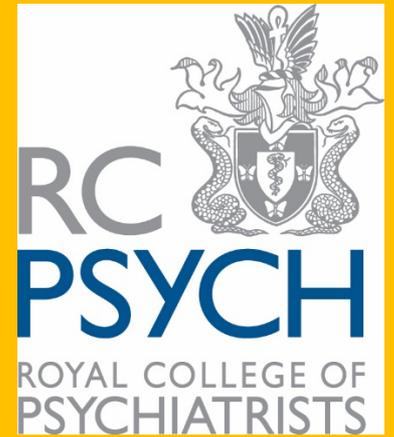


News and Notes



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

Issue 10, Spring 2020

News and Notes

History of Psychiatry
Special Interest
Group

Issue 10, Spring
2020

Editors for this issue:

Claire Hilton

and

Mutahira Qureshi

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Stop press!

Sort it out but don't throw it out!

Francis Maunze, College Archivist

In an attempt to follow government Covid-19 guidance and the need to maintain good mental wellbeing, we are aware that some of our members are trying to keep busy by sorting out their career-long paperwork. The College Archives is appealing to you to consider donating your historical records to the Archives rather than throwing them out.

The College has an archives collection development policy. Its main purpose is to ensure that we collect, maintain, document and preserve the history of the College. The policy also allows the Archivist to collect personal papers of officers, fellows and members of the College. These papers usually supplement and compliment institutional records collected from the various departments, committees, faculties and other bodies of the College.

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

diaries, memoirs, biographies;

official correspondence;

committee, faculty, section, group and division minutes, reports and files;

correspondence with colleagues, professional organisations, government bodies;

audio-visual records such as photographs, interviews, oral history tapes and transcripts.

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

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

or

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

or

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

Editorial

“A plague o’ both your houses”!

Mutahira Qureshi, co-editor

mutahira.gureshi1@nhs.net

With his dying breath, Shakespeare’s Mercutio utters the fateful curse “a plague o’ both your houses”, on the houses of Montague and Capulet, echoing the medieval consciousness that invoking plague is perhaps the worst punishment to be inflicted on mankind. Shakespeare echoes this numerous times in his plays, as characters wishing to be avenged call upon a contagion to wreak justice on their tormentors. A memorable example of this is Richard II’s invocation of wrath on the armies standing to dethrone him: “Yet know, my master, God omnipotent / Is mustering in his clouds on our behalf / Armies of pestilence.” In the tragic reality of our world finding itself in the middle of the COVID-19 pandemic, the medieval consciousness and fear is perhaps now also our own.

At the time of writing this, the pandemic has found a significant foothold in London. The A and E where I work as a liaison psychiatry doctor has been declared a Red Zone; schools are due to close; news tells us that military troops are on standby for a civil emergency; the city that prides itself for never sleeping has announced it will cancel night trains; and a complete lockdown is imminent.

Doctors everywhere under the national guidance are on the alert: to be ever ready for a move to A and Es and acute settings irrespective of their usual clinical specialties.

Hence on behalf of them all, before delving into some of the history around pandemics, I would like to echo Galen and Hippocrates’ advice on plagues and say, Cito, Longe, Tarde. It is so effective it is almost a battle cry: Cito! Longe! Tarde! Fly quickly! Go far away (alone)! Return slowly (back)! Or as most of the junior doctors will put it these days: do not attend emergency if you don’t need to! In fact, don’t be out and about in crowded places if you don’t need to. And if symptomatic, self isolate promptly in line with Public Health England guidelines.

So let’s rally together for mankind as a whole and cry to ourselves and strictly practice, Cito! Longe! Tarde!

In the months leading up to this as the pandemic spread, hitting China, Iran and Italy the hardest, there has been a state of global pandemonium. We have seen scenes of fights over commodities, frenzied-emptying of supermarket shelves leaving nothing for old or sick people, fuelled by so-called fake news and media-hype; evolving guidelines in the wake of piling casualties, and new research; deserted tourist haunts; conspiracy theories, and governments to blame.

Some have called it mass hysteria: a wave of contagion, both the rapid transmission of the virus and the behaviour wreaking havoc on the established order of the world.

It is a déjà vu, almost down to the minutiae of other pandemics that have afflicted the human race throughout history. And even though the culprit pathogens change – parasites to fungus to bacteria to now the virus – the human response, both physical and psychological, has remained much the same.

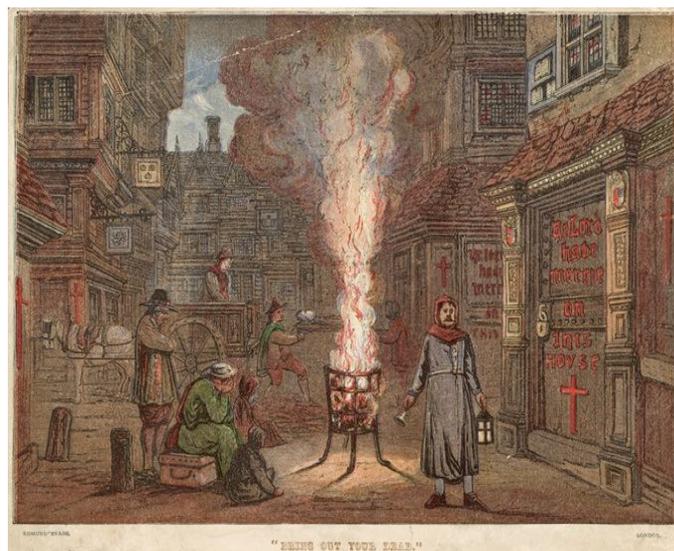


Figure 1: “Bring Out your Dead”: A street during the 1665 Great Plague in London with a death cart, by Edmund Evans (1826-1905). Note the deserted streets, and infected houses marked with a red cross. The inscription reads, *The Lord have Mercie on this Houſe*, echoing the sheer helplessness and the only remedy that appeared efficacious to the people at the time. Wellcome Collection, CC BY4.0 license



Figure 2: Copper engraving of Doctor Schnabel, i.e. Dr. Beak, a plague doctor in 17th century Rome (c.1656). From Laurel (2018), public domain

Boccaccio in *The Decameron* wrote of the year 1348 of his beloved city Florence during the Black Death: “To cure these infirmities neither the advice of physicians nor the power of medicine appeared to have any value or profit; perhaps either the nature of the disease did not allow for any cure or the ignorance of the physicians...did not know how to cure it.”

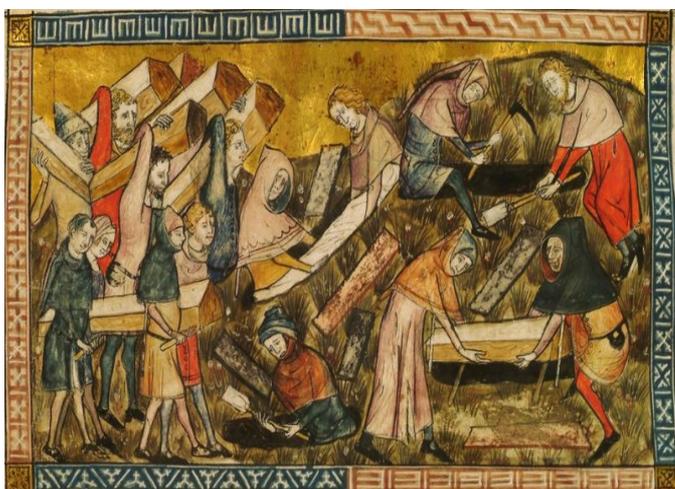


Figure 3: Citizens of Tournai bury Black Death plague victims. Miniature from *The Chronicles of Gilles Li Muisis* (c. 1272–1352). From Slack (2012). Public domain

He furthermore wrote, “But what gave this pestilence particularly severe force was that whenever the

diseased mixed with healthy people, like a fire through dry grass or oil it would rush upon the healthy...if I were not one of many people who saw it with their own eyes, I would scarcely have dared to believe it, let alone to write it down, even if I had heard it from a completely trustworthy person.”

In terms of the psychological effects of the plague and the social-contagion that further accelerated the spread, Boccaccio’s contemporary Marchionne di Coppo Stefani wrote in *Cronaca Fiorentina* (“Florentine Chronicle”): “There was such a fear that no one seemed to know what to do....It was such a frightful thing that when it got into a house...frightened people abandoned the house and fled to another.”

In Strasbourg in 1512, when the dancing fever seemed to grip the inhabitants of the city, what started as a likely infectious ailment of one woman turned into a psychic contagion and hysteria of the whole town, as they gathered in the town square to witness the inflicted, in turn catching their infection and panic alike. The situation was not helped by the town authorities who initially encouraged the people to do so, and went as far as hiring musicians to egg the crowd on, with the result that many died who should not have done. Eventually reason prevailed, and the afflicted were taken inside monasteries and hospitals, isolated and treated.



Figure 4: Triumph of Death (Trionfo Della Morte) Wall Painting at Palazzo Abatellis, Palermo (painter unknown, c.1448). From Alberghina et al (2019). CCBY4.0 license

As I finish writing this editorial the government has announced a lockdown and social distancing and self-isolation are now legally enforceable. We remember those who passed away in this pandemic to date and we pray that these new measures will flatten the uphill curve of mortalities.

In other news, since the last issue, HoPSIG and the College archivist organised a Witness Seminar on psychiatric hospitals in the 1960s (see page 10).

HoPSIG also joined with the Royal Society of Medicine to organise a one-day conference *Mind, State and Society 1960-2010: Half a century of UK psychiatry and mental health*.

On **17-18 September 2020** HoPSIG, in collaboration with the School of History, Classics and Archaeology at Newcastle University, is planning a two-day workshop *Understanding Death and Mortality in the Context of Mental Illness and Institutionalisation during the 19th and 20th centuries*. The details can be found on pages 13-14 and at <https://www.rcpsych.ac.uk/members/special-interest-groups/history-of-psychiatry/events>. Please save the date and we hope to see you there!

In the meantime, the editors hope you will enjoy reading this issue of *News and Notes*. Some of the articles are longer than usual, but are thought provoking and very worthwhile reading. Their content is informative, controversial, surprising, moving and humorous. I hope there will be a run on the second-hand book dealers' supplies of Hays' *New Horizons in Psychiatry* (1964, 1967 and 1971 editions / reprints), and that you will send us your feedback and write for us. Please **submit your articles, reviews, photos, ideas, requests for information etc for the newsletter**, please email them to claire.hilton6@gmail.com by **31 August 2020**.

Also, if you can help interpret the Italian inscription on page 17 please let the College librarian, Fiona Watson, know.

In this momentous time, we need to learn from the experience of history. The COVID-19 pandemic might have already hurt us deeply, but let's rally together to halt the spread, both of the fear and panic, and of the virus itself.

Cito, Lange and Tarde!

Further reading:

J Aberth, *The Black Death: The Great Mortality of 1348-1350: A brief history with documents* (New York: Palgrave Macmillan, 2005)

Maria Francesca Alberghina, Salvatore Schiavone, Caterina Greco et al. How Many Secret Details Could a Systematic Multi-Analytical Study Reveal About the Mysterious Fresco Trionfo della Morte? *Heritage*. 2019;2(3):2370-2383. doi:10.3390/heritage2030145

G Boccaccio, *The Decameron of Giovanni Boccaccio* (Charleston, SC: BiblioBazaar, 2008)

R Bray, *Armies of Pestilence* (Cambridge: James Clarke and Co., 2004)

C Cipolla, *Public Health and the Medical Profession in the Renaissance* (Cambridge: Cambridge University Press, 1976)

Edmund Evans, "Bring Out Your Dead, A street during the Great Plague in London, 1665, with a death cart and mourner".

<https://wellcomecollection.org/works/ynerdkf9>. Accessed March 26, 2020.

K Harrington, "Cito, longe, tarde: fly quickly, go far, return slowly", The Repository, Royal Society, Blogs, 2015. Available: <https://blogs.royalsociety.org/history-of-science/2015/03/09/great-plague/> [Accessed: 09 Mar 2020]

J Hays, *Epidemics and Pandemics* (Santa Barbara, Calif.: ABC-CLIO, 2006)

R Horrox, *The Black Death* (Manchester: Manchester University Press, 1994)

R Kantor and L Green, *Chronicles of the Tumult of the Ciompi* (Clayton, Vic.: Dept. of History, Monash University, 1991)

S Laurel, "Medicine as a sacred vocation", *Baylor University Medical Center Proceedings*. 2018; 31(1):126-131. doi:10.1080/08998280.2017.1400318

M Matossian, *Poisons of the Past* (New Haven: Yale University Press, 1989)

D Porter, *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times* (London: Routledge, 1999)

N Rodolico, *Cronaca Fiorentina di Marchionne di Coppo Stefani* (Città di Castello: S. Lapi, 1903)

P Slack, *Plague: a very short introduction* (Vol. 307). Oxford University Press, 2012

J Waller, "A forgotten plague: making sense of dancing mania", *Lancet*, 373, 624-625, 2009. Available: 10.1016/s0140-6736(09)60386-x [Accessed 25 March 2020]

P Ziegler, *The Black Death* (Stroud, Gloucestershire: Sutton Publishing, 2003)

Report from the Chair

George Ikkos*

HoPSIG continues to thrive. We now have 1,700 members and continue to enjoy the support of the College. In November, I attended a very constructive whole day event for SIG chairs which was organised by Dr Jan Falkowski, hon treasurer, introduced by Prof Wendy Burn, president and attended Dr Adrian James, registrar. Adrian is now president elect and will be taking office in the summer. He has been a staunch supporter of HoPSIG and the College Archives and we look forward to working closely with him and his successor. I remain grateful to Dr Peter Carpenter for his commitment and initiative as our finance officer and Francis Maunze as College archivist.

