

A Thesis Submitted for the Degree of PhD at the University of Warwick

Permanent WRAP URL:

<http://wrap.warwick.ac.uk/109478>

Copyright and reuse:

This thesis is made available online and is protected by original copyright.

Please scroll down to view the document itself.

Please refer to the repository record for this item for information to help you to cite it.

Our policy information is available from the repository home page.

For more information, please contact the WRAP Team at: wrap@warwick.ac.uk

Women and Depression in Interwar Britain:

Case Notes, Narratives and Experiences

By

Hye Jean Hwang

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of
Philosophy in History

University of Warwick

History Department

Centre for the History of Medicine

June 2018

Table of Contents

Declaration	vii
Acknowledgement	viii
Abstract	ix
Abbreviations	x
List of Tables	xi
Introduction	1
1. Research Questions	2
2. Historiography	11
Women and Madness	11
Medical History from Below	26
3. Case Notes as Historical Source	32
4. Mental Institutions: Holloway Sanatorium and the Maudsley Hospital	42
Holloway Sanatorium	43
The Maudsley Hospital	49
5. Structure of Thesis	61
Chapter 1. British Psychiatry in the Early Twentieth Century	66
1. Two Major Influences: Emil Kraepelin and Sigmund Freud in British	

Psychiatry	69
Freudian psychiatry	69
Kraepelinian Psychiatry	78
2. Psychiatric Practice in the Early Twentieth Century	83
Classification and Diagnosis.....	83
Treatment	89
3. Policy and Psychiatry.....	95
The External Environment of Psychiatry	96
Royal Commission on Lunacy and Mental Disorder.....	99
The Mental Treatment Act.....	103
4. Towards Psychiatrisation: Expansion of Psychiatric Concern and Diversification of Mental Health Services	111
5. Conclusion	116
Chapter 2. Depression in Early-Twentieth-Century Britain.....	118
1. Depression and Kraepelinian Psychiatry	120
2. The Concept of Depression.....	125
3. Terminology	131
4. Classification.....	136
The Great British Debate	137

5. Related Concepts	144
Involutional Melancholia.....	145
6. Conclusion	149
Chapter 3. Depression in Adolescence.....	151
1. Introduction.....	151
Sources, Sampling and Analysis.....	154
2. Demographic Analysis	156
3. Symptoms of Depression	162
4. Lay Causal Attributions	173
5. Sexuality of Young Women	182
7. Treatment: Cardiazol Shock Therapy	189
6. Conclusion	195
Chapter 4. Depression in Adulthood.....	198
1. Introduction.....	198
Sources and Sampling.....	199
2. Demographic Analysis	200
3. Lived Experience of Depression in Adulthood: Symptoms.....	210
Somatic Symptoms	211

Mood Disorders	212
Hallucination and Delusion	213
Suicidal Tendency and Attempt	216
4. Lay Causal Attribution of Depression in Adulthood.....	221
Depression Following Childbirth	224
Financial Hardships and Economic Concerns	232
Matrimonial Difficulties	239
Sexuality in Adulthood	243
Other Factors, Including Drinking Problems.....	256
5. Conclusion	261
Chapter 5. Depression in Middle and Old Age	266
1. Introduction.....	266
Sources and Sampling.....	277
2. Demographic Analysis	266
3. Lived Experience of Depression in Advanced Age: Symptoms	278
Somatic Symptoms	278
Mood Disorders	281
Hallucination and Delusion	284

Self-Reproach	293
Suicidal Tendency and Attempt	296
4. Lay Causal Attribution of Depression in Middle and Old Age.....	311
Bereavement	312
Family Affairs	314
Financial Hardships	314
Sexuality in Advanced Age.....	319
Alcoholism.....	320
Involutional Melancholia.....	323
5. Conclusion	327
Conclusion	330
Lived Experience of Depression: Gender, Class and Age	330
Women’s Life in Interwar Britain.....	337
Beyond ‘Women and Madness’: Men, Women and Madness	341
Epilogue: Depression, the Twentieth-Century Female Malady	348
Appendix I.....	352
Appendix II	357
Appendix III.....	360

Bibliography.....	364
-------------------	-----

Declaration

I hereby declare that this thesis has not been submitted, either in the same or different form, to this or any other University for a degree.

Signature:

Acknowledgement

First and foremost I would like to thank my supervisor, Hilary Marland. Without her guidance, encouragement and patience, neither could I finish this course, nor this research be completed. I cannot find a right word to express my gratitude and respect to her. I wish she found the long journey we led together enjoyable and satisfying as I did.

I also thank the staff of the Centre for the History of Medicine, all intelligent and passionate. In particular, I appreciate Roberta Bivins and Mathew Thomson, who helped me find a way when I was lost. My thanks are also due to fellow-students of the CHM: Kate Mahoney, Rebecca Noble and Jinping Ma.

I would like thank Colin Gale, the archivist of Bethlem Royal Hospital Archives and Museum, and Dele Olajide, the Caldicott Guardian of Southern London and Maudsley NHS Foundation Trust. I thank all the staff of Surrey History Centre, who are willing to help all the time. Very special thanks must go to Helen Clifford, for her warmest support as well as practical advice.

I appreciate my Warwick friends, without whom I could not have made it: Minjoo Leem, Jungju Shin, Sihwa Mun and Hanzhi Ruan. I also thank my old friends, now spreading all over the world: Eunjae Park and Jasub Koo in York, Hye Yun Kang in Chicago, Jinam Lee in Hong Kong, Eunhee Kim and Hannip Jang, the last two waiting for me in Seoul. Very special mention should be made of my best friend, Inhwa Jung, who has provided me with a shelter, both practically and emotionally, for two decades.

I am grateful for the support of Michelle Brankin and her family, who have allowed me a real home and family in England. Special thanks must go to Michael Tsang, the best flatmate ever. I already miss them.

Finally, I am deeply indebted to my parents, Jae-Yoon Hwang and Sung-Sook Min, and my bébé sister, Haesun Hwang, for their endless love and unwavering support. If I achieve anything, it should belong to them, as much as it belongs to myself. Here I would like to express my deepest gratitude and love. I dedicate this thesis to my Mum and Dad.

Abstract

This research is an attempt to reconstruct the lived experiences of female patients who were deemed to suffer from depression in interwar Britain and explore the ways in which these sufferers understood and attributed their mental illness. In order to achieve these goals, this research analyses women's own narratives embedded in medical records, notably case notes of the Maudsley Hospital and Holloway Sanatorium, and applies new concepts of life cycle and life event. What female patients experienced in the course of their mental illness, including the types and details of depressive symptoms, were largely decided by their social class, age and gender. They usually related the onset of depression to what they underwent in their daily lives, contrary to professional attributions which stressed heredity as a decisive aetiological factor. The case histories demonstrate that the patients were familiar with medical knowledge, not necessarily the latest ideas though, and that the lay understanding of health and ill-health affected considerably their experiences of mental depression. Moreover, the medical records inform us about women's life in general and women's sexuality: living as a woman in the interwar years meant that one had to cope with more traditional and conventional conditions rather than modern ones. This research also improves our understanding of British psychiatry in interwar years, as well as the status of depression as a medical concept. Contrary to the general claim that the Great War was the starting point of modern psychiatry, interwar years should be interpreted as a period of transition, when the influence of the nineteenth-century medical tradition was still strong. The modernisation of depression, which was to be completed only after the Second World War, owed much to the Victorian psychiatry, although it was authorised as a formal diagnosis and defeated its powerful predecessor, melancholia, during the interwar period.

Abbreviations

BRHAM	Bethlem Royal Hospital Archives and Museum
SHC	Surrey History Centre
LWIHM	London Welcome Institute of History of Medicine

List of Tables

[Table 1] The Number of Voluntary Patients in Brookwood Mental Hospital in the 1930s.....	106
[Table 2] The Number of Patients at Holloway Sanatorium.....	108
[Table 3] Word Frequency in the Journal of Mental Science Sampled Every Five Years between 1900 and 1940	132
[Table 4] Types of Causal Attributions	174
[Table 5] Types of Causal Attribution of Young Female Patients at the Maudsley Hospital	176
[Table 6] Number of Depression Patient among Female Admission at Holloway Sanatorium.	206
[Table 7] Number of Articles Applying ‘Puerperal Insanity’ as a Diagnostic Term in the Lancet and in the Journal of Mental Science	230

Introduction

I wish I could write out my sensations at this moment. They are so peculiar & so unpleasant. Partly Time of Life? I wonder. A physical feeling as if I were drumming slightly in the veins: very cold: impotent: & terrified. As if I were exposed on a high ledge in full light. Very lonely. [...] Very useless. No atmosphere round me. No words. [...] I am powerless to ward it off: I have no protection. And this anxiety & nothingness surround me with a vacuum. [...] I want to burst into tears, but have nothing to cry for. Then a great restlessness seizes me.¹

I had the flu again – but a slight attack, and I feel none the worse and in my view the whole thing is merely a mix up of influenza with my own remarkable nervous system, which, as everybody tells me, can't be beaten for extreme eccentricity, but works all right in the long run. I apologise for this egotism.²

Virginia Woolf, who was diagnosed with neurasthenia by George Savage as a young woman but nowadays is believed to have suffered from bipolar (manic-depressive) disorder,³

¹ Virginia Woolf, *The Diary of Virginia Woolf* Vol. 5 (London: Hogarth, 1985), p. 63.

² Virginia Woolf, *The Question of Things Happening: The Letters of Virginia Woolf* Vol. 2 (London: Hogarth, 1976), p. 560.

³ Thomas Caramagno, *The Flight of the Mind: Virginia Woolf's Art and Manic-Depressive Illness* (Berkeley: University of California Press, 1992), pp. 11; Suzanne Poirier, 'The Weir Mitchell Rest Cure: Doctor and Patients', *Women's Studies: An Interdisciplinary Journal*, 10:1 (1983), p. 33.

verbalised her experience of mental illness and elucidated her understanding of its cause, as shown in the above quotes. Her vast collection of literary works covering diverse genres provided Woolf with opportunities to articulate what she had experienced and discovered in the course of her insanity. In this sense, she was fortunate, compared with the overwhelming majority of those with troubled mind, yet unable to express themselves. Woolf had both the capability and the language to express herself and explain her illness, which is why she is regarded as one of a 'distinct minority' (usually in the company of Charlotte Perkins Gilman and Sylvia Plath).⁴ At this point, a question emerges: what about the large number of Woolf's contemporaries especially of the same sex, who had identical, or at least similar, problems to the writer's but had no way to express themselves and articulate their troubles? From this query, this research and thesis begins.

1. Research Questions

This research is an attempt to reconstruct the lived experiences of female patients who were deemed to suffer from depression in interwar Britain and to explore the ways in which these sufferers understood and attributed their mental illness. In order to achieve the goal, it exploits women's own narratives embedded in medical records, notably case notes, which can be the best channel to listen to them in a situation where 'first-hand accounts of madness'

⁴ Lesley A. Hall, 'Essay Review: Does Madness Have a Gender?', *History of Psychiatry*, 20:4 (2009), p. 498.

are scarce, unattainable and cumbersome.⁵ As noted by many feminist critics studying contemporary phenomena, women's accounts of mental illness not only provide a basis for exploring their experiences and understandings of the disorder, but also illustrate how both are shaped by the sociocultural context of their everyday lives.⁶ In this sense, this study can be read as an experiment to apply the feminist approach to analysing case histories of those suffering from depression in the interwar decades. By doing so, it is expected that we can discover patients' experiences and understandings of mental illness, their explanations of how their daily lives affected (or caused) their condition, and how this relates to the broader historical and sociocultural context.

The principal question is followed by a series of related questions. First of all, what kind of symptoms, both physical and psychological, did these patients exhibit? This issue should be raised, I would argue, because the way in which illness is manifested and experienced is largely dictated by culture rather than biology.⁷ Although this research is not in complete agreement with Edward Shorter, who claims that the unconscious selects the 'legitimate symptoms' allowed by the surrounding culture,⁸ it acknowledges the premise that, to quote Joan Jacobs Brumberg, 'even when an illness is organic, being sick is a social

⁵ Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Basingstoke: Palgrave Macmillan, 2004), pp. 95-96.

⁶ Janet M. Stoppard, *Understanding Depression: Feminist Social Constructionist Approaches* (London: Routledge, 2000), p. 24.

⁷ To understand how culture influences psychical symptoms, especially psychosomatic ones, see Laurence J. Kirmayer, 'Culture, Affect and Somatization: Part 1', *Transcultural Psychiatric Research Review*, 21:3 (1984), pp. 159-188; Kirmayer, 'Culture, Affect and Somatization: Part 2', *Transcultural Psychiatric Research Review*, 21:4 (1984) pp. 237-262; Edward Shorter, *From the Mind into the Body: The Cultural Origins of Psychosomatic Symptoms* (New York: Free Press, 1994); Shorter, *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era* (New York: Simon and Schuster, 1993).

⁸ Shorter, *From the Mind into the Body*, pp. 204-207.

act'.⁹ Secondly, this research will investigate the way in which sufferers ascribed their mental disorder: which aetiological factors were referred to by those patients out of heredity, reproduction, diverse adversities in life, and so on? What did the lay attributions mean? And related to this, how much did patients and doctors agree or disagree with each other in terms of their descriptions of symptoms, and, especially, causal attributions. By comparing the languages and explanations of the two parties, we can obtain insight into the relationship between lay and professional perspectives on mental disorder, and trace the flow (or circulation) of medical knowledge. Lastly, this research takes note of what female patients' narratives in case notes tell us about their individual lives and women's life, as a collective experience, and the contemporary society and culture, such as sexuality, domestic life, and female education and occupation.

In seeking answers to those questions, this research considers gender and class as the main factors in framing patients' experiences and understandings of mental disorder as well as shaping their everyday lives. For decades historians have studied varied psychiatric themes through the double lens of class and gender, on the premise that these concepts were 'literally built into the hospital infrastructure and thus operated as primary determinants' of a way of life,¹⁰ or on the assumption that they filtered through to asylums, as well as to psychiatry itself, and affected the lives of mental patients.¹¹ Consequently, our understanding of their profound and intertwined influence upon the experience of mental illness has been extended,

⁹ Joan Jacobs Brumberg, *Fasting Girls: The Emergence of Anorexia Nervosa as a Modern Disease* (Cambridge, MA: Harvard University Press, 1988), p. 8.

¹⁰ Diana Gittins, *Madness in its Place: Narratives of Severalls Hospital, 1913-1997* (London: Routledge, 1998), p. 5.

¹¹ Louise Hide, *Gender and Class in English Asylums, 1890-1914* (Basingstoke: Palgrave Macmillan, 2014), pp. 9-10.

compared to when Jonathan Andrews and Anne Digby pointed out that these two concepts have only sporadically been ‘addressed in tandem’.¹² However, it is still true that we do not know enough about what mental patients experienced and about how gender and class affected their experiences and lives.¹³ Another point worthy of our attention is that the majority of existing works considering gender and class as major factors focus on the Victorian period (and Edwardian period at the latest), leaving the early twentieth century understudied.¹⁴ Under these circumstances, this research is expected to enrich the ongoing discussion by encompassing experiences of both mental illness and daily life; by involving patients’ perceptions of disease as well as their life experiences; and by shifting the focus to the twentieth century.

In addition, this research takes ‘life cycle’ as another major determinant of the experiences of women suffering from mental illness. Even though age is commonly acknowledged as a major factor shaping our life experience alongside class, gender and ethnicity, it has rarely been fully engaged with in this historical genre. Most historical work taking life cycle into serious consideration focuses on a specific life stage or a certain age band rather than tracing the whole course of life cycle. However, feminist critiques and sociological studies on related subjects have adopted the notion of life cycle and revealed its

¹² Jonathan Andrews and Anne Digby (eds.), *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish psychiatry* (Amsterdam: Rodopi, 2004), p. 7.

¹³ Hide, *Gender and Class in English Asylums*, pp. 6-8.

¹⁴ Such unevenness of academic interests can be confirmed by reading the articles in Andrews and Digby (eds.), *Sex and Seclusion, Class and Custody*. Out of ten studies in this volume, excluding the Introduction, eight cover the Victorian and Edwardian years and only one discusses the twentieth century, focusing on shell-shock and psychopathic disorder, both commonly identified in men rather than women. Joan Busfield, ‘Class and Gender in Twentieth-Century British Psychiatry: Shell-Shock and Psychopathic Disorder’, in Andrews and Digby (eds.), *Sex and Seclusion, Class and Custody*, pp. 295-322.

utility as a factor which shapes women's everyday life as well as experience of ill-health. In *Understanding Depression: Feminist Social Constructionist Approaches*, for instance, Janet Stoppard analyses women's experiences of depression, by grouping those cases into three categories according to age: depression in adolescence, stressing a 'girl-poisoning culture'; depression and womanhood, in close relation to marriage and motherhood; and depression in mid- and old-age, focusing on ageing.¹⁵ In this book, as a feminist psychologist, Stoppard is very keen to find the best way to analyse women's accounts of the 'lived' or 'embodied' experience and finally claims that a material-discursive approach can serve this purpose.¹⁶ Nonetheless, this work suggests an exemplary case applying life cycle in interpreting depressed women's narratives and experiences. Stoppard successfully contextualises women's mental illness by historicising the notion of life cycle and definition of individual life stage, and by finding inseparable relations between women's experiences of depression and the female life cycle, life stage, and life events. This research follows such an approach, with some adjustments to accommodate a historical study.

It is noteworthy that such a life cycle approach is often subject to misconstruction as standing for biological reductionism, because it seems to follow the female reproductive cycle which begins with menarche, leads to pregnancy and childbirth, and ends with the menopause. However, the concept of life cycle is not concerned with reproductive events only. Rather, it embraces the social and psychological aspects of women's everyday life, as well as biological and reproductive events. What is considered to constitute each life stage encompasses various life experiences, which are closely related to women's daily life,

¹⁵ Stoppard, *Understanding Depression*, pp. 111-182.

¹⁶ *Ibid.*, p. 214.

identity, roles and responsibilities, all largely shaped by social values and culture, and not limited to those decided by nature and biology. As stated above, Stoppard has included girls' identity building processes, mature women's practices as wives and mothers, and the perception of being old amongst the elderly, as core life events constituting each life stage. In this regard, the preface of *Women from Birth to Death: The Female Life Cycle in Britain 1830-1914*, a historical anthology of Victorian and Edwardian materials on women's life cycle, is particularly worthy of our notice. According to Patricia Jalland and John P. Hooper, what 'appear to reflect simple biological stages in women's lives', such as menstruation and menopause, have a 'cultural specificity' peculiar to the time. They also point out that biology is 'partly a cultural construction'.¹⁷ Additionally, the criteria which divide life stages are neither tied to a certain age nor fixed exclusively by the reproductive cycle. Citing Stoppard again, a life stage can be a category which can be identified by 'a historically specific set of social, economic and political conditions'.¹⁸

Given that the life cycle approach has rarely been applied in historical research despite its utility as a tool to increase our comprehension of women and madness, this study is a new attempt to apply the concept in analysing mental illness experiences of early-twentieth-century female patients. In dividing life stages, this research draws on the mentioned works. Stoppard has grouped a woman's life largely into three stages: adolescence or girlhood; adulthood (encompassing marriage, motherhood, and housework); and midlife and advanced age.¹⁹ In *Women from Birth to Death*, Jalland and Hooper have compartmentalised a

¹⁷ Patricia Jalland and John P. Hooper, *Women from Birth to Death: The Female Life Cycle in Britain 1830-1914* (Brighton: Harvester, 1986), pp. x-xi.

¹⁸ Stoppard, *Understanding Depression*, p. 115.

¹⁹ *Ibid.*, pp. 111-182.

woman's life into four phases: menstruation and adolescence; marriage and maternity; female sexuality; and from menopause to death.²⁰ However, sexuality can be interpreted as an element constituting women's experience of individual life stages, rather than a discrete phase in the female life cycle. With this adjustment, the periodisation of women's life suggested by Jalland and Hooper is almost identical with the one made by Stoppard. Thus, this research draws on these precedents, dividing women's life into three periods. By employing life cycle for the analysis of female patients' narratives and experiences, it is expected that this approach will provide a useful framework and structure. In addition, as the life cycle approach embraces the biological, social and cultural aspects of women's lives, it helps us to better understand their experiences in a 'biopsychosocial context'.²¹

This research focuses on two mental hospitals and their medical records: Holloway Sanatorium and the Maudsley Hospital. The two institutions not only had distinctive features, segregating them from the main loci for psychiatric treatment of the time, county asylums, but also were very different from each other. Holloway Sanatorium was established in 1885 near Virginia Water, Surrey, as an asylum exclusively for 'the middle-class insane', occupying a 'niche' position and therefore having a rather unique institutional history.²² However, it shared many features with Victorian asylums, such as diagnostic schemes, therapeutic regimens, and the roles and responsibilities of the medical staff. Meanwhile, the Maudsley Hospital, that presented itself not as an asylum but a hospital, opened in 1923 in Denmark Hill, South London. At least seen from outside, the Maudsley 'could not have been

²⁰ Jalland and Hooper, *Women from Birth to Death: The Female Life Cycle in Britain 1830-1914*.

²¹ Stoppard, *Understanding Depression*, pp. 21-22.

²² Anne Shepherd, 'The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums', in Andrews and Digby (eds.), *Sex and Seclusion, Class and Custody*, pp. 226-227.

further from the traditional asylum'.²³ it was based on German-style university hospitals; aimed to treat early and acute psychiatric cases; ran an out-patient clinic; focused on research and teaching for post-graduate trainees;²⁴ and stood outside the certification system. By comparing the two mental hospitals and the case histories of a selection of their patients, this research will not only widen our understanding of female patients from various social strata and their experience of mental illness, but also contribute to the history of psychiatric institutions.

In addition, this research concentrates on cases of depression. This is because this affective disorder best represents both twentieth-century psychiatric phenomenon and mental illness as a gendered problem. As commonly acknowledged, depression became an increasingly demanding problem throughout the twentieth century, ranked as the fourth 'leading cause of burden' out of *all* diseases, both physical and psychological, and became 'the one most affecting productive life' at the end of the century.²⁵ However, the situation was hardly new. Already in the interwar decades, the diagnosis was applied to at least one third of all patients in English mental institutions, to become one of the most prevalent mental illnesses only a few decades after its introduction as an official diagnostic category.²⁶

²³ Edgar Jones, Shahina Rahman and Robin Woolven, 'The Maudsley Hospital: Design and Strategic Direction, 1923-1939', *Medical History*, 51:3 (2007), pp. 357-358.

²⁴ Maudsley Hospital, Medical Superintendent's Annual Report, Year ended 31st January, 1924, BRHAM, pp. 1-3.

²⁵ Lisa Appignanesi, *Mad, Bad and Sad: A History of Women and the Mind Doctors from 1800 to the Present* (London: Virago, 2008), pp. 459-460.

²⁶ Busfield points out that the meaning of 'depression' has changed 'very markedly' over time by tracing the brief nosological history of the concept. Thus, the question can be raised whether we can equate depression in the interwar period and depression to that of the late twentieth century. Joan Busfield, *Men, Women and Madness: Understanding Gender and Mental Disorder* (Basingstoke: Palgrave Macmillan, 1996), pp. 91-92.

Moreover, depression has been generally accepted as ‘a woman’s problem’, most frequently applied to women’s distress as a diagnostic category, and therefore offers an excellent opportunity to conduct a case study of ‘female malady’.²⁷ Current statistics report that ‘women are twice as likely as to experience depression as men’ over the life course,²⁸ and that ‘women are between 1.3 and 3.8 times more likely than men to have experienced depression in the previous twelve months’.²⁹ Even in the early decades of the century, the situation was similar: *in every institution*, the number (and rate) of female patients identified as suffering from depression (or melancholia) surpassed the figure of male cases;³⁰ and *all expert literature* asserted that ‘women [were] more liable to this disease than men’.³¹ Although Elaine Showalter sees schizophrenia as the twentieth-century female malady, it is depression that has troubled women the most in terms of prevalence as well as cultural meaning and representation throughout the century.³²

²⁷ Jane M. Ussher, *The Madness of Women: Myth and Experience* (London: Routledge, 2011), pp. 10-11.

²⁸ Appignanesi, *Mad, Bad and Sad: A History of Women and the Mind Doctors*, p. 6.

²⁹ Ussher, *The Madness of Women*, p. 24.

³⁰ This will be discussed later in Chapters 3, 4 and 5. It is sufficient here to mention that in almost all asylums more women were diagnosed with depression, depressive state, and melancholia than men, by a considerable margin.

³¹ Emil Kraepelin, Mary Barclay (trans.), and George Robertson (ed.), *Manic-Depressive Insanity and Paranoia* (Edinburgh: Livingstone, 1921), p. 174; D. K. Henderson and R. D. Gillespie, *A Textbook of Psychiatry for Students and Practitioners* (London: Oxford University Press, 1927), p. 117.

³² Elaine Showalter, *The Female Malady: Women, Madness and English Culture 1830-1980* (London: Virago, 1987), pp. 18-19, 203-219.

2. Historiography

Women and Madness

This research is located where two major branches of historical research of medicine, or more specifically psychiatry, intersect with each other: medical history from below and women and mental illness. The topic of 'women and madness' has attracted voluminous scholarly interest not just from history but also from various disciplinary fields, including sociology, literature, and feminist studies. Phyllis Chesler's pathbreaking book published in 1972, *Women and Madness*, was followed by decades-long debates on the subject. In this work, the feminist psychologist claims that women who act out of the devalued female role or reject, either totally or partially, gender stereotypes have been considered mad. Thus, she sees psychiatric categories employed for diagnosing those mad women 'sex-typed'.³³ Chesler locates the reason that women have outnumbered men in 'seeking psychiatric help and being hospitalised' in the 'help-seeking' nature of the female role, the objective oppression of the sex, and social changes that make useless or problematic females more visible than ever. Chesler also points to the 'patriarchal nature' of mental asylums and hospitals, wherein women are treated as children and are more likely to be 'enforced' to have treatments than men.³⁴

In *The Female Malady: Women, Madness and English Culture, 1830-1980*, Showalter

³³ Phyllis Chesler, *Women and Madness* (New York: Avon Books, 1972), p 56.

³⁴ *Ibid.*, pp. 34-38.

has argued that in the course of the nineteenth century madness was feminised and the stark contrast between rational men and irrational women was established. She finds the equation between femininity and insanity, not only in statistics on confinement through which she observes that ‘by end of the (nineteenth) century, women had decisively taken the lead as psychiatric patients, a lead they have retained ever since, and in ever-increasing numbers’,³⁵ but also from cultural representations of female lunatics in which women were identified as ‘irrationality, silence, nature, and body’ while men as ‘reason, discourse, culture, and mind’.³⁶ Showalter divides the period she examines, from 1830 to 1980, into three phases: psychiatric Victorianism (1830-1870), Darwinism (1870-1920), and Modernism (1920-1980). Although ‘new stories about the female malady’ are found in each stage, the themes, she observes, remained essentially the same – ‘the fundamental alliance between woman and madness’.³⁷ Showalter gives special attention to the Great War, as a diverging point of the second and third phases, when shell-shock became a mass phenomenon and subsequently ‘men and the wrongs of men occupied the central position in the history of madness’, a rare occasion. Showalter highlights the fact that the transition to psychiatric modernism occurred only when a horde of ‘male hysterics’ were in need of help and treatment, rather than during the heyday of hysteria, the typical female malady.³⁸

Showalter’s objectives of making a ‘contribution toward the feminist revolution in psychiatric history’ and to ‘supply the gender analysis and feminist critique missing from the history of madness’ seem to be achieved to a certain degree,³⁹ since *The Female Malady* has

³⁵ Showalter, *The Female Malady*, p. 52.

³⁶ *Ibid.*, pp. 3-4.

³⁷ *Ibid.*, pp. 17-18.

³⁸ *Ibid.*, pp. 18, 194.

³⁹ *Ibid.*, pp. 6, 19-20.

inspired a number of follow-up studies and produced ‘a distinctive feminist genre’ in this field. With the advancements made in the genre, however, Showalter’s arguments have been criticised for simplistic generalisation about psychiatric thoughts and institutions;⁴⁰ for overlooking the diversity of women’s experience of madness and considering them as a homogeneous group; and for lacking concrete and empirical support.⁴¹ Joan Busfield, for instance, impugns the validity of the groundings on which Showalter relies, and argues that neither ‘a cursory discussion of statistics on the confinement of lunatics in nineteenth-century asylums’ nor superficial and selective analysis of visual representations of insanity can be evidence of an affinity between femaleness and madness.⁴²

Showalter’s observation that female patients outnumbered their male counterparts throughout the nineteenth century has also been a major target of criticism. Andrew Scull claims that female dominance in asylum populations proceeded gradually only after the middle of the century and varied depending on the features of particular mental institutions. Furthermore, even when an imbalance existed, the gap between the female and male population amounted to ‘more than a few percent’, which Scull argues could be attributed to ‘the greater longevity of the “weaker” sex and to the disposition of the asylum authorities to keep female lunatics institutionalised longer than their male counterparts’.⁴³ More historians have joined the debate, mostly to contribute empirical and concrete evidence. In her work on the Ticehurst Private Asylum, one of the most privileged English mental institutions during

⁴⁰ Nancy Tomes, ‘Feminist Histories of Psychiatry’, in Mark S. Micale and Roy Porter (eds.), *Discovering the History of Psychiatry* (1994), pp. 364-366;

⁴¹ Joan Busfield, ‘The Female Malady? Men, Women and Madness in Nineteenth-Century Britain’, *Sociology*, 28:1 (1994), pp. 259-277.

⁴² *Ibid.*

⁴³ Andrew Scull, *Social Order, Mental Disorder: Anglo-American Psychiatry in Historical Perspective* (Berkeley, University of California Press, 1989), p. 270.

the nineteenth century, Charlotte MacKenzie has demonstrated ‘the preponderance of male over female patients’, inevitably connected with ‘property issues’ of sufferers’ family.⁴⁴ Meanwhile, in Anne Shepherd’s comparative research on two late-nineteenth-century asylums, she reveals that there was ‘no significant difference between the proportions of female to male admissions’ to Brookwood Asylum, the second Surrey Council pauper asylum established in 1867.⁴⁵ At Holloway Sanatorium, too, ‘the total number of certified patients admitted between 1885 and 1905 does not reveal any huge disparity between male and female admission’, although ‘thirty to thirty-three percent more women than men had been admitted’ in the early years of its operation.⁴⁶

Although some of the bold arguments put forward by Chesler and Showalter are under attack, the genre opened up by them continues to attract much attention. Following the lines taken by Chesler and Showalter, Jane M. Ussher has posed a fundamental question: why women are more mad than men? In her *Women’s Madness: Misogyny or Mental Illness?*, published in 1991, Ussher deconstructs the notion of madness and dissects patriarchal society and its misogynist culture, on the basis of a Foucauldian approach to ‘discourse’ and post-structuralist analysis of language.⁴⁷ According to her analysis, women are to be ‘positioned’ or ‘labelled’ as mad, whether they conform to the female role model or reject it,⁴⁸ and consequently become ‘the other’ who are silenced and therefore unable to challenge ‘the

⁴⁴ Charlotte MacKenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum 1792-1917* (Routledge, 2005), pp. 17-18.

⁴⁵ Shepherd, ‘The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums’, pp. 227-229.

⁴⁶ *Ibid.*, pp. 231-233; Anna Shepherd, *Institutionalizing the Insane in Nineteenth-Century England* (London: Pickering & Chatto, 2014), pp. 29-30.

⁴⁷ Jane M. Ussher, *Women’s Madness: Misogyny or Mental Illness?* (London: Harvester Wheatsheaf, 1991), pp. 9-14.

⁴⁸ *Ibid.*, pp. 166-170.

one'.⁴⁹ In her later work *The Madness of Women*, published in 2011, she criticises 'the regimes of knowledge' again, concluding that women's madness is a myth which is 'a culturally constructed label for distress and deviance', as well as, for many women a real experience, 'a reflection of deep discontent in (reasonable) response to the context of their lives'.⁵⁰

Meanwhile, Joan Busfield calls for a nuanced approach to scrutinise the controversial but widely accepted notion that mental disorder is a particularly female malady, and proposes a focus on gender and gender relations, not just on women and women's problems,⁵¹ which succeeds in obtaining consents of many feminist scholars, including Ussher.⁵² Like many feminist scholars working on women and madness, Busfield begins with the over-representation of the sex in psychiatric populations, both in the present-day and in the past.⁵³ Applying epidemiological data, however, she finds that 'there is no simple, consistent, female predominance' and rebuts 'the general claim that mental disorder is a female malady'. From the data, she discovers 'a gendered landscape' of mental patient populations: in which women are linked to some diagnoses, such as anorexia, anxiety and depression, whereas men to others, such as substance use disorders and drug addiction; and in which gender also intersects with various social factors, rather than shaping patients' experiences alone.⁵⁴ Close examination of concepts and theories concerning gender and mental disorder leads her to

⁴⁹ Ibid., p. 14.

⁵⁰ Ussher, *The Madness of Women: Myth and Experience*, pp. 13-14.

⁵¹ Busfield, *Men, Women, and Madness*, pp. 6-7.

⁵² Vicky Long, *Destigmatising Mental Illness?: Professional Politics and Public Education in Britain, 1870-1970* (Manchester: Manchester University Press, 2014), p.135; Ussher, *The Madness of Women*, pp. 12-13.

⁵³ Busfield, *Men, Women, and Madness*, p. 2.

⁵⁴ Ibid., pp. 13-30.

argue that any claims about gender differences in the prevalence of mental disorder are ‘always construct specific’.⁵⁵

The work of Ussher and Busfield provide us with exemplary cases applying social constructionism to this research genre, and prove the validity of the approach in understanding women and madness. It is hard to find a unitary theory of social constructionism, because it implies an enormous range of definitions, interpretations and usages across a variety of academic disciplines.⁵⁶ Limiting our interests to medical or psychiatric subjects, there are ‘three distinct and interconnected versions’ of social constructionism. The first and most prominent version focuses on the ‘social definition’, according to Phil Brown.⁵⁷ Taking this version of social constructionism, abnormality, deviance, or mental illness refers to ‘an ongoing interpretation of indeterminate events’, rather than ‘a thing to be discovered’, and is ‘not a way of behaving but a name or a label put on it can be understood as to stand on the same ground’.⁵⁸ The second version draws heavily on Foucauldian theories, takes note of discourse, and deconstructs language and symbols in order ‘to show the creation of knowledge and to explore the ever-changing and indeterminate realities’.⁵⁹ This approach implies that the concept employed to define and classify mental disorder shapes not only assessment and treatment, but also ‘the very manifestation of the

⁵⁵ Ibid., p. 9.

⁵⁶ Paul Atkinson and Maggie Gregory, ‘Constructions of Medical Knowledge’, in James A. Holstein and Jaber F. Gubrium (eds.), *Handbook of Constructionist Research* (London: Guilford Publications, 2013), p. 593-594; Arshi Shaikh and Carol Kauppi, ‘Postpartum Depression: Deconstructing the Label through a Social Constructionist Lens’, *Social Work in Mental Health*, 13:5 (2015), p. 461.

⁵⁷ Phil Brown, ‘Naming and Framing: The Social Construction of Diagnosis and Illness’, *Journal of Health and Social Behavior*, Extra Issue (1995), pp. 35-36.

⁵⁸ Ian Hacking, ‘Between Michel Foucault and Erving Goffman: Between Discourse in the Abstract and Face-to-Face Interaction’, *Economy and society*, 33:3 (2004), p. 296.

⁵⁹ Brown, ‘Naming and Framing: The Social Construction of Diagnosis and Illness’, p. 35-36.

illness itself'.⁶⁰ The last version concentrates on the production of scientific facts and knowledge by professionals. According to this 'science in action' viewpoint, the production of scientific facts is 'the result of mutually conceived actions by scientists in workaday life in the laboratory, combined with scientists' efforts to promote their work in public and official venues'.⁶¹ Busfield's work is more involved with the first approach, Ussher's is adjacent to the second, and the work of Stoppard has combined the first and second means.⁶² These feminist scholars (and most of their sociologist, psychologist and feminist colleagues) are clear about their methodology; however, medical and psychiatric historians seem to be cautious in this respect. Many of them remain silent about their methodology and approach, even when they share the basics of social constructionism or take one of the three steps described above. Concerning such reticence, Ludmilla Jordanova has asserted that social historians of medicine 'frequently adopt social constructionism *in one form or another*' even if they are not explicit about their conceptual manoeuvres.⁶³ This comment is very true with regard to the historical works which are heavily drawn upon by this research.

Besides these conceptual discussions on women and madness, various attempts have been made to reconstruct and historicise women's experiences of mental illness by investigating specific diagnoses and the sufferers. These inquiries usually relate to what have been considered traditionally and typically feminine disorders, such as hysteria and anorexia nervosa, and what can be experienced only by women, notably puerperal insanity. As for the

⁶⁰ Shaikh and Kauppi, 'Postpartum Depression: Deconstructing the Label through a Social Constructionist Lens', pp. 462-463.

⁶¹ Brown, 'Naming and Framing: The Social Construction of Diagnosis and Illness', p. 36.

⁶² Stoppard, *Understanding Depression*, pp. 21-22.

⁶³ Ludmilla Jordanova, 'The Social Construction of Medical Knowledge', *Social History of Medicine*, 8:3 (1995), p. 361.

story of hysteria, Showalter's work has to be revisited. In *The Female Malady*, she sees hysteria as 'the quintessential female malady', and contends that in the nineteenth century the diagnosis was a form of 'punitive psychopathological labelling' applied to women who flouted conventional gender roles and therefore functioned as 'a defensive reaction on the part of male professionals to new female assertiveness'.⁶⁴ Thus, Showalter claims that hysteria *within the specific historical framework of the nineteenth century* can be interpreted as 'an unconscious form of feminist protest,' suggesting a close relationship between the female malady and feminism. However, she warns simultaneously that 'such claims (...) come dangerously close to romanticising and endorsing madness as a desirable form of rebellion rather than seeing it as the desperate communication of the powerless'.⁶⁵

As regards eating disorders, defined largely as typically feminine mental illnesses, Brumberg has convincingly contextualised anorexia nervosa in the nineteenth-century context in *Fasting Girls: The Emergence of Anorexia Nervosa as a Modern Disease*. In this work, she openly rebuffs any anachronistic (mis)interpretation of women's fasting habit: some feminist researchers find a close resemblance between late-twentieth-century anorexics and the early-twentieth-century suffragist hunger strikers;⁶⁶ or regard both anorexia mirabilis and anorexia nervosa as a form of 'struggle by females striving for autonomy in a patriarchal culture'.⁶⁷ However, Brumberg argues that identifying medieval women's fasting with modern girls' food refusal on the ground of 'the symptomatic continuities' is misleading,

⁶⁴ Showalter, *The Female Malady*, pp. 129-134, 162-164; Mark S. Micale, 'Hysteria and its Historiography: A Review of Past and Present Writings', *History of Science*, 27:4 (1989), p. 326.

⁶⁵ Showalter, *The Female Malady*, p. 5.

⁶⁶ Susie Orbach, *Hunger Strike: The Anorectic's Struggle as a Metaphor for our age* (2nd edn, London: Karnac, 2005), pp. 33-35; Tomes, 'Feminist Histories of Psychiatry', p. 367.

⁶⁷ Rudolph Bell, *Holy Anorexia* (Chicago: University of Chicago Press, 1985), p. 86; Tomes, 'Feminist Histories of Psychiatry', p. 367.

because both meanings of the behaviour and reasons for the control of female appetite change over time.⁶⁸ The story of anorexia nervosa, she claims, can be read as a good example of ‘the extent to which disease is a cultural artefact, defined and redefined over time, and therefore illustrative of fundamental historical transformation,’⁶⁹ stressing the historical, social, cultural and economic contexts of a visible phenomenon and supporting the first version of a social constructionist approach to medical issues, though in silence.

With regard to depression, which I argue is the twentieth-century female malady, we have not many historical works to rely on.⁷⁰ In “*Shattered Nerves*”: *Doctors, Patients, and Depression in Victorian England*, Janet Oppenheim has analysed ‘what nervous breakdown meant to the Victorians’, both patients and doctors, by referring to the broad category of conditions which would be called major depression today. At first, she locates Victorian ‘alienists’ within their intellectual, professional and social settings, and describes medical theories and the treatments they applied. Then, Oppenheim moves her gaze to patients: exhausted men, neurotic women, and nervous adolescents. Regarding gender difference in mental illness, she takes note of professional causal attributions: male cases were more likely related to ‘personal choice and responsibility’, whereas female ones were assigned to their reproductive burdens or biological destiny.⁷¹ However, she emphasises that ‘both sexes were deeply affected by social tensions and cultural prescriptions’ and warns that ‘an unrelenting

⁶⁸ Brumberg, *Fasting Girls*, p. 5.

⁶⁹ *Ibid.*, p. 6.

⁷⁰ To understand the ‘general’ history of depression and its predecessor, melancholia, see Stanley W. Jackson, *Melancholia and Depression: From Hippocratic Times to Modern Times* (Yale University Press, 1986); Clark Lawlor, *From Melancholia to Prozac: A History of Depression* (Oxford: Oxford University Press, 2012).

⁷¹ Janet Oppenheim, “*Shattered Nerves*”: *Doctors, Patients, and Depression in Victorian England* (Oxford: Oxford University Press, 1991), pp. 181-232.

emphasis on the gendered nature' of patients' experience is not helpful for historians.⁷²

Oppenheim objects to 'the rebellion interpretation' of female mental illness, which has been favoured in some feminist works, claiming that such explanation 'confirms the Victorian equation of femininity and sickness' rather than rebutting it.⁷³

Meanwhile, Ali Haggett's *Desperate Housewives: Neurosis and the Domestic Environment, 1945-1970* provides significant insights into women's depression and their attributions against a backdrop of post-war Britain, although the work covers not only the affective disorder but a wider range of neuroses. Her study is also based on oral history methodology. Haggett claims that most middle-class housewives 'settled with ease into family life and domesticity' and did not find the main cause of their depression and anxiety from the banality of the domestic roles, contrary to their contemporary feminist commentators' rhetoric and popular perception.⁷⁴ Many of the interviewees in the study attributed their neurosis and the symptoms accompanied not to their role as mothers and homemakers, but to troubles occurring in family relationships, notably marital difficulties.⁷⁵ The studies of Oppenheim and Haggett have exerted crucial influences on this research in many ways, particularly in relation to the questions they raise, although they have left the interwar years unexplored. In this sense, filling up this void is a major task of this research.

Scholars from varied fields, including medicine, psychology, sociology, and feminist studies, have tried to explain why depression affects women more than men and what causes

⁷² Ibid., p. 229.

⁷³ Ibid.

⁷⁴ Ali Haggett, *Desperate Housewives, Neuroses and the Domestic Environment, 1945-1970* (London: Pickering & Chatto, 2012), pp. 1-10, 103.

⁷⁵ Ibid., pp. 86-97.

female depression, two themes inseparably related to each other. To introduce some of the frameworks that have been applied in social science disciplines, diathesis-stress models find sources of female depression in the interactions between individual and environment. Such approaches depict depression as a joint effect of personal characteristics (the diathesis component) and negative life events (the stress component), which ‘match’ particular personality types.⁷⁶ Secondly, psychological approaches are based on the assumption that certain personality traits heighten female ‘susceptibility’ to depression, and presume that women develop such characteristics ‘by virtue of being female’.⁷⁷ Thirdly, material-discursive approaches explain depression as ‘experiences which arise in conjunction with a woman’s embodied efforts to meet socially constructed standards defining the good woman’,⁷⁸ which is almost identical to the first form of social constructionist approach mentioned above. Lastly, social models, which share the main idea of this thesis in some ways, ascribe female depression to the environment of a person. Some researchers in this group focus on particular events or circumstances, so-called ‘adversity’.⁷⁹ Representatively, George W. Brown and Tirril Harris, in their influential work *Social Origins of Depression*,

⁷⁶ James C. Coyne and Valerie E. Whiffen, ‘Issues in Personality as Diathesis for Depression: The Case of Sociotropy-Dependency and Autonomy-Self-Criticism’, *Psychological Bulletin*, 118:3 (1995), p. 358; Stoppard, *Understanding Depression*, pp. 43-58; Thomas A. Widiger et al., ‘Personality and Depression in Women’, in Corey L. M. Keyes and Sherryl H. Goodman (eds.), *Women and Depression: A Handbook for the Social, Behavioral, and Biomedical Sciences* (Cambridge: Cambridge University Press, 2006), pp. 176-198.

⁷⁷ Stoppard, *Understanding Depression*, p. 59; Dana Crowley Jack, *Silencing the Self: Women and Depression* (Cambridge, MA: Harvard University Press, 1991); Susan Nolen-Hoeksema, *Sex Differences in Depression* (Stanford, California: Stanford University Press, 1990), pp. 130, 156-159; Joan S. Girgusand and Susan Nolen-Hoeksema, ‘Cognition and Depression’, in Keyes and Goodman (eds.), *Women and Depression: A Handbook for the Social, Behavioral, and Biomedical Sciences*, pp. 147-175.

⁷⁸ Stoppard, *Understanding Depression*, pp. 90, 108-109.

⁷⁹ Ronald C. Kessler, ‘The Effects of Stressful Life Events on Depression’, *Annual Review of Psychology*, 48:1 (1997), pp. 191-214.

have assessed adverse life events and the stress they produce in women's lives and noted the importance of 'the contextual details of people's everyday lives'.⁸⁰ Others in this circle go directly to gender differences in explaining sources of stress, and, therefore, blame straightforwardly women's (low) position in societies and feminine roles as dictated by cultures.⁸¹

Meanwhile, some of those who pursue the fundamental reason for the female predominance among patients with mental illness associate the phenomenon with the concept of depression and with the diagnosis criteria.⁸² Additionally, they regard depression as the best example of the 'medicalisation' of human nature and argue that diagnosing female depression is a way to pathologise the female body and mind.⁸³ Representatively, Agnes Miles points out that 'more social and emotional problems come to be interpreted within a medical, specifically psychiatric, framework' and subsequently to be regarded as an illness or disease to be cared and treated professionally.⁸⁴ Allan Horwitz and Jerome Wakefield provide a more detailed explanation and critical argument in *The Loss of Sadness*, namely

⁸⁰ George W. Brown and Tirril Harris, *Social Origins of Depression: A Study of Psychiatric Disorder in Women* (London: Tavistock Publications, 1978); idem, *Life event and Illness* (London: The Guilford Press, 1989), pp. 49-93.

⁸¹ Ellen Ed McGrath et al., *Women and Depression: Risk Factors and Treatment Issues: Final Report of the American Psychological Association's National Task Force on Women and Depression* (Washington, DC: American Psychological Association, 1990); Jeanne Marecek 'Social Suffering, Gender, and Women's Depression', in Keyes and Goodman (eds.), *Women and Depression: A Handbook for the Social, Behavioral, and Biomedical Sciences*, pp. 296-297.

⁸² Stoppard, *Understanding Depression*, pp. 25-29.

⁸³ Nicola Wright and Sara Owen. 'Feminist Conceptualizations of Women's Madness: A Review of the Literature', *Journal of Advanced Nursing*, 36:1 (2001), pp. 143-150; Stoppard, *Understanding Depression*, p. 97. Medicalisation is usually defined as 'the process and product of defining and treating human experiences as a medical problem'.

⁸⁴ Agnes Miles, *Women and Mental Illness: The Social Context of Female Neurosis* (Brighton: Harvester Wheatsheaf, 1988), pp. 7-10.

that contemporary psychiatry fails to provide an adequate conceptual distinction between disorder (depressive disorder) and non-disorder (natural and normal sadness); and that it pathologises a painful but important part of our humanity, and consequentially results in excessive and improper medicalisation of human problems.⁸⁵ Although this research criticises, or often even dismisses, the concept of depression, they are not to deny the anguish of those who are diagnosed as suffering from the disorder. Most of the cited works on depression, largely generated in the social science disciplines, are mainly concerned about what causes or triggers women's depression.

This research is engaged with women's experience of daily life in interwar Britain as deeply as with that of madness. On how to define the interwar period in terms of women's legal, economic, social and cultural reality, it appears that historians reached a broad consensus in the 1990s: although women won the vote, entered the professions, and gained some legislative improvement, the lives of most women in this period remained no better than those before the Great War. Historians have criticised that 'the emancipating effects' of the War had been exaggerated in earlier studies, and considered 'a post-war backlash' as central to women's experience in the 1920s and 1930s.⁸⁶ Deirdre Beddoe, for example, has described this period as anti-progressive, reactionary and anti-feminist in many aspects. She found that 'the notion that a woman's place is in the home' was unbeatably powerful throughout the period and that the general opinion about the employment of women was distinctively hostile. Women who went out to work despite the 'undesirable' images imposed

⁸⁵ Allan V. Horwitz and Jerome C. Wakefield, *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder* (Oxford: Oxford University Press, 2007).

⁸⁶ Adrian Bingham, "'An era of Domesticity?'" *Histories of Women and Gender in Interwar Britain*, *Cultural and Social History*, 1:2 (2004), pp. 225-233.

upon them were paid far less than men, and middle-class female professionals had to leave their job on marriage due to 'marriage bars'.⁸⁷

More recent works on women's history, however, stress the need to reassess the interwar period, noting that 'although there was certainly no revolution (...) the backlash model employed in many histories inhibits a proper understanding of those changes that did occur at this time'.⁸⁸ According to Adrian Bingham, earlier historical works which have blamed the media for its conservative and often misogynistic attitudes towards women and for playing a crucial role in confining women to a narrow domesticity can be 'very misleading'.⁸⁹ Rather, he claims, during the interwar years the press 'generally embraced modernity, encouraged women to become active citizens, and included career advice for those unable or unwilling to achieve marriage and motherhood'.⁹⁰ Many historians in this circle stress the significance of changes in the social opportunities and leisure activities of women and especially take notice of a distinctive youth culture which provided young women with new expectations, aspirations and self-consciousness.⁹¹ Birgitte Sølund, for instance, observes that in the 1920s, 'a cultural watershed', women came to enjoy more personal freedom, more pleasure and more self-expression, although her study covers not just

⁸⁷ Deirdre Beddoe, *Back to Home and Duty: Women between the Wars, 1918-1939* (London: Pandora, 1989).

⁸⁸ Bingham, 'Histories of Women and Gender in Interwar Britain', p. 226.

⁸⁹ Billie Melman, *Women and the Popular Imagination in the Twenties: Flappers and Nymphs* (Basingstoke: Macmillan, 1988), pp. 17-18; Beddoe, *Back to Home and Duty*, pp. 3-7.

⁹⁰ Adrian Bingham, *Gender, Modernity, and the Popular Press in Interwar Britain* (Oxford: Oxford University Press, 2004), pp. 246-247.

⁹¹ David Fowler, *The First Teenagers: the Lifestyle of Young Wage-Earners in Interwar Britain* (London: Woburn Press, 1995); Claire Langhamer, *Women's Leisure in England, 1920-1960* (Manchester: Manchester University Press, 2000); Bingham, 'Histories of Women and Gender in Interwar Britain', p. 230.

Britain but Western European countries.⁹² Hilary Marland even claims that ‘the characteristics of the “modern girl” with her “modern body” were created in the earlier period, already in the 1880s and 1890s, stressing the swift and dramatic shift in (re)presenting girlhood from ‘the wilting, pallid, awkward mid-Victorian girl’ to ‘a healthy body, honed by sports and physical exercise, clothed in modern attire (...), with an exuberant personality to match’.⁹³

Concerning women’s sex and sexuality, the interpretation of this period is a highly controversial subject. Basically, the question of whether or not ‘modern sexuality’ was constructed during the interwar years sharply divides historians and feminists engaged in this debate. On the one hand, those who prioritise ‘sexual freedom’ and find it widened between the Wars argue that modern sexuality was achieved in the period.⁹⁴ Researchers in this circle notice dissemination of sexual knowledge, praise for companionate marriage and sexual pleasure therein, and stress increasing adoption of new contraceptive appliances, as proof of modern sexuality. On the other hand, many highlight conservative attitudes towards sex and sexuality in this period, and pay close attention to the continuance of conventional behaviours. This is exemplified in the work of Kate Fisher and Simon Szreter: both have claimed that, regarding sex, traditional attitude and practices were predominant well into the mid-twentieth century.⁹⁵ Alternatively, we can encounter more nuanced approaches to this

⁹² Birgitte Sjøland, *Becoming Modern: Young Women and the Reconstruction of Womanhood in the 1920s* (Princeton, NJ: Princeton University Press, 2000).

⁹³ Hilary Marland, *Health and Girlhood in Britain, 1874-1920* (Basingstoke: Palgrave Macmillan, 2013), p. 3.

⁹⁴ Sheila Jeffreys, ‘Women and Sexuality’, in June Purvis (ed.), *Women’s History: Britain, 1850-1945* (London: Routledge, 1995), p. 212.

⁹⁵ Kate Fisher, ‘Uncertain Aims and Tacit Negotiation: Birth Control Practices in Britain, 1925–50’, *Population and Development Review*, 26:2 (2000), pp. 295-317; “‘Didn’t Stop to Think I Just Didn’t Want Another One’”: The Culture of Abortion in Interwar South Wales’, in Franz Eder, Lesley

subject. For instance, Lesley A. Hall not only acknowledges that some changes took place during the interwar years, but also simultaneously stresses their limitation, noting that ‘the liberalisation of sexual attitudes did not go very far’.⁹⁶ Such attitudes are also detected in her analysis of specific themes. From the interwar phenomenon that premarital sex was most common between courting couples, for example, Hall finds both ‘interwar modernity’ and the repetition of ‘older pattern of sex’, admitting that ‘the implications are obscure’.⁹⁷

Medical History from Below

Just as the study of women and madness has attracted much scholarly attention in recent decades, so too has the medical history of patients, sufferers and the lay perspectives, inspired by Roy Porter’s seminal article ‘The Patient’s View: Doing Medical History from Below’. In this work, he described ‘physician-centred’ medical history as incomplete and argued ‘we should lower the historical gaze on the sufferers’.⁹⁸ History of psychiatry, in particular, has achieved a good deal with regard to the lived experiences of mental patients and lay perspectives on mental illness, even though Flurin Condrau has suggested that ‘the history of

A. Hall and Gert Hekma (eds.), *Sexual Cultures in Europe: Themes in Sexuality* (Manchester: Manchester University Press, 1999), pp. 213–32; Kate Fisher and Simon Szreter, “‘They Prefer Withdrawal’: The Choice of Birth Control in Britain, 1918–1950”, *Journal of Interdisciplinary History*, 34:2 (2003), pp. 263–91; Simon Szreter and Kate Fisher, *Sex before the Sexual Revolution: Intimate Life in England 1918–1963* (Cambridge: Cambridge University Press, 2010), pp. 229–267.

⁹⁶ Lesley A. Hall, ‘Sexual Culture in Britain: Some Persisting Themes’, in Franz X. Eder, Lesley A. Hall and Gert Hekma (eds.), *Sexual Cultures in Europe: National Histories* (Manchester: Manchester University Press, 1999), pp. 45–46.

⁹⁷ Lesley A. Hall, *Sex, Gender and Social Change in Britain since 1880* (Basingstoke: MacMillan, 2000), pp. 121–122.

⁹⁸ Roy Porter, ‘The Patient’s View’, *Theory and society*, 14:2 (1985), pp.175–198.

the patient's view is as undeveloped now as it was back in the mid-1980s'. According to Condrau, there is a research imbalance in this genre, since 'the empirical side of writing the patient's history has been much enriched in recent years' whereas little has been achieved in terms of conceptualisation and 'methodological innovation'.⁹⁹ In particular, the author raises the necessity of 'a full debate' to reconcile two major approaches to this subject: one that 'the patient's view can be unearthed from the sources', an empirical approach; and the other that the patient is a construct of the medical gaze', a more Foucauldian perspective.¹⁰⁰ In a similar vein, L. Stephen Jacyna and Stephen T. Casper have indicated that 'the history of the patient remains curiously underwritten' at the beginning of their work about the construction of neurological patients.¹⁰¹ Most recently, Alexandra Bacopoulos-Viau and Aude Fauvel published an editorial article, 'The Patient's Turn: Roy Porter and Psychiatry's Tales, Thirty Years on', wherein they share the negative evaluation about recent developments in the history of psychiatry.¹⁰²

One of the most straightforward ways to reinstate patients in the doctor-patient encounter is to collect and listen to their first-hand accounts. In practice, anthologies of first-person narratives saw 'a remarkable explosion' after Porter's article,¹⁰³ including his own work on what mad people and their close observers revealed about madness.¹⁰⁴ For instance,

⁹⁹ Flurin Condrau, 'The Patient's View Meets the Clinical Gaze', *Social History of Medicine*, 20:3 (2007), p. 526.

¹⁰⁰ *Ibid.*, pp. 529, 535-536.

¹⁰¹ L. Stephen Jacyna and Stephen T. Casper (eds.), *The Neurological Patient in History* (Rochester: University of Rochester Press, 2012), p. 6.

¹⁰² Alexandra Bacopoulos-Viau and Aude Fauvel, 'The Patient's Turn: Roy Porter and Psychiatry's Tales, Thirty Years On', *Medical History*, 60:1 (2016), pp. 1-2.

¹⁰³ *Ibid.*, p. 7.

¹⁰⁴ Roy Porter, *Madmen: A Social History of Madhouses, Mad-Doctors and Lunatics* (London: Athlone Press, 1987); Porter, *The Faber Book of Madness* (London: Faber & Faber, 1991).

Dale Peterson produced a voluminous book on mad people and their experiences. Among dozens of narratives, Marcia Hamilcar's story is located closest to this research. In 1907, the fifty-seven-year old unmarried schoolteacher fell victim to severe depression accompanied by physical uneasiness and delusional ideas and was sent to 'a private nursing home' by her family for a temporary stay. In the institution, she was pronounced 'insane' even though she was not certified, and came to consider herself as 'legally dead'. Her narrative was replete with negative experiences, such as mal-treatment, both physical and psychological, unconsented extension of her confinement and disregard for her release.¹⁰⁵

Meanwhile, endeavours to understand sufferers' experience and perspective by focusing on their own narratives are not limited to history. Recently, Gail A. Hornstein produced an insightful work building on this tradition, yet adopting a somewhat different perspective to medical historians, as a researcher with a background in psychology.¹⁰⁶ In *Agnes's Jacket: A Psychologist's Search for the Meanings of Madness*, Hornstein has successfully demonstrated that first-hand accounts of mental patients 'serve two powerful functions': they reveal the limits of modern psychiatry, in terms of its ability to explain and to treat patients' conditions, which the author describes as being obsessed with biological explanations, chemical imbalance and pharmacology; and 'offer competing theories and methods that might potentially work better'.¹⁰⁷ Meanwhile, Michelle N. Lafrance has argued for the curative properties of such narratives in *Women and Depression: Recovery and*

¹⁰⁵ Dale Peterson (ed.), *A Mad People's History of Madness* (Pittsburgh: University of Pittsburgh Press, 1982), pp. 187-193.

¹⁰⁶ Gail A. Hornstein, *Agnes's Jacket: A Psychologist's Search for the Meanings of Madness* (Ross-on-Wye: PCCS Books, 2012).

¹⁰⁷ *Ibid.*, p. xxii.

Resistance.¹⁰⁸ In this work, Lafrance explores women's accounts of depression and pays special attention to recovery from the disorder, 'a neglected topic'.¹⁰⁹ By analysing first-hand accounts, she reaches a conclusion similar to Hornstein's: deconstructing biomedicine and its logics, and suggesting the need for alternative understandings of mental illness.¹¹⁰

In a more active attempt to restore patients to the centre of medical history, psychiatric historians have endeavoured to reconstruct the experiences of the majority of silent and mentally ill people. Recent 'post-revisionist' approaches have exerted a strong influence in analysing patients' views and experiences, and in particular 'detailed empirical studies' based on archival sources have enriched our understanding of this subject.¹¹¹ Even Condrau has recognised the productivity of social historians of psychiatry in terms of 'the empirical side of writing'.¹¹² It is possible (and helpful in understanding the historiography) to categorise those works according to sub-themes, such as the asylum experience, relationship between doctor and patient, and lay understandings of disease, all of which have substantial historiographies.

Research on patients' experience of asylums, which has been the main locus of psychiatric care at least until the deinstitutionalisation movement in the 1970s, is vast and based on varied approaches. Many of the post-revisionist works set institutions free from the often extreme and simplistic blame of revisionist historians who have portrayed the asylum

¹⁰⁸ Michelle N. Lafrance, *Women and Depression: Recovery and Resistance* (London: Routledge, 2009).

¹⁰⁹ *Ibid.*, pp. 2-6.

¹¹⁰ *Ibid.*, pp. 181-185.

¹¹¹ Long, *Destigmatising Mental Illness?*, pp. 9-10.

¹¹² Condrau, 'The Patient's View Meets the Clinical Gaze', pp. 526, 530-532.

‘as an instrument of social control’.¹¹³ In a comparative study of two late-nineteenth-century asylums, Shepherd offers a vivid picture of patients’ experiences, collectively rather than individually, which describes demographic features, admission and discharge, and therapeutic regimes. Relying on archival sources, Shepherd rebuts the established explanation of the institutionalisation of women being a means of oppression, concluding that ‘female incarceration was in some instances a desirable option for a variety of interested parties (including patients themselves) that cannot neatly be explained by accusation of social control’.¹¹⁴ Diana Gittins depicts what life in an asylum, Severalls Hospital in Essex, was like in the twentieth century, from the perspectives of patients, medical staff and other asylum staff. On the basis of oral history, Gittins argues that the mental institution provided its boarders with ‘social relations and interactions’, ‘a community’, and ‘a sense of belongings’, rebutting both anti-psychiatry doctrines and ‘community care’ policy.¹¹⁵

Lay perspectives on mental illness has also attracted the attention of social and cultural historians of psychiatry. In this context, Akihito Suzuki’s work, ‘Lunacy and Labouring Men: Narratives of Male Vulnerability in Mid-Victorian London’, is full of suggestions, especially relevant to the theme of this thesis. By analysing casebooks, this article assesses how patients and their families ascribed their mental disorder, and concludes that many of them found the cause in economic anxieties. Suzuki is fortunate to have concrete sources, case notes, which were recorded assiduously and systematically by John Conolly in order to locate the aetiology in the patients’ life-histories. By relating mental illness to ‘new working-class

¹¹³ Long, *Destigmatising Mental Illness?*, p. 9.

¹¹⁴ Shepherd, ‘The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums’, pp. 244.

¹¹⁵ Gittins, *Madness in its Place: Narratives of Severalls Hospital, 1913-1997*, pp. 219-223.

respectability and the concomitant notion of manhood', Suzuki has successfully situated mid-nineteenth-century mental illness and the sufferers in the social, cultural, economic and historical context.¹¹⁶

Similar attempts have been made to demonstrate current phenomena in the social sciences. A good instance is Vivienne Walter's work, 'Stress, Anxiety and Depression: Women's Accounts of Their Health Problem'. The beginning of this article reads that 'we still know relatively little about how women themselves understand and organise their experiences and how their experiences are structured by class, gender, race, ethnicity and age', which is almost identical to the main research question of this thesis except in time and space, as Walter's study focuses on contemporary Canada. In this article Walter investigates about 350 cases, randomly selected ones, in which female patients report minor mental health problems and discusses the way in which those women understand the sources of the ailments. The patients emphasise the social origins of their mental illness, 'noting the importance of gender roles and images of women'. Despite the 'strong social character' in aetiology, these women are not inclined to voice any strong rejection of such alleged causes, but tend to 'normalise' their problems and minimise their experiences. This research takes notes of differences between 'lay models of health and illness' and 'bio-medical models' mostly addressed by medical professionals.¹¹⁷

The relationship between lay and professional perspectives, as an extension of patients'

¹¹⁶ Akihito Suzuki, 'Lunacy and Labouring men: Narratives of Male Vulnerability in Mid-Victorian London', in Roberta Bivins and John V. Pickstone (eds.), *Medicine, Madness and Social History* (Basingstoke: Palgrave Macmillan, 2007), pp. 118-128.

¹¹⁷ Vivienne Walters, 'Stress, Anxiety and Depression: Women's Accounts of Their Health Problems', *Social Science & Medicine*, 36:4 (1993): 393-402.

understanding of expert knowledge, has also been explored intensively. Much empirical research has found that the flow of knowledge was never one-way and that patients did not remain passive consumers but were often actively involved in its production. Based on American and British medical literatures in the late nineteenth century, Nancy M. Theriot argues that female patients contributed to the formation of psychiatric and gynaecological knowledge through interaction with their physicians. In this process, patients were also able to shape ‘a modern sense of body and self’, as well as to ‘educate’ themselves about wellness and illness.¹¹⁸ More recently, Sarah Chaney has revealed that two Bethlem Royal Hospital patients were deeply engaged in ‘the construction and circulation of medical notions’ by helping their alienist work on a textbook in the last decade of the nineteenth century. Although their position, both in society and in the asylum, was far from representative of all the insane, these Bethlem inmates resisted a stereotype of mental patients as ‘victims of psychiatric power’, and proved that the position of patients was open to negotiation as was the relationship between doctor and patient.¹¹⁹

3. Case Notes as Historical Source

This research relies heavily upon patient case notes as my main historical source. As seen in

¹¹⁸ Nancy M. Theriot, ‘Negotiating Illness: Doctors, Patients, and Families in the Nineteenth Century’, *Journal of the History of the Behavioral Sciences*, 37:4 (2001), pp. 349-368.

¹¹⁹ Sarah Chaney, ‘No “Sane” Person Would Have Any Idea: Patients’ Involvement in Late Nineteenth-century British Asylum Psychiatry’, *Medical History*, 60:1 (2016), pp. 37-53.

the discussion above, medical historians investigating ‘history from below’ and/or ‘lay perspectives’ have shown a particular interest in patient records and made increasing use of them as research sources. Guenter B. Risse and John Harley Warner have effectively illustrated the value of patient records as a source of information about medical experiences and perceptions in the past, as well as probable problems and difficulties in using them. The authors take note that case histories provide precious chances to reconstruct patients’ experience, personal as well as collective, of illness; to ‘trace shifts in clinical practice, perception, and discourse’; to comprehend demographic features of patient populations; and to compare ‘clinical ideas with clinical activities’.¹²⁰ In particular, those benefits can serve the history of psychiatry more than any other specialist medical areas. In illustrating recent research trends, Volker Hess and Benoît Majerus point out that ‘the material turn’ to patient records has been ‘yielding astonishing results’ especially in the history of psychiatry’.¹²¹ As Marland points out, ‘case histories are often as close as historians can come to hearing the stories’ of the mentally ill.¹²² They furnish psychiatric historians with the best probable way to understand the clinical experience of both patients and doctors, and the psychiatric paradigm with regard to diagnosis, classification and treatment of pathological conditions.

However, case records are not flawless sources and historians have to deal with them with the utmost caution. First of all, case notes are far from ‘objective’.¹²³ The record keepers, mostly physicians, often distorted patients’ experience of illness, which were too

¹²⁰ Guenter B. Risse and John Harley Warner, ‘Reconstructing Clinical Activities: Patient Records in Medical History’, *Social History of Medicine*, 5:2 (1992), pp. 183-205.

¹²¹ Volker Hess and Benoît Majerus, ‘Writing the History of Psychiatry in the 20th Century’, *History of Psychiatry*, 22:2 (2011), pp. 141-142.

¹²² Marland, *Dangerous Motherhood*, pp. 95-96.

¹²³ *Ibid.*, p. 100.

complicated to standardise and sometimes inconsistent with the dominant medical knowledge system, into ‘something statistically regular and understandable’ in clinical records.¹²⁴ The materials, therefore, have to be understood in the context wherein they were originally written.¹²⁵ Secondly, case notes are multi-vocal material containing varied stakeholders, including doctors, other medical staff, patients and their families. Reading and analysing them, it is necessary to differentiate who said what. Making the situation more complicated, case files are ‘mediated narratives’, usually kept by doctors about their patients,¹²⁶ wherein sufferers frequently remained silent and occasionally said what was induced by their doctors.¹²⁷ Additionally, employing case files as a historical source is, practically, a herculean task, mostly due to the massive scale of the records. Thus, Risse and Warner advise historians to ‘determine the demographics of the patient population under study’ and then to ‘concentrate on representative charts’, in order to ensure research effectiveness.¹²⁸ However, the usefulness of this recommendation is doubtful, because it could be problematic to establish a standard set of ‘typical’ case histories. Namely, it is possible to project the prejudice of the researcher in setting up the criteria for selection, and it is practically almost impossible to suggest ‘representative’ ones since case histories are too diverse to be standardised.

Last but not least, the practical problems which historians have to face when employing case notes as historical sources should be mentioned. The Data Protection Law, which was

¹²⁴ Harriet Nowell-Smith, ‘Nineteenth-Century Narrative Case Histories: An Inquiry into Stylistics and History’, *Canadian Bulletin of Medical History*, 12:1 (1995), p. 48.

¹²⁵ Risse and Warner, ‘Reconstructing Clinical Activities’, pp. 192-93.

¹²⁶ Marland, *Dangerous Motherhood*, p. 101.

¹²⁷ Nancy M. Theriot, ‘Women's Voices in Nineteenth-Century Medical Discourse: A Step toward Deconstructing Science’, *Signs: Journal of Women in Culture and Society*, 19:1 (1993), pp. 16-18.

¹²⁸ Risse and Warner, ‘Reconstructing Clinical Activities’, p. 196.

enacted in 1998 and came into force in March 2000, has provided the basic guidelines for researchers for dealing with medical records and documents, both electronic and paper based. The Law requires the anonymisation of data and consent from all individuals therein, when drawing on patient-identifiable information for any research. Following this legislation, anxious voices, mostly medical scientists, claimed that the new restriction could ‘hinder legitimate study’ and would ‘jeopardise the methodological integrity of research and audit’.¹²⁹ The situation led some researchers, mostly from medical circles, to campaign for alternative ethical approaches to data on the grounds of ‘the benefit of public health’.¹³⁰ Edgar Jones, who has produced major works on the Maudsley Hospital and its patients during its early years, not only pointed out that the Act was unclear with regard to some issues, but also was concerned that ‘medical historians seeking to research patient records’ would be discouraged by the regulation.¹³¹ Risse and Warner also are concerned that ‘new legal questions of authorship, ownership, and access to clinical charts threaten to complicate matters for future researchers’.¹³² The right of individual patients to confidentiality should of course be upheld. However, scholarly and public interests, too, should be guaranteed by supplementary measures to facilitate academic research, whether in the medical science or medical humanities, unless they infringe upon patients’ rights.

Also, noteworthy is that the current system lacks consistency in terms of practical ways

¹²⁹ Rustam Al-Shahi and Charles Warlow, ‘Using Patient-Identifiable Data for Observational Research and Audit: Overprotection Could Damage the Public Interest’, *British Medical Journal*, 321:7268 (2000), pp. 1031-1032.

¹³⁰ Hester J. T. Ward et al., ‘Academic Medicine Campaign: Obstacles to Conducting Epidemiological Research in the UK General Population’, *British Medical Journal*, 329:7460 (July 2004), p. 277.

¹³¹ Edgar Jones, Shahina Rahman and Brian Everitt, ‘Psychiatric Case Notes: Symptoms of Mental Illness and their Attribution at the Maudsley Hospital, 1924–35’, *History of Psychiatry*, 23:2 (2012), p. 157.

¹³² Risse and Warner, ‘Reconstructing Clinical Activities’, p. 189.

to execute the policy, something rarely pointed out even by researchers exploiting such data for their studies. The rules and processes to access medical records containing sensitive information vary considerably according to the agency holding them. Research Ethics Committees, which review research involving medicine and medical services and decide on applications for related data, have different protocols. In addition, archives holding the materials have internal rules relating to access. Hence, a researcher in need of any medical records has to take disparate (and complicated) steps depending on which organisation has the authority to grant them access permission, as well as which archives holding the materials. Furthermore, the sanction given by one of the interested parties, either Research Ethics Committees or archives, cannot guarantee the approach to the data. Such practical difficulties have deterred a large number of researchers from carrying on their studies, since many are turned down even before they arrive at the archives. This situation is mainly derived from the fact that the Data Protection Law does not provide detailed and precise provisions. The earlier concerns that the restriction imposed by the 1998 Law would impede academic and scientific progress have proved true.

As this research drew extensively on patient-identifiable medical records, including case notes and Medical Registers, it needed to be approved by several authorities. Regarding the Maudsley Hospital records, all deposited at Bethlem Museum of the Mind, approval was given by the Research Ethics Committee of South London and Maudsley NHS Foundation Trust and the Caldicott Guardian, Dr Dele Olajide, who has overall responsibility to ensure the protection of patient confidentiality at the Foundation. Surrey History Centre, which holds the great majority of Holloway Sanatorium medical documents, granted me the access permission, after having consulted with ‘the health authority responsible for the deposit of

records' beforehand. Following the existing rules, all patient records are anonymised in an irreversible way. Any information which can be used for identifying individual patients, such as the name (of patients and their immediate relatives), age, address, and some unusual occupations will not be revealed throughout the research. Lastly, the data collected is securely stored and will be deleted permanently after completion of this study.

It should be mentioned here that re-diagnosis or re-interpretation of case histories is the last thing to be pursued in this research. As historians univocally claim, it is not historians' task to superimpose modern disease definitions and classification methods to past clinical cases, which has nonetheless been tempting to some scholars.¹³³ A few exceptional studies have analysed clinical cases of the past from a modern perspective with a particular purpose in mind, such as Trevor H. Turner's *A Diagnostic Analysis of the Casebooks of Ticehurst House Asylum, 1845-1890*.¹³⁴ However, even in Turner's work, the focus lay not on re-diagnosing but on reviewing the clinical features of the patients by applying modern operational diagnoses (the International Classification of Diseases),¹³⁵ to demonstrate that the majority of nineteenth-century case histories, especially those currently categorised as schizophrenia and manic-depressive disorder, meet the late-twentieth-century mental illness classification criteria.¹³⁶ Among the case histories exploited in this research, in some cases the symptoms obviously differ from those of typical depressive disorder, and in others, especially in those of long-term hospitalisation, the manifestation of mental illness changed remarkably over time, mostly from simple depressive to schizophrenic or manic-depressive

¹³³ Risse and Warner, 'Reconstructing Clinical Activities: Patient Records in Medical History', p. 193.

¹³⁴ Trevor H. Turner, *A Diagnostic Analysis of the Casebooks of Ticehurst House Asylum, 1845-1890* (Cambridge: Cambridge University Press, 1992).

¹³⁵ *Ibid.*, p. 14.

¹³⁶ *Ibid.*, pp. 18-21.

symptoms. Even in these cases, the original medical decision-makings and labellings will be respected, and re-diagnosis will not be made.

The medical records of the Maudsley Hospital and Holloway Sanatorium, the main historical sources for this research, have been seriously underused, despite the importance of the two mental institutions and the richness of their materials. We can find only a handful of historical works drawing upon them: Shepherd has exploited the case notes of Holloway Sanatorium, in comparison to those of Brookwood Asylum, a geographically close mental institution for pauper patients;¹³⁷ Jones and his colleagues have produced some articles, mostly about the early history of the Maudsley, based on its case notes and covering the years between 1923 and 1935.¹³⁸ Such under-utilisation can be understood to result partly from the extensive scale of patient records and the consequent intensity of the task of employing them as a historical source, and also partly from the practical issues related to archival access and the complicated processes of gaining access, as mentioned above.

With regard to Holloway Sanatorium's case notes and affiliated records, it is important to note some features of its record keeping practices. From the late 1920s, the mental hospital went through a series of changes in the way it documented its Annual Reports, patient registers, and case notes, although what brought about these changes is unclear. Annual Reports, which provided general information on the management of the Sanatorium and its

¹³⁷ See Shepherd, *Institutionalizing the Insane in Nineteenth-Century England*; Shepherd, 'The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums', pp. 223-48.

¹³⁸ See Jones, Rahman and Woolven, 'The Maudsley Hospital: Design and Strategic Direction, 1923-1939'; Jones, Rahman and Everitt, 'Psychiatric Case Notes: Symptoms of Mental Illness and their Attribution at the Maudsley Hospital, 1924-35'; Edgar Jones and Shahina Rahman, 'Framing Mental Illness, 1923-1939: The Maudsley Hospital and its Patients', *Social History of Medicine*, 21:1 (2008), pp. 107-25.

patient admission and discharge, were simplified after 1930. While the 'Report of the Committee of Management' and 'Report of the Medical Superintendent', both in the earlier part of every Annual Report, did not undergo any remarkable change in terms of format and length, the statistical tables attached in the latter part of the report were drastically reduced, from nineteen (in the copy for the year 1928) to only three (in the copy for 1931). Medical Registers, which included all the basic data on patients, including their demographic features, form of mental disorder and aetiological factors ended in 1930. A 'Register of Departures, Discharges and Transfers' came into use from around the year 1928 to replace the Medical Registers. The new type of register was sorted by the date of discharge, in contrast to its forerunner, but the content included was almost identical.

The format of the case notes also underwent a shift in the late 1920s. Previously, Holloway patient case notes had no fixed form, but were very consistent in terms of the content recorded. Each file began with the patient's registration number and admission and discharge dates; the patient's demographic information, such as name, age and marital status, came next; descriptions of current attack, history of previous episodes, supposed cause, and family history of insanity followed; if the patient was certified one, summary of medical certificates, usually two, were included; and the patient's physical and mental condition on admission was given. Then, a summary of regular medical examinations, descriptions of the patient's condition, and any special comment on the case, such as 'suicidal caution', were recorded in a free style in the order of date. From the late 1920s, however, a case file came to begin with standardised front pages, which included demographic information on the patient, 'medical certificates or statement', familial and personal history, diagnosis, prognosis, aetiology, and physical and mental condition on admission. The formatted reports were

followed by relatively freely kept notes which provided detailed descriptions of the patient's condition, prognosis, or treatment in sequence of date at intervals of a few weeks.

In tracing the history of the Maudsley Hospital and analysing the case histories of its patient, the Medical Superintendent's Reports and case notes will be intensively used here. Other medical materials, such as Registers of Admission and Departure, are not available, and it is uncertain as to whether they were kept in the 1920s and 1930s. During the period under study, the Maudsley Hospital Medical Superintendent's Reports were published five times: in January 1924, in January 1925, in December 1926, in December 1931, and December 1935. Unlike those of Holloway Sanatorium, the Maudsley Reports covered a wide range of subjects: administrative and financial information of the Hospital; statistics about its patients, including the numbers, diagnoses, and treatment they had; 'Clinical Observation' which included general commentary on varied mental disorders, methods of treatment, and a study of their aetiology; and the Report of the Work of the Central Pathological Laboratory.

In analysing the case histories of those who were treated at the Maudsley during the interwar period, there is an inevitable problem. With the closing of the Hospital in 1939 due to the outbreak of the Second World War, most of the patient case notes recorded in the second half of the 1930s were lost,¹³⁹ which is why the latest case histories available for this research were for patients discharged in 1935. Remaining case notes kept in the 1920s and 1930s are organised by the year of discharge, and materials compiled in the years 1924-27, 1928, 1931 and 1935 are digitalised, upon which this research intensively draws.

Maudsley patient files are notable for their exhaustiveness and comprehensiveness. All

¹³⁹ Jones, Rahman and Woolven, 'The Maudsley Hospital: Design and Strategic Direction', p. 366.

case files were divided into two parts: printed formats and free texts.¹⁴⁰ The first part began with a table on the front page, which included basic demographic information on the patient, diagnosis, aetiological factors (both physical and mental), prognosis, and sometimes the special remarks of physicians. In the following pages, the ‘condition of admission’ of the patient was described, in which a long table regarding physical condition came first, covering extensive bodily traits, ailments, and diseases, followed by a large space for a description of the patient’s nervous and mental condition. Then, the ‘history’ section covered family history, personal history, and the history of the current illness. The second part of the case notes was kept in a relatively free style and organised by time sequence. The contents of the latter part involved minute description of medical examinations; the medical officer’s observation of the patient’s condition; transcription of the patient’s own statement; and additional information provided by the patient’s family member. Often, ‘sample talk’ was added, which transcribed a part of the conversation between the patient and the medical staff verbatim. At the end of each file, various kinds of related documents were attached, such as a ward diary or the nurses’ notes; prescriptions; copies of correspondence from or to referrers; result sheets of medical tests; (only occasionally) follow-up reports drawn up after the patient’s discharge; and official reports to the London County Council, usually in cases where the patient had ‘a legal settlement in the County of London’ and therefore was treated at the subsidised rate.¹⁴¹ Although Maudsley case notes of inpatients are said to ‘commonly run to twenty pages’,¹⁴²

¹⁴⁰ Jones, Rahman and Everitt, ‘Psychiatric Case Notes: Symptoms of Mental Illness and their Attribution at the Maudsley Hospital, 1924–35’, pp. 157-158.

¹⁴¹ Maudsley Hospital, Medical Superintendent’s Annual Report, Year ended 31st January, 1924, BRHAM

¹⁴² Jones, Rahman and Everitt, ‘Psychiatric Case Notes: Symptoms of Mental Illness and their Attribution at the Maudsley Hospital, 1924–35’, p. 158.

the total volume of the case files often exceeded more than twice this average.

Working on the patient notes of the two mental hospitals was accompanied by all the problems mentioned earlier in this section. In particular, as case notes were kept mostly by medical officers and contained various voices, discerning ‘who said what’ in the materials is a conundrum. To retain objectivity in this sense, I have focused on the texts where the narrators were manifest or clearly indicated. The medical staff of the two institutions often specified who provided the information about the case. For instance, in many Maudsley patient notes, the ‘main informant’ of the case was written down: mostly it was a patient’s family member, but sometimes the patient spoke for himself/herself. In other cases, I have focused on sentences with quotation marks, as a second best way to identify narrators. I also have paid close attention to detailed content which only the patient could provide: including vivid explanations of physical symptoms; unique expressions of psychological conditions; specific descriptions of delusional ideas; and lived depictions of hallucinations. It is impossible to rule out, completely, the possibility of physicians distorting the original expressions and intentions of their patients in the medical records, because it was the medical staff who drafted these documents. Nonetheless, cautious reading and analysing of case notes still can lead historians as close as possible to the untrodden territory, the inside of those who were deemed to mad.

