris had demonstrated their lack of attachment to their home and as a result they could not possibly be suffering from Nostalgia (8).

Changes in the nineteenth century

Across the nineteenth century, the concept of Nostalgia changed from being a medical illness to becoming an understandable human emotion. Initially, the evolutionary theories of Lamarck (1744-1829) held sway. Lamarck postulated that it was the environment that shaped the organism. In that context, it was only natural that there should be an attachment between a man and the environment that shapes him. Thus, Nostalgia was initially considered to be a medical condition that in no way impugned the reputation of the sufferer, with no implication of cowardice or lack of military zeal. However, this standpoint slowly changed. Sufferers of Nostalgia were increasingly viewed as being immature, uncultured, less civilised and less emotionally evolved than their non-suffering army comrades. It was believed that rates of Nostalgia were higher among soldiers who originated from the countryside, compared to those who had lived in the cities, where life was supposedly more civilised.

The decrease in the number of soldiers suffering from Nostalgia in the latter half of the nineteenth century was put down to an increased level of French civilisation as well as to a greater sense of patriotism among the population. In reality, with the development of the railways and other faster

modes of transportation and communication, home seemed less distant. It was also easier for a soldier to get home while on leave. In 1867, Michel Levy (1809-1872), an inspector of army health in France, reported that the death rate from Nostalgia had decreased from 86 deaths per 100,000 men in the 1820s to one death per 100,000 (9).

By 1890 Nostalgia had almost disappeared as a diagnosis within the French army. However, its decline was closely linked with the rise in the diagnosis of neurasthenia and hysteria, which reached its apogee in the 1880s and 1890s. An alternative diagnosis was melancholia. The famous French clinician Charles Lasègue wrote that Nostalgia had never constituted a real pathological entity: it lacked a clear aetiology, clear physical signs and symptoms and was just a medical fantasy (10). Over time, Nostalgia became considered as a normal part of life, and it was only diagnosed if it developed an obsessional quality.

References

1. Hofer J (translated by Anspach 1934 from the original work 1688) Medical Dissertations on Nostalgia or Homesickness, Institute of the History of Medicine, 2: 376-391.

2. Jackson SW (1986) *Melancholia and Depression: From Hippocratic Times to Modern Times*, Yale University Press, New Haven.

3. Binneveld H (1997) *From Shellshock to Combat Stress: A Comparative History of Military Psychiatry*, Amsterdam University Press, Amsterdam, 3.

4. Forrest A (2002) *Napoleon's Men: The soldiers of the Revolution and Empire*, Hambledon Continuum, London, 150.

5. Rosen G (1975) Nostalgia: A "forgotten" psychological disorder, *Psychological Medicine*, 5: 340-354, 347.

6. La Chese G (1803) *Essai sur L'Hygiène Militaire*, Paris, 36.

7. Le Cointe J (1793) *La Santè de Mars ou l'Art de Conserver le Santè aux Gens de Guerre*, Batillot, Paris, 328.

8. Bullard A (2002) *Exile to Paradise: Savagery and Civilisation in Paris and the South Pacific*, Stanford University Press, California, 182-209.

9. Levy M (1867) *Rapport sur les Progrès de l'Hygiène Militaire*, Hachette, Paris.

10. Lasègue C, Duplay S (1875) De la Nostalgie, par Auguste Haspel, *Archives Générales de Médecine*, 760-763.

Chlorpromazine—part 3: The Elkeses

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Last time (News and Notes, Spring 2021) we left the story of chlorpromazine, the first antipsychotic, with the new drug's utility in the treatment of psychosis being established, and with rivalry between Jean Delay and Henri Laborit for the credit of the discovery of its antipsychotic properties. In this issue, we continue the story, and see how chlorpromazine started to gain recognition to become the mainstay for treating psychosis, in France initially, then in Europe, including England.

Use of chlorpromazine in France

As is wont to happen with many novel interventions, the introduction of chlorpromazine as an antipsychotic medication (not merely another sedative), was met with a considerable measure of scepticism in French psychiatric and neurological circles. Many doctors thought that it was just another sedative, and others complained that there wasn't sufficient evidence to back the new drug. Chlorpromazine started to make gradual inroads into French psychiatric institutes, mainly used by medical residents and young doctors who subscribed more than their older counterparts to the new drug and its potency.

The adoption of chlorpromazine into the French psychiatric hivemind was catalysed by the publication of the results of a major study by Le Comité Lyonnais de Recherches Thérapeutiques en Psychiatrie (The Lyonnais Committee for Therapeutic Research in Psychiatry). The committee was formed as an association of psychiatrists at Lyon's two main psychiatric hospitals, Bassens and du Vinatier. In 1954, the committee, chaired by Louis Revol, undertook to consolidate and present their experiences of using chlorpromazine in both hospitals, and to provide scientific evidence for its potency. This was done in two stages. In 1955, at a conference in Paris organized by none other than Jean Delay and Pierre Deniker, the committee presented the results of prescribing chlorpromazine to 458 chronically psychotic patients at Bassens Hospital. However, their major report only materialized the following year, when the effects of chlorpromazine on over 1400 psychotic patients, treated at both Bassens and du Vinatier, were published in *La Thérapeutique par la Chlorpromazine en Pratique Psychiatrique*. The evidence was overwhelmingly positive and it aided chlorpromazine's adoption into mainstream French psychiatry.

University Psychiatric Clinic (Universitäre Psychiatrische Kliniken), Basel **Source**: Wikimedia, https://commons.wikimedia.org/wiki/File:Upk1.jpg

Chlorpromazine in Europe

Chlorpromazine's gateway into Europe was through neighbouring Switzerland. In 1952, hearing about the new drug, John E Stählin, head of the outpatient department at the university psychiatric clinic in Friedmatt Hospital in Basel, sent one of his aides, Felix Labhardt to the Hôpital Sainte-Anne (Delay's hospital) to find out more about it. A year later, Labhardt returned to Basel and introduced chlorpromazine to his colleagues at Friedmatt. Gradually, chlorpromazine

started to replace other medications offered at the clinic for acutely psychotic patients.

Furthermore, Labhardt led on a major study of chlorpromazine in patients with schizophrenia. This was the first study of its kind outside France. The results were also highly favourable for chlorpromazine. Labhardt presented his initial findings at the first major chlorpromazine themed symposium outside France, the "Largactil-Symposium". The symposium was organized and chaired by Stählin (Labhardt's boss) and was held on 28 November 1953 at Friedmatt Hospital. Labhardt's research continued for another two years. He worked with 373 patients with schizophrenia and published his final results in 1956.

Around 1955, chlorpromazine was gaining acceptance in Europe and was being prescribed increasingly. That year, papers from Switzerland, England, Germany, Hungary, Canada, the United States, the USSR, and Latin America were published about trials of chlorpromazine and its efficacy. In October, the first international conference on the therapeutic use of chlorpromazine in psychiatry was held in Paris. It was organized by Delay and Deniker and had 257 delegates from 19 countries from Europe and North and South America: chlorpromazine was no longer a minority interest.

Chlorpromazine in England and the Elkeses

Joel and Charmian Elkes played pivotal roles, both in introducing chlorpromazine into England and consequently into the anglophonic sphere of America and Canada, and in being pioneers of randomized controlled trials (RCTs) in psychiatric research.

Joel Elkes was born in 1913 at Königsberg to a German Jewish family. His father was a Russian army doctor and served in the 1905 revolution and in the First World War. During that war, the family had to flee and moved to Lithuania. During their time in Lithuania, Joel's father worked as the personal physician to the British Ambassador who encouraged an academically brilliant Joel to study medicine in England. Joel enrolled at St Mary's Hospital Medical School, Paddington, London. When World War Two broke out, Joel was still a medical student and the war caused his social and financial support network to breakdown, with his family stranded back in continental Europe. He eventually found himself struggling to support himself and his sister Sarah who was with him at the time. It was then (1939) that Alistair Frazer, one of his former professors offered him a post at the newly commissioned transfusion service. During his work there, Joel met his wife, Charmian Bourne, the daughter of Alec Bourne, another of his former professors.

Clarence Memorial Wing, St Mary Hospital London, now part of Imperial College Healthcare NHS Trust. **Source:** Wikimedia, https://commons.wikimedia.org/wiki/File:St_Mary%27s_Hospital.jpg

Following graduation in 1941, Joel's initial career was oriented toward chemistry and pharmacology. He worked for nearly a decade at Birmingham University, initially as a research fellow then as a lecturer and a senior lecturer in pharmacology. It was thanks to his wife Charmian that he took a detour into psychiatry. She was also a doctor, and between 1945 and 1950, she, jointly with her husband, carried out a series of trials of using different substances, including amphetamines, mephenesin (a muscle relaxant), and amobarbital for

treating patients with catatonic schizophrenia. These trials brought the Elkeses to the attention of psychiatric circles in the UK. In 1950, Joel was appointed professor and chairman of the newly established department for experimental psychiatry in Birmingham.

The Elkeses were aware of Laborit's and Delay's findings around chlorpromazine and wanted to test the efficacy of the drug. The Elkeses' chlorpromazine trial was ground-breaking. Not only was it widely cited later as evidence for the efficacy of chlorpromazine, but it was also one of the first studies to introduce the concepts of randomization, blinding and controlling into psychiatric medication trials.

The trial had 27 in-patients with chronic "hyperactive" psychosis. Over the course of 22 weeks, the patients were given chlorpromazine (250-300 mg daily) for 6 weeks then placebo in the following 6 weeks. The group thus acted as its own control. The patients were blinded to which intervention they were receiving. The outcomes during the trial were monitored by structured nursing reports and weekly medical reviews.

The results were highly in favour of chlorpromazine: 25.9% of the patients had a "complete recovery"' and a further 40.7% had a "partial recovery". The Elkeses also found that chlorpromazine, when given to psychotic patients, did not cause immediate cessation of delusions and hallucinations but rather "dampened" their disturbing effect, causing the patients to be less distracted by them and more able to ignore them. This alludes to the aberrant salience model of psychosis developed later by Shitij Kapur. Their trial was also the first to establish weight gain in patients treated with antipsychotics: 9 of the patients in the trial gained 5-15 kg during the trial (22 weeks), although regain of appetite following recovery from psychosis would confound this finding. The patients also underwent regular blood tests including full blood count and liver function, and one patient developed transient neutropenia during the treatment period.

The Elkeses paper on chlorpromazine introduced the rigor of blinded randomized controlled trials into psychopharmacology and established it as a discipline with solid experimental evidence. They later moved to the United States, where they were also instrumental in establishing and developing psychopharmacology.

We leave this chapter of the chlorpromazine story with it starting to gain traction and recognition across Europe, and gradually becoming the "first-line" intervention for the management of psychosis. In the next instalment, we will move across the Atlantic and find out how chlorpromazine was introduced into the Americas, helped by the efforts of the Elkeses and a German immigrant psychiatrist.