As I write, Dr Graham Ash, hon archivist, and Dr Claire Hilton, historian in residence, are actively engaged with the College officers and Council in reviewing issues around the legacy of Hans Asperger, particularly his part in the extermination of disabled children in Nazi-ruled Austria. Graham is also leading on the HoPSIG response to the review of the College training curriculum. In response to this review Claire and Graham have led in writing an editorial[#] for *BJPsych* on “History of psychiatry in the curriculum? History is part of life and life is part of history: why psychiatrists need to understand it better”. Drs Robert Freudenthal and Thomas Stephenson, executive committee members and higher and core trainees respectively have also contributed. We argue that there is a very strong case for including the History of Psychiatry, given the review’s aim to train “dedicated doctors”, this requiring high standards of abstract reflection, ethics and citizenship.

Fully funded by the College and free of charge to all participants, the Witness Seminar on Psychiatric hospitals in the 1960s was held in October 2019. This was fully subscribed, much appreciated by the diverse participants and feedback has been positive. Congratulations to Claire Hilton and

.....

Editor’s notes: *This report was written before the Covid-19 crisis; # Now in press.

Tom Stephenson for the enormous amount of work in relation to this. They are working actively in publishing the transcript and reflective summary, which hopefully will help serve as a launchpad for applying for external funding for a further witness seminar in the next 12 to 18 months on aspects of psychiatry and mental health in the 1970s.

The joint meeting with the Royal Society of Medicine (RSM) Psychiatry Section on *Mind, State and Society 1960-2010: Half a Century of UK Psychiatry and Mental Health* was held at the RSM in January 2020. There were over 130 registrants and all formal and informal feedback confirmed that its aims were met, with 90% of those feeding back formally stating that they were met well or very well. All speakers were rated highly, including the most appreciated David Gilbert who, utilising multimedia and his poetry, spoke vividly and movingly about his experience as a service user during this period. I am grateful to him and other speakers; Professors Joanna Burke (history), George Szumkler (psychiatry and society), Paul McCrone (health economics), Peter Tyrer (psychiatry); Drs Louise Hide (history), Trevor Turner (psychiatry); and Paul Farmer (voluntary sector/Mind), for their superb contributions. I am especially grateful to my co-organisers Professors Tom Burns and Nick Bouras. Nick and I are actively working now on securing contributions and editing a volume with the same title as the meeting. We aim for it to be ready by the RCPsych International Congress, 2021.

An innovation for HoPSIG was the involvement of the internet based platform @mental_elf led by Andre Tomlin to publicise the RSM-HoPSIG event including with a short video and tweets; to actively tweet throughout the meeting assisted by service users Bethan Mair Edwards @pixiegirle and Mark Brown @MarkOneinFour; and to record and disseminate interviews with the speakers during breaks. Relevant material can be accessed via #mindstatesociety and <https://soundcloud.com/national-elf-service>. These have extended the reach of our activities significantly.

Andre @mental_elf has informed us that 233 people (from 11 different countries) participated in the tweeting. 1,283 tweets were sent (666 were retweets). The total number of Twitter impressions

was 23,317,965, though this does not mean that this number of people read the tweets! He has informed us that “There were about 20 people tweeting in the room, but 233 in total, so ten times as many people joined in from online. This 1:10 ratio is what we aim for (but rarely succeed in reaching) in terms of strong Twitter engagement, so that's a very good sign”. Information provided by @royalsocmed confirmed that this has been one of two top tweeted events from diverse medical specialties at RSM. We are grateful to RSM Psychiatry Section for taking the financial risk, administering and supporting this event, including funding @mental_elf activities. For those planning future meetings, it is worth remembering the relative numbers of followers: @rcpsych c86,400; @mental_elf c78,800; @royalsocmed c21,100; @rcpsychHoPSIG 949.

HoPSIG will be holding a joint meeting with Newcastle University's School of History, Classics and Archaeology, organised by Professor Nicol Ferrier and Dr Jonathan Andrews, reader in the History of Psychiatry. It will be held in Newcastle on 17-18 September 2020, on *Understanding death and mortality in the context of mental illness and institutionalisation during the 19th and 20th centuries*. Drs Claire Hilton and Andy Owens will contribute talks as representatives of HoPSIG. It promises to be a fascinating meeting and I urge you all to mark it in your diary and consider attending.

Finally, congratulations to former SLAM medical director, RCPsych hon treasurer and HoPSIG co-chair Fiona Subotsky on publication of her book *Dracula for Doctors* (CUP <https://doi.org/10.1017/9781911623281>) and her President's Lecture in February 2020 on this theme. The book is the culmination of long-standing interest and endeavour, in parallel with her other extensive professional activities. I would encourage many young colleagues to develop and cultivate an early interest in aspects of the history of psychiatry, as sustained effort can be rewarding both in academic and clinical terms, including understanding patient experience and perspectives. For older colleagues, it is never too late; really!

BETHLEM

MUSEUM OF THE MIND

The Anatomy of Melancholy Virtual Book Club starting April 6th



In a time of war, plague and pestilence, the seventeenth century author Robert Burton identified melancholy as the greatest threat to the health of the nation. His famous work, *The Anatomy of Melancholy*, is a treasure trove of esoteric learning, questionable conjectures and rambling diversions across a remarkable range of subjects, among them science, religion, food, love, and all manner of human behaviour.

The present coronavirus epidemic has closed many doors, including those of Bethlem Museum of the Mind, and we are concerned about the mental health effects of the social isolation measures it has been necessary for us all to adopt. Robert Burton's insights into causes, characteristics and cures of 'melancholia' are idiosyncratic, unreliable and of course dated, but they are always entertaining, and from time to time they are right on point.



On Monday 6 April 2020, we intend to start a virtual book club to read an abridged version of *The Anatomy of Melancholy*. The club will be supported by our social media channels, and is free for anyone to join. In addition, we have a small number of out-of-print, abridged editions of the book for sale, which we can post to any UK address upon receipt of £7.50:

- 1. The Anatomy of Melancholy, Adapted for the stage by Stan's Café (ISBN 9780954037550)**
- 2. On Melancholy, with an introduction by Nicholas Robins (ISBN 9781780942186)**

As far as we know, the Stan's Café abridgement isn't available anywhere else – to get it, you have to contact us. You may be able to obtain the Robins abridgement elsewhere, especially if you want an e-book version. We have limited stock of both titles, and will fulfil UK orders until we run out.

To make an order, you have to do three things by Thursday 2 April:

1. Send £7.50 by bank transfer to the Museum's bank account (sortcode 23-05-80, account number 31519403).
2. Give a reference to the payment to identify yourself and the edition you would prefer, according to the following form: First name initial, followed by first three letters of last name, followed by first three letters of your preferred edition

e.g. If your name is Richard Dadd, and you would prefer the Stan's Café edition, give the reference RDADSTA; if your name is Louis Wain, and you would prefer the Robins edition, give the reference LWAIROB. If your name is Cynthia Pell, and don't mind which edition you get, give the reference CPEL.

3. Send an email to the Museum's Director, Colin Gale (info@motm.org.uk), confirming the transfer and giving your UK postal address details.

RCPsych witness seminar: Psychiatric hospitals in the 1960s

Tom Stephenson

Core trainee, South London and Maudsley NHS Foundation Trust

In October 2019 the RCPsych hosted a witness seminar (What is a witness seminar? <http://www.histmodbiomed.org/article/what-is-a-witness-seminar.html>) focused on psychiatric hospitals in the UK in the 1960s. In the lead up to the College's 50th anniversary in 2021, it felt pertinent to examine the period leading up to its foundation. The event was audio-recorded and the transcript will soon be available on the College website.

It felt like a news conference, and in a sense, it was. A testimony from the past – people who had witnessed the hospitals from many different angles, rising to report back, half a century later. Gathered in the room were psychiatrists, a social worker, an occupational therapist, psychiatric nurses, a person who had grown up in hospital grounds, and most importantly, a former patient. They spoke of their first impressions of the hospital atmosphere, of the acute and so-called “back” (long-stay) wards and of practices emerging during the decade. We heard from some who were at the forefront of psychiatric leadership and from a woman psychiatrist working in what was then a male-dominated field. We heard about innovations and new roles, including those of the clinical psychologist and occupational therapist, today core multi-disciplinary team members. We heard about the achievements of a group of committed trainee psychiatrists who fought so that the College would establish a formal training programme to prepare them for the MRCPsych examination.

There were deeply troubling accounts too. Conditions on some wards were very poor. One speaker recalled ECT being delivered at the bedside on an old Nightingale-style ward. Having heard the testimonies, one audience member questioned whether it felt as though there was an “essential badness” in the institutions. Hearing the accounts, I did not conclude that there was. But significant ethical challenges emerged: how should we, as listeners, respond to hearing of abhorrent and sometimes humiliating practices going unchallenged at the time? Of outsized egos in teaching institutions creating cultures of impunity?

Public understanding of psychiatric practice in the 1960s continues to belong largely to the realm of myth and legend. For critics of our field, the period acts as a potent touchstone. As professionals we benefit from a better understanding our past, grounded in the experiences of those who were there at the time. To that end, witness seminars such as this one make a valuable contribution to lifting the shroud.

The transcript of the seminar has been edited, illustrated and annotated and is in the process of being checked by the witnesses. It will be released soon. I would encourage colleagues to read it and share it widely.

The Nottingham Psychiatric Archive

and other new resources online

The Nottingham Psychiatric Archive is dedicated to the memory of Dr Duncan Macmillan OBE BSc MD FRCP(Ed).

In 1930, at the age of 28, Duncan Macmillan was appointed as deputy medical superintendent of Mapperley Hospital and became superintendent in 1940. He retired aged 65 in 1967 and died suddenly two years later while on holiday. In total, he spent 37 years at Mapperley Hospital, 27 as medical superintendent.

The first part of the Archive deals with an important aspect of his work that has not been given the attention that it deserves. Duncan Macmillan's most notable achievement was to show (together with Dr TP Rees of Warlingham Park, Croydon, London) from the 1950s onwards, that it was possible to run an ordinary mental hospital without having any locked doors. Why was their example not followed by the many other similar mental hospitals?

The archive is a bibliography of research done in Nottingham that follows on from the interests of Duncan Macmillan, plus a collection of hard copies of documents that reflect Professor John E. Cooper's work with the World Health Organisation on case registers and the classification and epidemiology of psychiatric disorders.

John Cooper was appointed in 1971 and retired in 1991. Preparation of this Archive began in the 1990s, for many years with the support of Dr Ian Medley, and latterly the support of Dr Stuart Leask.

The archive is limited to studies concerned with the development and use of psychiatric services in Nottingham, and with the epidemiology of severe mental illness in Nottingham (particularly of schizophrenia and acute psychoses). It does not contain references to publications on the many other types of psychiatric research that have been conducted in Nottingham.

The Nottingham Psychiatric Archive is now available at <https://ledoofer.wixsite.com/nottpsycharchive>

Virtual history of medicine exhibition hosted by the Royal College of Surgeons showcasing some of the visual and historic treasures from their collection scan be accessed at

https://scp.rcseng.ac.uk/client/en_GB/exhibitions

Lunacy Act 1890...if you've ever wondered how it compares with the existing MHA...

<https://wellcomelibrary.org/item/b20417044#?c=0&m=0&s=0&cv=0&z=-0.7585%2C-0.0855%2C2.517%2C1.7106>

Out and about...

In London...

***Just opened!* - New medicine galleries at the Science Museum, London, include some fascinating exhibits on mental health**

... a complete padded cell (nine panels, door, base, gutters, padded with horsehair and coated with a rubberised (presumably waterproof) coating, built to fit a room at Farnborough Hospital, mid-20th century.