4. Mental Institutions: Holloway Sanatorium and the Maudsley Hospital

This research focuses on two mental institutions, Holloway Sanatorium and the Maudsley

Hospital, and heavily relies on the case notes kept by them. These institutions, however, were distinctive from other county asylums, the main locus of psychiatric care in this period, in many ways. Therefore, their stories cannot be read as representative of contemporary psychiatric hospitals, nor do their patients' case histories speak for all those depressed in interwar Britain. Nonetheless, they are worthy of our interest and notice, due to their special features. As a mental institution exclusively for middle-class patients, Holloway Sanatorium affords us the best chance of investigating the 'middling-sort' patients and their case histories, and pondering about the effect of class on psychiatric experience. In terms of patient care and hospital management, Holloway was, however, representative of traditional Victorian asylums. Meanwhile, the Maudsley, an up-to-date and continental style mental hospital, was a rare example of modern approaches in British psychiatry. As for the composition of patient population, it received its patients from a wide range of backgrounds; roughly half were well-to-do and the other half working-class. This offers a good contrast with Holloway as well as with other contemporary hospitals mostly filled up with those from the same stratum. The Maudsley and Holloway, therefore, can show us what otherwise cannot be shown. The two institutions and their cases widen our understanding of early-twentieth-century British psychiatry and give us new insights into female depression sufferers.

Holloway Sanatorium

On 15 June 1885, Holloway Sanatorium opened to provide the care and cure of 'the middle-class insane', at Virginia Water, Surrey. Just 20 miles from central London, it could easily be

accessed via rail from the ‘potential source of patients’.¹⁴³ Its founder, Thomas Holloway, was a wealthy medicine manufacturer and philanthropist. In the 1870s he launched two philanthropic projects, Holloway Sanatorium and Royal Holloway College. Little is known of his personal motivations, except that his setting up of the Sanatorium was influenced by Lord Shaftesbury, the first chairman of the Commissioners in Lunacy from its founding in 1845 until his death in 1885. They shared a critical viewpoint about the current system principally structured by the Lunacy Act of 1845, whereby middle-class patients were largely excluded from institutional psychiatric care. They were unwilling to be hospitalised in county asylums due to double stigma, of being certified as insane and being confined to an institution for the poor, and unable to afford expensive private asylums for upper-class patients, such as Ticehurst Private Asylum.¹⁴⁴ When Shaftesbury endeavoured to resolve this problem by raising funds for building a mental institution for the middle class, Holloway reached out his hand to realise the scheme.¹⁴⁵

The main remit of its establishment, as a mental asylum for the ‘middling-sort’, affected almost all aspects of the hospital. Its building and facilities were designed to meet the standard that would be expected by the middle classes. Consequently, even before its opening, the luxurious and lavish architecture attracted professional and public interest, as seen in an article in *The Builder* which applauded in 1882 that ‘such a combination of rich

¹⁴³ Shepherd, *Institutionalizing the Insane*, p. 19; Shepherd, ‘The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums’, p. 226.

¹⁴⁴ In order to understand the history of the institution, read MacKenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum 1792-1917*.

¹⁴⁵ According to Anna Shepherd, Holloway’s view on philanthropy was far from simple, firmly believing that ‘charity demeans the recipient of charity’ and that ‘help should be given to the deserving’, and he possessed so-called ‘London shopkeeper mentality’ mixed with liberal radicalism, which probably led him to pay attentions to hardships of the (lower) middle class. Shepherd, *Institutionalizing the Insane*, p. 17.

colouring and gilding is not to be found in any modern building in this country, except the House of Lords.’¹⁴⁶ Decoration of the building was so splendid that some of observers expressed openly abhorrence, finding it ‘very garish and ghastly but appropriate’.¹⁴⁷ The Sanatorium was equipped with various facilities for its inmates’ well-being and amusement, in the belief that entertainment served therapeutic purposes: including a swimming pool, a high-ceiling and vast recreation hall, tennis courts, billiard rooms, and Turkish baths.¹⁴⁸ Such amenities distinguished Holloway Sanatorium from other county asylums, and were to fill in the daily routine of its patients in a way suitable to their social class.

Additionally, the founder’s philanthropic intention that the ‘*deserving* middle-class cases would be admitted at reduced rates supplemented by the surplus accruing from those patients able to afford higher fees’ was realised by the strict admission policy.¹⁴⁹ In Holloway, there were three categories of patients based on rates they paid: the first- and second-class patients paying fees in full and the third paying aided rates. Applicants for the third-class admission had to meet the criteria of the middling sort set up by the institution, and their applications were not decided by the medical superintendent alone but considered at General Committee meetings. According to the first medical superintendent of Holloway Sanatorium, Sutherland Rees Philipps, ‘several hundreds of applications were received, the great number expecting to be admitted gratuitously or at a low rate of board’,¹⁵⁰ evidence of high demand amongst the middle class for psychiatric treatment at the assisted rate.

¹⁴⁶ Shepherd, ‘The Female Patient Experience’, pp. 226-227; Shepherd, *Institutionalizing the Insane*, p. 24.

¹⁴⁷ Shepherd, *Institutionalizing the Insane*, p. 24.

¹⁴⁸ *Ibid.*, p. 37-38.

¹⁴⁹ Shepherd, ‘The Female Patient Experience’, p. 227.

¹⁵⁰ Shepherd, *Institutionalizing the Insane*, p. 30.

In terms of principles related to admission and discharge, no patient could remain as an inmate for longer than a year; no patient whose case was hopeless could be received; and no patient could be readmitted after having been discharged. These rules were similar to those of other registered institutions, such as Bethlem Hospital, and were relaxed over time, as in other mental hospitals.¹⁵¹ By the start of the twentieth century, none of these policies were applied in practice. A vast number of patients were confined in Holloway more than twelve months, and some stayed even for several decades, mostly until their death. Consulting the Annual Report for the year 1901, among those who were discharged as recovered one sixth stayed longer than one year at the Sanatorium, and about 60 percent of those who died at Holloway resided there for more than twelve months.¹⁵² A large portion of inmates were diagnosed as suffering from incurable conditions, notably senile dementia: taking the year 1901 as an example again, out of 367 inmates who were on the register of the institution at the last day of the year, 83 patients had been diagnosed with dementia.

At its opening, Holloway Sanatorium could accommodate 200 patients. For the first six months, the institution accepted seventy inmates, including eight voluntary boarders, and in the following year, 1886, it received 89 certified and 17 voluntary patients. However, the number of patients increased rapidly so that the figure of certified patient admissions reached its peak, almost 200, in 1893.¹⁵³ During the first two decades, slightly over 4,000 patients were treated at Holloway in total, and thirty percent among them were voluntary boarders. Around the turn of the century, the number of admissions per year remained between 100 and 130, the total cases under treatment for one year was about 450 (and sometimes more than

¹⁵¹ Ibid., pp. 31-32.

¹⁵² Holloway Sanatorium, Annual Report for the Year 1901, No. 16, SHC Ac. 2620/1/4.

¹⁵³ Shepherd, *Institutionalizing the Insane*, p. 29; Shepherd, 'The Female Patient Experience', p. 232.

that) and the average number of residents was slightly over 350.¹⁵⁴ Throughout the early twentieth century the average daily number on the Register remained stable, but the number of admissions dropped somewhat probably due to the prolonged mean hospitalisation period.

As mentioned earlier, women's over-representation in asylum population has been a hot topic for a long time. At Holloway Sanatorium, during its first one and half years of operation, women accounted for about 60 percent of all patients. Such female predominance, however, did not last long. According to Shepherd, the ratio between the sexes among Holloway inmates in the years 1885 to 1905 was even: 51 percent of women and 49 percent of men. Nevertheless, she notes that there were gender differences, in that women stayed longer than men at the Sanatorium, and that this caused a chronic shortage of available beds for new female patients.¹⁵⁵ Therefore, the number of admissions and the number of residents need to be discussed separately. The rates of annual admissions varied considerably, making it hard to generalise: for instance, in 1890, the absolute majority of newly accepted inmates was male; for some years around the turn of the century male admissions outnumbered female ones; and in the 1910s and 1920s, female admissions exceeded those of men. However, in terms of the number of inmates, there was a tendency for female patients to consistently outnumber their male counterparts. The average number of patients on the Register had remained stable since the 1890s, approximately 150 males and 200 females,

¹⁵⁴ Holloway Sanatorium, Annual Report for the Year 1903-1904, Nos. 18-20, SHC Ac. 2620/1/4.

¹⁵⁵ According to Shepherd, the majority of female patients were single and their civil status acted to extend the confinement period. However, the ratio of single women fluctuated to a considerable degree that it is hard to suggest any general information. Furthermore, it is also difficult to find any correlation between patient's civil status and his/her length of stay at Holloway, which will be illustrated in detail in Chapter 5. In other words, it could be misleading that, as many medical historians assume, unmarried inmates remained longer than their married counterparts at asylums. Shepherd, *Institutionalizing the Insane*, p. 30.

which can be attributed to the accommodation capacity. It did not change at least until the outbreak of the Second World War.¹⁵⁶

As already mentioned, a considerable number of Holloway patients were uncertified ‘voluntary boarders’, who could confine and discharge themselves as they wanted unlike certified patients. Their existence makes the story of Holloway Sanatorium unique and remarkably complex. However, as Shepherd rightly points out, voluntary mental patients have kept out of the limelight of historical research mainly because ‘record keeping for these patients was less thorough’.¹⁵⁷ The Annual Reports of the Sanatorium only specified the number of male and female voluntary patients, but provided no further information concerning age, occupation, diagnosis, and prognosis. Consulting the case notes of voluntary patients, they were kept sparsely and only occasionally, and lacked in content and detail. Furthermore, those materials were poorly stored and a large number of them have gone missing. Consequently, although it is obvious that voluntary boarders’ experiences were different from those of certified patients, it is hard to tell how different they were or to suggest exactly what this group of patients experienced in the course of their mental illness and during their stay in the mental institution.

Although Holloway Sanatorium was distinctive in terms of the composition of its patient population and its luxurious exterior and facilities, it was very close in many ways to county asylums in terms of its practice and management. The conventionality of Holloway can be verified by the role of its medical superintendent, who was closer to an administrator, rather than a medical practitioner. The superintendent had ‘the entire direction of the

¹⁵⁶ Holloway Sanatorium, Annual Report for the Year 1936 and 1937, Nos. 51-52, SHC Ac. 2620/1/9.

¹⁵⁷ Shepherd, *Institutionalizing the Insane*, pp. 32-33.

institution': he was responsible for all the patients admitted as well as all the asylum's employees.¹⁵⁸ Although the final authority and responsibility lay with the superintendent, everyday practice was mostly directed by two assistant medical officers. It is little wonder that the sole and short article presented by its first medical superintendent, Sutherland Rees Philipps, in the *British Medical Journal* was about the position of the assistant medical officers in asylums.¹⁵⁹ In particular, it provides a stark contrast to Maudsley Hospital, where one of the purposes when it was established was to encourage and support research and teaching. As a result, many of its medical staff were actively engaged in publishing articles in medical journals. As for the diagnosis and treatment of patients, Holloway Sanatorium were not much different from county asylums, except that the middle-class asylum provided its inmates with diverse entertainments and recreational opportunities which were believed to be therapeutic.¹⁶⁰

The Maudsley Hospital

On 31 January 1923, the Maudsley Hospital finally and officially opened its door to Londoners. Most narratives of its history begin with Henry Maudsley's contribution of £30,000 to the London City Council in order to found a new type of mental hospital in 1907. However, the Maudsley Hospital was a joint work of Maudsley, a psychiatrist who ran a

¹⁵⁸ Shepherd, *Institutionalizing the Insane*, p. 28.

¹⁵⁹ *British Medical Journal*, 17 March 1894, p. 606.

¹⁶⁰ Shepherd, 'The Female Patient Experience', pp. 226-227.

private asylum for the rich in West London,¹⁶¹ and Frederick Mott, the first neuropathologist of the London County Council asylums and director of their laboratory.¹⁶² Mott felt keenly the necessity of ‘some earnest attempt to establish a means of intercepting for hospital treatment such cases of incipient and acute insanity as are not yet certifiable’, as well as of ‘a hospital with facilities for postgraduate training in psychiatry and neurology’.¹⁶³ He was deeply impressed by German university psychiatric hospitals, like Emil Kraepelin’s Clinic in Munich, which he claimed would ‘serve both a practical and a scholarly purpose’.¹⁶⁴ Mott influenced Maudsley so much that the two came to share ‘common causes’ and have ‘full sympathy’ around the time when they suggested a plan entitled ‘Proposed Hospital for the Care and Treatment of Acute Recoverable Cases of Mental Disease, with due Provision for Clinical and Pathological Research’ in July 1907 to the London County Council. According to the proposal, the new mental hospital was to treat early and acute cases only; to have an out-patient department; to be in a central position; to be made for clinical and pathological research; and to provide teaching and training for medical students. It was Mott who came to the forefront and led the negotiation with the London County Council until an overall agreement was reached regarding the plan. Meanwhile, Maudsley remained anonymous – in the proposal he was identified as ‘the Donor’ – and disclosed his name only when his offer

¹⁶¹ ‘Henry Maudsley’, Oxford Dictionary of National Biography
<https://doi.org/10.1093/ref:odnb/37747>.

¹⁶² Jones, Rahman and Woolven, ‘The Maudsley Hospital: Design and Strategic Direction’, p. 358; Patricia Allderidge, ‘The Foundation of the Maudsley Hospital’, in German E. Berrios and Hugh Lionel Freeman (eds.), *150 Years of British Psychiatry, 1841-1991 Vol. 1* (London: Gaskell, 1991), pp. 83-84.

¹⁶³ Jones, Rahman and Woolven, ‘The Maudsley Hospital: Design and Strategic Direction’, pp. 359-360.

¹⁶⁴ Rhodri Hayward, ‘Germany and the Making of “English” Psychiatry’, in Volker Roelcke, Paul Weindling and Louise Westwood (eds.), *International Relations in Psychiatry: Britain, Germany, and the United States to World War II* (Rochester, NY: University of Rochester Press, 2010), pp. 67-68.

was finalised in February 1908.¹⁶⁵

With the agreement made, the London County Council disbursed another £30,000 to cover a half of the expenditure needed to realise the scheme, and devised new legislation in 1915 to grant the new institution the privilege of receiving voluntary patients, which was allowed only to registered hospitals and licensed houses.¹⁶⁶ However, the plan was delayed by a series of troubles: it took three years just to find and purchase a desirable site for the Hospital; a building strike occurred in the very early stages of construction; and then the Great War broke out. As soon as the building was completed in 1916, the Hospital was yielded to the Royal Army Medical Corps and the Ministry of Pensions to treat ‘neurological cases arising in connection with the war’, so-called shell-shock.¹⁶⁷ Compared to Thomas Holloway who had never seen the completion of his grand project due to his untimely death in 1883, Maudsley was lucky to see in person his hospital doing good before his death in 1918, even though it was not serving its original purpose.¹⁶⁸ Finally, the Hospital was returned to the London County Council and opened to civilians in early 1923.

The Maudsley Hospital, borrowing Edgar Jones’ expression, ‘could not have been further from the traditional asylum’ when seen from outside.¹⁶⁹ It was located at Denmark Hill, South London, easily accessed by tram as well as train, which was distinct from Victorian institutions mostly based on remote areas and surrounded by high walls. As for the architecture style, the Maudsley building did not resemble conventional English asylums,

¹⁶⁵ Allderidge, ‘The Foundation of the Maudsley Hospital’, pp. 83-84.

¹⁶⁶ Jones, Rahman and Woolven, ‘The Maudsley Hospital: Design and Strategic Direction’, p. 363.

¹⁶⁷ Maudsley Hospital, Medical Superintendent’s Annual Report, Year ended 31st January, 1924, BRHAM, p. 1.

¹⁶⁸ Allderidge, ‘The Foundation of the Maudsley Hospital’, p. 86-88.

¹⁶⁹ Jones, Rahman and Woolven, ‘The Maudsley Hospital: Design and Strategic Direction’, p. 357.

because it followed a German prototype, the psychiatric clinic at Ludwig-Maximilians-Universität in Munich.¹⁷⁰ The accommodation capacity, 157 beds on its opening (72 beds for each sex and 13 private rooms), was much smaller than conventional large-scale asylums, which could house as many patients as a large village.¹⁷¹ However, its establishment purposes and functions made the Maudsley more distinctive from contemporary mental institutions. According to the first Annual Report, the medical superintendent declared five main purposes of the Hospital, a modified version of the original proposal of its co-founders: research into pathology and treatment; arrangements for teaching; cooperation with general practitioners; treatment of cases of organic and functional nervous disorders; and treatment of cases of psychoses with a high probability of recovery.

‘To promote exact scientific research into the causes and pathology of insanity’ was one of the original aims set by the Maudsley founders.¹⁷² The Central Pathological Laboratory, which had been led by Mott himself since 1895, was already transferred to the Maudsley site in 1916 when the building was just completed. Even after the full opening of the Maudsley, the Laboratory retained its autonomy and was not annexed to the Hospital, which however was to work well only while Mott held the post. Mott had proved that syphilis caused general paralysis of the insane (GPI) in the early stage of his career, which led him to be a ‘committed somaticist’ and to look for physical causes of mental disorders.¹⁷³ As not only the idea about mental institutions but also his understanding of psychiatry itself were

¹⁷⁰ Ibid., p.362.

¹⁷¹ For instance, Brookwood Hospital, the second county asylum of Surrey, was able to accommodate 650 patients when it was established in 1867. However, it expanded so quickly that by the 1930s it could house patients more than 2.5 times than the original capacity, ‘the size of a village’: Shepherd, ‘The Female Patient Experience’, pp. 225-226.

¹⁷² Jones, Rahman and Woolven, ‘The Maudsley Hospital: Design and Strategic Direction’, p. 371.

¹⁷³ Hayward, ‘Germany and the Making of “English” Psychiatry’, p. 70.

deeply influenced by Kraepelin, Mott was eager to apply Kraepellean frameworks to the Maudsley and to carry out scientific research to underpin them. However, Edward Mapother, the first superintendent of the Maudsley, and Frederick Golla, a new director of Central Pathological Laboratory succeeding Mott, differed from him in their understanding of psychiatry as well as in their attitude towards Kraepelinian psychiatry, which inevitably brought about changes in the direction of research from simply searching for physical causes of mental illness to pursuing ‘correlation between physical imbalances and mental disturbances’.¹⁷⁴ Later when Mapother and Golla were estranged from each other, it became difficult to expect close and systematic cooperation between the Hospital and the Laboratory.¹⁷⁵

The Maudsley out-patient department was opened to the public in December 1922, a couple of months earlier than its formal commencement. Then, the idea of treating mental patients without confinement was not completely new in English psychiatry, since some asylums, including St Thomas’ Hospital, Guy’s Hospital and St Mary’s Hospital, had launched outpatient clinics between the Lunacy Act of 1890 and the Great War and ‘Special Medical Clinics’ had been run by the Ministry of Pensions in order to treat veterans suffering from war neurosis after the War.¹⁷⁶ The outpatient department of the Maudsley, although not unprecedented, was an unparalleled success. The demand on this type of medical service surged so that the Maudsley had to recruit medical staff to work exclusively in this

¹⁷⁴ *Ibid.*, pp. 68-74.

¹⁷⁵ Jones, Rahman and Woolven, ‘The Maudsley Hospital: Design and Strategic Direction’, p. 358.

¹⁷⁶ Maudsley Hospital, Medical Superintendent’s Annual Report, Year ended 31st January, 1924, BRHAM; Jones, Rahman and Woolven, ‘The Maudsley Hospital: Design and Strategic Direction’, pp. 369-371.

department.¹⁷⁷ During the first year of its running, 898 patients (415 males and 483 females) in total attended the clinic, and among them 334 patients (140 males and 194 females) were admitted to the Hospital as inpatients. At the Maudsley, the outpatient department served ‘as the main channel of admission to the wards’, which explains why the ratio of ‘persons treated first as outpatients and later as inpatients’ was higher in this Hospital than in its German model clinics.¹⁷⁸ In the same vein, continual and prolonged treatment in the outpatient clinic was uncommon.¹⁷⁹ Nonetheless, the number of outpatients increased steadily throughout the interwar years, to exceed 2,000 a year in 1931.¹⁸⁰

The most remarkable privilege the Maudsley enjoyed was that it could treat all its patients, both inpatients and outpatients, ‘entirely on a voluntary basis’.¹⁸¹ At the Maudsley, therefore, ‘no patient should be admitted under certificate’ and any patient could leave the Hospital within 24 hours of giving notice of desire to do so.¹⁸² The medical superintendent declared the principle at the very beginning of the first Annual Report, and later expatiated upon it as a way to impose ‘the least possible restriction upon (patients’) liberty’.¹⁸³ Mental patients and their relatives might well believe that this policy exempted them from the stigma, inseparable from certification, but not all of them could benefit from this initiative. The Hospital drew a line to distinguish itself from ‘the network of asylums that traditionally

¹⁷⁷ *Ibid.*, p. 370.

¹⁷⁸ Maudsley Hospital, Medical Superintendent’s Annual Report, Year ended 31st January, 1924, BRHAM, pp. 7-14.

¹⁷⁹ *Ibid.*

¹⁸⁰ Maudsley Hospital, Medical Superintendent’s Annual Report, Period from 1st January, 1927, to 31st December, 1931, BRHAM.

¹⁸¹ Maudsley Hospital, Medical Superintendent’s Annual Report, Year ended 31st January, 1924, BRHAM.

¹⁸² *Ibid.*

¹⁸³ Jones, Rahman and Woolven, ‘The Maudsley Hospital: Design and Strategic Direction’, p. 364.

treated major mental illness' and identified some disorders which were considered to be suitable for noncertified treatment at the Maudsley.¹⁸⁴

neurosis (hysteria of various forms, neurasthenia, anxiety and obsessional states) and certain varieties of psychoses, e.g. mild phases of the manic-depressive types, psychoses associated with exhaustion, with pregnancy and the puerperal period, with post-infective states, with syphilitic brain disease of the interstitial types, with alcoholisms and other drug habits, with endocrine disturbances, and generally cases exhibiting mental symptoms associated with all forms of definite bodily disease.¹⁸⁵

Although the list of disorders 'amenable to study and treatment' went through some changes, notably the addition of schizophrenia, such guidelines survived the interwar period.¹⁸⁶ The Hospital, therefore, was often criticised for its selectiveness by experts in the same field, who claimed that the Maudsley filtered patients to receive those with a good prognosis only,¹⁸⁷ and that 'its training and research requirements predominated' over the demands of patients.¹⁸⁸

¹⁸⁴ Edgar Jones, 'Aubrey Lewis, Edward Mapother and the Maudsley', *Medical History*, Supplement 22 (2003), pp. 5-6.

¹⁸⁵ *Ibid.*

¹⁸⁶ Jones, Rahman and Woolven, 'The Maudsley Hospital: Design and Strategic Direction', p. 366.

¹⁸⁷ Edgar Jones and Shahina Rahman, 'Framing Mental Illness, 1923-1939: The Maudsley Hospital and its Patients', *Social History of Medicine*, 21:1 (2008), pp. 108-109.

¹⁸⁸ Jennifer M. Walke, *Repute and Remedy: Psychiatric Patients and their Treatment at Bethlem Royal Hospital, 1930-1983* (unpublished Ph.D. thesis: London School of Hygiene & Tropical

Compared with those who headed up traditional asylums, the medical superintendent of the Maudsley had a wider range of responsibilities. Mapother had run the special hospital for veterans suffering from war neurosis in the building constructed to house the Maudsley since 1919, and was appointed as the first medical superintendent of the Hospital at its official opening when aged forty-one. He held the position until his premature retirement due to ill health in 1939, only one year before his death. In the early years of the Maudsley, Mapother controlled all the admission cases in person by checking the junior medical staff's preliminary diagnoses and assessments.¹⁸⁹ Due to the close link between the Maudsley and the University of London, teaching was part of his responsibilities, too. In 1936, he was elected to a chair in clinical psychiatry, then newly founded, of the University.¹⁹⁰ Even with his busy schedule, he did not neglect research and published dozens of papers covering various subjects,¹⁹¹ including manic-depressive psychosis and its classification.¹⁹² Furthermore, it is no exaggeration to say that his administrative and sometimes statesmanlike ability decided the development of the Maudsley.¹⁹³ When troubled by the lack of funding, Mapother succeeded in attracting a significant endowment from the Rockefeller Foundation, by applying proper strategies to satisfy the criteria and lobbying key people with a direct

Medicine, 2015), pp. 53-54.

¹⁸⁹ Jones and Rahman, 'The Maudsley Hospital and its Patients', p. 112.

¹⁹⁰ 'Edward Mapother', Oxford Dictionary of National Biography
<https://doi.org/10.1093/ref:odnb/58394>.

¹⁹¹ To name a few, Edward Mapother, 'Treatment of mental disorder on a Voluntary Basis', *Lancet*, 204:5279 (1924), pp. 897-902; 'Impressions of Psychiatry in America', *Lancet*, 215:5564 (1930), pp. 848-852; 'Mental Symptoms Associated with Head Injury', *British Medical Journal*, 4012 (1937), pp. 1055-1061; 'The Physical Basis of Alcoholic Mental Disorders', *Addiction*, 36:3 (1939), pp. 103-132.

¹⁹² Edward Mapother, 'Discussion on Manic-Depressive Psychosis', *The British Medical Journal*, 2:3436 (1926), pp. 872-879. This presentation overheated the British debate on the classification of depression, which will be illustrated in detail in Chapter 2.

¹⁹³ *The British Medical Journal*, 1:4134 (30 March 1940), pp. 552-553.

influence on the decision making process.¹⁹⁴ The endowment of the Rockefeller, of course, was crucial in Maudsley's leap to a world-class institute of psychiatry. Mapother was described as 'a pluralist of no mean order' by his successor, Aubrey Lewis,¹⁹⁵ and his commitment to the Maudsley 'created an institution and environment in which research could flourish' in the post-war era.¹⁹⁶

At this point, however, we need to ask whether or not the Maudsley Hospital was as innovative as it was seen from outside. To conclude straightforwardly, there was little to be said about its innovative approach in terms of its daily practice. Although the medical staff were assiduous at 'research into pathology and treatment' in order to achieve the distinctive purposes of the Maudsley, they were not equipped with any special means of diagnosing and treating their patients.¹⁹⁷ The medical officers were involved in various kinds of clinical tests: in the first year, for instance, they tried gland therapy, insulin therapy and antisyphilitic remedies, which nonetheless were not in wide use but applied to only a limited number of patients mostly deemed to have specific somatic aetiologies.¹⁹⁸ Consulting case files, experimental or innovative therapies were rarely mentioned. For most of the patients, sedatives, such as bromides and paraldehyde, were frequently prescribed, and continuous baths were encouraged,¹⁹⁹ in a similar way to contemporary mental hospitals. Also, the fact

¹⁹⁴ Edgar Jones and Shahina Rahman, 'The Maudsley Hospital and the Rockefeller Foundation: The Impact of Philanthropy on Research and Training', *Journal of the History of Medicine and Allied Sciences*, 64:3 (2008), pp. 273-299.

¹⁹⁵ Aubrey Lewis, 'Edward Mapother and the Making of the Maudsley Hospital', *The British Journal of Psychiatry*, 115:529 (1969), pp. 1349-1366

¹⁹⁶ Jones, 'Aubrey Lewis, Edward Mapother and the Maudsley', pp. 16-17.

¹⁹⁷ Maudsley Hospital, Medical Superintendent's Annual Report, Year ended 31st January, 1924, BRHAM.

¹⁹⁸ Ibid.

¹⁹⁹ Jones, Rahman and Everitt, 'Psychiatric Case Notes: Symptoms of Mental Illness and their

that Mapother advocated ‘open-air treatment’ with a firm belief in the curative properties of fresh air and sunlight and boasted the Maudsley’s veranda system as the best way to implement it shows, in a way, the absence of ‘effective medicines and clinical procedures’.²⁰⁰ There were wide discrepancies between what the Maudsley pursued and what it could perform, which will be discussed again in the following chapter.

Regarding the population of Maudsley patients in the interwar years, it should first be mentioned that the number of cases treated at the Hospital rose fast. In the first year of its operation, outpatients numbered 898, inpatients 466, and the total number of cases treated 1012.²⁰¹ In the following year, the total number of outpatient cases was 1045, inpatient cases 590, and ‘the net number of persons treated’ exceeded 1300. Already in 1928 the total number of patients treated surpassed 220, and in 1930 the annual number of outpatient cases doubled compared to its opening. The figure of inpatients treated reached 800 in 1927 to remain almost the same for five years, and leaped up to 900 in 1932, which lasted for some years.²⁰² The average number of residents and the number of patients remaining at the end of each year showed a steep upwards curve: the figure was between 140 and 150 when it opened; and went up to slightly more than 170 in 1928 and to about 220 in 1932,²⁰³ which was facilitated by a series of ward expansions.

Attribution at the Maudsley Hospital, 1924–35’, pp. 164-165.

²⁰⁰ Ibid.; Jones and Rahman, ‘Framing Mental Illness, 1923–1939: The Maudsley Hospital and its Patients’, p. 123.

²⁰¹ Maudsley Hospital, Medical Superintendent’s Annual Report, Year ended 31st January, 1924, BRHAM.

²⁰² Maudsley Hospital, Medical Superintendent’s Annual Report, Period from 1st February, 1925, to 31st December, 1926, BRHAM, Medical Superintendent’s Annual Report, Period from 1st January, 1927, to 31st December, 1931, BRHAM.

²⁰³ Maudsley Hospital, Medical Superintendent’s Annual Report, Period from 1st January, 1932, to 31st December, 1935, BRHAM.

The demographic features of those treated at the Maudsley are located in the earliest records of the Hospital. In the first Annual Report, the medical superintendent noted that ‘a considerable proportion of patients has been of the well-educated classes, including a number of clergymen and doctors, hospital nurses and school teachers’. However, no concrete and detailed data to support this were suggested. What is worse, with regard to female patients’ social backgrounds, the Report noted that ‘statistics would be of little value’.²⁰⁴ Based on case notes, Edgar Jones and Shahina Rahman have analysed the class and occupational backgrounds of male patients. Amongst males treated in the 1920s and 1930s, 48 percent of inpatients were from upper and middle classes and 42 percent working class; 32 percent of outpatient came from affluent backgrounds and 55 percent from the labouring class.²⁰⁵ Though Jones finds ‘a bias in favour of middle-class patients’ from this result,²⁰⁶ it is more reasonable to assume that the disparity is inevitably related to financial burdens working-class households had to bear when their breadwinners were hospitalised.²⁰⁷ Regarding female patients’ social strata, Jones and Rahman mention little except that ‘the social class of females could not be assessed as most were recorded as housewives or living with

²⁰⁴ Maudsley Hospital, Medical Superintendent’s Annual Report, Year ended 31st January, 1924, BRHAM, p. 6.

²⁰⁵ Jones and Rahman, ‘The Maudsley Hospital and its Patients’, p. 118.

²⁰⁶ Ibid.

²⁰⁷ For more information about the importance of economic and financial consideration when deciding admission to (and discharge from) a mental hospital, see David Wright, ‘Getting out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century’, *Social History of Medicine*, 10:1 (1997), pp. 137-155; Joseph Melling and Bill Forsythe, *The Politics of Madness: The State, Insanity and Society in England, 1845–1914* (London: Routledge, 2006), pp. 145-175; Joseph Melling, ‘Buried Alive by Her Friends: Asylum Narratives and the English Governess, 1845–1914’, in Pamela Dale and Joseph Melling (eds.), *Mental Illness and Learning Disability Since 1850: Finding a Place for Mental Disorder in the United Kingdom* (London: Routledge, 2006), pp. 65-90; MacKenzie, *Psychiatry for the Rich*, pp. 15-23.

parents.’²⁰⁸ This issue will be delved into thoroughly in the following chapters on female patients’ experiences, to reach a conclusion that among female inpatients working-class women slightly outnumbered their upper-class counterparts and any preference for middle-class patients was hard to detect in the Maudsley medical records.

In the Maudsley patient population, with regard to both inpatients and outpatients, women’s numerical predominance lasted throughout the whole period under study. The first Annual Report read that ‘there has been considerably less pressure on the male wards than on female’, which, according to the medical superintendent, was ‘universal’ in mental institutions and therefore had been anticipated.²⁰⁹ It was because male and female wards (excluding 13 private rooms) were equipped with the same number of beds, 72 respectively, but they received 190 men and 236 women in 1923 and 197 males and 257 females in the next year.²¹⁰ Based on quantitative analysis of case notes, Jones and Rahman have concluded that among the whole patient population about 60 percent were women in the 1920s and 1930s, and that the gender difference in the Maudsley was, nonetheless, less marked compared to other contemporary institutions, such as the Bethlem Hospital, and the national average.²¹¹ In its outpatient department, the gap between male and female patients was almost the same:²¹² there were about one and half times more women than men throughout the 1920s.²¹³ Geographically, the great majority of Maudsley patients came from within

²⁰⁸ Jones and Rahman, ‘The Maudsley Hospital and its Patients’, pp. 116-118.

²⁰⁹ Maudsley Hospital, Medical Superintendent’s Annual Report, Year ended 31st January, 1924, BRHAM.

²¹⁰ Maudsley Hospital, Medical Superintendent’s Annual Report, Year ended 31st January, 1925, BRHAM.

²¹¹ Jones and Rahman, ‘The Maudsley Hospital and its Patients’, p. 116.

²¹² Ibid.

²¹³ Maudsley Hospital, Medical Superintendent’s Annual Report, Year ended 31st January, 1924, BRHAM; Year ended 31st January, 1925, BRHAM; Period from 1st February, 1925, to 31st December,

Greater London and only a small number of patients, less than 10 percent, were from beyond the boundary.²¹⁴ The regional distribution seemed to result mostly from medical fee issues: ‘patients having a legal settlement in the County of London’ could be admitted at a reduced rate, covered by the London County Council, and otherwise patients had to pay ‘the full maintenance rate’,²¹⁵ which was at least £5 per week in the year 1923.²¹⁶

5. Structure of Thesis

This thesis is divided into two parts: the first provides an overview of psychiatry and depression in the early twentieth century; and the second concentrates on the lived experience and lay understanding of patients. Chapter 1 draws a general picture about British psychiatry. At the outset, it illustrates how British psychiatry reacted to Freudianism and Kraepelinianism, two major doctrines which have been said to usher in modern psychiatry, and reconstructs psychiatric practice, in relation to diagnosis, classification and treatment. Then, mental health policy in those decades and related major legislation are examined in order to understand the conditions shaping psychiatry. This chapter concludes that in terms of

1926, BRHAM; Period from 1st January, 1932, to 31st December, 1935, BRHAM.

²¹⁴ Jones and Rahman, ‘The Maudsley Hospital and its Patients’, p. 118.

²¹⁵ Maudsley Hospital, Medical Superintendent’s Annual Report, Year ended 31st January, 1924, BRHAM.

²¹⁶ The cost corresponds to over £260 of today: <http://www.thisismoney.co.uk/money/bills/article-1633409/Historic-inflation-calculator-value-money-changed-1900.html> [accessed on 13 September 2017]

psychiatric development the interwar years should be defined as a transition period, rather than the beginning of psychiatric modernism, and suggests that nineteenth-century medical traditions should also be taken into serious consideration in understanding British psychiatry in this period.

Chapter 2 narrows its focus down to the notion of depression. It illustrates how the affective disorder was defined and classified by professionals in the early twentieth century, based on various expert literature. Even though by the interwar years the victory of depression over melancholia seemed irreversible, its status as an official diagnosis was not secure at all. Well into the interwar decades, psychiatrists could not yet resolve the confusion over terminology and classification of the affective disorder (as well as of its neighbouring concepts). They failed to make any remarkable advance from what nineteenth-century psychiatry had achieved, notably in re-conceptualising melancholia and introduction the term 'depression'. To see the birth of modern depression, one had to wait until post-war period. The story of depression, thus, can be read as one of the cases showing that interwar-period psychiatry was still under the strong influence of Victorian medical tradition and modern psychiatry did not arrive yet until the post-war era.

In the second part of the thesis, various experiences of female patients who were diagnosed as suffering from depression are reconstructed and analysed, based on case notes of the Maudsley Hospital and Holloway Sanatorium. These patients are categorised into three groups, according to the patient's life stage: adolescence, adulthood, and middle and old age. In analysing patients' narratives embedded in their case histories, the focus will be on their symptom descriptions and causal attributions. In Chapter 3, cases of adolescent patients are investigated, who were aged under their mid-twenties and single. Due to the limited sample

size, this chapter focuses on a close reading of case files. Regarding types of symptoms, what those young depression patients experienced did not differ much from their older counterparts. The details, contents and languages applied, however, exhibited some distinct features which were limited to this age group. Reading these cases of young patients demonstrates why guilt, shame, and self-reproach should be interpreted as a core part of female experiences of depression. Meanwhile, case notes selected for this chapter provide a vivid picture about girls' sexuality and sexual behaviour in the interwar period, proving their usefulness as a source for the history of sexuality.

Chapter 4 concentrates on mature patients, who were aged between their mid-twenties and mid-forties, and aims to reconstruct their experience of both mental illness and daily life. It analyses lay causal attributions of depression and explores the ways in which they did and did not relate life events to mental disorder. Symptom descriptions made by those female patients demonstrate that the manifestation of mental illness was largely decided by age, class and gender. In this age group, naturally enough, a large number of cases were related to childbirth. In such cases, patients and doctors shared a similar language to describe symptoms, and tended to reach a consensus about the aetiology with ease. It shows that the concept of puerperal insanity, a disorder framed in the nineteenth century, was not only still valid, although the notion had been discarded as a diagnosis in the expert group, but also popularised enough to shape lay understanding of the close relationship between pregnancy, childbirth and mental breakdown. It also demonstrates the lingering impact of Victorian medical tradition upon interwar-period psychiatry. Patients frequently mentioned financial hardship, matrimonial conflict and mental stress resulting from caring roles and responsibilities as aetiological factors, often combining one with another. Those cases

demonstrate that patients were more inclined to find the origin of their mental disorder in what they experienced in daily life, rather than from heredity or family history.

The last chapter examines middle- and old-aged patients and their case histories. Those patients aged over 45 were more inclined to suffer from hallucination and delusion than their younger fellows. In this age group, many expressed hypochondriacal concerns, especially worry about bowels, illustrating that established medical knowledge exerted strong influence on lay opinion and shaped the manifestation of mental illness and women's disease experience. Bereavement, financial hardship and burdens related to caring roles were most commonly referred to as causes or triggers of mental depression by these patients. However, menopause was rarely seen as a causal factor by female patients in their late forties and fifties. It makes a stark contrast to professional causal attributions made by the physicians of the Maudsley and Holloway, who highlighted that these patients were undergoing climacteric changes and their mental breakdown could be ascribed to the critical period itself.

The Conclusion confirms why patients' experience of depression can be located where age, sex and class intersected with each other, and stresses that lay understanding of health and ill-health was largely founded on medical knowledge produced and widely circulated in earlier periods, mostly in the Victorian era, rather than in the recent past. What the medical materials have informed us about women's life in general and women's sexuality in the interwar years will be briefly described. In a nutshell, living as a woman meant that one had to cope with more traditional and conventional conditions rather than new and modern ones. Then, it turns to male depression patients and their experiences to engage in the long-standing debate on gender and madness. By comparing and contrasting men's and women's depression experiences, it is possible to discern some feminine features of depression, notably

self-reproach. Lastly, a new question emerges, since there exist remarkable similarities between the experiences of early-twentieth-century female depression patients and their late-twentieth-century counterparts. In particular, gendered roles and adverse life events related to them were at the centre of the lay causal attributions both in the early and late twentieth century.

Chapter 1. British Psychiatry in the Early Twentieth Century

Around the dawn of the twentieth century, psychiatry was considered, by even medical professionals, as a ‘Cinderella’ of medicine, deprived of solid scientific ground, effective therapeutic methods, and the professional respectability associated with other branches of medicine.¹ The British public, too, showed a tepid sometimes even cold attitude towards psychiatry. Mentally ill patients and their relatives regarded this type of professional help as a ‘last resort’.² Compared to its counterparts in other European countries, and later in Northern America, British psychiatry was often seen as lacking competitiveness. This harsh environment originated mostly from the Victorian value set which stressed ‘self-reliance, moral earnestness and individual responsibility’ and, therefore, prohibited many people from seeking help openly before it was too late.³

Despite being under such huge pressure, British psychiatry moved forward slowly but surely during the first half of the twentieth century. Historians generally acknowledge this progress, but attribute the impetus for development to various and different factors. Many put emphasis on the Great War and the experience of shell-shock. Elaine Showalter regards the War as a turning point when the transition from psychiatric Darwinism to modernism took

¹ Vicky Long, *Destigmatising Mental Illness? Professional Politics and Public Education in Britain, 1870-1970* (Manchester: Manchester University Press, 2014), p. 13.

² Roy Porter, ‘Two Cheers for Psychiatry! The Social History of Mental Disorder in Twentieth Century Britain’, in Hugh Freeman and German E. Berrios (eds.), *150 Years of British Psychiatry Vol. II: The Aftermath* (London: Athlone, 1996), p. 385.

³ *Ibid.*, pp. 383-385.

place,⁴ while Joan Busfield notes that the shell shock cases changed the attitude to psychoanalysis and, furthermore, to psychiatry among the British.⁵ Kathleen Jones argues that mental health and psychiatry as a profession in charge of it came to ‘acquire a new and wider significance’ during the War.⁶ Others stress the prevailing social and cultural environment as an accelerator for psychiatric development and its application. Mathew Thomson has emphasised the importance of what happened outside of ‘professional formation and theoretical advance’ in establishing the new understanding of mental health.⁷ Meanwhile, Roy Porter points out that the main drive for advancement came from a combination of the self-generated motivation of psychiatry and the public’s growing interest in science.⁸ No matter what factors the historians consider, they all admit that British psychiatry managed to widen its borders both internally and externally during the early twentieth century.

At this point, it is necessary to question the characteristics of these changes that early-twentieth-century British psychiatry underwent. Some historians consider the interwar period when psychiatric modernism developed, without suggesting any definition of the term ‘modern’ or ‘modernism’. For example, Showalter divided the history of English psychiatry between 1830 and 1980 into three periods, Victorianism (1830-1870), Darwinism (1870-1920), and Modernism (1920-1980). She defined the last stage as when Freudian

⁴ Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (London: Virago, 1987), pp. 18-19.

⁵ Joan Busfield, ‘Mental Illness’, in Roger Cooter and John Pickstone (eds.), *Medicine in the Twentieth Century* (London: Routledge, 2000), pp. 644-645.

⁶ Kathleen Jones, *Asylums and After: A Revised History of the Mental Health Services, From the Early 18th Century to the 1990s* (London: Athlone, 1993), pp. 141-142.

⁷ Mathew Thomson, *Psychological Subjects: Identity, Culture, and Health in Twentieth-Century Britain* (Oxford: Oxford University Press, 2006), pp. 5-9.

⁸ Porter, ‘Two Cheers for Psychiatry!’, p. 385.

psychoanalysis wielded influence over psychiatry (and society) and new scientific knowledge and technological skills made rapid advances in this field.⁹ This chapter, however, doubts that such a definition is valid for interwar Britain. The main purpose of this chapter is to outline both the internal and external circumstances British psychiatry faced between the dawn of the twentieth century and the outbreak of the Second World War. Based on the existing picture drawn, which is far from simple and often confusing, I will argue that in terms of psychiatric development the interwar years should be understood as a transitional period, rather than modern one, and that it was only in the post-war era that the metamorphosis into modern psychiatry was completed.

In advance of the full discussion of psychiatric development in the early twentieth century, it should be clarified what is meant by modern psychiatry, in order to avoid confusion about the terminology and not to repeat the mistake frequently made in existing research. It is true that a definition of modern psychiatry agreed upon by all is hard to identify. In this chapter, as well as in the thesis as a whole, modern psychiatry will be defined as what satisfies the following conditions: that in terms of nosology and taxonomy there should be official frameworks, agreed by the majority of psychiatrists and therefore applied in unified form, both in theory and practice; that in terms of therapy there should be (relatively) efficient methods which psychiatrists can apply to treat patients depending on diagnosis and severity of the case (setting aside the value judgment about the means); that psychiatry should be taken as part of general medicine on an equal footing with other branches;¹⁰ and that from the patients' perspective, the entry barriers should be low enough

⁹ Showalter, *The Female Malady*, pp. 195-219.

¹⁰ Porter, 'Two Cheers for Psychiatry!', p. 400.

so that they could obtain access whenever they need professional help with their mental health issues.

1. Two Major Influences: Emil Kraepelin and Sigmund Freud in British Psychiatry

Literature on the history of twentieth-century psychiatry usually begins with two figures: Emil Kraepelin and Sigmund Freud. They have been generally considered as deciding the trajectory which psychiatric development took. For example, Clark Lawlor in his recent work on melancholia and depression explains that ‘the evolution of the thinking of [these] two major influences’ facilitated ‘psychiatric modernism’, but gives no additional explanation of the concept.¹¹ These psychiatrists had very little in common except that they both became involved in psychiatry around the turn of the century and swiftly gained an international reputation. The ways each of their psychiatric achievements were accepted in Britain were also different, and they will be illustrated now. This will reveal the distinctive features of British psychiatry, medicine and culture in the early twentieth century.

Freudian psychiatry

¹¹ Clark Lawlor, *From Melancholia to Prozac: A History of Depression* (Oxford: Oxford University Press, 2012), p. 135.

In Britain, Freudian psychiatry was not welcomed and psychoanalysis permeated only extremely slowly into medical society. A famous episode demonstrated the obvious animosity towards Freudianism among the British medical profession. In 1911, David Eder, one of the earliest British supporters of Freud, gave a presentation to the Neurological Section of the British Medical Association on the treatment of an hysteric patient using psychoanalysis. Before his talk was over, the whole audience, including the chair of the Section, left the room in icy silence.¹² In 1914, Freud himself admitted ‘in scientific circles in England interest in analysis has developed very slowly’, which he believed was a consequence of ‘the peculiar aptitude of the English’.¹³ It was not until the Great War that the medical community began to pay attention, albeit grudgingly, to Freudian theories and psychoanalysis.

In contrast, the attitude of the British public towards Freudian psychiatry was markedly different, showing considerable interest in it even before the War. Porter points out that they were open-minded to psychoanalysis and that the press and publishers were also positive about Freudian psychiatry.¹⁴ According to Dean Rapp’s analysis of forty-six popular magazines published between 1912 and 1919, the educated British public began to take note of Freud as early as 1912, and were already contributing to the creation as well as consumption of various texts on Freudian theories around the outbreak of the War.¹⁵ Such a positive lay response seems to have been closely related to a general atmosphere that is best illustrated by a phrase ‘psychology is everywhere’.¹⁶ As Porter explains, in the early

¹² Roy Porter, *Madness: A Brief History* (Oxford: Oxford University Press, 2002), p. 197

¹³ Suzanne Raitt, ‘Early British Psychoanalysis and the Medico-Psychological Clinic’, *History Workshop Journal*, 58:1 (2004), pp. 63-65.

¹⁴ Porter, ‘Two Cheers for Psychiatry!’, pp. 389-390.

¹⁵ Dean Rapp, ‘The Early Discovery of Freud by the British General Educated Public, 1912–1919’, *Social History of Medicine*, 3:2 (1990), pp. 217-243.

¹⁶ Mathew Thomson, ‘The Popular, the Practical and the Professional: Psychological Identities in

twentieth century the British public expressed a surge of interest in the social sciences, ‘an intellectual climate increasingly favourable to the promotion and popularisation of sciences of the self’.¹⁷ Under these circumstances, psychology, especially practical and lay versions rather than professional one, enjoyed great popularity, preparing the educated public for Freudianism.¹⁸

It should be remembered, however, that the British public were engaged with a modified version of Freudian psychiatry. It was not the authentic theory but, as Rapp has noted, ‘an eclectic, diluted interpretation of Freudianism’ that was popular among the public.¹⁹ From the concepts and practices suggested by Freud, they discarded what they found incompatible with the established value set, notably sexual theories, and picked out selectively what they considered useful in understanding the self, particularly the concept of the unconscious. Such adjustment was to be repeated when a group of medical professionals tried to embrace and apply Freudian psychiatry later. In the late 1910s, Jung’s disciples emphasised that Jung’s concept of unconsciousness was less sexual and more optimistic than Freud’s,²⁰ a reasonable strategy that appealed to the British public given the widely spread hostility toward sexual reductionism.

There was a small group of doctors who adopted and preached Freudianism before psychoanalysis found an increasingly broad base of support during and after the Great War.

Britain, 1901-1950’, in G. C. Bunn, A. D. Lovie and F. D. Richards (eds.), *Psychology in Britain: Historical Essays and Personal Reflections* (Leicester: BPS Books, 2001), p. 118.

¹⁷ Porter, ‘Two Cheers for Psychiatry!’, pp. 386-388.

¹⁸ Thomson, ‘The Popular, the Practical and the Professional: Psychological Identities in Britain’, pp. 115-124.

¹⁹ Rapp, ‘The Early Discovery of Freud’, pp. 218-219.

²⁰ Ibid.

Ernest Jones was representative of this group. He was a close friend and biographer of Freud, and in 1913 founded the London Psychoanalytic Society, renamed the British Psychoanalytical Society six years later. He also published *Papers on Psycho-Analysis*, the first account of psychoanalytic theory in the English language. Eder, whose presentation had faced such a chilly reception at the meeting of the British Medical Association in 1911, also ran a private psychiatric practice applying Freudian methods of treatment from 1912.²¹ There were several other psychoanalytic private practices, mostly in London, and some of them thrived.

A good example of how the Great War provided momentum for the proliferation of Freudianism can be found from the first public clinic offering psychoanalytic treatment in England.²² The Medico-Psychological Clinic was founded in 1913 by Dr Jessie Murray and Julia Turner, with the purpose of providing ‘various kinds of psychotherapeutic treatment’ to ‘those unable to afford the fees usually charged for private treatment’.²³ The Clinic was such a great success, that the following year it moved to a new spacious site to be equipped with a residential annex to accommodate the increasing number of patients. New aims were announced: ‘to provide at one convenient centre several of the different forms of treatment, both medical and psychological’ with ‘a price middle-class people could afford’.²⁴ In 1915, the Clinic opened its own training programme, which also enjoyed unquestionable success.

However, the reason why the Clinic should be taken seriously lies not only in its success but also on its representativeness, as it faithfully presented the typical features of

²¹ Porter, ‘Two Cheers for Psychiatry!’, p. 389.

²² Porter, ‘Two Cheers for Psychiatry!’, p. 391; Showalter, *The Female Malady*, p. 197.

²³ Raitt, ‘Early British Psychoanalysis and the Medico-Psychological Clinic’, p. 69.

²⁴ *Ibid.*

British psychoanalysis in its incipient phase. Firstly, in terms of qualifications, the staff had varied backgrounds. While Murray was a medical doctor and studied under Pierre Janet, a famous neurologist in Paris, Turner did not have any medical training. In an article about the Clinic, Suzanne Raitt points out that not only qualified doctors but also lay people, like Turner, could psychoanalyse before the War, a proof of the openness which was enjoyed only for a short period and which disappeared in the next decade.²⁵ Secondly, the staff administered a ‘watered-down version of Freudian theory’, comparable with that understood by the general public, which avoided causing distress. Furthermore, they had a good reason to rule out suppressed sexual drives as possible causes of psychosis: ex-soldier patients suffering from war neurosis whose cases were assumed to have an obvious origin other than the impulse and its repression.²⁶ Thirdly, the Clinic offered treatments that were far from ‘pure’ Freudian psychiatry, applying various ‘psychotherapeutic methods’ including re-education, hypnosis, persuasion, moral exhortation, as well as psychoanalysis. The sole common ground of these methods was ‘the centrality of the patient-therapist relationship’.²⁷ Last but not least, though the Clinic was founded to serve mainly female mental patients, it prospered by treating male patients discharged from military service.²⁸ Certainly, the War and war neurosis encouraged the wide and earnest use of psychoanalysis, and played a crucial role in raising the status of Freudian psychiatry in Britain.²⁹

After the War, the British psychoanalytic circle reached a ‘milestone’ with the opening

²⁵ Showalter, *The Female Malady*, p. 197.

²⁶ Raitt, ‘Early British Psychoanalysis and the Medico-Psychological Clinic’, pp. 69-70.

²⁷ *Ibid.*, p. 73.

²⁸ Showalter, *The Female Malady*, pp. 197-198.

²⁹ Busfield, ‘Mental Illness’, p. 645.

of the Tavistock Clinic.³⁰ In 1920, Hugh Crichton-Miller, a medical doctor who had earned a good reputation as a specialist in nervous disorders early in his career, and who had served as a consultant on shell shock during the Great War,³¹ founded the Tavistock to treat patients suffering from functional nervous disorders through psychoanalysis.³² The Clinic enjoyed the more favourable atmosphere, compared with that of the early 1910s, and took advantage of the ‘mental hygiene movement’.³³ While focusing on family psychodynamics and childhood problems, as demonstrated by its opening of a Children’s Department in 1926, it won both success and renown, rarely achieved by other English institutions based on Freudian tenets.

In the meantime, the Medico-Psychological Clinic went into an irreversible decline in the early 1920s. Several factors interacted to cause this: the early death of Murray in 1920, one of the two main pillars of the institution; its free and informal atmosphere, which contributed to its success at the beginning, but dragged the Clinic down later; and female dominance in its founding and running which met increasing resistance as psychoanalysis was institutionalised.³⁴ Furthermore, a new partner of the Clinic, James Glover, a qualified medical doctor who converted to orthodox Freudian psychoanalysis, denied ‘the eclectic practice’ which Murray and Turner had established, and tried to affiliate the Clinic to Jones’s

³⁰ Porter, ‘Two Cheers for Psychiatry!’, p. 391.

³¹ ‘Hugh Crichton-Miller’, *DNB* <http://dx.doi.org/10.1093/ref:odnb/51730>.

³² Showalter, *The Female Malady*, pp. 197-198.

³³ Porter, ‘Two Cheers for Psychiatry!’, p. 391. For more details about mental hygiene movement in Britain, see Jonathan Toms, *Mental Hygiene and Psychiatry in Modern Britain* (Basingstoke: Palgrave Macmillan, 2013); Mathew Thomson, ‘Mental Hygiene in Britain during the First Half of the Twentieth Century: The Limit of International Influence’, in Volker Roelcke, Paul Weindling, and Louise Westwood (eds.), *International Relations in Psychiatry: Britain, Germany, and the United States to World War II* (Rochester, NY: University of Rochester Press, 2010), pp. 134-155.

³⁴ Raitt, ‘Early British Psychoanalysis and the Medico-Psychological Clinic’, pp. 79-80.

British Psychoanalytical Society. Turner was forced to close the Clinic in 1922 soon after Glover left with most of the students and staff. Raitt and Showalter observe the same problem in relation to the Medico-Psychological Clinic. As psychoanalysis settled down on British soil, female lay analysts (like Turner) came to lose ground to qualified male analysts (like Glover and Jones) or professional organisations (notably the British Psychoanalytical Society).³⁵ Rhodri Hayward, too, finds this a crucial part of the process in which psychoanalysis in Britain came under institutional control, represented by Jones and the British Psychoanalytical Society.³⁶

Although Freudian psychiatry was naturalised into British culture and society after the War, we should be wary of overstating the extent to which it exerted an influence on medical experts and psychiatric practice. Raitt argues that psychoanalysis was widely respected and actively supported by ‘eminent figures’ in related fields and that ‘a substantial number of highly influential figures’ in psychiatry grafted psychoanalysis onto their treatment and advocated the new therapeutic method from the early 1910s.³⁷ However, this was far from what happened in British psychiatric practice at that time. Most of all, psychoanalysis was not yet taken seriously as a therapeutic method in most of the mental hospitals during the interwar years. Leading psychiatric hospitals rarely adopted Freudian psychiatry, either as a philosophy or as a therapeutic technique, which did not mean however that they entirely ignored it. For example, the Maudsley Hospital tried ‘all forms of psychotherapy’, including suggestion, re-education, hypnosis, and psychoanalysis, in the first year of its operation. With

³⁵ Ibid.; Showalter, *The Female Malady*, p. 198.

³⁶ Rhodri Hayward, *The Transformation of the Psyche in British Primary Care, 1880-1970* (London: Bloomsbury, 2014), pp. 52-55.

³⁷ Raitt, ‘Early British Psychoanalysis and the Medico-Psychological Clinic’, pp. 76-77.

regard to the ‘special treatment’, in the first Annual Report, the Maudsley medical superintendent concluded that ‘the number of cases which can be subjected to psycho-analysis in the full sense is very limited’. He further noted that ‘it would be quite premature to attempt any comparison of its results with those of other methods’, since clinical observation was still in its early stage. In an honest reflection of his own thoughts, the superintendent confessed that ‘I find myself incapable of accepting all the alleged facts of any school of psycho-analysis, or the concepts proposed to resume them’.³⁸ Although he conceded the existence of a group of Freudian followers in the Hospital, and did not reject the possibility of researching the new therapy, probably mindful of the establishment’s role as a research institution, psychoanalysis is not mentioned in the Maudsley Annual Reports thereafter.

A reading of expert literature also proves that Freudianism had a limited impact on British psychiatry. Among textbooks published in the 1920s and 1930s, only a few followed this doctrine. Raitt stresses that several Freudian followers had been deeply involved in publishing textbooks from its early days and they are a barometer of the influence of Freudian psychiatry. For example, Constance Long, a medical doctor who publicly and ardently supported psychoanalysis, wrote a chapter on the subject in Charles Lloyd Tuckey’s classical work about psychotherapy, *Psycho-Therapeutics, Or Treatment by Hypnotism and Suggestion*, published in 1913; W. H. B. Stoddart, an asylum doctor who later became a member of the London Psychoanalytical Society, added two chapters on psychoanalysis to the second edition of *Mind and Its Disorders* in 1912.³⁹ However, what happened during the

³⁸ Maudsley Hospital, Medical Superintendent’s Annual Report, Year ended 31st January, 1924, BRHAM, pp. 3-4.

³⁹ Raitt, ‘Early British Psychoanalysis and the Medico-Psychological Clinic’, pp. 77-78.

interwar years seems to rebut Raitt's argument. The majority of psychiatric textbooks mentioned little about Freudian psychiatry, either as a philosophy or as a therapeutic technique. In *A Text-Book of Psychiatry* published in 1927, one of the most successful psychiatric textbooks of the days, R. D. Henderson and D. K. Gillespie ignored Freud almost completely. In the first chapters which give a general knowledge of psychiatry, Freud was not even referred to once. In one chapter on aetiology, the authors, taking the traditional stance emphasising heredity, explained 'trauma' as a factor causing psychoses or neuroses in seventeen lines without referring to Freud.⁴⁰ In the very next paragraph, they explained that 'the commonest mental factors are financial and business worries, domestic difficulties, dissatisfactions of all kinds, disappointments and worries in the sexual sphere, and death of relatives'.⁴¹ Once again, they avoided mentioning Freud. In later chapters where they categorised mental illnesses in their own way and suggested therapeutic techniques for them, they never alluded to psychoanalysis.

To summarise, the Great War certainly acted as a catalyst for the adoption of Freudianism in British culture. At least with respect to psychoanalysis, the 'shell-shock story' seemed to be valid. However, throughout the interwar period, its impact on professional medicine was far from profound and remained extremely limited, and its achievements were circulated only within the circle of psychoanalysts, a minority group. Psychoanalytic clinics were not treated on the same footing as other mental hospitals. Although Porter attributes the failure of the Tavistock Clinic to achieve academic recognition from the University of

⁴⁰ D. K. Henderson and R. D. Gillespie, *A Text-Book of Psychiatry for Students and Practitioners* (Oxford: Oxford University Press, 1927), p. 56.

⁴¹ *Ibid.*

London to the check of the Maudsley Hospital,⁴² it also had something to do with the general status of Freudian psychiatry in Britain. The majority of psychiatrists never took the Freudian tenets and practices seriously and only adopted, if ever, what suited their palate. Freudian psychiatry was never mainstream in Britain during the period under scrutiny here.

Kraepelinian Psychiatry

It is undeniable that Emil Kraepelin made a great contribution to twentieth-century psychiatry, particularly to the psycho-diagnostic framework. However, despite his significance, stories about the psychiatrist himself and his psychiatry remained outside of public interest, a stark contrast to the case of Freud. Kraepelinianism did not lead to any broader cultural phenomenon, whereas Freudian ideas exerted a strong ‘influence in subsequent artistic and literary representations’.⁴³ Furthermore, historians have not shed enough light on him and his doctrine. In Showalter’s *The Female Malady*, Kraepelin’s name appears only once, when describing the emergence of the notion of ‘schizophrenia’, which the author regards as the twentieth-century female malady.⁴⁴ In ‘The British Reaction to Dementia Praecox 1893-1913’, R. M. Ion and M. D. Beer point out not only that the British reaction to Kraepelinian psychiatry has been left largely uncharted, but also that ‘the factors which shaped the eventual acceptance of this highly influential idea’ remain unknown’.⁴⁵

⁴² Porter, ‘Two Cheers for Psychiatry!’, pp. 391-392.

⁴³ Lawlor, *From Melancholia to Prozac*, p. 136.

⁴⁴ Showalter, *The Female Malady*, p. 203.

⁴⁵ R. M. Ion and M. D. Beer, ‘The British Reaction to Dementia Praecox 1893-1913, Part 1’, *History of Psychiatry*, 13:51 (2002), p. 286.

Therefore, the process in which British professionals accepted Kraepelinian psychiatry deserves a careful study.

Kraepelin, the so-called founder of modern psychiatry, 'recast the way psychiatrists thought about major diagnoses' and hugely influenced the development of psychiatry throughout the twentieth century.⁴⁶ He is famous for laying the foundation for modern diagnostic methods, most notably adopted in the *Diagnostic and Statistical Manual of Mental Disorders*, the first version of which was published in 1952. His fame as a modern psychiatrist has been largely based upon his successful series the *Textbook on Psychiatry*. He released the first edition in 1883 and the last and ninth edition appeared in 1927, a year after his death. Through this series, he earned a reputation, first among German-speaking countries, and before long, all over Europe and America. The successive volumes of the *Textbook* not only clearly illustrated the development of the author's view on mental illness and the evolution of his psychiatric concepts over almost a half century, but also revealed the development of general psychiatry during the late nineteenth and the early twentieth centuries.⁴⁷

The publication of Kraepelin's *Textbook* series in Britain provides an opportunity to chart the British reaction to his psychiatry. Despite the early success of his work in the mid-1880s on the Continent, it was not until 1902 that the first English edition was published. A. Ross Defendorf, an American psychiatrist at Yale University then, translated the sixth edition of the *Textbook*, the original German version of which had been published three years

⁴⁶ Edward Shorter, *A Historical Dictionary of Psychiatry* (Oxford: Oxford University Press, 2005), p. 156.

⁴⁷ It was a period when scientists influenced their colleagues by writing textbooks rather than learned articles.

previously, in order to introduce Kraepelinian psychiatry to English-speaking countries on both sides of the Atlantic. However, Defendorf's *Clinical Psychiatry: A Textbook for Students and Physicians* was not the same as Kraepelin's original work, but was 'abstracted and adapted from the sixth German edition of Kraepelin's *Lehrbuch der Psychiatrie*'.⁴⁸ Although it was an abridged edition, the publication presented the opportunity to raise awareness of Kraepelinian psychiatry. Hitherto, the previous editions of the *Textbook*, all in German, went unreviewed and no textbook referred to his nosology and nomenclature in Britain. According to Ion and Beer, until the appearance of *Clinical Psychiatry*, 'British psychiatrists did not ignore Kraepelin's concept (...) they were only unaware of it'.⁴⁹ On the publication of the seventh edition of the *Textbook* five years later, Defendorf adopted the same editorial strategy by publishing an 'abstracted and adapted' version. This time, there was also a four-year time lag between the release of the German volume and its English translation. The eighth edition had to wait even longer than the previous ones to be translated into English, which reflects both the conservatism of English medicine and anti-German sentiment created by the Great War.⁵⁰

The article by Ion and Beer provides a detailed instance of how British medical experts reacted to Kraepelinian psychiatry, through a case of an influential as well as controversial concept invented by him, dementia praecox. The authors examine the period between 1893, when Kraepelin employed the diagnostic term for the first time in his *Textbook* fourth edition, and 1913, when they see the concept had 'gained general recognition'.⁵¹ They note that it

⁴⁸ A. Ross Defendorf, *Clinical Psychiatry: A Textbook for Students and Physicians* (London: Macmillan, 1902).

⁴⁹ Ion and Beer, 'The British reaction to dementia praecox 1893-1913', p. 426.

⁵⁰ *Ibid*, p. 293.

⁵¹ Though Ion and Beer assume that by 1913 Kraepelin's dementia praecox 'gained general recognition'

took several years for British psychiatry to mention the concept in textbooks and major periodicals and that ‘serious debate’ only began with the publication of the English version of Kraepelin’s work. Those involved in the debate swiftly divided into two groups.⁵² They also notice that there existed a generation gap in the attitude towards the new diagnostic notion. Junior psychiatrists were more sympathetic to the concept than their senior colleagues,⁵³ which reflects the finding of German E. Berrios and R. Hauser that in France, too, younger psychiatrists ‘showed enthusiasm’ towards Kraepelinian nosology.⁵⁴ Though the article focuses on a specific concept, it gives a broad hint about the way in which British professionals reacted to, and finally accepted, Kraepelinian notions. A similar pattern was to be repeated when they encountered manic-depressive insanity (another major contribution of Kraepelin to twentieth-century psychiatry) and involuntional melancholia (one of the most confusing psychiatric concepts of the early twentieth century), which will be illustrated in the following chapter.

Once the initial indifference and associated reluctance of the British professionals had been overcome, Kraepelinian notions, terminologies and classification permeated into British psychiatry during the interwar years. For instance, the concept of ‘manic-depressive insanity’, which was finally clarified in the sixth edition of the *Textbook* published in 1899, was adopted in the 1906 edition *Nomenclature of Disease* by the Royal College of Physicians of London, in an attempt to establish an official taxonomy. In case of dementia praecox, the

in the British psychiatry circle, such periodisation seems to lack any solid ground.

⁵² Ion and Beer, ‘The British reaction to dementia praecox 1893-1913’, pp. 293-301.

⁵³ *Ibid.*, p. 429.

⁵⁴ German E. Berrios and R. Hauser, ‘Kraepelin: Clinical Section – Part II’, in German E. Berrios and Roy Porter (eds.), *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London: Athlone, 1995), p. 285.

notion was included as a formal diagnosis in the next and fifth edition of *Nomenclature*, published in 1918.⁵⁵ In medical practice, too, Kraepelinian nosology and terminologies had come into extensive use by the 1920s. Viewing various kinds of medical records kept during the interwar years, it is clear that even controversial concepts were applied in everyday practice. In the Maudsley Hospital, for example, dementia praecox had been employed as a diagnostic term during its early days, and was gradually replaced with schizophrenia, an alternative diagnostic term coined by Eugen Bleuler, in the late 1920s. In most mental hospitals, the concept ‘involitional melancholia’ was welcomed and usually applied to middle-age female patients whose illness had not appeared in the earlier life stage, even though the inventor discarded the notion as a discrete disease in the eighth edition of his *Textbook* published in 1915.

As Porter summarises, ‘mainstream academic and hospital psychiatry remained committed to the programme of describing and taxonomising the mental disorders stemming from Kraepelin’ until the breakout of the Second World War.⁵⁶ Within the expert group, Kraepelinian psychiatry held a commanding lead over Freudian psychiatry, showing the direction in which British psychiatry was heading during the interwar years. In the post-war era, Kraepelinianism revalidated its dominance with the publication of the *Diagnostic and Statistical Manual* in 1952, which adopted the most of salient features of Kraepelinian nosology and since then has become a worldwide standard criteria for classification of mental disease. Even though Kraepelinian psychiatry successfully initiated a new way of diagnosing mental disease and, by doing so, influenced the route taken by psychiatric development

⁵⁵ German E. Berrios, *The History of Mental Symptoms: Descriptive Psychopathology since the Nineteenth Century* (Cambridge: Cambridge University Press, 1996), p. 187.

⁵⁶ Porter, *Madness*, p. 213.

afterwards, it contributed little to the treatment of the mentally ill.

2. Psychiatric Practice in the Early Twentieth Century

Classification and Diagnosis

Throughout the nineteenth century, psychiatry made various attempts at framing mental diseases and categorising them into ‘separate and specific entities’. The last decades of the century, therefore, have been called ‘the era of classification’, in which Kraepelin presented the end and/or climax.⁵⁷ Most prominent psychiatrists had eagerly involved themselves in taxonomic work; including the German alienists, Wilhelm Griesinger, Richard von Krafft-Ebing and Karl Ludwig Kahlbaum, all of whom had an influence on Kraepelinian nosology in some way or another.⁵⁸ British psychiatry was no exception to this trend, aggravating the confusion in which various classification systems competed for predominance and authority. Furthermore, disagreement over terms and concepts exacerbated the chaos. In his criticism of the situation at the end of the century, Daniel Hack Tuke observed that ‘the wit of man has rarely been more exercised than in the attempt to classify the morbid mental phenomena

⁵⁷ Busfield, ‘Mental Illness’, p. 640.

⁵⁸ German E. Berrios, ‘Mood Disorders’, in German E. Berrios and Roy Porter (eds.), *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London: Athlone, 1995), pp. 391-394.

covered by the term insanity. The result has been disappointing'.⁵⁹

Amidst this chaos, endeavours were made to establish a standard diagnostic scheme after the turn of the century. In 1906 the Royal College of Physicians of London announced the fourth edition of *Nomenclature of Disease*, hoping rather ambitiously that it would put an end to the long-standing confusion over nosology and that it 'would be adopted throughout the English-speaking countries and then beyond'.⁶⁰ The *Nomenclature* applied a part of Kraepelinian classification and formalised some of his psychiatric concepts.⁶¹ Under the scheme, mental disease, setting aside disease of the nervous system, was grouped into four categories: 'errors of development' (so-called 'idiocy'); 'disorders of function' (including mania, melancholia, and circular insanity); 'result of infective, toxic, and other general conditions'; and 'degenerations' (including general paralysis of the insane and primary and secondary dementia). However, its validity as an official nosologic scheme is doubtful. In 1918 when the College put forward the fifth edition of *Nomenclature*, the members admitted that they had failed to achieve the aim of setting up a standard.⁶² This edition included three categories under mental disease; 'errors of development', 'disorders of function' and 'insanity of infective, toxic, and other general conditions'. The second group almost coincided with Kraepelin's notion of manic-depressive insanity, and the third included dementia praecox besides primary and secondary dementia, unlike the previous edition.⁶³

Meanwhile, the Medico-Psychological Association suggested another classification

⁵⁹ Ion and Beer, 'The British reaction to dementia praecox 1893-1913', p. 286.

⁶⁰ Ibid., p. 287.

⁶¹ Berrios, *The History of Mental Symptoms*, p. 315.

⁶² Ion and Beer, 'The British reaction to dementia praecox 1893-1913', p. 287.

⁶³ Ibid.

framework for mental disease around the same time. Its statistical sub-committee worked on the draft between 1902 and 1905, and presented the final version in 1906. The scheme categorised mental disease into two broad groups, depending on when symptoms developed: ‘Congenital or infantile mental deficiency (Idiocy and Imbecility) occurring early in life’ and ‘Insanity occurring later in life’. Under the latter group, every form of acquired mental disease was included, from affective disorder to general paralysis. The following year, the Lunacy Commission, which was to be replaced by the Board of Control in accordance with the Mental Deficiency Act of 1913, adopted the classification for administrative use in mental hospitals. The Commissioners established three sets of medical coding simultaneously: *Schedule of Forms of Insanity*, *Schedule of Causes and Associated Factors of Insanity* and *Schedule of Occupations of Patients Admitted*.⁶⁴ Accordingly, the medical staff of county asylums and registered hospitals were now expected to identify a patient’s illness in Medical Registers in two ways; by disease name and its symbol.⁶⁵ This system remained in use until 1948, with only one amendment in 1930 which added a form of mental illness to the existing list in order to cover a group of mental patients who were to be treated according to new legislation, the 1930 Mental Treatment Act. Though the Medico-Psychological Association classification was adopted by the Lunacy Commission and was recommended for medical administration in county asylums, mental hospitals (renamed according to the Mental Treatment Act of 1930), and registered hospitals throughout England and Wales, its use was not compulsory. Therefore, its validity and authority, also, have been doubted.⁶⁶

⁶⁴ Refer to Appendices in order to find the full-length document of *Schedule of Forms of Insanity* and *Schedule of Causes and Associated Factors of Insanity*.

⁶⁵ For instance, General Paralysis was II. 2.; Melancholia recent II. 9. a.; and Melancholia Chronic II. 9. b.

⁶⁶ Ion and Beer, ‘The British reaction to dementia praecox 1893-1913’, p. 287.

Professional literature produced in the early twentieth century prove that there was no standardised classification which could be universally applied, and that psychiatrists were still looking for effective methods. In most textbooks, authors mentioned existing nosologic schemes and their limits, and then suggested what they regarded the best way to categorise mental illness. For instance, Henderson and Gillespie in *A Text-Book of Psychiatry* began with direct opposition to the official scheme adopted by the British Medico-Psychological Association on the grounds that it failed to reflect what happened ‘in practice’. The psychiatrists were receptive to Kraepelinian taxonomy, particularly his ‘systematic symptomatological grouping with special attention to the course and outcome of the various types of disorder’.⁶⁷ Finally, they offered ‘a simple general scheme’ of classification, in which they ‘spoke of different types of mental disorder as different *types of reaction*’, following Adolf Meyer, then professor of Psychiatry at Johns Hopkins Medical School. The taxonomy suggested by Henderson and Gillespie failed to attract wide support.

Under such circumstances, confusion and inconsistency in psychiatric practice was unavoidable. What happened in everyday medical practice was much more complex than found in textbooks, major journals, and administrative discourses for policy making. Psychiatrists in the early twentieth century had neither any standard classification to rely on nor any widely agreed diagnostic tool to apply in their medical decision making process. As can be detected in various kinds of medical records, they sometimes seemed unwilling to make a diagnosis or were unsure about their medical decisions.

Taking Holloway Sanatorium as one instance, this institution seemed to faithfully

⁶⁷ Henderson and Gillespie, *A Text-Book of Psychiatry*, pp. 15-16.

follow the instruction of the Lunacy Commission, *Schedule of Forms of Insanity*, as a standard of mental disease classification and diagnosis. In Medical Registers, the medical staff specified a patient's mental disease, 'form of mental disorder', and put a 'schedule symbol' alongside the diagnostic name. They also identified 'aetiological factors', both principal and contributory, and relevant 'schedule symbols', following the *Schedule of Causes and Associated Factors of Insanity*.⁶⁸ In the Annual Reports, too, the same criteria were applied in presenting basic statistics about its boarders.⁶⁹ Even though these records seem thorough and reliable, viewing them in conjunction with adjacent records, notably case notes, raises perplexing questions. Firstly, the majority of case files do not include any disease name, supporting Trevor H. Turner's findings in his research on the casebooks of Ticehurst House Asylum.⁷⁰ Amongst cases with certain disease names in the casebooks, some show disparity between diagnosis in the Medical Register and the case notes. There are a number of cases where diagnosis in the Medical Register does not match the symptom description in the patient's case history.⁷¹ Generally, the Holloway medical staff seemed to be reluctant to make a diagnosis and lacked assurance about their medical decision making.

Meanwhile the Maudsley Hospital adopted a totally different strategy from that taken at Holloway. It applied its own classification scheme, dividing mental disease into three groups according to origin of illness. First came amentia, organic post-natal, nervous and

⁶⁸ Holloway Sanatorium, Medical Register: Females, SHC Ac. 3473/3/48.

⁶⁹ For example, tables 'showing the form of Mental Disorder on admission in the Direct Admissions and Transfers' or 'showing the Aetiological Factors and Associated Conditions assigned in the Direct Admissions' were compiled in accordance with the aforementioned *Schedules* suggested by the Lunacy Commission. Holloway Sanatorium, Annual Report for the Year 1922, No. 37, SHC Ac. 2620/1/8.

⁷⁰ Trevor H. Turner, *A Diagnostic Analysis of the Casebooks of Ticehurst House Asylum, 1845-1890* (Cambridge: Cambridge University Press, 1992), p. 20.

⁷¹ Some examples will be referred to in later Chapters exploiting case notes.

mental disorders connected with obvious physical causes or symptoms, and constitutional and psychogenic syndromes unconnected with obvious physical causes or symptoms.⁷² The second group included general paralysis, epilepsy, and alcoholic dementia, and the third, dementia praecox, manic depressive types of syndrome, neurasthenia, and hysteria.⁷³ As for diagnosis, the Maudsley records offer a somewhat confusing, but highly vivid picture. Within its casebooks, there are many cases with ambiguous and sometimes perplexing diagnoses. It is not difficult to find case sheets which had plural diagnoses on them or which had no disease name at all. The documents show that the medical staff of the Maudsley pondered much in order to identify mental diseases; they literally put question marks in the space for diagnosis, erased what they had recorded before by drawing a line through words, and revised the medical examinations sometimes over and over again. In cases where their diagnoses appeared insufficient to explain patients' symptoms, they often added a description to disease names: for example, 'depression with hysterical features' and 'chronic neurotic anxiety state'. The cases with dubious diagnoses, however, dwindled over time. Case sheets kept in the earliest days of the Hospital were more confusing compared to later ones, and the number of cases with double, or even triple, diagnoses decreased as time passed. However, the case notes kept in the mid- and late- 1930s still reflected the trouble which the psychiatrists had with identifying mental diseases.

⁷² Refer to Appendix III, to find more about nomenclature and taxonomy used at the Maudsley Hospital.

⁷³ Maudsley Hospital, Medical Superintendents' Annual Report, Year ended 31st January, 1924, BRHAM.

Treatment

It is not unfair to say that ‘treatment had a relatively small place within psychiatry’ in the early twentieth century and that the focus of the medical profession was custody and care rather than treatment, particularly in the asylum system.⁷⁴ What psychiatrists could offer in terms of care or cure for the mentally ill was not considerably different from what their predecessors in the previous century had provided. By the late 1930s, physicians recommended their mental patients sufficient diet, rest, bath, massage, occupation and amusement. Well into the interwar years, electrotherapy, heliotherapy and hydrotherapy were praised as cutting-edge therapeutic measures.⁷⁵ Although sedatives were, technically, to be prescribed only for patients in need of medication, they were given to the majority of those hospitalised in order to stabilise them or to induce sleep. Paraldehyde, ‘a foul-smelling liquid compared by many to the stench of rotten apples’, was commonly administered, and bromides had been widely used as conventional sedatives since the 1850s.⁷⁶ Things were not different even in privileged establishments. Edward Mapother, the first medical superintendent of the Maudsley Hospital, which was acclaimed as one of the leading mental hospitals in Britain then, explained this situation in the first Annual Report:

⁷⁴ Busfield, ‘Mental Illness’, p. 644.

⁷⁵ Jennifer Mary Walke, *Repute and Remedy: Psychiatric Patients and their Treatment at Bethlem Royal Hospital, 1930-1983* (unpublished Ph.D. Thesis: London School of Hygiene & Tropical Medicine, 2015), p. 199.

⁷⁶ Diana Gittins, *Madness in its Place: Narratives of Severalls Hospital 1913-1997* (London: Routledge, 2006), pp. 189-191; Walke, *Repute and Remedy: Psychiatric Patients and their Treatment at Bethlem*, p. 206.

in spite of any modern advances, it may be said that certain long established measures still form the foundation of any successful treatment of neuroses and psychoses, and that in mental disorders as much as in tuberculosis, suitable feeding, fresh air and sun, the regulation of rest, exercise and occupation, the procuring of sleep, are indispensable conditions.⁷⁷

Psychiatrists had to wait until at least the 1930s, when new somatic treatments were ready to be applied in practice and to bring about substantive change.

Therapeutic innovation began after the end of Great War all over Europe, heralding an era of physical intervention for mental disorders. It was not only to accelerate the change in the role of mental hospitals, from custody of patients to treatment of them, but also to consolidate the dominance of the body over the mind in psychiatric ideas and practice.⁷⁸ In the late 1910s Julius Wagner-Jauregg discovered that malaria inoculation worked effectively against the general paralysis of the insane, winning him a Nobel Prize for Medicine in 1927. In the following decades, various shock therapies became fashionable. Deep sleep therapy was attributed to Jakob Klaesi's success in inducing prolonged sleep with a combination of two barbiturates in 1922, almost instantly 'enjoying a hazardous vogue'. Insulin coma therapy was developed by Manfred Sakel, a Jewish Austrian psychiatrist, in 1927, and convulsion therapy by the Hungarian Ladislaus von Meduna, in 1935, both at first aiming to treat schizophrenic cases. Electroconvulsive therapy (ECT) came into use during the Great War in order to treat patients suffering from war neurosis. It was applied to ease depressive

⁷⁷ Maudsley Hospital Medical Superintendent's Annual Report, Year ended 31st January, 1924, p. 8.