References

Ban TA (2007). Fifty years chlorpromazine: a historical perspective. *Neuropsychiatric Disease and Treatment*, 3(4), 495–500.

Blackwell B (2015). Joel Elkes: an integrative life. https://inhn.org/fileadmin/user_upload/User_Uploads/INHN/EBOOKS/Chapter_3_-_Joel_Elkes_Blackwell_Pioneers.pdf August 20, 2015.

Carey B (2015). Joel Elkes, who shed light on psychosis, dies at 101. Obituary, *New York Times*. 17 November 2015

Elkes J & Elkes C (1954). Effect of chlorpromazine on the behaviour of chronically overactive psychotic patients. *British Medical Journal*, 2(4887), 560–565.

López-Muñoz F, Alamo C, Cuenca E, Shen W, Clervoy P & Rubio G (2005). History of the Discovery and Clinical Introduction of Chlorpromazine. *Annals of Clinical Psychiatry*, 17(3), 113-135.

Revol L, et al (1956). *La Thérapeutique par la Chlorpromazine en Pratique Psychiatrique*. Paris: Masson.

Editors' choice

Blogs, publications, archives, and repositories

Dear Readers,

Here we are again with a new list compiled by us of resources that might provoke your interest. If you go through them, do feel free to give us your feedback.
And, as always, please do keep suggesting similar things that you come across so we can share them here for more News and Notes readers!

1. Hidden Memories of Nottingham Mental Healthcare
   https://www.mentalhealthcarememories.co.uk/

2. History of psychiatry of old age podcasts| RANZCP

3. https://www.youtube.com/watch?v=UYmtzaHwCKo

   Film: Gaslight is a 1940 British film based on Patrick Hamilton's play, Gas Light (1938).
   Plot: Alice Barlow is murdered by an unknown man, who then ransacks her house, looking for her valuable and famous rubies. The house remains empty for years, until newlyweds Paul and Bella Mallen move in. Bella soon finds herself misplacing small objects; and, before long, Paul has her believing she is losing her sanity. BG Rough, a former detective involved in the original murder investigation, immediately suspects him of Alice Barlow's murder.
   This film may be of particular interest to people familiar with the former RCPsych HQ at 17 Belgrave Square: the Mallens' house is architecturally similar, giving it an additional layer of creepiness!

4. A wealth of full-text historical sources available at www.archive.org

5. A wealth of full-text historical sources, archives and images available at https://wellcomecollection.org/collections

And please don't forget to check the Future Archives winning entries here (also referenced in the Archives report) and witness seminar on UK psychiatric hospitals in the 1960s here

Yours truly,

Lydia, Mutahira, Nicol and Claire

Trespass and false imprisonment: a landmark case?

Dr Bob Adams

Retired consultant psychiatrist from Bootham Park Hospital, York. Now tribunal doctor, writer and historian. Dr Adams is currently half way through writing a history of the York Asylum: 250 years of Psychiatry.

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Around midnight on the 4 May 1818 a chaise turned up at Miss Jane Horsman's house in Poppleton, a village about four miles from York. Two men gained access and removed her under threat of force to the Clifton Asylum, a private establishment run by Mr Alexander Mather, a surgeon, and Dr William Belcombe, a physician. Dr Belcombe was also visiting physician to the York Retreat, the Quaker mental hospital, regarded as the model to follow after publication of Samuel Tuke's book outlining the principles of "moral" treatment.[1]

I came across the case of Jane Horsman while researching the history of the York Asylum, latterly known as Bootham Park Hospital. The York Asylum was only the fifth public asylum to be founded in England, in 1777, and it had no links with the Clifton Asylum.

Despite displaying no evidence of mental illness Miss Horsman was kept at the Clifton Asylum for twenty days and denied the use of pen, ink or paper. A year later she decided to sue for false imprisonment. The subsequent court case attracted a lot of press interest and has recently been cited as a trial that contributed to the making of modern law.[2]

The case of Jane Horsman

Jane (age 50) lived with her elderly mother and her niece Helen Scott in Ryder House, Poppleton. Their income, of £50 per annum, was derived from a small piece of land, supplemented to the tune of £200 annually by her brother who was resident in India. However, this latter income had recently become unreliable and Jane's uncle, Francis Bulmer, who had charge of the family finances, had started to withhold some payments to her, triggering family disputes.

Ryder House, Nether Poppleton. Now the home of a retired surgeon. Photo by Bob Adams

Jane was in bed on 4 May 1818 when Mr Matterson, an apothecary, and Dr Belcombe's manservant arrived at midnight. When they informed her that she was to be taken away to hospital she understandably became very distressed and tearful. She was informed that if she did not accompany them, they would use force. Dr Belcombe's man had a straight waistcoat under his arm. She agreed to go with them.

On arrival at Clifton Asylum, about a mile north of York's Bootham Bar, Miss Horsman was described as "fretting very much." She was taken to her room. She enquired if the bedsheets were clean. Although nurse Elizabeth Johnson observed that her conversation was not that of an insane person, she was secured to the bed with a strap attached to her leg which was in turn secured with a padlock.

After finding out about her friend's removal, Mrs Faber of Poppleton wrote to Jonathan Gray, a solicitor and well-known mental health reformer. Gray had recently published a book on the York Asylum, outlining its

history of poor care and subsequent reform.[3] Gray lost no time in contacting York magistrate, Mr Dickens, and asking him to investigate. At the time, private asylums were subject to the 1774 Act for the regulation of private madhouses which, outside London, put them under the jurisdiction of local magistrates. Mr Dickens, accompanied by Dr Baldwin Wake, the new physician to the York Asylum, went to Clifton to see the patient.

The house most likely to have been the Clifton Asylum as its garden is referred to as "Belcombe's Yard" on the 1852 OS Map. Photo by Bob Adams

At interview neither could find any evidence of mental illness. They advised discharge but that was refused. The next day a constable was sent to release the patient. He had to break down the door to gain access.

Dr William Belcombe. From a print at the York Medical Society (with permission)

The court case

Why it took Miss Horsman over a year to bring her case to court is a matter of conjecture. She may have held off because she wanted to achieve a reconciliation with her uncle. On the 4 August 1819, the case was listed at the York Assizes to be heard before Judge Baron Wood together with the Archbishop of York and a special jury. The courthouse was packed. The newspapers went to town describing the popularity of the spectacle stating that the court was "crowded beyond description" and that "the galleries were ready to bend under the weight of numbers," and even, "the whole displayed such an assemblage of female beauty as perhaps may never grace that court again." It was further stated that the case had excited interest because of the "respectability of the parties" and the "novelty and importance of a cause" and that it was the "power of the law to protect from rude and cruel invasion, the peaceful retreats of rural life." There was assembled a "fearful array" of counsel for both sides. The stage was set for an epic confrontation.

In the dock were Francis Bulmer, his son Reverend William Bulmer, Dr Belcombe, Mr Mather, Mr Matterson and Helen Scott.

Twenty witnesses for the plaintiff gave evidence first. All testified that Miss Horsman had never displayed any signs of insanity or intemperance. It was further alleged that Mr Matterson, who had signed the detention papers, had apparently been threatened by Francis Bulmer with a poker if he did not sign. Jonathan Gray gave evidence that Matterson had told him that he did not think that Miss Horsman was insane. When he subsequently informed Belcombe of this, Belcombe described Matterson as a "recreant knave." Belcombe also informed Gray that when a person was brought in under a certificate of lunacy, it was the doctor's duty to keep the patient a sufficient time to enable him to ascertain whether the patient was insane or not, otherwise the doctor should be answerable for the consequences.

The Judge acquitted Miss Scott as there was no case against her. This released her to appear as a witness for the defence. Various witnesses for the defence testified that there had been concerns about the plaintiff's secret drinking some time before the

removal. Miss Horsman had been drinking in the morning, between breakfast and dinner. She had secreted various bottles around the house. Miss Scott stated that she had changed greatly over the previous six months and the smell of rum was "never out of your nose". Bills from wine merchants testified to orders for wine and liquor well above what would be normal. It was reported that she had become increasingly irritable, especially towards her elderly mother. The public were particularly amused to hear that she had apparently attended a Methodist chapel in an intoxicated state. On one occasion, when she had been refused money, she had threatened to take laudanum, stating that if she could not take anything she would cut her throat. Miss Scott "dashed it out of her hand." A prosecution lawyer commented that laudanum was taken by "most respectable ladies."

The matron of Clifton Asylum was keen to point out that Miss Horsman had been well treated at the asylum. Nurse Johnson reported that she had only been secured to the bed at nights for about two weeks. Dr Wake, with his expert knowledge of mental illness, was questioned by the judge. In his opinion, habitual drunkenness could be a very powerful cause of insanity and was a reasonable ground for putting a person under restraint or even removing them to a safer place if there was a risk of injury. He did not give his opinion on whether Miss Horsman was unwell at the time of admission.

By this time, it was well after midnight and the court remained packed. Dawn was approaching by the time Judge Wood gave his summing up. He advised that Miss Horsman could have been suffering from a "temporary insanity" at the time of her detention. The jury returned after twenty minutes with a verdict for the plaintiff and an award of £50 in damages. It was 4am before the participants emerged into the morning light, after a marathon sixteen hours. Judge Wood was back in court five hours later apparently giving no sign that he had been up for most of the night.

Conclusions

This case remains relevant to the detention of patients to this day. Detaining professionals must see the patient and take time to make a full assessment. They must be clear that applicants have nothing to gain financially from the detention of their relatives. There is no right of access to a private property without a magistrates warrant (Mental Health Act 1983 Section 135) and there must be a speedy process of appeal following detention.

There is no indication that the verdict in the trial affected Dr Belcombe's or Mr Mather's reputation. Dr Belcombe's son took over the running of the asylum until it closed in 1852. I cannot find any information about what happened to Mr Matterson, although a William Matterson, surgeon, became Lord Mayor of York in 1841. Hopefully Jane Horsman was able to return to live in Poppleton with the support of her friends, rather than an excess of rum. Her mother moved to York to end her days in the care of the Bulmer family.

References

1. Samuel Tuke, *Description of the Retreat. An institution near York for insane persons of the Society of Friends* (1813).

2. e.g. re: Jane Horsman, in: *The Making of Modern Law. Trials 1600-1925* (Berkeley Law Library)

3. Jonathan Gray, *A History of* the *York Asylum* (York, 1815).

4. Newspapers consulted: York Herald, 7 and 14 Aug. 1819; Leeds Intelligencer, 9 Aug. 1819; Evening Mail (London), 9 Aug. 1819; Baldwin's London Weekly Journal, 14 Aug. 1819.

5. Prudence Bebb, *Georgian Poppleton* (York, 1994). pp.12 and 21, for information on the Horsmans (or Horsemans) of Poppleton.

