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**Changing Public Representations of Mental Illness in
Britain 1870 – 1970**

by

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

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Declaration of Material Included From a Prior Thesis

Chapters Four and Five of this thesis incorporate small sections of my MA dissertation. These inclusions have been indicated in the footnotes where they occur. This thesis is my own work and has not been submitted for a degree at another university.

Abstract

This thesis uses Habermas' arguments concerning the public sphere and Nancy Fraser's concept of counter-public spheres as a framework to explore how changes in the representation of mental illness occurred between 1870 and 1970. Within this period, the nineteenth-century polarisation of sanity and madness that had led to the segregation of the mentally ill within the asylum gave way to the belief that mental health and illness formed a continuum. Psychiatry extended beyond the walls of the asylum into the community, expanding its scope to incorporate the nominally healthy. These developments, which culminated in the creation of community mental health services and the closure of the asylums, suggest that mental disturbance was no longer seen solely as the problem of sick individuals but of the public at large, and points to a potential destigmatisation of mental illness. To examine if the representation of mental illness matched these developments in practice and to explain why, this thesis studies how groups directly connected to the mentally ill, conceptualised as sub-public groups, sought to represent mental illness. The groups studied are the Medico-Psychological Association in Chapter One, the National Asylum Workers' Union in Chapter Two, The Association of Psychiatric Social Workers in Chapter Three and a charity, the Mental After Care Association, in Chapter Four. The fifth chapter explores patients and the representation of mental illness. It is argued that such sub-public groups helped initiate a debate about mental illness and enabled a broader spectrum of people to participate in the debate. However, it is suggested that private and professional motivations impinged upon how groups chose to represent the mentally ill. The thesis argues that the difficulties groups experienced balancing the representation of their own interests with those of the mentally ill, combined with the negative perceptions some sub-public groups held regarding the general public's capacity to participate in a debate on mental illness, obstructed their efforts to communicate with the public and to represent the interests of the mentally ill. Finally, the thesis uses the case study of the BBC to explore the factors that influenced the media to cover the issue of mental health and illness. This final chapter illustrates the interactions that occurred between media organisations and sub-public groups.

Abbreviations

AGM	Annual General Meeting
APSW	Association of Psychiatric Social Workers
BBC	British Broadcasting Corporation
<i>BJPSW</i>	<i>British Journal of Psychiatric Social Work</i>
CGC	Child Guidance Clinic
COHSE	Confederation of Health Service Employees
<i>JMS</i>	<i>Journal of Mental Science</i>
MACA	Mental After Care Association
MHIWU	Mental Hospital and Institution Workers' Union
<i>Mirror</i>	<i>Morningside Mirror</i>
MPA	Medico-Psychological Association
MRC	Modern Records Centre, Warwick University
NAMH	National Association of Mental Health
NAWU	National Asylum Workers' Union
NEC	National Executive Council
NHS	National Health Service
PRSC	Public Relations Sub-Committee
PSW	Psychiatric Social Worker
REA	Royal Edinburgh Asylum
SSCL	Secret Society of Certified Lunatics
WAC	Written Archives Centre

Changing Public Representations of Mental Illness in Britain, 1870 - 1970

Introduction

1: The Public Sphere, Professionalisation and Mental Health Groups

Speaking to an audience of fellow psychiatrists, John Charles Bucknill mused on the problem of the public. ‘There are two kinds of public opinion’, he informed his fellow listeners, ‘the one morbid and irrational, the other sound and intelligent. The latter is based, indeed, upon the efforts made by scientific men themselves to create enlightened public opinion on this subject.’¹ This statement summarises several beliefs frequently expressed by individuals who belonged to mental health groups. First, Bucknill asserted that public opinion, if left to itself, was morbid and irrational. This situation could only be remedied if the public submitted to the guidance of professional experts, who were implicitly not part of the public. Thus, enlightened public opinion was not to be achieved by open debate and the free and equal exchange of ideas, but through a top down process of didactic education. A more enlightened public, it was often suggested, would benefit not just the mentally ill but also those professional groups and organisations whose fate was intimately bound up with them, which suggests that the motivations of those who sought to change public opinion should be examined. The quote also suggests a problem encountered by the historian who attempts to study public representations of mental

¹ Anonymous, ‘Occasional Notes of the Quarter: The Annual Meeting and Dinner’, *Journal of Mental Science*, 27 (1881-82), pp. 401–2. Quoted on p. 402.

illness from the records of professional organisations. What is in fact being represented here is a psychiatrist's opinion about the public, not public opinion.