⁷⁸ Busfield, 'Mental Illness', pp. 644-650.

symptoms by Ugo Cerletti, an Italian neuropsychiatrist, after 1938. In the late 1930s, a Portuguese neurologist, Egas Moniz, advocated the efficacy of leucotomy, especially for cases of obsession and depression, which was welcomed by American psychiatry in particular. Not all of the abovementioned therapies stood the test of time. Among these somatic interventions, only ECT is still in use, which has not been free from harsh criticism, as almost nothing is known about how the treatment works. Citing Porter's curt summary, 'some (were) effective, many dubious, a few dangerous.'⁷⁹

British psychiatric professionals kept up with these innovations, but seemed to be reluctant to apply them instantly in everyday practice. Articles about new treatments appeared shortly after original research had been published. Meduna published his first article on convulsion therapy using Cardiazol, which was originally developed as a mild cerebral and cardiac stimulant, in 1935, and produced a comprehensive review of his treatment under the title of 'Convulsion Therapy in Schizophrenia' about two years later.⁸⁰ Almost simultaneously in Britain an article with the same title was published in the *Lancet*, providing detailed illustrations of the therapeutic method, specific cases and possible ill effects.⁸¹ Innovations were swiftly adopted: insulin coma therapy was first employed in 1933, only a couple of years after Sakel had announced his clinical trial result in a German medical journal, and Cardiazol convulsion therapy in 1935, the same year as the release of Meduna's original article.⁸² Furthermore, a few new techniques were promptly introduced into practice, which, of course, varied depending on the characteristics of institution and/or medical staff in

⁷⁹ Porter, *Madness*, pp. 200-205.

⁸⁰ Shorter, *A Historical Dictionary of Psychiatry*, pp. 62-63.

⁸¹ Hunter Gillies, 'Convulsion Therapy in Schizophrenia', *Lancet*, 230:5942 (1937), pp. 131-132.

⁸² Shorter, *A Historical Dictionary*, pp. 142-143; Gittins, *Madness in its Place*, pp. 195-196.

charge.

On the whole, it was in the late 1930s that therapeutic innovations came to be deployed only gradually into medical practice in Britain. In Severalls Mental Hospital, the second Essex County Asylum, for example, insulin shock therapy was first employed in 1935, and Cardiazol convulsion therapy a couple of years later. The Hospital moved swiftly to adopt prolonged sleep therapy; at first barbiturates or opium derivatives were given to patients and later Somniphine was injected.⁸³ The medical staff of Severalls seemed to be positive about the result of shock therapies at that time, confirmed by a nurse's comment that 'many treatments of this nature (shock therapies) were given and we found a very marked improvement'.⁸⁴ However, it was only after the Second World War that they came into intensive use. ECT was not tried until after the War, and surgical treatments, notably leucotomy, had to wait longer, until the mid-1950s, to be implemented at Severalls. Compared to other contemporary mental hospitals, Severalls was neither fast nor slow in terms of the reception of new therapeutic measures.

Holloway Sanatorium, a conventional and Victorian-style asylum, proved to be a follower, rather than a leader or innovator. The Sanatorium was never involved in any experimental therapy, and seemed only to accept new treatments which were guaranteed as both safe and effective. It was only in 1937 that shock therapy was applied for the first time in this institution, lagging behind other mental hospitals by a few years. The reason that Holloway Sanatorium chose to remain conservative is little known, mainly because the medical staff left no comment on this issue. However, we can assume that as a successful

⁸³ Gittins, *Madness in its Place*, pp. 191-192.

⁸⁴ *Ibid.*, p. 196.

mental institution, in demand by those from affluent backgrounds, Holloway had little motivation to run any risks by trying new, and therefore unguaranteed, therapeutic methods. In addition, the Sanatorium was under less pressure to furnish effective therapies than other hospitals, because many of its patients, especially voluntary boarders, were categorised as mild cases and therefore did not stand in urgent need of aggressive intervention. Hence, we may well expect that the appointment of a new medical superintendent in 1937, T. E. Harper, succeeding Henry Devine who had been in the position for over ten years,⁸⁵ could lead to any innovation in treatment.⁸⁶

The approach of the Maudsley Hospital was quite different to that of Holloway Sanatorium. Following the precedents of German university psychiatric clinics and fulfilling its founding aims to treat patients, research and teach,⁸⁷ the Hospital was expected to experiment with new treatment methods. According to its Annual Report, the Hospital performed tests on gland therapy, insulin therapy, anti-syphilitic remedies, and

⁸⁵ It is difficult to tell exactly when H. Devine was appointed as a medical superintendent of Holloway Sanatorium due to the discontinuity of the records. Amongst those available, his name appears for the first time in the 1927 Annual Report. However, sources between 1924 and 1926 are not trackable, and the copy for the year 1923 has W. D. Moore's signature on it.

⁸⁶ Regarding the first attempt of Cardiazol treatment for Schizophrenic patients, the new medical superintendent seemed to be satisfied. In the Annual Report of 1937, he left a comment about the result: 'though it is early days to make a definite statement as to results, we have good reason to believe that there will be a relief of bad symptoms if not complete cures'. In the next year, Harper offered more detailed data as for the results of the new therapy in an optimistic mood: among the patients treated with the Cardiazol treatment, 10.76 percent recovered from what appeared to be a hopeless condition; 41.17 percent improved and showed a marked change in habits; 29.41 percent improved for a short time but relapsed into their former condition; 17.64 percent became worse after treatment, but they were long standing cases from whom good results were not expected: Holloway Sanatorium, Annual Report for the Year 1937-1938, No. 52-53, SHC Ac. 2620/1/9.

⁸⁷ Maudsley Hospital, Medical Superintendent's Annual Report, Year ended 31st January, 1925, BRHAM, p. 2.

psychoanalysis in the first year.⁸⁸ It also carried out clinical observations, including those on the treatment of neurosyphilis using Somnifen and on insulin therapy in the second year.⁸⁹ The Maudsley was certainly ahead of other contemporary mental institutions in developing and accepting new therapeutic measures. However, taking the lead in clinical experiments was one thing and applying state-of-the-art therapies to everyday practice was another. As shown by Mapother's statement earlier in this section, the basics of treatment stayed similar throughout the interwar years.

Furthermore, contrary to our expectations, the medical superintendent was famous for his scepticism towards new therapeutic methods. He openly objected to introducing some treatments on the grounds that he could not find any 'hard evidence' of their efficacy.⁹⁰ Mapother forbade clinical trials on Cardiazol treatment for fear of 'anxiety and terror' that convulsion therapy could bring about. He was also reluctant to take up insulin coma therapy, which significantly delayed its introduction into the Maudsley. His over-conservative attitude led some of his colleagues, particularly junior doctors, to raise objections to him and his decisions. Some young colleagues argued that 'treatment should be radical and applied at the earliest possible opportunity to arrest any degenerative process', challenging Mapother's therapeutic pessimism and 'overly modest goals'.⁹¹ This illustrates the extent to which the adoption of therapeutic innovation could rest on individuals, as on an institution's features.

⁸⁸ Maudsley Hospital, Medical Superintendent's Annual Report, Year ended 31st January, 1924, BRHAM.

⁸⁹ Maudsley Hospital, Medical Superintendent's Annual Report, Year ended 31st January, 1925, BRHAM, pp. 4-5.

⁹⁰ Edgar Jones and Shahina Rahman, 'Framing Mental Illness, 1923-1939: The Maudsley Hospital and its Patients', *Social History of Medicine*, 21:1 (2008), pp. 121-123.

⁹¹ *Ibid.*, p. 122.

As we have seen, between the two world wars, conventional therapeutic measures still prevailed, and newly invented treatments were not yet embraced in daily practice. Jennifer Walke's case study on Bethlem Royal Hospital, one of the prominent mental hospitals in Britain, reaches a similar conclusion about the 1930s. Regarding physical treatment, Bethlem adhered to the 'non-controversial' position, choosing to be 'a follower rather than a pioneer': its medical staff favoured traditional therapeutic regimens focusing on 'care and sedation'; and new techniques, notably Cardiazol shock therapy, only appear in case notes in 1940.⁹² It was only after the Second World War that innovative therapies dominated British psychiatric practice.⁹³ As Diana Gittins explains, for the new treatments to be applied in practice, particularly in public mental hospitals, 'better funding, the enactment of the National Health Service, and a new generation of young psychiatrists eager to prove themselves and their profession as scientific' were all required.⁹⁴ Therefore, if we consider the adoption of therapeutic innovation as a major criteria for the commencement of psychiatric modernism, the interwar years cannot be classified as modern, but rather should be considered as a transitional period.

3. Policy and Psychiatry

⁹² Walke, *Repute and Remedy: Psychiatric Patients and their Treatment at Bethlem*, pp. 198-201.

⁹³ David H. Clark, *The Story of a Mental Hospital: Fulbourn 1858-1983* (London: Process Press, 1996), p.32.

⁹⁴ Gittins, *Madness in its Place*, p. 196.

Nothing exists in a vacuum. Mental institutions, as a main locus of psychiatry, have always been under the influence of wider society, reflecting broader cultural attitudes towards madness, social atmosphere, economic situation and legal and political changes. Various factors affecting psychiatric practice, mental health policy and major legislation will be examined here as the primary external condition which decided the path psychiatry, as a system, took and shaped daily psychiatric practice. The focus will be on the Royal Commission on Lunacy and Mental Disorder, between 1924 and 1926, and the Mental Treatment Act of 1930, two major events which shaped the path taken by English psychiatry in the early twentieth century.

The External Environment of Psychiatry

Well into the twentieth century the main guidelines underpinning mental health policy in England were provided by the Lunacy Act of 1890. The Act provided legal standards for the reception, detention, and treatment of the mentally ill, and gave legal authority to the Justice of the Peace, to decide whether or not a patient needed admission to an asylum or licensed house.⁹⁵ The primary purpose of this law was to protect the liberty of subject.⁹⁶ On the one hand, it defended the liberty and safety of the sane by introducing compulsory detention of the insane. On the other hand, it protected the mentally ill against the danger of wrongful detention and abusive behaviour by formalising the admission process, elaborating the

⁹⁵ Tom Butler, *Mental Health, Social Policy and the Law* (Basingstoke: Macmillan, 1985), pp. 54-56.

⁹⁶ *Ibid.*

inspection of asylums by the Lunacy Commissioners, and specifying patients' rights.⁹⁷ The Act, however, was criticised for many reasons: putting the legal view before the medical one; being concerned with custody of the patients rather than with their treatment and care; and leading people to associate insanity with social nuisance, danger, and, what was worse, criminality. More than anything, the 1890 Act aggravated the general antipathy towards the asylum system and psychiatry. Mental hospitals and medicine were regarded as the last resort by both patients and their families, which deprived them of the possibility of early treatment.

Throughout the late nineteenth and early twentieth centuries, 'wrongful detention' was a major concern, among both the public and the policy makers. Many historians, like Tom Butler, saw the anxiety as coming mainly from the 1890 Act itself, as it allowed compulsory admission of mental patients.⁹⁸ Moreover, various events from time to time stimulated public fear and shook English society. Most notably, in 1921, the publication of a book reignited an age-old grievance against mental hospitals and their (mal)treatment of patients. Montague Lomax, a physician, published a provocative memoir, *The Experience of an Asylum Doctor*, revealing the cruel reality of the Prestwich Hospital where the author had once worked on the medical staff. According to his exposé, the institution had treated its patients in improper ways; poor food and clothing, solitary confinement, neglect and even abuse.⁹⁹ Public resentment over wrongful detention and unfair treatment was certainly incited by the book and was quickly aggravated by the press, leading the Ministry of Health to call an enquiry to investigate Lomax's charges about Prestwich. Around the same time, the Harnett case further fuelled existing public fear. A farmer in Kent, William Smart Harnett, had been wrongfully

⁹⁷ Ibid.; Long, *Destigmatising Mental Illness?*, p. 234.

⁹⁸ Butler, *Mental Health, Social Policy and the Law*, pp. 87-91.

⁹⁹ Ibid., pp. 83-84.

confined in a private asylum for nine years, and sued the Board of Control and the asylum manager after his escape from the institution. According to a contemporary observer, this case ‘profoundly excited more attention than any civil action for many years past, and it [had] afforded the popular press unlimited scope.’¹⁰⁰

Meanwhile, in the first quarter of the century, there arose another major issue inseparable from mental illness, ‘stigma’. Of course the shaming label attached to mental patients was not new, as it had been traditionally and consistently applied to lunatics. What was novel about the early-twentieth-century situation was that the issue of stigma became a primary concern in the arena of public policy.¹⁰¹ The focus of political discourse on insanity shifted from wrongful confinement and the violation of individual liberty to breaking down the stigma associated with certification and institutionalisation. Such change can be seen in official documents. Soon after the Board of Control was transferred from the Home Office to the Ministry of the Health, a new department created in 1919, the Board noticed that the new Ministry was worried about ‘the stigma associated with certification and psychiatry’. The Board of Control Report of 1920, therefore, emphasised that its redeployment ‘might help to dispel prejudices which often arouse against lunacy authorities and administration and more often affect injuriously patients under treatment or even after recovery’.¹⁰² The issue of stigma was to be delved into in earnest by a Royal Commission organised to cover a wide range of problems related to psychiatric practice.

¹⁰⁰ Clive Unsworth, *The Politics of Mental Health Legislation* (Oxford: Clarendon Press, 1987), pp. 186-187.

¹⁰¹ Thomson, ‘Mental Hygiene in Britain during the First Half of the Twentieth Century’, p. 136.

¹⁰² Butler, *Mental Health, Social Policy and the Law*, p. 81.

Royal Commission on Lunacy and Mental Disorder

In July 1924 a Royal Commission on Lunacy and Mental Disorder was called for by the Home Secretary. The series of episodes mentioned above and the public concern aroused by them exerted pressure on the political sphere and resulted in the appointment of a royal commission, which was then considered as the best way to investigate a nation-wide issue outside of party politics and as a prelude to further legislation in the near future.¹⁰³ During the interwar years public sensitivity to mental distress became greater than in the pre-war period and contributed to the nation-wide discussion of the issue. The Commission was led by Hugh Pattison MacMillan, who had become Lord Advocate for Scotland shortly before his appointment to the Commission and was sworn to the Privy Council in the same year. The aims of the MacMillan Commission were:

to enquire as regards England and Wales into the existing law and administrative machinery in connection with the certification, detention and care of persons who are or are alleged to be of unsound mind; to reconsider as regards England and Wales the extent to which provision is, or should be made for the treatment without certification of persons suffering from mental disorder; and to make recommendations.¹⁰⁴

¹⁰³ Anne Rogers and David Pilgrim, *Mental Health Policy in Britain* (2nd edn, London: Palgrave, 2001), pp. 53-57; Butler, *Mental Health, Social Policy and the Law*, pp. 84-85.

¹⁰⁴ Butler, *Mental Health, Social Policy and the Law*, p. 86.

The Commission held hearings for 42 days and summoned as witnesses more than one hundred people, including those who had been inmates of mental institutions, until it presented its final Report in July 1926.

The MacMillan Report began with presenting the procedure of the Commission and then summarised the basic historical background and the condition of the current system. The Commissioners noted that there was ‘no clear line of demarcation between mental illness and physical illness’ and that the distinction was based on the difference in symptoms, and not on its origins or causes, only for convenience. The Commission also pointed out that ‘the key-note of the past has been detention, (but) the key-note of the future should be prevention and treatment’,¹⁰⁵ reflecting the changes occurring in this field. In its conclusion, the Royal Commission made a series of recommendations on the issues of certification, detention and care of mental patients, private institutions, and local and central authorities.

More specifically, regarding the current certification system, the Commission pointed out that the Lunacy Act of 1890 had become an ‘obstacle’ since it had deprived the mentally ill of a chance to have early treatment and hospitalisation by requiring certification as a ‘pre-requisite’.¹⁰⁶ The Report stated that ‘contrary to the accepted canons of preventive medicine, the mental patient is not admissible to most of the institutions provided for his treatment until his disease has progressed so far that he has become a certifiable lunatic.’¹⁰⁷ They, therefore, emphasised the need for providing

¹⁰⁵ *Report of the Royal Commission on Lunacy and Mental Disorder* (London: HMSO Cmd. 2700, 1926), p. 17.

¹⁰⁶ *Ibid.*, pp. 18-19; *The British Journal of Psychiatry*, 72:299 (Oct 1926), p. 599.

¹⁰⁷ *Report of the Royal Commission on Lunacy and Mental Disorder*, pp. 18-19.

facilities for the treatment of incipient mental disorders without certification, which should be ‘the last resort in treatment, not the pre-requisite as is now commonly the case’.¹⁰⁸ They argued not only that facilities should be increased for the treatment of voluntary boarders, but also that they ‘should be provided for treatment without certification for a period’ of up to six months for involuntary patients with good prognosis.

The Commission criticised the long-standing association between lunacy and the Poor Law. Subsequently, members recommended that ‘the administration of the lunacy code should be associated with public health administration rather than the Poor Law’ on the grounds that the problem of insanity essentially related to public health ‘to be dealt with on modern public health lines’.¹⁰⁹ They also blamed the 1890 Act as socially divisive, allowing discrepancies between private and pauper patients, and insisted that there should be a common legal code for all patients irrespective of social status. As regards the role of central and local authorities, the Commissioners suggested that the Board of Control should continue as a central body for supervision and that county councils should have additional powers and duties to take up the control of the Poor Law, to provide accommodations for new cases, and to offer out-patient facilities.¹¹⁰

Since the appointment of the Royal Commission there had been great concern over its composition, as the majority who sat on it were legal experts. None of the commissioners had professional psychiatric backgrounds, and only two had medical qualifications.¹¹¹ Later the

¹⁰⁸ Ibid.

¹⁰⁹ Butler, *Mental Health, Social Policy and the Law*, p. 88.

¹¹⁰ Ibid.

¹¹¹ Jones, *Asylums and After*, p. 130.

chairman confessed that he had ‘come to the task (...) without any particular knowledge of lunacy’.¹¹² Upon the release of the final Report, however, the Commission turned out pro-medical in many ways.¹¹³ Most important of all, its suggestions included several clauses guaranteeing the status of medical staff and providing them with legal protection; for instance, it stated ‘medical practitioners should receive additional protection’ in case of involvement in law suits.¹¹⁴ As for the issue of wrongful detention and unfair treatment, the Commission concluded that there was no ‘systematically practiced cruelty’ in mental institutions, such as that exposed by Lomax in his memoir, although admitting to some unavoidable incidences of brutality and rough handling.¹¹⁵

The Commission seemed to be most concerned with the problem of stigma amongst various social concerns related to mental illness, reflecting the changes occurring in the circle of policy makers. However, such selectivity confounded the general public who called for the appointment of a Royal Commission focusing on wrongful detention. According to the MacMillan Report, the notion of stigma could be subdivided into four separate issues: the stigma of judicial certification; the stigma of lunacy itself; the stigma of pauperism; and the stigma preventing after-care. Accordingly, the Commission tried to seek solutions to each issue, suggesting alternative ways of hospitalisation without certification; the separation of mental health policy from the Poor Law; changes in terminologies; and integration of the mental hospital within the general hospital.¹¹⁶

¹¹² *The British Journal of Psychiatry*, 72:299 (Oct 1926), p. 598.

¹¹³ Jones, *Asylums and After*, p. 130; Rogers and Pilgrim, *Mental Health Policy in Britain*, pp. 54-55.

¹¹⁴ Rogers and Pilgrim, *Mental Health Policy in Britain*, p. 56.

¹¹⁵ *Report of the Royal Commission on Lunacy and Mental Disorder*, p. 113; Butler, *Mental Health, Social Policy and the Law*, pp. 88-89.

¹¹⁶ Butler, *Mental Health, Social Policy and the Law*, p. 87.

The Report of the Royal Commission was appraised as ‘of profound importance’ because, according to Clive Unsworth, it provided ‘eloquent expression to the fundamental changes of principle that were in progress’.¹¹⁷ In the same vein, Kathleen Jones has found the Report ‘more than an analysis of the existing situation’, but itself ‘a stage in development’.¹¹⁸ As both point out, the Royal Commission suggested the direction toward which British mental health policy should move during the next three decades.¹¹⁹ Most of the major recommendations of the Commission were soon addressed, notably in the Mental Treatment Act of 1930.

The Mental Treatment Act

By the time of the Royal Commission the reform of laws regulating the mental health service was ‘already firmly on the legislative agenda’, and the publication of the MacMillan Report gave momentum to the political and social climate for legal change.¹²⁰ Three years later the Local Government Act was enacted, the first step to realise the Royal Commission’s suggestions. The 1929 Act brought about major changes mainly with regard to the Poor Law and local government and finally terminated the long-lasting close relationship between the Poor Law and the mental health service. It abolished the Boards of Guardians, who had been

¹¹⁷ Unsworth, *The Politics of Mental Health Legislation*, p. 113.

¹¹⁸ Kathleen Jones, *A History of the Mental Health Services* (London: Routledge & Kegan Paul, 1972), p. 244.

¹¹⁹ The major legislation to bring about fundamental changes to mental health policy was made in 1959, the Mental Health Act, the most important impact of which was to move psychiatric treatment away from institutional care and into the community.

¹²⁰ Unsworth, *The Politics of Mental Health Legislation*, p. 186.

responsible for pauper patients so far, and set up Public Assistance Committees to replace them.¹²¹ By doing so, the new law, though not abrogating the Poor Law itself, empowered local authorities to seize the initiative in the provision of public health services.¹²² The 1929 Act also put an end to the stigmatising expression, 'pauper', by replacing it with 'rate-aided person'.¹²³

It was the Mental Treatment Act of 1930 that fulfilled the majority of the recommendations suggested by the 1926 Royal Commission.¹²⁴ This legislation induced the most important transitions in the first half of the twentieth century regarding mental health policy in England. Among the innovations achieved by the enactment the most notable was to allow mental patients to receive treatment without going through the certification process. The mentally disordered could now take two alternative routes, other than traditional hospitalisation. Patients capable of expressing their volition to have medical treatment were allowed to be admitted as 'voluntary patients' by filling in an application form. Voluntary patients were able to discharge themselves, too, with seventy-two-hour notice. Those who were considered as suffering from acute mental illness and expected to have good prognosis could be admitted as temporary patients. As these patients were assumed unable to make the right decision about treatment and admission or to express their own intention, medical practitioners had to take the responsibility. Temporary patients were supposed to have treatment for six months at most, with at maximum two further three-month extensions if

¹²¹ Gittins, *Madness in its Place*, p. 35; Jones, *Asylums and After*, pp. 134-135.

¹²² Butler, *Mental Health, Social Policy and the Law*, p. 94.

¹²³ Jones, *Asylums and After*, p. 135.

¹²⁴ Anne Rogers and David Pilgrim, *Mental Health Policy in Britain: A Critical Introduction* (1st edn, Basingstoke: Macmillan, 1996), pp. 60-61.

needed, as uncertified boarders.¹²⁵ Its aim was to enlarge the opportunity for early treatment, to facilitate access to non-custodial therapy, and to enable patients to avoid the stigma habitually acquired after certification. The Act also encouraged local governments to set up outpatient clinics and to provide after-care for those discharged from mental institutions. It ended old stigmatising terminologies, by replacing ‘asylum’ with ‘mental hospital’ and getting rid of ‘pauper patient’ from legislation.¹²⁶

The Mental Treatment Act certainly increased the choice available to both patients and their families and stimulated a surge in the number of patients who had treatment without being certified, the most dramatic change brought about by the legislation. It was, however, an unexpected and therefore surprising outcome for many involved in this field. A member of staff in a mental hospital recalled, when the Act was announced he expected that ‘nobody (...) fathomed how anyone could possibly volunteer to go into an asylum’.¹²⁷ Contrary to such expectation, voluntary admissions grew steadily, albeit ‘after a patchy start’. According to official statistics for 1938, ‘voluntary patients accounted for 35.2 percent of all admissions, and 15 percent of hospitals were admitting more than half their patients with voluntary status.’¹²⁸

However, the speed and extent of change varied between institutions. Generally speaking, county asylums were less likely to be influenced by the new system. In her case study of Severalls Hospital, Gittins discovered that the voluntary patient admission rate for the county facility remained far lower compared with the nationwide one. To be more

¹²⁵ Jones, *Asylums and After*, pp. 135-136.

¹²⁶ Butler, *Mental Health, Social Policy and the Law*, pp. 92-93.

¹²⁷ Gittins, *Madness in its Place*, p. 40.

¹²⁸ Jones, *Asylums and After*, p. 136.

specific, the proportion of its voluntary boarders was only 6 percent in 1932, but escalated up to 22 percent three years afterwards, and then exceeded 40 percent only by the mid-1940s.¹²⁹ Other public mental hospitals shared the same trend, a slow and faltering escalation of voluntary patient numbers. The Annual Report of Brookwood Mental Hospital, the second County Asylum of Surrey, provided a parallel example to that of Severalls. In the first year after the legislation there were only 6 voluntary patients, out of 291 admissions. Then the number edged to 47 out of 311 in 1934, 54 out of 314 in 1936, and 73 out of 351 in 1938.¹³⁰ Despite the steady increase, the rate barely reached 20 percent in 1938, not even close to the national average of 35.2 percent.

[Table 1] The Number of Voluntary Patients in Brookwood Mental Hospital in the 1930s¹³¹

Year	Voluntary Pt number	Total Admission
1931	6 (2%)	291
1932	26 (11%)	243
1934	47 (15%)	311
1936	54 (17%)	314
1938	73 (20%)	351

¹²⁹ Gittins, *Madness in its Place*, p. 40.

¹³⁰ Brookwood Mental Hospital, Annual Report with Audited Accounts for year 1930-1937, SHC Ac. 3043/1/1/2/20 – 27.

¹³¹ *Ibid.*

At this point, a question should be raised: who benefited most from the introduction of the new system? The politicians supporting the Bill expected that it would widen access to mental health services for working-class patients suffering from incipient mental illness. However, against their hope, the main beneficiaries were the middle class, more precisely the lower middle class. David Pearson's research on the Devon Mental Hospital has demonstrated that patients from 'the better-educated, more affluent and higher-status families' chose to stay in the Hospital as voluntary residents, and, by doing so, came to be major beneficiaries of the 1930 Act.¹³² The situation explained, at least partly, the reason why public asylums for the poor had fewer voluntary patients than the national average encompassing all mental institutions in England and Wales. In this sense, the purpose of the enactment seemed to have been only half achieved.

Considering that county asylums had far fewer voluntary patients than the national average, we need to check what happened in private mental institutions in order to trace where the majority of uncertified patients came from. Private institutions and registered hospitals were also affected by the 1930 Act, but in a different way and extent to public county mental hospitals. In this respect, Holloway Sanatorium, a mental hospital exclusively for the middle class, provides a good example. When the law was announced, its medical superintendent predicted in the Annual Report that the provision for voluntary patients would 'not affect the Sanatorium, except in minor differences in respect of admissions and

¹³² David Pearce, 'Family, Gender and Class in Psychiatric Patient Care during the 1930s: The 1930 Mental Treatment Act and the Devon Mental Hospital', in Pamela Dale and Joseph Melling (eds.), *Mental Illness and Learning Disability since 1850: Finding a Place for Mental Disorder in the United Kingdom* (London: Routledge, 2006), pp. 118-121, 128.

discharges’, as the institution had been providing ward and treatment to voluntary boarders since its establishment in 1885.¹³³ Nonetheless, the situation did change. Immediately after the enactment the proportion of voluntary patients increased manifestly and rapidly. The total number of its boarders remained by and large stable throughout the 1920s and 1930s, around 500 patients a year, and so did the number of patients on the register, about 350. The figure of voluntary patients, however, showed drastic variation; it was less than 50 in the early 1920s, mounted slowly but surely in the late 1920s and surged particularly from 1932.

[Table 2] The Number of Patients at Holloway Sanatorium¹³⁴

Year		1923	1928	1931	1934	1937
Total	Certified Pt.	419 (90%)	403 (85%)	378 (79%)	360 (77%)	315 (68%)
	Voluntary Pt.	48 (10%)	74 (16%)	95 (20%)	100 (22%)	139 (30%)
	Temporary Pt.			3 (1%)	6 (1%)	7 (2%)
	Total	467	473	476	466	461
Average Resident	Certified Pt.	341	333	324	296	270
	Voluntary Pt.	17	31	47	58	65
	Temporary Pt.			0	2	2

¹³³ Holloway Sanatorium, Annual Report for the Year 1930, No. 45, SHC Ac. 2620/1/9.

¹³⁴ Holloway Sanatorium, Annual Report for the Year 1923, No. 38, SHC Ac. 2620/1/8; Annual Report for the Year 1928, No.43, SHC Ac. 2620/1/9; Annual Report for the Year 1931, No. 46, SHC Ac. 2620/1/9; Annual Report for the Year 1934, No. 49, SHC Ac. 2620/1/9; Annual Report for the Year 1937, No. 52, SHC Ac. 2620/1/9.

The medical superintendent noted in the 1931 Annual Report that:

the total number of patients treated was 476 - 378 certified, 3 temporary and 95 voluntary patients. This last figure is interesting as showing how the modern practice of thus dealing with nervous and temperamental sufferers has grown during the last few years. Then years ago there were only 14 voluntary boarders, and when, in 1927, the number reached 54, it was considered a matter for special comments.¹³⁵

In the next year, he recorded:

for the first time in the history of the Sanatorium [the] number of voluntary patients exceeded 100. This number is actually double that of such patients in residence here five years ago, and illustrates *the effect of the Mental Treatment Act, 1930*.¹³⁶

As can be seen from the case above, although not directed towards private mental institutions, the 1930 Act exerted a considerable effect on their running. In terms of the increase in

¹³⁵ Holloway Sanatorium, Annual Report for the Year 1931, No. 46, SHC Ac. 2620/1/9, p. 5.

¹³⁶ Holloway Sanatorium, Annual Report for the Year 1932, No. 47, SHC Ac. 2620/1/9, p. pp. 5-6.

numbers, it wielded greater influence upon private hospitals than upon public asylums.

Although the Mental Treatment Act succeeded in introducing considerable changes into English mental health services, particularly with respect to the composition of psychiatric patients, its enactment did not mean the abolition of the Lunacy Act of 1890. Rather, as many historians have pointed out, the new law should be understood as a partial ‘modification’ of the old one.¹³⁷ The Mental Treatment Act, according to Pearce who has heavily stressed the impact of the 1930 Act, ‘amended rather than swept away the provisions of the 1890 lunacy legislation’.¹³⁸ Thus, until the passing of the Mental Health Act in 1959, the 1890 Act was to provide the fundamental principles for mental health policy. Crucially, the certification system still held good, for which Tom Butler provides a precise analysis in *Mental Health, Social Policy and the Law*.

After 1930, the procedure of certification continued as a penal sanction on the insane, which associated them with the criminal and the socially suspect.

Certification also acted as a social barometer which created a personal stigma for those mental patients discharged from the hospitals.¹³⁹

Still, asylums worked as the core of mental health services, which will be demonstrated later in this chapter.

¹³⁷ Gittins, *Madness in its Place*, p. 35.

¹³⁸ Pearce, ‘Family, Gender and Class in Psychiatric Patient Care’, p. 113.

¹³⁹ Butler, *Mental Health, Social Policy and the Law*, p. 98.

In terms of patients' rights, the 1930 Act made little progress. Many of the Royal Commission's recommendations in this area were omitted from or scaled down in the 1930 Act. For instance, the provision that 'information about legal rights of patients and relatives (should) be posted on hospital wards' was not included in the Act.¹⁴⁰ The legislation failed to assuage public sensitivity about wrongful detention, which was aggravated by a series of notorious events in the early 1920s and contributed to the appointment of the Royal Commission. Ironically, the law sanctioned, once again, forced treatment and detention without trial in the name of the 'medical-therapeutic ethos' and, by doing so, bolstered the professional power of doctors at the cost of patients' rights.¹⁴¹ Moreover, the Act provided considerable legal protection for all medical staff in mental hospitals in case of malicious charges against them.

4. Towards Psychiatrisation: Expansion of Psychiatric Concern and Diversification of Mental Health Services

The early twentieth century saw the expansion of psychiatry, which was to accelerate in the post-war era. The medical branch broadened its horizons to include symptoms and disorders which had failed to attract professional interest in the previous century. Medical historians have paid attention to the change in psychiatric interest during the interwar years.

¹⁴⁰ Rogers and Pilgrim, *Mental Health Policy in Britain: A Critical Introduction*, pp. 60-61.

¹⁴¹ Ibid.

Specifically, Porter has argued that ‘the interest of psychiatry shifted from major psychoses, statistically relatively rare occurrences, to the milder and borderline cases, the minor deviations from the normal average’ between the two World Wars.¹⁴² Although ‘nerve doctors’ had treated neuroses of ‘new and lucrative clientele’ since the last decades of the nineteenth century,¹⁴³ it was during the interwar years when emphasis fell upon the mild disorders ‘not severe enough to warrant hospitalisation or certification’ in mainstream psychiatry.¹⁴⁴ Such a transition enabled this medical branch to win over a large number of latent patients, heralding ‘psychiatrisation’ in the latter half of the century.

The most visible change that early-twentieth-century psychiatry went through was the ‘marked and continued’ increase in patients.¹⁴⁵ At the beginning of the century, the total number of those identified as insane reached nearly a hundred thousand in England and Wales, meaning that among the whole population of around 32 million, 3 out of 1,000 were considered to be mentally ill. The majority of the certified, about three quarters, was hospitalised in county asylums. The total number of confined mental patients grew even faster afterwards, doubling by the mid-twentieth century.¹⁴⁶ The upturn in inpatient numbers was to continue well into the 1970s.¹⁴⁷ Furthermore, especially after the 1930 Act, outpatients made a great contribution to the increase of the total number of mental patients. With voluntary patients mostly from middle-class backgrounds, they became the main recipients of the legislation. The rapid growth of patient numbers at the Maudsley outpatient

¹⁴² Porter, ‘Two Cheers for Psychiatry!’, pp. 395-396.

¹⁴³ Mark S. Micale, ‘The Psychiatric Body’, in Cooter and Pickstone (eds.), *Medicine in the Twentieth Century*, p. 328.

¹⁴⁴ Porter, ‘Two Cheers for Psychiatry!’, pp. 395-396.

¹⁴⁵ *Ibid.*, p. 399.

¹⁴⁶ Busfield, ‘Mental Illness’, p. 635.

¹⁴⁷ Porter, ‘Two Cheers for Psychiatry!’, p. 399.

department, which is illustrated in the Introduction, was to be repeated in other outpatient clinics which opened afterwards.

Another aspect of the expansion in psychiatric services during the interwar years was the ‘diversification’ of places offering mental illness care and, as a result, increased accessibility to psychiatric treatment. Although a private care sector had existed, only the rich had been able to afford it. It was only after the Great War that various mental health services outside asylums became available to the general public.¹⁴⁸ New psychiatric care venues included various kinds of after-care facilities, outpatient clinics, acute psychiatric units in general hospitals, psychoanalysis practice, and office-based, small and relatively sumptuous clinics, each of which was to serve a specific group of patients depending on seriousness of disorder or stage of illness. Convalescent homes, which were meant to provide after-care to ex-inpatients of admission hospitals, came to be equipped with ‘a more standardised and coordinated model of care’ and extended their operations in the 1920s and 1930s.¹⁴⁹ Institutions practicing psychoanalysis appeared around the War and prospered owing to the massive occurrence of shell shock and the social perception of neurosis aroused by it, as illustrated earlier in this chapter. Out-patient clinics secured the legal ground with the 1930 Act and came to attract a great number of patients whose cases were not severe enough to be certified or admitted. General hospitals contributed to the expansion of psychiatry by setting up acute mental patient units as well as outpatient departments. In this sense, the establishment of the Maudsley Hospital in 1923 could be seen as a major achievement of British psychiatry, marking the appearance of a new type of mental hospital addressing the

¹⁴⁸ Busfield, ‘Mental Illness’, p. 638.

¹⁴⁹ Stephen Soanes, *Rest and Restitution: Convalescence and the Public Mental Hospital in England, 1919–39* (unpublished Ph.D. Thesis: University of Warwick, 2011), p. 364.

trinity of ‘research into the causes and treatment of mental and nervous disorders’, ‘teaching of psychological medicine’ and ‘treatment of patients’ particularly in early and acute phase.¹⁵⁰

During this boom in new psychiatric services, public mental hospitals, the most common and traditional form of institution then existing, were the only providers to remain consistent in number. Only one mental hospital was newly built in England throughout the interwar years: in 1937 Runwell Mental Hospital opened in Wickford, Essex.¹⁵¹ According to Jones, Runwell represented ‘the most advanced thinking’ about mental institutions and ‘a new attitude to mental illness’ of the 1930s.¹⁵² It provided its inmates with resocialisation programmes, group therapy, and various entertainment facilities, including a swimming pool. Furthermore, it was equipped with a ‘research wing’, which reminds us of the establishment purpose of the Maudsley Hospital. Runwell, thus, could be considered as a proof that public mental hospitals in the interwar years pursued varied ways to reform and to modernise its service. It should also be remembered that public asylums, even though their importance seemed to decrease at this time, were still the ‘centre for provision’ of psychiatric treatment ‘surrounded by a more diverse range of additional services’, at least until the Second World War.¹⁵³

Whereas a consensus was reached amongst historians regarding the expansion of psychiatry, there has been sharp conflict over the quality of psychiatric institutions and their service in the early twentieth century. Some historians argue that psychiatry made remarkable

¹⁵⁰ Maudsley Hospital, Medical Superintendent’s Annual Report, Year ended 31st January, 1924, BRHAM, p. 2.

¹⁵¹ Rogers and Pilgrim, *Mental Health Policy in Britain*, p. 55.

¹⁵² Jones, *Asylums and After*, p. 138.

¹⁵³ Busfield, ‘Mental Illness’, p. 638.

progress in terms of the treatment conditions of patients. Jones concludes that in the 1920s and the 1930s the general condition of mental patients was improving and mental hospitals were 'humanised'. Patients were given better treatment, with regard to food, clothes and entertainment, and could take part in various activities provided by the institutions. Some inmates enjoyed a certain degree of freedom which had not been allowed before, for example they were allowed to wear their own clothes. Mental hospitals were increasingly staffed by better qualified workers, especially during the economic downturn.¹⁵⁴ Others on the contrary found little difference, let alone any development, between psychiatry in the Victorian age and during the interwar years. For instance, Anne Rogers and David Pilgrim point out that the death rate in mental hospitals was high throughout the early twentieth century and that the figure remained consistent after the introduction of new somatic treatments in the mid-1930s due to 'iatrogenic death'. They emphasise that the majority of mental patients, over 90 percent, 'were still detained compulsorily' after the 1930 Act, the legal endorsement of voluntary admission.¹⁵⁵

The physical condition of mental institutions has been visited and revisited since the heydays of the asylum system, as seen in Lomax's exposé of 1922. Of course, the situation varied significantly depending on the institutions and there may have been some mental hospitals which could not escape from harsh criticism. However, the death rate of mental hospital inmates declined on the whole throughout the early twentieth century, and the number of iatrogenic deaths was few, mainly because medical staff were passive about applying new treatments in practice. Taking Brookwood Hospital as a representative example

¹⁵⁴ Jones, *Asylums and After*, pp. 134-138.

¹⁵⁵ Rogers and Pilgrim, *Mental Health Policy in Britain*, pp. 55-57.

of a large-scaled public mental hospital,¹⁵⁶ its mean ‘percentage of death on average numbers resident’ declined throughout the late nineteenth and early twentieth centuries. Around the turn of the century, the figure fluctuated between 5 and 15 percent, making the average about 10; in the 1920s it swung between 4 and 10 percent; and during the next decade stayed less than 7 percent.¹⁵⁷ As for the cause of death, malpractice was not to blame, since the majority of deaths resulted from conventional causes, like senility, tuberculosis, pneumonia, cancer, and cardiac arrest, even in the late 1930s.¹⁵⁸ Considering these statistics, the critical assessment of Rogers and Pilgrim sounds excessive.

5. Conclusion

This chapter has followed the path that early-twentieth-century psychiatry took. Although the medical branch experienced a series of changes, some of which were considered innovative, modern psychiatry was still around the corner. Despite Showalter’s claim that the interwar years saw the coming of psychiatric modernism, on the grounds that Freudianism became

¹⁵⁶ This county mental hospital accommodated over 1,000 patients at a time from the mid-1870s, and the average resident number in the early twentieth century was about 1,200 and reached a record high, of more than 1500, during the Great War: Brookwood Mental Hospital, Annual Report with Audited Accounts (for year 1930-1937), SHC Ac. 3043/1/1/2/20 – 27.

¹⁵⁷ Brookwood Mental Hospital, Annual Report with Audited Accounts, SHC Ac. 3043/1/1/2/1-29.

¹⁵⁸ The principal causes of death in 1938 were: cardiac disease (21 patients), pneumonia (13), senility (13), tuberculosis (9), cancerous growths (5), and G.P. (3). There were no deaths related to new therapeutic measures throughout the 1930s. Brookwood Mental Hospital, Annual Report with Audited Accounts for year 1938, SHC Ac. 3043/1/1/2/29.

rooted in British soil and that therapeutic innovations were adopted in practice, there is little evidence to prove their impact at least during this period. The advent of modern psychiatry was to be realised only through additional fundamental changes and developments, inside and outside the medical department, after the Second World War: the organisation of the NHS in 1948 and subsequent integration of psychiatry into general medicine; the publication of the *Diagnostic and Statistical Manual of Mental Disorders* in 1952; the broad application of new therapeutic techniques, mostly having invented during interwar years, notably ECT and later pharmaceutical interventions, in psychiatric practice; and the Mental Treatment Act of 1959, the major impact of which was to move psychiatric treatment away from institutional care to community care. In the following chapter, what British psychiatry went through between the two World Wars will be illustrated in detail, and why it had not yet reached a stage of modernism will be re-asserted, through the lens of a specific diagnosis, depression.

Chapter 2. Depression in Early-Twentieth-Century Britain

The previous chapter examined British psychiatry in the early twentieth century to show that modern psychiatry had not yet emerged in the interwar years. Well into the 1930s British psychiatry was still under the strong influence of the nineteenth-century tradition, regarding diagnosis and treatment, as well as the whole system. This chapter focuses on a specific psychiatric diagnosis in this period, depression. The way in which this disorder was understood and interpreted by psychiatrists will be examined based on expert literature. Through the analysis, it will be suggested that the status of depression as a discrete mental disorder, with respect to its concept, terminology and classification, was far from secure until the outbreak of the Second World War. Also, it will be argued that the early twentieth century should be recognised as a part of the long process by which depression achieved its modernity, beginning in the early nineteenth century and ending only in the post-war era. Such findings accord with what has been suggested in the previous chapter on psychiatry in general, and stresses the continuity and lingering impact of Victorian psychiatry. Meanwhile, this chapter can be read as an exemplary study applying social constructionist approaches to medical history, as it aims to reconstruct the process in which a diagnosis was defined, classified and applied. As acknowledged in the Introduction to this thesis, there are ‘three distinct and interconnected versions’ of social constructionism according to the classification of Phil Brown: focusing on the social definition of medical concepts; interpreting the relationship between the medical discourse and the manifestation of illness; and

concentrating on the production of scientific facts and knowledge by professionals.¹ In particular, this chapter is deeply involved with the first and third versions of social constructionism, albeit not irrelevant to the second.

Historians with an interest in this affective disorder have engaged in a prolonged controversy over the relation between melancholia and depression. The major question is whether we can equate depression of today with melancholia, a very old diagnosis with Greek origins. Proponents of the continuity view, including Stanley W. Jackson, Allan V. Horwitz, Jerome Wakefield and Somogy Varga, argue that modern depressive disorder can be seen as the same condition as melancholia.² Jackson, for instance, insists that despite all the differences in the symptoms of melancholia affectivity has remained as its core feature, and finds a ‘remarkable consistency’ between long-lived melancholia and twentieth-century depressive disorder.³ On the contrary, discontinuity view supporters, such as German E. Berrios, Roy Porter, Åsa Jansson and Jennifer Radden, oppose such identification, arguing that the differences between melancholia and depression ‘preponderate over the similarities’.⁴

¹ Phil Brown, ‘Naming and Framing: The Social Construction of Diagnosis and Illness’, *Journal of Health and Social Behavior*, Extra Issue (1995), pp. 35-36.

² Stanley W. Jackson, *Melancholia and Depression: From Hippocratic Times to Modern Times* (London: Yale University Press, 1986), pp. 188-246; Stanley W. Jackson, ‘A History of Melancholia and Depression’, in Edwin R. Wallace and John Gach (eds.), *History of Psychiatry and Medical Psychology* (New York: Springer, 2008), pp. 443-460; Allan V. Horwitz and Jerome C. Wakefield, *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder* (Oxford: Oxford University Press, 2007); Somogy Varga, ‘From Melancholia to Depression: Ideas on a Possible Continuity’, *Philosophy, Psychiatry, and Psychology*, 20:2 (2013), pp. 141-155; Judith Misbach and Henderikus Stam, ‘Medicalising Melancholia: Exploring Profiles of Psychiatric Professionalisation’, *Journal of the History of the Behavioural Science*, 42:1 (2006), pp. 41-59.

³ Jackson, *Melancholia and Depression*, pp. 188-246.

⁴ German E. Berrios, ‘Mood Disorders’, in German E. Berrios and Roy Porter (eds.), *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London: Athlone, 1995), pp. 384-408; Berrios, ‘Melancholia and Depression during the Nineteenth Century: A Conceptual History’, *British Journal of Psychiatry*, 153:3 (1988), pp. 298-304; Berrios, *The History of Mental*

Berrios contends that even in the Napoleonic period low mood had not been considered as a critical symptom of melancholia and that it was only in the nineteenth century when melancholia came to be considered as an affective disorder.⁵ Jansson argues that mental illness should be interpreted as ‘specific to a particular historical moment’ and criticises continuity views that result from a misunderstanding of a ‘continuity of language’.⁶ This research stands on the middle ground between the two stances. I understand melancholia and modern depression to basically share the ‘core feature’, low mood, as proponents of continuity claim. However, until the nineteenth century, melancholia covered a wide range of mental disorders and abnormalities, which had little in common except sorrow and sadness.⁷ It was during the nineteenth century that melancholia was adjusted and reconceptualised enough to present itself as a medical diagnostic entity.

1. Depression and Kraepelinian Psychiatry

In tracing how British psychiatrists in the early twentieth century understood and explained

Symptoms: Descriptive Psychopathology since the Nineteenth Century, pp. 293-299; Jennifer Radden, *Moody Minds Distempered: Essays on Melancholy and Depression* (Oxford: Oxford University Press, 2009), pp. 37-56; Åsa Jansson, ‘From Statistics to Diagnostics: Medical Certificates, Melancholia, and “Suicidal Propensities” in Victorian Psychiatry’, *Journal of Social History*, 46:3 (2013), pp. 716-731; Jansson, ‘Mood Disorder and the Brain: Depression, Melancholia, and the Historiography of Psychiatry’, *Medical History*, 55:3 (2011), pp. 393-399.

⁵ Berrios, *The History of Mental Symptoms*, pp. 293-299.

⁶ Jansson, ‘Mood Disorder and the Brain’, pp. 394-395.

⁷ Berrios, ‘Melancholia and Depression during the Nineteenth Century’, p. 299.

melancholia and depression, Emil Kraepelin and his serial *Textbook on Psychiatry* provide a reasonable starting point. He devised solutions to many of the problems related to the affective disorder, including its nomenclature and taxonomy. As illustrated in the previous chapter, ‘the founder of modern psychiatry’ contributed greatly to the development of psychiatry in the early twentieth century by recasting the way we view major mental diseases and setting up a new framework for naming and categorising them.⁸ He made his reputation as a leading psychiatrist by publishing a succession of editions of his *Textbook*, the first edition being released in 1883 and the ninth one in 1927. This series, covering almost a half century, reveals how his view on every psychiatric issue had been developed and adapted over the time.⁹ Among the successive editions, the sixth published in 1899 has been considered as the most important and is mentioned most frequently. In this edition, Kraepelin finally cleared up the confusion over nomenclature and classification of mental disorders, both having challenged psychiatrists throughout the century. He put all kinds of psychotic illness into two categories, dementia praecox and manic-depressive insanity, depending on the involvement of any affective component, which has been appraised as a ‘dramatic compression’.¹⁰ This nosological framework was to lay the foundation for *the Diagnostic*

⁸ Edward Shorter, *A Historical Dictionary of Psychiatry* (Oxford: Oxford University Press, 2005), p. 156.

⁹ Kraepelin’s *Textbook* series illustrated the development of the author’s view and the evolution of general psychiatry during the late nineteenth century and the early twentieth century, because it had been published over several decades from 1883 to 1927. However, the content also caused confusion, and sometimes conflict, over how to understand it. ‘Involutional melancholia’ is a typical example. Kraepelin’s revision caused confusion among both psychiatrists back then and historians later. Meanwhile, as Berrios has pointed out ‘selective reading’ of Kraepelin’s work contributed to misunderstanding and misinterpretation of his main concepts, particularly affective disorder. According to him, ‘the history of the affective disorders after 1910 is no more than the analysis of the fragmentation of the Kraepelinian notion’. Shorter, *A Historical Dictionary of Psychiatry*, pp. 82, 175-176; Berrios, ‘Mood Disorders’, pp. 392-393; Berrios, *The History of Mental Symptoms*, p. 300.

¹⁰ Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New

and Statistical Manual of Mental Disorders, and the International Classification of Disease, both of which are still in intensive use all over the world.¹¹

In establishing twentieth-century depression, too, he played a key role. Firstly, he put an end to the long standing confusion about nomenclature, by overseeing the transition of terminology from melancholia to depression. Melancholia enjoyed an official position as a diagnostic term throughout the nineteenth century despite increasing dissatisfaction with its loose usage. Meanwhile, depression was either considered at best as a synonym for melancholia or used mostly in order to describe low mood state as a symptom of those suffering from various mental illnesses. The latter, however, was moving towards its modern meaning and usage during the Victorian era.¹² Finally, in 1896, Kraepelin abandoned melancholia as a diagnosis and introduced depression as its replacement in the fifth edition of the *Textbook*.¹³ Through his influence upon European psychiatry, depression was elevated to an official diagnostic term and the protracted terminological changeover seemed to be concluded. Secondly, Kraepelin suggested a new framework to classify depression and, as its superordinate concept, affective disorder. As mentioned earlier, in the sixth edition of his *Textbook*, he proposed two umbrella concepts covering all types of mental illness; dementia praecox and manic-depressive insanity. The latter included manic states, depressed states and

York: Wiley), p. 107.

¹¹ Ibid, p. 106.

¹² Clark Lawlor, *From Melancholia to Prozac: A History of Depression* (Oxford: Oxford University Press, 2012), p. 128.

¹³ In the United States, Adolf Meyer led the shift from melancholia to depression around the turn of this century. According to an article, he was ‘desirous of eliminating the term melancholia, which implied a knowledge of something that we did not possess. (...) If, instead of melancholia, we applied the term depression to the whole class, it would designate in an unassuming way exactly what was meant’: Jackson, ‘A History of Melancholia and Depression’, p. 445.

mixed states, all of which exhibited pathological emotional states as a core symptom.¹⁴

Depression was grouped into three types in a sequence of severity:¹⁵ simple depression, depression with delusions and hallucination, and stuporous condition.¹⁶ The nomenclature and taxonomy suggested by Kraepelin exerted a critical effect on the way in which European psychiatrists recognised depression (and affective disorder) thereafter, and largely decided the path that the psychiatric notion (and its related concepts) followed throughout the early twentieth century, which will be dealt with in detail later in this chapter.

Before illustrating the early-twentieth-century history of depression, it should be mentioned that Kraepelin faithfully followed the tradition of nineteenth-century psychiatry and handed many of its achievements over to twentieth-century medicine. In terms of the ways in which questions were raised and the answers found, he held fast to Victorian psychiatry. Dissatisfaction with this terminology issue was not only felt by Kraepelin, but had also been expressed by his predecessors in this medical branch throughout the nineteenth century. As early as 1820, Jean-Etienne Dominique Esquirol revealed deep discontent at melancholia,¹⁷ and replaced the old term with a new concept, *lypemia*, the first attempt to

¹⁴ Jackson, *Melancholia and Depression*, p. 189.

¹⁵ Emil Kraepelin, Mary Barclay (trans.), and George Robertson (ed.), *Manic-Depressive Insanity and Paranoia* (Edinburgh: Livingstone, 1921), pp. 75-97. The suggested categorisation of depression was never fixed one. Kraepelin changed the sub-groups of depression over time, as he did with many other diagnostic concepts. For instance, in the eighth edition of his *Textbook*, he grouped the disorder into six, again according to severity and accompanied symptoms: simple depression; stupor; melancholia gravis; paranoid depression; fantastic depression; and delirious depression.

¹⁶ Jackson, *Melancholia and Depression*, p. 191.

¹⁷ Jean-Etienne Dominique Esquirol (1772-1840) is said to be the ‘founder of the French tradition of psychiatric nosology’. The early years of his career as a psychiatrist had been under the strong influence of Philippe Pinel. Esquirol joined the Salpêtrière Hospital in 1811, and remained there until 1825 when he was appointed as a chief physician at Charenton National Asylum. Esquirol initiated France’s first course of psychiatry lectures in 1817 and was deeply involved with education throughout his career, and participated in the reform of asylums. However, he has been ‘mainly

introduce a substitute for the archaic term, melancholia.¹⁸ Also, the great interest in the classification of mental illness was pervasive throughout the century, and most prominent psychiatrists involved themselves eagerly in taxonomic work, including Wilhelm Griesinger, Richard von Krafft-Ebing, and Karl Ludwig Kahlbaum, all directly affecting Kraepelinian nosology.¹⁹ In terms of methodology, too, he followed the path paved by nineteenth-century psychiatrists. He was under the influence of a strong tradition of descriptive psychopathology, which was developed primarily by Esquirol and carried on by Griesinger and Krafft-Ebing.²⁰ Such a methodology offered Kraepelin a solid ground, as his study was rooted in the massive volume of descriptions collected from his practice. His longitudinal approach to insanity was inherited from senior German psychiatrists, notably Kahlbaum. Kraepelin considered the time dimension as an important factor in understanding mental illness and paid close attention to the course of a disorder, according to his own language, ‘prognosis’.²¹ Therefore, Kraepelinian psychiatry should be understood as being an extension of the nineteenth-century medical tradition, which does not necessarily deny his own contribution and achievement. That he clung to the conventions of Victorian psychiatry is as true as the appraisal that he opened the door for twentieth-century modern psychiatry. As a result, it means that in order to

remembered for his attempt to refine psychiatry diagnosis with such terms as monomania and lypemania’. Shorter, *A Historical Dictionary of Psychiatry*, pp. 100-101.

¹⁸ Berrios, *The History of Mental Symptoms*, pp. 303-304; Berrios, ‘Melancholia and Depression during the Nineteenth Century’, p. 300; Berrios, ‘Mood Disorder’, pp. 389-390.

¹⁹ The need to re-classify affective disorders during the nineteenth century had various origins. There was the taxonomic impetus driving the whole of medicine; an internal need to tidy up the nosology of psychiatry; the influence of faculty psychology; the ever looming presence of degeneration theory; and, late in the century, the need to identify homogeneous clinical groups for neuropathological study, particularly in relation to the differential diagnosis between melancholia and dementia. Berrios, ‘Mood Disorders’, pp. 387-388.

²⁰ Berrios, *The History of Mental Symptoms*, pp. 15-31.

²¹ Jackson, *Melancholia and Depression*, p. 449.

appreciate the early-twentieth-century professional understanding of melancholia and depression, which owed much to Kraepelinian psychiatry, we need to take the nineteenth-century psychiatric tradition and its achievements into serious consideration.

2. The Concept of Depression

In examining the history of depression in the early twentieth century, its definition could be the best departure point. Under the strong influence of Kraepelinian taxonomy, depression, with mania, was usually explained as a sub-category of manic-depressive psychosis. In the eighth edition of the *Textbook*, Kraepelin claimed that manic-depressive insanity ‘includes on the one hand the whole domain of so-called periodic and circular insanity, on the other hand simple mania, the greater part of the morbid states termed melancholia and also a not inconsiderable number of cases of amentia’.²² As sub-types of the umbrella concept, he distinguished manic states ‘with the essential morbid symptoms of flight of ideas, exalted mood, and pressure of activity’, whereas depressive states ‘with sad or anxious moodiness and also sluggishness of thought and action’.²³ *A Text-Book of Psychiatry for Students and Practitioners*, the first edition of which was published in 1927 by D. K. Henderson and R. D. Gillespie which was a huge instant success, took almost the same format.²⁴ Even though Henderson and Gillespie were against Kraepelinian psychiatry in many ways and were more

²² Kraepelin, *Manic-Depressive Insanity and Paranoia*, pp. 1-2.

²³ *Ibid.*, pp. 3-4.

²⁴ *The American Journal of Surgery*, 8:5 (May 1930), p. 1107.

inclined towards American rather than Continental psychiatry, they applied the concept of manic-depressive psychosis as it had been suggested by its originator and defined it as ‘disorders of affect’.²⁵

Most definitions of melancholia, depression or depressive state centred on the way in which the disorder manifested itself, namely symptoms. In his *Textbook*, Kraepelin described that ‘we distinguish (...) melancholia or depressive states with sad or anxious moodiness and also sluggishness of thought and action’.²⁶ Henderson and Gillespie recognised ‘a triad of symptoms’ present in all depression cases regardless of their severity, which were difficulty in thinking, mood depression and psychomotor retardation. Aubrey Lewis of the Maudsley Hospital, who actively engaged himself in publishing a series of articles on depression and melancholia from the early 1930s, suggested an exhaustive definition. He understood ‘depressive state’ as ‘a condition in which the clinical picture is dominated by an unpleasant affect, not transitory, without evidence of schizophrenic disorder or organic disorder of the brain, and in which moreover, the affective change appears primary, not secondary to other symptoms of ill-health’.²⁷ All of them stressed the affective feature of depression as a primary symptom.

The early-twentieth-century professional understanding of depression owed much to Victorian psychiatry. Throughout the nineteenth century melancholia went through a series of critical changes to acquire the main features which were noticeable in the aforementioned

²⁵ D. K. Henderson and R. D. Gillespie, *A Text-Book of Psychiatry for Students and Practitioners* (London: Oxford University Press, 1927), p. 116.

²⁶ Kraepelin, *Manic-Depressive Insanity and Paranoia*, pp. 3-4.

²⁷ Aubrey Lewis, ‘Melancholia: A Clinical Survey of Depressive States’, *Journal of Mental Science*, 80:329 (1934), p. 277.

early-twentieth-century definitions and later were to comprise ‘modern’ depression, as we understand it today, in the late twentieth century.²⁸ It was mania that had adjusted itself and narrowed down its boundary first to reach its modern meaning.²⁹ In this sense, Esquirol and his *lypemia* were often considered as signalling the beginning of the modern understanding of a mental disorder with an ancient origin.³⁰ In an essay published in 1820, this French psychiatrist introduced the new concept as a replacement of melancholia which he disdained mainly due to its deep association with humoral theories. He also emphasised affective and emotional nature of the disorder, the most significant change that happened to the understanding of melancholia according to Berrios.³¹ Thenceforth symptoms unrelated to emotion were gradually eliminated from the description of melancholia and depression; notably, delusion which had been considered as one of the main features lost its importance. From the mid-nineteenth century, definitions of melancholia were renovated, and related concepts which were called affective disorders in the next century were established. In the period between Esquirol and Kraepelin some assumptions were settled within expert circles: that the disorder was a ‘primary’ pathology of affect; was periodic in nature; had brain representation; and was hereditary and genetic in origin.³² Late in this century, Kraepelin took these features, adding or subtracting almost nothing, and passed them on to twentieth-century psychiatry.

²⁸ As Clark Lawlor points out, it was only in the late twentieth century that depression was made secure its modern sense in every aspect, see Lawlor, *From Melancholia to Prozac: A History of Depression*, pp. 151-152.

²⁹ Berrios, ‘Mood Disorder’, p. 385.

³⁰ Shorter, *A Historical Dictionary of Psychiatry*, p. 79.

³¹ Berrios, ‘Mood Disorders’, p. 385.

³² *Ibid.*, p. 387.

Therefore, with regard to its definition, twentieth-century depression did not vary much from its predecessor, nineteenth-century melancholia. The similarity between the two can be easily confirmed. *A Dictionary of Psychological Medicine*, so-called *Tuke's Dictionary*, published in 1892, shows that consensus had already been reached among the specialists at the end of the century.³³ In this *Dictionary*, melancholia was identified as 'a disorder characterised by a feeling of misery which is in excess of what is justified by the circumstances in which the individual is placed'.³⁴ The core feature lay in the extreme emotional state, illustrating the most important shift that melancholia had undergone during the Victorian age.³⁵ Texts written in the early twentieth century showed little difference. In an article published in the *Lancet*, in 1901, melancholia was identified with the 'emotion of fear',³⁶ and in another article issued in 1911, George M. Robertson, then a physician-superintendent of the Royal Edinburgh Asylum, claimed the disorder should be defined as 'being primarily and fundamentally a disease of depressed or painful emotion'.³⁷ As we have seen above, the definition of Henderson and Gillespie in the 1920s, and that of Lewis in the 1930s, showed remarkable similarity to them.

Regarding the aetiology of depression, late-nineteenth- and early-twentieth-century psychiatrists most commonly blamed heredity. To begin with, in the eighth edition of his *Textbook* Kraepelin claimed that 'the causes of the malady we must seek (...) essentially in

³³ Lawlor, *From Melancholia to Prozac*, p. 128.

³⁴ D. H. Tuke, *Dictionary of Psychological Medicine* (London: Churchill, 1892) pp. 787-796. In the *Dictionary*, however, depression was only considered just as a synonym of melancholia: searching it, there was only one line of explanation, 'see melancholia', a good contrast to the over eleven pages long description of the former terminology.

³⁵ Berrios, *The History of Mental Symptoms*, pp. 298-301; Jackson, 'A History of Melancholia and Depression', pp. 448-456.

³⁶ *Lancet*, 24 August 1901, pp. 516-518.

³⁷ *Lancet*, 1 April 1911, p. 865.

morbid predisposition'. Subsequently he demonstrated the 'hereditary taint' was responsible for about 80 percent of the cases which he had observed in Heidelberg.³⁸ In the aforementioned article in the *Lancet* Robertson argued that the attacks were 'largely due to the inheritance of an unstable nervous system'³⁹ and Henderson and Gillespie asserted 'there is no doubt that hereditary predisposition is the most important predisposing aetiological factor'.⁴⁰ Environments or circumstances were often mentioned along with heredity as a 'contributory' factor.⁴¹ Similarly, psychic influence, a representative example of which was shock followed by a close relative's death, was not rarely taken into consideration as sparking off individual attacks. Nevertheless, even while they were concerned about external stimuli, early twentieth-century mind doctors were usually obsessed by the internal and innate causes. This can be confirmed by Kraepelin's assertion that 'external influences could play a *subordinate* part in the causation of manic-depressive insanity',⁴² and that 'the *real* cause of the malady must be sought in *permanent internal changes*, which at least very often, perhaps always, are innate'.⁴³

With reference to gender, almost all psychiatrists believed that women were more vulnerable to mental illness than men, in line with the then widely held belief that depression was a female malady. Female dominance among the patients was confirmed by all text materials dealing with this subject. Kraepelin demonstrated that 'about 70 percent of the patients belong to the female sex'.⁴⁴ Two decades later, Henderson and Gillespie suggested

³⁸ Kraepelin, *Manic-Depressive Insanity and Paranoia*, p. 165.

³⁹ *Lancet*, 1 Apr. 1911.

⁴⁰ Henderson and Gillespie, *A Text-Book of Psychiatry*, p. 117.

⁴¹ *Lancet*, 14 May 1927.

⁴² Kraepelin, *Manic-Depressive Insanity and Paranoia*, p. 177.

⁴³ *Ibid*, p. 180.

⁴⁴ *Ibid*, p. 174

the same figure in *A Text-Book of Psychiatry* and stressed that ‘women are more liable to this disease than men’.⁴⁵ Common explanation for the reason behind the ‘obvious’ phenomenon was that it had something to do with the reproductive system of female body. Quoting Kraepelin again, ‘the processes connected with sexual life, the beginning of the menses, which not infrequently starts the first attack, parturition and puerperium and also involution, without doubt here play a part’.⁴⁶

At least regarding the definition, what we understand as depression can be traced back to the nineteenth century. Berrios’s derogation that before its re-conceptualisation during the Victorian period melancholia was ‘a rag-bag of insanity states whose only common denominator was the presence of *few* delusions’ appears too harsh.⁴⁷ In Robert Burton’s *The Anatomy of Melancholy*, published in 1621, sadness, sorrow and fear were at the centre of the experience of melancholia, corresponding to the continuity view.⁴⁸ Nonetheless, Berrios’s emphasis on the nineteenth-century transformation of melancholia seems convincing.⁴⁹ In the history of melancholia and depression, the early twentieth century can be interpreted as a period of transition, bridging the nineteenth century when the concept was re-launched and the late twentieth century when modern depression was finally established.⁵⁰

⁴⁵ Henderson and Gillespie, *A Text-Book of Psychiatry*, p. 117.

⁴⁶ Kraepelin, *Manic-Depressive Insanity and paranoia*, p. 174.

⁴⁷ Berrios, ‘Mood Disorder’, p. 385.

⁴⁸ Shorter, *A Historical Dictionary of Psychiatry*, p.175. Some say that Burton’s case was not pure depression, but ‘a mixture of depression and anxiety’.

⁴⁹ Åsa Jansson, another discontinuity view supporter, emphasises the contribution of Wilhelm Griesinger to the reconceptualization of melancholia in the nineteenth century. Jansson, ‘Mood Disorder and the Brain’, pp. 393-399.

⁵⁰ Lawlor, *From Melancholia to Prozac*, p. 134.

3. Terminology

As we have seen, throughout the nineteenth century psychiatrists agonised over terminology in relation to melancholia and depression. Although they noted growing discontent with the old term, solutions which could be agreed by all were hard to find. Approaching the end of the century, Kraepelin seemed to resolve the confusing situation, by making depression an official diagnostic term, replacing melancholia. However, it did not necessarily mean the transition was achieved swiftly. It took a long time for depression to replace melancholia, though historical research assumes that there was little place for melancholia in the twentieth-century psychiatric environment and that depression became dominant as soon as it gained authority as a diagnostic term. For instance, Jackson has declared that with the arrival of the category of manic-depressive insanity melancholia became ‘much less prominent’.⁵¹ More recently, Clark Lawlor has written, boldly enough, that ‘the death of the Victorian age meant the death of melancholia’.⁵² However, this does not seem to be how it happened in the early twentieth century.

Change came slowly in Britain. The *Nomenclature of Disease* published by the Joint Committee appointed by the Royal College of Physicians of London provides a good example to illustrate the atmosphere within British psychiatry in the early years of the twentieth century. In its 1906 version the official diagnostic term referring to pathological

⁵¹ Jackson, ‘A History of Melancholia and Depression’, pp. 444-445.

⁵² Lawlor, *From Melancholia to Prozac*, p. 134.

low mood was not depression but melancholia.⁵³ It is somewhat surprising and perplexing, especially considering that the *Nomenclature of Disease* authorised Kraepelinian classifying methodology and its basic concepts about manic-depressive insanity for the first time in Britain.⁵⁴ Although it was a decade later than Kraepelin had given up melancholia as a diagnosis in the fifth edition of *Textbook*, the old term was still applied as a formal disease name.

With respect to word frequency, melancholia held the upper hand over depression well into the early twentieth century too. In major medical journals, the old term appeared more frequently than the new one. For instance, in the *Journal of Mental Science*, melancholia was used more commonly and frequently as a diagnostic term than depression in the 1900s and 1910s. Specifically, in 1905, melancholia was employed in 42 articles or news items in the journal, but depression in 33, and in 1910 melancholia was applied in 36 items, while depression only in 15. As seen below, it was during and after the Great War that depression preponderated over melancholia in frequency. Taking the *Journal of Mental Science* as an example once again, only in the late 1910s did depression outstrip melancholia for the first time, and in the next decade it was applied more frequently, sometimes double, compared with the older term. Now the predominance of depression was established.

[Table 3] Word Frequency in the *Journal of Mental Science* Sampled Every Five Years between

⁵³ Royal College of Physicians of London, *Nomenclature of Disease* (4th edn, London, 1906), pp. 15-40.

⁵⁴ Berrios, *The History of Mental Symptoms*, p. 315.

1900 and 1940⁵⁵

Year	Melancholia	Depression	Manic-Depressive insanity (psychosis)
1900	73	47	0
1905	42	33	1
1910	36	15	22
1915	20	23	3
1920	6	17	13
1925	23	48	46
1930	49	49	64
1935	44	71	96
1940	11	39	21

However, even under these circumstances, melancholia continued to be given as a diagnosis. In daily practice, surprisingly, it stayed in use as a diagnostic term even after the War. Various kinds of medical records prove how hard and prolonged the transition was.⁵⁶ For instance in case notes of Holloway Sanatorium, well into the 1920s melancholia was still applied as a diagnostic term, often with adjectives, such as 'recurrent' or 'agitated'. In a case

⁵⁵ Source: <https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/>

⁵⁶ Ibid., pp. 121, 173.

book covering female admissions (certified only) between 1924 and 1926, over ten patients were diagnosed as suffering from ‘melancholia’, and only one was identified as manic-depressive insanity. ‘Depression’ and ‘depressed’ were used only for describing patients’ state in individual case files, and not applied for diagnosis even in a single case.⁵⁷ It seems that Holloway Sanatorium followed scrupulously the *Nomenclature of Diseases* published in 1906 at least up to this point. Such a finding appears to support Berrios’s claim that the *Nomenclature* lasted until the great British debate, which led the British psychiatrists into a stark clash of opinion after 1926, as will be examined later in this chapter.⁵⁸ At the Maudsley Hospital too, which claimed to be an ‘innovative’ mental institution, melancholia was occasionally applied to diagnosis, although ‘depressive state’ was favoured most amongst various terminologies synonymous with depression.⁵⁹

In expert literature, too, melancholia did not disappear completely. When Lewis of the Maudsley published his lengthy clinical survey of the depressive state in 1934, he applied ‘melancholia’ in the title. In this article, he explained that he meant ‘depressive state’ by melancholia and he used these words interchangeably.⁶⁰ On releasing the case materials used for the aforementioned article two years later in the *Journal of Mental Science*, Lewis used the old term in the title again, this time with no specific explanation about the use of the term.⁶¹ This was despite the fact that the official diagnostic term for the same clinical condition in the Maudsley was not melancholia but depression.⁶² From the 1930s

⁵⁷ Holloway Sanatorium, Case Book: Females [Volume 28], LWIHM, Acc. 343440, MS 5161.

⁵⁸ Berrios, ‘Mood Disorders’, p. 398.

⁵⁹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-067, Case No. 6269.

⁶⁰ Lewis, ‘Melancholia: A Clinical Survey of Depressive States’, pp. 277-378.

⁶¹ Aubrey Lewis, ‘Melancholia: Prognosis Study and Case-Material’, *Journal of Mental Science*, 82:340 (1936), pp. 488-558.

⁶² Maudsley Hospital, Medical Superintendents’ Annual Report, Year ended 31st January, 1924,

melancholia was increasingly used with an adjective, ‘involutional’, rather than being applied alone.⁶³ It was mainly because a debate on another confusing diagnostic concept ‘involutional melancholia’, referring to depression at the menopause, failed to reach any consensus within expert circles, and grew into a more serious conflict of opinion, which will be discussed below.

Strangely the wane of the term melancholia witnessed an interesting phenomenon in the late 1920s and 1930s, when ironically the term depression was just beginning to flourish.⁶⁴ The frequency of the word melancholia in medical journals soared around 1930. In the *Journal of Mental Science* melancholia appeared only six times in 1920, but 23 in 1925, 49 in 1930 and 44 times in 1935. Although its prevalence was less than that of its successor, depression, it still showed a steep increase. However, it is noteworthy that at this time the word melancholia indicated a different meaning and nuance. In his article ‘The Psychological Treatment of Mania and Depression’ of 1927 Ernest Snowden of the St. Bartholomew's Hospital distinguished depression and melancholia from each other, signifying severe cases with the latter.⁶⁵ In 1938, two years after the publication of ‘Melancholia: Prognostic Study and Case-Material’, Lewis also used melancholia in the same way in his new article ‘States of Depression: Their Clinical and Aetiological Differentiation’. This time he articulated that ‘melancholia was for acute cases’.⁶⁶ In a way, this change can

BRHAM.

⁶³ *Lancet*, 21 December 1940, pp. 787-788.

⁶⁴ Despite the uncertainties encircling its definition, classification and aetiology, depression was already the largest single diagnosis category by the 1920s, and became even more prevalent in the next decade. In the case of the Maudsley Hospital, among the entire patient population between 1923 and 1938, both in-patients and out-patients, over a third (37.5 per cent) was diagnosed with depression.

⁶⁵ *Lancet*, 14 May 1927. pp. 1016-1020.

⁶⁶ Aubrey Lewis, ‘States of Depression: Their Clinical and Aetiological Differentiation’, *British*

be related to the fierce debate on the nosology of affective disorder focusing on severity during the 1920s and 1930s, which will be illustrated below. It is difficult for us to check how many professionals agreed with the use of the old term in this way. However, it is reasonable to assume that it did not lessen the confusion relating to the application of the words, but rather aggravated the situation within expert circles.

4. Classification

Among various issues related to depression, it was classification of the affective disorder that puzzled British psychiatrists in the most obvious way during the first half of twentieth century. There was a sharp conflict between two perspectives: one held fast to the Kraepelinian view that every kind of affective disorder could be put under the all-inclusive category, manic-depressive insanity (or psychosis); and the other objected to such a unitarian standpoint, emphasising the necessity of distinguishing between severe and mild cases depending on the intensity of symptoms and drawing a line between endogenous and exogenous disorders based on the cause of depression. The debate on the classification of depression attracted leading psychiatrists and largely contributed to the atmosphere of this medical branch during the interwar years.

Medical Journal, 2:4060 (1938), pp. 875-878.

The Great British Debate

‘The great British debate’ began with the British Medical Association’s annual meeting of 1926 in Nottingham. At the opening of the section for neurology and psychology, Edward Mapother, the medical superintendent of the Maudsley Hospital, presented his article, which advocated the Kraepelinian umbrella concept, manic-depressive psychosis.⁶⁷ He claimed that ‘the distinction between neuroses and psychoses had neither basis nor meaning’, although admitting that it grew ‘out of the practical need and custom’.⁶⁸ According to him, various types of depression should be interpreted as located on a continuum rather than as discrete disorders, faithfully following Kraepelinian nosology.⁶⁹ Mapother’s presentation was followed by a furious discussion focusing on the classification of depression. The chairman of this section, Edward Farquhar Buzzard from the Royal College of Physicians, found Mapother’s claim ‘controversial and perhaps even provocative’.⁷⁰ He particularly refuted the

⁶⁷ However, Mapother’s support for the concept of manic-depressive insanity in the meeting did not mean that he completely stood by Kraepelinian psychiatry. According to Rhodri Hayward, Mapother was sceptical about the existence of the discrete disease categories in psychopathology. He argued that the categories were just convenient fictions and believed such diagnoses underestimated the psychobiological complexity of the patient. Furthermore, he made his anti-Kraepelin stance clear in his lecture in the late 1930s, by supporting the continuity of all forms of mental disorder: Rhodri Hayward, ‘Germany and the Making of “English” Psychiatry: The Maudsley Hospital, 1908-1939’, in Volker Roelcke, Paul Weindling, and Louise Westwood (eds.), *International Relations in Psychiatry: Britain, Germany, and the United States to World War II* (Rochester NY: University of Rochester Press, 2010), pp. 71-74.

⁶⁸ Edward Mapother, ‘Discussion on Manic-Depressive Psychosis’, *British Medical Journal*, 2:3436 (1926), pp. 872-876.

⁶⁹ Jackson, *Melancholia and Depression*, pp. 212-213.

⁷⁰ E. F. Buzzard was a leading physician in the field of neurology and psychiatry at his time. He contributed to improvement in the understanding of ‘shell-shock’ during the First World War, and built up his reputation by publishing textbooks and teaching in major institutions, such as the Royal College of Physicians, after the War. He was appointed as physician-extraordinary to King George V in 1923, became KCVO in 1927, and was created a baronet two years later. In 1928, he was appointed

speaker's argument that neurosis should be regarded as one of the subdivisions of the manic-depressive psychoses, as he regarded 'anxiety neurosis' as a discrete disorder.⁷¹ Then, T. A. Ross from Cassel Hospital came out against Mapother. He stood up for the essential differences between the psychoses and psychoneuroses, which was called a 'useless exercise' by the presenter.⁷² R. D. Gillespie from Guy's Hospital suggested a new way to divide affective disorders, adopting a nascent concept called 'reactiveness'.⁷³ The fierce and prolonged discussion ended with Mapother's brief closing comment, with no consensus achieved.

The controversy did not end here, and British psychiatrists persisted in stating their own opinions, mostly through articles. In 1929 Gillespie published a long paper in *Guy's Hospital Reports*, in which he divided depression cases into two main groups: 'reactive' and 'autonomous' depressions.⁷⁴ According to this dichotomy, the former exhibited 'a host of psychoneurotic symptoms', including anxiety and worry,⁷⁵ and 'the central feature' of cases falling into this group was 'responsiveness to influence, both external and internal'.⁷⁶ Patients in the latter group by contrast showed 'no reactivity'. Depression cases falling into

Regius Professor of Medicine at the University of Oxford, which was said to be 'the pinnacle of his career'; 'Farquhar Buzzard', *Oxford Dictionary of National Biography*, <http://dx.doi.org/10.1093/ref:odnb/32226>.

⁷¹ Mapother, 'Discussion on Manic-Depressive Psychosis', pp. 877-878.

⁷² Ibid.

⁷³ Ibid.; the five groups Gillespie suggested were manic-depressive disorders, reactive mood disorders, affective episodes in psychopathic personalities, psychoneurotic mood disorders, and miscellaneous groups.

⁷⁴ R. D. Gillespie, 'The Clinical Differentiation of Types of Depression', *Guy's Hospital Reports*, 79 (1929), pp. 306-344. However, Gillespie identified a limited number of 'involutional' depression cases, not falling into reactive or autonomous depression, which however were mostly ignored by contemporary psychiatrists and psychiatric historians.

⁷⁵ Shorter, *A Historical Dictionary of Psychiatry*, p. 84.

⁷⁶ Gillespie, 'The Clinical Differentiation of Types of Depression', p. 314.

this category exhibited such varied symptoms that Gillespie found them constituting a ‘heterogeneous group’, but they were all attributable to the ‘apparent manic-depressive heredity’.⁷⁷ Within this framework, the concept of ‘reactivity’ held the central position, the origin of which has been explained in several ways.⁷⁸ Berrios, for example, emphasises the influence of John T. MacCurdy, a Canadian psychiatrist, with whom Gillespie worked in collaboration at Cambridge University between 1927 and 1929. Gillespie, furthermore, had already mentioned MacCurdy’s research at the British Medical Association’s meeting when attacking Mapother’s unitarian view.⁷⁹ Stanley W. Jackson points out that Johannes Lange, Kraepelin’s student and colleague, was a major influence,⁸⁰ whereas Edward Shorter notes the fact that Gillespie had trained in Baltimore under the guidance of Adolf Meyer in his earlier career.⁸¹ However, no matter what the origin was, one thing seems obvious that in Britain the ‘reactive-autonomous’ dichotomy began with Gillespie. His deep involvement made this debate more like a competition between ‘two big authorities’ in London, Guy’s Hospital and the Maudsley.⁸²

In the following year Buzzard chaired another discussion at the annual conference of Royal Society of Medicine. The subject of this meeting was ‘the milder forms’ of manic-depressive psychosis. In its *Proceedings*, Buzzard himself distinguished neurotic from psychotic depression, specified main differences between the two types and deplored the ‘absence of proper guidance for practitioners’ on milder disorders despite their prevalence.

⁷⁷ Ibid., p. 326-329.

⁷⁸ Jackson, *Melancholia and Depression*, pp. 212-213.

⁷⁹ Berrios, *The History of Mental Symptoms*, p. 318; Berrios, ‘Mood Disorders’, p. 399.

⁸⁰ Jackson, *Melancholia and Depression*, pp. 212-213.

⁸¹ Shorter, *A Historical Dictionary of Psychiatry*, pp. 177-178.

⁸² Ibid. p. 84.

He also emphasised the difficulty of diagnosing mild forms of psychosis: ‘the milder the form, the more difficult the diagnosis’.⁸³ After his presentation, H. Crichton Miller from the Tavistock Clinic suggested the use of another discrete term ‘cyclothymia’ as a synonym for ‘milder manifestations’ in order to distinguish them from severe cases. In this session, the participants appeared to agree implicitly with the necessity of making a clear distinction between mild mood disorders and manic-depressive disorders, and to assume that affective disorders could be categorised into sub-groups according to severity. However, Miller’s proposal failed to gain enough support from them.⁸⁴

In the 1930s Lewis of the Maudsley took part in the debate and, subsequently, reignited the issue.⁸⁵ Throughout the decade he published a series of articles on melancholia and depression, including ‘Melancholia: A Clinical Survey of Depressive States’ in 1934 and ‘Melancholia: Prognosis Study and Case-Material’ in 1936. Among them, ‘States of Depression: Their Clinical and Aetiological Differentiation’ published in 1938 dealt with the subject of classification head on. Here he concluded ‘we have no sure means distinguishing’ the numerous cases so that we ‘must deny ourselves the ease of a simple classification’.⁸⁶ In addition, he warned against the ‘deceptive ease and deceptive simplicity’ that psychiatrists might gain by adopting any arbitrary classification.⁸⁷ By this assertion, Lewis showed himself as following his senior colleague, Mapother, and the unitarian perspective on manic-

⁸³ E. F. Buzzard, ‘Discussion on the Diagnosis and Treatment of the Milder Forms of the Manic-Depressive Psychosis’, *Proceedings of the Royal Society of Medicine*, 23:6 (1930), pp. 881-883.