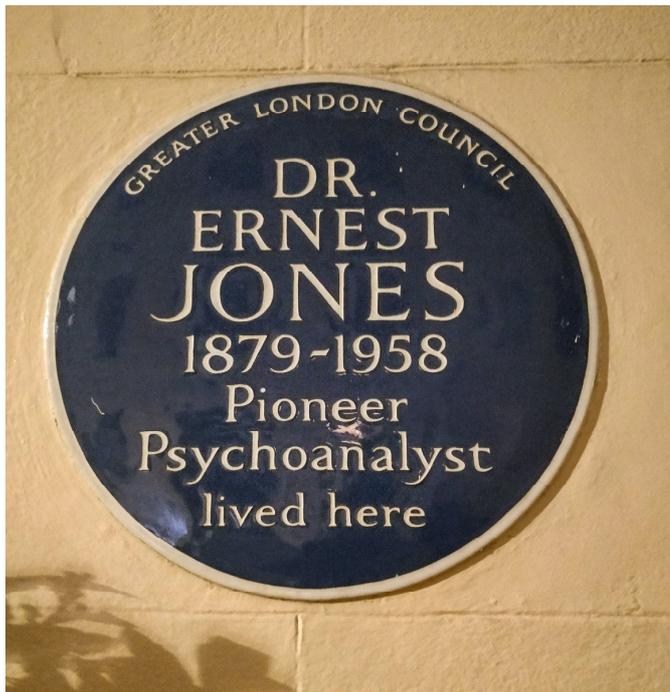
...a "pegging clock" time device was part of a "tell-tale system". The grandfather-type clock has no hands, but a rotating dial. Around the dial are "pegs". These had to be pushed in at the right time. It showed staff were alert and where they should be. It also showed they were safe from attack. This system is symbolic of the rules, regulations and surveillance routines in large Victorian asylums. It also shows how staff as well as patients were rigidly controlled by institutional life.

... A bird cage from Sussex Lunatic Asylum

... A straitjacket for adult patients in psychiatric hospitals (1930s-60s). It is made of heavy canvas. It has four ties on the main body and excessively long sleeves. The sleeves can be wrapped around the body, holding the patients' arms securely in place. Such garments restricted the movements of patients considered violent or unruly. Their use was phased out when anti-psychotic drugs and other methods of management were introduced.

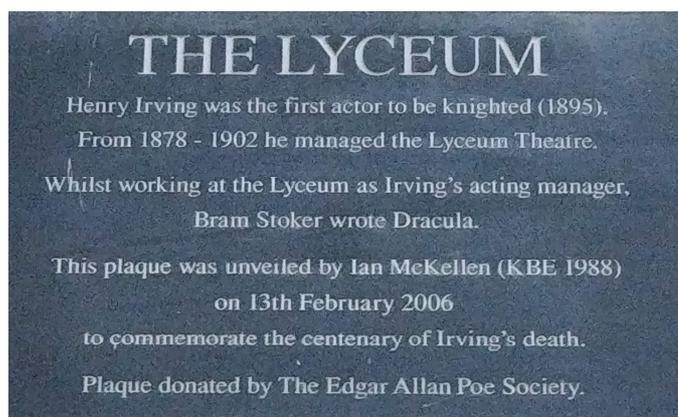
[Well worth going to have a look, so check it out here....](#)

Blue Plaque in York Terrace East, London, NW1



Dr Ernest Jones, president of the International Psycho-Analytical Association, was elected as an honorary member of the Royal Medico-Psychological Association in 1951.

And outside the Lyceum theatre, Covent Garden, related to *Dracula for Doctors* by Fiona Subotsky....



Just north of London....

The Highfield Park Trust has developed a history trail – which includes features of Hill End (psychiatric) Hospital and Cell Barnes Hospital (formerly, Cell Barnes Colony). It is well worth a look – and don't forget the “garden of rest”, the former hospital cemetery.....

To download the trail leaflet go to...

https://www.highfieldparktrust.co.uk/wp-content/uploads/2017/08/HPT_History_Trail.pdf

If you are in Yorkshire.....

Why not visit the Mental Health Museum in Wakefield.....

<https://www.southwestyorkshire.nhs.uk/mental-health-museum/home/>



High Royds Hospital, Yorkshire: a corridor. Pencil drawing by Paul Digby, 2003-4 (Wellcome Images, License CC BY 4.0)

and if you visit any of these places, or see any blue plaques or other items relating to psychiatric history then send us a picture or a comment.....



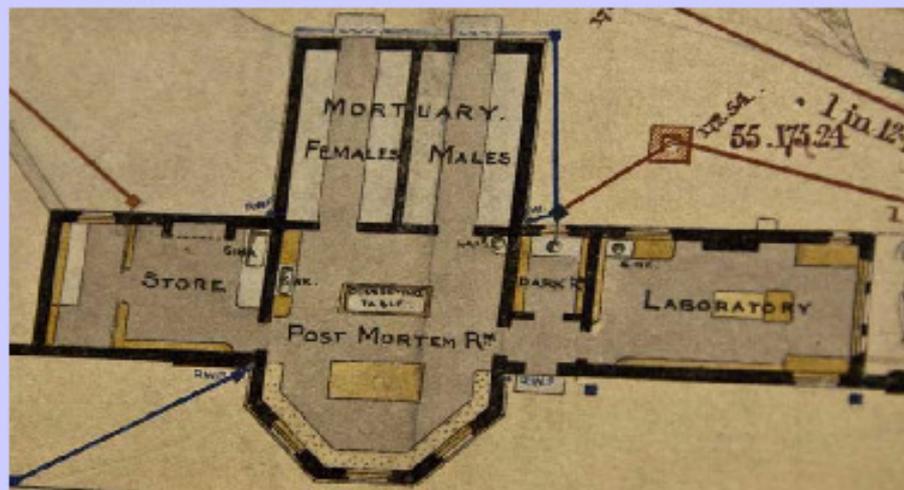
**“Understanding Death and Mortality in the Context of
Mental Illness and Institutionalisation
During the 19th and 20th Centuries”**
Thurs. 17 Sept. – Fri. 18 Sept. 2020, Newcastle University



A two-day Workshop funded by the School of History, Classics and Archaeology (HCA), Newcastle University, and by the History of Psychiatry Special Interest Group (HOPSIG), affiliated with the Royal College of Psychiatrists



November 1955. Outagamie County Asylum for the Chronic Insane, Appleton, Wisconsin, main corridor. Source: <https://eu.nostcrescent.com/story/news/local/2014/08/14/insane-asylum-cemetery-forgotten-stories/14070183/>

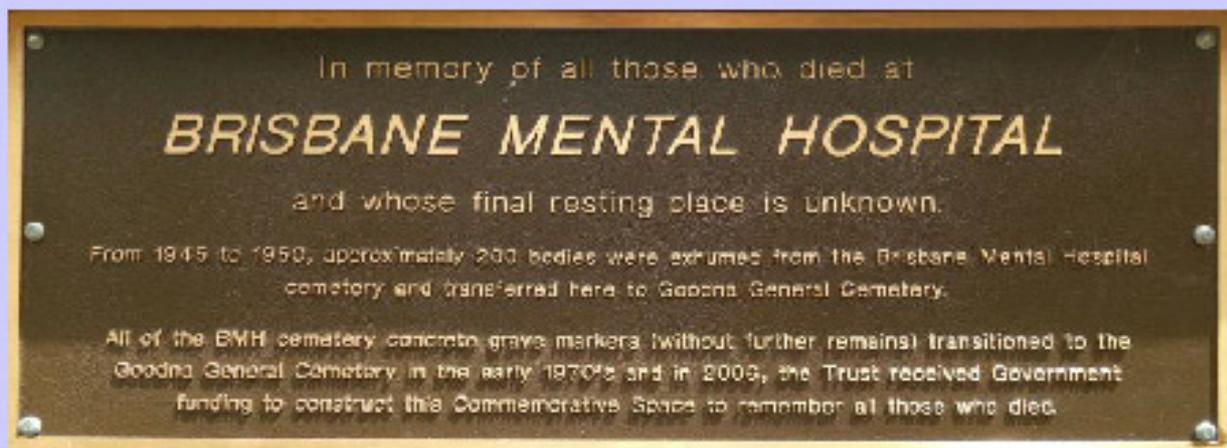


Wakefield Asylum, mortuary plan, 1860: Source: <http://www.wakefieldasylum.co.uk/insight/243-2/>

This two-day workshop, organised under the thematic title: 'Understanding Death and Mortality in the Context of Mental Illness and Institutionalisation during the 19th and 20th centuries', focuses on key themes and innovative research perspectives regarding mortality and mental illness in modern institutional settings. The workshop originates from the 'Life Cycles, Bodies, Health and Disease' (LCBHD) research strand in the School of History, Classics and Archaeology (HCA) at Newcastle University. The event is supported by a grant from HCA, within the Humanities and Social Science Faculty (HASS). It is additionally supported by the History of Psychiatry Special Interest Group (HOPSIG), affiliated with the Royal College of Psychiatrists, and will be featured and advertised in the latter's events programme <https://www.rcpsych.ac.uk/members/special-interest-groups/history-of-psychiatry/events>. It involves speakers and invites participation from historians (especially of medicine, psychiatry and mental health), historical geographers, architectural historians and other scholars adopting historical, (medical) humanities and social science research perspectives, and also from practising and retired psychiatrists/clinicians/mental health workers and psychologists broadly interested in death and mental illness.

Registration and attendance is free for Newcastle University staff, and for all students. There is a registration fee of £60 for others wishing to attend, to cover lunch, refreshments and workshop programme packs. Registration is limited to 50 participants max. on a first come first served basis.

To register and for further information, please email the workshop organisers: Dr Jonathan Andrews (Reader in the History of Psychiatry, Newcastle University) jonathan.andrews@ncl.ac.uk and Prof. Ian Nicol Ferrier (Emeritus Professor, Wolfson Research Centre, Institute of Neuroscience, and PhD candidate, Newcastle University) nicol.ferrier@ncl.ac.uk; i.n.ferrier@newcastle.ac.uk].



From blog by Lisa Herbert, who describes herself as "a cemetery wanderer, journalist and author of *The Bottom Drawer Book: an after death action plan*"; <https://thebottomdrawerbook.blog/2018/02/13/mental-asylum-mass-exhumations-and-missing-remains-the-tale-of-wolston-parks-lost-and-forgotten-patients/>

Libraries and donations: playing the long game

Fiona Watson, Librarian, Royal College of Psychiatrists

Fiona.Watson@rcpsych.ac.uk

One subject that has been on our mind recently in the College Library is donations. When I arrived at the College there was well over 150ft of uncatalogued, donated books. This is not unusual in libraries, cataloguing donations is rarely urgent and strangely never regarded as a key performance indicator by senior managers!

What I want to do in this piece, is to put into perspective what it means to donate books to a library like ours. When someone donates to a collection, that part of them passes into history. That might sound overly poetic but I hope I can illustrate the point by drawing a line for you between our newest donations and some of our oldest.

When a new donation arrives, we sift through it and decide what we want to keep based on the book's relevance to the collection. Those we do not keep currently go to Better World Books, whose good work you can read more about here <https://bit.ly/2NLihAR>. But once they have been weeded, the fact that they are a donation will always make them the preferred book or copy to keep when we are trying to make space. So, donations are much more likely to stay in their library and survive the test of time.

These books straddle the boundary between ordinary and rare books not because of their age but because of who donated them. It is hard to tell at the point of donation who will be remembered and whose life and work will add value to the books they leave behind. Newly donated books are unlikely to be those that library visitors are desperate to get their hands on. They are too old for common use but not old enough to be valuable for that alone. It is more like laying down wine, you catalogue and hope



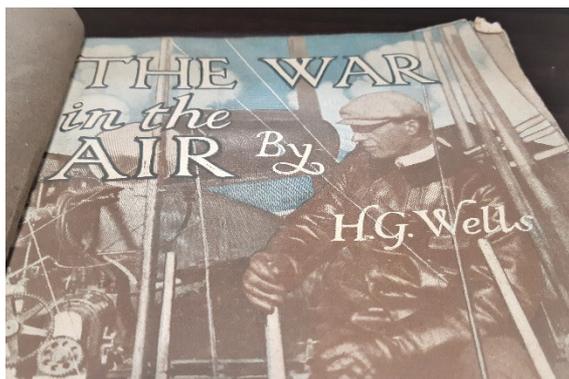
that those books will become useful to future generations. Some of this depends on the book and some on the person who donated them.

To put that into perspective, I wrote my Master's thesis on a small number of common religious texts, now at Trinity College, Cambridge, that once belonged to Thomas Becket.

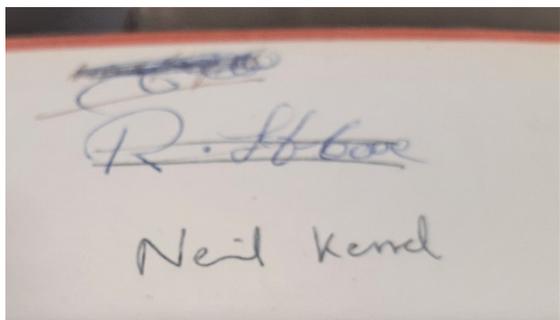
However, due to space pressures our donations could not remain uncatalogued forever and we have been making very good progress. This has been especially important as we continue to be offered new collections.