In this study, I have set out to examine the processes that led to certain ideas about mental illness being circulated, and whether these ideas can be designated as public. In part, this study also hopes to examine Habermas' concept of the public sphere through using mental disorder as a case study.² Habermas suggests that the growth of capitalism in the seventeenth and eighteenth centuries led to new forms of domestic privacy amongst the middle class, enabling new forms of sociability. Within the spheres of the coffee house or the popular press, private people could debate issues of public interest in an atmosphere of equality, using reasoned, critical debates to settle arguments in the common interest. The state, in turn, increasingly acted upon the opinions of the public, formed in this sphere, to legitimate its actions.

However, Habermas suggests that through the course of the nineteenth century, this public sphere paradoxically became eroded as it became more inclusive. The public became divided and polarised as capital, and subsequently social power, became concentrated in the hands of a few. Social historian Pat Thane has noted that in the early years of the twentieth century, 'the practice... of firmly governing an unequal but stable society through a process of negotiation among the major social factors, by an apparently

² J. Habermas, *The Structural Transformation of the Public Sphere* (1962, translation by T. Burger 1989, Cambridge, 1999).

neutral state means... was under pressure'.³ As the working classes lobbied the state to settle some of these inequalities, the state started to intervene in the affairs of private people to settle conflicts of interest that grew out of the private sphere. This led to the emergence of the welfare state. Subsequently, the social sphere became repoliticised as private institutions assumed a semi-public character. Habermas argues that these changes were accompanied by a shift from a culture debating to a culture consuming society. As the public and private realms became integrated, the public sphere became redundant. Institutions that arose from the private sphere, such as special interest associations, and those that had emerged from the public sphere, such as political parties, began to exercise power in co-operation with the state apparatus. Public opinion, Habermas claimed, was now brought in only to contribute approval.

Recently, a volume edited by Steve Sturdy has sought to apply the concept of the public sphere to analyse areas of medical history.⁴ Largely discarding Habermas' concept of a once unified public sphere that subsequently decayed, Sturdy's contributors chose to focus upon the institutions around which multiple medical publics developed, rather than analysing public discourse. Although many of these institutions have since been privatised, Sturdy argues that the continual formation of local publics, which participate collectively to encourage government activity through both debate and forms of collective action, discourages the notion that the public have been reduced to passive

³ P. Thane, 'Government and Society in England and Wales, 1750–1950', in F. M. L. Thomson (ed.), *The Cambridge Social History of Britain 1750–1950 Volume Three: Social Agencies and Institutions* (Cambridge, 1990), pp. 1–61. Quoted pp. 60–61.

⁴ S. Sturdy (ed.), *Medicine, Health and the Public Sphere in Britain, 1600–2000* (London, 2002).

consumers.⁵ ‘We impoverish our understanding of the public and its functions’, Sturdy warns, ‘if we confine ourselves to thinking solely in terms of discourse, and thereby neglect the role of institutionalized action in the constitution of the public sphere.’⁶

Through the course of this thesis, I have found Nancy Fraser’s reformulation of the public sphere, in particular her concept of counter-publics, a helpful way to examine how and why particular ideas were formulated and circulated about mental illness in the period 1870–1970.⁷ Noting that historically, members of subordinated social groups have found it helpful to constitute their own alternative publics, Fraser developed the concept of ‘*subaltern counterpublics*’, parallel discursive arenas that enabled members to formulate counter identities and discourses.⁸ However, in the field of mental health, many of these alternative publics were often not in open conflict and perhaps are best thought of as sub- rather than counter-publics (with the exception perhaps of the internal sphere of the mentally ill discussed in Chapter Five). The concept of a counter-public also suggests the existence of a main public, which seems problematic. Fraser, like other scholars, has argued persuasively that Habermas’ concept of the eighteenth-century public sphere was from the outset exclusionary and undemocratic, being defined as white, privileged, and male. She suggests that the participation of sub-publics, far from

⁵ *Ibid.*, p. 20.

⁶ *Ibid.*

⁷ N. Fraser, ‘Rethinking the Public Sphere: A Contribution to the Critique of Actually Existing Democracy’, in C. Calhoun (ed.), *Habermas and the Public Sphere* (1992, Cambridge, Massachusetts, 1999), pp. 109–42.