⁸⁴ The unfamiliar term was never repeated during the session and even after the meeting it was rarely found in expert literature. The term ‘cyclothymia’ was not an invention of Miller himself. In 1882, Karl Kahlbaum coined the word to mean ‘a circular mood disorder’. Shorter, *A Historical Dictionary of Psychiatry*, pp.81-82, 152.

⁸⁵ Berrios, *The History of Mental Symptoms*, p. 320.

⁸⁶ Lewis, ‘States of Depression’, pp. 875-878.

⁸⁷ *Ibid.*

depressive disorder. The debate did not end with either Lewis or the outbreak of another World War. When R. E. Kendell published a review article on this subject in 1976, he commenced by stating that ‘during the last fifty years, and particularly the last twenty, innumerable different classifications of depressive illness have been proposed’.⁸⁸

The British debate on the classification of depression during the interwar years is a reflection of the larger situation which British psychiatry faced. It also shows from whence early-twentieth-century psychiatry came and where it went. The debate, therefore, has to be understood as the result of various factors, coming from both within and outside of British psychiatry, working together. The direct cause was ‘the uncertainties concerning the nosological position of what was called ‘neurotic, reactive, exogenous, psychogenic, or constitutional affective disorders’.⁸⁹ The view that such disorders should be re-identified, re-named and re-classified resulted from various changes that early-twentieth-century psychiatry underwent and achieved. In explaining the origin of the great British debate, Berrios emphasises four factors that worked together: clinical observation; challenge to Kraepelinian dichotomy; the growth of the psychodynamic hypothesis; and the influence of Meyerian psychiatry.⁹⁰

Among these determinants, the shift in clinical observation during the early twentieth century, especially during and after the First World War, has been frequently mentioned as a primary cause of the classification debate. During the nineteenth century, the classification of

⁸⁸ R. E. Kendell, ‘The Classification of Depression: A Review of Contemporary Confusion’, *British Journal of Psychiatry*, 129:1 (1976), pp. 15-28.

⁸⁹ Berrios, ‘Mood Disorders’, pp. 397-399.

⁹⁰ Michael Gelder, ‘Introduction: Adolf Meyer and his Influence on British Psychiatry’, *History of Psychiatry*, 14:4 (2003), pp. 475-492; Berrios, *The History of Mental Symptoms*, pp. 316-317.

melancholia (and mania) had not been difficult, as most of the cases had been collected ‘from the severe end of the affective disorders’, in other words certified patients.⁹¹ In the early twentieth century, especially in the interwar years, the main interest of psychiatry moved from major, severe and relatively rare mental diseases to minor, mild and comparatively common cases.⁹² The venue for the care of mental illness diversified, with the coming of psychiatric units in general hospitals, out-patient clinics, private practices and after-care facilities, all of which promoted the chance to access to varied medical service outside the asylum.⁹³ Now, psychiatrists faced an increasing number of cases which could have been identified as ‘hypochondriasis, hysteria, neurasthenia or psychasthenia’,⁹⁴ and diagnosed most of them as depression or non-psychotic manic-depressive state.⁹⁵ Under the circumstances, psychiatrists came to find Kraepelinian nosology, which had been intrinsically based on data collected in Victorian-style asylums, unsatisfactory, and demanded an alternative framework that could be used to cover the majority of cases which could not be

⁹¹ Ibid.

⁹² Roy Porter, ‘Two cheers for Psychiatry! The Social History of Mental Disorder in Twentieth Century Britain’, in Hugh Freeman and German E. Berrios (eds.), *150 Years of British Psychiatry, Vol. II: The Aftermath* (London: Athlone, 1996), pp. 395-396.

⁹³ Joan Busfield, ‘Mental Illness’, in Roger Cooter and John Pickstone (eds.), *Medicine in the Twentieth Century* (London: Routledge, 2014), p. 638.

⁹⁴ Berrios pays special attention to the diagnostic concept of neurasthenia and argues that ‘the dismembering’ of the notion exerted a huge impact on the British debate on classification. Neurasthenia itself has a complex history, which cannot be summarised in a few lines. To understand its position in British psychiatry, see Simon Wessely, ‘Neurasthenia and Fatigue Syndromes’, in German E. Berrios and Roy Porter (eds.), *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London: Athlone, 1995), pp. 509-532; Mathew Thomson, ‘Neurasthenia in Britain: An Overview’, in Gijswijt-Hofstra and Porter (eds.), *Cultures of Neurasthenia*, pp. 77-95; Michael Neve, ‘Public Views of Neurasthenia: Britain, 1880-1930, in Gijswijt-Hofstra and Porter (eds.), *Cultures of Neurasthenia*, pp.141-160; Ruth E. Taylor, ‘Death of Neurasthenia and its Psychological Reincarnation’, *British Journal of Psychiatry*, 179:6 (2001), pp. 550-557.

⁹⁵ Berrios, ‘Mood Disorders’, pp. 397-399.

identified precisely by applying the manic-depressive insanity concept.⁹⁶

International influence also gave major impetus to the debate. Western European counterparts were a traditional and effective stimulant to British psychiatrists. The German concept of endogenous and exogenous depression, which originated with Paul J. Möbius in 1890s, filtered into Britain in the 1920s and helped ignite the debate.⁹⁷ As mentioned earlier, the concept of reactive melancholia, suggested by Lange, was also taken seriously in Britain. British psychiatry also received a new stimulus from across the Atlantic, as American psychiatry emerged as a major power in this field. Meyer, who articulated his grave reservations concerning the Kraepelinian nosology and considered psychiatric disorders as a maladaptive reaction pattern, was particularly influential in Britain, although he was far from being an international figure. His doctrine and practice were not only main factors stimulating the British debate, but also exerted huge influence upon young British psychiatrists as he was involved in their training.⁹⁸

Meanwhile, the debate on the classification of depression became a feature of British psychiatry and distinguished it from other European countries. The debate coincided with a divergence in European psychiatry, which had hitherto been unified. Until the turn of the century, there had been a set of views on melancholia and depression generally accepted and

⁹⁶ Berrios, *The History of Mental Symptoms*, pp. 316-317.

⁹⁷ Jackson, *Melancholia and Depression*, pp. 211-212; Shorter, *A Historical Dictionary of Psychiatry*, pp. 84-85.

⁹⁸ For instance, Meyer trained Aubrey Lewis of the Maudsley as a postdoctoral fellow between 1913 and 1915, and guided as his first chief resident D. K. Henderson, who later became a professor of psychiatry at Edinburgh. Meyer was also involved in training R. D. Gillespie of Guy's Hospital, who wrote one of the most successful textbooks in this field with Henderson. Jackson, *Melancholia and Depression*, pp. 195-202; Shorter, *A Historical Dictionary of Psychiatry*, p. 101; Rhodri Hayward, *The Transformation of the Psyche in British Primary Care, 1880-1970* (London: Bloomsbury, 2014), pp. 69-70.

circulated in expert psychiatric circles across Europe. Most psychiatrists, irrespective of nationality, had considered the disorder as an essentially emotional disease, a result of brain lesions, and morbidity under the huge influence of heredity.⁹⁹ From the 1920s, however, medical professions of major countries began to show their peculiarities, by selectively paying attention to certain aspects. French professionals were more concerned about heredity and environmental influence, while Germans focused on constitution and personality.¹⁰⁰ British doctors, as stated above, concentrated on classification and severity of depression, the core subject of the debate. To summarise, the fierce debate determined the trajectory of British psychiatry during the interwar period and afterwards, at the same time it reflected the more general medical context.

5. Related Concepts

Without examining the various concepts and terminologies that are closely related to depression, it is impossible to comprehend how early-twentieth-century depression was defined and understood. The concept did not stand by itself but was located within a larger taxonomy. Depression, on the one hand, had been in a kind of competition with melancholia, its predecessor, since the nineteenth century, and only won in the interwar period. On the other hand, the concept was cut across many other diagnoses, for instance, neurasthenia,

⁹⁹ Berrios, *The History of Mental Symptoms*, p. 316.

¹⁰⁰ *Ibid.*

hypochondriasis, cyclothymia and anxiety neurosis, making the history of depression complicated and multi-layered.¹⁰¹ Such associated concepts had somewhat different meanings, nuances and usages from depression, as well as from each other.¹⁰² However, the problem was that there was no authority to draw clear lines between them and to regulate their usages, aggravating the confusion surrounding depression. All of these concepts have their own stories, too varied and complex to be examined in detail here. Hence, this chapter focuses on the most problematic diagnostic concept during the period under study, involuntional melancholia.

Involuntional Melancholia

The story of involuntional melancholia is one of the most perplexing. This notion was introduced by Kraepelin in the fifth edition of his *Textbook* published in 1896. The psychiatrist defined it as ‘agitated depressions occurring for the first time in life after the age 45-50’. By adopting the concept, he distinguished depression acquired in the middle and old age, with neither predisposition nor previous history, from other forms of manic-depressive psychosis which manifested at an early age.¹⁰³ However, in the eighth edition of the *Textbook* released in 1913, Kraepelin not only discarded the notion as a separate diagnosis, but also

¹⁰¹ Berrios claims that the ‘dismembering’ of neurasthenia was one of the main triggers which led to the great British debate on the classification of depression. According to his explanation, ‘not all the cases this fragmentation set asunder could be taken over by its successor’, and such cases were to constitute a large group named as ‘constitutional depression’. Berrios, ‘Mood Disorders’, p. 398; Berrios, *The History of Mental Symptoms*, pp. 316-317.

¹⁰² Lawlor, *From Melancholia to Prozac*, p. 134.

¹⁰³ Berrios, *The History of Mental Symptoms*, p. 311; Berrios, ‘Mood Disorders’, pp. 392-393.

abolished the entire group of senile psychoses. He incorporated involuntional melancholic cases back into his umbrella concept, manic-depressive psychosis. According to the conventional explanation, it was George Louis Dreyfus's influence that made Kraepelin adjust his nosology.¹⁰⁴ In *Melancholy*, published in 1907, Dreyfus investigated over eighty cases diagnosed with melancholia to prove that 'there was no such entity as involuntional melancholia'.¹⁰⁵ However, it seems that Kraepelin's own research also contributed to his change of opinion, alongside what he learnt from Dreyfus's work. In order to justify his change of mind, he employed his clinical experience to draw new conclusions, which led him to believe that 'the arguments in favour of the separation of melancholia were not sound'.¹⁰⁶ Notwithstanding these findings, this did not mean the death sentence to involuntional melancholia. Rather, the concept survived, irrespective of the intention of its inventor, and contributed to the confusion and fierce debates about its entity as a discrete psychiatric disease. To quote Shorter, 'the concept of involuntional melancholia (...) went on to a hearty life outside of Kraepelin's *Textbook*' thereafter.¹⁰⁷

We can monitor the disorientation that British psychiatry experienced after Kraepelin abolished the concept. Many psychiatrists still found the concept useful and refused to convert to Kraepelin's new nosology. A good example can be found in Henderson and Gillespie's *A Text-Book of Psychiatry*. In this work the authors articulated their own perspective on this issue very clearly, declaring that 'we (...) are not willing to accept the

¹⁰⁴ Laura Hirshbein, 'Gender, Age, and Diagnosis: The Rise and Fall of Involuntional Melancholia in American Psychiatry, 1900–1980', *Bulletin of the History of Medicine*, 83:4 (2009), p. 714-715; Shorter, *A Historical Dictionary of Psychiatry*, p. 82.

¹⁰⁵ Henderson and Gillespie, *A Text-Book of Psychiatry*, pp. 158-159.

¹⁰⁶ Berrios, *The History of Mental Symptoms*, p. 312.

¹⁰⁷ Shorter, *A Historical Dictionary of Psychiatry*, p. 82.

Dreyfus-Kraepelin findings'. They confirmed that 'there is a group of cases which we can term involuntional melancholia distinct from manic-depressive states'.¹⁰⁸ Furthermore, the frequency of the term used in the professional circles proves that experts' interest in the notion did not fade away, despite Kraepelin's intention. Consulting the *Journal of Mental Science*, the term 'involuntional melancholia' was applied constantly between 1900 and 1930, although slightly dipping in the 1910s. In the 1930s, however, the concept was used three times more frequently than before, proving that psychiatrists still found the concept useful.¹⁰⁹ In an article published in the *Lancet* in 1940, involuntional melancholia was employed to refer to 'depression at the menopause', in the same way that Kraepelin had suggested in 1896.¹¹⁰

It is difficult to generalise about what happened in everyday medical practice in relation to this concept and terminology. It varied depending on practitioner and institution, like other issues related to depression and melancholia. At the Maudsley Hospital, it seems that the medical staff were reluctant to apply the terminology, as originally suggested, in their practice. Few cases were identified as 'involuntional melancholia', but some were diagnosed as 'involuntional depression' or 'involuntional depressive state'.¹¹¹ It implies that the Maudsley staff wanted to avoid applying the word 'melancholia', but they were aware of the utility of the concept of involuntional melancholia. At Holloway Sanatorium the diagnosis was occasionally applied in case notes, but not in the Medical Registers. This is because the *Schedule of Forms of Insanity*, based on which Medical Registers and Annual Reports had to

¹⁰⁸ Henderson and Gillespie, *A Text-Book of Psychiatry*, pp. 158-159.

¹⁰⁹ To count the total number of articles using the term 'involuntional melancholia' in the *Journal of Mental Science*, it was 50 in the 1900s, 29 in the 1910s, 48 in the 1920s, and 158 in the 1930s.

¹¹⁰ *Lancet*, 21 Dec. 1940, pp. 787-788.

¹¹¹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 9997; Patient Casenotes, BRHAM CFM-151, pp. 16-17.

be kept, did not include involuntional melancholia as a formal diagnosis.¹¹² Therefore, we can assume that even in these cases the terminology ‘involuntional melancholia’ was not in use, what the word implied was not denied. In daily practice, the notion was taken seriously, as an effective way to understand female patients at a specific life stage, usually aged between the mid-forties and fifties, which will be illustrated in Chapter 5.

This problem, however, was to claim the attention of British psychiatrists for decades after the debate, at least up to the 1980s. For instance, in an epidemiological study of mental illness, published in 1968, the authors adamantly argued that there was ‘nothing to suggest the existence of involuntional melancholia’, based on their analysis of about 2,000 psychiatric cases in Salford.¹¹³ The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* shows how long psychiatrists agonised over this issue. In 1968, involuntional melancholia came to be included in *DSM-II*, and was acknowledged as a formal diagnosis. However, in *DSM-V* published in 2013, it was left out from the list, losing its established status. Shorter claims that involuntional melancholia, as a psychiatric concept, was ‘put to rest’ in the 1970s, when ‘depression in the elderly responded in the same way to medication as in other age groups’. He therefore believes that the uniformity between involuntional melancholia and depression occurring at any life stage was scientifically proved.¹¹⁴ However, Shorter’s explanation is not convincing enough. If he is right, why did the *DSM* drop the concept only in 2013? The American Psychiatric Association should have reflected the finding in 1980,

¹¹² In the *Schedule of Forms of Insanity*, melancholia was divided into sub-types: recent, chronic and recurrent. To find out more about the *Schedule of Forms of Insanity*, which was used in most county asylums and many registered mental hospitals especially for official reports, refer to the Appendix.

¹¹³ A. M. Adelstein et al., ‘The Epidemiology of Mental Illness in an English City’, *Social Psychiatry*, 3:2 (1968), pp. 47-59.

¹¹⁴ Shorter, *A Historical Dictionary of Psychiatry*, p. 82.

1987, 1994 and 2000 when they revised the existing versions of the *DSM*. More than anything, if the conclusion had been reached, why are there so many articles looking for the answer still being published?¹¹⁵ It appears that involuntional melancholia has not yet been finally put to rest.

6. Conclusion

This chapter has centred on a diagnosis, depression. In a nutshell, depression in the interwar decades could not yet be called as ‘modern’. During the nineteenth century, depression had been reconceptualised, and came to be equipped with a clear definition as a medical concept around the turn of the century. In the interwar years, the diagnosis achieved some progress, notably in terms of terminology, approaching its modern form, but its status was still insecure. Melancholia, its predecessor, did not disappear easily, even after it was officially abolished in taxonomy scheme and was defeated by depression in terms of word frequency. What was worse, neighbouring notions, such as neurasthenia and cyclothymia, encroached on its domain, aggravating the conceptual confusions and causing practical problems. The classification of depression was a conundrum, in which many of the leading psychiatrists (and major mental institutions) were involved. This complex and confusing situation could not help but recur in everyday practice, which we will be able to detect in the following

¹¹⁵ S. Simões et al, ‘Is There Still a Place for Involuntional Melancholia Nowadays?’, *European Psychiatry*, 25 (2010), p. 617.

chapters.

In the previous chapter, it was claimed that in order to understand early-twentieth-century psychiatry, Victorian medical traditions need to be taken seriously and continuities noted. The same can be applied to the history of depression. Early-twentieth-century depression was an extension of the achievements of nineteenth-century psychiatry. Thus, in the history of depression, the interwar years can be interpreted as a part of a long process of its transformation and modernisation, which began with Esquirol, one of the first to lodge a complaint about melancholia in the early nineteenth century and was to be completed only in the late twentieth century with the establishment of *Diagnostic and Statistical Manual of Mental Disorders*.¹¹⁶

¹¹⁶ Lawlor, *From Melancholia to Prozac*, pp. 151-152.

Chapter 3. Depression in Adolescence

1. Introduction

This chapter focuses on women in their adolescence as the first step in reconstructing what female patients suffering from depression experienced in the course of their illness. How did they relate it to their everyday life, and how did they interpret these experiences and understand their mental disorder? The notion of adolescence and girlhood is of course elusive. Today adolescence is defined, according to the *Oxford English Dictionary*, as ‘the period following the onset of puberty during which a young person develops from a child into an adult’. Girl is defined as ‘a female child’ and ‘a young or relatively young woman’, and girlhood as ‘the state or time of being a girl’. However, the meaning varied in different periods, between societies, and according to social and economic backgrounds. Elizabeth Roberts, in her work on working-class women in the early twentieth century, defines ‘youth’ as ‘the period between a girl’s leaving school and getting married’, bridging childhood and independent adulthood. The period corresponded to ‘the ages of about fourteen and twenty-five’ for most girls at that time.¹ In *Young Women, Work, and Family in England 1918–1950* Selina Todd adopts the age of 25 as the point of demarcation between young women and

¹ Elizabeth Roberts, *A Woman’s Place: An Oral History of Working-Class Women 1890–1940* (Oxford: Blackwell, 1984), p. 39.

adult women, defining the former as ‘aged between 15 and 24 years’.² Hilary Marland has rightly pointed out that in the late Victorian and Edwardian eras ‘the idea of girlhood and its potential varied greatly according to social class’. For the working class, girlhood was ‘identified with elementary schooling and work outside of the home’, whereas for many middle-class girls ‘the experience of schooling outside the home’ was the main feature of girlhood.³ These historians, on the whole, share a way to define girlhood in the early twentieth century, which will be applied in this research. Considering that compulsory education ended at the age of 14 after 1918, and the mean age of marriage in the 1920s and 1930s was between 25 and 26,⁴ Todd’s demarcation seems reasonable.⁵

Early-twentieth-century medical experts, too, were engaged in defining the concept of adolescence. In one article in the *Lancet*, a physician characterised adolescence as a period between childhood and adulthood, ‘the years between 14 and 21’. ‘This limit is necessarily arbitrary and can be extended both ways,’ the author added, because ‘adolescence does not suddenly begin or end’.⁶ In another article, ‘the period of adolescence’ was marked more narrowly, covering years between 16 and 21.⁷ Frederick Mott, who took the leading role in

² Selina Todd, *Young Women, Work, and Family in England 1918–1950* (Oxford: Oxford University Press, 2005), pp. 1-2, 19-20.

³ Hilary Marland, *Health and Girlhood in Britain, 1874-1920* (Basingstoke: Palgrave Macmillan, 2013), pp. 4-5.

⁴ Jane Lewis, ‘Marriage’, in Ina Zweiniger-Bargielowska (ed.), *Women in Twentieth-Century Britain* (London: Routledge, 2013), p. 70.

⁵ In this research, adolescence, youth and girlhood will be used interchangeably, all referring to young women between their mid-teens and mid-twenties. Cases of those who were aged under 25 but married will be dealt with in the next chapter, which covers adulthood and its sub-themes such as marriage, motherhood and housekeeping.

⁶ Sybille Yates, ‘Some Problems of Adolescence’, *Lancet*, 221:5722 (1933), pp. 939-942.

⁷ W. C. Sullivan, ‘A Lecture on Crime and Mental Deficiency’, *Lancet*, 198:5120 (1921), pp. 787-791.

establishing the Maudsley Hospital, repeated Thomas Clouston's view on adolescence, while discussing the psychological features of this life stage.⁸ Clouston, who had been the superintendent of the Royal Edinburgh Asylum since 1873 and the first lecturer on Mental Disease in the University of Edinburgh since 1879,⁹ used the term 'adolescence' to 'denote the whole period of twelve years from the first evolution up to the full perfection of the reproductive energy', between 14 and 25, which was adopted by Mott.¹⁰

According to the medical knowledge of the early twentieth century, adolescence was a period when individuals, irrespective of sex, became more vulnerable to mental illness. Mott provided a representative example of how contemporary psychiatrists perceived mental health of the young. Delivering a lecture on 'The Psychopathology of Puberty and Adolescence' in 1921, he illustrated that there were 'two critical periods of life when insanity is especially likely to occur, viz., the adolescent and the involuntional', when sexual functions matured and waned.¹¹ Mott confirmed the general belief that 'adolescent insanity is much more likely to occur in stocks where there is a recognisable or known neuropathic or psychopathic hereditary predisposition',¹² and that mental illness, notably dementia praecox, affected females more than males mainly due to physical condition and social restrictions.¹³

⁸ Frederick Mott, 'The Psychopathology of Puberty and Adolescence', *The British Journal of Psychiatry*, 67:278 (1921), pp. 279-318; Mott, 'The Psychology of Adolescence', *The British Journal of Psychiatry*, 70:289 (1924), pp.199-208.

⁹ Edward Shorter, *A Historical Dictionary of Psychiatry* (Oxford: Oxford University Press, 2005), pp. 170-171; Thomas Smith Clouston, *Oxford Dictionary of National Biography* <http://doi:10.1093/ref:odnb/38634>.

¹⁰ T. S. Clouston, *Puberty and Adolescence Medico-Psychologically Considered* (Edinburgh: Oliver and Boyd, 1880), pp. 9-10; Clouston, *The Neuroses of Development* (Edinburgh: Oliver and Boyd, 1891).

¹¹ Mott, 'The Psychopathology of Puberty and Adolescence', pp. 279-280, 303-304.

¹² *Ibid.*, p. 298.

¹³ *Ibid.*, p. 303.

Based on a series of clinical examinations of general paralysis and dementia praecox, Mott claimed that there existed a correlation between ‘*certain forms of mental disease*’ and ‘*morbid changes in reproductive organs*’.¹⁴ In this article Mott was not concerned about manic-depressive insanity, which was one of the major diagnoses at that time. Such selectivity reflected the conventional assumption shared by medical experts that depression affected those in later stages of life, as we can infer from the term ‘*involutional melancholia*’. Moreover, young people were traditionally considered to be more susceptible to mania, rather than melancholia.¹⁵ In his *Textbook of Psychiatry*, Emil Kraepelin, too, claimed that ‘*depressive attacks show an almost continuous increase from twentieth to the seventieth year*’, and that ‘*states of depression are specially frequent at the more advanced ages*’, repeating the common medical belief.¹⁶ In the period under study here, psychiatrists did not see any close connection between adolescents and depression, and this preconception influenced medical judgment made in their everyday practice.¹⁷

Sources, Sampling and Analysis

¹⁴ Ibid., pp. 291-297.

¹⁵ In the late nineteenth century, Clouston illustrated that adolescence was ‘*very liable to those psychological cataclasm in weak brains, attacks of mania, that have a special relationship to the function of reproduction*’, reflecting the common and conventional understanding of youth and mania: Clouston, *Puberty and Adolescence Medico-Psychologically Considered*, p. 13.

¹⁶ Emil Kraepelin, R. Mary Barclay (trans.), George M. Robertson (ed.), *Manic-Depressive Insanity and Paranoia* (Edinburgh: Livingstone, 1921), pp. 167-174.

¹⁷ As we can see below, the number of young females diagnosed as suffering from depression was very limited, which could, at least partly, have resulted from the medical preconception shared by contemporary psychiatrists.

This research, as mentioned in the Introduction to this thesis, relies heavily on the case notes of two mental hospitals, the Maudsley Hospital and Holloway Sanatorium, and this chapter exploits case histories of adolescent female patients admitted during the interwar years. Given the volume of the material, the issue of data sampling should be considered first. The case notes at the Maudsley are organised first by the year of discharge, and second by alphabetical order of patients' names. I have viewed the materials compiled in the years 1924-27, 1928, 1931 and 1935, and collected the first hundred files from each year. Among 400 patient records, the ratio of the patients diagnosed with depression never fell under one third throughout the period, albeit with minor variation. However, among the depressed, the number of young patients aged between mid-teens and mid-twenties was very low, less than fifteen. From this small group, cases of those who were married or widowed are excluded, to be categorised as adulthood and dealt with in the next chapter. This results in a sample group consisting of nine cases from the Maudsley. From the Holloway Sanatorium records I have gathered all available case files of patients deemed to suffer from melancholia or depression during the 1920s and 1930s, over 150 in total. From them I have selected cases of those who were female, single and aged under their mid-twenties for this chapter. From all the case histories collected, only four satisfied the criteria, which is mainly because the proportion of young patients was limited in the Sanatorium. Viewing the Annual Reports of the 1920s, the number of female admissions aged between 15 and 24 remained very low throughout the period under study, between zero and two each year.¹⁸ To sum up, nine cases from the

¹⁸ Holloway Sanatorium, Annual Reports for the Years 1921, 1922, 1923, 1927, 1928 and 1930, SHC Ac. 2620/1/8-9.

Maudsley Hospital and four cases from Holloway Sanatorium, thirteen in total, will scrutinised in this chapter.

Before moving to a full discussion, it should be mentioned that, due to the limited sample group size, it is practically impossible to draw a comprehensive picture about the experiences of girl patients of both mental illness and adolescent life. Therefore, this chapter reads scrupulously collected case materials and probes deeply into individual episodes, rather than suggesting general information about cases of young female patients and a detailed quantitative analysis of the sample cases. Such an approach, focusing exclusively on qualitative analysis of limited samples, can prevent the risk of hasty generalisation. It provides the opportunity to view those patients' experience from a different angle, in contrast to the approach in the latter chapters, which is mainly qualitative but also incorporates a modest amount of quantitative analysis, and subsequently enriches the whole story of this research. Therefore, this chapter does not aim to reach any general conclusion concerning what young women experienced in the course of mental illness or in their daily life. But, it intends to present as many vivid and minute excerpts concerning their experience as possible, making the best use of the restricted sources available.

2. Demographic Analysis

As mentioned above, at Holloway Sanatorium the proportion of adolescent patients stayed very low throughout the period under study here. In the Annual Reports of the 1920s, the total

number of female admissions aged between 15 and 24 was almost negligible:¹⁹ the figure was zero out of 46 in 1921, one out of 40 in 1923, two out of 52 in 1927, and one out of 21 in 1930. The mean age on admission, which fluctuated between 45 and 50 throughout the 1920s, also proved that most of Holloway Sanatorium patients were in their middle and old age.²⁰ Thus, it is understandable that we have only a handful of depression cases falling into this age group. As for the age distribution of the four Holloway adolescent patients whose cases are selected for this chapter, they were aged between 22 and 26, and there was no teenager diagnosed with depression.²¹

In terms of economic and social backgrounds, patients of Holloway consisted of a relatively homogeneous group, the great majority from the middle class.²² This predominance of upper-class patients in Holloway can be confirmed by the occupation description in the Annual Reports. Consulting a table showing the occupations of the direct admissions during the year 1927, among 29 female admissions, seventeen patients were described as ‘independent means’, three as teachers and four with no occupation.²³ The adolescent sample cases, too, make a strong contrast with their working-class counterparts regarding occupation. Although case notes of these girls provide insufficient information

¹⁹ Tables showing the ages and civil state on admission and their occupations were available up until 1930. The Annual Reports in the 1930s were much simpler, containing a few tables showing the movement of the Hospital population and presenting analysis of the discharged cases: Holloway Sanatorium, Annual Reports, SHC Ac. 2620/1/9.

²⁰ Holloway Sanatorium, Annual Reports, SHC Ac. 2620/1/8-9.

²¹ Holloway Sanatorium, Case Book: Females, SHC Ac. 3473/3/16, 7267/3/24-29.

²² Anne Shepherd, ‘The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums’, in Jonathan Andrews and Anne Digby (eds.), *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam: Rodopi, 2003), p. 239.

²³ Holloway Sanatorium, Annual Report for the Year 1927, SHC Ac. 2620/1/8.

about their education and profession, it seems reasonable to assume that most of the young women had little working experience. The space for occupation in each case file was filled up with 'nil' or 'independent', or otherwise remained blank. In this sense, Miss DH's personal history was rather exceptional, compared to other girls at Holloway, as she had attended Art School, worked as a teacher at a school, and then looked after a boy as a governess. However, her career was interrupted repeatedly by non-financial causes, such as taking care of her family. Miss DH came to work as a dispenser one year before her admission, found the job enjoyable, but left the job under the pressure of work and nervousness.²⁴ Selina Todd's proposition that in interwar Britain 'paid work was a distinguishing characteristic of youth for many women' and 'work dominated their daily lives and shaped their social and domestic responsibilities and relationships' is applicable to working-class girls, whose cases will be illustrated below, rather than to middle-class women.²⁵

In the Maudsley Hospital, too, adolescent patients were a minority group. Although the Maudsley Annual Reports presented the number of child patients aged under sixteen, separately, it did not reveal any information about age distribution of its patient population.²⁶ According to the statistical analysis of the Maudsley patient population by Edgar Jones and Shahina Rahman, the ratio of young patients was higher than the figure of Holloway Sanatorium: among its inpatients 5.6 percent were aged between sixteen and twenty years, and 28.5 percent between 21 and 30.²⁷ The average age of patients, too, was remarkably

²⁴ Holloway Sanatorium, Case Book: Females, SHC Ac. 7267/3/29, V. 2344.

²⁵ Todd, *Young Women, Work, and Family*, pp. 1-2.

²⁶ Maudsley Hospital, Medical Superintendent's Annual Report, Year ended 31st January, 1924, BRHAM.

²⁷ Edgar Jones and Shahina Rahman 'Framing Mental Illness, 1923–1939: the Maudsley Hospital and its Patients', *Social History of Medicine*, 21:1 (2008), pp. 116-117.

lower than that of Holloway. Counting the female inpatients only, the mean age of admission was 37.3, about ten years younger than Holloway inmates.²⁸ This result is attributable to ‘the Maudsley’s strategic aim of treating the young in whom mental illness was incipient’. Even though Jones and Rahman assume a critical attitude towards the result, noting that ‘those aged between 31 and 60 constituted the bulk of the Maudsley’s population’, this Hospital received more young patients than other contemporary mental institutions did.

The number of adolescent patients amongst those diagnosed with depression was considerably low, compared to their proportion out of the whole patients. Of the first hundred female patients discharged in 1928, 38 were considered to have suffered from depression: only one patient in her teens, six in their twenties, twelve in their thirties, nine in their forties, seven in their fifties, two in their sixties, and one in her seventies.²⁹ The result is relevant to the medical preconception that depression affected middle-aged women the most. Among the nine Maudsley sample cases selected for this chapter, only one patient was in her teens, aged 18, and the rest were aged between 22 and 26.

In terms of socio-economic background, Maudsley patients covered a broad spectrum, compared to those at Holloway Sanatorium. Jones and Rahman have categorised male patients discharged between 1924 and 1938 according to their occupations: about 30 percent of male inpatients were from the professional class, 18 percent from the intermediate class, and 43 percent were from the working class, including skilled, semi-skilled and unskilled workers.³⁰ The composition of outpatients was considerably different though: 33 percent

²⁸ Ibid.

²⁹ Maudsley Hospital, Patient Casenotes, BRHAM, CFM-030, 031.

³⁰ In analysing patients’ occupation and their social class, Jones and Rahman have applied the classification of the 1911 Census. According to it, the intermediate class (Class II) includes shop-

from the upper and middle classes, and 54 percent from the working class. Jones and Rahman pay attention to the demographic gap between inpatients and outpatients, which, they argue, was ‘*probably* a consequence of the belief that those of low intelligence or limited educational achievement had a worse prognosis’. Subsequently they conclude that the Maudsley showed ‘a bias in favour of middle-class patients’, although not focusing exclusively on them.³¹ In order to understand the reason why more males from the upper classes were hospitalised than those from the lower classes, economic factors have to be taken into serious consideration. Empirical research on mental hospital admission has shown that men from well-to-do backgrounds were more willing to choose hospitalisation, mainly because they were free from the need to work for a livelihood, unlike their counterparts from the working class. For instance, in Ticehurst Asylum, one of the most luxurious private mental institutions for mental patients from the affluent class in Victorian Britain, there were more male admissions than females. In county asylums, however, women outnumbered men.³² As for class distribution of female patients, Jones and Rahman are reluctant to suggest any conclusion, confessing that ‘the social class of females could not be assessed as most were recorded as housewives or living with parents’.³³ The practical difficulty they faced can be overcome only by closer reading of case notes, especially the latter part which

keepers, salesmen and publicans; the skilled worker class (Class III) covers carpenters, electricians, printers, tailors and driver); the semi-skilled worker class (Class IV) includes postmen, grooms, policemen and caretakers; and the unskilled worker class (Class V) encompasses labourers, porters and watchmen.

³¹ Jones and Rahman, ‘Framing Mental Illness, 1923–1939: the Maudsley Hospital and its Patients’, pp. 116-119.

³² Charlotte MacKenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum 1792-1917* (London: Routledge, 2005), pp. 129-130.

³³ Jones and Rahman, ‘Framing Mental Illness, 1923–1939: the Maudsley Hospital and its Patients’, pp. 116-119.

were freely recorded with no fixed format.

All the Maudsley girl patients whose cases have been selected for analysis in this chapter, nine in total, had been engaged in paid work, contrasting with the Holloway Sanatorium patients. Occupations mentioned in their case notes included nurse, (shorthand) typist, assistant, box maker, nursemaid, domestic worker, and laundry maid. The positions they had held show that around a half of them were from lower-middle-class and the other half from working-class backgrounds, although we cannot construe any representativeness from these cases due to the limit of sample size. Their career path, however, was often interrupted by non-economic factors, as seen from the case of Miss DH of Holloway. Some stayed at home in order to take care of relatives or keep house in place of their mothers, which mirrored the social and cultural pressure on women to prioritise the role of unpaid care-giver rather than paid work outside the home.³⁴ Most of those young women seemed to take their job seriously and some expressed a sense of purpose related to their occupation: for instance, Miss MBS, a nurse aged 26, expressed her ‘ambition’ to succeed in her career that she had kept before falling ill, and did not hide the despair she felt when her ‘ambition (was) dead’.³⁵

Among the sample cases, one patient stands out due to her ethnic background. Miss AA who was admitted to the Maudsley in 1927 was Jewish, born in Holland, with parents both from East Europe. Her origin seemed to attract special interests of the Maudsley medical staff: her doctor found the whole family ‘typically excitable’ and attributed the feature to their

³⁴ Katherine Holden, ‘Family, Caring and Unpaid Work’, in Zweiniger-Bargielowska (ed.), *Women in Twentieth-Century Britain*, pp. 134-138.

³⁵ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 9193 / 3840.

‘race’.³⁶ This ascription can be read as a reflection of the prejudice prevailing in this profession that the Jews showed a higher manic-depressive psychosis rate than any other ethnic group.³⁷ Interestingly enough, in the case note of a French patient admitted to the Maudsley in the same year, Mrs ACB, aged 30, there was no special comment regarding her nationality and ethnicity except a few descriptive terms including ‘French’ and ‘Roman Catholic’.³⁸

3. Symptoms of Depression

Patients diagnosed as depressed suffered from various symptoms, on top of low mood, which is the focus of this section. Symptoms are not immutable. They change over time and vary depending on culture, particularly in the case of mental illness. Edward Shorter has stressed that culture shapes the presentation of mental illness, although his focus is on psychosomatic symptoms, by ‘giving people notions of what constitutes legitimate and illegitimate

³⁶ Maudsley Hospital, Patient Casenotes, BRHAM CFM-001, pp. 833-857.

³⁷ D. K. Henderson and R. D. Gillespie, *A Text-Book of Psychiatry for Students and Practitioners* (Oxford: Oxford University Press, 1927), p. 117: The Jews were considered to have a lower mental deficiency rate. According to contemporary research, the race had fewer alcoholic psychoses than any other race, but the percentage of drug addiction among them was higher than average. As for manic-depressive psychosis, Henderson and Gillespie argued that the Jews showed a higher percentage than any other.

³⁸ Maudsley Hospital, Patient Casenotes, BRHAM CFM-031, Case No. 2422 / 1258.

disease'.³⁹ In other words, a patient's physical and psychological experience of mental illness is affected by gender, age, class and ethnicity, and analysis of the experience can uncover the socio-cultural circumstances encircling the patient. In this context, various symptoms which bothered these young women will be analysed here, based on cases notes and, particularly, the patients' own narratives embedded in the records.

Depression was frequently accompanied by various somatic symptoms. Patients' own descriptions of physical problems were more diverse, detailed and concrete than their narratives about their emotional and psychological state. The most prevalent somatic problems experienced by depressive women were sleep disorders and loss of appetite, from which only a few patients were free. A considerable number of patients suffered from pain in various body parts, headache being the most common. They described the ailment in various ways: 'my head feels so bad'; my head feels 'as though it was flat or being pressed down'; and 'it is my head. It is tight as though it was drawn.'⁴⁰ Meanwhile, Miss EMB complained of a severe migraine, so terrible that she could not even describe it,⁴¹ and Miss AC said her eyes hurt badly, the reason of which was not obvious though.⁴² Miss DB of the Maudsley was afflicted with a tremble and palpitation of heart, both worsening in the night. She complained of a 'giddy feeling' during the attacks and experienced an 'electricity feeling' all

³⁹ Edward Shorter, *From the Mind into the Body: The Cultural Origins of Psychosomatic Symptoms* (New York: Free Press, 1994), pp. 204-207; Edward Shorter, *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era* (New York: Free Press, 1993); Allan V. Horwitz, 'The Sociological Study of Mental Illness: A Critique and Synthesis of Four Perspectives', in Carol S. Aneshensel, Jo C. Phelan and Alex Bierman (eds.), *Handbook of the Sociology of Mental Health* (2nd edn, Dordrecht: Springer, 2013), pp. 100-101.

⁴⁰ Maudsley Hospital, Patient Casenotes, BRHAM CFM-067, Case No. 5015.

⁴¹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, pp. 1247-1273.

⁴² Maudsley Hospital, Patient Casenotes, BRHAM CFM-031, Case No. 3580.

over her body.⁴³

The most common and distinctive feature of depression was of course low mood. Patients felt depressed, worried, restless, agitated, hopeless, apathetic, mournful, and miserable, to quote a few terms which were universally used to describe the mental state of patients in the case notes. Many of them even wept or cried. Despite the prevalence of what appears to be ‘pathological’ emotional states, however, patients’ own narratives of it are neither plentiful nor revealing. Furthermore, while describing their emotional state, patients usually applied (overly) simple and monolithic expressions, such as ‘I feel miserable’ and ‘I am so unhappy’. In most cases, their expression lacked concreteness, as seen from Miss EMB’s saying: ‘I have agony everywhere, so there is no particular agony’.⁴⁴ In some cases, moreover, patients suffered from mood swing. A medical officer of the Maudsley observed Miss EMB ‘switching from tears to laughter very quickly’, which, according to the patient herself, was totally ‘out of control’.⁴⁵ On the contrary, in a few cases, patients lost any kind of emotion and turned to insensitivity.⁴⁶ A 24-year-old patient of Holloway confided that she had ‘no natural feeling of remorse or sorrow’ for her mother’s serious illness.⁴⁷ Another patient of the Maudsley showed no emotional response to what was happening around her, turning ‘apathetic’ according to the medical staff in charge of her case.⁴⁸

Most sufferers possessed a negative self-image, and showed negative and overly

⁴³ Maudsley Hospital, Patient Casenotes, BRHAM CFM-068, Case No. 5329 / 2355.

⁴⁴ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, pp. 1247-1273.

⁴⁵ Ibid.

⁴⁶ Henderson and Gillespie, *A Text-Book of Psychiatry*, p. 136

⁴⁷ Holloway Sanatorium, Case Book: Females, SHC Ac. 7267/3/29, V. 2344.

⁴⁸ Maudsley Hospital, Patient Casenotes, BRHAM CFM-001, pp. 833-857.

critical attitudes towards themselves, such as saying ‘I am a failure’ or ‘I am wicked’.⁴⁹ The case note of Miss KB is filled up with detailed contents of the harsh, and mostly groundless, self-criticism. She identified herself as ‘wicked’ on the ground that she had wanted to ‘throw herself out of the window’; that she was ‘taking a place in hospital (...) when there are more worthy people waiting for beds’; and that she ‘caused all this trouble’. Miss KB believed that she was ‘of no use to anybody’, had ‘never fitted in anywhere’ and did ‘not deserve any kindness of others’.⁵⁰ The patient, who had worked as a nurse before being hospitalised, was scathing about her ability to carry on her career. Furthermore, the depressed were very pessimistic about their life and future, which was revealed in various comments made by patients themselves: ‘life is an agony’,⁵¹ I am ‘fed up with life and everything’;⁵² ‘my whole life is rotten’;⁵³ ‘life is so hopeless’; and ‘nothing to live for’.⁵⁴ As for the possibility of recovery from the mental illness almost all the patients were doubtful, commonly believing that they would never get well.

In serious cases, patients manifested the most dangerous feature of depression, suicidal impulse. The risk of suicide in depression cases was constantly stressed by contemporary psychiatrists, as being ‘of the greatest practical significance’.⁵⁵ They saw a very close connection between self-destructive behaviour and a depressive state, claiming that ‘most cases of suicide occur in people who are depressed’ or that 70 percent of suicidal cases fell

⁴⁹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 9193 / 3840

⁵⁰ Maudsley Hospital, Patient Casenotes, BRHAM CFM-151, pp. 121-159.

⁵¹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 9193 / 3840

⁵² Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, pp. 1247-1273.

⁵³ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 9193 / 3840

⁵⁴ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 8764.

⁵⁵ Kraepelin, *Manic-Depressive Insanity and Paranoia*, pp. 87-88; Aubrey Lewis, ‘Melancholia: A Clinical Survey of Depressive States’, *Journal of Mental Science*, 80:329 (1934), p. 340.

into the manic-depressive insanity group.⁵⁶ Among the samples, four Maudsley patients showed suicidal inclinations and two out of four actually put the idea into action: one during her previous attack and the other right before her admission to the Hospital. At Holloway Sanatorium, two patients, a half of the sample group, were classified as suicidal. Not all suicidal patients, however, took action. Miss IB of the Maudsley confessed that she would like to be dead and had kept considering her death with pleasure, but simultaneously she acknowledged that she ‘lacked the courage or initiative to kill herself’, a common attitude of those with suicidal propensity.⁵⁷

Although less serious than suicide, self-starvation was also a huge threat to depressed patients. Active food refusal often required medical interventions, such as tube feeding and ‘giving saline per rectum’. Medical experts who especially emphasised the importance of good nourishment for recovery were very willing to apply ‘artificial feeding without too much delay’ and recommended ‘light, nourishing, stimulating and various’ food for fasting patients.⁵⁸ Fasting was experienced almost exclusively by females, and it was a habit more prevalent among middle-class patients than among the poor. These features have drawn considerable scholarly interest from historians. Joan Jacobs Brumberg points out that ‘among affluent young Victorians food and eating were at the centre of a web of association that had a great deal to do with *gender and class identity*’;⁵⁹ and Anne Shepherd proves through an empirical comparative case study of Victorian asylums that eating disorders appeared frequently in mental institution for upper-class patients, but markedly less so in county

⁵⁶ Henderson and Gillespie, *A Textbook of Psychiatry*, p. 133.

⁵⁷ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 8764.

⁵⁸ Henderson and Gillespie, *A Textbook of Psychiatry*, pp. 155-156.

⁵⁹ Joan Jacobs Brumberg, *Fasting Girls: The Emergence of Anorexia Nervosa as a Modern Disease* (Cambridge, MA: Harvard University Press, 1988), p. 8.

asylums accommodating a large number of pauper patients.⁶⁰ Although it is not easy to draw any general conclusion due to the small number of sample cases, a pattern similar to Shepherd's finding emerges. Middle-class girls were more inclined to starve themselves than their counterparts from lower classes and more Holloway patients had trouble with eating than the Maudsley patients. These findings will be revisited in the next chapter.⁶¹

Even though contemporary psychiatrists considered hallucination one of the collateral symptoms experienced by a relatively small number of patients, a considerable number of patients complained of it, notably 'hearing and seeing imaginary sounds and objects'.⁶² In the Maudsley, three out of nine patients underwent illusionary experiences, and in case of the Holloway Sanatorium, two patients endured the symptom. Among its various forms, auditory hallucination was the most common.⁶³ One patient described her confusing experiences: 'I hear people speaking each side of me. I used to know their voices, but, I don't know whether they are coming from one side or the other'.⁶⁴ Another presented more detailed (and embarrassing) content: she heard other people saying that she had 'syphilis' behind her back

⁶⁰ Shepherd, 'The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums', p. 239.

⁶¹ Sometimes fasting developed in parallel with other symptoms, frequently delusional ideas. For instance, a Holloway Sanatorium patient refused her food from a false belief that it was 'contaminated', which was one of the most common explanations given by fasting women. Another young female patient of the Maudsley insisted that she could not eat at all because her throat was closed up and 'she had not got a front passage or back passage'. Maudsley Hospital, Patient Casenotes, BRHAM CFM-001, pp. 833-857.

⁶² Holloway Sanatorium, Case Books: Females, SHC Ac. 7267/3/26, T. 0033 (C. 5568).

⁶³ Hallucination itself is a good example showing the cultural influence upon mental illness symptoms. According to professional observations, auditory hallucination has been predominant in western culture, although it is not evident in other cultures. For example in Asian countries, seeing something unreal is a predominantly common experience among the mentally ill, regardless of the type of psychosis, rather than hearing. Henderson and Gillespie, *A Textbook of Psychiatry*, pp. 132-141; Lewis, 'Melancholia: A Clinical Study of Depressive States', p. 340.

⁶⁴ Maudsley Hospital, Patient Casenotes, BRHAM CFM-067, Case No. 5015.

and calling her 'syphilitic'. She did not however suggest a reason to explain her concern with venereal disease.⁶⁵ Delusion was less frequently experienced than hallucination. Out of nine patients from the Maudsley, only one suffered from delusional ideas. Miss AA, who was a 22-year-old shorthand typist, was seriously obsessed with somatic ideas, on which her doctor left a comment that 'there was well-defined delusional system, concerning the state of her own body'.⁶⁶ Such hypochondriacal delusions, which Lewis blamed on the egocentric-egoistic attitude presented by depressed patients, were remarkably prevalent among the middle- and old-aged depression patients, the details of which will be presented in following chapters.⁶⁷

Self-reproach was so common among female patients diagnosed as suffering from depression, regardless of age, that it constituted one of the main features of the disorder. From the sample cases of adolescent patients, about a half of them can be identified as self-reproachful. Psychiatrists in the early twentieth century also took note of self-reproach or self-accusation as a common attitude shown by the depressive. For instance, in *A Textbook of Psychiatry*, Henderson and Gillespie mentioned that a patient in acute depressive state would 'accuse himself of the most heinous wrongdoing, of having committed the unpardonable sin, and of bringing misfortune on others'.⁶⁸ Lewis was more concerned with self-reproach than his colleagues within the field. In a lengthy article 'Melancholia: A Clinical Survey of Depressive States', he found self-accusation one of 'the most striking melancholic symptoms', and categorised self-reproachful accounts collected by himself according to their

⁶⁵ Maudsley Hospital, Patient Casenotes, BRHAM CFM-003, pp. 760-779.

⁶⁶ Maudsley Hospital, Patient Casenotes, BRHAM CFM-001, pp. 833-857.

⁶⁷ Lewis, 'Melancholia: A Clinical Survey of Depressive States', pp. 312-313.

⁶⁸ Henderson and Gillespie, *A Textbook of Psychiatry*, p. 139.

content, such as moral issues, wrongdoing and sexual behaviour.⁶⁹ However, most of the experts failed to see the feminine feature of the symptom. Although self-reproach was not expressed exclusively by female patients, it was distinctively gendered. Firstly, more women experienced the symptom than men. In the sample case histories used in Lewis's article, about half the females suffered from self-accusation whereas less than one fifth of males did, although the author did not mention this disparity.⁷⁰ An article of David Wright on a Victorian public asylum and its patients shows that 'guilt' was exhibited by females about two times more than males even in the same diagnostic group, melancholia and mania.⁷¹ Secondly, the nature of self-reproach presented by females was different to those of males. They tended to be more concrete and very often relevant to gender role,⁷² also corresponding the finding of Wright that female patients' delusional contents centred mostly on their feminine roles in family and household.⁷³

In this sense, we can categorise the female patients' narratives of the self-condemnation according to subject and content. Women in the first group blamed themselves for vague reasons and sometimes without any proper reason.⁷⁴ In the aforementioned case of Miss KB,

⁶⁹ Lewis, 'Melancholia: A Clinical Survey of Depressive States', *Journal of Mental Science*, Vol. 80 (1934), pp. 312-318.

⁷⁰ Aubrey Lewis, 'Melancholia: Prognostic Study and Case Materials', *British Journal of Psychiatry*, 82:340 (1936), p. 525.

⁷¹ David Wright, 'Delusions of Gender?: Lay Identification and Clinical Diagnosis of Insanity in Victorian England', in Andrews and Digby (eds.), *Sex and Seclusion, Class and Custody*, pp. 166-168.

⁷² Lewis did not notice the predominance of females in the self-reproach cases he had collected, but detected, although not fully, difference between self-critical remarks of men and women. For instance, male patients were concerned more about mistakes in their work; and in self-reproach centring on sexual behaviour masturbation was the chief topic of men and pre- or extra-marital intercourse was the major subject of women. Lewis, 'Melancholia: A Clinical Survey of Depressive States', pp. 312-318.

⁷³ Wright, 'Delusions of Gender?', p. 153.

⁷⁴ More male cases fell into this group. Their words were usually vague, lacking concreteness,

for instance, she accused herself for her wickedness.⁷⁵ Another Maudsley patient, Miss IB, believed that she was ‘the direct cause of her own trouble and of the unhappiness that had come to her family’, with no acceptable explanation of what the trouble was.⁷⁶ In the second group, patients suffered from guilty conscience which originated from a traditional feminine role as care-giver. For example, Miss DH of Holloway Sanatorium blamed herself for the way in which she had treated her widowed mother. She said that she could not feel what she naturally should have for her mother.⁷⁷ The last group of self-reproachful patients expressed a sense of guilt arising from their sexuality and sexual behaviours, as noticed by Lewis in his article. The majority of them regretted masturbation, which according to Lewis was the chief theme of males. Miss IB said that she had ‘always had feelings of guilt’ ever since a friend had introduced her to masturbation and all the details of sexual intercourse at the age of twelve. Some young women confessed premarital sexual relation and strong guilty feeling coming from it. Miss MBR revealed her secret of ‘sexual play with [a] young man’ and ‘mutual masturbation’, and later admitted to have had occasional intercourse with her fiancé. The patient repented all the sexual experiences, believing that she would go to prison due to these wrong-doings.⁷⁸ Miss MBS of the Maudsley provided rather detailed information

compared to what female patients described. For example, Mr LWR of Holloway Sanatorium stated that he was ‘beyond forgiveness for his sins against his fellowmen’ without further explanation. A representative case suggested by Gillespie and Henderson showed a similar pattern: a patient ‘accuses himself of the most heinous wrongdoing, of having committed the unpardonable sins, and of bringing misfortune on others.’ In the article ‘Melancholia: A Clinical Survey of Depressive States’, one of Lewis’s male patients called himself ‘a damn coward’, and another identified himself as wicked. Lewis, ‘Melancholia: Prognostic Study and Case Materials’, p. 525; Lewis, ‘Melancholia: A Clinical Survey of Depressive States’, pp. 312-318; Henderson and Gillespie, *A Textbook of Psychiatry*, p. 139; Holloway Sanatorium, Case Book: Males, SHC Ac. 3473/3/26.

⁷⁵ Maudsley Hospital, Patient Casenotes, BRHAM CFM-151, pp. 121-159.

⁷⁶ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 8764.

⁷⁷ Holloway Sanatorium, Case Book: Females, SHC Ac. 7267/3/29, V. 2344.

⁷⁸ Maudsley Hospital, Patient Casenotes, BRHAM CFM-067, Case No. 5015.

about her sexual life, including a masturbatory habit that she had enjoyed since her early years, cohabitation with a man ‘as man and wife’, and sexual intercourse with him. Her guilt, however, centred on her ‘attachment of masturbation’, rather than premarital sex, which led her to attempt suicide by overdosing.⁷⁹

The ‘science of emotions’ claims that there are three types of emotions: basic emotions, which are universal and innate; culturally specific emotions, which can be developed only when special cultural conditions are in place; and higher cognitive emotions, which are universal but exhibit more cultural variation.⁸⁰ Guilt and shame belong to the last category. Although they are part of human nature, specific ways to experience and express them are shaped by culture and have to be learned. All the higher cognitive emotions are ‘fundamentally social’ and are said to be related to ‘commitment’ problems.⁸¹ Additionally, research into the history of emotions takes note of a series of changes in emotions in the Victorian age and their subsequent impact on human behaviour. During the period, negative emotions, such as guilt, fear and jealousy, ‘became highly gender-linked’ and the gendered qualities came to constitute ‘certain emotional standards’.⁸² Researchers in this discipline, in particular, recognise ‘the central importance of gender distinctions in Victorian emotional prescription’ and their (re)configuration, to ‘intertwine with power relations’ from the 1920s.⁸³ Following this argument, we can assume that female self-reproach and its

⁷⁹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 9193 / 3840.

⁸⁰ Dylan Evans, *Emotion: A Very Short Introduction* (Oxford: Oxford University Press, 2003), pp. 3-21.

⁸¹ *Ibid.*, pp. 36-37.

⁸² Peter N. Stearns, ‘History of Emotions: Issues of Change and Impact’, in Michael Lewis, Jeannette M. Haviland-Jones and Lisa Feldman Barrett (eds.), *Handbook of Emotions* (3rd edn, London: Guilford Press, 2008), pp. 24-25.

⁸³ *Ibid.*, p. 28.

manifestation is a cultural product which originated in the Victorian age due to changes in this period. The sense of guilt exhibited by the depressed women mirrored what early-twentieth-century British culture imposed on them and what society expected them to commit to. This approach suggests a reasonable explanation of why the content of self-accusation varied considerably depending on patients' sex, class and age.

Lastly, it should be briefly mentioned how age affected the experience of self-accusation and depression itself. In the adolescent patient group, guilt about sexual behaviour was most frequently revealed, as illustrated above; however, patients in their adulthood blamed themselves for their failure with their care-giving role, whether they cared for their children or invalid relatives. One of the most typical accounts of self-reproachful women in the older group was that 'I neglected my baby' or home. Another instance of generation specifics related to self-reproach is that religious language was applied rarely by adolescent patients, but commonly by middle- and old-aged patients. When it came to other symptoms, it was still true. In the older patient group, hallucinatory experience was frequently tinged with religious features, the most common manifestation of which was hearing voices of either God or the devil.

Despite the difficulties of drawing any general conclusions from the samples under analysis, it is still possible to detect some patterns within mental illness experienced by young women aged between their mid-teens and mid-twenties. Affective disorder was the basic component of depression, mostly low mood and less frequently unstable emotional states or insensitivity. It was accompanied by various somatic symptoms, most of which had no obvious organic origin, such as headache and abnormal palpitation. Hallucinatory and delusional experiences were reported occasionally. Fasting was common especially among

young female patients, who were neither rebellious nor radical, as many feminist critiques, notably Susie Orbach's *Hunger Strike*, claim.⁸⁴ Self-reproach is identifiable as a representative feminine symptom in terms of both frequency and concrete content. In serious cases suicidal impulse, the most dangerous symptom of depression exhibited, was often expressed but less occasionally attempted.

4. Lay Causal Attributions

As seen in the earlier chapters, psychiatrists in the early twentieth century blamed 'hereditary predisposition' as the most important aetiological factor, responsible for 60 to 80 per cent of manic-depressive patients.⁸⁵ They believed that being a woman itself increased susceptibility to mental illness, and claimed that in the adolescent period the general risk of mental breakdown heightened and 'inherited predisposition' raised the danger considerably.⁸⁶ On discussing the cause of mental disease, external aetiological factors, notably mental stress, were increasingly taken into professional consideration throughout the early twentieth

⁸⁴ Rudolph Bell, *Holy Anorexia* (Chicago: University of Chicago Press, 1985), p. 86; Nancy Tomes, 'Feminist Histories of Psychiatry', in Mark S. Micale and Roy Porter (eds.), *Discovering the History of Psychiatry* (Oxford: Oxford University Press, 1994), p. 367; Susie Orbach, *Hunger Strike: The Anorectic's Struggle as a Metaphor for Our Age* (2nd edn, London: Karnac, 2005), pp. 33-35.

⁸⁵ Kraepelin, *Manic-Depressive Insanity and Paranoia*, p. 165; Henderson and Gillespie, *A Textbook of Psychiatry*, pp. 117-119.

⁸⁶ Mott, 'The Psychopathology of Puberty and Adolescence', pp. 279-318.

century,⁸⁷ but were usually regarded as precipitating or contributory, rather than principal. Thus, now we need to ask how female patients understood the origin of their mental illness, and how different (or similar) the lay attribution of depression was from (or to) professional interpretation. This section, therefore, focuses on young female patients' own ascription in their medical record. Their testimonies suggest that the majority of them imputed mental breakdown to their everyday life experiences, such as occupation and sexuality, and negative emotional reaction to them, including anxiety and guilt.

In order to analyse patients' understanding of aetiology, Akihito Suzuki's framework in his article 'Lunacy and Labouring Men: Narratives of Male Vulnerability in Mid-Victorian London' will be applied with minor adjustments. In this article he delves into lay causal attribution of mental illness by exploiting case notes of working-class male patients treated at the Middlesex County Asylum.⁸⁸ In this work, Suzuki categorises narratives of patients and their relatives on the causes of insanity and, as shown in the table below, identifies some patterns in the way such aetiological factors were ascribed.

[Table 4] Types of Causal Attributions⁸⁹

Category	Subjects
----------	----------

⁸⁷ Rhodri Hayward, *The Transformation of the Psyche in British Primary Care, 1880-1970* (London: Bloomsbury, 2014), p. 69.

⁸⁸ Akihito Suzuki, 'Lunacy and Labouring Men: Narratives of Male Vulnerability in Mid-Victorian London', in Roberta Bivins and John V. Pickstone (eds.), *Medicine, Madness and Social History* (Basingstoke: Palgrave Macmillan, 2007), pp. 118-128.

⁸⁹ Ibid.

Internal	Mental	Defective characters	
External	Mental	Grief	Unemployment, Bereavement, Economic Loss
		Anxiety	Poverty, Work, Domestic, Others
		Distress	
	Somatic	Illness	
		Drinking	
		Injury	
		Fatigue	

By analysing the lay narratives, Suzuki concludes that overwork and anxiety about poverty were most commonly blamed as main causes of madness.⁹⁰ In this research, to facilitate the analysis of female patients' causal attribution of mental depression, 'guilt' will be added as a sub-category of External-Mental factor, alongside grief, anxiety and distress. As to be illustrated below, guilt and shame were repeatedly identified by female patients as factors affecting their mental condition or triggering the current mental episode. It gives these feelings a unique status in understanding female depression cases: the only subject that can be featured both as a symptom and an alleged cause of the mental illness. Furthermore, as seen from Suzuki's analysis of male Victorian cases, this type of negative condition was rarely

⁹⁰ Ibid.

mentioned by men, showing a gender gap in mental illness experience, which will be revisited in the conclusion of this research.

There is a major practical problem with identifying lay causal attributions in the samples studied in this chapter. The female patients rarely clarified what they believed to have caused their mental disorder in their case notes.⁹¹ Yes, there are a few cases in which patients voiced their own interpretation and attribution. Among nine sample cases from the Maudsley, for instance, two girls spotted a specific factor or event as the cause of their current mental breakdown. However, the majority of patients, rather than articulating what they thought had caused depression, described general circumstances facing them, or any life event around the onset of current illness, which might well be a way for them to reveal their view on aetiology. Therefore, in analysing the perspective of the patients on the cause of their mental disorder, I will focus on the way in which they explained the course of the illness, and particularly when and where it began on illustrating case histories. In most of the sample cases young female patients regarded depression as related to external mental factors. All the mental factors – grief, anxiety, distress and guilt – were fairly evenly referred to, and anxiety was most frequently blamed as a main cause of depression, with only slight variation.

[Table 5] Types of Causal Attribution of Young Female Patients at the Maudsley Hospital⁹²

⁹¹ Suzuki is relatively free from this problem, as the medical superintendent of the Hanwell Asylum, John Conolly, ‘conducted this time-consuming survey in order to find the cause of the disease in the life-history of the patients, as reported by their families’: Suzuki, ‘Lunacy and Labouring Men: Narratives of Male Vulnerability’, p. 119.

⁹² Maudsley Hospital, Patient Casenotes, BRHAM CFM-001; BRHAM CFM-003; BRHAM CFM-

Category			Subjects
External	Mental	Grief	Unemployment, Bereavement
		Anxiety	Poverty, Work, Domestic, Health
		Distress	Marriage, Work, Exam
		Guilt	Sexuality
	Somatic	Illness	
		Fatigue	

As an aetiological factor, anxiety was frequently relevant to work and employment in these cases of young female depression, reminding us of Suzuki's findings.⁹³ For example, Miss AA, a shorthand typist, traced the beginning of her depressive symptoms to when she had lost her job due to the closedown of a firm with which she had been working for several years. Her elder sister, the main informant of this case, also emphasised that the patient had been worried about being unable to get another job. In this case, the medical staff shared the same view as to the cause, recording that 'the only important factor in the aetiology, as yet known, is that the patient was worried by being out of work' in the case summary attached at the end of her case note. Miss AEB, a domestic worker, fell victim to depression, the second attack, three weeks before her admission to the Maudsley when she had moved to a new post. Then, according to the patient herself, she suddenly 'began to brood and worry' and 'felt unable to work'. In this case, Miss AEB and the medical staff were in outright confrontation

031; BRHAM CFM-068; BRHAM CFM-150; BRHAM CFM-151.

⁹³ Suzuki, 'Lunacy and Labouring Men: Narratives of Male Vulnerability', pp, 118-128.

with each other over aetiology. Her first attack, four years previously, had begun with her mother's death and the onset of the present episode was close to her father's death. The doctor suspected that the latter event had exerted a bad effect on her mental health. However, the patient vehemently denied the possibility, articulating that 'the death of her father from cancer did not affect her' because she was not involved in his nursing.⁹⁴ Besides the causes given in these two cases, various kinds of anxiety were attributed as the cause of depression, such as excessive worry about family circumstances and concern about health.⁹⁵

Among the sample cases, some patients ascribed their depression to grief, mostly over death of relatives. The case of Miss EMB of the Maudsley provides such an example. Six months before her admission, her boyfriend had committed suicide and the patient found the incident 'a great shock' which she could not get out of her mind. Although she never claimed directly that his death was responsible for her mental and emotional derangement, she enunciated clearly that her hallucinations began immediately after his suicide and the first severe attack of screaming and crying began on her way back from his funeral.⁹⁶ In another case which was allegedly triggered by bereavement, the patient revealed mixed sentiments.

⁹⁴ Maudsley Hospital, Patient Casenotes, BRHAM CFM-003, pp. 760-779.

⁹⁵ For example, Miss AC was extremely concerned about her health and insisted on talking about her condition: she went through a series of bouts of measles and whooping cough during her childhood; and had suffered from severe rheumatic fever two years previously, coinciding with her first mental breakdown; and she had not had 'normal courses' for many years. All of her anxiety centred on the possibility that 'there might be something wrong physically', representing a typical case of hypochondriacal preoccupations. Furthermore, she had no faith in medical professionals and their decisions, insisting that her doctor who had sent her to the Maudsley, had done her no good and had given her up. Her excessive concern about health, however, could be read both as the origin of her mental illness and as the presentation of it, suggesting a major limitation of patient's view on illness: Lewis, 'Melancholia: A Clinical Survey of Depressive States', pp. 306-310; Maudsley Hospital, Patient Casenotes, BRHAM CFM-031, Case No. 3580.

⁹⁶ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, pp. 1247-1273.

Miss DB repeatedly expressed not only grief and sorrow, but also a 'fear of death', aggravated by attendance at a colleague's funeral. Furthermore, she had an almost obsessive and delusional compulsion of thinking about herself as dead and being brought flowers.⁹⁷

Distress associated with occupation was as common in the narratives of the patients, as anxiety related to work. Miss KB admitted that her stress emanated from her job as a nurse, and linked it to her mental condition. Her clear recognition of the cause of mental depression made this case exceptional. She provided a detailed account of what had happened before the onset of depression, explaining that overwork due to exam preparation combined with her ward duties caused at first nervousness and somatic symptoms, and subsequently insomnia and emotional turbulence. In the third month of her stay in the Maudsley, she suddenly became very upset. The medical staff noted that 'if she had been well she would have been taking her nurse exam at present' and 'every time she is approached she mentions this'. The Maudsley medical staff attributed her case to 'stress and environmental' factors, sharing the patient's view, despite her family history which included an alcoholic father and a melancholic mother.⁹⁸

Meanwhile, these cases which were regarded as caused by work-related distress and anxiety reveal one of the major features of young women's lives in interwar Britain, what Selina Todd identifies as occupational 'aspiration'.⁹⁹ The nurse, Miss KB, was preparing for an examination required for promotion, while Miss AA, a shorthand typist, agonised over unemployment. Both professions were mostly females, and located in the lower grades of the

⁹⁷ Maudsley Hospital, Patient Casenotes, BRHAM CFM-068, Case No. 5329 / 2355.

⁹⁸ Maudsley Hospital, Patient Casenotes, BRHAM CFM-151, pp. 121-159.

⁹⁹ Todd, *Young Women, Work, and Family*, pp. 113 -144.

middle-class job category. Most young girls engaged in these jobs came from lower-middle-class backgrounds, but some were working-class but with better education compared to other girls in their social and economic stratum.¹⁰⁰ According to her case note, Miss KB was from a middle-class family, as her father was an engineer, and the patient herself had a higher education than the current standard, having left school at the age of 17.¹⁰¹ Given her accounts of her occupation and the examination she had prepared for, she seemed to be ambitious about her career and remarkably frustrated by the failure. The case of Miss AA, who was from an impoverished Jewish family that had moved from Eastern Europe, corresponds to Todd's explanation far better. She attended secondary school, owing to a scholarship, and had 'constantly' worked for seven years after leaving school. As Todd points out, the social aspirations of working-class girls were shaped 'by a desire to avoid poverty' and, therefore, 'self-sufficiency gained through secure employment' was central to the young, which helps us to understand the deep anxiety Miss AA felt.¹⁰²

Patients suffering from depression often found the origin of their illness in past wrongdoings or from a sense of guilt aroused by them, and among young patients many related their mental disorder to sexual misbehaviours, as seen above. For example, Miss MBS's narrative converged around a word, 'disgrace', which the patient felt described her situation best. In her accounts, she repeatedly reproached herself for her past sexual behaviour, which included masturbation and sexual intercourse, and attributed her current attack to her preoccupation with masturbation and to 'the drugs' she had taken to commit suicide a month

¹⁰⁰ Teresa Davy, "'A Cissy Job for Men; a Nice Job for Girls'": Women Shorthand Typists in London, 1900-39,' in Leonore Davidoff and Belinda Westover (eds.), *Our Work, Our Lives, Our Words* (Basingstoke: Macmillan Education, 1986), pp. 124-144.

¹⁰¹ The school-leaving age in the early twentieth century was 12 until 1921, and 14 until 1947.

¹⁰² Todd, *Young Women, Work, and Family*, p. 140.

previously. As a trained nurse, Miss MBS was clearly aware that she was ‘mentally ill’ and exceptionally assertive about the cause of her condition.¹⁰³ In another case, Miss IB, too, attributed her mental illness to her longstanding habit of self-abuse, although her mother, a main informant for her case, thought it stemmed from a major change in family relationship, and her physician was reluctant to suggest any specific cause.¹⁰⁴

As illustrated so far, in attributing the cause of their mental illness, young depression patients tended to relate their mental illness to their daily life experiences rather than to heredity or family history. Most of them found the cause in what contemporary psychiatrists would identify as ‘mental stress’ or ‘environmental factors’.¹⁰⁵ However, it does not mean that the patients were ignorant of the professional understanding of inheritance as a major aetiology. During her confinement in the Maudsley, Miss KB, whose mother had suffered from involuntional melancholia for a long time, was ‘frightened’ that her mother’s illness ‘might be coming out in her’, although attributing her depression to overwork and stress.¹⁰⁶ As will be suggested in following chapters, patients with a family history of psychosis or neurosis were more apprehensive about their cases, as well as pessimistic about their prognosis.

Lastly it is noteworthy that there existed a gap between what was said in medical literature and what was actually done in everyday practice in finding the cause of mental illness. Although psychiatrists claimed heredity was responsible for a large proportion of

¹⁰³ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 9193 / 3840. However, the medical staff of the Maudsley Hospital did not seem confident about her aetiology, as they ascribed her case vaguely to ‘physical illness and emotional strains’.

¹⁰⁴ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 8764.

¹⁰⁵ Kraepelin, *Manic-Depressive Insanity and Paranoia*, 179-181

¹⁰⁶ Maudsley Hospital, Patient Casenotes, BRHAM CFM-151, pp. 121-159.

manic-depressive cases, ranging roughly between 60 and 80 percent, the actual number of cases in which psychiatrists pointed out inheritance as a main cause of depression in practice was much lower. According to the Maudsley sample cases, four out of nine patients had a family history of psychosis or neurosis, with wide variations in diagnosis, severity and closeness of the invalid relative. Among them, nonetheless, only one case was attributed to hereditary transmission by professionals. At Holloway Sanatorium, too, the number of cases in which doctors imputed mental breakdown solely to inheritance was way below the figures suggested in textbooks, which will be checked against a larger sample case group in the next chapter.

5. Sexuality of Young Women

Historical research on sexuality has always suffered from the lack of concrete historical evidence due to the nature of the subject, as people are unwilling to speak about it.¹⁰⁷ The old complaint that most surviving historical documents are political and therefore inform us little of the private and intimate, such as sex and love, is not totally wrong. Therefore, recent studies on the subject tend to rely heavily on oral history as one of the best ways ‘to provide a sophisticated and empirically based portrait of sexuality’, as seen from the latest work of

¹⁰⁷ Paul Ferris, *Sex and the British: A Twentieth-Century History* (London: Michael Joseph, 1993), pp. 1-2.

Simon Szreter and Kate Fisher.¹⁰⁸ However, the methodology has a clear restriction in that it can only cover a limited time span, from the mid-twentieth century at best. In this sense medical records, particularly case notes, provide a concrete base for historical research on sexuality, and are relatively free from time limitation and contain first-hand accounts of related experiences. The case files which I have collected for this research prove themselves excellent materials, from which we can draw a vivid picture of sexuality in the interwar years, including all affiliated themes such as sex education, sexual experience, courtship, relationship and contraception. The case notes containing lively narratives of young female patients under scrutiny in this chapter naturally lead us to sexuality and the sexual experience of adolescents. The most commonly mentioned factor in the narratives is self-reproach originating from sexual experience, which was, as illustrated, a major part in understanding both symptom and aetiology of the depression cases.

In *A Woman's Place: An Oral History of Working-Class Women 1890-1940*, Elizabeth Roberts has claimed that 'the great majority of girls entered marriage almost ignorant about sex and sexuality' before the Second World War.¹⁰⁹ Synthesising accounts of young women admitted to the Maudsley, however, the assertion seems to be misleading. Although girls had little chance to have 'formal' sex education in the interwar years, only a few remained ignorant of the subject. Informative books providing practical advice on sex, such as Marie Stopes' *Married Love* (1918) and Isabel Hutton's *The Hygiene of Marriage* (1923), still stayed out of reach of young 'single' women.¹¹⁰ Well into the mid-1930s, 'the lack of

¹⁰⁸ Simon Szreter and Kate Fisher, *Sex before the Sexual Revolution: Intimate Life in England 1918–1963* (Cambridge: Cambridge University Press, 2010), pp. 1-2.

¹⁰⁹ Roberts, *A Woman's Place*, p. 80.

¹¹⁰ Lesley A. Hall, *Sex, Gender and Social Change in Britain since 1880* (Basingstoke: MacMillan, 2000), p. 111; Hall, 'Sexuality', in Zweiniger-Bargielowska (ed.), *Women in Twentieth-Century*

provision of adequate sex knowledge to young people' was deplored by various social agencies, including schoolteachers, medical experts, and social purity movement groups.¹¹¹ While the need for a proper sex education was increasingly voiced in the 1930s, girls were still informed, usually in their mid-teens, mostly by peer group members and only occasionally by senior female family members. Such 'lessons' delivered by friends often exerted a long-standing and bad influence on unprepared learners. Many expressed negative emotions, notably disgust, shame and guilt, brought about by the experience.¹¹² A rather exceptional case was Miss KB, a nurse, who had not known anything until she attended a nursing course.

It is almost impossible to estimate exactly how many girls were sexually experienced among the patients, not to mention among the whole single female population, mainly due to general reticence.¹¹³ For the interwar period and well into the mid-twentieth century, historians believed that premarital sex was enjoyed on rare occasion only by a small number of people, mostly by 'courting couples' who had promised marriage.¹¹⁴ However, the narratives of the Maudsley girls reveal that a not inconsiderable number of single women had

Britain, pp. 55-58.

¹¹¹ A schoolteacher wrote a letter to the National Vigilance Association, complaining that 'I am looking forward to the opportunity of answering questions from some of the older girls who are leaving school', but received a repressive reply recommending her to 'concentrate on modesty and decency': Hall, *Sex, Gender and Social Change in Britain since 1880*, p. 125.

¹¹² Typical is the case of Miss IB. According to her account, she had been given 'complete information' and 'introduced to masturbation' at the age of 12 by a friend of hers. When describing her sexual history, this patient did not hide her repulsion towards the friend, as well as a persisting sense of guilt from which she had not been free thereafter. Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 8764.

¹¹³ Ferris, *Sex and the British: A Twentieth-Century History*, pp. 1-2; Roberts, *A Woman's Place*, pp. 72-80.

¹¹⁴ Lewis, 'Marriage', p. 122; Ross McKibbin, *Classes and Cultures: England 1918-1951* (Oxford: Oxford University Press, 2000), p. 296.

extra-marital sexual relations, albeit hard to confirm exactly to what extent such experience was prevalent among the young. Out of six girls who were treated at the Maudsley in the 1930s, four had experience of courtship or relationships with men, and among them two admitted to have had sexual intercourse: one with a man having promised to marry, the other was not engaged. Furthermore, as Lesley A. Hall finds, young women were increasingly engaged in ‘various non-coital activities’, notably ‘mutual-masturbation’ which was also occasionally acknowledged in case notes.¹¹⁵ Taking all these cases into consideration, the number of young women with sexual experience seems higher than the conservative estimation of historians, which will be discussed in the next chapter about women in their adulthood.

Among varied issues relevant to sexuality in adolescence, it is masturbation that most frequently appears in case files, usually as grounds for self-reproach and self-abhorrence. Self-abuse was reported more often than contemporary observers and later historians have thought, both seeing it as a ‘male’ issue. For instance, Stopes claimed that, unlike their male counterparts, ‘very few’ women expressed concern about masturbation, and believed that the habit was far less universal in the female sex.¹¹⁶ However, the case notes of the Maudsley reveal that about half the girls had enjoyed masturbation, even though the precise proportion is not meaningful, because the sample is so small. Secondly and surprisingly, all the girls reporting the habit found a connection, in some way, between mental illness and this sexual manifestation. Such prevalent panic over masturbation could be attributed to the interaction of social, scientific, and medical factors, which created a general atmosphere stigmatising the

¹¹⁵ Hall, ‘Sexuality’, p. 59; Maudsley Hospital, Patient Casenotes, BRHAM CFM-067, Case No. 5015.

¹¹⁶ Hall, ‘Sexuality’, p. 60.

practice.

The roots of the anti-masturbation attitude are deep. Two texts published in the eighteenth century have been noted as marking its start: *The Heinous Sin of Self-Pollution* (c. 1710) and *A Treatise upon the Disorder Produced by Masturbation* (1766).¹¹⁷ However, it was not until the last quarter of the nineteenth century that direct and aggressive action against the habit was taken. The social purity movement, whose primary aim was to eliminate the double standard of sexual behaviour, launched an attack on masturbation as a way to purify male sexuality. The offensive against masturbation peaked between the turn of the twentieth century and the First World War, but almost disappeared in the interwar years.¹¹⁸ Naturally enough, the target of this camp were males: more specifically, with regard to age, the young; and in terms of social background, the upper and middle class. However, it did not mean that the movement completely exempted young women from the moral regulation, as its pamphlets made it clear that they aimed at ‘this habit (masturbation) in our youth of *both sexes*’.¹¹⁹

The British medical circle, too, endeavoured to stigmatise masturbation throughout the nineteenth century. From the 1820s a close connection was made between self-abuse and insanity, and during the second half of the century, leading psychiatrists, including David Skae, Thomas Clouston, and Henry Maudsley, blamed the habit for a major cause of mental

¹¹⁷ Lesley A. Hall, “‘It Was Affecting the Medical Profession’: The History of Masturbatory Insanity Revisited”, *Paedagogica Historica*, 39:6 (December 2003), pp. 685-699; Alan Hunt, ‘The Great Masturbation Panic and the Discourses of Moral Regulation in Nineteenth- and Early Twentieth-Century Britain’, *Journal of the History of Sexuality*, 8:4 (1998), p. 575.

¹¹⁸ Hunt, ‘The Great Masturbation Panic’, pp. 575-586.

¹¹⁹ *Ibid.*, pp. 597-598.

illness, particularly in relation to adolescent cases.¹²⁰ Furthermore, many of these medical experts supported the social purity movement and their objection to masturbation with their professional knowledge and authority. Around the beginning of twentieth century, however, the general opinion on ‘masturbatory insanity’ among psychiatrists altered. They gradually associated self-abuse with neurasthenia, a ‘lesser affliction’, and came to consider the habit as a psychological defect, rather than a mental illness.¹²¹ In discussing masturbation and mental illness allegedly caused by the habit, medical doctors, too, were more concerned about men than women, but did not forget to stress that in the case of girls the habit could contribute *hysteria*.¹²²

The interwar years saw new professional attitudes towards masturbation emerging. An increasing number of experts stopped stigmatising the practice, tried to interpret it as normal human behaviour, and even acknowledged its benefit, although they could not actively encourage it. For instance, Stopes stated that masturbation could be ‘sometimes’ helpful, especially for ‘women over thirty with no other sexual outlet’.¹²³ In the mid-1930s, Laura Hutton, a clinical psychologist at the Tavistock Clinic, asserted that, despite its potential side effects, masturbation could provide single women with ‘the best possible occasional solution for the problem of the relief of psychosexual tension’ unless it was followed by ‘feelings of guilt or failure’.¹²⁴ Around the same time, Anne Pedler, a medical doctor, who wrote in a

¹²⁰ Hall, ‘The History of Masturbatory Insanity Revisited’, pp. 688-689.

¹²¹ *Ibid.*, pp. 685-690.

¹²² Hunt, ‘The Great Masturbation Panic’, pp. 597-598.

¹²³ As seen here, most practical advice literature on sex, mostly produced in the forms of books and magazines, targeted married women and only sometimes mature single women and subsequently ruled out young and unmarried women. Thus, major works in this genre will be exploited in the next chapter focusing on mature women and their sexuality.

¹²⁴ Katherine Holden, *The Shadow of Marriage: Singleness in England, 1914-60* (Manchester: Manchester University Press, 2007), pp. 90-92.

magazine that ‘so-called bad habits’ were ‘not in themselves harmful or dangerous or abnormal. What is harmful is the sense of shame and humiliation.’¹²⁵ It seemed that Hutton and Pedler were fully aware of the problem that harassed the self-reproachful girl patients, but their advice was not yet followed.

Another social phenomenon exerted a profound influence on the way in which girls interpreted their sexual experience: the enforcement of heterosexuality as a sexual norm. The interwar years witnessed the establishment of a new ‘science’, sexology. This study, as feminist historians have noted, acted as a ‘new regulatory mechanism of male supremacy’ and therefore enforced heterosexuality with vigour. Consequently, love between the opposite sexes, ideally in marriage, ‘became increasingly defined as the only acceptable and normative mode of sexual expression’.¹²⁶ Even Stopes, an ardent advocate of women’s sexual pleasure, saw heterosexuality as the only ‘natural’ and desirable relationship.¹²⁷ The new mood not only re-stigmatised masturbation, but also aggravated existing anxiety about the habit. Now, women’s engagement in masturbation came to be regarded, in a new sense, as ‘abnormal’, ‘deviant’ and even ‘pathological’, which exacerbated girls’ self-accusation about the deed as we have noticed in their case notes.¹²⁸ It explains why Miss MBS was more concerned and self-reproachful about masturbation than her extramarital sexual relation with a man. Possibly, for her (as well as her peers), self-abuse was the worst option, if she had to

¹²⁵ Hall, *Sex, Gender and Social Change in Britain since 1880*, p. 125.