Insights from the autobiography of Walter Freeman

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Introduction and Context

The leucotomy—also known as the "lobotomy"—was first attempted by the Portuguese physician Antonio Egas Moniz who later won the Nobel Prize for the procedure (1). It was not until the experiments of Italian physician Amarro Fiamberti that the technique of transorbital leucotomy was developed in 1937 (2). American neurologist Walter Freeman adapted this technique using an ice-pick, allegedly straight out of his kitchen, creating the procedure that would come to be known as the transorbital lobotomy. The first of these procedures took place in January 1946 without his neurosurgeon partner, James Watts (3), knowing.

After stumbling upon a podcast by journalist Robert Evans (4), I was compelled to read Freeman's biography by Jack El-Hai (3), which in turn led me to request a scanned copy of Freeman's own unpublished autobiography from George Washington University (5). Jack El-Hai's biography is excellently researched but left me wanting to know more about Freeman's personality after reading about some of his alleged practices: taking an ice-pick to the orbits of his patients and then sending them home in a taxi (3), performing multiple lobotomies on children (6)and lobotomising John F. Kennedy's sister Rosemary with a catastrophic outcome which was then quietly covered up (7).This review is based mainly on Freeman's autobiographical memoir and El-Hai's biography.

Freeman's personal life

Born in 1895, "with the proverbial silver spoon in my mouth" (8), Freeman was the eldest of seven siblings. He began his lengthy career as a neurologist, working at St. Elizabeth's Hospital, Washington DC in 1924 at the age of 28. Between 1936 and 1967 he performed over 4,000 lobotomies all over North America (9). He followed up his lobotomy patients obsessively, covering thousands of miles to see them until his death in 1972.

Freeman married Marjorie Franklin in 1924, and they had six children together: Keen, Randy, Walter, Lorne, Franklin and Paul. Keen died tragically at the age of 11 by falling over a waterfall. After this event, Freeman wrote the following: "The function of parents, as I see it, is to stand ready to pick up the pieces, rather than caution or stop. How dreadfully this turned out (though I still think my method is best) occurred when Keen lost his life at Vernal Falls" (10). He later justified this further by saying it was worth it because his other children have done well: "Keen did not die in vain if the other children thereby achieve a greater self-reliance and are willing to forgo ease in quest of thrills" (11).

Freeman stated that his memoir was for his children and unlikely to be of interest to anyone else, but curiously, his children and his family life barely feature. He went into excruciating detail on his working routine, the structure of various medical organisations and the formation of examining bodies. Large chunks of the tome read like a bus timetable for a place that no longer exists. This is pushed to absurd degrees at times, whereby in the middle of several pages on the finer details of fly-fishing, he wrote one sentence to say that his son passed away and then immediately returned to discussing trout. Similarly, in 1968 when Randy died at the age of 31 of a brain tumour, Freeman attended a medical conference in Florida instead of attending the funeral. Of his other children, Walter went on to become a successful neuroscientist, Paul

became a psychiatrist and Franklin became a security guard (12).

There is a frustrating lack of information available, both in Freeman's own autobiography and in El-Hai's book, on Walter Freeman's relationship with his brother Norman. Norman Freeman (1903-1975) was a pioneering vascular surgeon who retired at the age of 59 due to depression (13). There are references in El-Hai's biography to the brothers corresponding over the years and a brief mention that Norman "once slugged Freeman during a violent episode and dislodged a few of his teeth" (14).

The few mentions of Freeman's wife Marjorie led me to think that he rather disliked her. He spent a great deal of time camping and hiking, but this may in part have been in an effort to get away from her. She became an alcoholic and he noted that, "the evenings are best when she is in bed by the time I have washed the dishes. I prefer the semistupor of the fifth glass of sherry to the caustic antagonism after the second" (15). As Marjorie's health deteriorated and she suffered an ischaemic limb in 1970, Freeman wrote, "I refused amputation because it was obvious that she would never recover" (16), and even threatened to take his sons to court over this decision. He neglected to mention that eventually his sons did arrange for the amputation, but she succumbed to pneumonia 2 months later (4). After Marjorie's death at St. Francis Hospital, Connecticut, despite the cause of death already being clear, he arranged for a post-mortem to be performed by the pathologist at his former workplace on the other side of the continent, El Camino Hospital, California (17).

Freeman's career

In his obituary, Freeman is ambitiously described as a neurologist, neuropathologist, psychiatrist, teacher, author and poet. After completing his undergraduate studies at Yale (1912-1916), he received his M.D. from the University of Pennsylvania in 1920 and continued to intern there over the following two years. In 1922 he travelled to Europe, where he trained in neurology and psychiatry at the Salpêtrière in Paris, and the "Clinica Psichiatrica" in Rome (18). He admitted that he was helped to prominence by his esteemed grandfather, William Williams Keen, who had performed America's first successful removal of a brain tumour in 1888 (19). And on his return from Europe it was Keen who arranged for Freeman's appointment to the pathology laboratory at St. Elizabeth's psychiatric hospital where he worked as Director of Laboratories for 10 years (3). Despite having taken advantage of his family connections, Freeman developed a colourful career in his own right, and actively practised both neurology and psychiatry, alongside a professorship of Neurology at George Washington University School of Medicine. He held the esteemed position of the first Secretary of the American Board of Psychiatry and Neurology for more than 12 years. His interest in scientific treatments of psychiatric disease, as opposed to psychotherapy, led to him reportedly being the first to treat psychotic patients on the open wards at the George Washington University Hospital (18).

Surprisingly, Freeman appeared humble and self-critical at times, although with a rigidity to his thinking which comes across as robotic. When he reported adverse patient outcomes after a lobotomy, such as continued hallucinations, he usually blamed this on poor patient selection. He mentioned few of his own emotions, let alone those of his patients. He sent thousands of Christmas cards out to the patients he had operated on, but he spoke about this in terms of a survey with the aim of receiving responses, as if being able to send a reply was a satisfactory measure of quality of life. Freeman initially received criticism when he first started to discuss his results in medical circles but is said to have "answered his critics in unruffled tones", before later being held in high esteem as lobotomy was more widely practised (18).

Between the years 1950 and 1955 Freeman was on the road performing patient follow up trips and must scarcely have been home. He

called this his "head-and-shoulder hunting", referring to the photographs he took of the patients as "trophies" (20).

Around 60% of all lobotomy patients were women, and 17 of Freeman's first 20 operations were on female patients (21). His comment: "During my internship I was rather shy of nurses. They knew too much" (22), raises some questions on his attitudes towards women. He also noted that when assisting with operations in general surgery, "I whiled away the time making eyes at the nurses" (23). The difference in professional boundaries of the era is somewhat illustrated by Freeman's statement that he and his colleagues had patients as housemaids (24).

Conclusions

Although Freeman's decisions may appear misguided to us now, given the poor prognosis of many patients in mental institutions in this era, I believe Freeman really thought he was acting in these patients' best interests. He compared lobotomy to emergency surgery for a strangulated hernia, stating it is for a "strangulated oedipal complex" (25). He measured his success with lobotomy by the proportion of patients he could discharge home from institutions and whether they could be "usefully occupied" (26).

Freeman ended his autobiography with a comment about *The Psychiatrist*, a book he had written which was poorly received: "Psychiatrists, I think, take themselves and their specialty quite too seriously. At least I had an enjoyable time writing the book" (27). This seems to have encapsulated his general philosophy quite well. I no longer think of Freeman as a psychopath, as I did at first, but he was reckless, and did not seriously consider the consequences of what he was doing. In conclusion, my overall impression of Freeman is that if I met him, he'd bore me with his anecdotes, rather than with an ice-pick.

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References

1. In 1949. Nobel Media. 2021. Egas Moniz – Facts. Available at: https://www.nobelprize.org/prizes/medicine/1949/moniz/facts/ [Accessed 26 April 2021]

2. *Encyclopædia Britannica*. 2021. Amarro Fiamberti - Italian surgeon. Available at: https://www.britannica.com/biography/Amarro-Fiamberti [Accessed 26 April 2021]

3. El-Hai, J. 2005. *The Lobotomist*. Hoboken, New Jersey: John Wiley and Sons, Inc

4. Evans, R. 2019. Episode 94. Behind The Bastards [Podcast]. 5 November 2019. Available at: https://www.iheart.com/podcast/105-behind-the-bastards-29236323/episode/part-one-the-bastard-who-invented-52193639/ [Accessed 26 April 2021]

5. Freeman, W. Autobiography (Unpublished Manuscript). George Washington Special Collections Research Centre. Available at: https://gwu.app.box.com/s/3901vy3w8il8q4ncaxbaue3bxgcl3kr1.

Hereafter: - "Freeman. Autobiography, chapter:page"

6. Prentice, C. 2021. Lobotomy: The brain op described as 'easier than curing a toothache'. Available at: https://www.bbc.co.uk/news/stories-55854145 [Accessed 26 April 2021]

7. Larson, K C. 2015. *Rosemary: The Hidden Kennedy Daughter*. New York: Houghton Mifflin Harcourt Publishing Company

8. Freeman. Autobiography, 1:2

9. Faria Jr, M A. 2013. Violence, mental illness, and the brain – A brief history of psychosurgery: Part 1 – From trephination to lobotomy. *Surgical Neurology International*. 4(49). doi: 10.4103/2152-7806.110146

10. Freeman. Autobiography, 15:12

11. Freeman. Autobiography, 15:24

12. Day, E. 2008. He was bad, so they put an ice pick in his brain.... Available at: https://www.theguardian.com/science/2008/jan/13/neuroscience.medicalscience [Accessed 26 April 2021]

13. Connolly, J E. 1995. Norman Freeman: the "first" American specialist in vascular surgery. *Journal of*

Vascular Surgery. 22(2):188-94. doi: 10.1016/s0741-5214(95)70116-8.

14. El-Hai, J. 2005. *The Lobotomist*. Hoboken, New Jersey: John Wiley and Sons, Inc. p. 270

15. Freeman. Autobiography, 2:5

16. Freeman. Autobiography, 19:11

17. Freeman. Autobiography, 19:12

18. Lebensohn, Z M. 1972. Walter Freeman 1895-1972. *American Journal of Psychiatry*. 129 (3), 356-357. doi:10.1176/ajp.129.3.356

19. *Encyclopædia Britannica*. 2021. William Williams Keen. Available at: https://www.britannica.com/biography/William-Williams-Keen [Accessed 16 August 2021]

20. Freeman. Autobiography, 18:2,5

21. El-Hai, J. 2016. Race and Gender in the Selection of Patients for Lobotomy. Available at: https://www.wondersandmarvels.com/2016/12/race-gender-selection-patients-lobotomy.html [Accessed 27 April 2021]

22. Freeman. Autobiography, 6:13

23. Freeman. Autobiography, 6:6

24. Freeman. Autobiography, 9:5

25. Freeman. Autobiography, 14:15

26. Freeman. Autobiography, 18:7

27. Freeman. Autobiography, 22:6

William Murdoch, cradle to grave alienist

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James William Aitken Murdoch was born in Dumfries in 1857. He trained in medicine at the University of Edinburgh, qualifying in 1880. Moving south, he became an Assistant Medical Officer at the Moulsford Asylum in Berkshire in 1881. He was to work in that asylum for his entire professional career until his untimely death, aged 60, in 1917. During his lengthy association, the asylum was, in 1897, re-named the Berkshire Lunatic Asylum. Long after Dr Murdoch's final departure, from the birth of the NHS in 1948, it became known as Fair Mile Hospital, which name it kept until its closure in 2003. His story is a window into the life of a Victorian pauper lunatic asylum and the extraordinary position (at least to our eyes) of the Physician Superintendent within it.