So, whose books have we been working with? The two main collections currently being catalogued belonged to Professor Neil Kessel and Professor Linford Rees. Both were donated posthumously. It is quite common to receive donations when people are close to the end of their life or from their family after they have passed away. Often the opportunity is missed to find out some background knowledge about the person whose books you are reviewing. Personally, I know very little about these two psychiatric giants, although mentioning Kessel's name has at least generated some lively recollections from those who knew him.

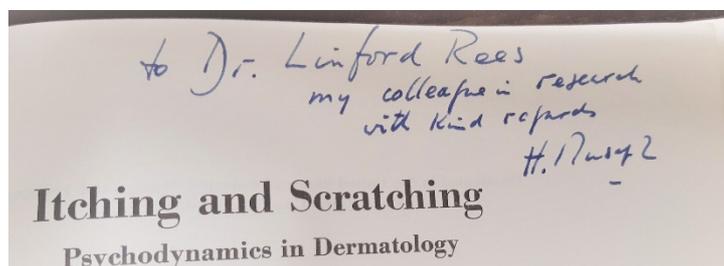
However, cataloguing a personal collection does give a strange window into someone's life and work. You nearly always find out their academic interests but I can now guess that Kessel had an interest in classic science fiction:



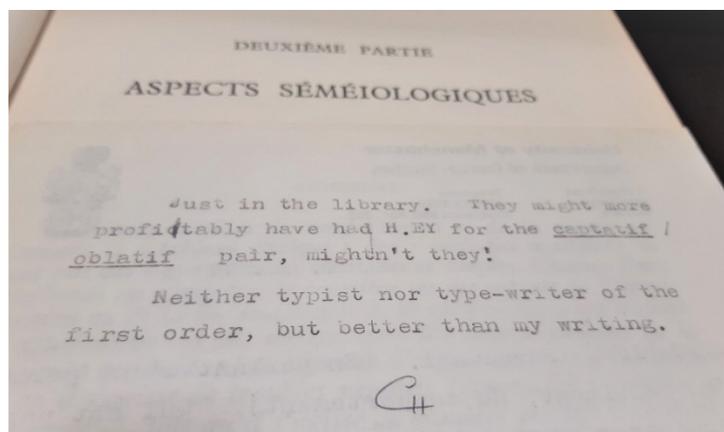
Often the only thing people leave in a book is their name:



Or it was clearly a gift to the donor:



For older books their trajectory is almost always more complicated. In one of Kessel's books I found the following:



We don't know who C.H. is, to which library they refer, or even what happened to the other volume.

This might seem trivial for book donated now but the further you go back the more mysterious it all

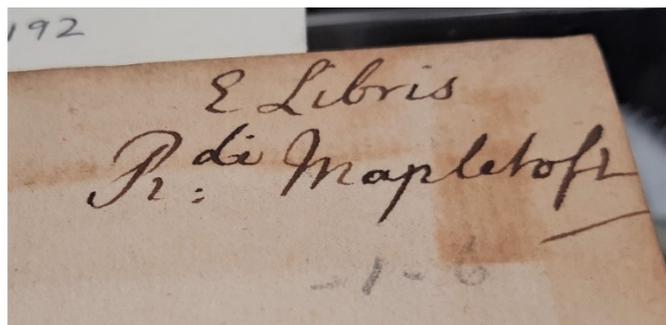
becomes. When the College was young in the 1890s, it asked for donations from members to start a College Library and they were so high quality that they still form a wonderful core of rare books at the heart of our collections.

Some older books still have a fairly reliable provenance, some from records of donation in the Archives and others from what we find in the book. This book belonged to Richard Robert Madden and we can conjecture that that might have been the famous doctor of that name who lived from 1798-1886.



The following bookplate is from the Mapletoft family:

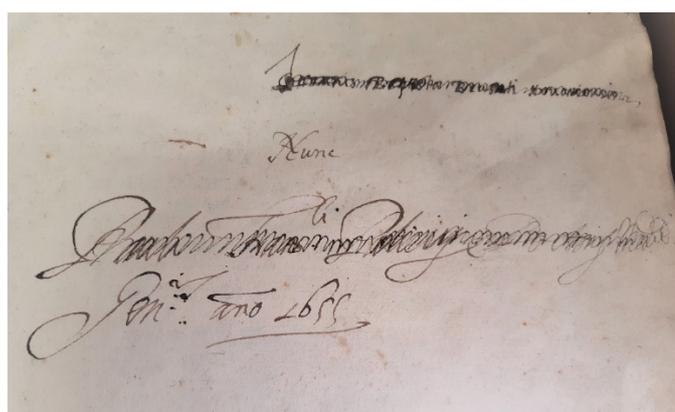
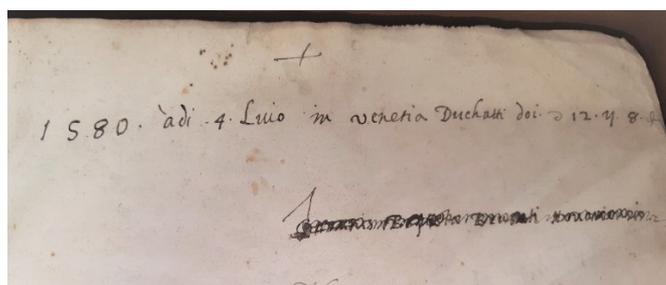




We also find indications of bookshops that books have passed through:



Then there are the most mysterious, which are difficult to decipher at all:



These two are from the same flyleaf. The book is from 1576 so both dates are later than the publication. My best guess regarding the first is that it may be a price, for 12 Venetian ducats and some change. But I may be wrong. The second picture may indicate who owned it in 1655, or perhaps it was the date of another book bound together with this one, at one time or another.

So it goes, in 500 years time it is likely the names Kessel and Rees will not mean much if the books travel to another library in another country. Or maybe they will find their way back again. I have received one antiquarian book in a donation that already had the College book plate. It had been appropriated by a member some decades before and re-donated posthumously. There are other libraries who have had books returned several *centuries* late if the borrower donates their books posthumously to the wrong institution and it takes another few hundred years before they make it back to the original library.

This kind of theft is not necessarily intentional; membership bodies often “suffer” from the members’ sense of belonging. This is *their* College so the books are *their* books. They might take a book along to a meeting (especially if they wrote it!) and then it ends up in their bag...

A certain amount of migration in this way is natural and a sense of entitlement to the College should be encouraged! Contrary to popular depictions librarians would rather see the books used and accept a certain level of attrition. But there is a reason our rare books are locked up!

So, look at your book collection with fresh eyes, what will they tell people about you 500 years from now? As for what advice a librarian would give, please consider the following:

- Donate your books to a library that will value them.
- Try and make sure you or your family gives the library a summary of who you were. This adds context for the reader and historian.
- Write in your books (but not the library books; they’re not yours). Even in rare books a note from a comparatively recent owner on the flyleaf is helpful to trace provenance. If you can’t bring yourself to mark a rare book, use a piece of acid free paper and insert it.
- Do not scribble out other people’s annotations.
- Sign your books and when you do please date it!
- If you give a book write a dedication.
- If you accidentally steal a book it is never too late to give it back.
- Leave your notes and letters in your books. The more outrageous the better. 150ft of cataloguing can get very dull.

History of psychiatry in Nigeria

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The history of modern psychiatry in Nigeria is a part of the larger history of medicine in West Africa. In the later half of the 19th century and early 20th century, the whole of the West African region was treated as one by Britain. British West Africa at this time included Sierra Leone, the Gold Coast and Lagos. Initially explorers such as Mungo Park (1771-1806) and William Balfour Baikie (1825-1864), who were European doctors, contributed to the opening up of the River Niger and what was to become the Nigerian hinterland, to trade and contact with Europeans. Hospitals were first established by missionary bodies such as the Roman Catholic Mission in coastal offshore islands like Sao Tome in 1504 and on the mainland by the middle of the 19th century. In Nigeria, the Roman Catholic Mission completed Sacred Heart Hospital in Abeokuta in 1895. Prior to this, small units were built in Lagos in 1873, Asaba in 1888 and later in Calabar in 1898. The Governmental Medical Service in Nigeria evolved out of the hospitals of the military cantonments such that by 1902 it had become a fully organised service for the West African region, and it became the fore-runner of the medical services of countries like Nigeria, Ghana, and Sierra Leone.

The amalgamation of the medical departments of the West African colonies in 1902 introduced a segregated service, and ensured that Africans were treated separately from Europeans, and African doctors were paid on a lower scale and were never to have seniority over the most junior European doctor. Parliamentary Papers for 1909 addressed this matter. Set up by Joseph Chamberlain (1836-1914), Secretary of State for the Colonies, the *Report of the Departmental Committee to enquire into the West African Medical Staff*, stated that they “do not believe that in professional capabilities West African natives are on a par, except in very rare instances with European doctors, or that they possess the confidence of European patients on the coast”. Furthermore, the Report stated that “in

hospital, where patients are practically always natives, it may be desirable to employ a native doctor, but such cases may be regarded as exceptional, and may be left to the discretion of the local governments” (Schram, 1971). Essentially, this was a plain racist position given that it strictly forbade the employment of non-Europeans, in particular West Africans, people of West African descent from the Caribbean and East Indian physicians. This position was not unchallenged. Edward Mayfield Boyle, Drs Lumpkin and Strachan, and Walter Egerton who was then Governor of Nigeria wrote to complain that the Report was evidence of racial prejudice and indeed the tenor of the Report was often not upheld in the colonies (Schram, 1971). The Dean of Medicine at Edinburgh University, Alexander R Simpson, also wrote on behalf of West African students as follows:

Many medical men pass through our University who have come from India, and the West Indies, and from East, West, and South African Colonies, as well as from Canada, Australia, and other Colonies populated by the Anglo-Saxon race. When such Colonials have done well in their various classes, and have proved themselves fully qualified in their professional examinations, it would seem a hardship that they should be excluded from official services in any part of His Majesty’s Empire because of their parentage (Johnson, 2010).

As Schram (1971) wrote:

it is difficult to understand how a low estimate of African ability could have been entertained, except by those not in a position to understand. Dr EF Easmon won the Liston Clinical Medal for surgery and five other prizes in London, and the MD at Brussels. Horton and Davis both obtained the MD as early as 1859. In Tanzania it was a West African doctor, Adrien Atiman, who was amongst the pioneers. As a freed slave, he travelled to Malta to graduate, and in 1888 walked from Sadani near Zanzibar to Karema, the White Fathers Mission station on Lake Tanganyika, a distance of 700 miles, to start a life of fifty-six years work there.

Ryan Johnson (2010) has argued persuasively that aside from the vulgar racist tone of the Report, there were financial reasons for its conclusions. The British Medical Association amongst others, had

lobbied for European doctors to have the opportunity for private practice in West Africa. This racialised position was merely another method to secure, for European doctors in West Africa, access to lucrative private practice without competition from native physicians. Employment in the government medical service was a position of immense influence and provided opportunity for lucrative private practice.

The development of specialist hospitals began in earnest in 1903 when a mental asylum was built in Lagos on a site given by the railways (the first patients were admitted in 1907), and another in Calabar in 1904. At about the same time an Infectious Diseases Hospital was built in Calabar in 1905; the forerunner of the Children's Hospital in Lagos was built in 1903; the Leper Asylum in Lagos in 1903; and the Nursing Home in the Cameroon in 1908. It is clear from the foregoing that there was a lot of developmental activity in the early part of the twentieth century. Prior to this, in the late 1800s, medical men had mostly been employed within the Army medical services or were in private practice. However, from the early 1900s, hospitals catering for the native population and for the few, but privileged, Europeans, started to be built.

I will now turn to the social context of the development of mental asylums in Nigeria including their medical leadership and their environmental conditions. The goal is merely to provide a brief overview of the subject. A more detailed account is available in Oyeboade (2006).

Social context of development of asylums

Lagos was annexed by Britain as a crown colony in 1861 and it became the capital of the colony and protectorate of Nigeria in 1914. By the late 1800s Lagos had a thriving press and an articulate and educated middle class. Sadowsky (1999) has shown how in the late 1880s and early 1890s the Lagos press became concerned about the mentally ill within the community. One of the newspapers, the *Weekly Record* was as concerned about public order and safety as it was about the condition of the individuals with apparent mental illness. In one editorial it stated that "the insane man is still at large and has been seen at night in the neighbourhood of Victoria Road and Breadfruit Street" and in another "the spectacle of them roaming about the streets in the pitiable condition they present is a reflection both upon our *Christianity and Civilisation*" (italics in the

original). The Lagos *Weekly Times* in 1890 reported on a case of suicide by disembowelling and argued for asylums to protect the public from having sight of such alarming incidents. These newspaper articles about mental illness and the need for asylums were part of broader public interest in medical matters and in politics. The newspapers were, by definition, campaigning organs for the native population who in Lagos had been under the yoke of colonisation for 40 or so years and were in the process of witnessing the subjugation and colonisation of the rest of Nigeria.