¹²⁶ Judy Giles, “‘Playing Hard to Get’: Working-Class Women, Sexuality and Respectability in Britain, 1918-40”, *Women’s History Review*, Vol. 1, No. 2 (1992), pp. 239-240; Sheila Jeffreys, ‘Women and Sexuality’, in June Purvis (ed.), *Women’s History: Britain, 1850-1945* (London: Routledge, 1995), p. 194.

¹²⁷ Hall, ‘Sexuality’, pp. 55-57.

¹²⁸ Katherine Holden, “‘Nature Takes No Notice of Morality’: Singleness and *Married Love* in Interwar Britain”, *Women’s History Review*, Vol. 11, No. 3 (2002), p. 497; Giles, ‘Playing Hard to Get’, pp. 239-240.

choose.¹²⁹ Sex with a male partner was the lesser of two evils, as it was closer to being ‘normal’.

Those who accused themselves of self-abuse appear to have been under the strong influence of the anti-masturbation atmosphere which had been established over a long period, at least since the mid-nineteenth century, considering it as disgraceful, shameful and even causing mental illness. Their attitude towards the sexual practice, however, did not yet reflect the contemporary professional interpretation, represented by Hutton and Peddler, which noted the harmfulness of guilt invoked by masturbation rather than the habit itself. It is highly probable that for the public it took time to learn and internalise the new knowledge. Such a time gap between the formation of medical knowledge, which, as mentioned in the Introduction, was not completely monopolised by professionals, and its acceptance by the public will be one of the subjects reiterated in this research. By consulting case files, it is very difficult to trace the way in which patients contributed to the production of expertise, but it is noticeable that they consumed professional knowledge and were often familiar with it.

7. Treatment: Cardiazol Shock Therapy

As mentioned in Chapter 1, it was not until the mid-1930s that the results of therapeutic innovation began to be applied gradually in everyday psychiatric practice. Before then,

¹²⁹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 9193 / 3840.

‘treatment had a relatively small place within psychiatry’.¹³⁰ Patients were recommended to have ‘plenty of light and exercise’ or encouraged to have ‘prolonged warm baths’, as light therapy and hydrotherapy were regarded as the latest therapeutic methods.¹³¹ Psychiatry relied heavily upon sedatives, such as bromides (introduced in the 1850s), paraldehyde (introduced in the 1880s) and phenobarbital (introduced in the 1910s),¹³² which is confirmed by the case notes of the two mental institutions examined in the research.¹³³ By the late 1930s sleep therapy, inducing ‘prolonged narcosis’ by injecting Somniphine, and convulsion therapy, usually applying Cardiazol in Britain and Continental Europe, were drawn on increasingly. Amongst the samples collected for this chapter, two Holloway Sanatorium cases illustrate this change vividly, and provide us a valuable opportunity, not to be given in other chapters, to ponder one of the sensitive issues related to mental illness: somatic treatment of the mentally ill.

At Holloway Sanatorium Cardiazol treatment was first introduced in 1937 to treat schizophrenic patients. In the Annual Report for 1937, T. E. Harper, then ‘acting medical superintendent’, concluded that ‘there would be a relief of bad symptoms if not complete

¹³⁰ Joan Busfield, ‘Mental Illness’, in Roger Cooter and John Pickstone (eds.), *Medicine in the Twentieth Century* (London: Routledge, 2000), p. 644.

¹³¹ Diana Gittins, *Madness in its Place: Narratives of Severalls Hospital 1913-1997* (London: Routledge, 2006), pp. 189-197; Jennifer Mary Walke, *Repute and Remedy: Psychiatric Patients and their Treatment at Bethlem Royal Hospital, 1930-1983* (unpublished Ph.D. Thesis: London School of Hygiene & Tropical Medicine, 2015), p. 199.

¹³² Phil Fennell, *Treatment without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People since 1845* (London: Routledge, 2002), pp. 129-132; Gittins, *Madness in its Place*, p. 189.

¹³³ In the Maudsley Hospital case notes, prescriptions and ward diaries were usually attached at the end of the files. These documents show that sedatives were regularly and often intensively used in cases of depression. Maudsley Hospital, Patient Casenotes, BRHAM CFM-151.

cures' although it was too early to make a definite statement about the treatment.¹³⁴ In the next year, Harper, now officially appointed as a medical superintendent, offered more detailed data on the results of the new therapy in an optimistic tone:

among the patients treated with the Cardiazol treatment, 10.76 percent recovered from what appeared to be a hopeless condition; 41.17 percent improved and showed a marked change in habits; 29.41 percent improved for a short time but relapsed into their former condition; 17.64 percent became worse after treatment, but they were long standing cases from whom good results were not expected.¹³⁵

In the Annual Report, he also stated that 'we are carrying out Insulin treatment, which is the induction of shock in a different way'.¹³⁶ However, the result did not seem to be satisfactory, as he mentioned nothing about the outcome of the treatment.

Contrary to the original intention that Cardiazol treatment was to be applied to the schizophrenic, some depressive patients also received the newly adopted therapy, as proved by two young female patients whose case notes are under scrutiny in this chapter. Miss WS, aged 26, was transferred from Bethlem Royal Hospital to Holloway Sanatorium in 1937. Even though she was categorised as a temporary patient on her admission to Holloway, she was certified in the following week, probably due to a regulation limiting the hospitalisation

¹³⁴ Holloway Sanatorium, Annual Report for the Year 1937, No. 52, SHC Ac. 2620/1/9, p. 12.

¹³⁵ Holloway Sanatorium, Annual Report for the Year 1938, No. 53, SHC Ac. 2620/1/9, pp. 11-12.

¹³⁶ Ibid.

period of temporary patients.¹³⁷ She was diagnosed as suffering from depression, and was also experiencing major hallucination, 'seeing and hearing imaginary objects and sounds'. As her condition did not change for another year in Holloway, she was given Cardiazol injections in 1938. At first, the treatment was administered every three to four days, but had to be discontinued after the seventh injection because of her physical condition, particularly the state of her veins. According to the medical staff of Holloway, it seemed to produce 'considerable improvement' while she was undergoing the injections. However, 'all signs of the improvement have disappeared' in less than a week after the intervention, which prompted the physician to admit that 'improvement during Cardiazol treatment was not maintained, and she relapsed completely'. Several months later, the patient was given six more injections, showing 'no improvement at all' this time. Then, five more attempts were made, inducing only one fit, and finally Cardiazol treatment was discontinued.¹³⁸

In another case, that of Miss DH, we can observe the patient's blunt reaction against Cardiazol treatment. On her admission to Holloway in 1935, she exhibited typical symptoms of depression: she was worried, agitated and anxious; and 'her conversation shows marked retardation'. However, as time went on, her condition was aggravated, as she came to have hallucinatory experiences and often turned 'impulsive'. Finally, she was given Cardiazol injections, 32 times, from May to August 1938 with three or four days' interval. Although she

¹³⁷ According to the Mental Treatment Act of 1930, temporary patients were supposed to have treatment for six months at most without certification, with at maximum two further three-month extensions if needed. In this case, the patient's condition showed little difference for over one year, while she had been admitted to Bethlem, and therefore certification was inevitable for her to stay longer in any mental institution. Kathleen Jones, *Asylums and After: A Revised History of the Mental Health Services, From the Early 18th Century to the 1990s* (London: The Athlone Press, 1993), pp. 135-136; Anne Rogers and David Pilgrim, *Mental Health Policy in Britain: A Critical Introduction* (Basingstoke: MacMillan Press, 1996), pp. 60-61.

¹³⁸ Holloway Sanatorium, Discharge Case Book: Female, SHC Ac. 7267/3/25, No. 5568.

did not articulate how much she disliked the treatment verbally, she definitely made her aversion noticed in various ways: on the 23rd injection she ‘cried out while it (Cardiazol) was going in’; she wrote to her brother requesting that he visit her, and on the 30th Miss DH ‘resisted’ so aggressively that she had to be ‘quietened down’. Regarding the result of this treatment, the physician in charge noted that ‘some temporary improvement (was) followed by complete relapse’ and that the patient was ‘now impulsive, unoccupied, antagonistic and ruled by auditory hallucinations’. Miss DH showed no improvement afterwards and after all was transferred to a county mental hospital.¹³⁹ These two cases are considerably different from the optimistic picture suggested in the Annual Reports.

The adverse effects of convulsion therapy were not unknown to contemporary psychiatrists. In the late 1930s, Cardiazol treatment was ‘the most widely used of the major somatic innovations in Britain’ and was preferred to Insulin therapy because Cardiazol was relatively simple and safe to administer.¹⁴⁰ Probably, the reason why the medical superintendent of Holloway Sanatorium mentioned very little about Insulin treatment and its results can be found from the fact that it was considered as an ‘elaborate and hazardous’ procedure.¹⁴¹ Bethlem Royal Hospital introduced Cardiazol treatment slightly earlier than Holloway,¹⁴² and its medical superintendent, Porter Phillips, acknowledged its side effects already in the early years.¹⁴³ One of them was that ‘it so terrified many patients that it

¹³⁹ Holloway Sanatorium, Discharge Case Book: Female, SHC Ac. 7267/3/24, No. 5515.

¹⁴⁰ Niall McCrae, “‘A Violent Thunderstorm’: Cardiazol Treatment in British Mental Hospitals”, *History of Psychiatry*, 17:1 (2006), p. 67; Walke, *Repute and Remedy: Psychiatric Patients and their Treatment at Bethlem*, pp. 208-211.

¹⁴¹ Fennell, *Treatment without Consent*, pp. 132-133.

¹⁴² Walke, *Repute and Remedy: Psychiatric Patients and their Treatment at Bethlem*, pp. 208-209.

¹⁴³ Fennell, *Treatment without Consent*, pp. 132-133.

rendered them more compliant to other more traditional approaches'.¹⁴⁴ Drug-induced shock treatment often caused 'significant' reverse effects, such as 'hairline fractures of the spinal vertebrae, resulting in severe back pain', and acute panic disorders.¹⁴⁵ Given that professional advice on 'overcoming patient resistance' was circulated, we can assume that the case of Miss DH was not uncommon.

The two Holloway cases, both adolescent ones, reveal some important aspects of Cardiazol treatment. Firstly, the practice was not limited to a specific diagnosis, although the Holloway medical superintendent mentioned that the therapy was introduced to treat cases of schizophrenia. Miss WS and Miss DH were diagnosed with depression; although both suffered from hallucination neither were seriously deluded. Secondly, on determining whether or not the practice could be administered, age appeared to be a main consideration, as much as gender, to the medical staff. Jennifer M. Walke has noted that the majority of those who were given Insulin coma treatment in the 1930s and 1940s at Bethlem were females.¹⁴⁶ Although it is hard to suggest definite statistics of Holloway cases, the younger patients were likely to receive somatic treatments. Considering that Miss WS was instantly exempted from the practice when her physical health was not good enough, use of the treatment could be related to the patients' general condition rather than age itself. However, most importantly, these two cases heralded a new era when mental patients were put under physical intervention in the name of treatment, often against their will, and gained little out of the hardship. From a patient's perspective, it could be another form of anguish she had to

¹⁴⁴ Ibid., pp. 136-138.

¹⁴⁵ Ibid.

¹⁴⁶ Walke, *Repute and Remedy: Psychiatric Patients and their Treatment at Bethlem*, p. 206.

undergo and endure in the course of mental illness.

6. Conclusion

In this chapter I have consulted cases of depression in young women treated at the Maudsley Hospital and Holloway Sanatorium during the interwar years. As it is hard (and undesirable) to draw general conclusions about their experiences, both of mental illness and adolescent life, due to the small sample size, I have prioritised description over analysis in this chapter. Nonetheless, it is still possible to identify patterns in the way that mental illness was experienced and in the way in which the patients attributed the cause of their disorders. Regarding the types of depression symptoms, what these patients aged under their mid-twenties experienced did not much differ from their older counterparts. Major symptoms included mood disorder, somatic troubles, physical and mental retardation, self-reproach, suicidal tendencies and suicide attempts, and food refusal. Some of these young patients suffered from delusional ideas and hallucinatory experiences, though these were not as frequent as in older patient groups. The detailed manifestation of these symptoms, however, varied depending on age groups, which will be illustrated in detail in the following chapters. As for lay attribution of mental depression, these girl patients tended to find the origins of depression in adverse life events and negative emotional reactions brought about by them, which had occurred before the onset of the current episode of illness, showing a stark contrast to professional ascriptions mostly to heredity. Grief caused by bereavement, anxiety about

poverty, distress related to occupation or relationships, and intense guilt about sexual behaviours, all were located as alleged causes of depression by the girl patients.

Noteworthy is that self-reproach was not only mentioned frequently as a symptom of depression, mostly in association with negative self-image, but also was pointed out as an aetiological factor in patients' narratives. The guilty conscience, I would argue, can be understood as a core experience of female depression in many ways: regarding its frequency, it was more commonly expressed in female cases rather than in male ones; in terms of its contents, female narratives were inclined to be more diverse, solid and concrete, compared to male ones being mostly limited and vague; and in many cases, the substances and grounds of self-reproach had inseparable relevance to feminine roles and responsibilities. This subject, too, will resonate throughout this research and in its conclusion.

Lastly, these case notes and the patients' narratives imbedded in them led us to a very sensitive subject, female sexuality, in which guilt and shame took the central position. A full discussion of sexual practice and behaviour in those years will be followed in the next chapter focusing on patients in their adulthood and covering a larger group of sample cases. Here, at the end of this chapter, it suffices to verify the utility of the case notes as a reliable source for historical research on sexuality and sexual habits. The medical records employed in this chapter are not sufficient to draw an overarching picture of young women's sexuality in interwar Britain, and are still open to interpretation and analysis, as seen from the debate on the prevalence of pre- or extra-marital sexual experience. Nonetheless, these case notes certainly demonstrate the ability to be a firm footing for historical research on sexuality, and successfully suggest a new methodology for historians with interests in this genre. In the following chapters which focus on females in adulthood and then in middle and old age, all

these issues will be revisited and discussed in full.

Chapter 4. Depression in Adulthood

1. Introduction

This chapter focuses on depressed female patients in adulthood. This period was regarded as crucial in a woman's life, because most of the attributes of complete womanhood, such as marriage, childbirth, mothering and home making, were to be fulfilled during this phase of life. Although there is no universally accepted definition of adulthood or womanhood,¹ for this research adulthood will be understood to embrace the years between 26 and 45. The beginning of this life stage is largely decided by one of the main life events, marriage. In the early twentieth century even though many women remained single all their life and some married only at an advanced age,² marriage was still 'central to the lives of most women and affected everything they did'.³ Throughout the interwar years the mean age of (first) marriage of women remained about 25.5,⁴ which will be applied as the line dividing young

¹ The Oxford Dictionary definition of adulthood is 'the state or condition of being fully grown or mature,' and womanhood as 'the state or condition of being a woman'; the qualities considered to be natural to or characteristic of a woman; and Women considered collectively.

<https://en.oxforddictionaries.com/> <accessed on 19 February 2017>

² The marriage rate per 1,000 women over 16 was 58.7 in 1911, 55.2 in 1921, 54.7 in 1931, and 74.5 in 1941: Jane Lewis, 'Marriage', in Ina Zweiniger-Bargielowska (ed.), *Women in Twentieth-Century Britain* (London: Routledge, 2014), p. 71.

³ Elizabeth Roberts, *A Woman's Place: An Oral History of Working-Class Women 1890-1940* (Oxford: Blackwell, 1984), p. 81.

⁴ Lewis, 'Marriage', p. 71.

from mature patients.⁵ The end of adulthood is linked to the decline of female reproductive capacity.⁶ Early-twentieth-century medical professionals saw the ‘involutional’ or ‘climacteric’ period in a woman’s life to begin at between the age of 45 and 50, although the notion and boundary was never agreed completely even in medical circles.⁷ In this research, following general agreement, the age of 45 will be taken as when adulthood ended and middle age commenced. As the delimitation based on age is far from rigid, exceptional cases will be added which shared in the major life events of this stage: notably, cases of those who were aged under 25 but were already married or bore babies are categorised as adult cases and analysed accordingly in this chapter.

Sources and Sampling

This chapter is based on 22 Maudsley Hospital cases and 24 Holloway Sanatorium cases, all diagnosed as suffering from depression or melancholia, making the total sample size 46.

Regarding the Maudsley samples, the most substantial cases have been chosen out of the data pool which contains the first 100 case files of the four year groups organised according to the

⁵ However, it is not to uphold the ideology that a woman’s life should be solely associated with family, marriage and domestic sphere, but to take the common experience shared by the majority of females in defining the boundary of research. Shani D’Cruze, ‘Women and the Family’, in June Purvis (ed.), *Women’s History: Britain, 1850-1945* (London: Routledge, 1995), p. 52.

⁶ Once again, such demarcation does not mean that I support some old assumptions that the ability to have a child is an essential part of a woman’s life and losing the capability means the end of femininity.

⁷ The notion of climacteric became a subject of fierce debate among experts during the interwar years and the demarcation was never hard and fast, which will be illustrated in depth in the next chapter which examines middle- and old-aged patients.

year of discharge: six from 1924-1927, six from 1928, five from 1931 and another five from 1935. As for the materials taken from Holloway Sanatorium, among cases admitted during the 1920s, examples which can be found *both* in secured casebooks and Medical Registers have been selected, resulting in fourteen sample cases.⁸ Due to the practice of record keeping of this institution, among them only one case was voluntary and the rest, thirteen, were certified.⁹ Of cases treated in the 1930s, those whose discharge records can be found in Registers of Departure have been singled out from secured casebooks. According to this strategy of sampling, ten cases were secured: among them, four were certified, four voluntary and two were identified as temporary, on their admission. Thus, the total number of Holloway Sanatorium sample cases is twenty-four.

2. Demographic Analysis

The composition of patients admitted to the Maudsley Hospital and Holloway Sanatorium varied significantly, a corollary of the characteristics of both institutions described in the

⁸ As illustrated in the Introduction to this thesis, at Holloway Sanatorium Medical Registers stopped being kept and Registers of Departure came into use in the late 1920s. Although this change in record keeping was not limited to Holloway, it is not easy to find any rationale behind the alteration, such as new regulations.

⁹ Until the late 1920s, casebooks of certified patients and voluntary boarders were kept separately, and the latter were poorly secured, a large part of which therefore went missing. However, new ways to keep case files were gradually applied in practice since 1928, organising case notes according to the order of discharge and binding certified and voluntary ones together. As a result, relating to voluntary cases admitted thereafter, most of case files remained intact.

Introduction to this thesis. Here, the Maudsley Hospital will be analysed first. At this Hospital, the proportion of patients identified as suffering from depression was over one third throughout the period under study, making this the most common diagnosis. Categorising those patients according to their age, the adult patient group covering the 26-45 age band made up the largest number of cases; the older group, aged over 46 was the second largest; and the younger group the smallest. These figures differ from Holloway Sanatorium where middle- and old-aged patients were the majority. At the Maudsley in 1928, for example, among the first hundred female patients discharged during this year, 37 were diagnosed as suffering from depression (including those with multiple diagnoses). Among them, nineteen patients, about a half, were in their adulthood, thirteen in middle and old age, and five in adolescence. This result is similar to what Edgar Jones and his colleagues have found in their research, based on statistically processed data of random samples treated between 1923 and 1938. According to their statistics the great majority of the Maudsley patients were in their twenties and thirties: in 1928, out of 55 female inpatient samples, fifteen (27%) were in their twenties, fourteen (25%) in their thirties, and eight (15 %) in their forties.¹⁰ The age distribution of the Maudsley patients did not show any significant change during the interwar period.

Analysing the 22 cases selected for this chapter, in terms of age, four patients were in the 21-25 age band, two were aged 26-30, six aged 31-35, seven aged 36-40, and three aged 41-45.¹¹ With regard to marital status, sixteen were married, four single, one widowed, and

¹⁰ Edgar Jones and Shahina Rahman, 'Framing Mental Illness, 1923–1939: The Maudsley Hospital and its Patients', *Social History of Medicine*, 21:1 (2008), p. 117-118.

¹¹ In terms of age these four patients can be identified as adolescents, but these cases are analysed as adult ones in this chapter, not in Chapter 3, since they were all married on admission and their life experiences were in accordance with what was regarded to constitute adult women's life.

one cohabiting. It is difficult to trace the occupations and social classes of these patients, mainly because, as medical historians commonly point out, married women were usually identified as ‘housewife’ at best.¹² Moreover, even in cases with specific information about the occupation of a patient herself or her husband, it is often hard to tell her (or their) social class on the basis of a particular occupational label. In order to understand a patient’s social stratum, thus, we need to take more details embedded in case histories into consideration, as well as to note the information provided on the front page of a case note. According to the ‘occupations’ listed on the first page of each case file, four women were housewives, and one each a waitress, shorthand typist, and teacher. In some cases, the occupation of the patient’s husband was filled in instead of that of patient: two were engineers, one a lawyer, two clerks, and one a taxi driver. Consulting the latter part of the case notes, which provides more detailed information, seven women (about 60 percent of those who could be classified as working-class) had worked as domestic servants or maids ‘before marriage’.¹³ This finding demonstrates that domestic service still attracted a large portion of young female labour well into the interwar years, despite its general decline.¹⁴ Besides domestic service, various other kinds of occupation appear in patients’ accounts: one had been a factory worker, another a ‘saleslady’ and another a ‘certified teacher’, all before marriage. By piecing together information related to patients’ and their families’ social and economic backgrounds, it

¹² Jones and Rahman, ‘Framing Mental Illness’, p. 118.

¹³ Roberts, *A Woman’s Place*, p. 54.

¹⁴ To understand more about the domestic service industry during the interwar years and those involved in this industry, mostly young women, see Mary Harrison, ‘Domestic Service Between the Wars: The Experiences of Two Rural Women’, *Oral History*, 16:1 (Spring 1988), pp. 48-54; Selina Todd, ‘Domestic Service and Class Relations in Britain 1900–1950’, *Past and Present*, 203 (2009), pp. 181-204; Lucy Delap, *Knowing their Place: Domestic Service in Twentieth-Century Britain* (Oxford: Oxford University Press, 2011).

appears that in this adult female patient group working-class patients slightly outnumbered those from the upper class.¹⁵

This conclusion not only rebuts Jones and Rahman's finding on the Maudsley patients' class distribution that the majority of them were from middle and upper classes,¹⁶ but also disproves a criticism levelled at the Hospital since its establishment, that its medical staff were selective about patients, preferring those from the middle class.¹⁷ As a result, a question should be raised: why does the social background distribution of female patients selected for this research differ from that of male patients in Jones and Rahman's work? It is possible that the discrepancy only reflects existing gender gaps in mental hospital admission. Considering what mental patients and their families took as criteria to decide on hospitalisation, notably financial interests, it is possible that men from affluent social and economic backgrounds were more likely to choose admission while male lower-class patients were reluctant to take this option due to the resulting cost and loss of income. The phenomenon might well have similarities to the situation at Ticehurst Asylum, a mental hospital 'for the rich', where male admissions dominated throughout the second half of the nineteenth century.¹⁸ In contrast, during the same period, county asylums for paupers accommodated more women than men,

¹⁵ The type analysis of patients in this research is not possible from solely relying on patient information from the formatted case sheets and applying quantitative analytical method based on them, as Edgar Jones and his colleagues have done in many of their works.

¹⁶ According to the research of Jones and his associates, 30 percent of male in-patients hospitalised between 1924 and 1938 were from the professional class, 18.3 percent worked in intermediate occupations, and 19.9 percent were skilled workers, based on the 1911 Census occupation classification.

¹⁷ Jones and Rahman, 'Framing Mental Illness', p. 118; Edgar Jones, Shahina Rahman, and Brian Everitt, 'Psychiatric Case Notes: Symptoms of Mental Illness and their Attribution at the Maudsley Hospital, 1924–35', *History of Psychiatry*, 23:2 (2012), pp. 156-168.

¹⁸ Charlotte MacKenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum, 1792-1917* (London: Routledge, 2005), pp. 129-130.

although many historians now argue that the gap was not significant.¹⁹ It is also feasible that there has been some misunderstanding about (or miscalculation of) patients' occupation and class in Jones and Rahman's work. Although not ignoring the latter part of the case notes, they rely heavily on information provided in the standardised case sheet, the first few pages of each file, when accumulating and analysing data. The problem is that occupation recorded on the cover sheet could be misleading, which is why free text in the latter part needs to be read thoroughly in order to understand the social position of the patients. For instance, on Mrs LB's case sheet, the patient's occupation was not revealed but her husband's job was noted as 'clerk'. Following the method applied by Jones, this patient and her family would be categorised as middle class, because 'clerk' belonged to an 'intermediate professionals and managers' group, equating to the lower middle class. However, upon reading the case file closely, a different conclusion is reached, namely that she was not middle-class: the patient had worked as a domestic servant before marriage; she had gone through financial hardships following her husband's unemployment; and she was transferred to a county mental hospital for rate-aided patients after a two-month stay at the Maudsley.²⁰ Considering that a large number of patients were engaged in literally 'intermediate' occupations, such as clerks and salesmen, which could be seen as either lower-middle-class or working-class,²¹ and if most

¹⁹ Anne Shepherd, 'The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums', in Jonathan Andrews and Anne Digby (eds.), *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam: Rodopi, 2004), pp. 224-228.

²⁰ Maudsley Hospital, Patient Casenotes, BRHAM CFM-003, Case No. 0740/1479.

²¹ Teresa Davy, "'A Cissy Job for Men; a Nice Job for Girls': Women Shorthand Typists in London, 1900-39,' in Leonore Davidoff and Belinda Westover (eds.), *Our Work, Our Lives, Our Words* (Basingstoke: Macmillan Education, 1986), pp. 124-144: With the influx of working-class men and women into these professions, a phenomenon accelerated since the late nineteenth century, familial background and the level of education became more important rather than name of occupation itself, when telling a post-holder's class.

of those patients have been regarded as middle-class, it is highly probable that the number of upper-class cases have been overestimated and the proportion of labouring-class patients have been underrated in the work done by Jones and Rahman. By depending on the limited information provided on the first part of the case notes, as they have done, quantitative data are easily reachable whereas subtle but crucial materials needed for qualitative research are missed.

Coming back to the selected samples, thirteen out of 22 patients were admitted during their first attack, whereas eight had previous attacks. Regarding family history, five patients had family members with psychotic or neurotic illness. The time gap between the onset of current illness and admission to the Hospital varied from three weeks to several years, from which it is hard to find any evidence that repeated mental breakdown shortened the time lapse before hospitalisation. Excluding one re-admission case, the mean length of stay at the Hospital was about 3.3 months, shorter than the average for county mental hospitals. For instance, at Surrey County Mental Hospital at Brookwood, female patients who left the Hospital as recovered in the year 1924 resided there for 9.6 months on average, and more than 40 percent of them stayed for between three to six months.²² The shortest stay at the Maudsley was only one week, whilst the longest was ten months. The total length of treatment could be somewhat longer, considering the time gap between the first medical examination and the actual admission to a ward. Such a delay frequently happened, mostly due to the shortage of beds, a chronic problem experienced by the Hospital, and sometimes due to the administrative process related to confirming the patient's 'London settlement'. At

²² Brookwood Mental Hospital, Annual Report with Audited Account for the Year ended 31 March 1925, SHC Ac. 3043/1/1/2/15.

the Maudsley, unlike other mental institutions at the time, readmission cases were rare, mainly due to its policy against this.²³

At Holloway Sanatorium too, depression was the most common mental illness. According to Annual Reports of the institution, throughout the 1920s ‘melancholia’ remained at the top in tables ‘showing the form of mental disorder on admission,’ usually followed by ‘confusional insanity’ and ‘delusional insanity’. Referring to the Medical Registers of Holloway Sanatorium kept during the decade, the proportion of melancholic patients among the whole female cases was 28 percent, with fluctuations according to the year,²⁴ slightly lower than the figure for the Maudsley Hospital where those suffering from depression accounted for more than one third of the whole patients.²⁵ At the Sanatorium, the number of adult patients, aged between 25 and 45, was relatively small, as the majority of the Sanatorium boarders were middle- and old-aged. Taking cases admitted every two years between 1920 and 1928, the total number of cases of female depression was 67, and, out of them, the number of adult cases was twelve (18 percent),²⁶ showing a stark contrast to the Maudsley where a half of depression patients were in their adulthood around the same period.

[Table 6] Number of Depression Patient among Female Admission at Holloway

²³ Edgar Jones, Shahina Rahman, and Robin Woolven, ‘The Maudsley Hospital: Design and Strategic Direction, 1923–1939’, *Medical History*, 51:3 (2007), pp. 357-378.

²⁴ Holloway Sanatorium, Medical Register: Females, SHC Ac. 3473/3/48: According to Medical Registers, in 1922 about 30 percent of female patients (sixteen out of 54) were diagnosed as suffering from melancholia, whereas in 1928 the figure was less than 25 percent.

²⁵ Holloway Sanatorium, Medical Register: Females, SHC Ac. 3473/3/48; Annual Report for the Year 1922, No. 37, SHC Ac. 2620/1/8; Annual Report for the Year 1928, No.43, SHC Ac. 2620/1/9.

²⁶ Holloway Sanatorium, Medical Register: Females, SHC Ac. 3473/3/48.

Sanatorium.²⁷

Year	Total Admission (Transfer included)	Number of Melancholia Case	Percentage of Melancholia Case	Number of Adulthood cases
1920	52	17	33%	7
1922	54	16	30%	3
1924	47	15	32%	2
1926	42	8	19%	0
1928	41	11	27%	0

Besides the age distribution of patients, another major difference between the two mental institutions was the length of hospitalisation. At Holloway Sanatorium, the average length of stay was much longer than for the Maudsley cases, as well as longer than the average at county asylums. Consulting the Medical Registers, those admitted to the Sanatorium in 1924 due to depression or melancholia remained there for 25.7 months on average.²⁸ Among them, patients in their adulthood stayed for far shorter time than the

²⁷ Holloway Sanatorium, Medical Register: Females, SHC Ac. 3473/3/48; Annual Report for the Year 1920, No. 35, SHC Ac. 2620/1/7; Annual Report for the Year 1922, No. 37, SHC Ac. 2620/1/8; Annual Report for the Year 1924, No. 39, SHC Ac. 2620/1/8; Annual Report for the Year 1926, No.41, SHC Ac. 2620/1/9; Annual Report for the Year 1928, No.43, SHC Ac. 2620/1/9.

²⁸ The average hospitalisation period of 'depression patients' remained generally stable throughout

average, for 6.7 months, still longer than the Maudsley cases in the same age group. It means that at Holloway younger patients tended to stay for shorter periods whereas older patients stayed much longer than their younger counterparts.

Analysing the sample group of adult patients, among 24 cases in total, two patients were in their twenties, five in their early thirties, five in their late thirties, and eleven in their early forties, showing that numbers increased with age. As for the patients' marital status, twelve out of 24 were single, eleven married and one widowed. The ratio of married/unmarried patients in Holloway Sanatorium is not much different from that of other mental institutions, including registered hospitals and county asylums, where about 40 percent of female psychiatric patients were married and 60 percent were single or widowed on average.²⁹ Even considering that one third of the female population never married in the interwar decades, single women were over-represented in this institution.³⁰ The majority of the patients under analysis had no specific occupation, but five were identified as having a job in the Medical Registers: one each was listed housewife, a lady companion, a secretary, a civil servant and a trained nurse. According to the Annual Reports, the great majority of Holloway patients had 'independent means', and more females belonged to this occupational

the 1920s. However, it is hard to calculate the general length of stay of the Sanatorium patients because of some practical obstacles. Its Annual Reports do not provide any information on the average length of residence, which was usually calculated when the patient was discharged in county mental hospitals. It is also hard to work out an individual patient's length of stay when they changed status from certified to voluntary boarder after discharge, which happened very often here.

²⁹ To suggest a typical instance, at the Brookwood Mental Hospital, among 147 women who were admitted directly in the year 1924, 74(50%) patients were single, 56(38%) married, and 16(11%) widowed. Four years later, the number of female admission was 114, and 52(46%) patients were single, 43(38%) married, and 19(17%) widowed.

³⁰ Katherine Holden, *The Shadow of Marriage: Singleness in England, 1914-60* (Manchester: Manchester University Press, 2007), pp. 28-29.

cluster than males. For instance, 75 percent of the female patients admitted in 1922 belonged to this group, higher than the average for both sexes, 67 percent;³¹ and in 1928, the proportion of female patients with independent means was 90 percent: 28 out of 31 patients.³² Considering these figures, it is reasonable to regard female patients who had no profession recorded in their case notes or Medical Registers as falling into this occupational group. Also, the assumption about the patients' social background was underpinned by their medical expenses: to give an example, the average weekly charge per patient in 1922 was £5 9s. 10d., which corresponds to around £250 today.³³ The fact that the patients and their families could afford it explains much about their financial circumstances.

One more thing should be clarified concerning Holloway patients, their status upon admission and departure. From its establishment in 1885 to the enactment of the Mental Treatment Act in 1930, Holloway Sanatorium categorised its patients into two groups: certified patients and voluntary boarders, corresponding to the certification system from which the Maudsley was exempt. During this period, the two groups of patients were administered separately, with discrete Medical Registers and casebooks as well as different numbering methods.³⁴ However, demarcation between them was occasionally complicated,

³¹ Holloway Sanatorium, Annual Report for the Year 1922, No. 37, SHC Ac. 2620/1/8.

³² Holloway Sanatorium, Annual Report for the Year 1928, No. 43, SHC Ac. 2620/1/9: in a table 'showing the occupation of the direct admission' during the year 1928, 28 female patients, out of 31, were described as having 'independent means,' two as artists, and one teacher.

³³ Holloway Sanatorium, Annual Report for the Year 1922, No. 37, SHC Ac. 2620/1/8; For the conversion of current value, <http://www.thisismoney.co.uk/money/bills/article-1633409/Historic-inflation-calculator-value-money-changed-1900.html>.

³⁴ For instance, four figure voluntary patients' registration numbers began with a 2 during the 1920s (for example, 2867), and those for certified patients' began with 4 in the early years of the decade (no. 4703, Miss RE) and 5 in the later years. Sometimes the staff put 'V' in front of a voluntary patient's serial number, and 'C' for a certified patient. In the 1930s contemporary patients' numbers came to begin with 0, for example 0002.

mainly due to cases where certified patients chose to remain as voluntary boarders after discharge or voluntary patients were certified and re-classified accordingly.³⁵ Among the Holloway samples hospitalised in the 1920s, fourteen cases, one was voluntary and thirteen were certified cases on their admission. However, the only voluntary boarder was certified soon after her admission,³⁶ and one of the certified patients remained as a voluntary boarder after being discharged as recovered.³⁷ After the Mental Treatment Act of 1930, there were three types of patients, certified, temporary, and voluntary patients, and the classification of patients became more complicated. Among the patients admitted during the 1930s, ten in total, four were certified, another four voluntary, and two were temporary cases. However, one of the certified patients remained as a voluntary boarder after discharge; one temporary patient chose to remain as a voluntary boarder when she was discharged after two months' treatment, and one voluntary patient changed her status twice during her stay in the Sanatorium, from voluntary to certified and, when she was discharged, from certified to voluntary.

3. Lived Experience of Depression in Adulthood: Symptoms

³⁵ The former cases were more frequent than the latter. Among the collected samples, only one case falls into the latter: Miss DHC was admitted in 1927 to the Sanatorium as a voluntary boarder, but was certified only a few weeks later due to her suicidal tendency: Holloway Sanatorium, Discharge Case Book: Female, SHC Ac. 7267/3/28, No. 1969.

³⁶ Ibid.

³⁷ Holloway Sanatorium, Case Book: Females [Volume 27], SHC Ac. 3473/3/17, No. 4863.

Somatic Symptoms

In 1874 Richard von Krafft-Ebing, an Austro-German psychiatrist then based in Graz and famous across Europe, analysed ‘major physical accompaniments of melancholia’, enumerating low energy, quick exhaustibility, hesitant movement and speech, disrupted sleep, headache, neuralgic sensations, palpitation, pressure on stomach, anorexia, and constipation.³⁸ All of these were experienced and mentioned by early-twentieth-century patients diagnosed with depression at the Maudsley and Holloway. Among them, the most frequently reported was pain in various parts of the body, and, in particular, headache, experienced across all age groups. For instance, Mrs MBS of the Maudsley kept complaining of pains all over her body: headache, backache, ‘a funny niggling pain in my throat’, ‘jumping pains’ and ‘shooting pains in the throat and stomach’.³⁹ Women who had experience of childbirth seemed to be prone to physical pains, which some of them related to their confinement. Mrs ABT is a representative case. She complained of pains in the head, on the left side of the abdomen and on the right side of her pelvis, and attributed all these symptoms to her first delivery ten years previously. She had, she explained, never been well ‘since the oldest child was born’ when she had been ‘badly torn’. She underwent several kinds of medical examination at King’s College Hospital, at the request of the Maudsley medical staff, which found ‘no physical cause’ and ‘nothing abnormal’ and concluded that she was in an ‘ordinary condition’.⁴⁰ The great majority of patients suffering from varied

³⁸ Edward Shorter, *From the Mind into the Body: The Cultural Origins of Psychosomatic Symptoms* (New York: Free Press, 1994), pp. 137-138.

³⁹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-068, pp. 112-139.

⁴⁰ Maudsley Hospital, Patient Casenotes, BRHAM CFM-003, Case No. 2761.

(psycho)somatic symptoms failed to find any organic origin of their pains and discomforts, including Mrs ABT.⁴¹

Mood Disorders

As illustrated in the previous chapter, negative emotional experiences were experienced by almost all patients suffering from depression: principally low mood, partly fluctuating mood and occasionally complete insensitivity. However, patients' accounts of such internal experiences were not as frequent as those relating to somatic symptoms. Typical descriptions of them include: she is 'agitated and depressed'; she has been 'restless'; and she 'shows little interest in things outside herself'.

With regard to patients' mood descriptions, the medical records of the Maudsley and Holloway show much variation between them. The contents of the former were diverse, employing a wide range of descriptive expressions and frequently quoting patients' own accounts; and those of the latter were relatively monotonous and less varied, applying a handful of words, notably 'depressed', 'agitated' and 'restless', with overwhelming frequency.⁴² However, this does not necessarily indicate that there was any significant gap in

⁴¹ In a similar way to many nineteenth-century neurasthenic patients: Hilary Marland, "'Uternine Mischief': W. S. Playfair and his Neurasthenic Patients", in Marijke Gijswijt-Hofstra and Roy Porter (eds.), *Cultures of Neurasthenia from Beard to the First World War* (Amsterdam: Rodopi, 2001), pp. 117-139.

⁴² At Holloway, a large number of files relating to cases of depression begin with some typical phrases: 'patient is depressed and restless, (...) says she is so tired' or 'patient is depressed and unstable, easily becoming agitated.' Holloway, Case Book: Females [Volume 26], SHC Ac. 3473/3/16, No. 4703; Holloway Sanatorium, Case Book: Females [Volume 27], SHC Ac. 3473/3/17, No. 4842.

the affective experiences of these patients at the two hospitals. Rather, it is reasonable to see such discrepancies originating in the ways in which psychiatrists examined patients and their psychology. Aubrey Lewis of the Maudsley once mentioned in his article on melancholia that at the Maudsley a patient was given neutral questions, such as ‘how do you feel?, ‘how is your mood?’ and ‘how are your spirits?’, in order to ‘let him find his own description’. In contrast, he pointed out, some other psychiatrists (notably Henderson and Gillespie) preferred more specific questions, for example ‘are you sad?’ or ‘are you worried?’, which Lewis believed to ‘offer the patient a choice of words’ and therefore led the patient to narrate what doctors expected to hear.⁴³ Considering Lewis’s comment, it is probable that the medical staff at Holloway employed relatively ‘specific’ questions and prompted patients to use limited vocabularies and that it accounted for the marked gap between the narratives relating to emotional experience recorded at the two institutions, although we have few ways to prove this medical practice.

Hallucination and Delusion

More adult than adolescent cases were recorded as showing symptoms of delusion. Their delusional experiences generally coincided with contemporary professional explanations in terms of both subject and content. According to psychiatric literature of the time, there existed distinctive patterns in the delusions of the depressed, such as ideas of disease, sin,

⁴³ Lewis, ‘Melancholia: A Clinical Survey of Depressive States’, *British Journal of Psychiatry*, 80:329 (1934), p. 279.

persecution and poverty.⁴⁴ The case history of Mrs AC, a working-class housewife in her mid-forties, provides a good example of hypochondriacal preoccupation, which Lewis regarded as the most significant and prevalent type of delusion.⁴⁵ On her admission to the Maudsley in 1927, she thought that her bowels were ‘all twisted about’ and rarely working.⁴⁶ Such delusions related to bowel movement, defecation and constipation were common among female patients in all age groups, although more frequent in older groups, which will be discussed in depth in Chapter 5.⁴⁷ Delusional ideas of sin or wrong-doing were occasionally related to self-reproach. Mrs WBB, who was admitted to Holloway with melancholia following confinement, aged 39, kept ‘praying for forgiveness for some awful sin she has committed’ with the Bible in her hands. She also firmly believed that ‘the police were coming for her to take her to prison on account of great sin’, another common expression of delusionary patients.⁴⁸ Contrary to the younger patient group, mature women often exhibited delusional ideas with a religious tinge, typically admitting an ‘unforgivable sin’ or confessing that ‘I have the devil in myself’.⁴⁹ Delusions of persecution presented some patterns too. A certified Holloway patient was terribly harassed by the idea that she would be taken away by some men around her,⁵⁰ and another patient imagined that someone intended to kill her and that her friends were already murdered.⁵¹ Lastly, delusion about destitution was more

⁴⁴ Emil Kraepelin, Mary Barclay (trans.), George Robertson (ed.), *Manic-Depressive Insanity and Paranoia* (Edinburgh: Livingstone, 1921), pp. 19-22; D. K. Henderson and R. D. Gillespie, *A Textbook of Psychiatry for Students and Practitioners* (London: Oxford University Press, 1927), pp. 132-141; Lewis, ‘Melancholia: A Clinical Survey of Depressive States’, pp. 306-312.

⁴⁵ Lewis, ‘Melancholia: A Clinical Survey of Depressive States’, pp. 306-312.

⁴⁶ Maudsley Hospital, Patient Casenotes, BRHAM CFM-031, Case No. 1469.

⁴⁷ Lewis, ‘Melancholia: A Clinical Survey of Depressive States’, p. 308.

⁴⁸ Holloway Sanatorium, Case Book: Females [Volume 26], SHC Ac. 3473/3/16, No. 4551.

⁴⁹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-031, Case No. 1469.

⁵⁰ Holloway Sanatorium, Case Book: Females [Volume 26], SHC Ac. 3473/3/16, No. 4703.

⁵¹ Holloway Sanatorium, Case Book: Females [Volume 25], SHC Ac. 3473/3/15, No. 4510.

prevalent amongst those from affluent backgrounds, rather than working-class patients. As the age of patients increased, so did the number of sufferers with obsessional ideas of poverty. This type of delusion was, therefore, most prevalent among elderly middle-class patients.

Delusional ideas related to childcare were experienced almost exclusively by female patients in this specific life stage. A good example is the case of Mrs NC. This patient, a housewife aged 36, fell into a depressive state about a month after a prolonged labour with her second child. According to the statements made by her husband and herself, the main problem was an obsessional idea of doing harm to her children.⁵² Such delusions and obsessions concerning childbirth and childcare were markedly common among female patients in puerperal, postnatal and lactational periods.⁵³ This accords with what David Wright has found through his analysis of delusions of mid-Victorian county asylum patients diagnosed with melancholia and mania. According to Wright, although in terms of types of delusion men and women showed little difference between them, their contents and themes were conspicuously divided. False ideas that preoccupied women were usually associated with personal health, family and household, which, Wright argues, reflected the current culture and social values associated with women and the domestic sphere.⁵⁴ Gender roles imposed by culture considerably influenced women's experience of mental illness, as well as of everyday life.

Hallucination was more common than delusion. Amongst varied false sensory

⁵² Maudsley Hospital, Patient Casenotes, BRHAM CFM-031, Case No. 628/1262/3052.

⁵³ Ian Brockington, *Motherhood and Mental Health* (Oxford: Oxford University Press, 1996), p. 168.

⁵⁴ David Wright, 'Delusions of Gender?: Lay Identification and Clinical Diagnosis of Insanity in Victorian England', in Andrews and Digby (eds.), *Sex and Seclusion, Class and Custody*, pp. 153, 166-171.

experiences, aural ones, notably ‘hearing a voice (or voices)’, was most frequent. The case of Mrs RNE, a certified patient at Holloway Sanatorium, provides an example where simple hallucinations gradually worsened and finally turned into a compound state. According to her own explanation, at first she heard a voice telling her simple things, such as ‘get up’. Soon after the voice began to state horrible things, including that ‘it had killed her boy’, by then the Holloway doctors saw the patient as lacking ‘a sense of reality’.⁵⁵ The case of Mrs AJB provided an unusual hallucinatory experience: she suffered from ‘hallucinations of taste’, rarely experienced among the depressed, followed by a serious eating disorder that necessitated forced feeding.⁵⁶ Some patients experienced multiple forms of hallucination: for instance, Mrs SBR, aged 34, suffered from auditory and visionary hallucinations simultaneously, which also deprived her of her awareness of reality. In her ‘reflections’ or ‘shadows’, according to herself, she saw her brother and her husband surrounded by coffins or standing on an altar. The patient heard neighbours saying ‘unpleasant things’ about herself, such as ‘she is damaged goods’.⁵⁷

Suicidal Tendency and Attempt

As regards suicidal tendency and attempted suicide, which contemporary psychiatrists saw as the most serious problem the depressed could experience, the Maudsley and Holloway reveal rather different pictures. It is noteworthy that patients at Holloway showed a greater tendency

⁵⁵ Holloway Sanatorium, Case Book: Females [Volume 27], SHC Ac. 3473/3/17, No. 4850.

⁵⁶ Maudsley Hospital, Patient Casenotes, BRHAM CFM-151, Case No. 3941.

⁵⁷ Maudsley Hospital, Patient Casenotes, BRHAM CFM-003, Case No. 676/1361.

to commit suicide than those at the Maudsley. At the Maudsley, among twelve patients admitted in the 1920s, three showed a suicidal tendency and only one made an attempt to kill herself. In the 1930s, three out of ten cases were suicidal, all having taken actions to kill themselves before admission. At Holloway, out of the 24 sample cases, twelve patients, that is half, were marked as 'suicidal' in their case files and seven among them put the idea into practice before or during their hospitalisation. Such a high proportion runs counter to the finding of Anne Shepherd and David Wright that in Victorian private asylums the rate of suicide was fairly low, between 10 and 15 percent, because boarders in those institutions did not need to prove their dangerousness in order 'to secure access to a dwindling resource of beds' as county asylum inmates did.⁵⁸ The discrepancy is attributable to the fact that Shepherd and Wright have regarded private asylum patients as a homogeneous group. At Holloway, however, voluntary boarders and certified patients showed remarkable difference in terms of the seriousness of their mental illness. In the former group, the figure suggested by Shepherd and Wright might be valid, whereas in the latter the rate was much higher. Among the twelve suicidal cases at Holloway, eleven were certified on admission and only one was voluntary, who was eventually certified due to self-destructive behaviour during her stay in the Sanatorium. Therefore, it is neither possible nor desirable to suggest any general conclusion about patients' suicidal tendency or suicidal rate in mental institutions. Rather, it is important to recognise that patients displayed different features in terms of suicidality depending on the seriousness of mental illness.

The difference between the Maudsley Hospital and Holloway Sanatorium relating to

⁵⁸ Anne Shepherd and David Wright, 'Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint', *Medical History*, 46:2 (2002), pp. 194-195.

suicidal propensity reflected not only the features of the two institutions but also the nature (and limit) of the certification system. As declared on its establishment, the Maudsley sought to provide patients in the early stage of mental illness with proper psychiatric care and treatment.⁵⁹ Accordingly, the Hospital welcomed sufferers whose condition was not severe enough to require certification and, therefore, lead patients in the incipient phase to seek medical help before it became too serious, which helps explain why there were fewer suicidal patients at this institution. At Holloway Sanatorium in contrast, except for cases of voluntary boarders, a patient had to be certified in order to be hospitalised and given medical treatment. Considering the social stigma, it was understandable that patients and their family members wanted to avoid the process of certification and hospitalisation as far as possible, which could result in missing opportunities to access treatment. It was only when a patient's condition went beyond the control of family or presented practical danger that admission to a mental institution came under earnest consideration. It explains why the great majority of certified patients were admitted to the Sanatorium only after having attempted suicide. Among its certified patients hospitalised during the 1920s, thirteen in total, nine women were categorised as 'suicidal' and six made attempts before admission. These figures show how ineffective the certification system was in terms of preventing mental illness or providing opportunities to help psychiatric patients.

Methods chosen by patients for self-destruction also reveal different patterns between the two institutions. Holloway patients were inclined to adopt conventional and feminine

⁵⁹ Maudsley Hospital, Medical Superintendent's Annual Report, Year ended 31st January, 1924, BRHAM, p. 2; Jones, Rahman, and Woolven, 'The Maudsley Hospital: Design and Strategic Direction', pp. 358-359.

ways, including drowning, mutilating, and strangulation.⁶⁰ Among suicidal cases admitted in the 1920s, Miss RE, aged 33, was found by her father in her bathroom ‘with a cord around her neck’, after having been betrayed by her fiancé. Before this she had threatened to jump out of the window and had almost managed this several times. However, the actual attempt seemed to convince her family of the urgent need to hospitalise her.⁶¹ This case appears representative, in terms of the practical means of suicide and the timing of admission, immediately after an attempted suicide.⁶² Meanwhile, the Maudsley patients made different choices about how to die. It is not a coincidence that three among the four patients who attempted suicide during the period under analysis here applied the same method, gassing: Mrs MR, aged 21, who suffered from depression following confinement, was found lying on the kitchen floor with her head in the gas oven by her husband;⁶³ Mrs WBT, a middle-class housewife, became markedly self-reproachful after a love affair, and finally attempted suicide by gassing at home;⁶⁴ and Miss IBH, a 28-year-old ‘general maid’, was found by her mistress ‘lying on the kitchen floor by the stove with the gas turned on’ after giving birth to an illegitimate child and taking the baby to an orphanage.⁶⁵

⁶⁰ Shepherd and Wright, ‘Madness, Suicide and the Victorian Asylum’, pp. 186; 175-196; Frederick Hopkins, ‘Attempted Suicide: An Investigation’, *British Journal of Psychiatry*, 83:342 (1937), pp. 71-94.

⁶¹ Holloway Sanatorium, Case Book: Females [Volume 26], SHC Ac. 3473/3/16, No. 4703.

⁶² To suggest typical case histories, a trained nurse, aged 41, suffering from recurrent melancholia attempted to strangle herself a week before her admission, and a 24-year-old housewife ‘deliberately took an overdose of the tablets (that) she had for sleeping’. What were usually regarded as ‘male’ methods were only occasionally applied: for example, a ‘spinster’ in her mid-forties attempted to cut her throat with a razor which she had taken from her brother’s room. Holloway Sanatorium, Case Book: Females [Volume 25], SHC Ac. 3473/3/15, No. 4519; Case Book: Females [Volume 26], SHC Ac. 3473/3/16, No. 4658; Case Book: Females [Volume 27], SHC Ac. 3473/3/17, No. 4752.

⁶³ Maudsley Hospital, Patient Casenotes, BRHAM CFM-151, Case No. 3900.

⁶⁴ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 4212.

⁶⁵ Maudsley Hospital, Patient Casenotes, BRHAM CFM-068, Case No. 2519.

Choosing gassing as a means of suicide reflects major changes in both material conditions and contemporary values. Gas had been introduced as a domestic fuel in the last decades of the nineteenth century.⁶⁶ With the arrival of gas in the domestic household, it rapidly became a new means to commit suicide, which was noticed by contemporary observers almost immediately.⁶⁷ However, the reason that these women chose to gas themselves cannot be completely explained by the material condition, as their choices were largely shaped by gender. In all the cases, the space where such tragedies happened was in the kitchen, the most gendered sphere in the home. Mrs MR and Mrs WBT were both found in their own kitchens by their husbands, whereas Miss IBH made her attempt at her place of employment. The tools used for self-destruction were also symbolic of domesticity: ovens and stoves were used almost exclusively by women, more feminine than any other appliances in the household. Gas was handled by housewives, who were regarded as the main consumers of the fuel from its early days, as shown in the marketing strategies employed by major English gas companies.⁶⁸ The choice of the means and place of suicide was clearly related to gender roles and the ideology of domesticity.

As noted earlier, the gender differences in suicidal practice were noticed by contemporary psychiatrists and observers. In his article on depression, Lewis mentioned, albeit briefly, that in cases involving gas, poison and burning ‘the patients (were) mostly women’.⁶⁹ In an article about ‘attempted suicide’, a psychiatrist found that in female cases various poisonings, including gas-coal, corrosive and sedative poisonings, were most

⁶⁶ D’Cruze, ‘Women and the Family’, pp. 66-67.

⁶⁷ Olive Anderson, *Suicide in Victorian and Edwardian England* (Oxford: Clarendon, 1987), p. 367.

⁶⁸ Anne Clendinning, “‘Deft Fingers’ and ‘Persuasive Eloquence’: The ‘Lady Demons’ of the English Gas Industry, 1888–1918”, *Women's History Review*, 9:3 (2000), pp. 501-537.

⁶⁹ Lewis, ‘Melancholia: A Clinical Survey of Depressive States’, p. 341.

frequently attempted, whereas in male cases gas-coal poisoning and throat cutting were adopted most commonly.⁷⁰ The number of men employing the latter, however, 'exceeded women by three to one'. Astonishingly enough, according to the statistics provided, about 70 percent of women who succeeded in committing suicide in the 1930s employed gas-coal poisoning.⁷¹ Historians have reached a similar conclusion. Olive Anderson in particular has noted the relationship between the adoption of new technology and its impact on suicidal behaviour, focusing on the fast spread of gassing during the interwar years.⁷² Gender, age and class therefore can be seen to have played significant roles in deciding methods of suicide.

4. Lay Causal Attribution of Depression in Adulthood

Professional interpretations of the causes of depression will be examined in advance of lay causal attributions in both institutions. At Holloway Sanatorium, the medical staff seemed to

⁷⁰ Gassing was often applied by men, too. It is possible to find a few cases in which male patients employed the method from Lewis's article on melancholia and depression. For example, a schoolboy, aged 16, was brought to the Maudsely Hospital in 1928 after a suicide attempt. For a few months, he felt dizzy and frightened, and kept thinking about his wrong-doings. He came to believe that 'some harm would happen to his family'. Recently, he confided to his father that he had been masturbating and that his scout-master had committed pederasty. Then, the boy 'tried to kill himself with gas because he felt so miserable'. Aubrey Lewis, 'Melancholia: Prognostic Study and Case-Material', *British Journal of Psychiatry*, Vol. 82 (1936), pp. 510-511, 519-520; Lewis, 'Melancholia: A Clinical Survey of Depressive States', pp. 340-342.

⁷¹ Hopkins, 'Attempted Suicide', pp. 75-82.

⁷² Anderson, *Suicide in Victorian and Edwardian England*, p. 367.

have been uncertain about the aetiological factors in many of the cases. According to its Medical Registers, among the thirteen certified cases admitted in the 1920s, six were attributed to prolonged mental stress, which therefore became the most common aetiological factor in this patient group.⁷³ The second prevalent causes were heredity and eccentricity: four cases were ascribed to ‘insane heredity’ and another four to ‘eccentricity’. Among these factors noted, eccentricity, which was usually marked by its code ‘B. 3.’ in the Medical Registers, is a perplexing aetiological concept, because it explains almost nothing about what brought about depression in those cases.⁷⁴ For instance, a depression case of Mrs SAE was ascribed to eccentricity in the Medical Register, while it had ‘unknown’ cause recorded in the case note.⁷⁵ Considering the frequency in using this term and integrating all the information provided in these medical records, it may well be that ‘eccentricity’ was applied as a useful aetiology when the medical staff had only limited information about the cause and case history. Following these cases with major aetiologies, came a handful of cases involved with alcohol problems, physical illness, and childbirth in the Medical Registers. Aetiological factors recorded in individual case notes often differed from what was written in the Medical Registers. Four out of thirteen certified patients admitted to Holloway in the 1920s had no specific cause of their mental trouble, with marks of ‘nil’, ‘unknown’, ‘uncertain’, and ‘not known’ respectively, in the case files. Two cases were attributed to childbirth; two to ‘worry’; two to ‘love affair’; and one to overwork and stress. Interestingly enough, according to the case files, none of them had a hereditary origin, contradicting common explanations provided

⁷³ Holloway Sanatorium, Medical Register: Females, SHC Ac. 3473/3/48-49.

⁷⁴ Refer to the Appendix for more information about the *Schedule of Causes and Associated Factors of Insanity* commonly used in mental hospitals and their official records.

⁷⁵ Holloway Sanatorium, Medical Register: Females, SHC Ac. 3473/3/48; Case Book: Females [Volume 26], SHC Ac. 3473/3/16, No. 4594.

in contemporary expert literature.⁷⁶ By crosschecking the four cases identified as having ‘insane heredity’ in the Medical Registers, we find that two of them were ascribed to ‘worry’, one to a drinking habit, and one to ‘uncertain’ cause in the case files. To sum up, causal attributions made by Holloway professionals were neither certain nor consistent.

At the Maudsley Hospital, too, psychiatrists failed to provide simple and unified explanations for causes of depression. In the sample cases of female adult patients, stress and worry were blamed most frequently as aetiological factors by the medical staff, even though the details are too varied depending on the situation of each patient to be generalised. However, in many cases the space for ‘aetiological factors’ on the first page of individual case notes was left blank, and in more cases aetiological factors addressed at the beginning of the document were inconsistent with ‘suggested causes’ on the back pages. For instance, in the case of Mrs MS, ‘influenza’ was mentioned as the main aetiology in the case sheet on the first page of her case note, whilst ‘worry over husband’s work’ was specified as a suggested cause in the following record written in free format.⁷⁷ Also, noteworthy is that the number of cases in which heredity was indicated as a main cause of mental illness was limited in the Maudsley too. Unlike the special emphasis upon ‘hereditary predisposition’ in medical texts, none of the Maudsley cases under scrutiny in this chapter were considered to be attributable to inheritance by the medical staff, even though seven out of 22 sample cases were reported as having a family history of nervous or mental disorder. In this sense, medical records of both the Maudsley and Holloway illustrate that there existed a considerable gap between texts

⁷⁶ Kraepelin, *Manic-Depressive Insanity and Paranoia*, pp. 165-167; Henderson and Gillespie, *A Textbook of Psychiatry*, pp. 117-119.

⁷⁷ Maudsley Hospital, Patient Casenotes, BRHAM CFM-031, Case No. 3189.

and practice.

As noted in Chapter 3, there exists a practical difficulty in revealing the patients' own perspectives on aetiology, as the majority of them remained reticent about the subject or assumed an ambiguous attitude. Thus, except in some cases where patients were willing to set forth their views, in analysing lay attributions the focus will be on the way in which patients explained the course of their current attack. In order to examine how these patients attributed the cause of their mental illness, sample cases are grouped according to what could have affected their mental health condition, including childbirth, financial hardship, matrimonial conflict, sexuality issues and drinking problems. Under these themes we can trace how these patients did or did not relate such life events and everyday experiences to their mental illness.

Depression Following Childbirth

Reading the case notes of the Maudsley and Holloway Sanatorium, we encounter numerous cases where female patients had recently given birth and subsequently fallen victim to depression. In these cases, doctors, patients and their families easily reached a consensus about the origin of mental illness.⁷⁸ Most of these patients identified the starting point of their current mental breakdown to the recent experience of pregnancy, childbirth, or ensuing

⁷⁸ At the Maudsley, for instance, among five puerperal cases, disagreement over the aetiology between lay and professional interpretations is detected in only one case. In analysing the case history, the Maudsley doctors took note of the long time lapse, almost ten years, between the confinement and onset of depression and did not categorise the case as a postnatal one, despite the patient's strong claim that the cause of her mental and physical troubles originated from the birth of her first child.

changes. However, the two institutions showed a remarkable contrast in the number of these cases. At the Maudsley, along with financial hardship, childbirth was the most common aetiological factor blamed by sufferers in this patient group, accounting for more than one fifth of female admissions aged between 25 and 45.⁷⁹ At Holloway, the ratio was much lower: only two cases, both certified, in the sample group fell into this category.⁸⁰ Annual Reports of the Sanatorium also inform us that it had none or only one patient each year whose mental illness originated from ‘child bearing’ or ‘puerperal state’ each year throughout the 1920s.⁸¹ Medical Registers also illustrate that as an aetiological factor ‘following confinement’ was exceeded by ‘prolonged stress,’ ‘heredity’ and ‘worry’.⁸²

Although it is neither meaningful nor possible to find an archetypal case of post-natal depression, some patterns emerge from the collected case histories. With regard to the onset, depression occurred usually in a few months after giving birth, a half year at the longest, except the case of Mrs MR at the Maudsley who fell victim to low mood and severe headache during her premarital pregnancy. However, in this case too, the condition was aggravated dramatically after giving birth.⁸³ As for the symptoms, puerperal cases did not considerably differ from those that occurred in other stages in a woman’s life. However, there existed detailed features which were exhibited only in postnatal cases, as these patients were more

⁷⁹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-003, Case No. F519/FW258; Case No. 1579/800; BRHAM CFM-067, Case No. 2541/5576; BRHAM CFM-151, Case No. 3941; Case No. 3900.

⁸⁰ Holloway, Case Books: Females [Volume 26], SHC Ac. 3473/3/16, No. 4551; Case Books: Females [Volume 27], SHC Ac. 3473/3/17, No. 4842.

⁸¹ Holloway Sanatorium, Annual Report for the Year 1923, No. 38, SHC Ac. 2620/1/8; Annual Report for the Year 1927, No. 42, SHC Ac. 2620/1/9; Annual Report for the Year 1928, No.43, SHC Ac. 2620/1/9.

⁸² Holloway Sanatorium, Medical Register: Females, SHC Ac. 3473/3/48.

⁸³ Maudsley Hospital, Patient Casenotes, BRHAM CFM-151, Case No. 3900.

inclined to suffer from what were inevitably related to their newly acquired role as a mother. More than anything, delusion, obsession, and self-reproach about their new responsibility was common. For example, Mrs LJB at the Maudsley, a 34-year-old housewife, held the false but firm belief that she had neglected her baby and family, the most typical account given by female patients at this life stage;⁸⁴ another patient at Holloway accused herself of having no maternal affection towards her newborn baby;⁸⁵ and Mrs SBY at the Maudsley expressed strong antipathy towards her children and complained about overwhelming fatigue, both physical and mental, resulting from her caring responsibility as a mother and a housewife.

The selected case histories show that the origin of postnatal depression did not lie solely in childbirth and childcare. Rather, the disorder disturbing these patients was precipitated by a compound of mothering experiences and other everyday hardships: notably financial difficulties and matrimonial problems. A large number of the postnatal cases were considered as related to economic distress not only by the patients themselves but also by their family members. A case of a 21-year-old mother provides a representative and explicit example. While working as a domestic servant, Mrs MR had gone through an unwanted pregnancy and following unexpected marriage, which made her lose financial independence. What was worse, her husband fell out of employment after marriage, pushing the household to the edge of financial crisis. In her case note, lay causal attribution of the husband was recorded minutely, who was regarded as a 'very intelligent and reliable' informant by the medical officers at the Maudsley. According to the informant, the patient had to face multiple hardships in her daily life: the newly born baby's waywardness, the deprivation of sound and

⁸⁴ Maudsley Hospital, Patient Casenotes, BRHAM CFM-151, Case No. 3941.

⁸⁵ Holloway Sanatorium, Case Book: Females [Volume 25], SHC Ac. 3473/3/15, No. 4510.

refreshing sleep, mental and physical fatigue and exhaustion and above all, the aggravating economic condition of the household, all of which the husband believed contributed to her mental breakdown.⁸⁶

Although not as often as economic concerns, matrimonial problems were frequently blamed as an aetiological factor, in tandem with childbirth and childrearing. While describing the onset and course of depressive disorder, some patients revealed coldness towards their husbands or expressed discontent at married life, implying that such experience had worked as one of the main sources of ‘prolonged stress’ and therefore exerted a harmful influence on their mental health.⁸⁷ One such case from Holloway provides a good example. Following her own narrative, Mrs AJR, a 24-year-old housewife, became depressed and delirious six weeks after giving birth to her first child and suffered from repeated mental breakdowns. Eventually she tried to kill herself by overdosing, which was immediately followed by admission to the Sanatorium. While agonising over her indifference to her child, Mrs AJR admitted to her dislike for her husband and, moreover, ‘a great admiration’ for another man. Quoting her own words, she was not happy in her marriage because she ‘had very little in common with (her) husband’ and became distressed at the idea of facing married life with him. When she was advised to leave the institution as recovered, she resolutely refused to return to her family and chose to remain as a voluntary boarder at Holloway where she had ‘felt very happy’.⁸⁸

In postpartum depression cases, we have seen that the most common attribution was a combination of childbirth and financial hardship. It is closely related to the fact that postnatal

⁸⁶ Maudsley Hospital, Patient Casenotes, BRHAM CFM-151, Case No. 3900.

⁸⁷ It will be discussed in more detail in the next section about matrimonial problems and their influence on women’s mental health.

⁸⁸ Holloway Sanatorium, Case Book: Females [Volume 27], SHC Ac 3473/3/17, No. 4842.

depression was more prevalent among working-class women than among middle- and upper-class mothers, and provides clues in explaining why such a phenomenon emerged. As indicated above, the number of those experiencing depression following childbirth at Holloway was lower than at the Maudsley where the patients' social composition was relatively mixed. Of the Maudsley patients who had their first attack of depression after giving birth, all were working-class,⁸⁹ reminding us of the finding of Hilary Marland who has noted that 'the vast majority of women diagnosed with puerperal insanity were poor'.⁹⁰ Among them, furthermore, no patient seemed to be free from economic distress. Mrs MR was overly concerned about the unemployment of her husband;⁹¹ and Mrs LJB discharged herself, against the advice of the Maudsley doctors, because, according to the patient herself, her family could not afford the medical expenses.⁹² The case of Mrs SBY is noteworthy in providing an unusual yet certainly indicative picture of working-class women and households.⁹³ She found that her symptoms, including feeling ill and sad, losing interest in

⁸⁹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-067, Case No. 2541/5576; BRHAM CFM-151, Case No. 3941; BRHAM CFM-151, Case No. 3900.

⁹⁰ Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Basingstoke: Palgrave Macmillan, 2004), p. 142.

⁹¹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-151, Case No. 3900.

⁹² Maudsley Hospital, Patient Casenotes, BRHAM CFM-151, Case No. 3941.

⁹³ Mrs SBY, married, aged 24, visited the Maudsley on 2 April 1931 as an out-patient due to depression, but showed little improvement against the examiner's expectation that her prognosis would be good. She was admitted on 1 August 1931, 4 months after her first visit to the Maudsley. She had worked as saleslady after leaving school at 14 until getting married. In January 1931, she gave a birth to her second child. Early in April after missing her period, she felt ill and sad, about which she later recalled '(I) thought I must be pregnant again, I was positive'. The patient could neither feel interest in anything, nor cope with her housework any more. In particular, she could not endure 'when the baby shouts, Mum, Mum, Mum'. At the Maudsley, she mostly stayed depressed and numb, cried very often, slept and ate only poorly. In following sessions, she complained that the 'baby irritated her by crying' and admitted that 'she would not stand another baby so soon.' Fortunately she recovered quickly enough to be discharged within a month. Maudsley Hospital, Patient Casenotes, BRHAM CFM-067, Case No. 2541/5576.

everything, getting 'irritated' by her children and failing to cope with them, began when she came to be sure about another pregnancy. Before her admission to the Maudsley she had holidays on her own for convalescence, but on returning home her condition was exacerbated. According to the patient, she then 'felt that load came on again, the babies, all that housework, and the worry (about getting pregnant)'. Although she seemed to worry over pregnancy, what actually concerned her was not childbirth itself but various responsibilities accompanied by it, notably material ones, that she had to endure as a mother and homemaker, two main roles constituting womanhood in this life stage.

Cases of depression occurring after childbirth provide insights into how we can understand the clinical condition in the early twentieth century and the progress of psychiatry in those years. In many points the descriptions and analyses of the case files are very similar to those of 'puerperal insanity'. Puerperal insanity is 'very much a disorder that belonged to the nineteenth century in terms of its medical and social setting,' which existed from the 1820s and prevailed as a discrete mental disorder throughout the century.⁹⁴ However, its separate status was questioned even from its height in the 1860s, and the diagnostic term finally disappeared from this field around the turn of the century. Emil Kraepelin who established the foundation of twentieth-century psychiatric nosology, too, was involved in the prolonged dispute over the status of puerperal insanity. The psychiatrist refused to see any causal relationship between insanity and childbearing, and claimed that puerperal psychosis, as a clinical entity, did not exist.⁹⁵ After Kraepelin, puerperal insanity was excluded from all the official disease classification methods, and remained a good example of 'the power of

⁹⁴ Marland, *Dangerous Motherhood*, pp. 4, 29-31.

⁹⁵ Ibid, pp. 203-209; Irvine Loudon, 'Puerperal Insanity in the Nineteenth Century', *Journal of the Royal Society of Medicine*, 81:2 (1988), pp. 76-79.

nosology to consign a disease to oblivion'.⁹⁶

However, materials collected for this research prove that the notion of puerperal insanity was not only still valid during the interwar years, even though the terminology had been dismissed, but also was popularised in lay understanding of the disorder. Expert literature produced in the early twentieth century gives an impression that the notion was definitely out of date: major psychiatric textbooks rarely mentioned puerperal insanity or puerperal melancholia as a discrete mental illness; in professional journals, the diagnostic term was no longer favoured. Taking the *Lancet* as an example, the number of articles employing the term 'puerperal insanity' increased throughout the second half of the nineteenth century, reached its peak in the first decade of the twentieth century, and then dropped suddenly and drastically. The *Journal of Mental Science* revealed the same pattern, as seen below.

[Table 7] Number of Articles Applying 'Puerperal Insanity' as a Diagnostic Term in the *Lancet* and in the *Journal of Mental Science*⁹⁷

Years	<i>Lancet</i>	<i>Journal of Mental Science</i>
1850-1860	5	3
1860-1870	5	13

⁹⁶ Loudon, 'Puerperal Insanity in the Nineteenth Century', p. 76.

⁹⁷ Source: <https://www.thelancet.com/search/advanced?searchType=advanced>;
<https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/>

1870-1880	7	22
1880-1890	18	25
1890-1900	20	51
1900-1910	36	58
1910-1920	10	19
1920-1930	20	10
1930-1940	14	15

By the interwar period, the terminology lost its authority within the medical profession, and it was not applied in any title even once for the next two decades. In psychiatric practice, too, the term was rarely applied during the interwar years. Viewing the official documents of the Maudsley Hospital and Holloway Sanatorium, it is extremely hard to find any case reference to ‘puerperal insanity’. Even in the case notes of those who suffered from depression following pregnancy and delivery, the phrase was seldom employed.⁹⁸ However, the unwillingness to use the term in both institutions did not mean that the medical staff refused to differentiate the postnatal cases from other cases of depression. Although they did not apply the terminology, the psychiatrists still marked, in a variety of ways, that those cases had relevance to pregnancy, confinement, delivery, childbirth, or ‘lactational period’, and treated

⁹⁸ Among the samples collected, the term was applied only once in the case of Mrs WBB who was admitted to Holloway Sanatorium in July 1920. In her Medical Register, the principal aetiological factor was identified as ‘puerperal state’, whereas in her case note the supposed cause was found ‘following confinement’. Holloway Sanatorium, Medical Register: Females, SHC Ac. 3473/3/48; Case Book: Females [Volume 26], SHC Ac. 3473/3/16, No. 4551.

these cases accordingly.⁹⁹ In practice, psychiatrists of the interwar period did not differ fundamentally from nineteenth-century alienists in terms of the way they understood postnatal depression.

Furthermore, a large part of the descriptions provided by these patients corresponded to the language used in the previous century. The common lay attribution in locating the principal cause of depression following pregnancy or childbirth was closely related to the fear that the process of reproduction could be dangerous and sometimes life-threatening and that it could heighten female vulnerability to mental and physical illness. As illustrated, it was during the Victorian era that such perceptions had grown and influenced both medical circles and the general public. The symptom descriptions also reveal that their experiences of depression differed little from their nineteenth-century counterparts: various physical complaints, emotional lowness or turbulence, hypochondriacal ideas, suicidal propensity and delusions particularly centred on the newborn. These case notes demonstrate that, although the term ‘puerperal insanity’ went out of use, the concept remained valid, still in use in daily life. Furthermore, the persistence of ideas within Victorian psychiatry not only lingered on in strength in medical practice, but also moved into the popular sphere to shape the general public’s understanding of mental health and illness well into the interwar years.

Financial Hardships and Economic Concerns

As seen from some of the aforementioned postnatal cases, female patients in both institutions

⁹⁹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-151, Case No. 3941.

often mentioned financial hardship, and related it to their experience of mental illness. Patients and their relatives often attributed insanity to economic distress, as Akihito Suzuki has illustrated in his study of patients of Middlesex County Asylum at Hanwell in the mid-nineteenth century. A considerable number of working-class men, according to Suzuki, suffered from ‘intense fear of poverty and deep anxiety about their economic future’, which the patients and their families believed drove them mad. His work has successfully demonstrated the link between mental disease experienced by Victorian working-class men and the social pressures put upon them, such as respectability, independence and manhood.¹⁰⁰ Marland’s study on nineteenth-century puerperal insanity quoted earlier in this chapter concludes that poverty and anxiety about it was often associated with female mental illness by doctors.¹⁰¹ Marjorie Levin-Clark has demonstrated that female patients in a county asylum, as well as medical practitioners, frequently associated their mental illness with their economic situation, notably ‘a lack of work’, in Victorian England.¹⁰² In the sample cases under study here, similar narratives, concerns and attributions are noticeable.

At the Maudsley Hospital and Holloway Sanatorium, the number of patients imputing their mental illness to material hardships differed considerably, and so did the composition of those patients. In the Maudsley cases, worry over financial difficulties was the most common cause of mental depression of female patients aged between 25 and 45. If cases in which multiple aetiological factors were mentioned are also included, then at least six out of the

¹⁰⁰ Akihito Suzuki, ‘Lunacy and Labouring Men: Narratives of Male Vulnerability in Mid-Victorian London’, in Roberta Bivins and John V. Pickstone (eds.), *Medicine, Madness and Social History* (Basingstoke: Palgrave Macmillan, 2007), pp. 118-128.

¹⁰¹ Marland, *Dangerous Motherhood*, pp. 142-143.

¹⁰² Marjorie Levin-Clark, ‘“Embarrassed Circumstances”: Gender, Poverty, and Insanity in the West Riding of England in the Early-Victorian Years’, in Andrews and Digby (eds.), *Sex and Seclusion, Class and Custody*, pp. 123-148.

sample of 22 fall into this group. More specifically, among them, four women were from working-class backgrounds, all troubled by unemployment of main wage-earners.

Psychiatrists at the Maudsley seemed to sympathise with the apprehension of these patients and agreed to the lay attributions, as in most of these cases they found supposed causes from ‘prolonged stress’ or ‘worry’.¹⁰³ At Holloway, however, only a few patients related financial distress to their mental condition and, more importantly, most of them were single.¹⁰⁴ Even though there were many patients suffering from delusional ideas about destitution, especially common in the middle- and old-aged patient groups, such cases were related more to anxiety rather than the real experience of poverty.

Mrs LBB’s case is representative of married women suffering from financial hardships. This 39-year-old housewife was admitted to the Maudsley in 1927, due to mood depression, anxiety, migraine, inability to manage her baby and loss of memory for recent events. According to Mrs LBB, both she and her husband had been ‘under much financial stress’ for most of their marriage. She also clarified that the current attack had begun 6 months previously, coinciding with her husband’s ‘lack of employment’. Her case notes are filled with the details of her husband’s employment and unemployment and his income and expenses.¹⁰⁵ In many ways, it can be read as a case of typical working-class married women who were responsible for household management but distressed by lack of economic resources due to their husbands’ being out of work.

¹⁰³ Maudsley Hospital, Patient Casenotes, BRHAM CFM-003, Case No. 0740/1479; BRHAM CFM-031, Case No. 1396/2709; BRHAM CFM-031, Case No. 3189.

¹⁰⁴ However, in this mental hospital for middle-class patients, there were a large number of boarders suffering from delusional ideas about destitution and poverty, which was much more prevalent among older patient group and, therefore, will be discussed in the next chapter.

¹⁰⁵ Maudsley Hospital, Patient Casenotes, BRHAM CFM-031, Case No. 1396/2709.

Single middle-class women whose cases were attributable to their economic difficulties, although outnumbered by their married counterparts, shared some distinctive features besides their social class and marital status: employment instability, ensuing financial uncertainty, social prejudice against single women, and, as the result of them, prolonged mental stress and nervous breakdown. An exemplary case of the ‘spinster’ is provided by Miss LBS, a 37-year-old shorthand typist.¹⁰⁶ On admission to the Maudsley, she suffered from various symptoms: she could neither concentrate nor work properly; she felt miserable, depressed and anxious; the blood rushed up to her head; and she felt that her whole body was twisted. When asked about the onset of her current illness, the patient dated it from her dismissal from work, from when she had ‘never been the same’.¹⁰⁷ She also expressed her concern about her own competency in her profession and strict attitude towards her life, stating that ‘I am afraid of not being my best’ and that ‘I have not made the most of it (life)’.¹⁰⁸

The case of Miss LBS can be understood as representative of middle-class ‘spinsters’ in many aspects. More than anything, Miss LBS’s occupation, as a shorthand typist, typified middle-class female work during the interwar years, which also included teaching and nursing. Although this profession was opened up for some fortunate working-class girls, mostly with better education, and had various grades as regards pay, status and working condition, it was still considered a desirable occupation for middle-class women.¹⁰⁹ Despite

¹⁰⁶ Davy, ‘Women Shorthand Typists in London, 1900-39’, pp. 124-144.

¹⁰⁷ However, she did not ascribe her depression solely to the unemployment. She added some other contributory factors: nursing her younger sister, who was single too, which she found ‘physically’ very exhausting; and intense guilt feeling about masturbation which was believed to have ruined her body and soul.

¹⁰⁸ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 3643.

¹⁰⁹ Davy, ‘Women Shorthand Typists in London, 1900-39’, pp. 126-127.

such respectability and desirability, however, female shorthand typists were never exempt from various disadvantages experienced by working women. Because of the feminisation of the profession in the late nineteenth and the early twentieth centuries wages fell to 60 to 80 percent compared with men in comparable positions.¹¹⁰ They had to choose between marriage and work due to formal and informal marriage bars; their career was not taken seriously, but seen as ‘a stop-gap between school and marriage’. They only had limited promotional opportunities, which were restricted to similar forms of work.¹¹¹ Furthermore, single women with paid jobs were considered as competitors with, or a threat to, men returning from the Great War. This hostile atmosphere was to worsen in the context of high male unemployment throughout the interwar decades.¹¹² This was precisely Miss LBS’s predicament, as she had been fired from her long-held position in 1923, at a time when women were packed back to their place in the home.¹¹³ According to the patient, her dismissal directly and deeply affected both her mental health and financial status, as she was responsible for the livelihood not only of herself but also of her family.

Miss LBS’s case also demonstrates what a job meant to middle-class ‘spinsters’ in the interwar years, when single women had to endure various kinds of prejudice related to their marital status. As acknowledged, there existed some ‘central characteristics associated with spinsterhood,’ mostly negative, and unmarried women were under greater pressure than

¹¹⁰ Holden, *The Shadow of Marriage: Singleness in England*, p. 40; Guerriero R. Wilson, ‘Women’s Work in Offices and the Preservation of Men’s “Breadwinning” Jobs in Early Twentieth-Century Glasgow’, *Women’s History Review*, 10:3 (2001), pp. 463-482.

¹¹¹ Holden, *The Shadow of Marriage: Singleness in England*, p. 40.

¹¹² *Ibid.*, pp. 38-40.

¹¹³ Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (London: Virago, 1987), pp. 195-197.

unmarried men.¹¹⁴ The Great War struck a blow to the structure of the British population, eliminating a whole generation of young men and therefore depriving young women of potential husbands. Those who remained single due to lack of male counterparts were often treated as ‘surplus women’, the notion of which went back to the mid-nineteenth century,¹¹⁵ or they were viewed as ‘imaginary widows bereaved by the War.’¹¹⁶ The demographic catastrophe did not affect every class to the same extent. A higher casualty rate among officers meant that women from the same social backgrounds were more troubled by the gender ratio discrepancy.¹¹⁷ Middle-class girls attending secondary or higher education were alerted to the shortage of future husbands, and prompted to make a choice between the two incompatible options, marriage or career. For some middle-class spinsters of a certain age, thus, a ‘professional identity’ became an essential alternative to marriage.¹¹⁸ It helps us understand why Miss LBS could not overcome the stress following her dismissal. The frustration she felt was directly related to this wider identity crisis. Such an explanation can also be applied to another Maudsley patient, Miss ED, single and aged 44. She had worked as a teacher, another typical middle-class female occupation, since the age of nineteen, and found the mental stress related to the job and the relationships at work the main cause of her disorder.¹¹⁹ In these cases, it appears that a career was central to the patients’ life, and

¹¹⁴ Ibid., pp. 4-9.