Whilst the term "pauper lunatic asylum" summons up narratives of dehumanisation and quarantining, the ethos of the county asylum system, mandated in 1845 by the County Asylums Act, was, for the most part, one of compassion and care. There was an explicit desire to rehabilitate patients whenever possible and while some patients were incarcerated long-term, the discharge rates were high during Murdoch's tenure. "Paupers" were simply the ordinary folk who did not have the means to pay for private asylum care; the word "lunatic" was used because none more apt had yet been dreamt up and an asylum is, at least in one meaning, a place of safety and refuge. All

involved were charged with doing the best they could with the tools and materials to hand and, at least to an extent, some asylums largely succeeded in these aims (1).

In 1892, Murdoch was promoted to the post of Physician Superintendent. By all accounts he was industrious, determined and highly respected as a good doctor. Testaments to this are the strongly positive monthly reports of the Visitors—a governing committee, mostly Justices of the Peace, appointed by the overseeing magistrates—and similar reports following the annual inspections by the Commissioners in Lunacy. Despite Murdoch's assiduousness, the asylum was not without its problems, notably recurrent outbreaks of enteric fever (typhoid) and other gastrointestinal infections, linked to what had become the archaic sewage systems, overcrowding and sporadic violence. Although Murdoch may be among the worthies shown in Figure 1 below, of a Committee of Visitors of about 1910, sadly no certain identification has been made. The dignified personage in top hat and spats is Mr JT Morland, long-serving Clerk to the Visitors. The other seated gent might be either Dr Murdoch or the committee's chairman, Mr Martin. Murdoch did not always condescend to attend the monthly meetings. Since the Superintendent was accountable to the Visitors in nearly all matters—and highly dependent on their support and permission where any expenditure of public funds was required—the doctor's absences may not have been entirely helpful. The photograph is taken from Ian Wheeler's book, *Fair Mile Hospital – a Victorian Asylum* which draws together many aspects of the founding, design, growth, operation, tribulations and notable personages that the hospital witnessed over its 133-year lifespan (2).

Figure 1. The Committee of Visitors who oversaw the governance of the Berkshire County Lunatic Asylum. (Courtesy of Tony Spackman.)

Murdoch ran a tight ship and, like his predecessors and many of his peers, was involved in every aspect of asylum life from patient care to ordering materials for the buildings and the adjoining farm. There are several reports of his being called to the bedside of dying patients and he attended several of their funerals. Murdoch was a strong proponent of moral therapy, or what he referred to as the "Moral Method", and was energetic in finding and encouraging occupation for the patients most notably on the farm and in the laundry (3). He was also adamant that they should receive as good food as was available and get ample amounts of fresh air and exercise. His staff thought highly of him, although that was partly linked to his granting them better allowances and leave, and working hard to improve the living conditions for the many staff who lived in the asylum buildings and grounds. Despite perennial problems with recruiting sufficient personnel with the required skills, discipline and tenacity for asylum nursing, morale is said to have been high.

Murdoch, however, was very conservative and suspicious of change, although he claimed this resistance was in the patients' best interests. The science of psychiatric medicine was finding its feet but for many

years he refused to attend conferences of his peers, so that what we would now call his "Continuing Professional Development" was not up to date. Conversely, his prioritisation of his own asylum may partly explain his strong local reputation. He was a strong advocate of degeneracy theories of mental illness popular at the time (4). He was also critical that "asylums are looked upon as nursing homes for the demented and aged, and as houses of detention for idiots and imbeciles" and considered that other establishments existed that were better suited to the care and treatment of these conditions (5). One might have some sympathy with his views on asylum admissions (over which he had less control than he would have wished) but not with his eugenicist views of how these problems should be sorted. He stated that those with congenital defects, or who had ever been asylum patients, should not be allowed to have children, as they were certain to be "defective" and lamented that "state interference as regards marriage is I fear out of the question under present-day ideas as to the liberty of the subject, but much might be done however in educating the masses in this matter" (6).

Murdoch, like many other of his psychiatric peers at the clinical head of Victorian asylums, lived in some splendour in the Physician Superintendent's quarters right in the centre of the hospital. As was the custom, he delayed marrying Celia Cozens—very much younger than he was and the daughter of a local farmer—until he had been appointed to the top post. As the patients were strictly segregated according to sex, the sight of her taking exercise on her safety bicycle at the main entrance (Figure 2), must have caused a few of the male inmates' hearts to flutter!

Figure 2. Mrs Celia Murdoch on her bicycle in about 1900. (Courtesy of Tony Spackman.)

Between 50 and 100 patients of Fair Mile died each year during Murdoch's tenure; the apparently high figure can be partly explained by the number of geriatric cases received, often referred from the local workhouses, which were unsuited to managing some of the distressing infirmities of the aged. Many other patients died from then-untreatable physical diseases that had often affected their mental functioning or from the direct effects of florid mental illnesses, which frequently caused "exhaustion" or emaciation. Perhaps reflecting his training in Edinburgh, which was then at the forefront of pathological research in asylums, Dr Murdoch was a strong advocate of the view that post-mortems should be performed to determine the causes of both the death and the insanity. The post-mortem rate was notably high in this asylum during his tenure. An unknown number of deceased patients were reclaimed by their families for private burial but the majority were interred at nearby St Mary's Church, Cholsey where, later, Agatha Christie, a long-established resident of the parish, was also buried. Her grave is adorned by a fine headstone, but for the lunatics there was a pauper grave. These plots were often reused after as decent an interval as possible. The graves were initially marked by a simple, numbered iron cross

but these were soon removed probably because, as Wheeler drily notes, they were impediments to mowing. The graves were thus unmarked. In 2003, when the hospital was closing, local efforts led to the plaque in Figure 3 being placed on the cemetery wall in commemoration.

Figure 3. At the time of the asylum's closure, local people, including former staff, marked their respect for the many deceased Fair Mile patients with this plaque at St Mary's, Cholsey.

Murdoch died suddenly in 1917 aged 60 following an operation for acute appendicitis in Reading. At his explicit instruction, he was interred in the asylum's allocated ground at St Mary's. The funeral was attended by a large number of staff and some patients. On his gravestone, his epitaph reads:

WRITE ME AS ONE WHO (LABOURED FOR)

LOVED HIS FELLOW MEN,

THE ANGEL WROTE.

Much later, in 1962, his widow joined her husband there. Their grave, complete with a statue of an angel, once blowing a trumpet but now eroded by time and weather, is pictured in Figure 4. The featureless plot that can be seen behind is that of his erstwhile pauper patients. Murdoch, evidently, wished to look after and over them in death as he had in life…or perhaps one could say his patients could not escape him even in death! On the one hand, the photograph is symbolic of Murdoch's commitment to what he considered was "his" asylum, but, on the other, to the overwhelming power imbalance in Victorian asylums and patients' lack of agency within them.

Figure 4. Murdoch chose to be laid to rest among his former patients.

References

1. Smith, Leonard. *Cure, Comfort and Safe Custody: Public lunatic asylums in early nineteenth-century England*. A&C Black, 1999.

2. Wheeler, Ian. *Fair Mile Hospital: A Victorian Asylum*. The History Press, 2015.

3. Scull, Andrew T. "Moral treatment reconsidered: some sociological comments on an episode in the history of British psychiatry," *Psychological Medicine* 9 (1979): 421-428.

4. Pick, Daniel. *Faces of Degeneration: A European disorder, c. 1848-1918*. Cambridge University Press, 1989.

5. Stevens, Mark. *Life in the Victorian Asylum: The world of nineteenth century mental health care*. Pen and Sword, 2014.

6. Tyte, Kate. "Fair Mile Hospital, Cholsey, 1870-1948," *Berkshire Old and New, Journal of the Berkshire Local History Association* 24 (2007): 28-38.

Management of Charles Darwin's chronic illness from a psychiatric perspective

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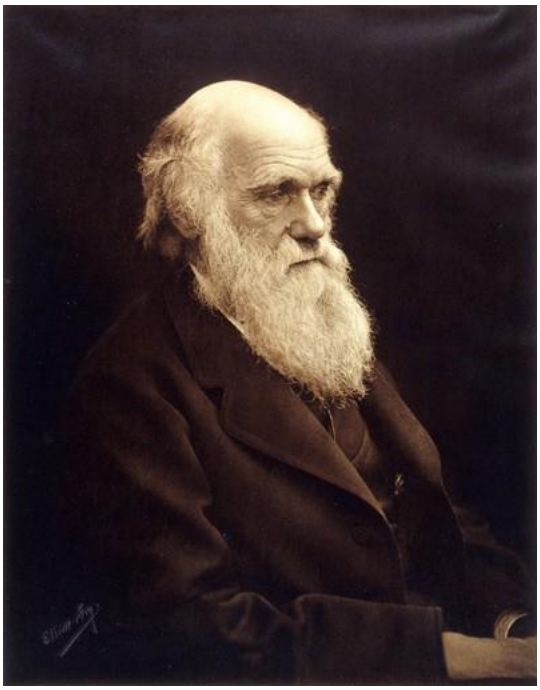

Eugenics Society, photographic portrait of Charles Darwin. Wellcome Collection. https://wellcomecollection.org/works/b2a4kgcx (Public domain)

Charles Darwin (1809-1882), the British naturalist who developed the theory of evolution by natural selection, reportedly suffered from a range of chronic and debilitating illnesses over his lifetime (1). He sought medical help from several physicians, receiving varying opinions on diagnoses and management, with limited success.

Whilst there has been a wealth of literature describing Darwin's symptomatology, the management he received has been less explored. Psychiatrist Ralph Colp (1924-2008) wrote extensively on Charles Darwin, focusing on diagnostic issues, but, to our knowledge, few other psychiatrists have offered their perspectives. This overview outlines the management Darwin received, through the lens of modern psychiatric practice.