The so called Adeola Scandal has been described in detail by Adeloje (1985) and Ayandele (2013). Adeola was a woman patient, admitted on 4 June 1888 and discharged on 20 June 1888, having been in hospital without prescription, with the diagnosis of incurable elephantiasis. She was removed to the bush near the hospital and lay in the open, overnight, before her re-admission. She subsequently died on 29 June 1888 and was hurriedly buried. The doctor in charge, Dr Cecil Digby, was notorious for his hatred of Africans. The jury at the Coroner's inquest unanimously found the two doctors involved in her care, Drs Digby and Mattei, guilty of manslaughter, but the coroner, Mr Haddon Smith, overruled the jury's judgement. The people of Lagos wrote to the Secretary of State for the Colonies, Lord Knutsford, describing the irregularities of the case. Eventually the governor and the Colonial Office in London provided the justice that the people of Lagos believed that Adeola, and they, had been denied. The two doctors were relieved of their duties.

The Adeola Scandal revealed a number of problems about the practice of medicine in a colonial hospital in the late 19th and early 20th century. The hospitals were all-purpose institutions with scarce resources, the interaction between the expatriate doctors and their African patients was through interpreters and liable to miscommunication, and the attitude of some of the European doctors towards the patients and charges was adversely influenced by the colonial relationship between the African and European. Although the Adeola case was not a psychiatric case, it demonstrated the degree to which the Lagos middle class were interested in social welfare matters, recognised the political dimension of these issues, and were prone to act collectively to pursue their aims. It also reflected how badly African

patients could be treated within the system of care set up in the colonial medical services. In this respect, the Adeola case symbolised the fact that the mere existence of hospitals did not ensure welcome, fair treatment, respect, or compassion.

In the 1880s the government began to formulate policy for the care and custody of “lunatics”. The Prison Service had hitherto been responsible for them. In 1906, the lunacy ordinance was passed which emphasised the custody of the vagrant insane. This was the setting for the development of asylums in Nigeria. This situation was mirrored in other parts of Colonial Africa. Kissy Lunatic Asylum in Freetown Sierra Leone was built in 1847; the first asylum in the Gold Coast was opened at Victoriaborg in 1888; the new asylum in Accra in 1907; Ingutsheni in the outskirts of Bulawayo in 1908; and, the Zomba asylum in Nyasaland in 1910. Many of these asylums were extensions of the local prisons and often complemented other designated areas in prisons and annexes that functioned as prisons. In Nigeria, such complementary facilities existed in Sokoto, Jos, Lokoja, and Port-Harcourt.

Medical management of asylums

Dr Curtis Crispin Adeniyi-Jones (1876-1957) was appointed first superintendent of the Yaba Asylum in Lagos in 1906. He was born in Wellington, Sierra Leone and attended Sierra Leone Grammar School before studying at Durham and Dublin. He graduated in 1901 and by 1907 was one of only four African doctors working in the colonial medical service, out of sixty-eight. His other African colleagues were Charles Jenkins Lumpkin, William Alexander Cole and Oguntola Sapara. Adeniyi-Jones and these colleagues jointly signed a memorandum of objection to the *Report of the Department Committee to enquire into the West African Medical Staff* (1909) and Lumpkin, as the most senior of the four, protested to the Colonial Office in a letter endorsed by the governor Walter Egerton and the principal medical officer Dr Henry Strachan. Adeniyi-Jones later became active in the politics of Lagos. He was president of the Nigerian National Democratic Party and was elected to the Legislative Council in Lagos in 1923 serving until 1938. He was very active in nationalist politics. Adeniyi-Jones wrote two reports about Yaba Asylum in 1907. These indicated that “as of the 31st October, 14 lunatics, 8 women and 6 men, had been admitted, and an additional inmate was admitted in

November” (Sadowsky, 1999). Adeniyi-Jones confirmed that “as in many societies tearing at clothing and ultimate nakedness are among the commonest outward signs of lunacy in southern Nigeria, and this applied to the early inmates at Yaba” (Sadowsky, 1999). Adeniyi-Jones made appeals for clothing, cigarettes, and snuff for the inmates and identified a need for handcuffs and a padded cell. In his political role as a Legislative Council member, Adeniyi-Jones also expressed dissatisfaction about the management of the medical services. In 1924 he tabled a motion demanding the re-opening of a dispensary which had, since its inception in the 19th century, catered for people living in several districts of Lagos including Olowogbowo, Isale Eko, Otin, Balogun and Idumota. Adeniyi-Jones went on to question the standard of medical practice in Lagos Colonial Hospital, and the staff structure of the hospital with respect to West African doctors.

Adeniyi-Jones was succeeded in 1909 at Yaba Asylum by a European, Thomas Beale Browne. In the period following Adeniyi-Jones, the Colonial government employed European doctors. Only when Thomas Adeoye Lambo (1923-2004), who had studied medicine in Birmingham and trained in psychiatry at the Maudlsey Hospital, London, returned to Nigeria in 1953 to work at the Neuropsychiatric Hospital Aro, Abeokuta, was a trained Nigerian psychiatrist appointed in a Nigerian asylum.

The Yaba Asylum was developed in the former headquarters of the Nigerian Railways. It is accepted that the material conditions and resources were poor (Sadowsky, 1999). Bruce Home wrote a report in 1928 describing dark, congested cells, poor bathing facilities, lack of basic supplies and the use of chains. There was a recognition that the conditions were indistinguishable from prison conditions. At the time of his report there were only 500 beds for the whole country and Home estimated that there was a need for facilities for at least 4,000 patients. A memorandum from 1956 complained that the Yaba Asylum building was unsafe and had a leaking roof.

Dr R Cunynham Brown surveyed the care and treatment of “lunatics” in West Africa in 1936. He visited the Zaria Asylum, the Lokoja Prison Asylum, the Kano Asylum, the Jos Prison Asylum, the Yaba Asylum and the Calabar Asylum. Cunynham Brown

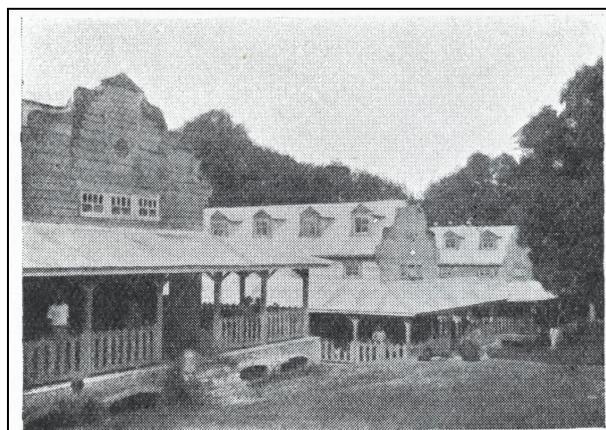
concluded that the government institutions were deficient. Most were run down and poorly serviced and were no more than prisons. He was most concerned about the use of prisons as asylums. He recommended the use of a village system of care so that patients could remain within a traditional living environment whilst receiving modern medical attention and this was instituted by Lambo in the late 1950s (McCulloch, 1995).

In 1955, Dr JC Carothers carried out a review of mental health services in Nigeria for the Federal Government of Nigeria. Carothers was himself in charge of Mathari Mental Hospital Kenya and held controversial views about Africans, for example, that normal Africans “more closely resembles the European child” and that “normal African mentality resembles that of European psychopaths” (Carothers, 1951). Nevertheless, he visited the prison asylums and concurred with Cunynham Brown that they were unsuitable for caring for the mentally ill. Most of the “insane” were held in single cells and shackled to an iron ring. During the day they were kept in small courtyards. He concluded that these prison asylums were unsatisfactory in comparison to institutions he had seen in other developing countries (McCulloch, 1995). Carothers found the Yaba Asylum gloomy and dilapidated. The Calabar Asylum was in better condition and offered better accommodation but it was remote from the population at large and had no attending psychiatrist. Carothers recommended that Lantoro, which had originally been a convict prison in Abeokuta, be an adjunct to Aro, the modern hospital which was still under construction at the time of the visit.

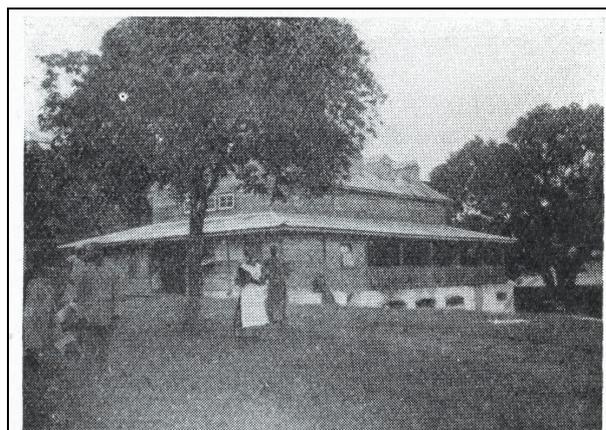
Conclusions

The history of psychiatry in Africa in the early part of the 20th century is an expanding area of study. This was a period of rapid change in African societies. The colonial experience, although comparatively short in most of Africa, has had lasting impact on society and culture. The effects of the struggle for independence and the aftermath of independence on psychiatry, psychiatric practice and mental health services have yet to be adequately investigated. The development and expansion of asylums, the responses of society to the problem of the vagrant psychotic, and the potential abuses of psychiatry for political purposes are all subjects worthy of investigation. In this brief review, I have situated the

development of asylums in Nigeria, specifically the Yaba asylum, in the wider context of the development of modern medical services in West Africa. As in other parts of the world, the actual facilities were poorly resourced and maintained.



Male Lunatic Asylum (Kissy).



Female Lunatic Asylum (Kissy).

Asylum at Kissy, Freetown, Sierra Leone, Credit: [Wellcome Collection](#). [CC BY](#)

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Sigmund Freud and his critics: Criticism during Freud's lifetime between 1896 and 1939

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Sigmund Freud's loyal supporters have always outnumbered his critics. Nevertheless, he had very severe critics starting in the 19th century. A number of his most severe and accurate critics are from the late 19th century and early 20th century.

Richard von Krafft-Ebing, chairing a lecture on the sexual origin of the neuroses in April 1896, having heard Freud speak about his theories, stated that they were like a "scientific fairy tale" (Krull, 1896). Despite this, Krafft-Ebing supported Freud's application for a minor professorship. Freud did not show him any gratitude for this. Gratitude was not something Freud dealt in and never forgave him for stating that his theory was a scientific fairy tale. Freud remained paranoid about Krafft-Ebing for the rest of his life. Indeed, Freud's response to Krafft-Ebing and other critics (Krull, 1896) was to describe them as "asses" incapable of appreciating the importance of "the solutions to a more than thousand-year-old problem" which Freud estimated to be equivalent to finding the "source of the Nile" (Schur, 1972; letter to Wilhelm Fleiss, 28th April 1896 in Masson, 1985). Freud was here describing his theory of the aetiology of hysteria in sexual terms. Fleiss (Masson, 1985) in his letters to Freud questioned the extent that "Freud was reading his own thoughts into the minds of his patients and thereby projecting his personality into his theories". Fleiss was as much a fantasist as Freud. Maybe it took someone similar in personality to Freud to see through him. These criticisms are still valid today. Freud's psychoanalysis was his own analysis of his personality. It was sophistic.

Freud (1914) wrote about the 1896 meeting:

that the material losses I had willingly undergone would be made up for by the interest and recognition of my colleagues. I treated my discoveries as ordinary contributions to science and hoped they would be received in the same spirit. But the silence my communications met with, the void which formed itself about me, the hints that were conveyed to me, gradually made me realise that assertions on the part of sexuality in the aetiology of neurosis cannot count upon...

reasonable responses.

The most brilliant medical doctor in Vienna at time, indeed the medical doctor's doctor, Josef Breuer, concluded at the end of 19th century that Freud was a man "given to absolute and exclusive formulations" and "excessive generalisation" (Hirschmuller, 1978). Freud changed from being a scientist when he worked with Ernst Brucke in his laboratory, to being a mystic when he developed psychoanalysis. No mysticism would be tolerated by Ernst Brucke who was a meticulous scientist.

1900-1910

William James wrote in 1909 (James, 1920) in a letter to Henri Flournoy, that psychoanalysis was "a most dangerous method". William James went on to criticise Freud's theories because he found Freud to be

a man obsessed with fixed ideas. I can make nothing in my own case out of his dream theories and obviously symbolism is a most dangerous method and I strongly suspect Freud of being a regular hallucine.

Freud paid attention to symbolism and dream analysis in his understanding of psychopathology and these were extremely important to him in understanding the human mind. This was a profound assessment of Freud by William James, which is quite similar to the slightly earlier one by Breuer already quoted.

1910-1920

Karl Kraus (Szasz, 1977) noted in *Fackel*, a periodical, that "psychoanalysis is the disease [of] which it claims to be the cure". Indeed, very long, five-times-a-week psychoanalysis for 10 years or more interferes with normal life and can be a kind of new "disease" which takes over the person's life. Yves Delage (1917) continued this description of psychoanalysis as a disease and that it was

threatening “to invade France...[and that] its progress at first very slow, soon became rapid and the spread of the evil generally now knows no pause”.