¹¹⁵ Judith Worsnop, ‘A Reevaluation of “the Problem of Surplus Women” in Nineteenth-Century England: The Case of the 1851 Census’, *Women's Studies International Forum*, 13:1/2 (1990), pp. 21-31.

¹¹⁶ Katherine Holden, ‘Imaginary Widows: Spinsters, Marriage, and the “Lost Generation” in Britain after the Great War’, *Journal of Family History*, 30:4 (2005), pp. 388-409.

¹¹⁷ Holden, *The Shadow of Marriage: Singleness in England*, p. 29.

¹¹⁸ Ibid., pp. 38-41.

¹¹⁹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-031, Case No. 1438/2792. According to her detailed description in the case history, the onset of depression coincided with her trouble with the school headmistress, with whom the patient had ‘a very close friendship’ for a long time. She also

therefore any problem they had at work affected their whole life, including their mental health.

However, this context did not apply to the majority of Holloway's single female patients, who were identified as being of 'independent means'.¹²⁰ Among the certified female patients admitted to the Sanatorium in the 1920s, thirteen in total, seven were unmarried. Only two patients among them had occupations recorded in either case notes or Medical Registers: one was a lady companion and the other a civil servant.¹²¹ Considering that at least three quarters of Holloway patients hospitalised in the decade were identified as of 'independent means', it is reasonable to assume that the rest of the patients with no profession recorded, seven in total, also fell into this occupation group. We cannot expect that they experienced what single women with occupations went through, including financial difficulties, responsibility to support family, and discrimination at work. In this context, we need to reconsider female 'spinsterhood' or 'singleness' in the interwar decades. Catherine Holden has found that 'the necessity of establishing a professional identity as an alternative to marriage was important for this generation of (middle- and upper-class) women'.¹²² The claim seems to be definitely applicable to the aforementioned cases of Miss LBS and Miss ED, but not to the Holloway patients with financial support but without occupations. It means that we cannot postulate a homogeneous group of unmarried middle-class women, and we need to take note of various forms of singleness and various strata in the middle class, in

admitted that she had never liked her job and that it had always been stressful to her.

¹²⁰ Holloway Sanatorium, Annual Report for the Year 1923, No. 38, SHC Ac. 2620/1/8; Annual Report for the Year 1927, No. 42, SHC Ac. 2620/1/9.

¹²¹ Holloway, Case Books: Females [Volume 25], SHC Ac 3473/3/15, No. 4510; Case Books: Females [Volume 27], SHC Ac 3473/3/17, No. 4863.

¹²² Holden, *The Shadow of Marriage: Singleness in England*, pp. 38-39.

order to understand spinsterhood in the interwar period, one of the crucial characteristics of society at the time.

Matrimonial Difficulties

Matrimonial problems, notably marital discord, were one of the common themes reiterated in female patients' narratives and were often blamed as the origin or trigger of their mental breakdown. Although the detailed attribution in each case varies significantly, some patterns can still be found. The most noticeable feature was that the great majority of those relating depression to their matrimonial difficulties were middle-class housewives. They rarely found marital troubles as the sole cause of their mental disorder, but saw them as one of the multiple factors working in combination. One Holloway case perfectly demonstrates such features: Mrs AJR, a 24-year-old housewife from a middle-class background, was admitted to the Sanatorium due to mood depression and suicidal impulse, which began after giving birth to her first child. The medical staff of Holloway found the 'supposed cause' of this case from 'birth of child' and recognised her case as a postnatal one, probably due to the six-week time lag between the confinement and onset of her current attack. However, the patient herself kept expressing a deep dissatisfaction with her husband and their relationship, saying that she was not happy because she 'had very little in common' with him. Furthermore, she finally confessed to an antipathy towards her husband and a strong feeling for another man, which she believed 'corrupted' her mental condition.¹²³

¹²³ Holloway Sanatorium, Case Book: Females [Volume 27], SHC Ac. 3473/3/17, No. 4842.

The complaints of Mrs AJR mirrored crucial contemporary changes in the attitude towards marriage. During the first half of the twentieth century, romantic love crept into marriage, particularly middle-class one. Women's sexual pleasure within marriage was increasingly regarded as significant, and it consequentially raised expectations on the marital relationship. Notably, through *Married Love*, originally published in 1918, Marie Stopes claimed that passion should be part of marriage. Her 'path-breaking marriage advice manual' exerted a stronger influence on women with middle-class backgrounds than on those from lower classes.¹²⁴ The author herself claimed that her guidance was primarily for 'our educated classes'.¹²⁵ Besides the emphasis on sexual satisfaction, the interwar years witnessed heightened expectation about marital intimacy and spousal roles in middle-class marriage.¹²⁶ Now, middle-class wives who remained unsatisfied, either emotionally or sexually, by their husbands came to feel more frustrated than their forbears from the same social background, as well as than their contemporary working-class fellows.

However, such changes did not seem to exert the same degree of influence upon those from different social and economic classes. As Elizabeth Roberts and Jane Lewis have found, for working-class women (and men), well into the interwar decades marriage was still largely about building up a life-long partnership based on a gendered division of labour, between male breadwinner and female household manager.¹²⁷ Such a 'practical and unromantic view'

¹²⁴ Lesley A. Hall, 'Sexuality', in Zweiniger-Bargielowska (ed.), *Women in Twentieth-Century Britain*, pp. 55-58; Ellen M. Holtzman, 'The Pursuit of Married Love: Women's Attitudes toward Sexuality and Marriage in Great Britain, 1918-1939', *Journal of Social History*, 16:2 (1982), pp. 39-51.

¹²⁵ Judy Giles, *Women, Identity and Private Life in Britain, 1900-50* (Basingstoke: Macmillan, 1995), p. 97.

¹²⁶ Marcus Collins, *Modern Love: An Intimate History of Men and Women in Twentieth-Century Britain* (London: Atlantic, 2001), pp. 76-77.

¹²⁷ Lewis, 'Marriage', pp. 76-77.

on marriage held by the working class led to the tolerance of lack of sentiment or affection within marriage.¹²⁸ Accordingly, working-class wives had relatively low expectations and demands on their husbands, with regard to emotional support and sexual satisfaction.¹²⁹ This might explain why class differences existed in relation to lay causal attributions in the postnatal depression cases mentioned earlier. Some middle-class patients saw that childbirth and conjugal unhappiness acted in combination to cause their mental disorder, as seen from Mrs AJR's case, while the majority of working-class women imputed mental depression to financial hardships or unemployment. It seems that what Marcus Collins calls 'modern love' in marriage, firmly based on mutuality in companionship and sexual pleasure, had begun to influence middle-class couples by the interwar decades, but had not reached the lower classes.¹³⁰

In the sample cases, what we usually think of as causing matrimonial problems, such as a husband's rampage and domestic violence, was rarely mentioned by married patients. Traditionally, troublesome husbands, notably 'drunks, womanisers, and bullies,' were often considered as 'the root cause' of the mental illness of wives by both patients and doctors, as illustrated in Marland's work on nineteenth-century puerperal insanity.¹³¹ In such cases, a patient's condition was expected to improve only by removing her from the domestic circumstances, confirming the cause of the ailment. However, what married patients of the Maudsley and Holloway experienced in the early twentieth century appear considerably far

¹²⁸ Roberts, *A Woman's Place*, pp. 82-83.

¹²⁹ Collins, *Modern love*, pp. 101-102.

¹³⁰ *Ibid.*, pp. 1-5: Collins defines 'mutuality' as an intimate equality established between men and women through companionate marriage and sexual pleasure following Edward Carpenter, a utopian socialist in the late nineteenth century, and sees the concept as a crucial component of modernity in twentieth-century Britain as well as a counterpart to the Victorian stereotype of prudery.

¹³¹ Marland, *Dangerous Motherhood*, pp. 160-163.

from the stereotypical descriptions. In the samples under study, no husband was accused of heavy drinking, beating, swearing, or cheating. In the aforementioned case of Mrs AJR, the patient did not see the marital difficulties as resulting from any wrong-doing of the husband.¹³²

Of course, the fact that no case in this study involved domestic violence and abuse does not mean that such tragedies were not experienced by married women in the interwar decades. The reason that only few cases were related to conventional and typical matrimonial problems can be deduced from the characteristics of both institutions and the class of their patients: traditional middle class at Holloway Sanatorium and lower middle class and respectable working class at the Maudsley Hospital. If we avert our eyes to county asylums for rate-aided patients, the situation might well have been different: the lower a patient's social background, the higher the chance that brutality was involved. As we can see through the letters of working-class mothers, well into the early twentieth century domestic violence, abuse and neglect were not unusual in their families: a brutal man 'fought his poor wife' who was in the last month of pregnancy 'as if she were another man'; a husband 'used to lose his work through drink'; and another did not work at all for the much of the time.¹³³ What ordinary working-class girls recalled about their daily life in interwar London did not differ much. Domestic violence was ubiquitous in most overcrowded neighbourhoods, and so were poverty and drinking problems.¹³⁴

¹³² Holloway Sanatorium, Case Book: Females [Volume 27], SHC Ac. 3473/3/17, No. 4842.

¹³³ Margaret Llewelyn Davis (ed.), *Maternity: Letters from Working Women* (London: Virago, 1978), p. 91, 113-114.

¹³⁴ Sally Alexander, *Becoming a Woman and Other Essays in Nineteenth and Twentieth Century Feminist Histories* (London: Virago, 1994), pp. 218-219.

Sexuality in Adulthood

Diverse themes related to sexuality were pointed out as a cause or trigger of mental depression, and more often as grounds for self-reproach, including unhappy relationships, love affairs, various sexual behaviours and even venereal disease. These cases reveal the close connection between women's sexuality and their mental health, especially among patients who were in their adulthood and therefore were more actively engaged in sexual activity, compared to their younger and older counterparts. At the same time, as proved in the previous chapter, these cases provide astonishingly vivid pictures of female sexuality in the early twentieth century, as well as demonstrating that medical records can be a wonderful historical source for research on sexuality, a subject which suffers from the chronic problem of securing evidence.¹³⁵

Among varied sexuality-related issues, unhappy and sometimes inappropriate relationships were frequently mentioned in female patients' narratives concerning their experience of depression, as either what directly caused their mental disturbance or what was circumstantially related to its onset. It is not difficult to find cases where single women were heartbroken by philanderers, liars and married men, or where married women had extramarital affairs and subsequently suffered from deep self-reproach. Among those admitted to Holloway as certified patients during the 1920s, thirteen in total, three pointed to

¹³⁵ Simon Szreter and Kate Fisher, *Sex before the Sexual Revolution: Intimate Life in England 1918–1963* (Cambridge: Cambridge University Press, 2010), pp. 1-2; Paul Ferris, *Sex and the British: A Twentieth-Century History* (London: Michael Joseph, 1993), pp. 1-2.

a ‘love affair’ as a cause or trigger of their mental illness, although not all were corroborated by the medical staff. Miss LKD, for instance, claimed that the end of her relationship with a man was responsible for her mental breakdown shortly afterwards, whereas her doctors blamed her own ‘eccentricity’.¹³⁶ In another case of Miss RE, the patient’s father who had been actively involved in collecting her case history attributed her current situation to the insincere man who had broken off their engagement.¹³⁷ In the case file it appears obvious that the patient’s father took the initiative and the medical practitioners at Holloway added only a little to his account. Thus, this case provides a good example of how and to what extent a mental patient’s relative could exert influence on the whole process of medical decision-making, notably when deciding on confinement or taking individual and family history.¹³⁸ At the Maudsley, a middle-class housewife mentioned an extramarital love affair

¹³⁶ Holloway Sanatorium, Case Book: Females [Volume 25], SHC Ac. 3473/3/15, No. 4510.

¹³⁷ Holloway Sanatorium, Case Book: Females [Volume 26], SHC Ac. 3473/3/16, No. 4703.

¹³⁸ The influences of gender, family and social class on admission, treatment and discharge of mental patients have been the subject of long debate amongst medical and psychiatric historians. For more information on the involvement of patients’ families in the medical decision-making process, see J. K. Walton, ‘Casting Out and Bringing Back in Victorian England: Pauper Lunatics 1840–1870’, in W. F. Bynum, Roy Porter and Michael Shepherd (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry, Vol. II* (London: Tavistock, 1985), pp. 132–146; Richard Adair, Joseph Melling and Bill Forsythe, ‘Migration, Family Structure and Pauper Lunacy in Victorian England: Admissions to Devon County Pauper Lunatic Asylum, 1845–1900’, *Continuity and Change*, 12:3 (1997), pp. 373–401; David Wright, ‘The Discharge of Pauper Lunatics from County Asylums in mid-Victorian England: the Case of Buckinghamshire, 1853–1872’, in Joseph Melling and Bill Forsythe (eds.), *Insanity, Institutions and Society, 1800–1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999), pp. 93–112; David Wright, James Moran and Sean Gouglas, ‘The confinement of the insane in Victorian Canada: the Hamilton and Toronto asylums, c. 1861–1891’, in Roy Porter and David Wright (eds.), *The Confinement of the Insane: International Perspectives, 1800–1965* (Cambridge: Cambridge University Press, 2003), pp. 100–128; David Pearce, ‘Family, Gender and Class in Psychiatric Patient Care during the 1930s: The 1930 Mental Treatment Act and the Devon Mental Hospital’, in Pamela Dale and Joseph Melling (eds.), *Mental Illness and Learning Disability since 1850: Finding a Place for Mental Disorder in the United Kingdom* (London: Routledge, 2006), pp. 112–130.

of a 'platonic nature', its associated incidents, and a strong sense of guilt resulting from them, as the origin of her depression. However, the Maudsley medical staff seemed not to have agreed with her attribution, leaving the space for supposed cause blank.¹³⁹

Adult patients were troubled with masturbation and self-reproach resulting from the habit, as adolescent patients studied in the previous chapter were. However, the number of those suffering from a sense of guilt was less than that of younger patients, and most of them were single. Although Lewis of the Maudsley Hospital found that masturbation was a chief topic of self-accusation amongst male patients, whereas pre- and extra-marital intercourse was the main concern of females, such a division was not evident in practice.¹⁴⁰ In this sense, Miss LSC at Holloway Sanatorium provides an exemplary case. This patient, single and aged in her mid-forties, was hospitalised due to serious melancholia accompanying delusion, immediately after a failed suicidal attempt by hanging. The patient was certain that her 'guilty conscience' concerning masturbation brought about her depression and delusion, contrary to the psychiatrists at Holloway who found no specific supposed cause from her case history. She added that she had taken 'a considerable quantity of alcohol regularly', which she thought could also have affected her condition.¹⁴¹

The fact that many single patients related their mental illness to their sexual activities, notably extramarital relationships and masturbation, raises the necessity of delving into the sexuality of 'spinsters', and in particular those from middle-class backgrounds. In the context of interwar Britain, the single, in principal both male and female, were considered as 'a

¹³⁹ Maudsley Hospital, Patient Case Files, BRHAM CFM-150, Case No. 4212.

¹⁴⁰ Lewis, 'Melancholia: A Clinical Survey of Depressive States', p. 315.

¹⁴¹ Holloway Sanatorium, Case Book: Females [Volume 25], SHC Ac. 3473/3/15, No. 4519.

problematic category' and faced numerous prejudices against them, including those related to sexuality.¹⁴² Unmarried women, as a result, encountered double difficulties of being single and being female. They were also the victims of a distorted image of them, that is, the idea that they were 'imaginary widows bereaved by the War'.¹⁴³ In a social environment which emphasised the desirability of heterosexuality, ideally within marriage, single women were often regarded as suffering from sexual deprivation, frustration or perversion. Newly emerging disciplines, notably sexology and 'new' psychology, took the initiative in pathologising spinsters and spinsterhood in the name of science.¹⁴⁴ Celibacy was deemed harmful for women's health, both physically and psychologically. For instance, Stopes took note of problems experienced only by women who had 'never had any normal sex-life or allowed any relief to their desires', such as nerves and sleeplessness, in her prominent work *Married Love*.¹⁴⁵ These factors marginalised spinsters and labelled their sexuality as aberrant.

Professional warnings of the danger of singleness were often followed by solutions, as seen from various advice books. However, the solutions had obvious limitations, because they could not solve the fundamental problem underlying this phenomenon, the gender imbalance and the still powerful social convention that marriage was 'the only safe container' for sexuality of both sexes.¹⁴⁶ Nonetheless, the sexual instinct of the unmarried, which had no 'normal outlets', had to be controlled. Hence, advice books, mostly published in the late

¹⁴² Katherine Holden, "'Nature Takes No Notice of Morality": Singleness and *Married Love* in Interwar Britain', *Women's History Review*, 11:3 (2002), p. 481.

¹⁴³ Holden, *The Shadow of Marriage: Singleness in England*, p. 29.

¹⁴⁴ Penny Tinkler, 'Women and Popular Literature', in Purvis (ed.), *Women's History: Britain, 1850-1945*, pp. 146-147.

¹⁴⁵ Holden, *The Shadow of Marriage: Singleness in England*, pp. 84-89.

¹⁴⁶ Holden, 'Singleness and *Married Love* in Interwar Britain', p. 483.

1920s, offered a wide range of cursory recommendations, including masturbation, heterosexual relationships, sublimation and same-sex relationships (or friendships), none of which were uncontentious though.¹⁴⁷ Professional advice on masturbation, for example, advocated the behaviour as a proper sexual manifestation for the single ‘having reached a certain age’. Stopes claimed that masturbation could sometimes be beneficial for ‘women over thirty with no other sexual outlet’, but only if they understood the accompanying risk and they should keep the practice to ‘less than twice a month’.¹⁴⁸ Laura Hutton, a clinical psychologist at the Tavistock Clinic, asserted that masturbation could provide single women with ‘the best possible occasional solution for the problem of the relief of psychosexual tension’ unless it was followed by ‘feelings of guilt or failure’.¹⁴⁹ Notwithstanding the professional justification and approval of masturbation, as we have seen from the case files in this study, many single women who engaged in the habit suffered from a sense of guilt and self-reproach resulting from it. It is doubtful therefore that such practical and professional advice had much effect.

Even in cases where issues of female sexuality were not blamed as a cause or a trigger of mental illness, various subjects related to it were frequently mentioned. As a result we are informed about the manifestation of sexuality and how it affected women and their lives during this period. The case notes of both hospitals reveal that sexual intercourse before or outside marriage was not uncommon in the interwar decades, particularly among courting couples. This finding refutes much historical research on the subject that assumes until the

¹⁴⁷ Holden, *The Shadow of Marriage: Singleness in England*, pp. 89-105.

¹⁴⁸ *Ibid.*, pp. 90-92.

¹⁴⁹ *Ibid.* Despite her positive stance on the habit, she warned of the possibility that masturbation might disturb a woman from ‘getting full physical pleasure from a man’.

early twentieth century (or before the Sexual Revolution in the late 1960s), premarital sex was enjoyed only on the rare occasion and by a small number of people. Some emphasise the influence of English strictness about sexuality in preventing such improper behaviour.¹⁵⁰ Others refer to quantitative data that shows that the number of illegitimate births remained at a low level throughout the first half of the twentieth century, ranging between 4 and 5 percent,¹⁵¹ and argue that the figures prove both the rarity of extramarital sexual relations and the dominant morality of society. However, the picture which emerges from the collected case notes and narratives embedded in them is somewhat different from that suggested by these works. For example, Miss FD at Holloway Sanatorium, who attributed her mental disorder to a ruined relationship with a man, readily admitted to having sexual intercourse with him several times.¹⁵² Reading the Maudsley materials, over a third of married women conceded or implied that they had had premarital relations, higher than the aforementioned presumption. For instance, Mrs MBS had an eight-year courtship with her husband before marriage, and had engaged in sexual intercourse, as well as mutual masturbation, for the last two years of their engagement.¹⁵³ Such cases suggest that sex was most frequent between courting couples, especially ones with a long-standing relationship, corresponding to Lesley A. Hall's finding. However, the implication of this phenomenon is not obvious, as some historians regard it as a proof of 'interwar modernity', whereas others find an 'old pattern of sex within courtship'.¹⁵⁴

¹⁵⁰ Ross McKibbin, *Classes and Cultures: England 1918-1951* (Oxford: Oxford University Press, 2000) p. 296.

¹⁵¹ Lesley A. Hall, *Sex, Gender and Social Change in Britain Since 1880* (Basingstoke: Macmillan, 2000), p. 122; Roberts, *A Woman's Place*, p. 80.

¹⁵² Holloway Sanatorium, Case Book: Females [Volume 27], SHC Ac. 3473/3/17, No. 4863.

¹⁵³ Maudsley Hospital, Patient Casenotes, BRHAM CFM-068, pp. 112-139.

¹⁵⁴ Hall, *Sex, Gender and Social Change in Britain since 1880*, p. 122.

Premarital pregnancy can also be found from the case notes, although they are not as frequent as those of premarital sex. Premarital pregnancy generally met with shame, which according to women living in the interwar Britain was ‘the most usual attitude’ as well as ‘the worst part’ of the incident, and was often followed by marriage.¹⁵⁵ The case of Mrs MR at the Maudsley can be read as representative in this sense: she found herself pregnant during her courtship, which made her ‘gloomy and depressed’; and she married in a hurry immediately after her husband proposed. According to her husband, the main informant of this case, what later became known as a ‘shotgun marriage’ was seen as the only measure appropriate under the circumstances.¹⁵⁶ This was the most common solution for women who became pregnant out of wedlock, and occurred rather frequently. Around the time of the outbreak of the Second World War, official statistics claimed that almost 30 percent of mothers conceived their first babies before their marriage,¹⁵⁷ meaning that more than 30 percent of women were involved in premarital sex. This is why we cannot regard the low rate of illegitimate births as a reliable indication of the low frequency of extramarital sexual relationship.

Unwanted pregnancy and sudden marriage was not the worst thing that could happen, as a Maudsley case reveals. Miss IBH, a 28-year-old domestic worker, was hospitalised in 1931 after attempting suicide. Before her admission to the Maudsley, she had gone through a series of hardships. Following a close relationship with a married man she gave birth to an illegitimate child, and had to take the baby to an institution notwithstanding her best effort to

¹⁵⁵ Roberts, *A Woman's Place*, p. 79.

¹⁵⁶ Lewis, ‘Marriage’, pp. 74-75. The expression ‘shotgun wedding’ came into general use in the 1960s when with the coming of the sexual revolution, premarital sex and pregnancy increased drastically, and as a result, so did the number of sudden marriages.

¹⁵⁷ Hall, *Sex, Gender and Social Change in Britain since 1880*, p. 122.

sustain the boy by herself. Recalling when she sent her baby to an orphanage, she said, she did not cry at all '[although she] had a rich sort of feeling' for the boy. Thereafter she became depressed, miserable and careless about her work, and continually said that she was a 'failure.' After skipping her visit to the baby, she put her head in the stove with the gas turned on, and was found by her mistress. When she was transferred to the Maudsley from a general hospital where she had emergency treatment, she was diagnosed as suffering from depression.¹⁵⁸ The Maudsley medical staff found the root of her mental illness from the tragic personal history, noting 'leaving illegitimate child in institution' as a supposed cause.¹⁵⁹ Miss IBH was deeply sympathised with, rather than harshly judged, by both the medical professionals of the Hospital and her employers, who had given her work, cared for her and her condition, and organised her hospitalisation. Such an attitude is very similar to that of nineteenth-century asylum doctors who showed non-judgmental sympathy, rather than condemnation, towards female patients with illegitimate children and suffering from subsequent puerperal insanity.¹⁶⁰

The collected case notes, particularly of the Maudsley, provide crucial information about the practice of contraception during the interwar years. Although the data accumulated for this research is not enough to suggest any general conclusion, the medical documents and narratives embedded in them can enrich the ongoing discussion about lay attitudes towards birth control and common methods adopted. It is generally said that in the late nineteenth and the early twentieth centuries, 'the initial stages of fertility decline', traditional methods of

¹⁵⁸ Maudsley Hospital, Patient Casenotes, BRHAM CFM-068, Case No. 2519.

¹⁵⁹ Although not suggesting any strong opinion about the origin of mental illness, the patient began her case history at the point when she had met her baby's father, suggesting the source of her depression.

¹⁶⁰ Marland, *Dangerous Motherhood*, pp. 154-157.

contraception, notably withdrawal and abstinence, were dominant, whereas by the interwar years 'modern' appliances, such as condoms, pessaries and caps, were increasingly used. However, some historians, including Kate Fisher and Simon Szreter, argue that old methods, notably withdrawal, were certainly preferred to new ones, well into the mid-twentieth century.¹⁶¹ The Maudsley patients' accounts uncover the unembellished reality of contraception in the interwar decades. Contraception was extensively practiced by married couples, even from the very early stage of marriage. Among various contraceptive methods coitus interruptus was still used most frequently, despite fierce condemnation of contemporary birth-control campaigners stating that it was 'the most primitive and the most unreliable method in use'.¹⁶² 'Modern' techniques of birth control were in limited use, applied only by a few couples who had desperate reasons to avoid pregnancy;¹⁶³ and mostly it was not a wife but a husband who was in charge of this conjugal as well as sexual matter.¹⁶⁴ Such findings correspond to what Fisher has concluded from research on birth control in Britain largely based on oral history.¹⁶⁵ Moreover, the medical records demonstrate that even couples who were seriously concerned about limiting fertility were not actively taking up new commercial contraceptive techniques that were widely available by this period.¹⁶⁶ A

¹⁶¹ Kate Fisher, *Birth Control, Sex, and Marriage in Britain 1918-1960* (Oxford: Oxford University Press, 2006), pp. 109-110; Kate Fisher and Simon Szreter, "'They Prefer Withdrawal': The Choice of Birth Control in Britain, 1918-1950", *Journal of Interdisciplinary History*, 34:2 (2003), pp. 263-291.

¹⁶² Fisher and Szreter, 'The choice of birth control in Britain, 1918-1950', p. 270; Maudsley Hospital, Patient Casenotes, BRHAM CFM-003, Case No. F519/FW258; Patient Casenotes, BRHAM CFM-068, pp. 112-139.

¹⁶³ Maudsley Hospital, Patient Casenotes, BRHAM CFM-003, Case No. 676/1361.

¹⁶⁴ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 4212.

¹⁶⁵ Kate Fisher, 'Uncertain Aims and Tacit Negotiation: Birth Control Practices in Britain, 1925-50', *Population and Development Review*, 26:2 (2000), pp. 295-317; Fisher, *Birth Control, Sex, and Marriage in Britain 1918-1960*, pp. 109-110; Fisher and Szreter, 'The choice of birth control in Britain, 1918-1950', pp. 263-291.

¹⁶⁶ Maudsley Hospital, Patient Casenotes, BRHAM CFM-003, Case No. F519/FW258; Patient

good instance is the aforementioned case of Mrs SBY. In this case, even though the worry over another pregnancy was so severe as to push the patient into depression, according to her account she (and her husband) did not take any action to control her fertility beforehand, though they reported that they were anxious about another pregnancy. At the same time, this case reveals the carelessness of those who would have been expected to adopt family planning as promoted by contemporary birth control campaigners.¹⁶⁷ In this regard, Mrs SBR's case is exceptional. Admitted to the Maudsley in 1925 due to depression, she said that she had adopted several contraceptive methods, including condoms and douching, throughout her married life, for almost ten years. It was because of her great fear that she might have syphilitic children, as her husband had once contracted venereal disease.¹⁶⁸ In the sample group of female adult patients, only this case demonstrates an engagement with what we might call active and proper contraception, in terms both of attitude and practice. The couple had discussed reproduction, reached a consensus, applied practical and reliable methods, and adjusted their plan when needed, although this was due to the manifest danger of syphilis and its transmission to children. The evidence presented here supports the argument that contraceptive behaviour in the interwar years was 'ill-thought-out, barely discussed, [and followed] haphazard actions that could not be relied upon to prevent pregnancy.'¹⁶⁹

One of the aforementioned cases provides a chance to understand the general attitude towards abortion at the time. Studies on this subject provide us with somewhat contradictory conclusions. Some argue that abortion was, according to Hall, 'very much a no-no' in the

Casenotes, BRHAM CFM-067, Case No. 2541/5576.

¹⁶⁷ Fisher, 'Uncertain Aims and Tacit Negotiation', p. 313.

¹⁶⁸ Maudsley Hospital, Patient Casenotes, BRHAM CFM-003, Case No. 676/1361.

¹⁶⁹ Fisher, 'Uncertain Aims and Tacit Negotiation', p. 313.

interwar years,¹⁷⁰ whereas others claim that abortion was widespread, especially among working-class women, and often considered as a form of contraception.¹⁷¹ Well into the twentieth century, the latter contends, it was regarded as ‘perfectly acceptable to end a pregnancy in its early states before quickening’.¹⁷² The case of Mrs WBT of the Maudsley implies that the interwar attitude to abortion was closer to the latter interpretation than to the former. Mrs WBT had ‘a mild romantic attachment of a platonic nature’ with ‘an unconventional man’, and informed the man’s wife of the state of affairs in order to put an end to it. The wife took the news so sensibly that a week later she had a ‘miscarriage by intention’. She was known to have taken ‘drugs’ in order to ‘bring it about’. According to Mrs WBT herself, the whole situation drove her into deep self-reproach and mental depression.¹⁷³ Interestingly enough, throughout the record, miscarriage and abortion were used interchangeably, combining the nowadays incompatible words, ‘miscarriage’ and ‘by intention’.¹⁷⁴ This case supports Elizabeth Roberts’ finding that ‘contraception and abortion were more or less the same thing’ for some correspondents in her research.¹⁷⁵ Although the patient felt strong guilt about the incident, as she believed she had led the woman to make the decision, it seemed to have little to do with moral judgment about the behaviour. Abortion or

¹⁷⁰ Hall, *Sex, Gender and Social Change in Britain since 1880*, p. 111; ‘Sexuality’, p. 51.

¹⁷¹ Barbara Harrison, ‘Women and Health’, in Purvis (ed.), *Women’s History: Britain, 1850-1945*, pp. 172-174; Roberts, *A Woman’s Place*, pp. 97-100; Kate Fisher, “‘Didn’t Stop to Think I Just Didn’t Want Another One’”: The Culture of Abortion in Interwar South Wales’, in Franz Eder, Lesley A. Hall and Gert Hekma (eds.), *Sexual Cultures in Europe: Themes in Sexuality* (Manchester: Manchester University Press, 1999), pp. 213–32.

¹⁷² D’Cruze, ‘Women and the family’, p. 58.

¹⁷³ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 4212.

¹⁷⁴ It is possible to find similar cases in which abortion and miscarriage were applied as synonyms to each other. According to data collected and suggested by a Welsh birth control clinic in the interwar years, for example, it said that women ‘habitually brought on miscarriages’, which of course meant intended abortion: Fisher, ‘The Culture of Abortion in Interwar South Wales’, p. 225.

¹⁷⁵ Roberts, *A Woman’s Place*, p. 97.

induced miscarriage, no matter how it was referred to, was one of the available options that a woman could choose, and the practical means to carry it out were easily accessible. Although it is impossible to draw any general conclusion about this subtle subject through this case, we can at least confirm that, as a phenomenon, access to abortion was widespread in the 1930s.

The last thing to be mentioned relating to female sexuality is the culture of ‘silent women’ that was still powerful in interwar Britain. In a recent work, Paul Peppis rightly points out that women had been deprived of ‘a vocabulary to describe and discuss the realities of their sexual life’ and thus, could not counter the distortions in male discourses of sex. This cultural status quo, according to Peppis, faced a dramatic change in the interwar years, in the move towards ‘modernism’. A good example of this force for change is the publication of Stopes’ *Married Love*.¹⁷⁶ However, this idea is half right and half wrong. The reticence of the British about sexuality, especially female sexuality, was too persistent to be abolished by the publication of several books and articles written by a handful of well-educated women. The absence of a vocabulary with which female sexuality could be described and discussed in everyday life lingered on well into the 1930s. This is best represented in the case of Mrs EMW. This patient, aged 42, was hospitalised at Holloway in 1935, due to depression accompanying delusional ideas. When asked about her married life, she expressed a sense of satisfaction, describing her husband as ‘the most devoted person’. As for the reason that she had no child after seven years of marriage, she stated that she had not wanted children at first. However, later she confessed to the medical practitioner that ‘intercourse had never taken place’ between the couple and that the patient could not reveal

¹⁷⁶ Paul Peppis, *Sciences of Modernism: Ethnography, Sexology, and Psychology* (Cambridge: Cambridge University Press, 2014), pp. 148-149.

the fact to anybody, even to her mother or sisters.¹⁷⁷ This case reminds us of Stopes' anecdote that for the three years of her first marriage her husband failed to 'consummate'.¹⁷⁸ However, Mrs EMW, unlike Stopes, was fully aware of what was wrong with her marriage, and what she lacked was not knowledge but 'language'. It was still a powerful taboo to bring up any issue connected with sexuality, even amongst those who were close to each other. Under the circumstances, can we really contend that sexual modernism was established in interwar Britain in the manner that Peppis argues?

Nonetheless, the interwar period witnessed some profound changes in sexuality: knowledge on sexual behaviour was widely circulated; premarital relations increased, albeit unmeasurable; new contraceptive techniques became easily accessible to all; affection became a major component of (middle-class) marriage; some taboos weakened, such as the one against masturbation by the unmarried; and various 'experts' in sexuality issues were active in raising public awareness.¹⁷⁹ However, the case notes have indicated that conventional attitudes and practice persisted well into the late 1930s: rarely had women any way to express themselves in this matter. The male partner, either in courtship or in marriage, held the initiative in almost all sexual issues, notably contraception. Premarital sex and pregnancy was condemned, and especially the latter was usually followed by marriage. More than anything, heterosexuality was 'the norm'. The argument for 'interwar modernity' in sexuality seems to be anachronistic. Rather, this period should be understood as a period

¹⁷⁷ Holloway Sanatorium, Discharge Case Book: Female, SHC Ac. 7267/3/27, No. 5500.

¹⁷⁸ Hall, 'Sexuality', pp. 55-57.

¹⁷⁹ Hall, *Sex, Gender and Social Change in Britain since 1880*, pp. 116-132.

when modern sexuality coexisted with traditional features, which were still strong, and permeated into different levels of society at different speeds and to different depths.

Other Factors, Including Drinking Problems

Lay causal attributions were not limited to the handful of themes mentioned above, and life events occurring in female adulthood were too diverse to be grouped into categories. In this section, therefore, less frequently mentioned but still crucial life events, allegedly related to mental illness, will be examined. Firstly, cases relating to bereavement will be analysed.

Although loss of family members and loved ones was not limited to one certain life stage, the experience was more common in middle and old age than in earlier phases, which is why bereavement as a life event will be discussed in detail in the next chapter. In this chapter, it will suffice to illustrate a distinctive characteristic shown by female patients in the 25-45 age band. In this life stage, death of a child was frequently mentioned in relation to mental depression and its onset. Even though infant mortality was steadily decreasing and the average health and growth of children rapidly improving during the early twentieth century, 6 to 10 percent of live-born babies did not survive infancy in the interwar decades.¹⁸⁰ In most of the cases involving the death of a child, doctors, patients, and relatives easily agreed on the cause of the woman's illness. For instance, Mrs EBW, aged 24, visited the Maudsley in 1928 as an outpatient due to 'mild depression associated with many bodily aches and pains', which

¹⁸⁰ Timothy J. Hatton, 'Infant Mortality and the Health of Survivors: Britain, 1910-50', *The Economic History Review*, 64:3 (2011), pp. 951-972.

did not appear to have ‘any definite physical cause’. According to the patient, her symptoms began about one year earlier when she lost her second child, then six-months-old. Thereafter, she was unable to stand her surviving baby’s crying, which provoked a strong impulse to ‘do it (commit suicide)’. The medical staff seemed to have no doubt about the aetiology, identifying ‘stress: child’s death’ and marking ‘upset by baby’s death’ in the space for special remarks in her case file.¹⁸¹ Mrs HK at Holloway Sanatorium suffered from a similar experience. Some months before admission, she had lost her daughter to scarlet fever, which seemed to push her into serious mental depression. On medical examination, she admitted that she could ‘think of nothing but this’. The medical superintendent, too, wrote ‘death of only child in June’ as the ‘supposed cause’ on her case notes and put the code ‘F. 1.’ – sudden mental stress – as the principal aetiological factor on the Medical Register.¹⁸²

Now we need to turn to what has been generally considered an unfeminine theme, alcoholism. A few cases in the sample group are attributable to excessive or habitual drinking. Among the 22 Maudsley sample cases, one was connected with alcohol problems by the medical staff. In the case of Mrs AC, the medical practitioners wrote down ‘mental defect and distress about syphilis’ and ‘alcoholism?’ as mental and physical aetiological factors respectively. At Holloway Sanatorium, the situation differed considerably from the Maudsley. Out of fourteen depression cases, including both certified and voluntary, hospitalised in the 1920s, three were attributed to alcoholism by the medical staff, according to Medical Registers. In one case the aetiology was principal and in the other two contributory. Reading

¹⁸¹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-030, Case No. 3025.

¹⁸² Holloway Sanatorium, Discharge Case Book: Female, SHC Ac. 7267/3/28, No. 2238; Register of Departure, Discharges and Transfers of Voluntary, Temporary and Certified Patients, SHC Ac. 3473/3/54.

their individual case notes, two of these patients readily admitted that their drinking habit had affected their mental health. Miss LSC gave ‘guilty concerns from masturbation, alcohol and love affair’ as supposed causes of her ‘breakdown’ on her admission;¹⁸³ and Mrs HL provided detailed accounts of her own attribution, saying that ‘spirits’ she had drunk some months ago ‘dried up her brain’. The condition of the latter appeared serious, as the patient called herself a ‘raving lunatic’ or ‘hopeless insane’ and turned so suicidal that she tried to strangle herself during her detention at Holloway. The case of Mrs HL is the only medical record applying the term ‘inebriety’, which was not in frequent use in those years, as a supposed cause amongst the whole sample cases collected for this research, reaching almost a hundred.¹⁸⁴

Noteworthy is that those who ascribed their mental depression to a drinking problem were all middle-class, rebutting commonly circulated ideas of drunkenness. Drinking has been regarded as a social problem closely related to a specific group of people, working-class males. Such a perception is largely based on the tradition of the nineteenth century, when ‘class and gender more sharply defined drinking habits (...) than in any previous era’.¹⁸⁵ The stereotype also decided the attitude and approach of policy-makers in the early twentieth century, who tried to regulate excessive drinking habits, a national problem inevitably connected to productivity of the whole economy. On devising and instigating practical measures, such as restricting licensing hours, increasing liquor taxes, and raising prices while cutting alcoholic strength, they assumed working-class men as the major target.¹⁸⁶ The

¹⁸³ Holloway Sanatorium, Case Book: Females [Volume 25], SHC Ac. 3473/3/15, No. 4519.

¹⁸⁴ Holloway Sanatorium, Case Book: Females [Volume 27], SHC Ac. 3473/3/1, No. 4738.

¹⁸⁵ David W. Gutzke, ‘Gender, Class and Public Drinking in Britain during the First World War’, *Historie Sociale/Social History*, 27:54 (1994), pp. 367-368.

¹⁸⁶ Roberts, *A Woman’s Place*, p. 122; Gutzke, ‘Gender, Class and Public Drinking in Britain’, p. 369.

perspective of most historians is not fundamentally different, since they tend to focus on labouring men and their (often excessive) drinking habits, usually in connection with the culture of public house.¹⁸⁷ Recent studies on working-class culture and leisure, however, try to deviate from this approach, acknowledging that ‘the image of male indulgence and female exclusion is a stereotype’.¹⁸⁸ New approaches to female drinking take note of changes happening in the early twentieth century when the level of female drinking gradually increased, while the average quantity drunk was on the decrease. It became socially acceptable for ‘respectable’ women to go into pubs in male company, mostly their husbands;¹⁸⁹ and some women began to drink ‘independently’ in public, although this was not common, during the interwar decades.¹⁹⁰ Some research pays attention to the relation between wartime experience and female alcohol consumption, such as the dramatic increase of females in public house during the World Wars and the subsequent intense opposition to this custom after the Wars.¹⁹¹ These works are relatively free from the gendered stereotype, but not from the classist prejudice, because they usually cover women from the working class, and only occasionally ones from the lower middle class, leaving upper- and middle-class female drinking under-researched.

As a result, the aforementioned cases in which female patients with middle- or upper-class backgrounds ascribed their mental illness to drinking urge us to modify our approach to

¹⁸⁷ Brad Beaven, *Leisure, Citizenship and Working-Class Men in Britain, 1850-1945* (Manchester: Manchester University Press, 2005), pp. 60-81.

¹⁸⁸ Martin Francis, ‘Leisure and Popular Culture,’ in Zweiniger-Bargielowska (ed.), *Women in Twentieth-Century Britain*, p. 236.

¹⁸⁹ Roberts, *A Woman’s Place*, p. 122.

¹⁹⁰ Francis, ‘Leisure and Popular Culture,’ p. 236.

¹⁹¹ Gutzke, ‘Gender, Class and Public Drinking in Britain’, pp. 367-391; Claire Langhamer, “‘A Public House is For All Classes, Men and Women Alike’: Women, Leisure and Drink in Second World War England’, *Women’s History Review*, 12:3 (2003), pp. 423-443.

this subject. They prove that intemperance troubled those who have been expected the last people to suffer from it. In this sense, existing studies on drinking have missed a large part of the social problem, women's private drinking habit in their own homes. Mrs HL's detailed description implies that it was in her own home where she drank regularly and sometimes heavily. One recent work by Christine Crabbe on female habitual drunkards in the late nineteenth and early twentieth centuries gives us a clue to understand these cases. The Wine and Beer Houses Act of 1869 enabled women to purchase alcohol without entering a beer house or public house and to drink discreetly in privacy. It was not a coincidence that concerns about women's habitual drinking were unprecedentedly high, and that a strong revulsion against the practice was expressed publicly in the following decades. Now, middle-class women sent their servants out to obtain alcohol, and respectable working-class wives bought drink for themselves at grocer's shops.¹⁹² Crabbe's work provides a useful explanation of the gendered attitude towards drinking and its affect on female drunkards, but does little to explain the class gap in the group of women with alcohol issues. One explanation for higher rates of alcoholism among middle-class wives compared to their working-class counterparts is the former had available resources, including time and money, and were free from the everyday burdens of managing households in person. Most working-class housewives had to 'work in very tightly drawn parameters', struggled to make ends meet as 'family financial managers', and spent a long time on housework, in a period yet to see the wider use of modern domestic appliances.¹⁹³ All these factors prohibited them from indulging in such a habit. However, even if this was the case, the explanation is not

¹⁹² Christine M. Crabbe, *On the Borderland of Insanity: Women, Dipsomania and Inebriety, 1879-1913* (unpublished PhD Thesis, University of the West of England, 2014), pp. 40-42.

¹⁹³ Roberts, *A Woman's Place*, pp. 125, 163, 202-203.

satisfactory. The predominance of upper-class women over their lower-class fellows in this matter needs to be examined in the context of interwar Britain, and has the potential to cast new light on the inter-relationship of societal, gender and class issues. This subject will be discussed in the next chapter in order to provide a detailed picture of the female drinking problem and its relevance to gender and class.

5. Conclusion

As for identifying aetiological factors, consensus is hard to attain, even among the professional group. In the case of Mrs ARB, the Maudsley practitioners revealed a sharp conflict of opinion on the cause of her depression. The patient, a 37-year-old widow, remained silent throughout her stay and treatment at the Maudsley and her sister afforded crucial information necessary to understand her case history. Mrs ARB had been always weak and shy; the patient's husband went missing for six months and was reported dead during the War. She had had an operation for uterine fibroids three years previously which induced an 'artificial menopause'.¹⁹⁴ According to her case note, one doctor focused on her 'stress coming from husband's missing and death' in the case sheet at the beginning of case notes.

¹⁹⁴ In some middle-aged female cases, artificial menopause induced by gynaecological surgery was appointed as a cause of depression, which will be scrutinised closely in the next chapter in juxtaposition with (non-artificial) involitional melancholia cases. Suffice it to say here that artificial and therefore abrupt menopause was generally considered more threatening to a woman's condition, both physically and mentally, than natural climacteric changes.

The other, however, found the origin of this case in the gynaecological operation she had undergone, which is confirmed by a letter to her referee, a general practitioner, attached at the end of the case file.¹⁹⁵ In this case, it seems that they failed to reconcile their differences in the attribution.

Under the circumstances we cannot expect all of those involved in a case to speak with one voice about the cause of mental depression. Nonetheless, with some aetiological factors, doctors and patients (and often their relatives) tended to readily concur with each other, but with other causes, they did not. Representatively, in ‘depression following childbirth’ cases, consent was obtained with ease. As seen above, among the five Maudsley cases which could be identified as postnatal ones, four cases reached an agreement on the cause of depression. In those cases, patients saw pregnancy, childbirth, or lactation as a trigger of their mental breakdown and doctors rarely raised an objection to this lay attribution. Other issues related to motherhood, too, gained recognition as aetiological factors by patients and doctors, as we have seen from the cases in which a patient lost her child or another gave birth to an illegitimate child. Attribution to mental stress resulting from financial hardship and unemployment was also highly likely to be agreed by both parties.

However, if a patient referred her mental breakdown to sexuality issues or self-reproach related to sexual behaviour, it was hard for her to convince her psychiatrists of the attribution. For instance, Mrs WBT consistently found the origin of her mental depression and suicidal impulse from her love affair with a man, unexpected tragic incidents followed by it, and ensuing self-reproach. However, the medical staff of the Maudsley seemed to be very

¹⁹⁵ Maudsley Hospital, Patient Casenotes, BRHAM CFM-003, Case No. 2254.

reluctant to suggest any supposed cause of this case, mentioning nothing about it throughout the case file.¹⁹⁶ Similar pattern can be found from another Maudsley case: Mrs LB, a widow in her late forties, attributed her mental depression to her love affair and subsequent guilt, whereas the medical staff centred on her husband's death and financial worries.¹⁹⁷ Furthermore, self-reproach related to sexual behaviour was usually taken as a symptom rather than a cause of mental depression by these experts. Even Lewis, who expressed interest in the manifestation of self-accusation more than any other among his contemporary psychiatrists, regarded it as one of the major symptoms accompanied by depressive state.¹⁹⁸ Therefore, it seems that female patients were rarely understood concerning what they felt about their sexuality and sexual behaviour even by the physicians in charge of their cases. It would not be unreasonable to say that well into the interwar years female sexuality was the least understood element of what constituted women's adulthood, as well as women's life.

This chapter has covered a number of cases in which reproduction was central in reconstructing case histories. Such cases exhibited some clear patterns: many of these patients suffered from somatic symptoms and related them to their recent childbirth experience; if they were deluded or hallucinated, the contents were likely to be associated with their role as a mother; regarding lay attribution, most of them related their mental and bodily trouble to the hardship of child-birth or child-rearing; however, they did not ascribe depression solely to their motherhood experience, but found links with other adversities they had in their everyday life, notably economic hardship and matrimonial discord. More than

¹⁹⁶ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 4212.

¹⁹⁷ Maudsley Hospital, Patient Casenotes, BRHAM CFM-068, Case No. 2319. This case will be analysed in full in the next chapter on middle- and old-aged female patients and their mental illness experiences.

¹⁹⁸ Lewis, 'Melancholia: A Clinical Survey of Depressive States', pp. 312-316.

anything, the way in which these patients interpreted their sufferings reminded us of puerperal insanity, a disorder of the nineteenth century, and confirmed the lingering influence of Victorian medical and psychiatric tradition.

Although marriage and motherhood constituted essential parts of female adulthood and shaped the lives of the majority of women, there were more elements to be considered in order to draw a whole picture about womanhood and adulthood. Thus, worthy of notice are cases informing us of what 'spinsterhood' in interwar Britain was like. Single women, especially those from middle-class backgrounds, set a high value on their job and economic independency, as a main part of their identity. At work they had to face varied disadvantages, such as marriage bars, low wages and limited chances of promotion, which often cost their mental health. Also, during the interwar decades, the sexuality of unmarried women was often misunderstood, pitied and even ridiculed in a social atmosphere where 'married love' was increasingly accepted as a norm. There was little available professional support with this issue, whereas contemporary married women were the main beneficiaries of expanding knowledge on sex. In this sense, it was those single women who experienced the interwar backwardness most intensively and enjoyed its progress and developments the least.

Lastly, noteworthy is that case notes analysed in this chapter, those of mature patients, have proved their availability as a reliable source for historical research on sexuality and sexual practice. The medical records provide very detailed information about sex education, courtship, contraception, extramarital relationship and venereal disease in those years, which otherwise could not be revealed. What we have discovered by consulting the case notes of adult patients, notably findings about the general attitude towards contraception and real practices of birth control, corresponds to the latest achievements made in this historical genre,

mostly based on oral history. Moreover, it opens up the possibility that historians can explore earlier periods which the oral history methodology cannot cover.

Chapter 5. Depression in Middle and Old Age

1. Demographic Analysis

As mentioned in previous chapters, patient demographic features of the Maudsley Hospital and Holloway Sanatorium diverged in many ways. With regard to patients in middle and old age, the most visible distinction between the two was the proportion of those falling under this age category. To consult the composition of patient population, the majority of the Maudsley patients were in their adulthood. Taking the year 1928 as an instance, among the first hundred female patients discharged during this year, 37 were categorised as suffering from depression. To group them according to age, 19 patients were aged between 26 and 45 and 13 were aged over 46.¹ Although the exact percentage of each age group changed each year, their order did not: patients aged between 26 and 45 consisted of the largest group, those aged over 46 came next, and those aged under 25 made up of the smallest category. This corresponds with the findings of Edgar Jones and Shahina Rahman which is based on a large scale sample cases, over 1,000, between 1923 and 1939 and their statistical analysis.² On the contrary, at Holloway Sanatorium, the great majority of its patients were middle- and old-aged. According to its Annual Report of 1927, the mean age of female patients on admission

¹ To be more specific, among the 37 depression patients, a total 5 were aged under 25; 8 were aged between 26 and 35; 11 between 46 and 55; 4 over 56.

² Edgar Jones and Shahina Rahman, 'Framing Mental Illness, 1923–1939: The Maudsley Hospital and its Patients', *Social History of Medicine*, 21:1 (2008), pp. 116-117.

was 49.54. Among 52 female certified patients admitted during the year, the number of those aged between 25 and 44 was 19, whereas the figure of those aged over 45 was 31.³ In some years, the average age of patients even exceeded 50.⁴ Such disparity in patient age distribution of these mental hospitals was inevitably related to the characteristics of each institution, and was to produce other differences, including ratio of patient with previous mental or nervous collapse history, average length of hospitalisation, practice of discharge and, more than anything, the number and percentage of those who died.

The Maudsley patient cases will be analysed first. Numbers of admissions declined with age: thirteen in the 46-55 age band; five in the 56-65 age band; and two in the over-66 age band. The oldest patient among them was 70 years old on admission.⁵ As for the marital status of these patients, the rate of those widowed was high, reflecting one of the central attributes of this age group. In the sample group, eight women were married, eight widowed and four single. Slightly over one half of patients were from the middle class and little below a half were from working-class backgrounds, except some cases in which no clue was provided to indicate the class or occupation of patients and their families (mostly husbands). The proportion of working-class patients in this age group is lower than found with adult patients in previous chapters. However, it is still higher than the estimation in existing research on the Maudsley patients, notably that of Jones and Rahman, who record that around 40 percent of male inpatients were from the working class.⁶ Patients' occupation varied

³ Holloway Sanatorium, Annual Report for the Year 1927, No. 42, SHC Ac. 2620/1/9.

⁴ In 1922, the average age of female certified patients was 52.05 and that of both sexes was 50.12, obviously showing the age composition of Holloway patients: Holloway Sanatorium, Annual Report for the Year 1922, No. 37, SHC Ac. 2620/1/8.

⁵ Maudsley Hospital, Patient Casenotes, BRHAM CFM-030, pp. 789-812.

⁶ Jones and Rahman, 'Framing Mental Illness, 1923-1939', pp. 117-118. For more description of class distribution of Maudsley patients, refer to the demographic analysis in Chapter 4.

considerably, from domestic servant to government inspector,⁷ but the most common ones recorded on case sheets were ‘housewife’ and ‘teacher’, with three patients in each category. However, as most of the housewives were identified as having no ‘proper’ job in their medical documents, and had no record in the space for occupation on their case sheets, especially if they were married or widowed, they can be considered as homemakers too. Among the four single women in the sample group, all were teachers, except one patient who had been engaged in millinery for a long time.⁸ These findings mirror the social and cultural preferences related to female occupation, in particular that of middle-class girls, which defined what was and was not deemed appropriate for them on the grounds of existing ideas about gender roles and values. This limited the spectrum of acceptable careers, which included teaching, nursing and shorthand typing, and attracted the great majority of female workers with middle-class backgrounds.⁹ The professions of patients’ husbands were diverse, ranging from sweet-maker and actor to school master and clergyman. Some widows took up the jobs their husbands had lost on death. For example, when Mrs LB was suddenly bereaved she assumed a ‘commercial traveller’ occupation like her deceased husband;¹⁰ and Mrs EA went to work at the arsenal where her husband had dropped dead on duty.¹¹

In the group of patients aged over 46, the rate of those who had a mental or nervous

⁷ Maudsley Hospital, Patient Casenotes, BRHAM CFM-151, pp. 16-51; CFM-031, Case No. 2881/1474; CFM-031, Case No. 3297/1639.

⁸ Maudsley Hospital, Patient Casenotes, BRHAM CFM-031, Case No. P261; CFM-067, Case No. 6171; CFM-149, Case No. 8737; CFM-150, Case No. 8232/3472.

⁹ Ross McKibbin, *Classes and Cultures: England 1918-1951* (Oxford: Oxford University Press, 2000), pp. 48-49; Teresa Davy, ‘A Cissy Job for Men; a Nice Job for Girls’: Women Shorthand Typists in London, 1900-39,’ in Leonore Davidoff and Belinda Westover (eds.), *Our Work, Our Lives, Our Words* (Basingstoke: Macmillan Education, 1986), pp. 124-144.

¹⁰ Maudsley Hospital, Patient Casenotes, BRHAM CFM-068, Case No. 2319.

¹¹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-001, Case No. F016.

breakdown history was fairly high, about 60 percent, in stark contrast to their younger counterparts in the same institution. Among the Maudsley adult patients, aged between 26 and 45, about one third were reported as having a previous history of psychiatric attacks. For instance, Miss EBY, a middle-aged female patient, was described as having been 'nervous for the whole life' and had been diagnosed with neurasthenia ten years earlier, serious enough to have left work.¹² In another case, Mrs JAN, 50 years old, had at least three previous 'breakdowns', according to the patient's own report.¹³ The average length of stay at the Maudsley also varied depending on the age group of patients. The mean hospitalisation period of middle and old age patients was 5.1 months, whereas adult patients of the Hospital, aged between 26 and 45, stayed 3.3 months on average. In the group of patients over 46, the number of long term inpatients whose hospitalisation period was over six months reached seven out of twenty, while among the female patients aged between 26 and 45, only three out of 22 stayed for more than six months at the Maudsley. The shortest stay was only one week, whereas the longest was slightly over one year.¹⁴ However, some patients belonging to this age group were readmitted to the Maudsley, which rarely happened in other age groups. Even though the Maudsley accepted more old patients with a history of mental breakdown history and allowed some of them readmission, it did not mean that the Hospital modified its policy precluding treatment of those whose cases could be identified as chronic, incurable or being in late stages. Rather, it reflected a major feature of the elderly patients group: prevalence of relapsing cases.

Despite the general acknowledgement of the high treatability of depression, about a

¹² Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 8232/3472.

¹³ Maudsley Hospital, Patient Casenotes, BRHAM CFM-066, pp. 391-420.

¹⁴ Maudsley Hospital, Patient Casenotes, BRHAM CFM-003, Case No. FP 6.

half of these middle- and old-aged patients were predicted as having an unfavourable prognosis, especially when a patient had a previous history of mental or nervous attacks or her condition was identified as depression occurring 'in the senile period'. Therefore, the rate of cases with doubtful or poor prognosis is the highest in this age group of patients, compared with younger cohorts. The condition of these patients on discharge did not appear better than that of younger patients, albeit it is hard to generalise. About 30 percent of patients aged over 46 left the Hospital as 'recovered', and 40 percent as 'improved'. The rest had not improved on leaving the Hospital, which however did not mean that they had discharged themselves without professional approval. Many of those unimproved patients were transferred to other mental institutions, and their whereabouts appeared to be decided by their social and economic backgrounds. For instance, Mrs RA, aged 50, who had been working as a tailoress after her husband's death, was transferred after a seven-month stay in the Maudsley to Horton Mental Hospital in Surrey, founded and run by London County Council.¹⁵ Mrs FBT, a stockbroker's wife of the same age as Mrs RA, was removed to Holloway Sanatorium, after less than three months in the Maudsley, even though her condition was identified as improved.¹⁶ A few patients suffering from any other physical illnesses were discharged from the Maudsley and sent to another specialised hospital for treatment. All these factors contributed to the highest transference rate of those patients in senescence.

The situation at Holloway Sanatorium was different in many ways from that at the Maudsley. Age distribution of Holloway patients will be considered first. As noted previously, the great majority of Holloway inmates were middle- and old-aged and the

¹⁵ Maudsley Hospital, Patient Casenotes, BRHAM CFM-066, Case No. 2399.

¹⁶ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 4969.

number of patients rose with age. Sample cases from the Sanatorium were selected to cover the whole age band evenly, they do not represent the spread of the patient population as it was. To address this problem, the patients' age on admission has been analysed for one year. In 1927, the total number of female admission was 85; and among them 54 cases were certified and 31 were voluntary. Out of 52 certified cases (excluding two 'congenital cases' from the total certified cases), about 60 percent were aged over 45, and the number of patients in the senile stage outnumbered those in the climacteric period, aged between 45 and 55.¹⁷ From the Annual Reports, it is possible to state that, in the late 1920s, 50 to 60 percent of the female patients were single, 30 to 40 percent married, and about ten percent widowed. The results that emerge from the sample group are however different: one half were married and the other half were single or widowed, over-representing the married. As for profession, the great majority of the patients had no record. In cases in which patients' occupations were recorded, two women were housewives, both married, one a trained nurse, one a companion and one a retired schoolmistress. The occupation of patient's husband or other family member was not noted in any case file. As the overwhelming majority of female boarders had, according to the Annual Reports, 'independent means', they can be regarded as having a middle- and upper-class background.

It is difficult to arrive at any general conclusion about the proportion of cases with previous mental breakdown history from Annual Reports of Holloway Sanatorium.¹⁸ The

¹⁷ To suggest the age distribution of female admissions in 1927, out of 52 certified patients, those aged under 24 were 2; those aged between 25 and 34 were 6; those aged between 35 and 44 were 13; those aged between 45 and 54 were 10; those aged between 55 and 64 were 15; and those aged over 65 were 6. Holloway Sanatorium, Annual Report for the Year 1927, No. 42, SHC Ac. 2620/1/9.

¹⁸ Table B4. showing in the Direct Admissions during the year 19XX (excluding the Congenital Cases and the cases, "Unknown whether First Attack of not") – (a) The age at commencement of the Present Attack of mental disorder in both the First-Attack and Not-First-Attack cases, respectively,

number of 'first-attack' and 'not-first-attack' cases among the female patients varied according to the year.¹⁹ However, even in the year when the rate of recurrent cases was the lowest, the figure was still higher than that of other contemporary institutions. For instance, in 1927 out of 45 female cases only sixteen were categorised as not-first-attack ones, making the rate 36 percent. Brookwood Mental Hospital, for instance, had 166 female admissions in 1924 and, among them, nineteen were identified as cases having 'previous attacks'.²⁰ Four years later, the number of female admissions was 128 and about a quarter of them were not-first-attack cases.²¹ At Holloway, the proportion of patients aged over 45 among all not-first-attack cases was not consistent at all, either. Even though in the group of recurrent cases patients aged over 45 mostly outnumbered those under 45, the predominance did not appear meaningful given the high proportion of middle- and old-aged patients. Out of 20 sample cases selected for this chapter, seven were identified as not-first-attack cases.

At Holloway, not only was the average length of stay markedly longer than other county mental hospitals as well as the Maudsley, but also the number of long-term inpatients was fairly high, confirmed in its Annual Reports and individual sample cases. According to the Annual Report of the year 1928, among twelve female cases discharged as recovered in the year, three patients stayed at the Sanatorium less than six months, five for six to twelve

arranged according to their civil state; (b) and the age on First-Attack in the Not-First-Attack cases. (Voluntary Boarders excluded)' was suggested in Annual Reports only until 1930, after when no statistical data were provided in Annual Reports regarding the number and ratio of first-attack and not-first-attack cases.

¹⁹ Those terms, 'first-attack-case(s)' and 'not-first-attack-case(s)', were in use in varied medical records of Holloway Sanatorium, including Annual Reports, Medical Registers, and individual case notes. The rate of first-attack-cases and non-first-attack-cases fluctuated in this period. The percentage of non-first-attack-cases was 40 in 1921; 53 in 1923; 36 in 1927; and 56 in 1929.

²⁰ Brookwood Mental Hospital, Annual Report for the Year 1924, SHC Ac. 3043/1/1/2/15.

²¹ Brookwood Mental Hospital, Annual Report for the Year 1928, SHC Ac. 3043/1/1/2/19.

months, one for one to two years, one for two to three years, and one over three decades.²² The picture drawn based on sample cases is not much different. Out of twenty, seven patients stayed at the Sanatorium less than 3 months, and another two less than one year. The hospitalisation period of the rest varied, ranging from twenty months to two decades. Mrs JL was admitted in September 1923, at the age of 65, to reside there until her death in October 1944, the longest institutionalisation amongst the sample cases.²³ It is noteworthy that there was no obvious correlation between the patient's marital status and the length of confinement, contradicting the commonly accepted assumption that single women were inclined to stay longer mainly in order to avoid practical issues related to their care and support.²⁴ The mean stay of patients aged over 46 was over four and half years. Considering that female patients admitted for depression to the Sanatorium in 1924 remained there for 25.7 months on average, it is obvious that the elderly stayed overwhelmingly longer than their younger fellow patients. Compared with the Maudsley cases, the figure is more surprising. As seen above, patients of the Hospital aged between 26 and 45 remained there over three months on average and those aged over 45 stayed about five months. Among twenty sample cases, eleven were discharged as recovered or relieved: a few of them however chose to remain at the Sanatorium as voluntary boarders, and one patient transferred herself to a convalescence home. In the sample group, two patients left Holloway without making any satisfactory improvement: Miss PM, aged 49, was transferred to Brookwood Mental

²² Holloway Sanatorium, Annual Report for the Year 1928, No. 43, SHC Ac. 2620/1/9.

²³ Holloway Sanatorium, Medical Register: Females, SHC Ac. 3473/3/48; Case Book: Females [Volume 27], SHC Ac. 3473/3/17, No. 4815.

²⁴ Joseph Melling, 'Buried Alive by Her Friends: Asylum Narratives and the English Governess, 1845–1914', in Pamela Dale and Joseph Melling (eds.), *Mental Illness and Learning Disability Since 1850: Finding a Place for Mental Disorder in the United Kingdom* (London: Routledge, 2006), pp. 65-90.

Hospital as a 'pauper', probably due to inability to pay the medical costs,²⁵ and Mrs EM discharged herself against professional advice after a three-month stay.²⁶ Four died at the Sanatorium: all were long term inpatients, among whom the shortest stay was over eight years and the longest 21 years; except one patient, all were in their eighties on death, confirming the medical superintendent's statements in the Annual Reports that most deaths were 'from natural causes'.²⁷ The huge gap between Holloway and the Sanatorium regarding the mean length of hospitalisation itself reveals the major characteristics of the two institutions: the former being a mental institution serving affluent patients and their families and the other a mental hospital fastidious in limiting its intake to treatable patients.

1. Introduction

This chapter aims to explore the varied experiences of middle- and old-aged patients suffering from depression by consulting case notes of the Maudsley Hospital and Holloway Sanatorium. Like many other notions about life cycle and life stages, it is difficult to achieve a precise definition of middle age and the elderly. However, as seen in previous chapters, during the early part of the twentieth century the 'biological viewpoint' was taken seriously when dividing women's life stages. Then, female adulthood was thought to begin with the maturation of the reproductive system and was considered as 'the most important stage in the

²⁵ Holloway Sanatorium, Case Book: Females [Volume 25], SHC Ac. 3473/3/15, No. 4527.

²⁶ Holloway Sanatorium, Discharge Case Book: Female, SHC Ac. 7267/3/29, No. 2383.

²⁷ Holloway Sanatorium, Annual Report for the Year 1923, No. 38, SHC Ac. 2620/1/8.

female life cycle' when most of the major events in a woman's life occurred, such as marriage and pregnancy.²⁸ Likewise, middle age was defined in relation to the decline and eventual loss of reproductive capability.²⁹ According to a common explanation circulated within medical expert groups, the menopause and other climacteric changes, both physical and psychological, began in the mid-forties of a woman's life, albeit with minor variations in exact timing. In particular, the psychiatric professions, who were deeply involved in the overheated debate on involuntional melancholia, as seen in Chapter 2, generally agreed that the period referred to 'life after the age 45-50'.³⁰ R. D. Gillespie and D. K. Henderson, fervent advocates of the notion (even after it was discarded by Emil Kraepelin, who had introduced involuntional melancholia to psychiatric taxonomy around the turn of the century),³¹ put the onset of this stage to 40 to 45.³² This early-twentieth-century criteria will be adopted in this research, and the age of 45 will be taken as the dividing point when adulthood ended and mid-life began.

While the decision judging when ageing commences is primarily biological (and medical), determining 'being old' involves more social, cultural and often legal factors, especially in relation to retirement and receipt of pension, in addition to biological markers.³³

²⁸ Patricia Jalland and John P. Hooper, *Women from Birth to Death: The Female Life Cycle in Britain 1830-1914* (Brighton: Harvester, 1986), pp. 117-118.

²⁹ *Ibid.*, pp. 281-286.

³⁰ German E. Berrios, *The History of Mental Symptoms: Descriptive Psychopathology since the Nineteenth Century* (Cambridge: Cambridge University Press, 1996), p. 311.

³¹ Edward Shorter, *A Historical Dictionary of Psychiatry* (Oxford: Oxford University Press, 2005), p. 82.

³² D. K. Henderson and R. D. Gillespie, *A Textbook of Psychiatry for Students and Practitioners* (London: Oxford University Press, 1927), p. 158.

³³ In order to situate old age in English/British psychiatry, see Emily S. Andrews, *Senility before Alzheimer: Old Age in British Psychiatry, c. 1835-1912* (unpublished Ph.D. Thesis, University of Warwick, 2014).

Historically, old age was ‘defined by function, capacity, and cultural markers, rather than by chronology’ and the age of sixty was considered as the beginning of senescence at least since the late nineteenth century.³⁴ This criterion was still held as valid between the World Wars. According to public opinion surveyed before the amendment of related regulations in 1925, the present criterion of a pensionable age of 70 was then thought too high, and the age of 65 was widely accepted as appropriate, alluding to the recognised standard of old age in those years.³⁵ Women were regarded as old and unable to work at an earlier age than men, showing that culture affected the way in which old age was perceived. However, Pat Jalland and John Hooper have pointed out that Edwardians had no clear ‘point of transition to old age’ and that they saw the menopause as the beginning of the final stage before death. Furthermore, medical professionals had not yet turned their interests to the elderly, still believing that senescence was not a treatable condition.³⁶ These beliefs hindered the establishment of any distinction between middle and old age in the interwar decades, and were reflected in the expert literature of medicine. Although not defending the early-twentieth-century attitude towards ageing and the aged, that failed to see senescence as a discrete stage, this chapter examines old age with middle age cases, as continuous phases in the female life cycle.

³⁴ Janet Roebuck, ‘When Does “Old Age” begin?: The Evolution of the English Definition’, *Journal of Social History*, 12:3 (1979), p. 417; Pat Thane, *Old Age in English History: Past Experiences, Present Issues* (Oxford: Oxford University Press, 2000), pp. 4-6; Andrews, *Senility before Alzheimer*, p. 5.

³⁵ Pat Thane, ‘Ageing: Older Women’, in Ina Zweiniger-Bargielowska (ed.), *Women in Twentieth-Century Britain: Social, Cultural and Political Change* (Harlow: Pearson, 2001), pp. 107-108.

³⁶ Jalland and Hooper, *Women from Birth to Death*, p. 285.

Sources and Sampling

This chapter is based on twenty Maudsley Hospital case notes, with another twenty from Holloway Sanatorium. Regarding the Maudsley samples, five of the most substantial cases have been chosen out of the data pool of each year: 1924-27, 1928, 1931 and 1935, organised according to the year of discharge. Selection has been made according to the age distribution within the group, in order to include middle- and old-aged patients corresponding to the original spread of the patient population of this institution.³⁷ In the Maudsley, as described in Chapter 4, the majority of its female patients were in their adulthood, and the number of patients aged over 45 was relatively small, in stark contrast to Holloway Sanatorium. At the Maudsley, as the patient age went up, the patient group size went down. Therefore, around a half of the sample cases fall into the age band 46-50; about a quarter of the selected cases relate to patients in their fifties and another quarter covers those aged over sixty. The same sample size has been taken for Holloway Sanatorium. All the available case files of female patients aged over 46 were procured.³⁸ The total number of case histories admitted between 1920 and 1935 were 97. From these which were organised by the order of admission, every fifth case has been selected to make the total sample number twenty.³⁹ In this chapter,

³⁷ To be more specific, in the selected Maudsley sample group, 20 in total, the number of patients in the age band 46-50 is 9; 51-55 is 4; 56-60 is 2; 61-65 is 3; and 66-70 is 2.

³⁸ Among cases admitted before 1930, the admission records had to be found in Medical Registers, which ended in 1930; and out of cases discharged after 1928, their discharge records had to be confirmed in Registers of Departure, which came into use in 1928. This double-checks the data in individual case notes and the records in official registers and, by doing so, secures the reliability of these materials.

³⁹ In this case, the patient committed suicide after discharge, probably by throwing herself out of a train, and the incident appeared in the press. The staff of Holloway Sanatorium made a clipping of the newspaper article at the end of the case file. A similar case can be found from the Maudsley Hospital

therefore, forty cases collected from the two institutions will be used as the main source, in order to reconstruct what middle- and old-aged female patients experienced in the course of their mental illness.

2. Lived Experience of Depression in Advanced Age: Symptoms

Somatic Symptoms

Pain in various parts of body was the most common complaint made by female depression patients in middle and old age. Mrs EA, aged 56, provided an unusual but vivid description of pain on her face, which ‘started deep in the right side of face, in front of the ears, and spread along the upper jaw to the mouth, and sometimes along the lower jaw.’ The Maudsley medical staff described it as a kind of hyperaesthesia, without identifying any cause.⁴⁰

Headache was, as seen in the previous chapters, more common than any other physical suffering. One patient of the Maudsley suffered from a ‘strange feeling in the back of her head’, ‘pins and needles in fingers’ and ‘awful taste in mouth’, which headed her complaint. This patient attributed her varied functional disorders, notably an inability to concentrate and

records, in which a discharged patient killed herself by gassing. The two will be juxtaposed and analysed in a section about suicidal attempts of the depressed and care (and aftercare) of self-destructive patients.

⁴⁰ Maudsley Hospital, Patient Casenotes, BRHAM CFM-001, Case No. F016.

to remember recent things, to her headaches.⁴¹ Another Holloway patient complained of severe headache accompanied by a ringing in her left ear, which, citing her own words, was ‘rushing and bugging through the head’. The medical staff of the Sanatorium found bromides helpful in controlling both the sound in the ear and the pain in her head.⁴²

Troubles with ‘bowels’ were astonishingly commonly mentioned in narratives of depressive patients aged over 46, and very often were intertwined with hypochondriacal ideas or obsessions. The most prevalent complaints made by them were that ‘my bowels do not act properly’ and that ‘my bowels are closed up’ or ‘blocked’. An interesting as well as typical illustration involving the somatic (and sometimes psychosomatic) symptom can be found from a Holloway patient. Mrs HTR was once put under ‘Weir Mitchell Treatment’ at home after having been worn out due to overwork, which did not accomplish the intended goal and rather caused severe constipation.⁴³ Since then, she found it extremely difficult to eat,

⁴¹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 8232/3472.

⁴² Holloway Sanatorium, Case Book: Females [Volume 27], SHC Ac. 3473/3/17, No. 4727.

⁴³ Silas Weir Mitchell, a neurologist from Philadelphia, consulted for a private nervous clinic since his return from the U. S. Civil War, and disseminated so-called the ‘rest cure’ by publishing books and articles from 1875, a treatment especially suitable for neurasthenic patients according to him. His books gained great popularity in Europe immediately after being translated into four languages, and his work was introduced to the British medical profession by William Smoult Playfair, an obstetric physician, from the early 1880s. Rest cure was almost always prescribed to women who were diagnosed as suffering from hysteria, hypochondriasis and notably, neurasthenia. The most famous patients who had been under this therapy were Charlotte Perkins Gilman and Virginia Woolf, both being vehement opponents to rest cure. The former was treated by S. W. Mitchell himself, and in the famous novel *The Yellow Wallpaper* described vividly how devastating the experience had been. Woolf also blamed George Savage, who prescribed her to have the perfect rest by neither reading nor writing, as ‘tyrannical’ and ‘short-sighted’, and found rest cure rather disastrous to her condition: Joanne Trautmann Banks, ‘Mrs Woolf in Harley Street’, *Lancet*, 351:9109 (1998), p. 1124; Ellen Bassuk, ‘The Rest Cure: Repetition or Resolution of Victorian Women's Conflicts?’, *Poetics Today*, 6:1 (1985), pp. 245-257; Hilary Marland, “‘Uterine Mischief’: W. S. Playfair and his Neurasthenic Patients’, in Marijke Gijswijt-Hofstra and Roy Porter (eds.), *Cultures of Neurasthenia from Beard to the First World War* (Amsterdam: Rodopi, 2001), pp. 118-123; Suzanne Poirier, ‘The Weir Mitchell Rest Cure: Doctor and Patients’, *Women's Studies: An Interdisciplinary Journal*, 10:1 (1983), 15-40;

believing that her bowels never acted and therefore her whole body was full up with food. On admission to the Sanatorium, she was, according to the medical staff, 'perfectly clear in her orientation' so that she could 'give a good account of her illness'. Mrs HTR, however, was fully persuaded by her own idea about her bowels and body, and suffered from stoppage and food refusal, resulting from the false belief, throughout her stay in the Sanatorium.⁴⁴

Constipation was not the only trouble related to bowels, of course. One Maudsley patient reported nausea and diarrhoea. She wondered, at first, if she had an abdominal problem, but came to believe that 'there is something seriously wrong inside'.⁴⁵ Another Maudsley patient ceaselessly complained about 'awful feelings in the stomach'. She associated the abdominal discomfort with pregnancy, even though the chance was fairly low considering her age, almost fifty.⁴⁶ These issues will be revisited later with regard to hypochondriacal delusions.

Food refusal, in an active way, was as prevalent amongst the older patients as their younger counterparts. Commonly, fasting has been regarded as a pathologic behaviour of female, middle class (or bourgeois) and the young. As acknowledged, anorexia nervosa was named and identified as a discreet illness in the modern sense in the late nineteenth century, and has been frequently associated with melancholia and depression, as well as with suicidal tendency. Joan Jacobs Brumberg, in her monumental work on the cultural history of anorexia nervosa, relates the food-refusing habit of female adolescence to their gender and class identity.⁴⁷ Anne Shepherd also finds in her research comparing two late-nineteenth-century

Shorter, *A Historical Dictionary of Psychiatry*, p. 180.

⁴⁴ Holloway Sanatorium, Case Book: Females [Volume 27], SHC Ac. 3473/3/17, No. 4862.

⁴⁵ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 4133.

⁴⁶ Maudsley Hospital, Patient Casenotes, BRHAM CFM-031, Case No. 3297/1639.

⁴⁷ Joan Jacobs Brumberg, *Fasting girls: The Emergence of Anorexia Nervosa as a Modern Disease*. (New York: Vintage Books, 1988), pp. 6-8.

mental institutions, that eating disorders were frequently experienced by middle-class patients whereas ‘markedly less so’ in cases of county asylum patients.⁴⁸ Such association between fasting and class is still observed in the sample cases relating to Holloway Sanatorium and the Maudsley Hospital scrutinised here. There is a wide discrepancy in the rate of food-rejecting patients between the hospitals, as more than twice as many Holloway inmates were troubled by eating disorders than the Maudsley patients. Even though the Maudsley was never solely for working-class or pauper patients, most of its self-starving patients were from middle-class backgrounds. Taking the most severe cases, in which tube feeding was applied for therapeutic purpose, the patients shared similar backgrounds: Miss BC and Miss LAP were from the middle class and worked as teachers before having their current attacks.⁴⁹ However, the tentative conclusion that those suffering from eating disorders were mostly young women does not fit with what Holloway Sanatorium patients experienced. Among the sample cases, at least a quarter strongly resisted food and most of the fasting patients had to be tube-fed. It seems that we need to be free from the stereotype of ‘fasting girls’ in order to have a proper understanding of eating disorder as a female issue.

Mood Disorders

⁴⁸ Anne Shepherd, ‘The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums’, in Jonathan Andrews and Anne Digby (eds.), *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam: Rodopi, 2003), p. 239.

⁴⁹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-031, Case No. P261; CFM-149, Case No. 8737; CFM-149, Case No. 8737.

Low mood was the core experience, almost no patient was free from it. However, as pointed out in previous chapters, detailed and vivid descriptions of patients' emotional states are more difficult to attain than those of physical condition. The case notes for Holloway Sanatorium are straightforward and monotonous regarding what and how its patients felt, compared to those of the Maudsley. The medical staff of Holloway appeared to be more passive observers, watching sufferers' behaviours and recording them, rather than active engagers who induced patients to express verbally their inner turbulence. As a result, the details about patients' emotional states are based more on professional perception than on individual patient's verbal description, unless what a sufferer articulated in person is specifically indicated. The terms frequently applied to describe a patient's mental condition, at the beginning of every case note alongside the physical condition, included 'depressed', 'agitated' and 'restless'. 'Anxious', 'worried' and 'miserable' were also used fairly often, and 'unoccupied' or 'unable to occupy herself' and 'self-centred' were regularly used.⁵⁰ Nonetheless, it is still possible to trace what Holloway patients felt, through some (exceptional) cases in which patients articulated their inner states spontaneously. For example, Miss LMR, aged 50, stated she was less able to control her thoughts than she had been before, that she regarded herself as a complete failure, and that she could find 'nothing humane' inside herself.⁵¹

The Maudsley Hospital records provide more opportunities to unearth personalised experiences of mental illness, both psychological and physical. According to Aubrey Lewis, who had been working as a 'first assistant medical officer' since 1928 at the Maudsley, the medical staff of the Hospital put 'neutral questions' to patients, such as 'how do you feel?',

⁵⁰ Holloway Sanatorium, Case Book: Females, SHC Ac. 3473/3/15-16.

⁵¹ Holloway Sanatorium, Discharge Case Book: Females, SHC Ac. 7267/3/28, No. C5131/V2016.

‘how are your spirits?’ and ‘what is your mood?’, in order to let patients find their own description.⁵² Some of the Maudsley case files include ‘sample talk’, the transcripts of a part of a conversation between patient and doctor taken during the medical examination, through which we can reconstruct the everyday medical practice of the Hospital as well as grasp what occurred in a patient’s mind and how they themselves articulated their illness. In order to comprehend the emotional turbulence of those suffering from depression, it would suffice here to cite an exemplary case in which the patient revealed her condition in person. Miss EBY, a 46-year-old millinery worker, was hospitalised at the Maudsley due to depression accompanying somatic troubles in 1935. In her sample talk, when asked how she felt, Miss EBY answered ‘I feel sort of dazed, awkward and funny. I can’t describe it’. To the next question regarding her ‘spirits’, she replied only briefly: ‘very low.’ In a series of following inquiries, she enumerated typical expressions of depression: such as ‘I am all alone, as if I am living by myself’ and ‘I seem, such a helpless thing’.⁵³ In relation to other patients’ case files, complaints with regard to their mood hardly digressed from typical contents. For example, one said ‘I am being in a world all of my own’, which was repeated in various forms by many other patients. Another complained of inability to function as before, stating ‘I can’t concentrate. (...) I can’t pull myself together to think or do anything’. Still another presented a pessimistic view of herself, saying ‘I will never be able to do anything at best’. Interestingly enough, expressions which were frequently applied by the medical staff of the Holloway Sanatorium, such as ‘depressed’, ‘agitated’, ‘miserable’, ‘restless’, and ‘unoccupied,’ were

⁵² Aubrey Lewis, ‘Melancholia: A Clinical Survey of Depressive States’, *Journal of Mental Science*, 80:329 (1934), p. 279: Lewis argued that questions which could offer patients a choice of words, such as “are you worried?”, should be eschewed, although some of prominent contemporary psychiatrists, notably Henderson and Gillespie, preferred them.

⁵³ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 8232/3472.

rarely used by those patients themselves to explain their mood. However, this does not mean that patients suffering from depression in the two mental hospitals went through different kinds of symptoms from each other. Such discrepancy can be understood as resulting from the way in which the patients' experience was heard and how their medical records were kept, rather than what the sufferers underwent during the course of mental illness.

Hallucination and Delusion

One of the distinctive features recorded of depression occurring in midlife and senescence was the high frequency of hallucination and delusion. Depression was thought to be, basically, a form of affective disorder, and therefore the distorted sensory experiences and false beliefs were regarded as non-essential manifestations of the mental illness. When Henderson and Gillespie applied the expression 'a triad of symptoms' of depression, it included 'difficulty in thinking, (mood) depression, and psychomotor retardation'.