Understanding Darwin's symptoms

Darwin had suffered mental and physical health difficulties since youth. Family and physicians described him as having a vulnerable disposition to illness. He often avoided events that might upset or excite him, concerned that any extreme mental stimulation might trigger an episode of illness. His father, Dr Robert Darwin, described this as "lability of the autonomic nervous system"; Darwin himself referred to it as feeling "knocked up". Episodes were reported to involve trembling, shivering, experiencing gastrointestinal upsets, followed by periods of exhaustion (2). This was a theme throughout his life. In adulthood, Darwin reported a diverse range of symptoms, including anxiety, hysterical sobbing, sensations of dying, inexplicable fear, insomnia, flatulence, vomiting and dyspepsia (1-3). In Darwin's time, the term "dyspepsia" was used to describe a variety of symptoms, including a physical weakness, loss of appetite, depression of spirits, morbid despondency and gloom.

There were occasions in later life when Darwin was reported as depressed, thought to be a consequence of these episodes of illness (2). Darwin was never considered as primarily depressed or "melancholic" (a term which changed its meaning over Darwin's lifetime). In Victorian England, labels such as "melancholia" sometimes carried with them the stigma of hereditary degeneracy, and

could be associated with incarceration in an asylum. Darwin was not diagnosed as melancholic, perhaps because he was an upper-class gentleman of private means, or perhaps due to the relatively mild nature of his depressive symptoms, without associated challenging behaviours (4-5).

Predisposing and precipitating factors contributing to Darwin's difficulties have been extensively considered in previous literature. Prominent events in his life included the sudden death of his mother when Darwin was aged eight (6). His elder sisters later insisted that no reference be made to her thereafter due to the upset that caused. Darwin later stated that he had limited memory of his mother (6). John Bowlby (1907-1990) theorised that Darwin's failure to grieve for the loss of his mother may have left Darwin vulnerable to depression and psychosomatic symptoms (7). Darwin suffered loss again in 1851 when his ten-year-old daughter Annie Darwin died following an acute illness, which was followed by a marked and prolonged bereavement reaction. For many years, he avoided visits to her grave and the place of her death (2).

With regard to other triggers, Darwin reported periods of flatulence, weakness and vomiting from July to September 1840 during his wife's first pregnancy. Darwin complained: "What an awful affair a confinement is: it knocked me up, almost as much as it did Emma herself". During her second pregnancy, Darwin suffered similar symptoms (2). His health diaries between 1849-1854 reveal that any event which disrupted his routine could trigger his flatulence, such as when travelling into London, to his son's preparatory school or to the British Museum (2).

There is little report of relieving factors, leading to Darwin continually seeking medical advice. He restricted his attendance at scientific meetings in an attempt at managing his health, albeit with limited success. He described "the effort of sitting for 2 or 3 (or even less) [hours] in a public chair would be quite intolerable to me" (2). In February 1849, Darwin wrote "regular doctors cannot check my incessant vomiting at all" (3).

Diagnostic discussion is beyond the scope of this essay, but what is important to note is the range of views and theories which continue to this day. Dr James Gully (1808-1883) suggested "nervous dyspepsia", as described above (2). Sir Henry Holland (1788-1873) suggested "nearer to suppressed gout", a form of gout without inflammation which was commonly diagnosed in Victorian times (2). Recent retrospective considerations have included Chagas disease, irritable bowel syndrome, inflammatory bowel disease, cyclical vomiting syndrome and mitochondrial dysfunction (1). Primary psychiatric causes have also been considered.

Understanding Darwin's management

Darwin trialled a range of management options, ranging from physical interventions, optimising diet and lifestyle factors as well as strategies more akin to a psychosocial approach. All are described below, in the order he used them. They illustrate the range of options available at the time, as well as Darwin's motivation to seek treatment.

Galvanism

Darwin commenced self-treatment with "galvanisation" in 1846. This was the application of an electric current from a voltaic battery developed by Isaac Pulvermacher and was a popular therapeutic treatment during the first half of the nineteenth century (8-9). It involved the use of a hydro-electric chain with alternating brass and zinc wires, giving electric shocks when moistened with vinegar, and was reportedly used to treat various conditions, including several nervous disorders and cases where the muscles were too relaxed (2). After several courses of treatment, Darwin stopped because he still suffered "three days of bad sickness" (2).

Darwin might have been tempted by galvanisation due to effective marketing, with pamphlets on "volta-electric chain bands". Electric belts were advertised in the *Times* from 1852 onwards, as the "patent portable hydro-electric chain". Later advertisements included testimonials from the people Darwin mentioned in his letters, such as Charles Locock, the first physician accoucheur to Queen Victoria (9). It was reported that the treatment was also acknowledged by several distinguished associations, including the Royal College of Physicians in 1851 (10). Pulvermacher's hydro-electric chain bands also appeared in an article the *Lancet* in 1851 (11).

The legacy of using electricity as a form of treatment in the nineteenth century is still with us, although nowadays the use and procedure of electroconvulsive therapy bears no resemblance to the electric chains that Darwin used (12).

Hydropathy

In March 1849 Darwin moved with his entire family to Malvern in order to undertake Dr Gully's "water cure". Hydropathy under Gully principally involved bathing or douching in cold water, using wet towels and rubbing the body. There was also a domestic healing component, where Darwin would wake early, take walks, rest, engage in limited mental activity, eat a plain diet and drink spring water (13-14).

Darwin used hydropathy over several years, including keeping up the ritual of using a heat lamp, followed by icy showers and soaking sheets at home. In the short-term he reported notable success (1). In May 1849, he wrote: "It has answered to a considerable extent: my sickness much checked and considerable strength gained" (15). His reported success was not to last and Darwin continued to search for alternative remedies.

There are various ways in which to interpret his reported improvement with hydropathy from a modern psychiatric viewpoint. Staying at Gully's establishment was monotonous, without Darwin's usual mental stimulations or stressors. Darwin wrote that staying there induced "the most complete stagnation of mind" (16). Submerging in water or simply splashing the face is known to activate the mammalian dive response, resulting in cardiovascular benefits (16). If interpreted in light of possible inflammatory bowel disease, cold water likely increased cortisol production leading to immunosuppression which could temporarily ameliorate symptoms (17).

Diet and alcohol

In his 1849 book, Gully advised patients to give up alcohol and tobacco, which he deemed harmful to anyone with a "nervous disorder or shattered constitution" (18). By May 1849, Gully had made Darwin give up smoking. However, interestingly Darwin was prescribed wine as a remedy by Dr Headland in 1860. In 1863 Darwin reported that he was "kept going only by repeated doses of brandy" when his "nervous system…failed" (2). His son observed that he "enjoyed and was revived by the little he did drink" (2). Theories surrounding the benefits of alcohol were disputed by many at the time. Darwin's father thought of alcohol as having "evil effects" and his grandfather, Dr Erasmus Darwin, similarly spoke of alcohol's toxicity. The conflicting advice may have been a struggle for Darwin, who was reportedly horrified by drunkenness (2).

On 20 March 1864, Dr William Jenner (physician to Queen Victoria) prescribed Darwin a combination of antacids and purgatives that included lime-water, chalk, and carbonate of magnesia for incessant vomiting. Darwin reported significant improvements, albeit only temporary (19-21). He also attempted taking a range of diets, dietary restrictions and purgatives (22-24).

In the absence of modern psychopharmacological options, a healthy diet with limited alcohol and tobacco may have been the most now-recognisable beneficial strategy to which Darwin had access. The positive impact of the purgatives

he trialled is of course less convincing from a modern psychiatric perspective. Gully did suggest homeopathy, available and prominent at the time. Darwin described the idea of homeopathy as absurd (25).

Spinal ice

In May 1865, Darwin tried spinal ice treatment. Dr John Chapman, a prominent London physician at the time, developed this for several diseases including dyspepsia and seasickness. It involved placing ice, in a specially designed bag, onto the spine three times daily, each time for ninety minutes (2). It did not lead to success for Darwin and in July he gave up this daily regime.

The rest cure

Darwin underwent several periods of rest, both in his own home and in a fashionable sanatorium (13). The "rest cure" was described as a practical solution offered to sufferers of "nervous wear and tear". In the Victorian era, patients with melancholia were often recommended special diets and regimens of rest. The rest cure was typically expensive and only available to the wealthy, with the alternative being a medicinal "nerve tonic" offered to poorer patients (8).

The theory of rest as an effective treatment had emerged at the beginning of the 19th century, a prominent example being William Tuke's "moral treatment" which was practiced with great success at the Retreat in York (26). This treatment involved several strands, including sufficient periods of rest, nutrition and therapeutic activity, regulated by order, discipline and benevolence from the governors (26, 27). Patient-centred care with individualised plans tailored to the patient's symptoms was utilised.

Rest periods with associated support were the closest treatment to what we now refer to as psychotherapy, a therapy from which Darwin would probably have benefited, especially considering his bereavement reactions following the death of both his mother and daughter.

Conclusions

Darwin's case provides an interesting overview of the management strategies available for chronic illness during the nineteenth century, offering many learning points and sources of reflection for historians and clinicians. His desperation and hopelessness as a result of his health struggles is evident, as was his persistence in seeking support. His case highlights a class discrepancy in the nineteenth century, which resonates today. Darwin had access to a large range of management options, unlikely to be offered to a person of lower socio-economic status. It was customary for the rich to be treated at home or in private care for mental illness, partly to avoid scandal and stigma (4).

Nowadays, one can speculate that Darwin would have been offered a full medical assessment for his symptoms with multi-disciplinary team input. A range of pharmacological treatments would of course be available. He would probably receive psychotherapy, perhaps employing a psychodynamic approach, exploring early traumas such as his childhood bereavement, or cognitive behavioural therapy to improve symptom management.

Despite him being confined to his home and disabled by illness for long periods of time, it is fascinating that he still became one of the world's most influential and successful scientists (28).

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References

1. Campbell AK, Matthews SB. (2005) 'Darwin's illness revealed', *Postgraduate Medical Journal* 81(954):248–251.

2. Colp R. Jr. (2008) *Darwin's Illness*. University Press of Florida.

3. Charles Robert Darwin (1849) Darwin Correspondence Project (hereafter: - "DCP") Letter no. 1228. https://www.darwinproject.ac.uk/letter/?docId=letters/DCP-LETT-1228.xml;query=DCP-LETT-1228;brand=default;hit.rank=1#hit.rank1 (Accessed: 01 June 2021)

4. Scull A. (2015) *Madness in Civilisation*. London: Thames and Hudson.

5. Heyse-Moore L. (2016) 'Charles Darwin's (1809–1882) illness – the role of post- traumatic stress disorder', *Journal of Medical Biography* 27(1):13–25.