Karl Jaspers (1913) described Freud's work as “incautious” and that “an error in Freud's teaching lies in the increasing simplicity of his understanding” which is associated with the transformation of understandable relationships into theory. Theories impose simplicity; understanding finds infinite variety. Freud thought that almost every psychological act could be attributed to sexuality in a broad sense, as if it were the only primary force. Writings by many of his pupils in particular are unbearably tedious because of this simplicity. One always knows that the same thing will be found in each article, and that “empathetic Psychology is not making progress here”. This was written by Jaspers in 1913 and it is still true. Indeed, other theorists who followed Freud became equally repetitive and simplistic in their interpretations which were pretty much always predictable once you knew what theory they were using. In fact, Freud himself had a very poor capacity for real empathy with people. As Freud developed psychoanalysis it became more specious and Freud's brilliant stylistic writings were full of special pleadings and special reasoning. Freud was one of the most persuasive and brilliant writers of the 20th century.

Delage, pointed out that it was

among psychologists and medical men and more especially among psychiatrists, that the evil perpetuates its ravages to a really disquieting extent:...It is a malady without any apparent lesion of the central nervous system, a purely psychical affliction; in a word, a psychosis. Its name, coined by the very persons who are its victims, is Psychoanalysis.

Anna O (Breuer and Freud, 1955) called it a talking cure. This was not said to Freud but to the true founder of psychoanalysis, Breuer, who was treating her at the time. Delage went on to discuss psychoanalysis'

irresistible tendency to seek in the sexual factor the universal the sole, universal and omnipotent cause of all human actions....The psychoanalyst is a police-magistrate, a compound of an inquisitor and erotomaniac; and it is because he finds in psychoanalysis the satisfaction of his

erotomania and he loves his complaint, as the dipsomaniac, the cocaine-and-morphinomaniacs love their person....Like all mad men, the psychoanalyst lives in an imaginary world.

Delage also described the psychoanalyst as “an observer who, from the depths of a dark passage, with his eye glued to a hole in the wall, regales himself on the scenes enacted in a brothel”. Dawson (1917), writing about Drapes who translated Delage (1917), commented that psychoanalysis “in the view of many sober thinkers is, in much of its theory, scientifically unsound and at least capable of becoming demoralizing in practice”.

Delage noted that

in the event of a contagious malady making its appearance in any country, it is the duty of the medical man who first has cognisance of the evil to raise a cry of alarm, so as to ensure the adoption without delay of the necessary prophylactic measures....This new affliction which threatens to invade France, had its birth in Austria, Vienna, some 20 years ago...it is a malady rigorously limited to intellectuals. Among these artists, savants devoted to the exact sciences and to physicochemical studies are generally exempt.

Dunlap (1920) also noted Freud's “selective reasoning, or the drawing of preconceived conclusions from...observations”. Freud's method was described by Dunlap “as the anecdotal method, which is so copiously exemplified in spiritualism and in psychoanalysis”.

1921-1930

Freud's effect in the early part of the 20th century was described by Morton Prince (1928) when he wrote that “Freudian psychology has flooded the field like a full rising tide, and the rest of us were left submerged like clams buried in the sands at low water”. The opposite was the truth. Dallenbach (1955) remembered the first time, in 1923, that Freud's name was mentioned at a meeting of the American Psychological Association. Dallenbach went on to state that:

During the discussion following the reading of a paper—the kind of thing that Freud had forbidden in his meetings—a member of the audience started to tell how Freud would explain the results obtained. Before he had proceeded far, J.

McKeen Cattell arose and, after expressing astonishment and painful surprise that a member of the Association should be so wanting in wisdom as to introduce Freud's name at a scientific meeting, castigated him for his folly.

Nevertheless, the Freudian "tsunami" swept America from that time onwards.

Dunlap noted that philosophical mysticism and psychoanalysis furnished alarming evidence of the pitfall that Freud fell into. Of course, the persons with mystical tendencies, as Freud had, are attracted to his mystical writings. Freud wrote "A note upon the 'Mystic Writing Pad'" (1925). Indeed, you can see all Freud's theoretical writings as being done on a "mystic writing pad".

In 1920 Daniel Leary pointed out that "psychoanalysis (is) in a state of hopeless confusion due to misunderstandings, insufficient knowledge, prejudice and rivalry". Jastrow (1932) noted that Leary pointed out that the words censor, catharsis and "libido" are either fictions or non-logical. Leary went on to note that psychoanalysis was "dereistic, autistic, primitive, pre-logical or non-logical; it is in terms of wishes, chance associations, analogies, purpose and desire, rather than in terms of fact, observation, relation, experiment and congruity with other findings". Prinzhorn (1929) wrote that psychoanalysis was "a one-sided doctrine adhering to a single point of view, and making that absolute – sexuality"

1930-1939

Hollingsworth (1930) pointed out that "we can dispense with the Oedipus Complex as easily as we can dispense with fairies, demons and Santa Claus". He pointed out that "these are all in the imagination of the psychoanalyst not in the patient's material". Hollingsworth went on to point out that Freud's concepts are "literary analogues" and "mysticism and demonology".

In 1932, Karl Kraus (Szasz, 1977) in *Fackel*, linked the "swastika" with "the despicable business of psychoanalysis". Kraus quoted Otto Rank as stating "I believe an analysis has become the worst enemy of the soul. It killed what it analysed. I saw too much analysis with Freud and his disciples which became pontifical and dogmatic" (Szasz, 1977).

Also in 1932, Jastrow wrote that Freudians "rarely leave the more congenial occupation of adding two

untested hypotheses which are weakly tested interpretations". The Freudian world shrugs its "shoulders at resisting reactionaries". Jastrow pointed out that Freud's psychoanalysis was "built upon sand and with crumbly cement" with his "fictions" and "myths". Freud's theories are like a Rorschach test which allows one project endless meanings. Jastrow quoted an American psychiatrist as stating

nothing could be more deadening to the future progress of true scientific understanding of mental disorders than the general acceptance of a theory which explains mental illness in terms of mysterious psychogenic factors.

Jastrow quoted Dunlap (1920) as stating that "psychoanalysis became an assault on the very life of the biological sciences. Psychoanalysis attempts to creep in wearing the uniform of science and to strangle it from inside". At the same time Jastrow noted Trotter's comment on psychoanalysis that one is "oppressed by the odour of humanity with which it is pervaded" with questionable "validity". In the early 1930s Jastrow wrote to Holt to ask him if he had changed his mind about psychoanalysis and Holt wrote back to him: "I believe the concepts of the libido and sublimation are erroneous and misleading", and that he found "little interest in psychoanalysis as a theory". Jastrow also mentioned an effect of psychoanalytic treatment was that it "wrecked lives" and caused "suicide" and the psychoanalyst "tampered" with the "holy of holies in the lives of bewildered patients". He was referring to New York psychoanalysis. Jastrow quoted Schmalhasen as describing psychoanalysts as "crude surgeons of the soul" with "dogmatic certainty" and that they also interfere with the patient's "self-respect" undermining his confidence and thwarting his courage and he "comes off actually much worse off". Negative outcomes are not in the exclusive domain of psychoanalysis but occur in all therapies. Paradoxically this shows that if not inert, of course it can interfere negatively with the normal course of people's lives. Jastrow also stated that in future people would see that "the great mass of psychoanalytic literature as one of the strangest anomalies and fantastic vagaries of the 20th century". Jastrow stated that behaviour critics saw psychoanalysis as "mystical, fantastic, assumptive ...a fashion for the idle rich". Jastrow also described

psychoanalysis as an “occult science” and entirely “untenable”.

Jastrow noted that for Schmalhausen, analysts engaged in “dogmatism, magic, authoritarianism, smart-aleck interpretations, bullying, irritating silence, windy wordiness, the slinging around of Freudian jargon”. Jastrow wrote that “my experience with cults is fairly extensive. This tendency to join the refrain when the leader sets the text, then continuous repetition is a mistake for added evidence. Cults form schisms and factions, each seeing nothing but futile heresy in the other”. I have heard the remark by an analyst that Freudians may presently be limited to fellow-Freudians for interactions. It is the cult in psychoanalysis that betokens the fall of the house of Freud (Jastrow, 1932). This proved correct. In 1934 Kraus wrote in *Fackel* about “the degradation of mankind through: psychoanalysis” (Szasz, 1977). In 1939 James Joyce spoke of the master Freud as a “traum conductor”. He called incest a “freudful mistake” and portrayed one of his characters as “yung and easily freudened”. Joyce was in desperation over the mental illness of his daughter and took her to Jung for psychoanalytic treatment. Jung's theories were even more bizarre than Freud's. There is clearly a similarity between the criticisms of psychoanalysis in the 19th century and today. Its flaws were identified right at the very beginning.

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Freud and his cures: based on some of his famous case histories (Anna O, Little Hans, Rat man, and Wolf man) in a form of lurid dream-sequence alluding to Freud's *Interpretation of Dreams*. Artist: Mutahira Qureshi (*News and Notes* co-editor and core trainee)

History inspired wedding cakes...

Jason Holdcroft-Long sent us the following pictures from his wedding

The cakes celebrate Philippe Pinel (1745–1826), and the asylum architects George Hine (1842–1916) and Charles Howell (c.1824–1905). They were made by Claire Ratcliffe

<http://www.facebook.com/Aboutcake.co.uk> who combines cake artistry with being a mental health nurse (and many other things!)

Also, thanks to Jason for the cover illustration: The Retreat, York



The hospital case conference and other learning experiences

RHS Mindham

A medical student at Guys...

During my undergraduate placement in psychiatry in 1958 I was attached to a firm in the York Clinic, Guy's Hospital where we participated in clinical work with both inpatients and outpatients. David Stafford-Clark, my consultant, was well known from his radio programme *The Silver Lining*, for his role as the first TV psychiatrist and for his book addressed to the general reader, *Psychiatry Today*.¹ His lectures drew large audiences and he competed in this regard only with the lectures on forensic pathology given by the redoubtable Keith Simpson. Both gave entertaining accounts of morbid subjects in great style. Ward case conferences in the York Clinic had a similar character and told us a lot about our teachers as well as the patients. Some said that DS-C was the Pied Piper for psychiatry! David Stafford-Clark viewed the problems presenting to psychiatrists as falling on a spectrum from those cases suited to a medical approach, to those more appropriately viewed in psychological terms, to those more readily understood in social terms. Many cases required an understanding in all three areas. This was an unfamiliar concept to a medical student in those days and an important lesson.

In addition to teaching at Guy's there were visits to Bexley Hospital, Kent where we were shown around the hospital and attended clinical demonstrations in which a senior member of staff introduced a series of inpatients and interviewed them in front of us. These patients were for the most part suffering from florid or chronic mental illness and displayed behavioural, cognitive and perceptual abnormalities. Such was the severity of symptoms displayed by these patients that it is unlikely that they were able to give informed consent to appear before students

even if it had been sought. Demonstrations like this certainly stick in the mind. We saw several wards in the hospital and the thing that impressed me was that in the chronic wards the beds were very close together being separated by little more than a foot. I was later to learn that most mental hospitals reached their maximum population of patients at about this time.^{2 3}

A trainee psychiatrist at the Bethlem Royal and Maudsley...

By the time I became a psychiatric trainee in 1964 clinical demonstrations had largely disappeared from the teaching programme and were replaced by the case conference. The hospital case conference, as distinct from a ward conference, was a teaching event and was attended by staff from several disciplines. The hospital case conference at the Maudsley Hospital was a very formal affair. The chair was taken by the most senior member of the professorial unit available and this was almost always Professor Sir Aubrey Lewis. He would arrive on the dot of the appointed hour and when he sat down the conference began. A case was presented by a trainee according to a specific formula, in great detail and often supported by reports from a number of informants. The patient was interviewed by the chairman mainly to elicit features of the mental state. There followed a review of the psychopathology revealed in the interview, a consideration of alternative diagnoses and proposals for management. The hapless trainee had to attempt to combine these factors in a formulation of the case. I later recognised that we had been led to follow in the footsteps of Adolf Meyer.⁴ A feature of these conferences was that senior members of staff, of whom many attended, would be invited to offer an opinion on the case. Their contributions were highly predictable from their well-known orientations, practices and prejudices. At times these rituals were the subject of parody in the hospital magazine.

In addition to the major conference at the Maudsley Hospital there were several smaller events. Eliot Slater was known for his scientific rigour and defence of the English language as editor of the

¹ Stafford-Clark, D. *Psychiatry Today* (Harmondsworth: Penguin Books, 1952)

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

³ Tooth GC and Brooke EM. Trends in mental hospital

populations and their effect on future planning. *Lancet* (1961) i. 710-713.

⁴ Mindham, RHS. My father knew Adolf Meyer. The currency of Meyer's ideas in British psychiatry. *BJPsych* (1984) 144: 323-325.