⁸ *Ibid.*, p. 132. Italics used in original text.

circumventing the democracy of the public sphere, help to contribute to it by enabling a broader cross section of people to participate in debate. Fraser does, however, note that such 'counter-publics' were not always democratic, as some operated their own methods of exclusion. Organisations seemed keener to inculcate correct opinions than to encourage genuine debate about the issues surrounding mental illness amongst the public. This appears to confirm Habermas' argument regarding the engineering of public consent by the intervention of pressure groups in the media.

These sub-public mental health groups need to be examined against the backdrop of what Harold Perkins has described as the rise of a professional society.⁹ He suggests that the earlier organisation of society around capital and class conflict gave way in the late-Victorian era to a society structured around career hierarchy and competition for resources between rival occupations with their own interests. Professions emerged which offered trained, expert, specialised services to society, seeking in return status, income and authority. As different professional groups competed for public resources, charitable organisations petitioned the state for funding for deserving causes and trade unions sought to protect their conditions of employment, the state became the mediator for disputes of interest.¹⁰ Eliot Freidson's work has examined how occupations sought security by attempting to gain the support of the state for the right to have their sphere of work protected from competition.¹¹ Gaining recognition as a 'profession', Freidson

⁹ H. Perkins, *The Rise of Professional Society: England Since 1880* (London, 1990).

¹⁰ *Ibid.*, pp. 1–17.

¹¹ E. Freidson, 'The Theory of Professions: State of the Art', in R. Dingwall and P. Lewis (eds), *The Sociology of the Professions: Lawyers, Doctors and Others* (London, 1983), pp. 19–37.

argued,

Was important to occupations not only because it was associated with traditional gentry status, but also because its traditional connotations of disinterested dedication and learning legitimated the effort to gain protection from competition in the labour market...The ideologies of special expertise and moral probity provided by the traditional concept of status profession...provided just such a basis for legitimating protection.¹²

Freidson also reminds us that the term profession can be defined and used in a variety of ways by people with different purposes: by occupations which are prestigious and widely recognised as professions, holding exclusive control over a specific area of work for example, but also by those occupations which seek to tackle their poor economic conditions and lack of status by describing themselves as professions.¹³ The mental health occupations in this study need to be considered in light of the interactions between competing occupations and the state in this period.

This competition was also structured around gendered notions of what constituted suitable work for women. Charlotte MacKenzie, for example, has examined how the professionalisation and medicalisation of care of the mentally disordered marginalised female practitioners. By the early twentieth century, Mackenzie argued, 'women had regained some of the ground lost through professionalisation of the treatment of the insane. Yet they worked within a profession, and body of psychiatric theory, which had

¹² *Ibid.*, p. 24.

¹³ *Ibid.*, pp. 28, 35.

been constructed by men, and from which it was difficult to deviate at a time when their professional status and respectability were so newly acquired.’¹⁴ In her analysis of American psychiatric practice in the early twentieth century, Elizabeth Lunbeck has discussed the impact that gender could have on the relative power of different sub-publics.¹⁵ Not only does Lunbeck describe how the delineation of gender roles fell within the scope of psychiatry within this period, but she also examines the interactions of psychiatry with the emerging profession of psychiatric social work, a profession dominated by women. The gender balance within professions and the struggles that ensued to maintain these had a significant impact on the types of representations of mental illness that different organisations sought to promote.

2: Government Inquiries into Mental Illness

In Habermas’ account, the public sphere in its golden age stood as a counter weight to the state apparatus, communicating the wishes of the public to the government. Yet, if Habermas is correct to suggest that increasing state intervention in the lives of its citizens circumvented the public sphere and gave government institutions a quasi-public character, perhaps state representations of mental illness should be examined as a form of public representation. Throughout the period I have chosen to study, the mechanisms for

¹⁴ C. MacKenzie, ‘Women and Psychiatric Professionalisation, 1780–1914’, in London Feminist History Group, *The Sexual Dynamics of History: Men’s Power, Women’s Resistance* (London, 1983), pp. 107–19. Quoted on p. 119.

¹⁵ E. Lunbeck, *The Psychiatric Persuasion: Knowledge, Gender and Power in Modern America* (Princeton, 1994)

treating the insane were questioned and revised, through Acts passed in 1890, 1930 and 1959. A brief examination of the reports of government committees in this era points to the interactions between the government and interested parties, and also suggests that the public, and public opinion, became a more central issue over time when the laws were examined. However, whom exactly the public were and how their opinion was to be measured was left somewhat vague within the reports.