6. Colp R. Jr. (1987) 'Charles Darwin's "insufferable grief"', *Free Associations* 1(9):7-44. https://www.pep-web.org/document.php?id=fa.001j.0007a (Accessed: 04 August 2021)

7. Bowlby J. (1991) *Charles Darwin. A New Biography*. Pimlico: Butler and Tanner Ltd.

8.Colwell H. (1922) *An Essay on the History of Electrotherapy and Diagnosis.* London: Heinemann. https://wellcomecollection.org/works/t76gq922

9. Science Museum (2020) 'From nerves to neuroses', https://www.sciencemuseum.org.uk/objects-and-stories/medicine/nerves-neuroses#main- (Accessed: 04 August 2021)

10.Anon. (1851) *Pulvermacher's Patent Portable Hydro-electric Chain for Personal Use*. London: C Meinig. https://wellcomelibrary.org/item/b17999753#?c=0&m=0&s=0&cv=0&z=-0.6929%2C-0.0824%2C2.3859%2C1.6475 (Accessed: 01 June 2021)

11. Bird G. (1851) 'Remarks on the hydro-electric chain of Dr Pulvermacher', *Lancet* 58(1496):388-389

12. Royal College of Psychiatrists (2017) 'Statement on Electroconvulsive Therapy' (ECT). https://www.rcpsych.ac.uk/docs/default-source/about-us/who-we-are/electroconvulsive-therapy---ect-ctee-statement-feb17.pdf?sfvrsn=2f4a94f9_2 (Accessed: 07 October 2020)

13. Darwin (1849) DCP, Letter 1236. https://www.darwinproject.ac.uk/letter/?docId=letters/DCP-LETT-1236.xml;query=DCP-LETT-%201236;brand=default;hit.rank=1#hit.rank1 (Accessed: 04 August 2021)

14. Marland H, Adams J. (2009) 'Hydropathy at home: the water cure and domestic healing in mid-nineteenth-century Britain', *Bulletin of the History of Medicine* 83(3):499-529.

15. Darwin (1849) DCP, Letter no. 1241. https://www.darwinproject.ac.uk/letter/DCP-LETT-1241.xml (Accessed: 02 June 2021)

16. Hayman J. (2019) 'Charles Darwin's illness and the "wondrous water cure"' https://hekint.org/2019/08/21/charles-darwins-illness-and-the-wondrous-water-cure/ (Accessed: 01 June 2021)

17. Podolsky DK. (2002) 'Inflammatory bowel disease', *New England Journal of Medicine* 347:417–429.

18. Gully JM. (1849) *The Water Cure in Chronic Disease: An Exposition*. London: John Wiley.

19. Darwin (1864) DCP, Letter 4461. https://www.darwinproject.ac.uk/letter/?docId=letters/DCP-LETT-4461.xml (Accessed: 01 June 2021)

20. Darwin (1865) DCP, Letter 4762. https://www.darwinproject.ac.uk/letter/DCP-LETT-4762.xml (Accessed: 01 June 2021)

21. Darwin (1865) DCP, Letter 4788. https://www.darwinproject.ac.uk/letter/DCP-LETT-4788.xml (Accessed: 01 June 2021)

22. Darwin (1850) DCP, Letter 5003. https://www.darwinproject.ac.uk/letter/DCP-LETT-5003.xml (Accessed: 04 August 2021)

23. Darwin (1865) DCP, Letter 4924. https://www.darwinproject.ac.uk/letter/?docId=letters/DCP-LETT-4924.xml;query=DCP-LETT-%204924;brand=default (Accessed: 04 August 2021)

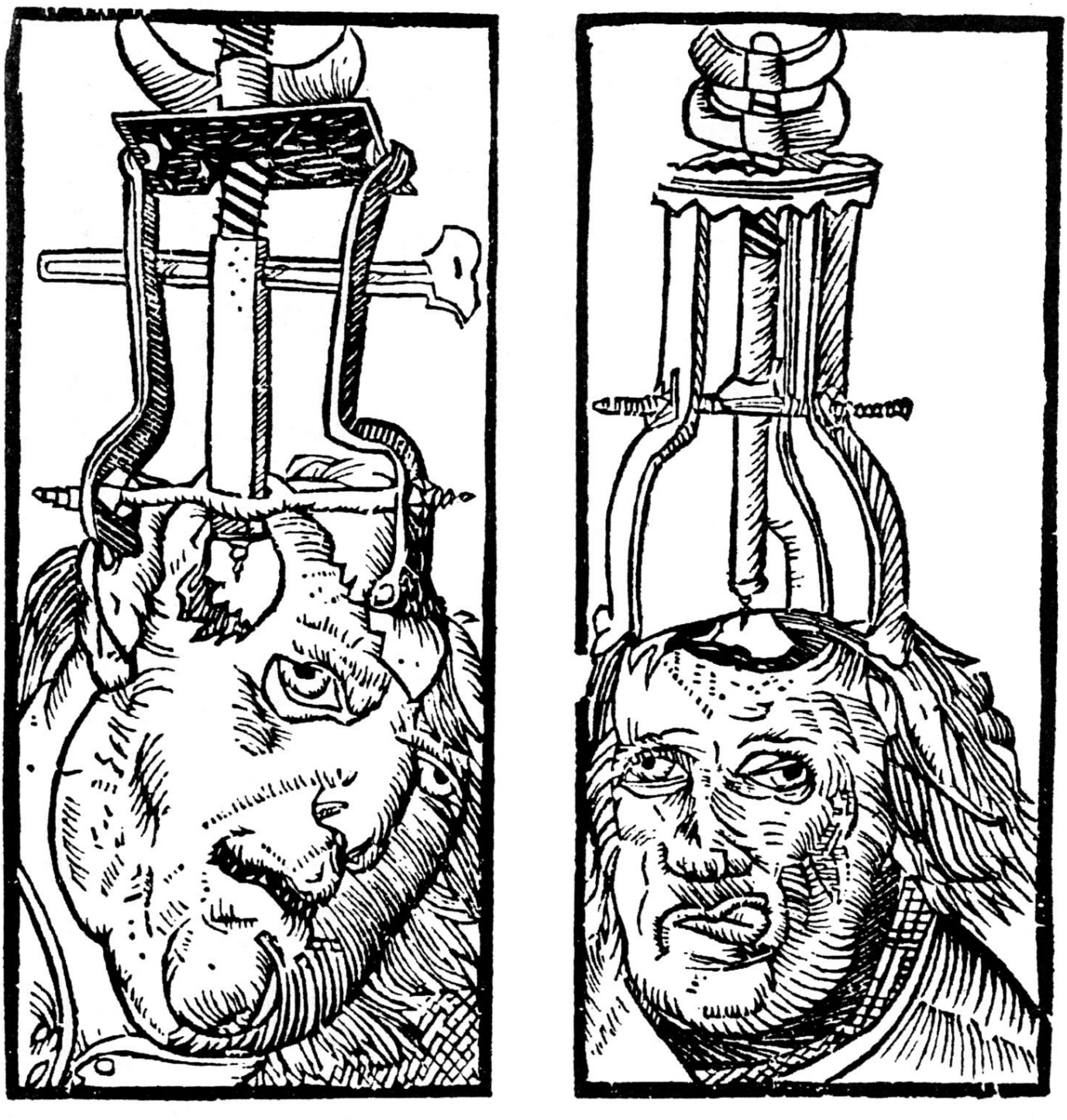
24. Anon. (2020) Darwin's illness. https://www.darwinproject.ac.uk/commentary/curious/darwins-illness (Accessed: 01 June 2021)

25. Darwin (1850) DCP, Letter 1352. https://www.darwinproject.ac.uk/letter/DCP-LETT-1352.xml (Accessed: 02 June 2021)

26. Charland LC. (2015) 'Moral treatment'. In: *The Encyclopedia of Clinical Psychology*. RL Cautin and SO Lilienfeld (eds.) New York: John Wiley.

27. Charland LC. (2007) 'Benevolent theory: moral treatment at the York Retreat', *History of Psychiatry* 18(1):61–80.

28. Natural History Museum (2021) 'Charles Darwin: history's most famous biologist', https://www.nhm.ac.uk/discover/charles-darwin-most-famous-biologist.html (Accessed: 04 August 2021)

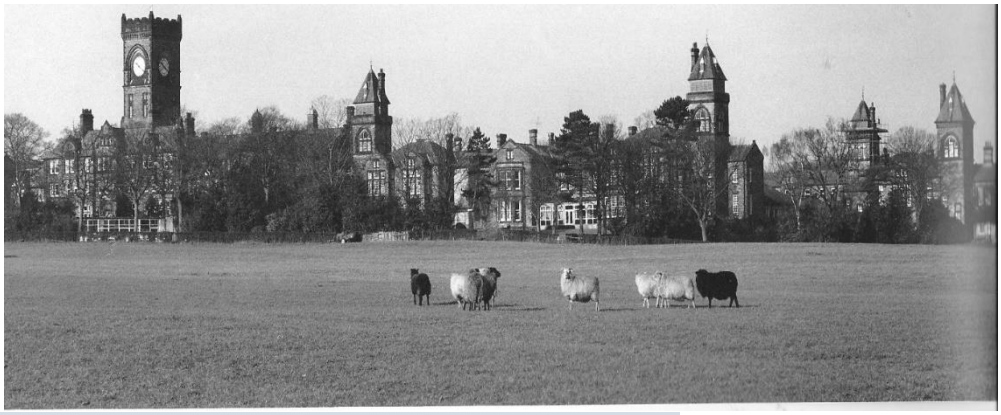


Engraving of trepanation by Peter Treveris for *The Noble Experyence of the Vertuous Handy Warke of Surgeri* by Heironymus von Braunschweig (1525). Wikimedia Commons https://en.wikipedia.org/wiki/File:Peter_Treveris_-_engraving_of_Trepanation_for_Handywarke_of_surgeri_1525.png

Working in a mental hospital in its closing years: High Royds Hospital 1977-2000

RHS Mindham

This article was originally written by Professor RHS Mindham in 2012 and appeared in the Newsletter of the Yorkshire Medical and Dental History Society (1). This version has been edited slightly, and an accompanying reflective piece written by Professor Mindham in 2021 follows it.



Panorama of High Royds Hospital, 1995. One in a series of photographs taken by Norman Hodgson (technician, Department of Psychiatry and Behavioural Sciences, Leeds School of Medicine) to celebrate RHS Mindham's 60th birthday

Introduction

The West Riding of Yorkshire Pauper Lunatic Asylum at Menston was the third such institution to be built in the county. The layout was a development of earlier designs for mental hospitals prepared under the leadership of the County Engineer, J Vickers Edwards. Whittacker's of Horsforth were the main contractors. Work began in 1884 and the hospital was opened in 1888 (2). Many further buildings and alterations were added before it closed in March 2003 (3). The name of the asylum was changed to High Royds Hospital [HRH] when it was brought into the National Health Service in 1948 and this revived the name of the farm on which the hospital had been built.

The policy of the authorities in the West Riding was to create very large hospitals which served a segment of the county rather than serving particular towns or cities. This, and the policy of siting mental hospitals in the countryside, led to HRH serving the populations of both Leeds and Bradford but not being situated in or having a close identity with either. When the hospital was opened, out-patient work was undeveloped and there was no close relationship with general hospitals or with general practice. Indeed, the hospital had its own infirmary and many attending staff. It was envisaged as being self-sufficient in many ways with its own farm and services for laundry, shoe repairs, tailoring, baking and catering, and even its own water supply, cemetery and dance band.