British Journal of Psychiatry. Furthermore, he was a co-author of the standard psychiatric text-book Mayer-Gross, Slater and Roth which had a strong biological leaning.⁵ He conducted a much smaller, weekly, case conference which had a different character from that conducted by Sir Aubrey Lewis but was no less bracing for trainees. Loose talk was not permitted.

Case conferences at Bethlem Royal Hospital were more intimate affairs, where a senior member of staff discussed a patient with a number of trainees. These were very useful learning experiences especially in observing different approaches to the interviewing of patients. There was also an experiential group for trainees at Bethlem, conducted by Dr Bob Hobson, a psychotherapist of Jungian background. Our guide memorably demonstrated the use of the tobacco pipe and the stammer in concentrating attention on a particular issue. This was an enjoyable social experience whose purpose and value only became clear to us afterwards; in some cases, years afterwards.

As a consultant....

Moving north to Mapperley Hospital, Nottingham, in 1972, where the staff of the new university department of psychiatry were seeking to introduce case conferences which would be suitable for undergraduate students as well as for trainees in psychiatry, the formal case conference, on the lines of those at the Maudsley Hospital, was the model. In the early days of undergraduate teaching the conferences suffered from the lack of a culture in which consultants attended the conferences on a regular basis. Their contributions were missed. Then, as now, it was important for trainees to realise that opinions on many matters differ among experienced members of staff but that these differences can be constructively discussed.

In Leeds, in 1977, the conferences were of a formal type but there was some uncertainty as to their conduct and purpose. As the years passed, at High Royds Hospital, which served the western part of Leeds and where I worked, the conferences became part of the hospital's regular programme and were attended by most of the medical staff, medical undergraduates and a few members of other

disciplines. Unlike the earlier examples, the chairmanship of the conference rotated among the senior staff, with occasional visiting chairmen, and junior staff took it in turn to present cases. This arrangement had the effect of drawing more staff into the programme. As time passed, senior registrars occasionally took the chair as well as members of some other disciplines, notably clinical psychologists. Perhaps the most striking development was when consultants began to present cases! This led to the discussion of a different type of patient; usually someone known to the consultant for a number of years and presenting difficult and persisting problems in management; the kind of cases not even senior registrars often encountered.

Overall...

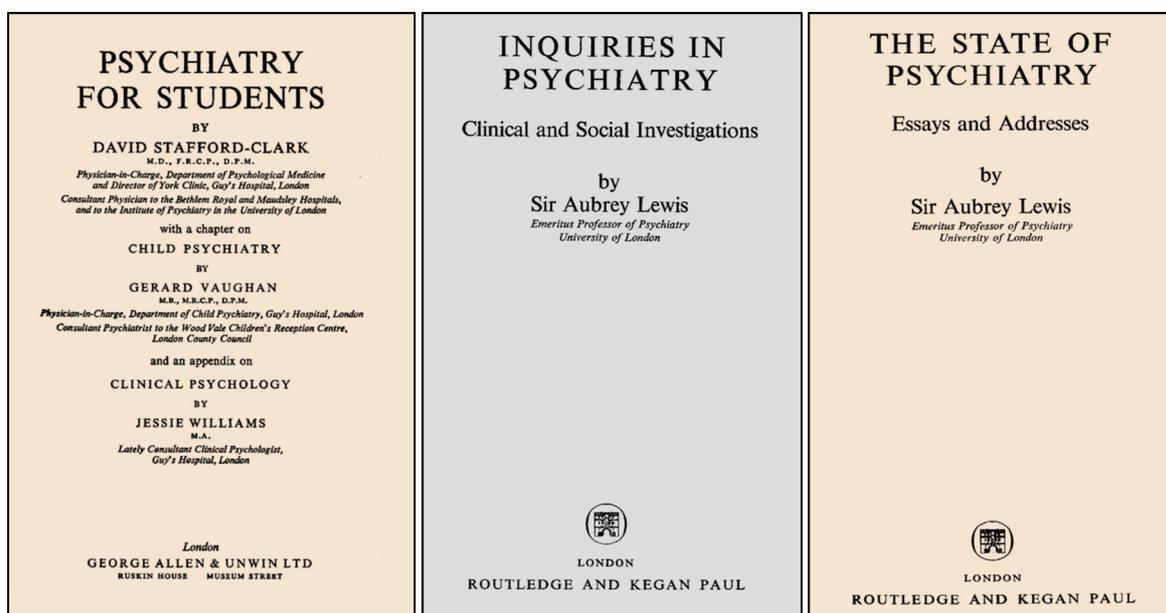
I believe that hospital case conferences were of educational value and of a character that is difficult to provide in any other way. I do however recognise that some members of staff felt it inappropriate to interview patients before of a group of people who were not immediately concerned in their care. Closed circuit television went some way to meeting this issue. On the positive aspects of the case conference, some of those staff attending revealed striking skills in interviewing, some were good at characterising features in the mental state examination and others demonstrated the elusive skill of formulation. The educational value of attending case conferences was recognised by the College in its requirements for recognition of continuing professional development for senior members of staff. This need was also seen in staff of professorial status! It was only when I was close to retirement in 2000 that I recognised that case conferences attended by colleagues are an important aspect of audit; where a firm or a member of staff was not functioning well this became quite clear to his or her colleagues and provided an opportunity for it to be rectified.

It would be wrong of me to portray the hospital case conference as a grim ritual, needed for training and professional progression. In my experience, it was also a social event in which colleagues enjoyed each other's company whilst they seized the opportunity

⁵ Mayer-Gross W, Slater ETO, Roth M, *Clinical Psychiatry* (London: Baillière, Tindall and Cassell, 1955)

to discuss matters of central professional relevance. We revealed ourselves to our colleagues in many ways! I enjoyed taking part in these teaching events,

in differing rôles as the years passed by, and in observing events unfold.



“We don’t know what we are looking for?”

Reflections on New Horizons in Psychiatry by Peter Hays

(second edition, Penguin Books, Harmondsworth, Middlesex, 1971)

George Ikkos

It is a cardinal principle in psychiatry that causation is always multiple, including physical, psychological and constitutional (meaning, approximately, inborn) part-causes, so that treatment, ideally at eradicating the cause, is never unitary. (p.15)

In introducing his book, Peter Hays acknowledged the advice of experienced specialists in academic and forensic psychiatry and history of psychiatry as well as neurosurgery and psychology. The result is a broad, yet succinct, presentation of the scope and limitations of psychiatry at the time of publication including the addictions, intellectual disability, children, old age and the law. The 1971 second edition of *New Horizons* was preceded by a 1967 reprint of the original 1964 volume, so it must have enjoyed considerable success. In 2021, the RCPsych will mark 180 years since the establishment of the Association of Medical Officers of Asylums and Hospitals for the Insane and the 50th anniversary the College, so it seems timely to use Hays’ book to reflect on changes in psychiatry during the last half century.

The author

Peter Hays was born in 1927. He served as Staff Sergeant with the Royal Engineers between 1945 and 1948. He qualified at St George’s Hospital Medical School where he became senior lecturer in Psychiatry before being appointed Professor of

Psychiatry, University of Alberta, Canada. The book's brief introductory bio informs us that he also wrote novels. His style is urbane and his account lively. It is laced with sharp wit and he is not shy of serving criticism, including against some of his contemporary judges who he found to fail "through the ignorance of ordinary things that seems such a surprising and common failing among them" (p.213), and some medicolegal experts whom he considered to belong to the "lunatic fringe" (p.301). Although it may or may not have been judged so back then, some of his commentary is patronising, even stigmatising. e.g.

only one method of treatment, psychoanalysis, claims to be able to refashion the personality, and this treatment, even if experimental evidence supported the claims of its enthusiasts, is inapplicable to the dull, the inadequate, the ill-educated, the uncooperative and, in countries where medical attention must be paid for, the poor – adjectives that describe the great majority of the addicts treated (p.201)

Also, this about psychiatrists:

But it is, after all, easy to succeed in psychiatry, and some who do well would have done less well in a line where results could be more precisely measured; some strange people go in for it; and the patients whom psychiatrists see are seldom in danger of death in a direct way that surgical patients may be. Nevertheless, there are important reasons why even modest psychiatrists wish that the specialty was treated less like a totally destitute relation (about 14% of consultant psychiatrists received monetary merit awards in 1951, compared with 67% of neurologists). (p.169)

New Horizons therefore is valuable both for its positive qualities and for the opportunity to reflect on cultural change and its favourable impact on psychiatry, including the formation and attitudes of psychiatrists.

As far Hays' social attitudes go, he was: wise to the wide range of human sexuality and the lack of necessity and impotence of psychiatry as its "treatment"; favourably disposed towards liberalising laws on homosexuality which were enacted between the first and second edition; and open minded about the use of chemical castration subject to genuine patient consent (i.e. not in

forensic institutions). He advocated discretion when sentencing those convicted in relation to substance misuse, a common view of the middle classes at the time who wanted to protect their offspring from judicial fury. He was very hostile towards abortion in general and surgical castration in forensic settings. It is not clear what his politics may have been, perhaps somewhat muddled like most of us, but this quote might give a flavour of his style, even if no certainty about his political reasoning:

... the occidental world is becoming faceless and cold: because of their greater efficiency, the giant corporations are winning the day; where a country is not big enough to support a number of these, it enters into a union with another. Policy and expedience, never apart, become one. No one knows to whom to complain, who is responsible, why he bothers to vote. (p. 214)

Hmm...

The times

By Hays' account, social psychiatry was all the rage at the time he was writing, and he gives this, and psychodynamic psychotherapy, a fair airing. Together with the promise of neurobiology, it was the moral imperative of de-institutionalisation and the mystique of psychodynamic psychotherapy that were key to drawing me into psychiatry in the late 1970s / early 1980s.

It is interesting to note the emphasis he places on leadership in asylum life and deinstitutionalisation; and the conformity of his views with what we would consider today middle of the road formulations and treatment in psychodynamic psychotherapy (1). His observations on leadership were facilitated by the continued life of the mental asylums. He had opportunities to observe directly the differential impact of individual medical superintendents on various comparable institutions. His observations on psychotherapy also reflect that although behaviour therapy (BT) had emerged as effective treatment for simple phobias, enuresis and obsessive-compulsive disorder (OCD), cognitive behaviour therapy (CBT) had not yet been demonstrated as a valid treatment for common mental disorders. With respect to BT for enuresis he relates the following interesting information too:

The rational treatment therefore consists of the provision of a series of learning experiences, encouraging the linkage, along classical lines, of

high pressure in the bladder with both closure of the sphincters and waking up.

In parts of West Africa this is accomplished by placing a certain type of snail on the inside of the thigh, this snail staying immobile when dry but starting to move at once when wetted; the moving snail wakes the child and it is credibly reported that, as a conditioning stimulus, the sensation is hard to beat. (p.179)

Perhaps BT seemed more innovative at the time of its “discovery” because of its contrast to psychoanalysis, rather than compared to what had gone on before either of these widely divergent modern psychiatric treatments.

Unusually, Hays makes several references to psychiatry in Russia and in the wider USSR (Union of Soviet Socialist Republics), which he had visited. Of course, one reason for such reference is the seminal role of St Petersburg’s Ivan Pavlov and his description of classical conditioning. Hays described clearly the circumstances and details of Pavlov’s discoveries and their significance, whilst also expressing scepticism about what he saw as excessive emphasis by Soviet colleagues on reflex theory in trying to understand psychopathology in general. Other references to the USSR include: the hostile attitude to Freudian psychology; that the life span had approximately doubled since the 1917 communist revolution; and that psychosurgery was outlawed in 1950. The Soviet Union also employed what he called “barber surgeons” with circumscribed areas of practice. They sound quite like halfway between Mao’s Chinese “barefoot doctors” and today’s physician assistants/associates.

Hays also wrote that “In Russia psychiatrists, in common with their other medical colleagues, have provided a welcome buffer between the state and the people” (p. 64). The reality was that whilst some psychiatrists did indeed attempt to provide a buffer to the systematic abuse of psychiatry to silence political dissidents during the 1950s-70s, they were abused/tortured with “treatment” themselves. Other psychiatrists participated actively in the abuse. One psychiatrist who did resist was Anatoly Koryagin (2). I remember when he was invited as a key-note speaker to a RCPsych annual conference. It may have been in 1988, when he was elected honorary fellow, the highest honour the College bestows. He had survived insulin “treatment” and ECT, i.e.

torture, and spoke with simplicity, clarity and striking dignity about his ordeal, the overcoming of which exemplified the resilience of the human spirit at its best. Hearing him speak has been one of a handful of top highlights of my professional life. I thought Dr Jim Birley, the president of the College who introduced him to us, was an exceptionally impressive man too, especially in terms of embodying moral integrity and authority.