Hallucination and delusion were among what could be superadded to those basic symptoms. However, among those diagnosed with depression and aged over 46, the two symptoms were so prevalent, especially delusion, that only a minority of patients were completely free from them, in contrast with their younger counterparts. For instance, in the Holloway patient group, eighteen out of twenty were deluded, albeit to varying degrees, and seven suffered from hallucinatory experiences, mostly aural ones. With long-stay patients, the detailed aspect and experience of these symptoms could change over time.⁵⁴ At the Maudsley, among

⁵⁴ If the symptoms were aggravated remarkably, the medical staff of Holloway Sanatorium had to

twenty patients in the sample group, eleven were troubled by delusional ideas and four by hallucinatory experiences. These figures are lower than those of Holloway Sanatorium, but still higher compared to younger patient groups in the same institution, where about over one third suffered from these unreal experiences.

In the cases that involved hallucination, most of the patients had auditory experiences. Mrs GF, aged 68, heard God's voice informing her when she was to be 'taken away' and to go to Hell;⁵⁵ Mrs JL, in her mid-sixties, said to the nurse that 'whisperings' listed the wicked things she had done and they seriously agitated her;⁵⁶ Mrs KLY, a 46-year-old housewife, was 'interrupted' during medical examination because of a voice constantly telling her 'that is all a pack of lies';⁵⁷ and Miss EFT, a retired teacher, also heard voices accusing her of crimes and threatened to broadcast them to everyone.⁵⁸ As these examples show, many of these patients heard imaginary voices blaming them for their wrong-doings, and applied religious expressions, such as sin, God and Hell. Although not as frequent as auditory hallucination, visual experience often troubled depressed patients. A Holloway patient, for instance, saw a medical officer of the Sanatorium in her room when he was not there. An exceptional case is that of Mrs SA, who suffered from multiple hallucinations with aural, osmatic and tactual natures. She heard a voice usually threatening her, felt 'various sensations of electric shocks' all over her body, and furthermore smelt gas. In describing such experiences, she applied unique expressions: some gas was blown into her room through pipes from the lavatory in her

check to see whether the case had turned into senile dementia. However, even when the professionals observed symptoms beyond the bounds of simple depression or melancholia, re-diagnosis was rarely made.

⁵⁵ Holloway Sanatorium, Case Book: Females [Volume 27], SHC Ac. 3473/3/17, No. 4727.

⁵⁶ Holloway Sanatorium, Case Book: Females [Volume 27], SHC Ac. 3473/3/17, No. 4815.

⁵⁷ Holloway Sanatorium, Discharge Case Book: Female, SHC Ac. 7267/3/24, No. C5464.

⁵⁸ Holloway Sanatorium, Discharge Case Book: Female, SHC Ac. 7267/3/27, No. C5491.

house; and another had an ‘unearthly smell’ which she associated with brothels and her husband’s mistress. As this case demonstrates, hallucinatory experiences were often inseparable from delusional ideas, and sometimes reinforced, or were reinforced by, the false beliefs.⁵⁹

In both institutions, more patients suffered from delusion than hallucination and their experiences were too varied to generalise. In identifying patterns in patients’ narratives relating to their delusional ideas and experiences, a classificatory frame suggested by Lewis in his ‘Melancholia: A Clinical Survey of Depressive States’ can be applied here. Lewis categorised the ‘false judgments’ into four sub-groups depending on the subject: those about one’s self (of sin and fault); about one’s possession (of poverty and ruin); about the possibility of recovery (or hopelessness); and about others (of being despised, punished, persecuted, and of causing harm).⁶⁰ All the subjects he mentioned in the list were experienced, of course, by female patients of the Maudsley and Holloway, with some variances in the details.

‘I am so wicked’ was a typical opening line of patients who believed themselves to have done something wrong, either morally or practically. Although, as seen from previous chapters, delusional ideas about fault and sin were not uncommon amongst young patients suffering from depression, such false judgments were markedly prevalent in the older patient group under scrutiny in this chapter. They were expressed more eloquently through the application of various and vivid language. Mrs JL of Holloway, a housewife from a middle-class background, introduced herself as the worst woman in the world, who had committed

⁵⁹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-001, Case No. 350/673.

⁶⁰ Lewis, ‘Melancholia: A Clinical Survey’, pp. 306-312.

every crime, including murder, an archetypal remark of those with delusional ideas of wrongdoing.⁶¹ The description of delusion provided by Mrs RA, a Maudsley inpatient, was somewhat verbose: that she had done wrong consistently; that she had committed a crime; that the police were after her in order to send her to prison; and that she was under surveillance,⁶² all of which appeared common. Besides, she made a prediction that ‘a big thing was going to happen to everyone’.⁶³ As seen in Mrs RA’s narratives, patients suffering from these kind of delusional ideas frequently used certain words: crime, police, arrest and prison, indicating the broader picture of their delusion. Meanwhile, many of patients belonging to the over 46 age band applied religious (or religion-tinged) language in describing their delusion, much more frequently than their younger counterparts. One Holloway patient insisted that she was a sinner, being ‘under [an] evil spell’,⁶⁴ another identified herself as a ‘devil’,⁶⁵ and still another was convinced that she had two people inside, herself and Satan.⁶⁶

Delusional ideas about possession and deprivation, the second category suggested by Lewis, were especially prevalent among middle- and upper-class patients, although this kind of false belief the psychiatrist ‘found in only a few patients’.⁶⁷ However, in contradiction to his conclusion, many Holloway patients were obsessed with poverty. For instance, a 50-year-old married woman worried that she would be ‘turned out in the street with [her] children’,⁶⁸

⁶¹ Holloway Sanatorium, Case Book: Females [Volume 27], SHC Ac. 3473/3/17, No. 4815.

⁶² She even stated that ‘I sometimes feel that I was being watched. I was a bit suspicious that two of the nurses were watching me’, and pointed out the two nurses in person.

⁶³ Maudsley Hospital, Patient Casenotes, BRHAM CFM-066, Case No. 2399.

⁶⁴ Holloway Sanatorium, Case Book: Females [Volume 26], SHC Ac. 3473/3/16, No. 4607.

⁶⁵ Holloway Sanatorium, Case Book: Females [Volume 25], SHC Ac. 3473/3/15, No. 4527.

⁶⁶ Holloway Sanatorium, Case Book: Females [Volume 26], SHC Ac. 3473/3/16, No. 4654.

⁶⁷ Lewis, ‘Melancholia: A Clinical Survey’, pp. 306-307.

⁶⁸ Holloway Sanatorium, Case Book: Females [Volume 26], SHC Ac. 3473/3/16, No. 4617.

and another lady in her sixties firmly believed that she had to ‘sell matches in the street’.⁶⁹ Several other patients complained of a lack of money, food or clothes, all using surprisingly similar expressions.⁷⁰ Nonetheless, few Maudsley patients revealed such obsessions, in stark contrast to the Holloway cases. It appears that the discrepancy shown between the two institutions with regard to delusion of poverty related to class identity or crisis consciousness which was shared by the conventional middle class in an era of change. It also illustrates that anxiety over financial instability, which according to Akihito Suzuki had driven labouring men into insanity in the mid-Victorian age, still wielded a strong influence even over those who belonged to a different sex and social class.⁷¹ The issue will be discussed in detail later when I deal with prolonged mental stress related to financial states as an aetiological factor.

Following Lewis’s classification, obsession with death was a part of ‘false judgment about one’s possession’.⁷² Delusional ideas associated with death were intensively experienced especially by the elderly and were fairly common among either those who had recently experienced bereavement or those whose physical condition was not good. In an exemplary case, Mrs AN, a 50-year-old widow, was obsessed about her husband’s illness and death and her own death. Since her bereavement, eight months before her admission to the Maudsley, she had suffered from vivid imaginative representations of her husband’s funeral. She repeatedly expressed a great fear of death, which she believed was pending, and detailed

⁶⁹ Holloway Sanatorium, Case Book: Females [Volume 26], SHC Ac. 3473/3/16, No. 4612.

⁷⁰ Holloway Sanatorium, Case Book: Females [Volume 28], LWIHM Acc. 343440, MS 5161; Case Book: Females [Volume 27], SHC Ac. 3473/3/17.

⁷¹ Akihito Suzuki, ‘Lunacy and Labouring Men: Narratives of Male Vulnerability in Mid-Victorian London’, in Roberta Bivins and John V. Pickstone (eds.), *Medicine, Madness and Social History* (Basingstoke: Palgrave Macmillan, 2007), pp. 118-128.

⁷² Lewis, ‘Melancholia: A Clinical Survey’, pp. 306-307.

her own funeral that she saw in her imagination.⁷³ More common complaints made by those who were anxious about death were associated with the possibility of being killed. For instance, Miss BE of Holloway Sanatorium was assured ‘you [the medical staff of the Sanatorium] are all killing me inch by inch’.⁷⁴

Thirdly, hypochondriacal preoccupation was much more prevalent among those in mid-life and senescence stages than their younger counterparts, and the likelihood of having this sort of delusion increased when a patient suffered from any somatic symptom. In his article, Lewis took special note of these false beliefs applied to the condition of health, assigning a good deal of space to analysing hypochondriacal cases, which seems to reflect how commonplace it was amongst depressed patients.⁷⁵ It accords with Edward Shorter’s finding in his work on cultural origins of psychosomatic symptoms that delusions relating to the body became more frequent in the early twentieth century when delusional depression was in general and drastic decline.⁷⁶ Among various obsessions regarding body and health, extreme pessimism over the recovery from the mental illness was by far the most commonplace, which was never limited to middle- and old-aged patients. For example, a Holloway patient said that ‘I never shall get well again,’⁷⁷ and a Maudsley patient repeated that it was impossible for her to recover and feared that she might die at the Hospital.⁷⁸

Unreasonable concern over ‘bowels’ was expressed with great frequency by old female

⁷³ Maudsley Hospital, Patient Casenotes, BRHAM CFM-001, Case No. F4660/F1349.

⁷⁴ Holloway Sanatorium, Case Book: Females [Volume 26], SHC Ac. 3473/3/16, No. 4607.

⁷⁵ Lewis, ‘Melancholia: A Clinical Survey’, pp. 307-311.

⁷⁶ Edward Shorter, *From the Mind into the Body: The Cultural Origins of Psychosomatic Symptoms* (New York: Free Press, 1994), pp. 140-141.

⁷⁷ Holloway Sanatorium, Case Book: Females [Volume 26], SHC Ac. 3473/3/16, No. 4607.

⁷⁸ Maudsley Hospital, Patient Casenotes, BRHAM CFM-001, Case No. F4660/F1349.

patients, corresponding to Lewis's findings from his medical practice.⁷⁹ A good example was provided by Mrs HTR of Holloway. The patient suffered from abdominal discomforts and subsequently had considerable difficulties in eating. She was convinced that her body was filled up with food, 'right up to her throat', because of the malfunction of her bowels.⁸⁰ Another Holloway patient, Mrs TEA, a housewife in her late forties, already troubled by various obsessive ideas, developed delusions about 'stoppage' during her confinement at the Sanatorium and came to insist that 'it [her rectum] had not opened'.⁸¹ The narratives of Mrs HTR and Mrs TEA were surprisingly similar to what Lewis cited in his articles based on case histories he had collected in person through his medical practice.⁸² To suggest less conventional examples, Mrs GF was certain that there was a 'milk-clot in her intestine',⁸³ and Mrs LC, aged about 50, interpreted abdominal discomfort and strange feelings in her stomach as indications of pregnancy.⁸⁴

Here a question should be raised. Why were these patients so obsessed with their bowels rather than other parts of their bodies? James Whorton's work provides a hint which can help us trace the origin of such pathological preoccupation with defecation. According to him, during the mid-nineteenth century a 'culture of constipation' emerged in Britain (and America), as a result of a variety of factors working together: scientists devised so-called 'intestinal autointoxication theory', warning of the possibility of self-poisoning from one's own faeces lodged in the intestines; physicians emphasised the importance of 'daily

⁷⁹ Lewis, 'Melancholia: A Clinical Survey', p. 308.

⁸⁰ Holloway Sanatorium, Case Book: Females [Volume 27], SHC Ac. 3473/3/17, No. 4862.

⁸¹ Holloway Sanatorium, Case Book: Females [Volume 27], SHC Ac. 3473/3/17, No. 4763.

⁸² Aubrey Lewis, 'Melancholia: Prognostic Study and Case-Material', *British Journal of Psychiatry*, 82:340 (1936), pp. 488-558; Lewis, 'Melancholia: A Clinical Survey', p. 308.

⁸³ Holloway Sanatorium, Case Book: Females [Volume 27], SHC Ac. 3473/3/17, No. 4727.

⁸⁴ Maudsley Hospital, Patient Casenotes, BRHAM CFM-031, Case No. 3297/1639.

evacuation of the bowels', because it was the most positive proof that the body was functioning efficiently; medical entrepreneurs were eager to make a handsome profit by meeting the drastically increasing demand for purgative medicines; and reformers working for improvements of sanitary, hygiene and health joined this movement.⁸⁵ By the turn of the century, constipation, the opposite of such regularity, came to be considered 'the mother of all disease', and during the early twentieth century the 'culture' enjoyed its climax. The public mind was fixated on autointoxication theory and intestinal health as never before.⁸⁶ By the interwar years, the medical profession was about to abandon the theory and related practices, including colectomy, albeit some remained fervent advocates, notably Sir William Arbuthnot Lane who was called 'the greatest modern interpreter of autointoxication'.⁸⁷ The popular belief and behaviour, however, moved in the opposite direction, as obsession with constipation by the lay public reached its golden age between the World Wars.⁸⁸ The hypochondriacal concerns, often excessive, over bowel movement shown by female patients in Holloway and the Maudsley appeared to be direct reflection of this social and cultural climate. It is likely that in such an environment these patients found their bowels a socially acceptable focus for their hypochondriasis, albeit rarely applying the jargon 'autointoxication'.⁸⁹

The last category of false judgment experienced by the depressed concerned a

⁸⁵ James Whorton, *Inner Hygiene: Constipation and the Pursuit of Health in Modern Society* (Oxford: Oxford University Press, 2000), pp. 1-54; Whorton, 'Civilisation and the Colon: Constipation as the "Disease of Diseases"', *British Medical Journal*, 321:7276 (2000), p. 1586.

⁸⁶ Whorton, *Inner Hygiene*, pp. 56-57.

⁸⁷ Ina Zweiniger-Bargielowska, 'Raising a Nation of "Good Animals": The New Health Society and Health Education Campaigns in Interwar Britain', *Social History of Medicine*, 20:1 (2007), pp. 73-79.

⁸⁸ Whorton, *Inner Hygiene*, p. 79.

⁸⁹ Shorter, *From the Mind into the Body*, pp. 13-19.

preoccupation with ‘others’, too varied subjects to be grouped under one heading. The descriptions that delusional patients gave of their preoccupation with others differed little from narratives centred on themselves. The most frequent fears included false and unreal beliefs that their families or friends were endangered, killed, followed by the police or imprisoned. Mrs AAC, a voluntary boarder of Holloway, believed that her son was outside the Sanatorium ‘being murdered’, and was eventually certified when her delusion became aggravated.⁹⁰ Miss BC of Maudsley, a 50-year-old teacher, feared that she would kill her sister, which led her to implore strangers to separate them in order to prevent such an incident before her admission.⁹¹ Miss LAP, also a teacher in her early fifties, constantly alluded to a sexual relationship between herself and her brother-in-law. Simultaneously, she worried that she was to be arrested for the misconduct, and believed that her brother-in-law would get into trouble too.⁹²

Closing the clinical analysis on delusions in depression cases, Lewis added that there was ‘a definite and overt sexual colouring to the delusions and preoccupations’,⁹³ which was true with older female patients. Some patients mentioned briefly that they had ‘sexual disturbances’, ‘sexual ideas’, or ‘sexual feelings’, without giving any detail,⁹⁴ whereas others provided vivid descriptions of the obsessions they had. At the Maudsley, the aforementioned case of Miss LAP contained sexual elements in her false belief about herself and her brother-

⁹⁰ Holloway Sanatorium, Discharge Case Book: Female, SHC Ac. 7267/3/24, No. C5373/V2289.

⁹¹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-031, Case No. P261.

⁹² Maudsley Hospital, Patient Casenotes, BRHAM CFM-149, Case No. 8737.

⁹³ Lewis, ‘Melancholia: A Clinical Survey’, pp. 311-312.

⁹⁴ Holloway Sanatorium, Case Book: Females [Volume 26], SHC Ac. 3473/3/16, No. 4607; Case Book: Females [Volume 27], SHC Ac. 3473/3/17, No. 4740; Discharge Case Book: Female, SHC Ac. 7267/3/28, No. C5131/V2016.

in-law,⁹⁵ and another patient developed a delusion concerning her husband's fidelity.⁹⁶ Worse, Mrs MFA claimed that her husband and her daughter had had 'illicit intercourse'.⁹⁷ At Holloway Sanatorium, Mrs AAC, a 73-year-old widow, built up delusional ideas during her stay at Holloway that she was pregnant by a doctor there and would marry him soon.⁹⁸ Mrs KLY, a 47-year-old housewife, developed 'elaborate delusions', that the flat below hers was a 'brothel' where people 'practiced every imaginable kind of vice' and even her husband and her brother had homosexual relations.⁹⁹

Self-Reproach

As illustrated in earlier chapters, self-reproach was a distinctively feminine characteristic of mental illness, from which the aged patients were not immune. Although guilty conscience was so common in all age groups as to be called one of 'the most striking melancholic symptoms' by Lewis,¹⁰⁰ its content and basis varied with age. Applying the classification of female self-reproach cases which has been suggested in Chapter 3, the first category was about those who blamed themselves on the ground of vague reasons: including moral or religious failings, minor wrongdoing in the past, and misinterpretation of reality. In particular, ideas of sin were a regular feature of self-accusation among those in middle and old age, and

⁹⁵ Maudsley Hospital, Patient Casenotes, BRHAM CFM-149, Case No. 8737.

⁹⁶ Maudsley Hospital, Patient Casenotes, BRHAM CFM-031, Case No. 2881/1474.

⁹⁷ Maudsley Hospital, Patient Casenotes, BRHAM CFM-001, Case No. F1446.

⁹⁸ Holloway Sanatorium, Discharge Case Book: Female, SHC Ac. 7267/3/24, No. C5373/V2289.

⁹⁹ Holloway Sanatorium, Discharge Case Book: Female, SHC Ac. 7267/3/24, No. C5464.

¹⁰⁰ Lewis, 'Melancholia: A Clinical Survey', p. 312.

certain adjectives, such as ‘wicked’, ‘selfish’ and ‘evil’, were intensively employed in describing this kind of guilt. For example, Mrs FBT firmly believed that she had committed ‘the unpardonable sin’, with no further explanation, and spent most of the time in the Maudsley reading her Bible in order to repent. Kraepelin’s claim that ‘the domain of religion’ provided peculiarly favourable soil for self-reproach was more true with this group of patients, since the older patients got, the more they inclined to adopt a religious tinge to their self-accusation.¹⁰¹ Meanwhile, Lewis pointed out that the self-reproachful tended to misrepresent actual happenings, rather than inventing them, and to exaggerate personal responsibilities in the process. Interestingly enough, many patients blamed themselves for falling victim to mental disorder: Miss LAP, aged 51, accused herself for ‘causing the state of mind’,¹⁰² and Miss PGC, in her mid-sixties, condemned herself for bringing ‘disgrace’ to her family by being admitted to a mental institution.¹⁰³

The second group of self-reproach cases related to the traditional feminine role of caregiver. Amongst younger patients, as seen in earlier chapters, many denounced themselves as either neglectful mothers or unqualified housewives. In the older generation, however, the focus of self-accusation shifted, as more subjects were involved in nursing the invalids within the family, which reflected the change in the role of women in this life stage. For instance, Mrs EGK, aged 60, suffered from tremendous guilt about ‘neglecting her parents’. She had taken care of them for years, both aged over 90, and came to develop a guilty conscience in the course of repeated admissions to Holloway that she had not carried out her responsibility

¹⁰¹ Emil Kraepelin, Mary Barclay (trans.), and George Robertson (ed.), *Manic-Depressive Insanity and Paranoia* (Edinburgh: Livingstone, 1921), pp. 81-83.

¹⁰² Maudsley Hospital, Patient Case Files, BRHAM CFM-149, Case No. 8737.

¹⁰³ Holloway Sanatorium, Case Book: Females [Volume 28], LWIHM Acc. 343440, MS 5161, No. 4926.

as a carer. She further evolved delusional ideas about the ‘terrible state’ of her parents’ house, with ‘all the windows (...) broken’.¹⁰⁴ In many cases, the experience of bereavement seemed to increase the feeling of guilt. Mrs MRB of the Maudsley, a 52-year-old widow of a clergyman, accused herself for neglecting her family and believed that her own illness ‘hasted the end of her husband’.¹⁰⁵ Miss CEE of Holloway, aged 64, had lived with a life-long friend, who passed away five months previously to her admission. According to the certificate, the patient believed that she was responsible for her friend’s death and was ‘full of remorse for [her] callous conduct’. Her case file is filled with various expressions of guilt: she had led a selfish life while living with the friend; and she did not treat the friend well enough especially when she was ill.¹⁰⁶ As pointed out repeatedly, social convention imposed the responsibility of care-giving upon women, which influenced the character of the mental illness experiences.¹⁰⁷ Both the sense of burden engendered by this traditional feminine role and the sense of guilt which these women felt on finding themselves failing in the task were frequently experienced, especially in specific stages of female life.

In the last category, patients’ self-reproach centred on their sexual behaviour. As seen in previous chapters, this kind of self-accusation was made fairly often by female patients in earlier life stages, notably regret for masturbation or premarital/extramarital intercourse. However, in the middle- and old-aged patient group, the number of those feeling guilty about sexual experience in the past was low, compared to observations taken from cases relating to younger patients. In this patient group, only a handful were troubled by a sense of shame

¹⁰⁴ Holloway Sanatorium, Discharge Case Book: Female, SHC Ac. 7267/3/29, No. 2398.

¹⁰⁵ Maudsley Hospital, Patient Casenotes, BRHAM CFM-003, Case No. FP 6.

¹⁰⁶ Holloway Sanatorium, Case Book: Females [Volume 26], SHC Ac. 3473/3/16, No. 4654.

¹⁰⁷ Katherine Holden, ‘Family, Caring and Unpaid Work’, in Zweiniger-Bargielowska (ed.), *Women in Twentieth-Century Britain*, pp. 134-147.

from self-abuse, the chief topic for self-reproachful adolescent patients. A 50-year-old Maudsley patient stated that ‘it was a wrong thing to do to herself’ and feared that she might be sent to prison for her habit of masturbation.¹⁰⁸ Guilt over extramarital sexual relationships, one of the common subjects referred to by mature female patients, was only occasionally expressed. A Holloway boarder, aged 49, confessed that she was not a virgin when she married and that this had caused her guilty conscience thereafter.¹⁰⁹

Suicidal Tendency and Attempt

As acknowledged, suicidality covers various behaviours and intentions, ranging from simple wish to die to successful attempt of self-murder, which means that it is necessary to give a clear definition of the term.¹¹⁰ In this discussion the term will be applied only to those who attempted suicide with the firm intention of dying or were on the brink of such action. Thus, those who only expressed a desire for death or threatened to ‘end it all’ will be excluded on discussing the subject here.¹¹¹

At the Maudsley Hospital, the tendency of female patients aged over 46 to attempt suicide was considerably lower than that of Holloway patients in the same age group, but higher than that of younger patients treated at the same institution. Among the sample cases,

¹⁰⁸ Maudsley Hospital, Patient Casenotes, BRHAM CFM-066, Case No. 2399.

¹⁰⁹ Holloway Sanatorium, Case Books: Females, SHC Ac. 3473/3/16, no. 4590.

¹¹⁰ Anne Shepherd and David Wright, ‘Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint’, *Medical History*, 46 (2002), p. 179.

¹¹¹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-031, Case No. 3297/1639.

twenty in total, five women took direct actions to take their own lives during their current attack, and one of them repeatedly attempted suicide. If those who had ever thought about or had threatened to commit suicide were included, however, the total number of suicidal patients rose to around a half of all the patients. Regarding the self-destructive measures used by the middle-aged and the elderly, gassing was used most, accounting for three out of five attempts,¹¹² and drowning the second, a conventional feminine way of self-killing.¹¹³ The result coincides, by and large, to what has been found based on younger patient cases in the previous chapter. Exceptionally, Mrs AB, who had a long history of suicidal attempts dating back eight years, exploited a knife in her second attempt to end her life two weeks before her admission to the Maudsley, a method rarely adopted by women.¹¹⁴

At Holloway Sanatorium counting the proportion of suicidal patients is more complicated because there were two groups of patients, markedly different from each other in terms of the severity of their condition: certified patients and voluntary boarders. In general, more Holloway inmates than Maudsley patients were suicidal, and the propensity of patients aged over 45 to attempt suicide at Holloway was not much different from those under 45. If sample cases are consulted, twelve patients out of twenty had been labelled as suicidal by the medical staff on admission or while confined. Among them, eight put their self-destructive

¹¹² Maudsley Hospital, Patient Casenotes, BRHAM CFM-030, pp. 789-812; CFM-031, Case No. 3063/1545; CFM-067, Case No. 6171.

¹¹³ Maudsley Hospital, Patient Case Files, BRHAM CFM-150, Case No. 4969. Consulting the nineteenth-century data, female committers chose drowning most, hanging second, and poisoning third as methods of suicide, whereas males applied hanging and cutting most frequently for the same purpose: Anna Shepherd, *Institutionalizing the Insane in Nineteenth-Century England* (London: Routledge, 2014) p. 154.

¹¹⁴ This finding coincides to what we have seen in the previous chapter about mature female patients: gas oven was frequently adopted especially by suicidal women who kept household by themselves and therefore were familiar to the device.

ideas into practice during the current attack, all of whom were certified. The case of Miss PM was exceptional: she cut her throat with a pair of scissors while she was hospitalised at Holloway Sanatorium as a voluntary boarder. In total, about 40 percent of certified patients could be classified as suicidal, whereas less than 10 percent of voluntary boarders showed suicidal propensity and most of them went on to be certified and re-categorised accordingly. The means used by these Holloway patients to attempt suicide were varied: strangulation and drowning were common; the use of knife, scissors, an overdose, and gassing appeared once each in the case study.

According to Olive Anderson, in Victorian and Edwardian England ‘a middle-aged married woman suffering from melancholia’ was increasingly considered as a stereotype of suicidality, under which many of the patients under scrutiny in this chapter fell.¹¹⁵ Then, is it possible to apply this proposition to the female patients treated during the interwar period whose case histories are examined in this research? Consulting Holloway case notes of certified patients who were hospitalised between 1922 and 1926 and diagnosed as suffering from either melancholia or depression, 27 out of 50 inmates were identified as suicidal. The figure is much higher than the estimate suggested in this research, because the Holloway medical staff included those who were ‘inactively’ suicidal, that is dreaming about it or threatening to do it, besides those who actually made suicidal attempts. Also, the figure is considerably higher than the average suicide rate, which was ‘superficially’ 20 to 30 percent of the whole inmate population,¹¹⁶ because all the cases were certified and therefore

¹¹⁵ Olive Anderson, *Suicide in Victorian and Edwardian England* (Oxford: Clarendon, 1987), pp. 406-407.

¹¹⁶ This figure should not be taken as it is because the danger of individual patients was in many cases exaggerated due to practical reasons, notably securing a bed in already crowded asylum wards. Therefore the ‘real’ scale of suicidal patients could be smaller than the suggested percentage.

relatively more severe than average. Grouping the suicidal patients according to marital status, the number of those who were married was almost double the figure for those who were single or widowed. However, age did not make any significant difference in terms of suicide rate, except that the figure dropped in the elderly group, notably those aged over 65.¹¹⁷ The nineteenth-century belief that the female suicide rate ‘increased markedly though briefly at both puberty and the menopause’ did not fit the pattern shown by the Holloway patients in their climacteric period, aged between 46 and 55.¹¹⁸ The stereotype of suicide and suicidality reflected and explained only part of the reality.

With regard to the methods of suicide, the experience of those studied here coincides not only with what contemporary psychiatrists observed, but also with what is argued by historians with special interests in this subject. Even in the last decades of the nineteenth century asylum doctors had identified gender differences in suicidality: men tended to attempt suicide less often, but more successfully, mainly because they applied more violent methods, such as cutting and shooting; women were more inclined to commit suicide than men, but preferred drowning and poisoning, less destructive measures, with a lower success rate.¹¹⁹ Two contemporary observers studying suicidal cases from two British towns in the 1880s revealed that males preferred hanging and cutting (of the throat) whereas females chose drowning.¹²⁰ The clinical survey on melancholia made by Lewis confirmed these patterns, noting that female committers preferred specific ‘forms’ of self-destruction, such as

Shepherd and Wright, ‘Madness, Suicide and the Victorian Asylum’, p. 194.

¹¹⁷ Holloway Sanatorium, Case Book: Females [Volume 26], SHC Ac. 3473/3/16; [Volume 27], SHC Ac. 3473/3/17; [Volume 28], LWIHM Acc. 343440, MS 5161.

¹¹⁸ Anderson, *Suicide in Victorian and Edwardian England*, p. 45.

¹¹⁹ Shepherd and Wright, ‘Madness, Suicide and the Victorian Asylum’, p. 186.

¹²⁰ *Ibid.*, pp 186-187; Shepherd, *Institutionalizing the Insane in Nineteenth-Century England*, p. 154.

drowning, poison and gas, but did not suggest why there existed such gender difference.¹²¹ Meanwhile, some historians have identified changes in the methods chosen to commit suicide over time, mostly brought about by the introduction of new technology. As illustrated in the previous chapter, the gas oven, which rapidly spread from the last decade of the nineteenth century, offered a new ‘painless, accessible, reassuringly familiar means of escape from this world’ to more women than men. Resort to this new method of suicide soared particularly amongst women, and had overtaken traditional means already by the mid-1920s.¹²² As noted earlier, over half the suicidal patients at the Maudsley used the gas oven in their own kitchen, and, as seen in Chapter 4, more women in their adulthood attempted suicide using this method. At Holloway, however, only a few chose this method, suggesting that social class influenced the means chosen to take life.

Nonetheless, class differentials in suicidal methods were neither mentioned by contemporary observers, nor have attracted the academic interests of historians which the subject deserves. Even Anderson, who has emphasised that various factors, including time, place, gender and age, affected individual experiences of suicide, did not take class seriously in relation to the choice of method to commit suicide.¹²³ At Holloway, well into the interwar years, patients of all ages preferred conventional feminine ways of death, such as drowning and strangulation, to the novel (and feminine) method, gassing. Surprisingly, the number of female boarders at Holloway who adopted so-called male means of suicide, notably cutting, was even larger than the figure of those who used gas. During the nineteenth century the

¹²¹ Lewis, ‘Melancholia: A Clinical Survey’, pp. 340- 343.

¹²² Anderson, *Suicide in Victorian and Edwardian England*, p. 367.

¹²³ *Ibid.*, p. 3.

advent of the railway network introduced a new way of committing suicide,¹²⁴ but it did not have the same impact on every category of suicide. Jumping beneath a moving train was preferred by middle-class (and middle-aged) women and was rarely tried by members of the working class or the young. The generational differences in the choice of suicide methods, like that relating to class, remains an uncharted subject.

Professional care for the suicidal had been one of the major responsibilities of mental hospitals since the Victorian age, which have been highly appreciated by historians. Anderson, whose work is focused on the social and cultural history of suicide, suggests that in the late nineteenth century the number of deaths by suicide within asylums was very small.¹²⁵ Historians who have worked upon the historical development of asylum system and psychiatry as a special medical profession during the nineteenth century, notably Anne Shepherd and David Wright and more recently Sarah York, have confirmed Anderson's assessment.¹²⁶ They see this success as owing to 'strict surveillance and the frequent use of sedatives' in the absence of physical restraints which were still in use in the earlier period.¹²⁷ Some give credit to a wide group of professionals, including asylum attendants as well as 'alienists' and medical superintendents.¹²⁸ In this sense, the Maudsley and Holloway Sanatorium appeared to be successful in preventing fatal incidents, at least within their institutions, and in superseding their predecessors in the care of those for which they were

¹²⁴ Ibid., pp. 424.

¹²⁵ Ibid.

¹²⁶ Shepherd and Wright, 'Madness, Suicide and the Victorian Asylum', pp. 175-196; Sarah York, 'Alienist, Attendants and the Containment of Suicide in Public Lunatic Asylums, 1845-1890', *Social History of Medicine*, 25:2 (2012), p. 342.

¹²⁷ Shepherd and Wright, 'Madness, Suicide and the Victorian Asylum', p. 193.

¹²⁸ York, 'Alienist, Attendants and the Containment of Suicide', pp. 330-342.

responsible.

Through a consultation of Holloway Sanatorium's Annual Reports, it appears that almost all the deaths occurring within its walls were natural ones. The Reports for 1927 and 1928, when the number of deaths was at its highest in the 1920s, reveal that the Sanatorium had 27 fatalities each year. In 1927, twelve males and fifteen females died, all due to 'natural causes'. Many of the deaths 'occurred in those of very advanced age', as confirmed by the fact that the average age at death was about 67. The table 'showing the principal cause of death' also illustrated that no death was artificial, in spite of some cases which, retrospectively, can be deemed to be caused by managerial mistakes, like death due to 'inspiration of regurgitated food into the lungs'.¹²⁹ In 1928, there was no substantial difference from the previous year, except in the sex ratio of the dead: the average age at death was 69, and eleven out of 27 were 'over 75 years of age'.¹³⁰ According to the Annual Reports, nobody succeeded in self-murder at the Sanatorium in the 1920s. However, this did not mean that the suicidality of all the patients was under complete control. Individual case notes reveal more complicated, and sometimes tragic, stories, since some patients threatened or attempted suicide, albeit not always fatal, during their confinement. For instance, a 68-year-old patient suffering from 'recurrent melancholia', although not suicidal, attempted to kill herself while having a bath, shortly after admission. She was immediately issued with a suicide caution card, and was put under intensive vigilance of ward nurses.¹³¹ Although the mortality rate of Holloway Sanatorium was relatively high, it was attributable to the

¹²⁹ Holloway Sanatorium, Annual Report for the Year 1927, No. 42, SHC Ac. 2620/1/9.

¹³⁰ Holloway Sanatorium, Annual Report for the Year 1928, No. 43, SHC Ac. 2620/1/9.

¹³¹ Holloway Sanatorium, Case Book: Females [Volume 28], LWIHM Acc. 343440, MS 5161, No. 4952.

demographic composition of the patients, as the majority of its occupants were senile, and owed almost nothing to suicide.¹³²

The Annual Reports of the Maudsley Hospital provided a less bright but more realistic picture than the official records of Holloway Sanatorium. During the first year of its running the Hospital had two deaths by suicide, both male: one suffering from dementia praecox cut his throat with a razor; the other, already identified as suicidal, threw himself from a ladder in the garden. The Maudsley was exonerated from all blame related to these accidents 'by the verdict at the inquest', and the medical superintendent saw such tragedies as 'inseparable from the policy of taking risks to give liberty (...) deliberately adopted here'.¹³³ The excuse of Edward Mapother, the first medical superintendent of this Hospital, reminds us of the conflict that nineteenth-century asylum doctors experienced, regarding the supervision of suicidal patients: to what extent liberty should be allowed to them.¹³⁴ Reading another Report covering the years 1927 to 1931, the Hospital accommodated 3,248 patients in total, excluding outpatients, and had 167 deaths. Among them, three were suicidal cases. The

¹³² At Holloway Sanatorium, the mortality rate was high, even compared to county asylums. For instance, in 1927 and 1928 the figure was 8.11 percent, while at Brookwood Mental Hospital, the closest county asylum to the institution, the rate was around 5.5 percent. However, as the superintendent of Holloway Sanatorium emphasised in Annual Reports, the high mortality was attributable to the demographic composition of the patients, and most of the deaths were natural ones: Holloway Sanatorium, Annual Report for the Year 1927, No. 42, SHC Ac. 2620/1/9; Annual Report for the Year 1928, No. 3, SHC Ac. 2620/1/9.

¹³³ Maudsley Hospital, Medical Superintendents' Annual Report for the Year ended 31st January, 1924.

¹³⁴ Anderson, *Suicide in Victorian and Edwardian England*, pp. 413-417. The alienists in the previous century not only had to keep patients with suicidal propensity safe by watching them closely and continuously, but also needed to make them to feel trusted, which could not be achieved by ceaseless vigilance. The question, to what extent liberty should be allowed to suicidal inmates, divided the experts, and the application in medical practice was usually decided by 'the personality and therapeutic opinions' of the medical superintendent of every asylum, due to the lack of consensus.

medical superintendent of the Maudsley revealed that there were an ‘enormous’ number of frustrated attempts of suicide, and concluded that the proportion of suicidal death was ‘moderate’ especially considering that one third of its patients suffered from what were ‘mostly likely [to] lead [patients] to suicide’, depression and anxiety.¹³⁵ The self-evaluation of the superintendent makes sense, and generally corresponds to what historians have found.

As seen, Holloway Sanatorium and the Maudsley Hospital were competent in caring and controlling the suicidal while they were hospitalised, but both could do almost nothing once those patients were discharged. Suicidal death amongst previous asylum occupants was prevalent throughout the nineteenth century, as Shepherd and Wright have pointed out, from which early-twentieth-century mental hospitals were not free.¹³⁶ Furthermore, if a former mental patient succeeded in suicide after discharge, or while on leave,¹³⁷ the medical staff were still blamed and the reputation of the mental institution could be damaged too.¹³⁸ Worse, the medical superintendent who sanctioned the patient’s discharge might be obliged to undertake the legal responsibility for the medical (mis)judgment.¹³⁹ Despite the gravity of the issue, suicidal attempt or death of those discharged from mental institutions has not attracted the academic interest which it deserves, partly because of the difficulties of tracing patients and their case histories after their release. In this sense, Holloway and the Maudsley

¹³⁵ Maudsley Hospital, Medical Superintendent’s Report, Period from 1st January 1927 to 31st December 1931.

¹³⁶ Shepherd and Wright, ‘Madness, Suicide and the Victorian Asylum’, p. 194.

¹³⁷ As a way to provide its patients with an environment very close to their home and normal life, the medical staff of Holloway Sanatorium allowed their inmates various opportunities to go out for the day, for shopping or for tea, to make an excursion, and even to take a leave, sometimes as long as several months, if the patient’s condition allowed. Many patients (and their families) asked for discharge while on leave, and most of the request were confirmed by the medical superintendent.

¹³⁸ Anderson, *Suicide in Victorian and Edwardian England*, p. 415.

¹³⁹ Shepherd and Wright, ‘Madness, Suicide and the Victorian Asylum’, p. 194.

provide a good opportunity for us to delve into suicide after discharge through case history records.

A representative case comes from Holloway Sanatorium. Mrs HAL, a 54 year-old housewife, was admitted due to melancholia in 1922, which the medical superintendent deemed to be caused by the menopause. On admission, she was deemed highly suicidal, since she had tried to strangle herself, and had been found to keep a knife under her bed. During her stay at the Sanatorium her condition had improved gradually, so that she could be discharged, as 'relieved', some months later. Less than three months later, however, she had made another suicide attempt. According to an article in the *Daily Mail*, after a search made when a train door was seen to be open 'a well-dressed woman was found lying' on the rail track with severe injuries to the head. The article, although not mentioning her history of mental illness and confinement to Holloway, gave her name, age and residence. The short news titled 'English Railway Tunnel Mystery' was clipped at the end of her case notes.¹⁴⁰

Another case from the Maudsley was that of Mrs LB, a widow in her late forties, who attended the Hospital as an outpatient in February 1929, complaining of mood depression and 'feelings of extreme guilt'. She was finally hospitalised in November 1930 when she found her eighteen-month stay in a convalescence home non-beneficial. The Maudsley medical staff attributed her problem to 'the severe mental stress involved in the deaths of her husband and father and the operation upon her daughter', which had all happened in the previous three years. Her history of suicidal tendency was vague, mainly due to the contradictory statements of the patient herself and partly due to the lapse of time between the first medical

¹⁴⁰ Holloway Sanatorium, Case Book: Females [Volume 26], SHC Ac. 3473/3/16, No. 4672.

examination and her admission. Whatever the case, she was discharged with professional approval, as relieved, in October 1931. Just under four months later she was found by her daughter, sitting close to the gas oven and unconscious. With treatment at Fulham Hospital she soon regained consciousness and recovered, but died only a few days later due to the sudden development of pneumonia. This case was reported in detail in a major newspaper, including the findings of the inquiry held at Hammersmith Coroner's Court. The newspaper report was attached to the last page of her case notes. The article entitled 'Fulham Widow who Suffered Torture', included her full name, age, civil status and residence, as well as her history of mental illness. The newspaper report was informative and enlightening, rather than scandalous, and, most importantly, emphasised the 'social responsibility' for such tragedy. The article ended with the Coroner's statement in the Court: 'I feel that this poor woman was not fully responsible for what she did. She had been a voluntary patient in a mental hospital, had been morbid and depressed, and for no substantial reason decided that life was not worth living. Her troubles were more imaginary than real, and she was probably suicidal without those around her knowing it'.¹⁴¹

The two cases reveal the realities of suicide in this period which otherwise would be hard to reconstruct. Some former mental patients took advantage of the 'freedom' attained on discharge to kill themselves,¹⁴² and mental institutions had neither any practical way to manage the suicidal risk of ex-patients nor the powers to compel them to report the condition after leaving. Both institutions learnt of these deaths through the newspapers, and were probably not informed by the patients' relatives or the authorities involved. The Maudsley

¹⁴¹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-068, Case No. 2319.

¹⁴² Shepherd and Wright, 'Madness, Suicide and the Victorian Asylum', p. 194.

only tracked a handful of case histories after discharge and left records of the follow-ups, mainly for educational purposes rather than as a way to check on its previous patients.¹⁴³ The Hospital also intermittently received letters from other mental institutions where former patients were (re)admitted, usually asking for previous medical records or giving information on their current condition. Former patients and their families rarely reported the state of those discharged or their suicidal propensities. Under the circumstances, it did not seem rational to make the medical staff take any responsibility for suicidal deaths solely on the ground that they approved discharge.¹⁴⁴ Rather, these cases prove that there existed a large blind spot in medical practice, which cost the lives of former mental patients. In this respect, the article covering Mrs LB's death is worth notice: the Coroner indicated the institutional inertia, mentioning that despite her history as a mental patient she failed to have proper help, either personal or professional.¹⁴⁵

The two articles reporting the tragedies also revealed changing attitudes towards death by suicide by mental patients. In her analysis of 'suicide culture' in Victorian and Edwardian England, Anderson illustrates that the attitude of the general public to suicidal death 'remained at the level of cliché' throughout the period. She identifies and categorises 'four traditional stereotypes of suicide', from the representation of death in popular culture and newspaper reporting: sad, wicked, strange and comic.¹⁴⁶ Using this classification system, the

¹⁴³ For instance, Miss D was admitted to the Maudsley in 1928. Her case was classified as 'hysteria', and she discharged herself against professional advice a month later. In 1935 two of the Maudsley medical staff visited her in order to 'follow-up' what had happened to her subsequently, including further treatment after discharge, her general state of 'health and personality' and the present condition: Maudsley Hospital, Patient Casenotes, BRHAM CFM-030, pp. 97-132.

¹⁴⁴ Shepherd and Wright, 'Madness, Suicide and the Victorian Asylum', p. 194.

¹⁴⁵ Maudsley Hospital, Patient Casenotes, BRHAM CFM-068, Case No. 2319.

¹⁴⁶ According to this classification of traditional attitudes towards suicidal death, the tone of the article dealing with Mrs HAL's case was fairly close to 'strange'. Anderson, *Suicide in Victorian and*

report on Mrs HAL equates with 'strange' death, as it highlighted the mysterious features of the incident and stimulated people's curiosity. Its tone was somewhat provocative and close to tabloid, confirmed by the title of the article. However, the report on Mrs LB, which was written almost ten years later, reads differently from that on Mrs HAL. It is impossible to find in the piece any mockery or excitement which had been fairly common in nineteenth-century reporting. It rather gave prominence to the tragic features of the incident by stressing that it was the daughter who first discovered the scene of Mrs LB's poisoning by gas. The news article seems intended to inform and educate readers by direct quotation from the Coroner's report, which emphasised the limited responsibility of the deceased for her death and expressed deepest sympathy with her and her family. The difference between the two articles reveal that during the interwar period there was a (gradual) transformation of public attitude towards suicide and the mentally ill.¹⁴⁷

The last subject related to the administration of the suicidal is readmission. Anderson claims that in the late Victorian period most patients with suicidal tendencies left mental institutions fully recovered, or at least relieved, and were therefore 'never readmitted' to asylums.¹⁴⁸ This does not accord with what the case histories of Holloway and the Maudsley suggest. The rosy picture seems to be drawn from nineteenth-century medical beliefs that suicidal propensity was usually 'transient' and highly treatable.¹⁴⁹ For instance, George Fielding Blandford, a lecturer on psychological medicine at St. George's Hospital in London, said in confidence that suicidal melancholia was 'easy of diagnosis and the prognosis (was)

Edwardian England, p. 421.

¹⁴⁷ *Ibid.*, 422-426.

¹⁴⁸ Anderson, *Suicide in Victorian and Edwardian England*, pp. 416-417.

¹⁴⁹ *Ibid.*, p. 406.

favourable if the general health be not much broken'.¹⁵⁰ Furthermore, nineteenth-century psychiatrists found the strong impulse to commit suicide last only for a short period, 'one month or six weeks'.¹⁵¹ Statistics based on asylum records also show that the majority of suicidal patients recovered sufficiently to be discharged quickly: according to York, 50 to 60 percent of those classified as suicidal on their admission were discharged as recovered in less than a year.¹⁵² However, these promising analyses, either by contemporary psychiatrists or by later medical historians, failed to reflect the possible recurrence of suicidality and depression and, consequently, to take readmission cases into account. Allowing for repetitive and chronic cases, the result is less optimistic. For instance, among twenty Maudsley patients aged over 45 whose cases are under study, more than a half had previous histories of mental or nervous breakdown, and, what was worse, one of them counted the existing attack of depression as the fourth one in her life.¹⁵³ It did not seem that repeated attacks raised the risk of suicidality, but a patient who had shown suicidal tendencies in the past was more prone to turn self-destructive. If the nineteenth-century alienists saw melancholia as manageable and recoverable, it may well be because they compared it to other 'irreversible' mental illnesses, such as dementia praecox. It was a total misunderstanding that depressive patients with suicidal impulses recovered after a short period of treatment in an asylum, mostly for less than a year, and never experienced a return to the pathological condition or institutional care.

While asserting that few suicidal patients were readmitted, Anderson has depended

¹⁵⁰ George Fielding Blandford, *Insanity and its Treatment: Lectures* (London: Oliver and Boyd, 1871), pp. 165-167; 'George Blandford', *Oxford Dictionary of National Biography* <http://dx.doi.org/10.1093/ref:odnb/31921>.

¹⁵¹ Anderson, *Suicide in Victorian and Edwardian England*, pp. 407.

¹⁵² York, 'Alienist, Attendants and the Containment of Suicide', p. 340.

¹⁵³ Maudsley Hospital, Patient Casenotes, BRHAM CFM-066, pp. 391-420.

largely on asylum records wherein she finds few cases of readmission. At this point, a question should be raised whether or not medical records of certain mental hospitals are a reliable source for tracing admission and readmission history. The main problem is that it is practically impossible to cross-check all the admission records of every mental institution. In readmission cases, it was highly probable that a patient was hospitalised in an asylum other than the previous one and did not inform the former institution about the second or later confinement. If that is the case, historians have to face practical difficulties in completing a patient's life-long case history. Taking an exemplary case, Mrs AB was admitted to the Maudsley in 1928 after a failed suicide attempt, and diagnosed with 'recurrent depression'. On her admission, she stated that she had been confined to Bethlem for about 12 months 8 years ago, when she had had the first attack and had attempted suicide by gassing. Her symptoms, however, did not disappear during her stay at Bethlem, and lasted for another four years after discharge from it. In this case, neither the Maudsley Hospital nor the patient herself informed Bethlem Hospital of her (re)admission to the Maudsley, as there is no letter to the institution attached to her case file.¹⁵⁴ At Holloway Sanatorium, on Miss EFT's admission, the institution did not notify her (re)hospitalisation to the Maudsley, where the patient had been treated during her first attack several years earlier.¹⁵⁵ Anderson finds from nineteenth-century asylum cases that well into the interwar decades in most mental institutions readmission rate was low,¹⁵⁶ but due to unreported readmission cases, it is

¹⁵⁴ It was routine to attach any document, sent to or received from other institutions at the end of individual case file, in both institutions.

¹⁵⁵ Holloway Sanatorium, Discharge Case Book: Female, SHC Ac. 7267/3/27, No. C5491.

¹⁵⁶ At Holloway Sanatorium, the readmission rate was higher than most of contemporary mental institutions, because middle-class patients, if they had to be, preferred to be readmitted to the Sanatorium, as having little alternatives. Therefore, in such cases, it is relatively easy to trace admission and readmission history of individual patients. Furthermore, for the same reason, many of

difficult to prove that discharged mental patients were rarely re-hospitalised.

3. Lay Causal Attribution of Depression in Middle and Old Age

Before examining lay causal attributions of depression occurring in middle and old age, it is helpful to first consult professional interpretations of aetiology in both institutions. At the Maudsley, problems were attributed most frequently to mental stress followed by bereavement and menopause. About a half of the sample cases had no supposed cause written down on case notes though. At Holloway Sanatorium, when counting principal and contributory aetiological factors concurrently in the Registers, the most common were climacteric, heredity, and mental stress, referred to six times respectively. A summary of supposed causes in individual case notes reveals similar findings, bar the low frequency of heredity. The critical period of life was mentioned the most, and worry second. Many of the professional attributions are ambiguous and uninformative, for example the use of terms such as 'worry' and 'stress'. Grouping sample cases according to them necessarily leads to failure in mirroring patients' experience as well as in understanding lay attribution of depression. Therefore, in this chapter, case histories are categorised depending on what reasonably could have affected patients' mental condition: bereavement, family affairs, financial difficulties, sexuality issues, drinking problems and menopause. Under these keywords, it is possible to

Holloway patients had relatives who had been treated at the same institution.

investigate how those middle- and old-aged patients connected (or did not connect) such life events and daily experiences to their mental disturbance.

Bereavement

Bereavement was considered to be one of the major life events usually experienced in the later stages of the life cycle, although it was not monopolised by the elderly,¹⁵⁷ and was often ascribed as one of the causes of depression especially in patients of middle and later age. Even though younger women, too, experienced bereavement and were traumatised by loss, the rate of cases in which the death of loved ones was associated with mental breakdown, either as a direct cause or a precipitating factor, was by far higher amongst the elderly. Some contemporary psychiatrists emphasised that ‘the death of near relatives’ could affect mental breakdown ‘during the involitional period’.¹⁵⁸ In three out of twenty sample cases at the Maudsley, bereavement was mentioned straightforwardly as a ‘supposed cause’ by the medical staff. In Holloway Sanatorium, at least two cases out of twenty were attributed to loss of family members or friends. Amongst thirteen cases which can be checked in Medical Registers, four had ‘prolonged mental stress’ noted as the ‘principal aetiological factor’ and two of them were described as attributable to death of a member of the family or a friend. In those cases, patients and doctors generally shared the same view on the aetiology.

The experience of bereavement, the emotional effect of which never appeared to have

¹⁵⁷ Jalland and Hooper, *Women from Birth to Death*, p. 284.

¹⁵⁸ Henderson and Gillespie, *A Textbook of Psychiatry*, p. 160.

diminished no matter how common death was, was described in great detail in several case files. The death of a husband was most frequently referred in the case notes which are consulted in this chapter. The case of Mrs AN who suffered from vivid images of her own funeral, as well as that of her husband's, after being widowed can be read as typical. She was oriented towards very limited and interrelated topics, including illness, death, funeral and all the troubles that she had gone through due to her husband's ill health and passing. She was not only haunted by a 'great fear of death', but also obsessed by the idea that she would be better dead as her life was 'one long misery'. The patient and her family all began the description of her case history from her husband's illness and death, from which we can infer how they attributed the cause of her disorder.¹⁵⁹ Another exemplary case is that of Mrs MRB, a widow of a clergyman. This patient was shocked by her husband's sudden death while she was on convalescence at a nursing home, which aggravated her nervousness. Then, she was diagnosed with depression and hospitalised at the Maudsley. According to the description of the medical staff, the patient expressed her guilty consciousness, as well as a sense of responsibility, in relation to her husband's sudden death.¹⁶⁰

Loss of loved ones other than a husband also affected mental and emotional conditions of the elderly, a good example of which is the aforementioned case of Miss CEE. Five months before her admission to Holloway, her life-long friend, with whom the patient had lived, passed away, since when Miss CEE had become sleepless, restless and self-reproachful. Three days previously, she was completely obsessed with delusional ideas, mostly about self-accusation, which led her to the certification process and hospitalisation.

¹⁵⁹ Maudsley Hospital, Patient Casenotes, BRHAM CFM-001, Case No. F4660/F1349.

¹⁶⁰ Maudsley Hospital, Patient Casenotes, BRHAM CFM-003, Case No. FP 6.

Although she never clarified the origin of her mental trouble, her conscience dwelt on her friend's death, leading her to repent of her perceived wrongdoings. Meanwhile, the case reveals what influenced the decision to admit and, later, to discharge mental patients. In this case, Miss CEE was certified as an urgent case and admitted to the Sanatorium barely three days after the onset of mental disorder, a fairly rapid process especially considering that she had no previous history of mental breakdown.¹⁶¹ This urgency seemed to reflect the determined will of her family, because, as psychiatric historians note, it was usually patients' relatives who decided whether or not to institutionalise patients. It was probable that none of her family members were willing to take care of Miss CEE, especially in her disoriented condition, and they preferred to consign the elderly single woman to professional care.¹⁶² That she was not wanted by her relatives was confirmed two and half months later when she was allowed to leave the institution as fully recovered but remained at Holloway as a voluntary boarder, following either her own free will or her family's decision.

Financial Hardships

As seen in earlier chapters, financial difficulties and related worries were most frequently

¹⁶¹ Holloway Sanatorium, Case Book: Females [Volume 26], SHC Ac. 3473/3/16, No. 4654.

¹⁶² To find more about the role and importance of family members in deciding admission and discharge of mental patients, refer to: David Wright, 'Getting out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century.' *Social History of Medicine*, 10:1 (1997), pp. 137-155; Richard Adair, Joseph Melling, and Bill Forsythe, 'Migration, Family Structure and Pauper Lunacy in Victorian England: Admissions to the Devon County Pauper Lunatic Asylum, 1845–1900', *Continuity and Change*, 12:3 (1997), pp. 373-401; David Pierce, 'Family, Gender and Class in Psychiatric Patient Care during the 1930s: The 1930 Mental Treatment Act and the Devon Mental Hospital', in Dale and Melling (eds.), *Mental Illness and Learning Disability since 1850*, pp. 112-130.

blamed as a cause of mental illness in cases of any age of either sex. Female patients in advanced life stages whose cases are under study in this chapter were not free from these problems. Although the rate of attribution of mental illness to material conditions is low compared to younger patients, some still ascribed mental depression to economic hardships. A typical and representative case is that of Miss MIB. She was single and aged slightly over 60 when she visited the Maudsley due to low mood, pain in her head and a suicidal impulse. She had attempted to take her own life about one month earlier, by gassing. She had supported herself by working as a teacher (or governess) for her whole life, and had suffered from 'great financial stress' for the last few months, which she believed led her to her depressive state. According to her own account, she recently felt that 'she was not capable of undertaking the pupil' offered to her, and that her 'head would not work any longer'. Another Maudsley patient, Mrs SA, a widow in her late sixties, believed that her current mental breakdown coincided with her unemployment. She explained that she had lost her work as wardrobe mistress in a theatrical company eight months earlier and could not get another employment. Then she became depressed, worried over joblessness, lost her appetite and slept badly. However, as she admitted, she was far from falling into poverty, having 'just enough to live on'. It was not poverty itself but anxiety about it which drove her into depression, almost identical to the aforementioned delusional cases in which patients with middle-class backgrounds suffered from obsessive ideas about indigence. These two cases sound very familiar, reminding us of the concerns of younger patients in previous chapters. It seems that the fear which threatened the mental health of respectable working-class males in Victorian England was not dispelled until well into the mid-twentieth century and was also

experienced by women.¹⁶³

Family Affairs

Some patients found the central source of their mental stress or cause of their mental depression to derive from domestic troubles and conflicts. Matrimonial discord was occasionally blamed as the origin of mental illness by married women aged over 45, albeit less frequently compared with their younger counterparts. Mrs JAN, aged 50, complained bluntly, on her admission to the Maudsley in 1930, that she had had trouble with her husband for two years. According to her description, the husband was secretive and difficult with money and drank alcohol all the time, and this worried her throughout their married life. She added that she had been always been dragged down by concern over her husband and had ‘felt awfully miserable’ after marriage. As such, Mrs JAN did not hesitate at all to reveal what she believed to be the cause her anxiety and depression, making her case history exceptional in the way that a patient made her own attribution clear.¹⁶⁴

Various changes in family relationships, in a broad sense, resulted in stress for women of all ages, but especially amongst those in middle and old age. It was particularly the marriage of offspring that led to family feuds and, as a result, to female mental problems. While explaining the onset of her current attack, Mrs EBD, a 53 year-old housewife from a working-class background, cast back to when her ‘eldest and favourite’ son married without

¹⁶³ Suzuki, ‘Lunacy and Labouring Men: Narratives of Male Vulnerability’, pp. 118-128.

¹⁶⁴ Maudsley Hospital, Patient Casenotes, BRHAM CFM-066, pp. 391-420.

her approval. Thereafter she had been so upset, worrisome and tired of life, that her daughter had to sit with the patient. Nonetheless, a fortnight before her admission to the Maudsley, Mrs EBD was found with her head in a gas oven and unconscious; she later explained that she only 'felt tired and wanted a rest'. In this case, the patient, her family, and the medical staff all agreed that it was the marriage of her son that had adversely affected her psychological condition.¹⁶⁵ The case history of Mrs RCK followed a similar pattern, albeit less dramatic. Her existing attack coincided with her daughter's marriage and departure from the parental home, two and a half years previously, after which she became depressed, agitated and obsessed with delusional ideas.¹⁶⁶

Amongst the various domestic events experienced and tasks undertaken by women, their caring role and responsibility exerted the strongest influence upon female patients in all age groups, though its detailed aspect varied depending upon the age. As seen in the previous chapter, the domestic role of women in their adulthood focused on supporting both husband and children, as well as running the household. However, women in advanced life stages were gradually exempted from child-rearing and increasingly engaged in other forms of caring. Attendance on invalids was the traditional feminine role, which was expected to be carried out mostly either by females in adolescence who had left school but were not yet married or those who had already brought up children. Amongst sample cases studied in this chapter, several show how female patients complied with this 'gendered' work and responsibility.¹⁶⁷ The aforementioned case of Mrs EGK at Holloway Sanatorium, who suffered from a guilty conscience and delusional ideas, all related to nursing her elderly

¹⁶⁵ Maudsley Hospital, Patient Casenotes, BRHAM CFM-031, Case No. P261.

¹⁶⁶ Maudsley Hospital, Patient Casenotes, BRHAM CFM-031, Case No. 2881/1474.

¹⁶⁷ Holden, 'Family, Caring and Unpaid Work', pp. 134-147.

parents, exemplified how burdensome the responsibility could be. In this case, the patient, aged 60, narrated her history of mental illness, beginning with her collapse after giving birth to her only child 30 years previously, and the progression of her current attack, which was taken seriously by the medical staff of Holloway. Mrs EGK never ascribed her mental depression directly to her caring role, yet definitely associated the onset of her current episode with nursing her mother one year previously, explaining that she ‘gradually became depressed and sleepless’ thereafter. She was discharged as relieved following a three-month stay at the Sanatorium, but was re-admitted barely one week later as a voluntary boarder. This time, her condition was much worse: depressed, agitated, anxious and self-reproachful. She constantly worried about not being able to look after her parents and blamed herself for neglecting them. She quickly developed vivid delusional ideas about her parents and their house. The medical staff of Holloway Sanatorium attributed her mental disorder to ‘prolonged strain’, surely related to her caring role.¹⁶⁸ Another Holloway case relating to Mrs BLG, aged 57, was also associated with the responsibility of being a carer. The main complaints made by Mrs BLG were of mild mental depression and delusion about her husband and religion. On admission she gave the medical superintendent ‘a good account of her recent history’, and enunciated clearly that ‘family circumstances had contributed to this depression’, one of the rare cases in which a patient set forth her own view on attribution. According to her explanation, she was under double pressure, as she had been helping her mother, very old, ill and needy, with running a household and nursed her son who had been seriously injured five months previously. Once exempted from the duties, she recovered quickly, and was discharged one month later.¹⁶⁹ As can be seen from these cases, women

¹⁶⁸ Holloway Sanatorium, Discharge Case Book: Female, SHC Ac. 7267/3/29, No. 2398.

¹⁶⁹ Holloway Sanatorium, Discharge Case Book: Female, SHC Ac. 7267/3/27, No. C5473.

could find the caring role so arduous, both physically and psychologically, that they believed it caused their mental disorder.

Sexuality in Advanced Age

Some older female patients attributed their mental disorder to wrongdoings related to sexuality and sexual relationships, although they accounted for far fewer cases than amongst younger patients. In this group, too, masturbation was a common topic. For example, Miss OC, aged 47, who was certified and hospitalised in Holloway in April 1922, was typical. According to the detailed case history provided by herself, she had practiced ‘a degrading habit of self-abuse’ for many years, and had been unable to control it since her first mental breakdown, eight months earlier. She firmly believed that masturbation had caused her mental disorder, to which the medical officers of the Sanatorium seemed to agree leaving congruent records in the Medical Register and case file of the patient.¹⁷⁰ Considering there were still some cases in which patients in and over the middle age confessed to practicing masturbation, even though not attributing their mental trouble directly to it, the habit seemed to perturb a large number of women irrespective of their age.

Negative emotions related to love affairs, notably guilt, were often ascribed as a main cause of mental illness by younger female patients. Older female patients also experienced the same guilt, a good example of which is the case of Mrs LB at the Maudsley. She had been widowed three years previously, when she was in her mid-forties, and came to be ‘very

¹⁷⁰ Holloway Sanatorium, Case Book: Females [Volume 27], SHC Ac. 3473/3/17, No. 4740.

friendly with a man' soon after. On describing her case history, the patient admitted that she had sexual intercourse with him while being in the relationship but broke off the 'friendship' because she feared pregnancy. Obsessed by the idea that she had conceived a baby by a man other than her husband, she consulted several doctors, although she was not convinced by them. Thereafter, she suffered from 'feelings of extreme guilt', eventually falling into deep self-accusation and mental depression. What is problematic about this case is the difference in attribution between the patient and the professionals. Mrs LB persistently attributed her sense of guilt to her extramarital relationship and ascribed the mental breakdown and ensuing suicidal attempt to her negative feelings about her conduct. The Maudsley medical officers, identifying Mrs LB as a 'very decent woman', associated her disorder with bereavement and the practical hardships she went through after it, notably financial worry. Unfortunately, the case file does not provide any way of aligning these incompatible judgements. All we can conjecture is that the experience of the love affair affected her as a heavy mental and moral burden, no matter what the professionals argued.

Alcoholism

As pointed out in Chapter 4, the problem of female drinking was a skeleton in the closet of individual households, as well as being a social issue that had triggered fierce debates since the late nineteenth century.¹⁷¹ The same issue can be detected in older patient groups,

¹⁷¹ In order to understand the history and historiography of female drinking and its relevance to mental illness, refer to Chapter 4. Aetiology: Other Factors; David W. Gutzke, 'Gender, Class and Public Drinking in Britain During the First World War', *Historie Sociale/Social History*, 27:54 (1994),

providing another chance to delve into the relationship between alcoholism and mental illness as well as to widen our understanding of female intemperance in this period. Amongst the sample cases at Holloway Sanatorium, three were identified as caused or precipitated by alcoholism by its medical officers. At the Maudsley, in contrast, few cases were associated with alcohol abuse habit of patients, either by professionals or the patients themselves. It reinforces the conclusion reached in the previous chapter that the inebriety of women was more an issue amongst the affluent rather than the working class. The number of cases blamed on drinking among middle- and old-aged patients at Holloway and their younger counterparts at the same institution are similar: three out of twenty and three out of twenty-two. The difference between the two groups lies in the fact that in most of the older patient cases alcoholism was pointed out as a 'principal aetiological factor' whereas in the majority of younger cases it was taken as a secondary consideration, suggesting that the problem was more serious in the former category.

Consulting two cases at Holloway Sanatorium, in which 'alcohol' or 'alcoholism' was referred to as a 'principal' aetiological factor, several things in common emerge. Mrs JL, aged 65, was admitted as a voluntary boarder to Holloway in 1923, suffering from mood disorders, psychosomatic troubles, notably trembling, and delusional ideas about sin and crime. She was identified as suicidal on admission, and was finally certified after a suicide attempt made during her stay at Holloway. She remained at the Sanatorium until her death in 1944, presumably with another change in her status into voluntary, which however cannot be confirmed due to the discontinuity of her case file, ending at some point in the year 1926. In

pp. 367-391; Claire Langhamer, "A Public House is For All Classes, Men and Women Alike": Women, Leisure and Drink in Second World War England', *Women's History Review*, 12:3 (2003), pp. 423-443.

this case, Mrs JL was more inclined to voice her own view on her mental illness than most of Holloway patients. On examinations, she conceded that she had drunk regularly and sometimes excessively, providing detailed descriptions of her habit. However, she seemed to attribute her mental problem not to alcohol abuse but to a long-lasting family feud: severe conflicts with children, as well as her husband, and final separation from him. As far as she remembered, it was after the separation that she began to drink ‘heavily’. She insinuated that familial discord was the fundamental problem lying behind all the problems that she had, including her alcoholism and mental depression.¹⁷²

Mrs KLY, aged 47, was admitted in 1934, primarily due to unusual delusions of a sexual nature. During her stay at Holloway she developed more delusional ideas in relation to persecution and experienced various hallucinations, both visual and aural. She stayed at the Sanatorium until she died at the age of 56 as a result of gradual decline of general health and subsequent ‘myocardial failure’ in 1943.¹⁷³ Unlike Mrs JL, this patient was reticent about her experiences and opinions. Instead, her main informant, her lawyer who had known the patient for more than 25 years, played an important part in gathering the case history. As the patient was severely deluded and other relatives were absent on admission, the informant was the only and best route to comprehend the case. The lawyer described her long history coherently and described her drinking habit in detail, all taken convincingly by medical professions of the Sanatorium. According to the informant, Mrs KLY had led an especially complicated life, going through marriage at the young age of eighteen, divorce, re-marriage, estrangement, and second divorce. Around her first divorce and second marriage, with only a few years’ time

¹⁷² Holloway Sanatorium, Case Book: Females [Volume 27], SHC Ac. 3473/3/17, No. 4815; Medical Register: Females, SHC Ac. 3473/3/48.

¹⁷³ Holloway Sanatorium, Discharge Case Book: Female, SHC Ac. 7267/3/24, No. C5464.

lapse, her ‘temperament changed very greatly’ and the morbid habit begun. When she left her second husband about ten years previously, ‘she drank a great deal’ again, and ‘alcoholism recurred’ thereafter, the lawyer added. He was clearly aware that her bleak life events had affected her habitual drinking and, subsequently, mental health. It was obvious that he saw the patient’s mental trouble as having originated from alcoholism.

In both cases, alcohol abuse was understood as both the cause and effect of depression, rather than being a simply aetiological factor. It appears that lay perspectives on the relationship between inebriety and mental illness, evidenced by the two cases, were not linear at all, even when alcoholism was a major factor of depression. Rather than settling for the simple explanation that alcohol was the origin of all the problems, patients and their relatives went further to find root causes, most of which were deeply related to their life event experiences or the practical issues of everyday life.

Involitional Melancholia

As illustrated in Chapter 2, the concept and terminology of ‘involitional melancholia’ caused confusion and prolonged debates among medical experts after its introduction around the turn of the century. Although no consensus was reached officially during the interwar decades, it was frequently applied in daily practice even by those who were not particular advocates of the concept, mostly ‘for convenience and lack of knowledge’.¹⁷⁴ In the medical records of

¹⁷⁴ ‘The Problem of Involitional Melancholia’, *British Medical Journal*, 1:4089 (1939), pp. 1039-1040.

the Maudsley Hospital, involuntional depression was applied often as a diagnostic term,¹⁷⁵ discordant with the stance of its staff who did not regard it as ‘a unitary or distinctive’ mental illness.¹⁷⁶ In this sense, the concept provides one of the best chances to see the wide discrepancy between what appeared in expert literature and what was actually done in practice.

Among the twenty sample cases from Holloway Sanatorium, seven were ascribed to the life stage and its distinctive features in Medical Registers and Registers of Departure: in five cases ‘climacteric’ was identified as a ‘principal aetiological factor’ and in two it was a ‘contributory’ cause.¹⁷⁷ Amongst them, six cases were ascribed to the same origin in the individual case files, albeit with some variations in terms of terminology. It is no exaggeration to say that the medical staff of Holloway blamed ‘change of life’ as a cause of mental depression in female patients aged between the mid-forties and mid-fifties unless they could find any other obvious reason. As a result, the climacteric period was the most common aetiology in the sample group of female patients aged over 46, followed by (prolonged) mental stress and heredity. At the Maudsley, three out of twenty sample cases were considered to have relevance to the critical period in women’s life by its medical officers. Although the number of so-called involuntional cases at the Maudsley was smaller than at Holloway, it was not because the Maudsley medical staff found their origin from elsewhere, but mainly because they avoided suggesting any specific aetiological factor in individual case files unless they were convinced otherwise. At the Maudsley, too, the involuntional period was

¹⁷⁵ Maudsley Hospital, Patient Casenotes, BRHAM CFM-151, pp. 16-51.

¹⁷⁶ Aubrey Lewis, ‘The Experience of Time in Mental Disorder’, *Proceedings of the Royal Society of Medicine*, 25:5 (1932), pp. 617-618.

¹⁷⁷ Holloway Sanatorium, Medical Register: Females, SHC Ac. 3473/3/48-49; Register of Departure, Discharges and Transfers of Voluntary, Temporary and Certified Patients, SHC Ac. 3473/3/54.

attributed to being the second commonest cause of depression occurring in women in pre-senile stage.

Interestingly enough, however, in those cases attributed to the involutorial period by experts in the two institutions, only a handful of patients agreed with them about the cause of their mental disorder. This was partly because many of the sufferers remained silent about the subject and did not find a direct link between the 'change of life' and their abnormal mental condition. During the interwar period the public seemed to have limited opportunities to get accustomed to the notion of involutorial melancholia and the idea of the critical period as being a challenge to female mental health. Such ignorance of lay people could be related either to the fact that this was a relatively new concept, invented around the turn of the century, or to the situation in which the professionals were too divided over the validity of the diagnostic notion. As the notion of involutorial melancholia had been a controversial issue since its introduction by Kraepelin in the expert circles, the history of this concept has stimulated the interest of medical and psychiatric historians.¹⁷⁸ On the contrary, lay perspectives on this concept in its early period have been rarely studied, and have not received the scholarly attention they deserve. Thus, it is difficult to suggest any convincing explanation for the reason that female patients in their forties and fifties did not find any correlation between their mental problem and this specific life stage. It is clear however that these patients neither considered the climacteric as a time when women became more vulnerable to mental illness, nor did they see the menopause as a potential cause of mental disease.

¹⁷⁸ For further information about involutorial melancholia and debates about this concept, refer to Chapter 2.

The last section of this chapter will focus on ‘artificial menopause’. As hysterectomy and ovariectomy came to be applied extensively around the turn of the century, artificial menopause following such operations began to appear in medical discourses. According to the general professional understanding of the subject, ‘the symptoms following surgical castration could be more severe than those which followed the course of nature, and were sometimes alarming’. It was observed that artificial menopause could lead to diverse physical troubles, such as ‘flushings of heat and cold’, headache and skin infections, and psychical disturbance, varying ‘from a slight change in character through melancholia states to insanity’.¹⁷⁹ In the medical records of the two mental institutions under study here, a number of patients were identified as having had a hysterectomy, and most of these cases were ascribed to ‘climacteric’, unless any other convincing aetiological factors were found. At one extreme, Mrs GS, aged 50, ‘had a complete hysterectomy for fibroids’ and ensuing menopause two years before her admission to Holloway due to mood depression and severe self-reproach. According to the patient, she felt that ‘she had changed completely’ about one year after the operation, concluding that her mental disorder had been aggravated by the operation. The medical staff of Holloway, too, regarded this case as having its cause in climacteric changes.¹⁸⁰ At the other extreme, Miss OC, aged 47, who had also undergone hysterectomy and menopause two years previously, found the cause of her mood depression and delusional ideas from an entirely different factor, masturbation.¹⁸¹ In most instances, patients said little about the surgery, unnatural menopause and following changes, and

¹⁷⁹ ‘The Artificial Menopause’, *British Medical Journal*, 1:3825 (1934), pp. 761-762.

¹⁸⁰ Holloway Sanatorium, Case Book: Females [Volume 28], LWIHM Acc. 343440, MS 5161, No. 4992.

¹⁸¹ Holloway Sanatorium, Case Book: Females [Volume 27], SHC Ac. 3473/3/17, No. 4740.

psychiatrists labelled them as involuntional or climacteric cases and attributed accordingly. Through these cases, it is confirmed that doctors specialising in mental illness saw artificial menopause as one of the factors that raised the risk of mental illness in midlife, setting aside whether or not they favoured the notion of involuntional melancholia. It is hard to tell how the patients themselves understood these sudden changes.

4. Conclusion

This chapter has centred on a group of female patients in their middle and old age, diagnosed as suffering from depression, and examined their case histories in order to reconstruct their experience of mental illness and everyday life. The kinds of symptoms experienced by these patients differed little from those of the younger cohort, but the details exhibited considerable dissimilarities, reflecting some aspects of the life stages. As mentioned in previous chapters, there was a discernible generation gap in the prevalence of hallucinatory and delusionary experiences: the older the patient group was, the more such symptoms developed. In terms of the contents of delusions, for example, patients in their middle and old age were inclined to apply religious language in illustrating their illusionary experience and were frequently obsessed with hypochondriacal concerns, notably about their 'bowels'. Meanwhile, many of self-reproachful cases were involved with care-giving roles and responsibilities, reflecting the main features of the sex and the life stage. Suicidal cases under scrutiny in this chapter show clearly why mental illness experience should be interpreted as standing where gender and

class intersect with each other, as the two factors decided the patterns and the detailed behaviours of the self-destructive attempts.

The way in which patients ascribed their mental illness, too, was related to the major life events occurring in these phases. As anticipated, bereavement was most commonly pointed out, by both sufferers and doctors, as an alleged starting point of current mental breakdown. The pressure related to care-giving roles and various domestic affairs, such as a feud with family members, followed the loss of loved ones in lay causal attributions. These factors illustrate what constituted women's middle and old age in interwar years, as well as what worked as adverse life events in the later stages of female life. Regarding lay attributions of depression specifically occurring in the late forties and fifties, noteworthy is that few women facing climacteric changes found the cause of their mental depression in this factor itself, showing a stark contrast to professional diagnosis and attribution. Even though many of them were identified as suffering from 'involutional melancholia' by psychiatrists, they remained silent about the physical and psychological changes experienced at this life stage and mostly understood the origin of mental depression in close connection with their everyday experiences and life events.

What these women patients aged over 45 experienced in the course of depression and what they found as a possible cause of their mental illness reveals an important aspect of early-twentieth-century medicine. As stressed earlier in this chapter, over-concern about constipation, a very common theme especially amongst the elderly, had its deep root in Victorian medical knowledge, which had warned of the possibility of self-poisoning and therefore emphasised regular evacuation of the bowels. The medical common sense of the public, however, remained loyal to the concept of 'autointoxication' even after medical

professionals abandoned it,¹⁸² which was clearly shown by the psychosomatic symptoms, delusional ideas, and causal attributions of those patients at Holloway and the Maudsley. Cases classified as ‘involitional melancholia’ by psychiatrists, too, led us to a comparable conclusion. While doctors found the origin of such depression cases in the critical period itself, based on recently developed (and still controversial) professional knowledge about the relationship between women’s reproductive cycle and female mental health, patients did not. Mostly, these female patients related their mental illness to daily life experiences and adverse life events other than menopause, and appeared to be ignorant about the new concept of ‘climacteric’ circulated in the expert circles. These findings, on the one hand, illustrate the time lag between the production of professional knowledge and its popularisation, although we cannot tell how long the difference was. Similar episodes can be found in previous chapters, too, including masturbation insanity in Chapter 3 and puerperal insanity in Chapter 4. On the other hand, these cases demonstrate that the Victorian psychiatric tradition was still powerful and that the lay understanding of health and ill-health was under the powerful influence of nineteenth-century medical knowledge.

¹⁸² Whorton, *Inner Hygiene*, pp. 56-57.

Conclusion

Lived Experience of Depression: Gender, Class and Age

In the previous chapters, a wide range of professional literature, largely from the specialty of psychiatry and some from general medicine, and almost one hundred case notes of those deemed to suffer from depression have been examined.¹ These materials divulge stories about early-twentieth-century psychiatry, depression and, above all, patients troubled by the affective disorder. Firstly, it was possible to ascertain that well into the interwar decades, British psychiatry, as a medical branch and as an institution, did not yet enter its period of modernism, contrary to the claims of some historians that the Great War was the starting point of modern psychiatry.² In this period, psychiatry underwent a series of crucial changes in many aspects: it came to be equipped with new theories, nosology and taxonomy; new therapeutic innovations were made and gradually introduced in practice; and existing problems surrounding its system were publicised and the discussion was followed by legislation. However, it was still under the strong influence of the Victorian medical tradition, which was therefore crucial in understanding interwar British psychiatry.

Secondly, similar themes could be applied to explaining depression in this period. The

¹ The total number of cases notes examined in this research totals 99: 13 cases in Chapter 3 on adolescent patients, 46 cases in Chapter 4 on women aged between mid-twenties and mid-forties, in their adulthood, and 40 cases in Chapter 5 on those aged over 45, middle- and old-aged women.

² Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (London: Virago, 1985).

concept was reinvigorated in the course of the nineteenth century, coming closer to its modern meaning and our current interpretation of the disorder. Objections to the label of melancholia, an ancient term which has a long history tracing back to Hippocratic Greece, as well as its indiscrete usage, appeared to be resolved by introducing and authorising its replacement, depression, around the turn of the century. However, the process was neither fast nor smooth. Melancholia did not readily disappear, even though its defeat against depression seemed irreversible by the 1920s in terms of word frequency, and varied associated concepts, notably neurasthenia, obtruded upon depression as a ‘standard’ diagnosis. The confusion and conflicts surrounding depression, particularly in relation to its classification, perturbed interwar psychiatrists, as nineteenth-century melancholia had done for their predecessors. Despite all these problems, however, depression became one of the most prevalent mental illnesses already in the 1920s, making up around a third of the whole institutionalised patient population.³

According to the case notes of those who were diagnosed with depression (or melancholia) and treated at the Maudsley and Holloway, these patients suffered from various symptoms, including somatic troubles, mood disorder, hallucination, delusion, self-reproach and suicidal tendency. The kinds of symptoms did not vary much according to gender, age and class. However, the detailed experiences and contents were largely decided by these factors. For instance, considering class, obsessions about poverty and destitution were more prevalent amongst the middle-class patient group than amongst their working-class counterparts. If a suicide attempt was made, the most dangerous accompaniment of

³ Brookwood Mental Hospital, Annual Report for the Year 1924, SHC Ac. 3043/1/1/2/15; Annual Report for the Year 1928, SHC Ac. 3043/1/1/2/19; Holloway Sanatorium, Annual Report for the Year 1922, No. 37, SHC Ac. 2620/1/8; Annual Report for the Year 1928, No. 43, SHC Ac. 2620/1/9.

depression, the means was often decided by the patient's occupation, living environment, or social background. In terms of age, the older patients were, the higher the probability that they would experience delusions and hallucinations. As for the contents, among old patients, obsessive ideas related to the bowels and other hypochondriac concerns were very common. Even though self-reproach was commonly expressed in all age groups, its causality showed a generation gap too. Amongst the young, guilty feelings related to their sexual behaviour were often mentioned, whereas in the mature patient groups most common was a sense of guilt on the grounds that they failed to fulfil their responsibility as a mother, a wife, a carer or a homemaker.

Analysing lay causal attributions in these case notes, life cycle and life events emerge as a key subject. Contrary to contemporary psychiatrists' claim that the great majority of cases of affective disorder could be ascribed to hereditary predisposition, the majority of female patients associated their mental illness with adverse life events, which they had experienced prior to the current attack in their everyday lives. Thus, their interpretation of aetiology varied depending on patients' gender, class and age, which is why life stage and life events should be taken into serious consideration as a factor deciding women's experience of mental illness. In all age groups, economic concerns, financial hardships or occupational worries were commonly expressed. In the younger patient groups, a sense of guilt coming from sexual practice or aberration was frequently mentioned as being related to their mental breakdown. Female patients in their (late) twenties and thirties most frequently referred to childbirth and childrearing as a major source of stress or a trigger of mental depression, mirroring the core life event in this life stage. Following childbirth, financial difficulties and matrimonial problems were commonly blamed as aetiological factors by patients in their

adulthood. ‘Spinsters’ were more concerned about their financial independence and frequently troubled by occupational issues, in contrast to their married counterparts. In older patient groups, bereavement was one of the most common aetiologies. However, menopause or climacteric changes were rarely mentioned by patients, though they were often pointed to as a principal aetiological factor by the physicians treating them. Although the burden resulting from their caring roles and responsibilities, physical and psychological, was a commonly reiterated theme irrespective of women’s age, the object of commitment varied depending on their age and marital status: most married adult patients were concerned about their children and middle- and old-aged women were responsible for an invalid in the family.