From the time of its opening until shortly after the Second World War the hospital had been administered by a medical superintendent and his staff. Although he was accountable to his employers, the medical superintendent had complete authority within the hospital extending even to the running of the hospital farm. The reputation of a hospital relied on the appointment of a doctor who had the appropriate experience, personal qualities and management skills. There were many medical superintendents of mental hospitals of outstanding ability, as was the case at the Wakefield Asylum, and this was reflected in the reputation of their hospitals (4).

Enoch Powell outlined the Government's plans for mental hospitals and the mental health services in his speech to the National Association for Mental Health in 1961 (5). By 1977, none of this plan had been brought into effect for the mental health services provided from HRH, although a more local

service had been developed in Bradford at Lynfield Mount Hospital which formerly housed reception wards for the area. HRH showed a pale impression of the arrangements which had been in place in the earlier days of its existence.

Working at HRH: 1977 and after

I came to work at HRH in 1977 and continued to work there until my retirement in 2000 shortly before the hospital closed. There were many difficulties in conducting a satisfactory service from the hospital during my time as a member of staff. These were in part due to a failure to make satisfactory plans for the psychiatric services and to bring these into effect. After the passing of the anguish which these problems created at the time, it is interesting to look back on the experience of working there in a calmer frame of mind and from a distance.

After the abolition of the post of medical superintendent, responsibility was divided between the heads of the various departments and consultants exercised their clinical responsibilities individually making it much more difficult to administer and develop hospitals and their services. In 1977 HRH showed evidence of these difficulties; it had proved impossible to adopt coherent and consistent policies in the clinical work of the hospital (6). This had led to inconsistent clinical practices, a failure to develop new services as needs changed, poorly coordinated services for the care of important groups of patients such as the very disturbed, the chronically sick, those needing rehabilitation and resettlement and in the care of the physically ill. However, amid this incoherent service there were many examples of good and dedicated care to patients which made the organisational problems all the more striking.

The result of this lack of coordination led to the hospital having a large number of patients, wards containing patients with very different problems and needs, poor links with other hospitals and medical services, poor recruitment of junior medical staff and the hospital's poor reputation among the local population. HRH reached the maximum number of patients it ever accommodated in 1958, which amounted to two and a half thousand people. The timing of this peak in occupancy was reflected in most other mental hospitals in the UK. The numbers of patients had become so great that an annex had been opened at a former tuberculosis hospital at Grassington and this was also full. In 1977 HRH held 1350 patients and there were 300 patients at Grassington.

This state of affairs was all the more anomalous because the hospital had many natural advantages: the grounds were extensive and well kept, there was plenty of space within the buildings, many of the mental health disciplines had their offices on the site, and the food for patients and staff was excellent. The hospital housed two units supported by the Medical Research Council: one directed by Dr Roy Hullin concerned with the biology of affective disorders, and another directed by Dr Don Bannister concerned with the study of disorders of thinking in psychiatric illness. Moreover, the hospital had been splendidly built in an attractive setting and with proximity to local facilities.

The reasons for the state of things at HRH in 1977 were many and various. An important influence was that there had been several plans to close the hospital, none of which had come to pass. This had led to a planning blight which had prevented the development of alternatives. Even in my relatively short period in the service there were three distinct plans to provide a new unit in the centre of Leeds to provide for acute admissions from the hospital's catchment area; none of these came to fruition even though detailed plans were prepared. This was in part due to the frequent reorganisations of the NHS during this period.

Conducting a psychiatric service from a very large site was expensive. This was recognised by the Yorkshire Regional Health Authority who made a special payment of several millions of pounds to meet these costs. In the late 1990s when the Yorkshire and Northern Regional Health Authorities were amalgamated to form a Strategic Health Authority, this extra payment was abruptly stopped leading to a crisis in a service which had previously been able to run within its budget allocation. A somewhat fanciful plan was put forward which claimed

both to deal with the deficit and improve the services. This led to three consultants of the Leeds psychiatric services, which included myself, writing to the press. Our letter led to a campaign by the *Yorkshire Post*, which was widely supported by patients, staff and the general public, leading to the involvement of the Community Health Council and of Members of Parliament (7). The Minister of State for Health, Frank Dobson, ordered an enquiry. The report of the enquiry underlined many deficiencies in the services and suggested ways of improving these. However, its most important effect was to stimulate the preparation of plans for the mental health services and to promote their implementation.

Throughout my time at HRH I was aware of the privilege of working in such a splendid building. Approaching the hospital from the main driveway was always a pleasure; the impressive group of buildings standing in its rural setting with Rombald's Moor to the west, Otley Chevin to the east and Wharfedale to the north. HRH stood forlorn for some time after its closure but after its sale to developers plans emerged for its conversion to domestic use with some additional facilities including a school, a general practice and light industrial accommodation. The first phase of development was the demolition of buildings from between the wars and their replacement by the type of modern housing only too familiar around the country. Subsequently development of the main buildings produced a range of apartments overlooking the extensive grounds. The overall effect in 2011 was stunning although still incomplete. It is gratifying to one who enjoyed the hospital as a working environment, that it is now preserved to be enjoyed by others as their residence. The completion of redevelopment of the whole site is likely to take several more years.

The whole of my service at HRH was during a period of retrenchment. In that time the number of patients in the wards was reduced to more manageable levels. New services were developed, notably the Psychiatric Service for the Elderly and the Forensic Service, and a range of day hospitals were established by diverting funds released by the reduction in the number of beds. Closure of some wards led to intense pressure on beds for new admissions which seemed incongruous in a hospital which was so large. For a few years prior to its closure the nurse training centre for the whole of Leeds was based in a part of the hospital: this arrangement gave the hospital a higher level of activity and a more lively atmosphere than would otherwise have been the case.

Looking back on my 23 years at HRH I have mixed feelings. The hospital was not suitable for the practice of modern psychiatry. In spite of its natural advantages, it could not overcome its isolation, lack of community facilities, and reputation with the population served. However, I enjoyed my time there working with committed colleagues in a wonderful building in an attractive setting. In many ways our job was to make an orderly retreat from an outmoded service. I think we may have done this and can only hope that our successors are able to develop better services using the resources gathered, retained, and developed by earlier generations.

Administrative Block 2, High Royds Hospital, 1995, Norman Hodgson

Reflections on a career in psychiatry, 2021

RHS Mindham

I wrote the article above about my time at High Royds Hospital ten years ago when I had recovered from some of the setbacks we experienced in developing the psychiatric services for the west of Leeds. Since then, I have reflected upon my career in psychiatry and what it represents in the development of our speciality. We worked in the field at a most important stage in its evolution.

As a medical student in the 1950s I witnessed the beginnings of the widespread use of effective treatments in psychiatry. The shortcomings of care in mental hospitals were being recognised and alternatives were emerging. I subsequently worked in a great variety of psychiatric facilities including general hospital units, several mental hospitals, an observation ward, a day hospital, a variety of out-patient departments, and visited many patients in their homes.

After retirement I came to appreciate that what I had experienced was a remarkable period of change. The role of the mental hospital throughout these changes was central. Mental hospitals were heavily criticised for their failings without critics recognising how their roles had developed. The mental hospitals dealt not only with patients suffering from the functional psychoses, but also with a range of severe disorders including dementia, epilepsy, dementia paralytica and the late effects of encephalitis lethargica, as well as hereditary disorders such as Huntington's disease. Many of these conditions were then incurable but have become amenable to alternative methods of management. It was only in the twentieth century that the treatment of patients who were living at home or were suffering from more minor disorders began to become an important part of psychiatric practice.

During my work in psychiatry the changes in the requirements of the service were recognised but the services were being delivered from premises which had been built to serve a different purpose. Simply abandoning the mental hospital was not an option until alternative provision on a very large scale, as envisaged in Enoch Powell's plans for the service, had been provided. The retention of those parts of the provision provided by the mental hospitals which were still likely to be needed was strongly advocated. The withdrawal from the mental hospitals while at the same time maintaining services was a major administrative task. My successors will be able to judge how successfully this has been achieved. Being a participant in the process was at times agonising but at the same time rewarding.

References

1. Mindham RHS [2012] Working in a mental hospital in its closing years. High Royds Hospital 1977-2000. *Newsletter of the Yorkshire Medical and Dental History Society*, 47: 9-12.

2. Roberts JM [1987] Madhouse to Modecate - Psychiatry in West Yorkshire, 1750-1986. *University of Leeds Review*, 30: 163-183.

3. Hullin RP [1988] *High Royds Hospital, Commemorative Brochure 1888- 1988*, Yorkshire Regional Health Authority.

4. Ashworth AL [1975] *Stanley Royd Hospital, Wakefield. One Hundred and Fifty Years. A History*. Wakefield: Wakefield Area Health Authority.

5. Powell E [1961] "Opening speech" ("Water Tower") 5–10. In *Emerging Patterns for the Mental Health Services and the Public: Proceedings of a Conference at Church House Westminster, 9–10 March 1961*. London: NAMH.

6. Davison J [2009] *The Dark Threads*, Bedlinog UK: Accent Press Ltd.

7. *Yorkshire Post* [1999] A series of articles, interviews and photographs.

Conversion Therapy – a personal memoir

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Introduction

It is perhaps ironic that the scenario I am going to relate here took place in 1957, just after the Wolfenden Report had concluded that homosexual acts in private should no longer be subject to legal sanctions. This, though, did not become law until 10 years later, when in July 1967, the Sexual Offences Act (England and Wales) allowed homosexual acts between two consenting adults. The possibility of civil partnerships or same-sex marriage was not envisaged at that time.

In 1973, homosexuality ceased to be classified as a mental illness by the American Psychiatric Association which removed it from the second edition of its Diagnostic and Statistical Manual (DSM). The World Health Organization only removed homosexuality from its International Classification of Diseases in 1992. Since then, the medical profession has been much less involved in the treatment of homosexuality in terms of changing orientation, though, of course, homosexual patients may still suffer from psychiatric disorders, such as depression or anxiety or psychoses, and seek psychiatric advice.

In 1957, I was 27 years old and a trainee psychiatrist. I had been qualified for 4 years and had completed about 3 years of psychiatric training and had just been awarded the Diploma in Psychological Medicine.

The scenario

The patient was a professional man in his late thirties, who had been aware of his homosexual orientation but had tried to adjust to it by getting married. In order to relieve his feelings of sexual tension, as he found it virtually impossible to have a successful sexual relationship with his wife, he had taken to what was often referred to in those days as "cottaging", making casual encounters with other men in public toilets. Even with the 1967 legislation, it is doubtful whether this would have been considered "legal" but in the 1950s, police forces were anxious to enhance their arrest rates and it was not unknown for police officers in plain clothes to act as *agents provocateurs*. When the case came to court, medical evidence was called, and the magistrate agreed that this man should receive medical treatment that would "cure" his "homosexual illness" (James, 1962).