The book

After an introductory chapter on psychopathology and psychodynamics, with some discussion of suicide risk, the author discusses the causation of schizophrenia (Ch 1). He expands on psychoanalytic, schizophrenogenic mother, double-bind, social, epidemiological, genetic, hallucinogenic drug, other biochemical and even immune theories of causation. He devotes considerable space to Gregory Bateson and Theodore Lidz’ double-bind theory of communication in schizophrenia and its clinical application at the Yale University affiliated psychiatric services; also, Friedhoff and Van Winkle’s work on the urine “pink spot” in schizophrenia. Both ultimately failed at explanation and treatment. What impresses is his astuteness about the shortcomings of each of the many theories and his equanimity about the resulting uncertainty. He emphasises the multifactorial nature of mental disorder; that schizophrenia is a term for a syndrome and not a discreet disease; that ignorance breeds theories driven by the fashion of the day; and that where many theories prevail none is likely to be true. He also argues against Kraepelin, suggesting that the very clarity of his clinical descriptions confirms that he had subsumed in his series cases of epilepsy, general paralysis of the insane and other organic conditions. He suggests this weakens the persuasiveness of his nosographic formulations. In Hays’ opinion, “we do not know what it is that we are looking for the cause of.” (p.68)

In chapter two, “New drugs in psychiatry”, like many before and since, he noted the enormous impact of the discovery of phenothiazines in the treatment of psychosis, whilst underscoring the crucial need for rehabilitation in order to achieve maximum efficacy; also, the favourable impact of rehabilitation in chronic schizophrenia even in the absence of psychopharmacological treatment. He made the crucial point that on wards where chlorpromazine was introduced, the behaviour of both those who

had and had not been prescribed it, improved as a result of the general positive change in atmosphere when the behaviour of the former group improved first. Other than low doses of haloperidol in delirium, very few people now must be using any of the antipsychotics available in 1971. Early second-generation antipsychotic medication, even sulpiride and amisulpiride, were still sometime in the future. Although antipsychotics have serious limitations, they have made a difference and indeed are lifesaving (3). Reading Hays might be a good way for people who berate antipsychotics for their side effects to have a better clinical understanding of their beneficial as well as their undoubted adverse side effects.

When it comes to medication for affective disorders, what is most striking is how limited the range of medications available at the time was compared to now: imipramine, amitriptyline, isocarboxazid, tranlycypromine and lithium; that was it. It is difficult for colleagues who did not practise before the discovery and marketing by Eli Lilly of fluoxetine (Prozac), to understand the profound positive impact this has had including, but not limited to, reduced fatality following overdose. Today there are entirely legitimate concerns that selective serotonin reuptake inhibitors (SSRIs) are being overprescribed. Of course, any current overuse is due to pharma marketing, inappropriate healthcare system factors and poor doctoring rather than the inherent beneficial properties of SSRIs. Regardless of such factors, extensive overuse would never have happened with such antidepressant and mood regulating medication as was available in 1971 because the efficacy to side effects ratio and mortality in overdose were unacceptable to both patients and doctors. For example, because of its side effect profile and lethality in overdose, the risk of over-prescription of lithium is very low indeed! Interestingly, in contrast to early antipsychotics, early antidepressants and mood stabilisers continue to be used, even mono-amine oxidase inhibitors, exceptionally.

In chapter 3, "The current role of physical treatments", and in relation to ECT the author described the now discredited original rationale for its use, its side effects and the antipathy towards it by some psychiatrists and many patients. He also made the following interesting comment:

When the mood-elevating drugs imipramine (Tofranil) and iproniazid came on the market in the late nineteen-fifties there was a tendency to use them in place of electric treatment; but the consequent delay in improvement, increase in suicides and attempted suicides, and failure in many patients to end the depressive illness led to a reconsideration of the available drugs, and a return to electric treatment for many of the "endogenously" depressed people admitted into hospital. (p.109)

I do not know whether this statement is based simply on his observations or hearsay. Perhaps there were empirical studies that he does not reference. These days, I rarely recommend courses of ECT, perhaps only 2-3 cases every 5 years or so. These are for patients who have invariably seen other mental health colleagues, including psychologists or psychotherapists for considerable treatment, but have failed to respond to combination of this with medication. Indeed, sometimes it is the psychologist who makes the referral. Other times it is the GP or relatives because the patient has failed to respond to medication advised by one or more other psychiatrists. With such conservative practice the results are quickly transformational for the patient and very satisfying for me as clinician. I am concerned that one or two of my patients remain chronically symptomatic and disabled because, having the mental capacity, they have refused ECT despite its great therapeutic promise for them in my opinion. None of these patients are psychotic; rather, they are at the severe end of moderate, or the moderate range of the severe end of the spectrum. I am concerned that many younger colleagues now do not have enough exposure to ECT to have a feel of the right candidate for successful treatment with this method. For social reasons rather than lack of efficacy, ECT therefore may not be sustainable long term (4).

The section on insulin coma therapy is alarming. It was adopted with insufficient scientific scrutiny not long after the discovery of insulin. It had a relatively high mortality rate; was carried out over prolonged periods with an average of 40-60 comas; and required a lot of doctor and nurse time. Evidence of lack of efficacy emerged before WWII and definite confirmation of such lack was provided in 1957 by Ackner, Harris and Oldham in a controlled trial (5). At the time of publication of Hays' book 15 years

later, it continued being used though less frequently. At a recent Royal College of Psychiatrists' Witness Seminar on psychiatric hospitals in the 1960s (6) we heard from a senior psychiatrist, who was a junior at the time, that one of those that had persisted in using such treatment was Dr William Sargant in South London. This must be one of those psychiatrists Hays refers to as "physicians whose views command respect" (p.114). The truth is that he divided opinion. Sargant seems to me to have been a confidence trickster. I recall during my training in Group Analysis, the psychiatrist and psychotherapist Dr Lionel Kreeger talking about his encounter with Sargant. Kreeger and colleagues had asked Sargant for a second opinion. Sargant advised ECT. When Sargant was told that it had been tried and failed, he responded "but you did not believe in it". I do not recall whether the course he recommended failed or succeeded; I suspect the latter, as Kreeger's point was the importance of positive expectations.

The 1960s and 70s were the years of "tripping" and chapter 9, "Addiction to drugs", delves into opioid dependence (and "cold turkey"), the hallucinogen fad (and LSD [Lysergic acid diethylamide] "echo" phenomena), the iatrogenic amphetamine epidemic in the 1950s (and "purple hearts" i.e. amphetamine-barbiturate combination) etc. As in all else psychobiological, Hays' knowledge is commendable. It must be said, however, that his confidence in barbiturates when stating that the evidence "testifies to the safety of this sedative" (p. 216) has not been supported by posterity. His relaxed attitude towards cannabis has been relatively better sustained but not entirely vindicated because of long term severe psychiatric disability sometimes emerging as a result of heavy use. He also discusses obesity as an addiction related problem. The prejudices of his day, as well as lack of understanding of the metabolic syndrome back then, are betrayed by his statement that

it may be useful to a man who is sixty pounds overweight if he loses half that because he can do his shoe laces again and run for the bus, but the woman who has slimmed but has not achieved ideal weight makes a relatively small gain. (p.215)

There are chapters on alcoholism, children, and old age. The chapter on children is mostly about intellectual disability and the impressive progress

made in understanding causation during the previous decades. I thought that the section on "functional disorders in the young" missed a trick as it does not refer to John Bowlby's seminal and well-established at the time work on attachment. Child protection / safeguarding children, probably one of the most significant developments in relation to the whole of psychiatry to have taken off in the late 70s / early 80s, quite understandably is not discussed at all. Neither had the results of the equally significant Isle of White studies by Rutter and colleagues been published.

Epidemiology has probably shown itself to be the most robust of basic medical sciences in psychiatry. The chapter on old age benefits from the emphasis on this. Such emphasis was partly dictated by the fact that this was emerging as an increasingly important proportion of the population with relatively little other empirical research, at least compared to schizophrenia.

Chapters on "personality deviations", "the impact of psychiatry on the law" and "the law relating to psychiatric patients" rely heavily on clinical experience and personal opinion.

Back to the future

Given that this is a book about *New Horizons in Psychiatry*, what about Hays' predictions for the future? Chapter 6, "The future of psychiatric services" is about prediction. Here are some statements from this, and from one or two other chapters, with my comments as bullet points:

i. On treatment trials:

"The easiest results to obtain in any therapeutic trial are misleadingly optimistic ones." (p.68)

- In his chapter on drugs in psychiatry, Hays devoted considerable space to explaining the importance and mechanics of treatment trials. Sadly, this risk has continued to materialise, augmented by bad pharma behaviour, but not only.

ii. On ECT:

"In the future it is likely that the advent of new antidepressive drugs will make electric treatment as dispensable as some of its critics would say it is already." (p.190)

- This prospect has not quite materialised but hangs in the balance.

iii. On leucotomy:

“In the immediate future there may be a small swing of the pendulum in favour of leucotomy, because the largely beneficial results of discriminating, modified procedures are becoming well known. The old standard operation, which is still occasionally used, will probably entirely be abandoned”. (p.134)

- Modified psychosurgery has survived. However, though I have no principled opposition to it, I have never referred anyone for it during my more than 35 years of psychiatric practice. This is mostly because I have not suggested it but perhaps also because one or two patients that I may have raised it with as a possibility did not wish to pursue it.

iv. On deinstitutionalisation and realities of community care:

“The impact of the vigorous discharge policy on families and public has not yet been assessed. Word of mouth reports and a few studies have it that often discharge represents a hardship for the whole group involved: The patient may not only deteriorate but be aware of this and of his failure; the family are distressed by his oddities, behaviour disorders and the social consequences of having the chronic patient present at entertainments and in about a quarter of such families the distress is described as considerable....But if all or most that the new discharge policies accomplish is the redistribution of the load of care and responsibility from the hospital to the family and local community, nothing above a book-keeping gain has been made, and the patience of the non-psychotic citizens will soon be exhausted.” (p.165-6)

- Sadly, I frequently noticed this as a community psychiatrist in the 1980s and 90s. I was rather distressed by what patients and their families had to go through because of “revolving door” policies.

v. On staff recruitment:

“There is no sign that a great training programme is underway, or even planned: In fact, the staff situation looks like getting worse. Doctors may be going in for psychiatry to a

lesser rather than a greater extent (this is certainly so in the United States).” (p.167)

- This has proven to be a serious and persistent problem in psychiatry. To be fair, the RCPsych has devoted much thinking, time and effort to recruitment and there are signs that the situation may be improving somewhat. However, there remain many vacancies, and the very high rate of attrition of experienced psychiatrists from the NHS is contributing to this.

vi. On DGH (district general hospital) psychiatric units:

“To the established medical and nursing interests of a general hospital the psychiatric patients, looking robustly healthy, spending much of their time loafing about, taking their own discharges if they feel like it and being readmitted if they change their minds, often complaining or indifferent and occasionally killing themselves, are likely to compare unfavourably with the brave and disciplined ranks of patients offering themselves for surgery, and may therefore be unwelcome guests. Some of the staff’s emotional problems, of very high voltage and great duration, noted in psychiatric hospitals when some of the wards were free and easy (along the ward–community lines described earlier) where some remained hierarchical, are likely to be repeated in general hospitals harbouring new psychiatric units of any size. Yet, if psychiatric treatment is to be done properly, the psychiatric wards must be different and, as it would seem, privileged: in the planning of these hospitals, if they come about, it is to be hoped that the psychiatrists, despite their low prestige, will be able to insist on their own specifications.” (p.170-2).

- Hays’ discriminatory language aside, his point mostly stands. My experience as a DGH community psychiatrist with special interest in liaison psychiatry was rather disappointing. We attracted hostility particularly from A and E staff who were prejudiced against both our patients and us. Some of my colleagues stoked such prejudice. Recently, I had occasion to visit a patient in a unit located a stone’s throw from the local general hospital. I was rather horrified by its poor design, dark surroundings, harsh

nursing manner and horrid stench; all in contrast to the general hospital across the road. The shortcomings of DGH psychiatric units have been amongst the greatest surprises of my career as I had set much faith in them at the beginning. Taken in the round, I am not persuaded that they have been an improvement on mental asylums, except for their closer proximity to their communities usually.

vii. On psychiatric treatment discovery:

“Practically all of them [psychiatric treatments] were chance discoveries, and no promising lines of proven utility in psychiatry are being followed up that may be expected to revolutionise morbidity.” (p.172)

- This was a good call. Such treatment discoveries as we have made reflect significantly the benefits of serendipity and opportunism rather than an original, coherent and consistent research programme. Tomas Insel, former Director of the US Institute of Mental Health said in 2017 (7): “I spent 13 years at NIMH really pushing on the neuroscience and genetics of mental disorders, and when I look back on that I realize that while I think I succeeded at getting lots of really cool papers published by cool scientists at fairly large costs—I think \$20 billion—I don’t think we moved the needle in reducing suicide, reducing hospitalizations, improving recovery for the tens of millions of people who have mental illness.”

viii. On expert witness training:

“There is probably something to be said for excluding the lunatic fringe of psychiatrists from court by requiring a minimum of training experience before expert testimony may be offered, but not all the peculiar opinions heard in court come from the most poorly trained; something seems to come over psychiatrists when they get into the witness box.”

- Requirements for training of expert witnesses have been introduced. Otherwise I make no comment!

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