Meanwhile, the case histories examined in this research provide a good opportunity to observe the ways in which these patients and the lay public became accustomed to professional knowledge. The language applied by patients in their symptom descriptions and causal attributions demonstrates that they were familiar with some medical concepts, though not necessarily with the latest knowledge. For instance, young patients seemed to be alarmed by the risk of ‘masturbation insanity’, as they commonly expressed a strong sense of guilt related to the self-abusing habit and often attributed their mental disorder to it. The clinical concept dated from the Victorian period and by the interwar years it was almost abandoned by medical professionals.⁴ However, patients’ obsession with the idea that masturbation could be a contributory cause of insanity did not disappear immediately even when experts agreed that the habit itself was neither harmful nor dangerous.⁵ A similar time lag between

⁴ Lesley A. Hall, “‘It Was Affecting the Medical Profession’”: The History of Masturbatory Insanity Revisited’, *Paedagogica Historica*, 39:6 (December 2003), pp. 685-699; Alan Hunt, ‘The Great Masturbation Panic and the Discourses of Moral Regulation in Nineteenth- and Early Twentieth-Century Britain’, *Journal of the History of Sexuality*, 8:4 (1998), pp. 575-615.

⁵ Lesley A. Hall, *Sex, Gender and Social Change in Britain since 1880* (Basingstoke: MacMillan,

professional knowledge and lay perceptions of health and ill-health can be found in excessive hypochondriacal concerns about 'bowels', especially amongst the elderly. Based on the so-called 'intestinal autointoxication theory', late Victorian physicians emphasised the importance of 'daily evacuation of the bowels' and regarded constipation as 'the mother of all disease'.⁶ While medical professions discarded the theory by the interwar years, the public were more fanatical about it than ever before, which was reflected vividly in the case notes of female patients in their advanced age.⁷ However, middle-aged female patients whose cases were related to menopause by psychiatrists found the cause of their mental depression elsewhere, mostly related to practical problems. Although the concept of 'involutional melancholia' was one of the fiercely-debated subjects in the expert circles during interwar years, it was as yet unknown to the public. As such, in the interwar years the medical common sense of lay people was largely founded on what had been produced and circulated in the expert group in the nineteenth century, and thus was still under the strong influence of the Victorian medical tradition.

Furthermore, these cases can be read as examples which underpin social constructionist approaches to medical knowledge and mental illness experience. As mentioned in the Introduction to this thesis, the second version of social constructionism centres on discourse. This approach suggests that 'the concept invented by physicians (...) to account for disorders and diseases come to shape, not only assessments and treatments, but also the very

2000), p. 125.

⁶ James Whorton, *Inner Hygiene: Constipation and the Pursuit of Health in Modern Society* (Oxford: Oxford University Press, 2000), pp. 1-54; Whorton, 'Civilisation and the Colon: Constipation as the "Disease of Diseases"', *British Medical Journal*, 321:7276 (2000), p. 1586.

⁷ Whorton, *Inner Hygiene*, p. 79.

manifestation of the illness itself'.⁸ The case histories analysed in this research show that symptoms of depressions troubling those patients were considerably shaped by medical discourse, a good instance of which is the hypochondriacal obsession with bowels as seen above. Also, we have seen in previous chapters, patients' lay causal attribution was strongly influenced by professional psychiatric knowledge, though not necessarily the latest ideas. These cases demonstrate the ways in which medical discourse, mostly produced by professionals, affected the reality of illness and experience of sufferers, albeit the flow of knowledge did not run in one direction.

Those case histories under scrutiny also reveal the remarkable difference between what was said in medical literature and what was done in daily medical practice. As stressed repeatedly in the previous chapters, most contemporary psychiatric textbooks claimed that the majority of manic-depressive insanity cases were attributable to hereditary predisposition: although the exact numbers varied, they were usually between 60 and 80 percent.⁹ However, as we have witnessed in previous chapters, the number of cases which were ascribed to heredity or family history by psychiatrists at the Maudsley Hospital and Holloway Sanatorium was much smaller than the figure suggested in expert literature. For instance, among the twenty Holloway patients, scrutinised in Chapter 5, all aged over 45, six (30 percent) were considered as to have insane heredity or neurotic heredity as aetiological

⁸ Phil Brown, 'Naming and Framing: The Social Construction of Diagnosis and Illness', *Journal of Health and Social Behavior*, Extra Issue (1995), pp. 35-36; Arshi Shaikh and Carol Kauppi, 'Postpartum Depression: Deconstructing the Label through a Social Constructionist Lens', *Social Work in Mental Health*, 13:5 (2015), pp. 462-463.

⁹ D. K. Henderson and R. D. Gillespie, *A Textbook of Psychiatry for Students and Practitioners* (London: Oxford University Press, 1927), pp. 117-118; Emil Kraepelin, Mary Barclay (trans.), and George Robertson (ed.), *Manic-Depressive Insanity and Paranoia* (Edinburgh: Livingstone, 1921), pp. 165-167.

factors according to the Medical Registers or Registers of Departure. In this patient group, heredity was not the most common cause, since mental stress and climacteric period were mentioned with the same frequency.¹⁰ In the adult patient group at the same institution, aged between their mid-twenties and mid-forties, heredity ranked second amongst aetiological factors in the Medical Registers, slightly over 30 percent of all the cases. In this category, the rate of cases attributed to prolonged mental stress was over 40 percent.¹¹ Furthermore, the sum of cases which were thought to have hereditary origins in individual case notes was much lower than the figure estimated based on the Registers. At the Maudsley, only a few cases were ascribed directly to heredity or predisposition by the medical staff, in all age groups.¹² This finding not only confirms the gap between what was said in the literature and what was done in practice, but also shows the change that interwar psychiatry was undergoing, the proliferation of ‘the auxiliary concept of stress’.¹³

At the end of this research, it should be remembered that the picture drawn herein is not representative of all situations. Firstly, the Maudsley Hospital and Holloway Sanatorium were not typical interwar mental hospitals: as stressed repeatedly in this research, both were unique. Thus, if we avert our eyes to county asylums, accommodating mostly pauper patients (and after the Mental Treatment Act of 1930 rate-aided patients), the psychiatric scenery becomes completely different, regarding the demographic features of the inmate population;

¹⁰ Holloway Sanatorium, Medical Register: Females, SHC Ac. 3473/3/48-49; Register of Departure, Discharges and Transfers of Voluntary, Temporary and Certified Patients, SHC Ac. 3473/3/54.

¹¹ Ibid.

¹² For detailed information on causal attributions made by the medical staff of both institutions, see the section illustrating Causes of Depression in Chapter 4 and Chapter 5 of the thesis, especially the beginning of each section comparing professional and lay causal attributions.

¹³ Rhodri Hayward, ‘The Invention of the Psychosocial: An Introduction’, *History of the Human Science*, 25:5 (2012), pp. 3-4; Mark Jackson, *The Age of Stress: Science and the Search for Stability* (Oxford: Oxford University Press, 2013), p. 16.

patients' experiences of daily life and mental illness; and the composition of diagnoses. Secondly, as this research centres exclusively on depression and depressive patients, some conclusions reached by analysing these cases cannot be applied to those who were identified as having other mental diseases. The experiences of those who suffered from severe psychoses accompanying loss of intellectual ability could differ considerably from those of depression patients, in terms of the certification process, treatment, hospitalisation period, prognosis and causal attribution. With regard to cases of dementia praecox or schizophrenia in the same period, for instance, more patients could have been certified on their admission and given shock therapies and other somatic treatments. This research has aimed to uncover hidden (or less-revealed) pieces of the scenery of early-twentieth-century British psychiatry, rather than suggesting a whole picture of it, by focusing on depressive disorder, female patients, and two hospitals in the Greater London area. Thus, we can see different sceneries of psychiatry, if we avert our eyes to other diagnoses than depression; to male patient cases; to county-run asylums and their lower-class patients; or to the urban environments.

Women's Life in Interwar Britain

As mentioned, this research is concerned about women's life itself as much as women's madness. The medical records on which this research heavily relies uncover women's everyday life experiences as well as clinical ones, and help us to reconstruct varied life events which necessarily constituted their lives and often were accused as driving them into

depression. The historical interpretation of the interwar years concerning women's status has considerably changed over time: from an emphasis on the emancipatory effects of the wartime experience; to the backlash model which stresses the reactionary movement of putting women back to home and domestic duty; and to more recent works taking note of meaningful, albeit not revolutionary, changes in women's daily lives, such as clothing and consuming culture. The medical records under analysis here illustrate that between the Wars, basically, women's place was the home and their primary role was as mother, wife, homemaker, or care-giver. Noteworthy is that the great majority of women would aspire to carry out those traditional feminine roles, rather than protesting both the reversion of Victorian femininity and the invalidation of wartime achievements. This is supported by the large number of cases in which women took these roles seriously, felt over-burdened by the responsibilities, and thus fell victim to mental illness. Also, it can be underpinned by details in the case notes of a great many self-reproachful women, who blamed themselves for their incompetence as carers. Furthermore, when recovered from mental breakdown, most of them returned to their previous positions to undertake the same duties once again. Such cases seem to reject some of the feminist critiques which simply interpret women's madness as an 'unconscious form of feminist protest' or a 'rebellion against patriarchy'.¹⁴

However, not all women found their place at home. Those engaged in varied occupations outside the home had to cope with very different troubles, and exhibited different interests and identities from those at home. Many young girls, especially those who had

¹⁴ Showalter, *The Female Malady*, p. 5; Janet Oppenheim, "*Shattered Nerves*": *Doctors, Patients, and Depression in Victorian England* (Oxford: Oxford University Press, 1991), p. 229; Carroll Smith-Rosenberg, 'The Hysterical Woman: Sex Roles and Role Conflict in Nineteenth-Century America', *Social Research*, 39 (1972), pp. 654-655, 671.

desirable jobs for women, such as typist and teacher, did not hesitate to reveal their 'aspiration' to achieve in their careers.¹⁵ The ambitions and frustration they felt when the expectation was not satisfied often drove them into depression, as we have seen in Chapter 3.¹⁶ Meanwhile, single working women in their full adulthood, who were condescendingly called as 'spinsters' or 'surplus women', frequently claimed that work-related troubles and the stress coming from them were responsible for their mental depression, demonstrating what constituted core life events as well as the identity of those single women.¹⁷ However, it is certain that the atmosphere was not favourable to them, as acknowledged in existing research: many faced (the possibility of) dismissal from their work and varied disadvantages applied only to female workers, including marriage bars and lower wages.¹⁸

Sexuality and sexual practice is also crucial in understanding women's lives during this period. The main sources of this research, psychiatric case notes, have provided detailed information, unavailable anywhere else, on this sensitive subject and proved themselves to be a reliable material which can be applied to this theme. Regarding issues of sexuality, the interwar years exhibited both novel and conventional trends, but could not yet be identified as 'modern'. New knowledge and discourses about sex, contraception and marriage, as a main

¹⁵ Selina Todd, *Young Women, Work, and Family in England 1918–1950* (Oxford: Oxford University Press, 2005), pp. 113–144.

¹⁶ Maudsley Hospital, Patient Casenotes, BRHAM CFM-151, pp. 121–159.

¹⁷ Maudsley Hospital, Patient Casenotes, BRHAM CFM-150, Case No. 3643.

¹⁸ Katherine Holden, *The Shadow of Marriage: Singleness in England, 1914–60* (Manchester: Manchester University Press, 2007), pp. 28–29; Guerriero R. Wilson, 'Women's Work in Offices and the Preservation of Men's "Breadwinning" Jobs in Early Twentieth-Century Glasgow', *Women's History Review*, 10:3 (2001), pp. 463–482; Teresa Davy, "'A Cissy Job for Men; a Nice Job for Girls': Women Shorthand Typists in London, 1900–39,' in Leonore Davidoff and Belinda Westover (eds.), *Our Work, Our Lives, Our Words* (Basingstoke: Macmillan Education, 1986), pp. 124–144; Deirdre Beddoe, *Back to Home and Duty: Women between the Wars, 1918–1939* (London: Pandora, 1989), pp. 3–7.

and desirable venue for sexual relationship and satisfaction, became highly available by the 1920s, with the emergence of sexology and the active circulation of practical advice books on this subject, notably Marie Stopes' *Married Love*. It appears that an increasing number of the young people were involved in relationships and were active sexually, although it is impossible to suggest precise estimates of the figure here. However, extramarital sex, which was on the increase too, was usually practised in courting couples, 'repeating the old pattern' of the behaviour.¹⁹ The heightened expectations about intimacy among married couples, both emotionally and sexually, did not affect all to the same extent, since middle-class housewives seemed to be more influenced by this shift than their working-class counterparts. Despite the wide commercialisation of modern contraceptive devices, including condoms, the case notes analysed here demonstrate that the majority of married couple still clung to 'the most primitive and the most unreliable method', coitus interruptus (so-called withdrawal), underpinning recent studies on this subject and stressing the continuity of old habits.²⁰ Moreover, they were not as serious about birth control and family planning as their contemporary birth-control campaigners and later historians anticipated.²¹

¹⁹ Hall, *Sex, Gender and Social Change in Britain Since 1880*, p. 122.

²⁰ Kate Fisher and Simon Szreter, "'They Prefer Withdrawal': The Choice of Birth Control in Britain, 1918-1950", *Journal of Interdisciplinary History*, 34:2 (2003), pp. 263-291; Fisher, *Birth Control, Sex, and Marriage in Britain 1918-1960* (Oxford: Oxford University Press, 2006), pp. 109-110. However, in a recent study, Claire L. Jones reaches a different conclusion. She takes a commercial approach in examining contraceptive practice in England between 1880 and 1960, and relies on 'underutilised parliamentary sources and the hitherto neglected business records of manufacturers, vendors and distributors'. According to this research, consumption patterns of modern contraceptive methods, such as condoms and douches, were more complicated than Fisher and Szreter have found, depending on gender, class, and region: Claire L. Jones, 'Under the Covers? Commerce, Contraceptives and Consumers in England and Wales, 1880-1960', *Social History of Medicine*, 29:4 (2016), pp. 734-756.

²¹ Kate Fisher, 'Uncertain Aims and Tacit Negotiation: Birth Control Practices in Britain, 1925-50', *Population and Development Review*, 26:2 (2000), pp. 295-317.

In general, living as a woman in the interwar decades meant that one had to cope with more traditional and conventional conditions rather than modern ones. Although there were some shifts that affected women's lives which could be described as 'modern', such as the creation of youth culture and the increase in extramarital sexual relationships, during this period the circumstances were not generally favourable to change. In this sense, the historical assessment which regards the interwar years as reactionary and anti-progressive is neither misleading nor excessive.²² Moreover, the great majority of female patients whose cases are under analysis here did not reveal any grievance against the regressive traits of interwar British society, but were receptive to the revived 'shopworn roles and old routines'.²³

Beyond 'Women and Madness': Men, Women and Madness

This research has focused on women's depression, as a gendered problem. However, as Joan Busfield stresses, in order to understand the gendered geography of madness correctly, it is necessary to take a nuanced approach to this issue, focusing on gender and gender relations, not just on women and keeping male cases in the frame too.²⁴ Notwithstanding, historical research has paid little attention to men.²⁵ Furthermore, most existing studies of men's

²² Beddoe, *Back to Home and Duty*, pp. 3-7.

²³ Showalter, *The Female Malady*, pp. 196-197.

²⁴ Joan Busfield, *Men, Women, and Madness: Understanding Gender and Mental Disorder* (Basingstoke: Palgrave Macmillan, 1996), pp. 6-7.

²⁵ Louise Hide, *Gender and Class in English Asylums, 1890-1914*. (Basingstoke: Palgrave Macmillan, 2014), pp. 10-11.

experiences of mental illness are concerned with war trauma, leaving ‘ordinary men outside the extraordinary sphere of military combat’ out of focus.²⁶ It is only recently that historians, as well as sociologists and feminist critics, began to gaze at men’s experiences and male cases. Recent works reflecting such shifts in academic interests confirm that little is known about male mental illness compared to female experiences, and provide with ‘a very different pattern of gendered psychological illness’.²⁷ In this sense, Akihito Suzuki’s study on male mental patients and their lay attribution in the Victorian era is exemplary. This article has successfully shown the close relationship between the experience of mental disorder and the social, cultural and economic pressure put upon those men, such as manhood, respectability and independence.²⁸ More recently, Ali Hagggett has confronted ‘the commonly perceived notion that women are more likely than men to experience mental disorders’, demonstrating against the backdrop of post-war Britain that men, like women, suffered from psychological disorders but in different ways from their female counterparts’.²⁹ Men are ‘less likely to recognise, express or report’ their mental illness and ‘more likely to present with somatic symptoms’.³⁰ The gender difference in the prevalence of specific mental disorders and in the manifestations of them is detected by psychiatrists and psychologists too. Daniel and Jason Freeman find that women ‘experience higher overall rates of psychological disorder than men’, a conclusion that Hagggett would openly dispute, and that males are more susceptible to

²⁶ Ali Hagggett, *A History of Male Psychological Disorders in Britain, 1945-1980* (Basingstoke: Palgrave Macmillan, 2015), pp. 3-4.

²⁷ Ibid.

²⁸ Akihito Suzuki, ‘Lunacy and Labouring Men: Narratives of Male Vulnerability in Mid-Victorian London’, in Roberta Bivins and John V. Pickstone (eds.), *Medicine, Madness and Social History* (Basingstoke: Palgrave Macmillan, 2007), pp. 118-28.

²⁹ Hagggett, *A History of Male Psychological Disorders in Britain*, pp. 145-146.

³⁰ Ibid., pp. 1-2, 148-149.

only a few mental illnesses compared with females, such as alcohol and drug abuse.³¹

What could early-twentieth-century cases of two institutions contribute to this discussion? At the Maudsley Hospital and Holloway Sanatorium, at least during the period under study in this research, female patients outnumbered their male counterparts. The Maudsley was equipped with the same numbers of beds for both sexes (except private rooms), 72 respectively, on its opening in 1923, but accommodated 189 male and 263 female patients, about 40 percent more women than men, for the first year of its running. The medical superintendent admitted that there was ‘less pressure on the male wards than female’, which was universal and therefore expected according to himself.³² However, the gap between male and female admissions widened over time, due to an extension of the facility and the adjustment of bed numbers. At the outpatient clinic too, female patients outnumbered male all the time.³³ At Holloway Sanatorium, there were more beds for female inmates than male, based on ‘the average number of daily Registers’: in the early 1920s about 210 for women and 140 for men.³⁴ The number of patients treated in a year showed a similar pattern at Holloway: about 60 percent of ‘the total cases under treatment during the year’ were female and 40 percent male. The admission cases fluctuated in number during the period under study, but in most years females dominated. Holloway Sanatorium exhibited a bigger gender gap in admission numbers compared to the Maudsley, demonstrating that the

³¹ Daniel Freeman and Jason Freeman, *The Stressed Sex: Uncovering the Truth about Men, Women and Mental Health* (Oxford: Oxford University Press, 2013), pp. 3-4.

³² Maudsley Hospital, Medical Superintendent’s Annual Report, Year ended 31st January, 1924, BRHAM, p. 6.

³³ Maudsley Hospital, Medical Superintendent’s Annual Report, Year ended 31st January, 1924, BRHAM; Year ended 31st January, 1925, BRHAM; Period from 1st February, 1925, to 31st December, 1926, BRHAM; Period from 1st January, 1932, to 31st December, 1935, BRHAM.

³⁴ Holloway Sanatorium, Annual Report for the Year 1921, No. 37, SHC Ac. 2620/1/8.

composition of the patient population varied considerably between mental institutions.

Focusing on depression, in the interwar decades, the number of male cases diagnosed with depression was not limited, but much smaller than that of female ones. In expert literature, the estimation was that about 70 percent of manic-depressive insanity patients were women.³⁵ At Holloway Sanatorium, the medical staff were not reluctant to identify male patients as suffering from depression or melancholia. For instance, in 1922, out of 22 male admissions, excluding voluntary boarders, six were recorded as suffering from melancholia, which made the diagnosis one of the most frequent 'forms of mental disorder' in this sex, alongside 'delusional insanity'.³⁶ In 1928, the rate of depression among male admissions was slightly lower than that for 1922, but the order of forms of mental disorder was the same: melancholia and delusional insanity came first and primary dementia followed them.³⁷ At Brookwood Mental Hospital, for another example, in 1930, 19 out of 94 male admissions (20 percent) were identified as melancholic compared with 56 out of 138 female admissions (40 percent). At this county asylum, however, melancholia and primary dementia were the most frequent forms of mental disorder amongst its male patients.³⁸

Case histories reveal that the 'lived experience' of male depression could differ from that of females in the early twentieth century. However, it does not mean that there was a notable discrepancy in the types of symptoms, but suggests that the contents and details of the symptoms exhibited differences. Men who were diagnosed with depression also suffered

³⁵ Kraepelin, *Manic-Depressive Insanity and Paranoia*, p. 174.

³⁶ Holloway Sanatorium, Annual Report for the Year 1922, No. 37, SHC Ac. 2620/1/8.

³⁷ Holloway Sanatorium, Annual Report for the Year 1928, No. 43, SHC Ac. 2620/1/9.

³⁸ Brookwood Mental Hospital, Annual Report with Audited Accounts for year 1930, SHC Ac. 3043/1/1/2/20.

from mood disorder, general retardation, delusion, hallucination, suicidal impulse, and occasionally guilty feelings. Among them, suicidality, the most dangerous symptom associated with depression, provides a good example of gender difference. As mentioned in previous Chapters, men tended to attempt suicide less often than women, but more successfully, mainly because they applied more lethal measures, such as cutting.³⁹ Such a conclusion about male suicidal attempts was shared by contemporary observers and psychiatrists, as well as by later historians, and coincided largely with the late-twentieth-century phenomenon.⁴⁰ In his article on depression, Aubrey Lewis, the First Assistant Medical Officer at the Maudsley Hospital, took notice of such gender difference, demonstrating that less destructive measures, including drowning, poison and gas, were chosen by women.⁴¹

Regarding self-accusation, which I have recognised as a ‘feminine’ symptom of depression, male patients experienced this differently, in terms of both frequency and its subjects, and applied dissimilar language to describe the experiences compared to their female counterparts. Consulting Lewis’ clinical observations of depressed states, among the Maudsley case histories collected by himself the great majority of self-reproachful patients were women. Out of 27 cases in which the symptom was ‘prominent and persistent’, only six were male.⁴² Furthermore, the grounds on which those men accused themselves were very

³⁹ Anne Shepherd and David Wright, ‘Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint’, *Medical History*, 46:2 (2002), p. 186; Olive Anderson, *Suicide in Victorian and Edwardian England* (Oxford: Clarendon, 1987), p. 367.

⁴⁰ Haggitt, *A History of Male Psychological Disorders in Britain*, p. 2; Freeman and Freeman, *The Stressed Sex*, pp. 9-10.

⁴¹ Aubrey Lewis, ‘Melancholia: A Clinical Survey of Depressive States’, *Journal of Mental Science*, 80:329 (1934), pp. 341-342.

⁴² Aubrey Lewis, ‘Melancholia: Prognostic Study and Case-Material’, *British Journal of Psychiatry*, Vol. 82 (1936), pp. 488-558; ‘Melancholia: A Clinical Survey of Depressive States’, pp 312-313.

limited. The majority condemned their self-abusive habit, confirming Lewis' finding that 'the self-reproach of a great number of patients centred on their sexual behaviour' and masturbation were 'the chief topic' amongst men.⁴³ In male patient groups, the next common cause of self-accusation was cowardice, which was rarely applied in female patients' accounts. A 27-year-old butler kept saying that 'I am a damn coward', and an electrical engineer in his early sixties blamed himself as a coward and failure.⁴⁴ As seen in earlier chapters, female patients tended to suggest specific and concrete reasons for their self-reproach, accusing themselves mostly in relation to their caring roles and frequently due to sexual behaviours. On the contrary, men were likely to be more obscure about the grounds, except when they blamed sexual wrong-doings, and usually applied only vague language in describing the subjects and contents of self-accusation. Although Lewis paid scrupulous attention to self-reproachful cases, he did not catch the gendered features of 'the most striking of melancholic symptom'.⁴⁵ Self-reproach is one of the best examples showing stark gender differences in mental illness experience, fundamentally belonging to female experience of depression, either as a symptom or an aetiological factor, and feminine manifestation of the affective disorder.

Compared to contemporary research on gender and mental illness, there is an interesting point to be mentioned here. According to recent studies focusing on male cases, men suffer from mental illness as women do, but in a very different way from women's. For instance, whilst tackling male psychological disorders against the backdrop of the late twentieth century, Haggett takes note of gender differences in those experiences, elaborating

⁴³ Lewis, 'Melancholia: A Clinical Survey of Depressive States', p. 315.

⁴⁴ Lewis, 'Melancholia: Prognostic Study and Case-Material', pp. 524-529.

⁴⁵ Lewis, 'Melancholia: A Clinical Survey of Depressive States', p. 312.

that men were more likely to present with somatic symptoms, such as stomach-ache and indigestion, whereas women exhibited low-mood, sadness, anxiety and lack of motivation, all ‘easy to recognise’.⁴⁶ However, in the materials scrutinised in this research, both in case notes and expert literature, descriptions either of gender gaps in experiencing bodily troubles or of distinctively male features of (psycho-)somatic symptoms were hard to find. Of course, the early-twentieth-century psychiatrists were aware of a wide range of physical abnormalities accompanied by depression. Kraepelin allotted a long section to illustrate ‘bodily symptoms’ of manic-depressive disorder, which included varied problems of sleep, appetite, weight, circulation, respirations and ‘metabolism’.⁴⁷ In *A Textbook of Psychiatry for Students and Practitioners*, D. K. Henderson and R. D. Gillespie enumerated headache, lack of appetite, a bad taste in the mouth, constipation, general weakness and fatigue, and actual exhaustion, as common complaints of ‘milder forms of depression’.⁴⁸ Lewis, too, mentioned ‘aches and pains’ with no organic cause, as a part of ‘neurotic symptoms’ of depressed state.⁴⁹ However, few psychiatrists recognised such gender differences in presenting depression symptoms. On the one hand, it could be because early-twentieth-century men were less inclined to undergo physical troubles compared to late-twentieth-century male patients. If such is the case, this episode can be understood as an example demonstrating that patients ‘choose’ the legitimate symptoms allowed by the surrounding culture, as Edward Shorter claims.⁵⁰ On the other hand, the absence of the information can be attributable to the failure

⁴⁶ Haggett, *A History of Male Psychological Disorders in Britain*, p. 2.

⁴⁷ Kraepelin, *Manic-Depressive Insanity and Paranoia*, pp. 44-53.

⁴⁸ D. K. Henderson and R. D. Gillespie, *A Textbook of Psychiatry for Students and Practitioners* (London: Oxford University Press, 1927), pp. 133-134.

⁴⁹ Lewis, ‘Melancholia: A Clinical Survey of Depressive States’, pp. 359-360.

⁵⁰ Edward Shorter, *From the Mind into the Body: The Cultural Origins of Psychosomatic Symptoms* (New York: Free Press, 1994); pp. 204-207.

of early-twentieth-century psychiatrists to detect male ways of experiencing depression. In this case, this episode can be read as an instance of the social construction of medical knowledge, which ‘deals mainly with the origins of professional belief’.⁵¹

To sum up, early-twentieth-century men suffered from depression, although apparently not as frequently as their female counterparts, and were not rarely diagnosed with the disorder by psychiatrists. However, in terms of the ways in which they suffered from depression, there were dissimilarities between male and female patients. Although only a few feminine or masculine traits were observed by contemporary psychiatrists, such as suicidal tendencies and suicide attempts, most gender differences in the experience of depression, as well as of other mental illnesses, were unnoticed: including the prevalence of somatic symptoms amongst male patients and the frequent and detailed expressions of self-reproach in the female patient group.

Epilogue: Depression, the Twentieth-Century Female Malady

Analysing the experiences of women who suffered from depression in the interwar decades, I have found remarkable affinities between what these case histories reveal and what sociological studies of late-twentieth-century women’s mental health issues discover. The ways in which the female patients interpreted their experiences of depression, particularly in

⁵¹ Brown, ‘Naming and Framing: The Social Construction of Diagnosis and Illness’, p. 37.

relation to the cause or trigger of their mental breakdown, are comparable to the conclusion reached by George W. Brown and Tirril Harris. In *Social Origins of Depression: A Study of Psychiatric Disorder in Women*, one of the key studies in the 'women and madness' genre, they have demonstrated that most cases of female depression can be attributed to the 'experience of loss and disappointment'. What they mean by 'loss' is not limited to the death of loved ones, but covers more general experiences concerning 'a person, or object, a role, or an idea'.⁵² Their emphasis on experience of loss as 'causal effects' or 'aetiological roles' coincides with the way in which female patients admitted to the Maudsley and Holloway in the 1920s and 1930s interpreted the origin of their mental disorder, attributing depression to recent life events such as bereavement, unemployment, change in family relationship and even (sexual) misbehaviour.

Moreover, recent studies reach similar conclusions which are almost identical to the findings of this research. For instance, James Y. Nazroo and his colleagues claim, through a case study of one hundred couples living in London in the 1990s, that the gender differences in the prevalence of depression results from 'gender differences in roles, which lead to differences in the experience of life events'. According to their observation, women are at greater risk of depression, compared to men, *only* when they undergo an event 'involving children, housing and reproduction', all traditionally identified as women's responsibility.⁵³ Such findings reflect a large number of sample cases examined in this research, in which female patients associated their mental breakdown with their role as a mother, wife, or care-

⁵² George W. Brown and Tirril Harris, *Social Origin of Depression: A Study of Psychiatric Disorder in Women* (London: Tavistock, 1978), pp. 272-275.

⁵³ James Y. Nazroo, Angela C. Edwards, and George W. Brown, 'Gender Differences in the Prevalence of Depression: Artefact, Alternative Disorders, Biology or Roles?', *Sociology of Health and Illness*, 20:3 (1998), pp. 312-330.

giver, as well as with the negative experience, notably the burdensomeness, related to it. Also, this conclusion can be read as an answer to the question as to why most female narratives describing the onset of their depression centred on some specific life events. Meanwhile, based on Canadian female cases collected in the 1990s, Vivien Walters demonstrates that women locate their mental health problem 'in the context of broader social influence', namely 'gender roles and images of women'. Females suffering from depression, anxiety, or stress often complain of 'the heavy workload' that is expected of them, and 'point to the burden of gendered caring roles and to the problematic nature of relationships with partners and other family members'. All these complaints sound very familiar, after consulting almost hundred case histories of interwar-period British female patients. Even though the women in Walter's sample group appear to possess critical attitudes towards the gender-biased culture and society, they rarely go further: they 'normalise' the mental problems they have, as well as 'the problems of everyday living' which they find contribute to their mental disorder.⁵⁴ It seems that they choose to internalise the values rather than bringing up problems, as interwar-period female patients remained faithful to their roles and most of them returned to their position at home after recovery.

In conclusion, the gendered culture is pervasive in understanding female depression cases both in the earlier and later twentieth century. The feminine roles, which vary in a woman's life according to the life stage she belongs to, are crucial in interpreting women's experiences of mental disorder, as seen in this research as well as in the mentioned works exploring recent phenomenon. Life events which are inevitably related to womanhood, such

⁵⁴ Vivienne Walters, 'Stress, Anxiety and Depression: Women's Accounts of their Health Problems', *Social Science & Medicine*, 36:4 (1993), pp. 393-402.

as marriage and motherhood, decide the course of mental disorder, not to mention the path of a woman's life. This finding, on the one hand, demonstrates why depression is the twentieth-century female malady and why the affective disorder should be understood as a gendered issue. On the other hand, it indicates the extent to which the life-cycle approach is helpful in understanding women and madness.

Appendix I

SCHEDULE OF CAUSES AND ASSOCIATED FACTORS OF INSANITY.

HEREDITY (excluding Cousins, Nephews, Nieces and off-spring)

- | | |
|--|-------|
| Insane Heredity | A. 1. |
| Epileptic Heredity | A. 2. |
| Neurotic Heredity [including only Hysteria, Neurasthenia, Spasmodic (idiopathic)
Asthma and Chorea] | A. 3. |
| Eccentricity (in marked degree) | A. 4. |
| Alcoholism | A. 5. |

MENTAL INSTABILITY as revealed by—

- | | |
|---|-------|
| Moral Deficiency | B. 1. |
| Congenital Mental Deficiency, not amounting to Imbecility | B. 2. |
| Eccentricity | B. 3. |

DEPRIVATION OF SPECIAL SENSE—

- | | |
|----------------------------------|-------|
| Smell and Taste (either or both) | C. 1. |
|----------------------------------|-------|

Hearing C. 2.

Sight C. 3.

CRITICAL PERIODS—

Puberty and Adolescence D. 1.

Climacteric D. 2.

Senility D. 3.

CHILD BEARING—

Pregnancy E. 1.

Puerperal state (nor septic) E. 2.

Lactation E. 3.

MENTAL STRESS—

Sudden Mental Stress F. 1.

Prolonged Mental Stress F. 2.

PHYSIOLOGICAL DEFECTS AND ERRORS—

Malnutrition in early life (signs of Rickets, &c.)	G. 1.
Privation and Starvation	G. 2.
Over-exertion (physical)	G. 3.
Masturbation	G. 4.
Sexual excess	G. 5.

TOXIC—

Alcohol	H. 1.
Drug Habit (morphia, cocaine, &c.)	H. 2.
Lead and other such poisons	H. 3.
Tuberculosis	H. 4.
Influenza	H. 5.
Puerperal sepsis	H. 6.
Other specific Fevers	H. 7.
Syphilis, acquired (all patients believed to have suffered)	H. 8.
Syphilis, congenital (at any time in their lives from Syphilis)	H. 9.
Other Toxins	H. 10.

TRAUMATIC—

Injuries	I. 1.
Operations	I. 2.
Sunstroke	I. 3.

DISEASES OF THE NERVOUS SYSTEM—

Lesions of the Brain	K. 1.
Lesions of the Spinal Cord and Nerves	K. 2.
Epilepsy	K. 3.
Other defined (Limited to Hysteria, Neurasthenia, Neuroses, Spasmodic Asthma, Chorea)	K. 4.
Other Neuroses, which occurred in Infancy or Childhood (limited to Convulsions and Night-terrors)	K. 5.

OTHER BODILY AFFECTIONS

Haemopoietic System (Anaemia & c.)	L. 1.
Cardio-Vascular degeneration	L. 2.

Valvular Heart Disease	L. 3.
Respiratory System (excluding Tuberculosis)	L. 4.
Gastro-intestinal System	L. 5.
Renal and Vesical System	L. 6.
Generative System (excluding Syphilis)	L. 7.
Other General Affections not above included (<i>e.g.</i> , Diabetes, Myxoedema, &c.)	L.

8.

Instances in which NO PRINCIPAL FACTOR could with certainty be assigned, but in which one or more Factors were ascertained, and were returned as Contributory or Associated

M.

NO FACTOR ASSIGNABLE, notwithstanding full history and observation

N.

NO FACTOR ASCERTAINED, history defective

O.

Appendix II

SCHEDULE OF FORMS OF INSANITY

I. Congenital or Infantile mental deficiency (Idiocy or Imbecility), occurring as early in life as it can be observed.

Intellectual—

I. 1. *a.* With Epilepsy.

I. 1. *b.* Without Epilepsy.

I. 2. Moral.

II. Insanity occurring later in life.

II. 1. Insanity with Epilepsy.

II. 2. General Paralysis of the Insane.

II. 3. Insanity with the grosser brain lesions.

II. 4. Acute Delirium (Acute delirious mania).

II. 5. Confusional Insanity.

II. 6. Stupor.

II. 7. Primary Dementia.

Mania—

II. 8. *a.* Recent.

II. 8. *b.* Chronic.

II. 8. *c.* Recurrent.

Melancholia—

II. 9. *a.* Recent.

II. 9. *b.* Chronic.

II. 9. *c.* Recurrent.

II. 10. Alternating Insanity.

Delusional Insanity—

II. 11. *a.* Systematised.

II. 11. *b.* Non-Systematised.

Volitional Insanity—

II. 12. *a.* Impulse.

II. 12. *b.* Obsession.

II. 12. *c.* Doubt.

II. 13. Moral Insanity.

Dementia—

II. 14. *a.* Senile.

II. 14. *b.* Secondary or Terminal.

Appendix III

Diagnosis Classification Table of the Maudsley Hospital

A. Amentia

B. Organic nervous and mental disorders

(1) Senile changes

(2) Cardiovascular disorders

(a) Arteriosclerosis and its results

(b) Other forms

(3) Neurosyphilis

(a) Interstitial types

(b) G.P.I.

(c) Tabes

(4) Infections other than Syphilis

(a) Influenza

(5) Various gross lesion of nervous symptom

(a) Head injuries

- (b) Tumour of brain
 - (c) Encephalitis
 - (d) Paralysis Agitans
 - (e) Disseminated Sclerosis
 - (f) Chorea
- (6) Epilepsy
- (7) Endocrine disorders and Autointoxications
- (a) Glycosuria
 - (b) Renal Disease
 - (c) Hyperthyroidism
 - (d) Hypothyroidism
- (8) Alcoholism
- (a) Dipsomania
 - (b) Confusional and hallucinatory types
 - (c) Paranoid types
 - (d) Korssakow's Psychosis
 - (e) Pseudo-paresis
 - (f) Other forms

(9) Various drugs and poisons

(a) Lead

(b) Cocaine

(c) Morphia

C. Functional Syndromes

(1) Confusional states

(2) Schizophrenic states

(3) Paranoid states

(4) States of excitement

(5) States of depression

(6) Neurasthenia

(7) Anxiety states

(8) Hypochondriacal states

(9) Obsessional states

(10) Moral abnormalities

(11) Hysteria

D. Single symptoms

- (1) Headache
- (2) Neuralgia
- (3) Tinnitus
- (4) Tic
- (5) Torticollis
- (6) Enuresis
- (7) Stammering

* This version of Diagnosis Classification is based on the Medical Superintendent's Annual Report, Year ended 31st January, 1925. The content varied, not much though, depending on the publication year, but the main framework of the classification remained almost the same throughout the interwar years.

Bibliography

MANUSCRIPT SOURCES

Bethlem Royal Hospital Archives and Museum (BRHAM)

Maudsley Hospital

- Medical Superintendent's Annual Reports
- Patient Casenotes

Surrey History Centre Archive (SHC Ac.)

Brookwood Mental Hospital

- Annual Report

Holloway Sanatorium

- Annual Reports
- Case Book: Females
- Case Book: Males
- Discharge Case Book: Female

- Medical Register: Females

- Register of Departure, Discharges and Transfers of Voluntary, Temporary
and Certified Patients

London Wellcome Institute of History of Medicine Archive (LWIHM Acc.)

Holloway Sanatorium

- Case Book: Females

GOVERNMENT PUBLICATIONS

Report of the Royal Commission on Lunacy and Mental Disorder (London: HMSO, Cmd. 2700,
1926).

Royal College of Physicians of London, *Nomenclature of Disease* (4th edn, London: HMSO,
1906).

NEWSPAPERS AND PERIODICALS

Lancet

The British Journal of Psychiatry (The Journal of Mental Science)

British Medical Journal

CONTEMPORARY ARTICLES, BOOKS, PAMPHLETS AND SPEECHES

The British Journal of Psychiatry, 72:299 (1926), pp. 597-616.

‘The Artificial Menopause’, *British Medical Journal*, 1:3825 (1934), pp. 761-762.

‘The Problem of Involutional Melancholia’, *British Medical Journal*, 1:4089 (1939), pp. 1039-1040.

Blandford, George Fielding, *Insanity and its Treatment: Lectures* (London: Oliver and Boyd,

1871).

‘Discussion on the Diagnosis and Treatment of the Milder Forms of the Manic-Depressive Psychosis’, *Proceedings of the Royal Society of Medicine*, 23:6 (1930), pp. 881-895.

Clouston, T. S., *The Neuroses of Development* (Edinburgh: Oliver and Boyd, 1891).

———, *Puberty and Adolescence Medico-Psychologically Considered* (Edinburgh: Oliver and Boyd, 1880).

Defendorf, A. Ross, *Clinical Psychiatry: A Textbook for Students and Physicians* (London: MacMillan, 1902).

Gillespie, R. D., ‘The Clinical Differentiation of Types of Depression’, *Guy’s Hospital Reports*, 79 (1929), pp. 306-344.

Henderson, D. K. and R. D. Gillespie, *A Text-Book of Psychiatry for Students and Practitioners* (Oxford: Oxford University Press, 1927).

Hopkins, Frederick, ‘Attempted Suicide: An Investigation’, *British Journal of Psychiatry*,

83:342 (1937), pp. 71-94.

Kraepelin, Emil, R. Mary Barclay (trans.), George M. Robertson (ed.), *Manic-Depressive Insanity and Paranoia* (Edinburgh: Livingstone, 1921).

Lewis, Aubrey J., 'The Experience of Time in Mental Disorder', *Proceedings of the Royal Society of Medicine*, 25:5 (1932), pp. 611-620.

———, 'Melancholia: A Clinical Survey of Depressive States', *British Journal of Psychiatry*, 80:329 (1934), pp. 277-378.

———, 'Melancholia: Prognostic Study and Case Materials', *British Journal of Psychiatry*, 82:340 (1936), pp. 488-558.

———, 'States of Depression: Their Clinical and Aetiological Differentiation', *British Medical Journal*, 2:4060 (1938), pp. 875-878.

———, 'Edward Mapother and the Making of the Maudsley Hospital', *British Journal of Psychiatry*, 115:529 (1969), pp. 1349-1366.

Mapother, Edward, 'Discussion on Manic-Depressive Psychosis', *British Medical Journal*, 2:3436 (1926), pp. 872-879.

——— 'Impressions of Psychiatry in America', *Lancet*, 215:5564, (19 April 1930), pp. 848–852.

——— 'Mental Symptoms Associated with Head Injury', *British Medical Journal*, 4012 (1937), pp. 1055-1061.

——— 'The Physical Basis of Alcoholic Mental Disorders', *Addiction*, 36:3 (1939), pp. 103-132.

——— 'Treatment of mental disorder on a Voluntary Basis', *Lancet*, 204:5279 (1924), pp. 897–902.

Mott, Frederick, 'The Psychology of Adolescence', *British Journal of Psychiatry*, 70:289 (1924), pp.199-208.

———, 'The Psychopathology of Puberty and Adolescence', *British Journal of Psychiatry*, 67:278 (1921), pp. 279-318.

Tuke, D. H., *Dictionary of Psychological Medicine* (London: Churchill, 1892).

Yates, Sybille, 'Some Problems of Adolescence', *Lancet*, 221:5722 (1933), pp. 939-942.

[Anon.], review of D. K. Henderson and R. D. Gillespie, *A Text-Book of Psychiatry for Students and Practitioners* (2nd edn, 1930), *American Journal of Surgery*, 8:5 (1930), p. 1107.

PUBLISHED SECONDARY SOURCES

Adair, Richard, Joseph Melling, and Bill Forsythe, 'Migration, Family Structure and Pauper Lunacy in Victorian England: Admissions to the Devon County Pauper Lunatic Asylum, 1845–1900', *Continuity and Change*, 12:3 (1997), pp. 373-401.

Adelstein, A. M., and others, 'The Epidemiology of Mental Illness in an English City', *Social Psychiatry*, 3:2 (1968), pp. 47-59.

Alexander, Sally, *Becoming a Woman and Other Essays in Nineteenth and Twentieth Century Feminist Histories* (London: Virago, 1994).

Allderidge, Patricia, 'The Foundation of the Maudsley Hospital', in German E. Berrios (ed.), *150 Years of British Psychiatry, I: 1841-1991* (London: Gaskell, 1991), pp. 79-88.

Anderson, Olive, *Suicide in Victorian and Edwardian England* (Oxford: Clarendon, 1987).

Andrews, Jonathan, and Anne Digby (eds.), *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam: Rodopi, 2003).

Al-Shahi, Rustam, and Charles Warlow, 'Using Patient-Identifiable Data for Observational Research and Audit: Overprotection Could Damage the Public Interest', *British Medical Journal*, 321:7268 (2000), pp. 1031-1032.

Appignanesi, Lisa, *Mad, Bad and Sad: A History of Women and the Mind Doctors from 1800 to the Present* (London: Virago, 2008).

Atkinson, Paul, and Maggie Gregory, 'Constructions of Medical Knowledge', in James A. Holstein and Jaber F. Gubrium (eds.), *Handbook of Constructionist Research* (London: Guilford Publications, 2013), pp. 593-608.

Bacopoulos-Viau, Alexandra, and Aude Fauvel, 'The Patient's Turn: Roy Porter and Psychiatry's Tales, Thirty Years on', *Medical History*, 60:1 (2016), pp. 1-18.

Banks, Joanne Trautmann, 'Mrs Woolf in Harley Street', *Lancet*, 351:9109 (1998), p. 1124-1126.

Bassuk, Ellen, 'The Rest Cure: Repetition or Resolution of Victorian Women's Conflicts?', *Poetics Today*, 6:1/2 (1985), pp. 245-257.

Beaven, Brad, *Leisure, Citizenship and Working-Class Men in Britain, 1850-1945* (Manchester: Manchester University Press, 2005).

Beddoe, Deirdre, *Back to Home and Duty: Women between the Wars, 1918-1939* (London: Pandora, 1989).

Bell, Rudolph, *Holy Anorexia* (Chicago: University of Chicago Press, 1985).

Berrios, German E., 'Melancholia and Depression during the Nineteenth Century: A Conceptual History', *British Journal of Psychiatry*, 153:3 (1988), pp. 298-304.

———, 'Mood Disorders', in German E. Berrios and Roy Porter (eds.), *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London: Athlone, 1995), pp. 384-408.

———, *The History of Mental Symptoms: Descriptive Psychopathology since the Nineteenth Century* (Cambridge: Cambridge University Press, 1996).

Berrios, German E., and Hugh Freeman (eds.), *150 Years of British Psychiatry, I: 1841-1991* (London: Gaskell, 1991).

———, *150 Years of British Psychiatry, II: The Aftermath* (London: Gaskell, 1996).

Berrios, G. E., and R. Hauser, 'Kraepelin: Clinical Section – Part II', in German E. Berrios and Roy Porter (eds.), *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London: Athlone, 1995), pp. 261-302.

Berrios, German E., and Roy Porter (eds.), *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London: Athlone, 1995).

Bingham, Adrian, “‘An era of Domesticity?’ Histories of Women and Gender in Interwar Britain”, *Cultural and Social History*, 1:2 (2004), pp. 225-233.

———, *Gender, Modernity, and the Popular Press in Interwar Britain* (Oxford: Oxford University Press, 2004).

Bivins, Roberta, and John V. Pickstone (eds.), *Medicine, Madness and Social History* (Basingstoke: Palgrave Macmillan, 2007).

Brockington, Ian, *Motherhood and Mental Health* (Oxford: Oxford University Press, 1996).

Brown, George W., and Tirril Harris, *Social Origin of Depression: A Study of Psychiatric Disorder in Women* (London: Tavistock, 1978).

———, *Life Events and Illness* (London: The Guilford Press, 1989).

Brown, Phil, ‘Naming and Framing: The Social Construction of Diagnosis and Illness’, *Journal of Health and Social Behavior*, Extra Issue (1995), pp. 34-52.

Brumberg, Joan Jacobs, *Fasting Girls: The Emergence of Anorexia Nervosa as a Modern*

Disease (Cambridge, MA: Harvard University Press, 1988).

Busfield, Joan, 'The Female Malady? Men, Women and Madness in Nineteenth-Century Britain', *Sociology*, 28:1 (1994), pp. 259-277.

———, *Men, Women and Madness: Understanding Gender and Mental Disorder* (Basingstoke: Palgrave Macmillan, 1996).

———, 'Class and Gender in Twentieth-Century British Psychiatry: Shell-Shock and Psychopathic Disorder', in Jonathan Andrews and Anne Digby (eds.), *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam: Rodopi, 2003), pp. 295-322.

———, 'Mental Illness', in Roger Cooter and John Pickstone (eds.), *Medicine in the Twentieth Century* (London: Routledge, 2014), pp. 633-652.

Butler, Tom, *Mental Health, Social Policy and the Law* (Basingstoke: Macmillan, 1985).

Bynum, W. F., Roy Porter and Michael Shepherd (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry, II: Institutions and Society* (London: Tavistock, 1985).

Caramagno, Thomas, *The Flight of the Mind: Virginia Woolf's Art and Manic-Depressive Illness* (Berkeley: University of California Press, 1992).

Clark, David H., *The Story of a Mental Hospital: Fulbourn 1858-1983* (London: Process Press, 1996).

Clendinning, Anne, 'Deft Fingers' and "Persuasive Eloquence": The "Lady Demons" of the English Gas Industry, 1888–1918', *Women's History Review*, 9:3 (2000), pp. 501-537.

Chaney, Sarah, 'No "Sane" Person Would Have Any Idea: Patients' Involvement in Late Nineteenth-century British Asylum Psychiatry', *Medical History*, 60:1 (2016), pp. 37-53.

Chesler, Phyllis, *Women and Madness* (New York: Avon Books, 1972).

Collins, Marcus, *Modern Love: An Intimate History of Men and Women in Twentieth-Century Britain* (London: Atlantic, 2001).

Condrau, Flurin, 'The Patient's View Meets the Clinical Gaze', *Social History of Medicine*,

20:3 (2007), pp. 525-540.

Cooter, Roger and John Pickstone (eds.), *Medicine in the Twentieth Century* (London: Routledge, 2014).

Coyne, James C., and Valerie E. Whiffen, 'Issues in Personality as Diathesis for Depression: The Case of Sociotropy-Dependency and Autonomy-Self-Criticism', *Psychological Bulletin*, 118:3 (1995), pp. 358-378.

Dale, Pamela, and Joseph Melling (eds.), *Mental Illness and Learning Disability since 1850: Finding a Place for Mental Disorder in the United Kingdom* (London: Routledge, 2006).

Davidoff, Leonore, and Belinda Westover (eds.), *Our Work, Our Lives, Our Words* (Basingstoke: Macmillan Education, 1986).

Davis, Margaret Llewelyn (ed.), *Maternity: Letters from Working Women* (London: Virago, 1978).

Davy, Teresa, "A Cissy Job for Men; a Nice Job for Girls": Women Shorthand Typists in London, 1900-39', in Leonore Davidoff and Belinda Westover (eds.), *Our Work, Our*

Lives, Our Words (Basingstoke: Macmillan Education, 1986), pp. 124-144.

D'Cruze, Shani, 'Women and the Family', in June Purvis (ed.), *Women's History: Britain, 1850-1945* (London: Routledge, 1995), pp. 51-84.

Delap, Lucy, *Knowing their Place: Domestic Service in Twentieth-Century Britain* (Oxford: Oxford University Press, 2011).

Digby, Anne, 'Women's Biological Straightjacket', *Sexuality and Subordination: Interdisciplinary Studies of Gender in the Nineteenth Century* (1989), pp. 192-220.

Eder, Franz X., Lesley A. Hall and Gert Hekma (eds.), *Sexual Cultures in Europe: National Histories* (Manchester: Manchester University Press, 1999).

Evans, Dylan, *Emotion: A Very Short Introduction* (Oxford: Oxford University Press, 2003).

Fennell, Phil, *Treatment without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People since 1845* (London: Routledge, 2002).

Fisher, Kate, "'Didn't Stop to Think I Just Didn't Want Another One': The Culture of Abortion

in Interwar South Wales', in Franz Eder, Lesley A. Hall and Gert Hekma (eds.), *Sexual Cultures in Europe: Themes in Sexuality* (Manchester: Manchester University Press, 1999), pp. 213-232.

———, 'Uncertain Aims and Tacit Negotiation: Birth Control Practices in Britain, 1925–50', *Population and Development Review*, 26:2 (2000), pp. 295-317.

———, *Birth Control, Sex, and Marriage in Britain 1918-1960* (Oxford: Oxford University Press, 2006).

Fisher, Kate, and Simon Szreter, "'They Prefer Withdrawal": The Choice of Birth Control in Britain, 1918-1950', *Journal of Interdisciplinary History*, 34:2 (2003), pp. 263-291.

Ferris, Paul, *Sex and the British: A Twentieth-Century History* (London: Michael Joseph, 1993).

Fowler, David, *The First Teenagers: The Lifestyle of Young Wage-Earners in Interwar Britain* (London: Woburn Press, 1995).

Francis, Martin, 'Leisure and Popular Culture', in Ina Zweiniger-Bargielowska (ed.), *Women in Twentieth-Century Britain* (London: Routledge, 2014), pp. 229-246.

Freeman, Daniel, and Jason Freeman, *The Stressed Sex: Uncovering the Truth about Men, Women and Mental Health* (Oxford: Oxford University Press, 2013).

Gelder, Michael, 'Introduction: Adolf Meyer and his Influence on British Psychiatry', *History of Psychiatry*, 14:4 (2003), pp. 475-493.

Gijswijt-Hofstra, Marijke, and Roy Porter (eds.), *Cultures of Neurasthenia from Beard to the First World War* (Amsterdam: Rodopi, 2001).

Giles, Judy, "'Playing Hard to Get": Working-Class Women, Sexuality and Respectability in Britain, 1918-40', *Women's History Review*, 1:2 (1992), pp. 239-255.

———, *Women, Identity and Private Life in Britain, 1900–50* (Basingstoke: Macmillan, 1995).

Gittins, Diana, *Madness in its Place: Narratives of Severalls Hospital 1913-1997* (London: Routledge, 2006).

Girgusand, Joan S., and Susan Nolen-Hoeksema, 'Cognition and Depression', in Keyes and Goodman (eds.), *Women and Depression: A Handbook for the Social, Behavioral, and*

Biomedical Sciences (Cambridge: Cambridge University Press, 2006), pp. 147-175.

Gutzke, David W., 'Gender, Class and Public Drinking in Britain during the First World War',
Historie Sociale/Social History, 27:54 (1994), pp. 367-391.

Hacking, Ian, 'Between Michel Foucault and Erving Goffman: Between Discourse in the
Abstract and Face-to-Face Interaction', *Economy and society*, 33:3 (2004), pp. 277-302.

Haggett, Ali, *Desperate Housewives, Neuroses and the Domestic Environment, 1945–1970*
(London: Pickering & Chatto, 2012).

———, *A History of Male Psychological Disorders in Britain, 1945-1980* (Basingstoke:
Palgrave Macmillan, 2015).

Hall, Lesley A., 'Sexual Culture in Britain: Some Persisting Themes', in Franz X. Eder, Lesley
A. Hall and Gert Hekma (eds.), *Sexual Cultures in Europe: National Histories*
(Manchester: Manchester University Press, 1999), pp. 29-52.

———, *Sex, Gender and Social Change in Britain since 1880* (Basingstoke: Macmillan, 2000).

———, “‘It Was Affecting the Medical Profession’: The History of Masturbatory Insanity Revisited’, *Paedagogica Historica*, 39:6 (2003), pp. 685-699.

———, ‘Essay Review: Does Madness Have a Gender?’, *History of Psychiatry*, 20:4 (2009), pp. 497-501.

———, ‘Sexuality’, in Ina Zweiniger-Bargielowska (ed.), *Women in Twentieth-Century Britain* (London: Routledge, 2014), pp. 51-68.

Harrison, Barbara, ‘Women and Health’, in June Purvis (ed.), *Women’s History: Britain, 1850-1945* (London: Routledge, 1995), pp. 142-171.

Harrison, Mary, ‘Domestic Service between the Wars: The Experiences of Two Rural Women’, *Oral History*, 16:11 (1988), pp. 48-54.

Hatton, Timothy J., ‘Infant Mortality and the Health of Survivors: Britain, 1910–50’, *Economic History Review*, 64:3 (2011), pp. 951-972.

Hayward, Rhodri, ‘Germany and the Making of “English” Psychiatry: The Maudsley Hospital, 1908-1939’, in Volker Roelcke, Paul Weindling, and Louise Westwood (eds.),

International Relations in Psychiatry: Britain, Germany, and the United States to World War II (Rochester NY: University of Rochester Press, 2010), pp. 67-90.

———, ‘The Invention of the Psychosocial: An Introduction’, *History of the Human Sciences*, 25:5 (2012), pp. 3-12.

———, *The Transformation of the Psyche in British Primary Care, 1880-1970* (London: Bloomsbury, 2014).

Hess, Volker, and Benoît Majerus, ‘Writing the History of Psychiatry in the 20th Century’, *History of Psychiatry*, 22:2 (2011), pp. 139-145.

Hide, Louise, *Gender and Class in English Asylums, 1890-1914* (Basingstoke: Palgrave Macmillan, 2014).

Hirshbein, Laura, ‘Gender, Age, and Diagnosis: The Rise and Fall of Involutional Melancholia in American Psychiatry, 1900–1980’, *Bulletin of the History of Medicine*, 83:4 (2009), pp. 710-745.

Holden, Katherine, “‘Nature Takes No Notice of Morality’: Singleness and *Married Love* in

Interwar Britain', *Women's History Review*, 11:3 (2002), pp. 481-504.

———, 'Imaginary Widows: Spinsters, Marriage, and the "Lost Generation" in Britain after the Great War', *Journal of Family History*, 30:4 (2005), pp. 388-409.

———, *The Shadow of Marriage: Singleness in England, 1914-60* (Manchester: Manchester University Press, 2007).

———, 'Family, Caring and Unpaid Work', in Ina Zweiniger-Bargielowska (ed.), *Women in Twentieth-Century Britain* (London: Routledge, 2014), pp. 134-148.

Holstein, James A., and Jaber F. Gubrium (eds.), *Handbook of Constructionist Research* (London: Guilford Publications, 2013)

Holtzman, Ellen M., 'The Pursuit of Married Love: Women's Attitudes toward Sexuality and Marriage in Great Britain, 1918-1939', *Journal of Social History*, 16:2 (1982), pp. 39-51.

Hornstein, Gail A., *Agnes's Jacket: A Psychologist's Search for the Meanings of Madness* (Ross-on-Wye: PCCS Books, 2012).

Hunt, Alan, 'The Great Masturbation Panic and the Discourses of Moral Regulation in Nineteenth- and Early Twentieth-Century Britain', *Journal of the History of Sexuality*, 8:4 (1998), pp. 575-615.

Horwitz, Allan V., 'The Sociological Study of Mental Illness: A Critique and Synthesis of Four Perspectives', in Carol S. Aneshensel, Jo C. Phelan and Alex Bierman (eds.), *Handbook of the Sociology of Mental Health* (2nd edn, Dordrecht: Springer, 2013), pp. 95-112.

Horwitz, Allan V., and Jerome C. Wakefield, *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder* (Oxford: Oxford University Press, 2007).

Ion, R. M., and M. D. Beer, 'The British Reaction to Dementia Praecox 1893-1913: Part 1', *History of Psychiatry*, 13:51 (2002), pp. 285-304.

Jack, Dana Crowley, *Silencing the Self: Women and Depression* (Cambridge, MA: Harvard University Press, 1991).

Jackson, Mark, *The Age of Stress: Science and the Search for Stability* (Oxford: Oxford University Press, 2013).

Jackson, Stanley W., *Melancholia and Depression: From Hippocratic Times to Modern Times* (London: Yale University Press, 1986).

———, ‘A History of Melancholia and Depression’, in Edwin R. Wallace and John Gach (eds.), *History of Psychiatry and Medical Psychology* (New York: Springer, 2008), pp. 443-460.

Jacyna, L. Stephen, and Stephen T. Casper (eds.), *The Neurological Patient in History* (Rochester: University of Rochester Press, 2012).

Jalland, Patricia, and John P. Hooper, *Women from Birth to Death: The Female Life Cycle in Britain 1830-1914* (Brighton: Harvester, 1986).

Jansson, Åsa, ‘Mood Disorder and the Brain: Depression, Melancholia, and the Historiography of Psychiatry’, *Medical History*, 55:3 (2011), pp. 393-399.

———, ‘From Statistics to Diagnostics: Medical Certificates, Melancholia, and “Suicidal Propensities” in Victorian Psychiatry’, *Journal of Social History*, 46:3 (2013), pp. 716-731.

Jeffreys, Sheila, 'Women and Sexuality', in June Purvis (ed.), *Women's History: Britain, 1850-1945* (London: Routledge, 1995), pp. 193-216.

Jones, Claire L., 'Under the Covers? Commerce, Contraceptives and Consumers in England and Wales, 1880-1960', *Social History of Medicine*, 29:4 (2016), pp. 734-756.

Jones, Edgar, 'Aubrey Lewis, Edward Mapother and the Maudsley', *Medical History*, Supplement 22 (2003), pp. 3-38.

Jones, Edgar, and Shahina Rahman, 'Framing Mental Illness, 1923-1939: The Maudsley Hospital and its Patients', *Social History of Medicine*, 21:1 (2008), pp. 107-125.

———, 'The Maudsley Hospital and the Rockefeller Foundation: The Impact of Philanthropy on Research and Training', *Journal of the History of Medicine and Allied Sciences*, 64:3 (2008), pp. 273-299.

Jones, Edgar, Shahina Rahman, and Brian Everitt, 'Psychiatric Case Notes: Symptoms of Mental Illness and their Attribution at the Maudsley Hospital, 1924-35', *History of Psychiatry*, 23:2 (2012), pp. 156-168.

Jones, Edgar, Shahina Rahman, and Robin Woolven, 'The Maudsley Hospital: Design and Strategic Direction, 1923–1939', *Medical History*, 51:3 (2007), pp. 357-378.

Jones, Kathleen, *A History of the Mental Health Services* (London: Routledge & Kegan Paul, 1972).

———, *Asylums and After: A Revised History of the Mental Health Services, From the Early 18th Century to the 1990s* (London: Athlone, 1993).

Jordanova, Ludmilla, 'The Social Construction of Medical Knowledge', *Social History of Medicine*, 8:3 (1995), pp. 361-381.

Kendell, R. E., 'The Classification of Depression: A Review of Contemporary Confusion', *British Journal of Psychiatry*, 129:1 (1976), pp. 15-28.

Kessler, Ronald C., 'The Effects of Stressful Life Events on Depression', *Annual Review of Psychology*, 48 (1997), pp. 191-214.

Keyes, Corey L. M., and Sherryl H. Goodman (eds.), *Women', Women and Depression: A*

Handbook for the Social, Behavioral, and Biomedical Sciences (Cambridge: Cambridge University Press, 2006).

Kirmayer, Laurence J., 'Culture, Affect and Somatization: Part 1', *Transcultural Psychiatric Research Review*, 21:3 (1984), pp. 159-188.

———, 'Culture, Affect and Somatization: Part 2', *Transcultural Psychiatric Research Review*, 21:4 (1984) pp. 237-262.

Lafrance, Michelle N., *Women and Depression: Recovery and Resistance* (London: Routledge, 2009).

Langhamer, Claire, *Women's Leisure in England, 1920-1960* (Manchester: Manchester University Press, 2000).

———, "'A Public House is For All Classes, Men and Women Alike": Women, Leisure and Drink in Second World War England', *Women's History Review*, 12:3 (2003), pp. 423-443.

Lawlor, Clark, *From Melancholia to Prozac: A History of Depression* (Oxford: Oxford

University Press, 2012).

Levin-Clark, Marjorie, “‘Embarrassed Circumstances’: Gender, Poverty, and Insanity in the West Riding of England in the Early-Victorian Years’, in Andrews and Digby (eds.), *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam: Rodopi, 2004), pp. 123-148.

Lewis, Jane, ‘Marriage’, in Ina Zweiniger-Bargielowska (ed.), *Women in Twentieth-Century Britain* (London: Routledge, 2014), pp. 69-85.

Long, Vicky, *Destigmatising Mental Illness? Professional Politics and Public Education in Britain, 1870-1970* (Manchester: Manchester University Press, 2014).

Loudon, Irvine, ‘Puerperal insanity in the 19th century’, *Journal of the Royal Society of Medicine*, 81:2 (1988), pp. 76-79.

MacKenzie, Charlotte, *Psychiatry for the Rich: A History of Ticehurst Private Asylum 1792-1917* (London: Routledge, 2005).

McCrae, Niall, “‘A Violent Thunderstorm’: Cardiazol Treatment in British Mental Hospitals’,

History of Psychiatry, 17:1 (2006), pp. 67-90.

McGrath, Ellen Ed, and others, *Women and Depression: Risk Factors and Treatment Issues: Final Report of the American Psychological Association's National Task Force on Women and Depression* (Washington, DC: American Psychological Association, 1990).

McKibbin, Ross, *Classes and Cultures: England 1918-1951* (Oxford: Oxford University Press, 2000).

Marecek, Jeanne, 'Social Suffering, Gender, and Women's Depression', in Corey L. M. Keyes and Sherryl H. Goodman (eds.), *Women and Depression: A Handbook for the Social, Behavioral, and Biomedical Sciences* (Cambridge: Cambridge University Press, 2006), pp. 283-308.

Marland, Hilary, "'Uterine Mischief": W. S. Playfair and his Neurasthenic Patients', in Marijke Gijswijt-Hofstra and Roy Porter (eds.), *Cultures of Neurasthenia from Beard to the First World War* (Amsterdam: Rodopi, 2001), pp. 117-139.

———, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Basingstoke: Palgrave Macmillan, 2004).

———, *Health and Girlhood in Britain, 1874-1920* (Basingstoke: Palgrave Macmillan, 2013).

Melman, Billie, *Women and the Popular Imagination in the Twenties: Flappers and Nymphs* (Basingstoke: Macmillan, 1988).

Melling, Joseph, 'Buried Alive by Her Friends: Asylum Narratives and the English Governess, 1845–1914', in Pamela Dale and Joseph Melling (eds.), *Mental Illness and Learning Disability since 1850: Finding a Place for Mental Disorder in the United Kingdom* (London: Routledge, 2006), pp. 65-90.

Melling, Joseph, and Bill Forsythe, *The Politics of Madness: The State, Insanity and Society in England, 1845–1914* (London: Routledge, 2006).

——— (eds.), *Insanity, Institutions and Society, 1800–1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999).

Melman, Billie, *Women and the Popular Imagination in the Twenties: Flappers and Nymphs* (Basingstoke: Macmillan, 1988).

Micale, Mark S., 'Hysteria and its Historiography: A Review of Past and Present Writings II',

History of Science, 27:3 (1989), pp. 319-351.

———, ‘The Psychiatric Body’, in Roger Cooter and John Pickstone (eds.), *Medicine in the Twentieth Century* (London: Routledge, 2014), pp. 323-346.

Micale, Mark S., and Roy Porter (eds.), *Discovering the History of Psychiatry* (Oxford: Oxford University Press, 1994).

Miles, Agnes, *Women and Mental Illness: The Social Context of Female Neurosis* (Brighton: Harvester Wheatsheaf, 1988).

Misbach, Judith, and Henderikus Stam, ‘Medicalising Melancholia: Exploring Profiles of Psychiatric Professionalisation’, *Journal of the History of the Behavioural Science*, 42:1 (2006), pp. 41-59.

Nazroo, James Y., Angela C. Edwards, and George W. Brown, ‘Gender Differences in the Prevalence of Depression: Artefact, Alternative Disorders, Biology or Roles?’, *Sociology of Health and Illness*, 20:3 (1998), pp. 312-330.

Neve, Michael, ‘Public Views of Neurasthenia: Britain, 1880-1930’, in Marijke Gijswijt-

Hofstra and Roy Porter (eds.), *Cultures of Neurasthenia from Beard to the First World War* (Amsterdam: Rodopi, 2001), pp.141-160.

Nolen-Hoeksema, Susan, *Sex Differences in Depression* (Stanford, CA: Stanford University Press, 1990).

Nowell-Smith, Harriet, 'Nineteenth-Century Narrative Case Histories: An Inquiry into Stylistics and History', *Canadian Bulletin of Medical History*, 12:1 (1995), pp. 47-67.

Oppenheim, Janet, "*Shattered Nerves*": *Doctors, Patients, and Depression in Victorian England* (Oxford: Oxford University Press, 1991).

Orbach, Susie, *Hunger Strike: The Anorectic's Struggle as a Metaphor for Our Age* (2nd edn, London: Karnac, 2005).

Pearce, David, 'Family, Gender and Class in Psychiatric Patient Care during the 1930s: The 1930 Mental Treatment Act and the Devon Mental Hospital', in Pamela Dale and Joseph Melling (eds.), *Mental Illness and Learning Disability since 1850: Finding a Place for Mental Disorder in the United Kingdom* (London: Routledge, 2006), pp. 112-130.

Peppis, Paul, *Sciences of Modernism: Ethnography, Sexology, and Psychology* (Cambridge: Cambridge University Press, 2014).

Peterson, Dale (ed.), *A Mad People's History of Madness* (Pittsburgh: University of Pittsburgh Press, 1982).

Porter, Roy, 'The Patient's View', *Theory and society*, 14:2 (1985), pp.175-198.

———, *Madmen: A Social History of Madhouses, Mad-Doctors and Lunatics* (London: Athlone, 1987).

———, *The Faber Book of Madness* (London: Faber & Faber, 1991).

———, 'Two Cheers for Psychiatry! The Social History of Mental Disorder in Twentieth Century Britain', in Hugh Freeman and German E. Berrios (eds.), *150 Years of British Psychiatry, II: The Aftermath* (London: Athlone, 1996), pp. 383-403.

———, *Madness: A Brief History* (Oxford: Oxford University Press, 2002).

Porter, Roy, and David Wright (eds.), *The Confinement of the Insane: International*

Perspectives, 1800–1965 (Cambridge: Cambridge University Press, 2003).

Poirier, Suzanne, 'The Weir Mitchell Rest Cure: Doctor and Patients', *Women's Studies: An Interdisciplinary Journal*, 10:1 (1983), pp. 15-40.

Purvis, June (ed.), *Women's History: Britain, 1850-1945* (London: Routledge, 1995).

Radden, Jennifer, *Moody Minds Distempered: Essays on Melancholy and Depression* (Oxford: Oxford University Press, 2009).

Raitt, Suzanne, 'Early British Psychoanalysis and the Medico-Psychological Clinic', *History Workshop Journal*, 58 (2004), pp. 63-85.

Rapp, Dean, 'The Early Discovery of Freud by the British General Educated Public, 1912–1919', *Social History of Medicine*, 3:2 (1990), pp. 217-243.

Roberts, Elizabeth, *A Woman's Place: An Oral History of Working-Class Women 1890-1940* (Oxford: Blackwell, 1984).

Roelcke, Volker, Paul Weindling, and Louise Westwood (eds.), *International Relations in*

Psychiatry: Britain, Germany, and the United States to World War II (Rochester NY: University of Rochester Press, 2010).

Risse, Guenter B., and John Harley Warner, 'Reconstructing Clinical Activities: Patient Records in Medical History', *Social History of Medicine*, 5:2 (1992), pp. 183-205.

Roebuck, Janet, 'When Does "Old Age" Begin?: The Evolution of the English Definition', *Journal of Social History*, 12:3 (1979), pp. 416-428.

Rogers, Anne, and David Pilgrim, *Mental Health Policy in Britain: A Critical Introduction* (1st edn, London: Palgrave, 1996).

———, *Mental Health Policy in Britain* (2nd edn, London: Palgrave, 2001).

Scull, Andrew, *Social Order, Mental Disorder: Anglo-American Psychiatry in Historical Perspective* (Berkeley, University of California Press, 1989).

Sengoopta, Chandak, "'A Mob of Incoherent Symptoms"?: Neurasthenia in British Medical Discourse, 1860-1920', , in Marijke Gijswijt-Hofstra and Roy Porter (eds.), *Cultures of Neurasthenia from Beard to the First World War* (Amsterdam: Rodopi, 2001), pp. 97-

Shaikh, Arshi, and Carol Kauppi, 'Postpartum Depression: Deconstructing the Label through a Social Constructionist Lens', *Social Work in Mental Health*, 13:5 (2015), pp. 459-480.

Shepherd, Anne, 'The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums', in Jonathan Andrews and Anne Digby (eds.), *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam: Rodopi, 2003), pp. 223-248.

Shepherd, Anna, *Institutionalizing the Insane in Nineteenth-Century England* (London: Routledge, 2014).

Shepherd, Anne, and David Wright, 'Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint', *Medical History*, 46:2 (2002), pp. 175-196.

Shorter, Edward, *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era* (New York: Free Press, 1993).

———, *From the Mind into the Body: The Cultural Origins of Psychosomatic Symptoms* (New

York: Free Press, 1994).

———, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: Wiley, 1997).

———, *A Historical Dictionary of Psychiatry* (Oxford: Oxford University Press, 2005).

Showalter, Elaine, *The Female Malady: Women, Madness, and English Culture, 1830-1980* (London: Virago, 1987).

Simões, S., and others, 'Is There Still a Place for Involutional Melancholia Nowadays?', *European Psychiatry*, 25 (2010), p. 617.

Smith-Rosenberg, Carroll, 'The Hysterical Woman: Sex Roles and Role Conflict in Nineteenth-Century America', *Social Research*, 39 (1972), pp. 652-678.

Søland, Birgitte, *Becoming Modern: Young Women and the Reconstruction of Womanhood in the 1920s* (Princeton, NJ: Princeton University Press, 2000).

Stearns, Peter N., 'History of Emotions: Issues of Change and Impact', in Michael Lewis,

Jeannette M. Haviland-Jones and Lisa Feldman Barrett (eds.), *Handbook of Emotions* (3rd edn, London: Guilford Press, 2008), pp. 17-31.

Stoppard, Janet M., *Understanding Depression: Feminist Social Constructionist Approaches* (London: Routledge, 2000).

Sullivan, W. C., 'A Lecture on Crime and Mental Deficiency', *Lancet*, 198:5120 (1921), pp. 787-791.

Suzuki, Akihito, 'Lunacy and Labouring Men: Narratives of Male Vulnerability in Mid-Victorian London', in Roberta Bivins and John V. Pickstone (eds.), *Medicine, Madness and Social History* (Basingstoke: Palgrave Macmillan, 2007), pp. 118-128.

Szreter, Simon, and Kate Fisher, *Sex before the Sexual Revolution: Intimate Life in England 1918–1963* (Cambridge: Cambridge University Press, 2010).

Taylor, Ruth E., 'Death of Neurasthenia and its Psychological Reincarnation', *British Journal of Psychiatry*, 179:6 (2001), pp. 550-557.

Thane, Pat, *Old Age in English History: Past Experiences, Present Issues* (Oxford: Oxford

University Press, 2000).

Theriot, Nancy M., 'Women's Voices in Nineteenth-Century Medical Discourse: A Step toward Deconstructing Science', *Signs: Journal of Women in Culture and Society*, 19:1 (1993), pp. 1-31.

———, 'Negotiating Illness: Doctors, Patients, and Families in the Nineteenth Century', *Journal of the History of the Behavioral Sciences*, 37:4 (2001), pp. 349-368.

Thomson, Mathew, 'The Popular, the Practical and the Professional: Psychological Identities in Britain, 1901-1950', in G. C. Bunn, A. D. Lovie and F. D. Richards (eds.), *Psychology in Britain: Historical Essays and Personal Reflections* (Leicester: BPS Books, 2001), pp. 115-132.

———, 'Neurasthenia in Britain: An Overview', in Marijke Gijswijt-Hofstra and Roy Porter (eds.), *Cultures of Neurasthenia from Beard to the First World War* (Amsterdam: Rodopi, 2001), pp. 77-95.

———, *Psychological Subjects: Identity, Culture, and Health in Twentieth-Century Britain* (Oxford: Oxford University Press, 2006).

———, ‘Mental Hygiene in Britain during the First Half of the Twentieth Century: The Limit of International Influence’, in Volker Roelcke, Paul Weindling, and Louise Westwood (eds.), *International Relations in Psychiatry: Britain, Germany, and the United States to World War II* (Rochester, NY: University of Rochester Press, 2010), pp. 134-155.

Tinkler, Penny, ‘Women and Popular Literature’, in Purvis (ed.), *Women’s History: Britain, 1850-1945* (London: Routledge, 1995), pp. 131-156.

Todd, Selina, *Young Women, Work, and Family in England 1918–1950* (Oxford: Oxford University Press, 2005).

———, ‘Domestic Service and Class Relations in Britain 1900–1950’, *Past and Present*, 203 (2009), pp. 181-204.

Tomes, Nancy, ‘Feminist Histories of Psychiatry’, in Mark S. Micale and Roy Porter (eds.), *Discovering the History of Psychiatry* (Oxford: Oxford University Press, 1994), pp. 348-383.

Toms, Jonathan, *Mental Hygiene and Psychiatry in Modern Britain* (Basingstoke: Palgrave Macmillan, 2013).

Turner, Trevor H., *A Diagnostic Analysis of the Casebooks of Ticehurst House Asylum, 1845-1890* (Cambridge: Cambridge University Press, 1992).

Unsworth, Clive, *The Politics of Mental Health Legislation* (Oxford: Clarendon Press, 1987).

Ussher, Jane M., *Women's Madness: Misogyny or Mental Illness?* (London: Harvester Wheatsheaf, 1991).

Varga, Somogy, 'From Melancholia to Depression: Ideas on a Possible Continuity', *Philosophy, Psychiatry, and Psychology*, 20:2 (2013), pp. 141-155.

Walters, Vivienne, 'Stress, Anxiety and Depression: Women's Accounts of their Health Problems', *Social Science & Medicine*, 36:4 (1993), pp. 393-402.

Walton, J. K., 'Casting Out and Bringing Back in Victorian England: Pauper Lunatics 1840-1870', in W. F. Bynum, Roy Porter and Michael Shepherd (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry, II: Institutions and Society* (London: Tavistock, 1985), pp. 132-146.

Ward, Hester J. T., and others, 'Academic Medicine Campaign: Obstacles to Conducting

Epidemiological Research in the UK General Population', *British Medical Journal*, 329:7460 (2004), pp. 277-279.

Wessely, Simon, 'Neurasthenia and Fatigue Syndromes', in German E. Berrios and Roy Porter (eds.), *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London: Athlone, 1995), pp. 509-532.

Whorton, James, *Inner Hygiene: Constipation and the Pursuit of Health in Modern Society* (Oxford: Oxford University Press, 2000).

———, 'Civilisation and the Colon: Constipation as the "Disease of Diseases"', *British Medical Journal*, 321:7276 (2000), p. 1586.

Wilson, Guerriero R., 'Women's Work in Offices and the Preservation of Men's "Breadwinning" Jobs in Early Twentieth-Century Glasgow', *Women's History Review*, 10:3 (2001), pp. 463-482.

Widiger, Thomas A., Stephanie Mullins-Sweatt, and Kristen G. Anderson, 'Personality and Depression in Corey L. M. Keyes and Sherryl H. Goodman (eds.), Women', *Women and Depression: A Handbook for the Social, Behavioral, and Biomedical Sciences* (Cambridge: Cambridge University Press, 2006), pp. 176-198.

Worsnop, Judith, 'A Reevaluation of "the Problem of Surplus Women" in Nineteenth-Century England: The Case of the 1851 Census', *Women's Studies International Forum*, 13:1/2 (1990), pp. 21-31.

Wright, David, 'The Discharge of Pauper Lunatics from County Asylums in Mid-Victorian England: The Case of Buckinghamshire, 1853–1872', in Joseph Melling and Bill Forsythe (eds.), *Insanity, Institutions and Society, 1800–1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999), pp. 93–112.

———, 'Delusions of Gender?: Lay Identification and Clinical Diagnosis of Insanity in Victorian England', in Jonathan Andrews and Anne Digby (eds.), *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (Amsterdam: Rodopi, 2003), pp. 149-176.———, 'Getting out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century." *Social History of Medicine*, 10:1 (1997), pp. 137-155.

Wright, David, James Moran and Sean Gouglas, 'The Confinement of the Insane in Victorian Canada: The Hamilton and Toronto Asylums, c. 1861–1891', in Roy Porter and David Wright (eds.), *The Confinement of the Insane: International Perspectives, 1800–1965* (Cambridge: Cambridge University Press, 2003), pp. 100-128.

Wright, Nicola, and Sara Owen. 'Feminist Conceptualizations of Women's Madness: A Review of the Literature', *Journal of Advanced Nursing*, 36:1 (2001), pp. 143-150.

York, Sarah, 'Alienist, Attendants and the Containment of Suicide in Public Lunatic Asylums, 1845-1890', *Social History of Medicine*, 25:2 (2012), pp. 324-342.

Zweiniger-Bargielowska, Ina, 'Raising a Nation of "Good Animals": The New Health Society and Health Education Campaigns in Interwar Britain', *Social History of Medicine*, 20:1 (2007), pp. 73-89.

——— (ed.), *Women in Twentieth-Century Britain* (London: Routledge, 2014).

UNPUBLISHED PAPERS AND THESES

Andrews, Emily S., *Senility before Alzheimer: Old Age in British Psychiatry, c. 1835-1912* (unpublished Ph.D. Thesis, University of Warwick, 2014).

Crabbe, Christine M., *On the Borderland of Insanity: Women, Dipsomania and Inebriety, 1879-*

1913 (unpublished Ph.D. Thesis: University of the West of England, 2014).

Soanes, Stephen, *Rest and Restitution: Convalescence and the Public Mental Hospital in England, 1919–39* (unpublished Ph.D. Thesis: University of Warwick, 2011).

Walke, Jennifer Mary, *Repute and Remedy: Psychiatric Patients and their Treatment at Bethlem Royal Hospital, 1930-1983* (unpublished Ph.D. Thesis: London School of Hygiene & Tropical Medicine, 2015).

WEB SOURCES

Oxford Dictionary of National Biography (DNB)

<http://www.thisismoney.co.uk/money/bills/article-1633409/Historic-inflation-calculator-value-money-changed-1900.html>.