My consultant considered that the best treatment would be aversion therapy which was, at the time and for some years later, also used as a treatment for alcoholism (MacCulloch & Feldman, 1967). I was instructed by my consultant to administer aversion therapy to the patient in order to "cure him of his perversion". In common with my consultant, I had had no previous experience of administering this form of treatment and was predictably apprehensive about the technique.

The technique employed was to allow the patient to become sexually aroused by erotic pictures of men, then to give either electric shocks or induce vomiting, thus associating a pleasing stimulus with an unpleasant one. In some cases, the patient would later be "rewarded" with erotic pictures of women. This somewhat naïve psychological theory assumed that aversion to homoerotic stimuli would result in heterosexuality. My consultant had some difficulty in planning the treatment as it was not easy to get hold of the necessary homoerotic material. He had had some connections with the Home Office and discovered that the Home Office held confiscated material to which he would be allowed access strictly for the purposes of the treatment. I was therefore presented with a file of photographs of nude males – some of whom even showed erections. The plan was to present the patient with a picture and then give him an injection of apomorphine which would cause vomiting. I think we carried out this treatment twice a day over 3 days, I then asked this somewhat dehydrated and exhausted man to tell me how he felt. His reply was that he had only survived the ordeal by enjoying the male

erotic pictures that had been presented to him.

Alas, I had no information as to what happened to the man I had treated after he was discharged from hospital, but the encounter had had a profound effect upon me.

Reviewing the literature at that time, on aversion therapy and some other physical methods to "treat" homosexuality, such as chemical or physical castration, electroconvulsive therapy and even psychosurgery, they all seemed to contain a punitive element. Likewise, "treatments" devised by certain religious groups included beating, starvation and group pressures condemning homosexual practices, or even such feelings, as being against the will of God, and therefore deserving of punishment (Smith et al, 2004).

The author

While a medical student I had had a brief flirtation with the more fundamentalist Christian student union of the university and had been quite convinced that my own homosexual feelings were unacceptable to God. To avoid any confusion, the word "conversion" was then used a great deal by religious enthusiasts. It meant opening oneself to Jesus and becoming a true Christian, giving a commitment to God through Jesus Christ, and then going on to convert others to ensure their, and one's own, eternal salvation.

By the time I was giving the conversion therapy to my patient I had become much less convinced of the possibility of divine retribution (or even salvation), but I still believed that putting my own homosexual feelings into action would be against the law as it was in the 1950s. I had been somewhat ashamed that I had, of course, as was my duty, examined the pictures that I had given as part of the aversion treatment and had been able to enjoy them without the fear of vomiting, but the whole experience was distressing for me and I feared that I too might have to undergo such drastic treatment if I was ever to lead an emotionally and professionally satisfying life. Should I opt for psychoanalysis? In 1935, Freud himself had written to a mother concerned about her son's orientation: homosexuality is "nothing to be ashamed of, no vice, no degradation; it cannot be classified as an illness". However, his daughter Anna in 1950 had said that many of her patients had lost their inversion (homosexuality) with analysis (Socarides, 1969). I admit that I was not really tempted by psychoanalysis, intellectually or emotionally, quite apart from the expense, and I soldiered on with my career in this country and the United States until I returned to this country in 1965 as a consultant.

Reflections

Looking back, I have no regrets about my professional life which has continued for 65 years and which has been varied, intellectually stimulating and at times exciting and challenging (Bradley, 2017). I have lived happily in a partnership for almost 40 years.

As I have had no religious conviction or affiliation for many years the feeling that I was a "sinner" is no longer relevant, but I am very much aware of the burden that many suffer even in this country, in a multicultural society, who still feel the need to undergo some form of conversion treatment to rid themselves of homosexual feelings to make them acceptable to their community or to their God. The purely medical treatments as have been outlined above are unacceptable, particularly to medical professionals, but various psychological and "brainwashing" techniques used in some religious communities are still technically permissible in this country even though psychiatric and psychological professionals are in almost unanimous agreement that change of sexual orientation is impossible.

Capital punishment for homosexual activity has not been used in this country since 1835, but it is still used in some Islamic countries such as Saudi Arabia and Iran (Amnesty International, 2021). Oddly, in Iran, execution can be avoided by agreeing to undergo surgical sex change procedures. The Islamic Malaysian Government as recently as 2017 endorsed conversion therapy, believing that it is possible to "cure" homosexuality. In many other countries there are some selective restrictions on conversion techniques. Many places have

introduced a full or partial ban, including Malta, Germany and Albania, a predominantly Muslim country. The ban for England and Wales was announced in the Queen's Speech (2021), but it will be preceded by a consultation.

References

Amnesty International (2021). Iran: Murder of gay man highlights dangers of state-sanctioned abuses against LGBTI people. https://www.amnesty.org/en/latest/press-release/2021/05/iran-murder-of-gay-man-highlights-dangers-of-state-sanctioned-abuses-against-lgbti-people/ (Accessed: 26 August 2021)

Bradley J. (2017) Sixty years in psychiatry. *Medico-Legal Journal* 85(4),210-214.

James B. (1962) Case of homosexuality treated by aversion therapy. *BMJ* 1(5280),768-770.

Smith G, Bartlett A & King M. (2004) Treatments of homosexuality in Britain since the 1950s – an oral history: the experience of patients. *BMJ* 328(7437), 427.

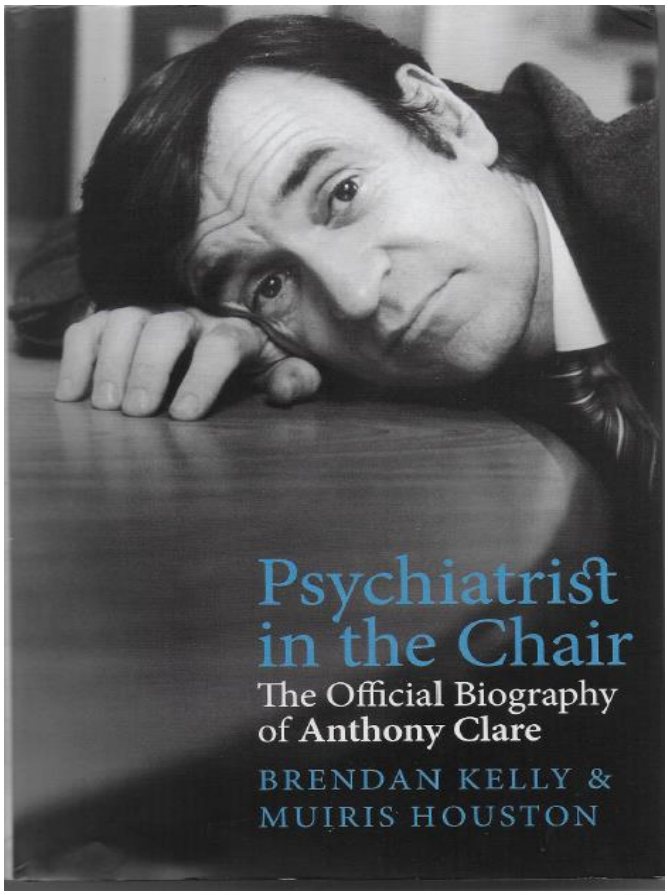
MacCulloch MJ & Feldman MP. (1967) Aversion therapy in the management of 43 homosexuals. *BMJ* 2(5552),594-597.

Socarides CW. (1969) Psychoanalytic therapy of a male homosexual. *Psychoanalytic Quarterly* 38(2),173-190.

Book review

Psychiatrist in the Chair: The Official Biography of Anthony Clare by Brendan Kelly & Muiris Houston. 2020, Newbridge, Co. Kildare Merrion Press. pp 292. ISBN 9781-758373-29-9.

RHS Mindham



Only rarely does one read a biography, as distinct from an obituary, of a medical colleague, but in the case of Tony Clare this is well justified. I first met him when we were trainees in psychiatry at the Institute of Psychiatry, London in the late 1960s and had contact with him through academic circles until about 2000. We all realised that there was an exceptional person in our midst. Tony came with a record of outstanding success in debating when a medical student at University College Dublin. We found him

to be a most engaging colleague. He was strikingly intelligent, articulate, industrious, and agreeable. Unlike some ambitious contemporaries he did not engender jealousy or resentment.

He made his mark more widely in 1976, when he was only in his early thirties, with the publication of *Psychiatry in Dissent* (1) How audacious it was of someone so young to question the work of his seniors; but it proved to be well justified and a taste of what was yet to come. He pursued his career in psychiatry but then burst onto the public scene with his broadcasts on BBC radio and then television. He was David Stafford-Clark's successor as the psychiatrist in the media and in many respects surpassed him. He became best known for his programme *In the Psychiatrist's Chair* broadcast on the BBC between 1982 and 2001. This was a series of gripping interviews with prominent people which delved into their backgrounds, personalities and careers using some of the interviewing skills he had learned as a psychiatrist but taking public revelation of psychological processes to a new level. At the same time, he was prodigiously active in writing questioning articles in a range of intellectual periodicals, notably the *Spectator*. Polemic was the breath of life to him.

In 1983 he was appointed head of the department of psychiatry at St Bartholomew's Hospital in the City of London. For six years he combined the duties of the head of an academic department with an active role in the media and raising a large family. To the surprise of many, in 1989 he returned to Dublin as Medical Director of St Patrick's Hospital and as Clinical Professor of Psychiatry at Trinity College. From Dublin he conducted a hectic programme of teaching, research, writing and appearances in the media in England and elsewhere. Tragically he died suddenly in 2007 shortly before he was due to retire.

In the preparation of this biography the authors have had full access to Clare's papers, the support of his family, and accounts from contemporaries. They have recorded in detail every period of his life and have documented his work in every sphere. They do not avoid important issues in his career; in particular, was his return to Dublin wise? He left a well-established career and social circle in London for a very different environment in which psychiatric services were facing major changes, and left the familiar world of the NHS for private practice. One might add; was it really possible for one individual to fill all of these roles at the same time?

The authors have presented a comprehensive account of the most prominent psychiatrist of our generation. Psychiatrists will find this account fascinating; trainees may find it inspiring, but it also carries warnings for many of us.

Reference

1. Clare A [1976] *Psychiatry in Dissent. Controversial Issues in Thought and Practice*. London: Tavistock Publications.

Dates for your diary etc

Next issue

Please send your articles, reviews, photos, ideas, requests for information etc by **31 January 2022,** to nicol.ferrier@newcastle.ac.uk

Mind, state and society 1960-2010: History of psychiatry and mental health in Britain

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French psychiatrist Philippe Pinel (1745-1826) releasing lunatics from their chains at the Salpêtrière, Paris, 1795.
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