The 1877 Select Committee Report on the Operation of the Lunacy Law was concerned primarily with the protection afforded by the legislation against wrongful confinement. In an index to the report, which spanned 117 pages, only two citations were given for the public, or public opinion. In one of these instances, the Earl of Shaftesbury attributed the improved quality of many private asylums in part to public opinion:

Public opinion is very much alive to these things...It was utterly dead; and even as far back as 1859 people were not easily moved to consider these matters, but of late years it is astonishing to what an extent they have been inquiring into it. All that movement acts upon the minds of the superintendents and others...¹⁶

The issue of the public had become more important by the 1926 Report of the Royal Commission on Lunacy and Mental Disorder, established to enquire into the existing law and to examine if provision for treatment without certification should be instituted. The Committee wanted the public to believe that certification was not a source of stigma, but

¹⁶ The Earl of Shaftesbury (12 July 1877), British Parliamentary Papers, 1877 [373] XIII, Operation of the Lunacy Laws: Select Committee Report with Minutes of Evidence, Appendix and Index (1877), paragraph 11378, pp. 548–9.

also felt that the rights of a public should be safeguarded against the potential threat posed by the mentally ill.¹⁷ The difficulties experienced by the Committee when trying to balance patient and public interest resurfaced when the problems posed by the isolation of mental hospitals from the community were examined. While isolation might be detrimental to patients, it was felt that ‘the general public can hardly be expected to visit these places’, and that subsequently, ‘mental hospitals can hardly be made more accessible to the public than they are at present’.¹⁸

By the time of the 1957 Report of the Royal Commission on the Law Relating to Mental Illness and Mental Disorder, the relevance of the issue was posited not on the conflicting needs of the public and the mentally ill, but the belief that the mentally ill were part of the general public. ‘The proper treatment of people suffering from disorders of the mind, and any restrictions on the liberty of individual citizens which this may involve’, the report argued, ‘are matters of public interest which may at any time become of immediate personal importance to anyone living in this country’.¹⁹ In a section entitled ‘the public attitude today and our own general approach’, the Committee stated their belief that the public were more knowledgeable about mental illness and were more sympathetic than they had been in earlier eras, citing the impact of first hand knowledge, hospital open days, media coverage and popular books on the topic. They still felt,

¹⁷ HMSO, *Report of the Royal Commission on Lunacy and Mental Disorder* [Cmd 2700], (London, 1926), paragraphs 92 and 168, pp. 43, 88.

¹⁸ *Ibid.*, paragraph 185, pp. 97–98.

¹⁹ HMSO, *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Disorder 1954–1957* [Cmnd 169], (London, 1964), paragraph 63, p. 21.

however, that on some issues prejudice and ignorance continued to predominate, especially regarding the relationship between crime and mental illness, and also mental deficiency, which was seldom the topic of media coverage.²⁰ The small place accorded in this thesis to the representation of what was termed mental deficiency derives from the fact that many people perceived and represented the topic as different from mental illness. It also reflects the more general avoidance and low status of mental deficiency in this period. Fortunately, this neglect has been addressed by recent literature, as historians have examined how categories of mental deficiency were constructed, problematised and visually represented through photography.²¹ However, it is important to recognise that the term mental illness is also somewhat problematic, given that other terms with slightly different meanings such as insanity and lunacy were also in use to varying degrees during the period under study. The term mental illness represents mental disorder as an illness amenable to medical management and treatment in a way that insanity and lunacy do not.²² Thus I am artificially imposing a sense of conformity that did not exist.

²⁰ *Ibid.*, paragraphs 67–73, pp. 22–24.

²¹ See, for example, M. Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy, and Social Policy in Britain, c. 1870–1959* (Oxford, 1998); M. Jackson, *The Borderland of Imbecility: Medicine, Society and the Fabrication of the Feeble Mind in Late Victorian and Edwardian England* (Manchester, 2000).

²² As can be seen, for example, in Chapter Six, when the majority of respondents to a BBC questionnaire in 1957 continued to differentiate mental illness from insanity. BBC/WAC T32/846/1 *The Hurt Mind*. BBC, *An Audience Research Report - 'The Hurt Mind' - An Enquiry into Some of the Effects of the Series of Five Television Broadcasts About Mental Illness and Its Treatment* (1957).

What these government committees all had in common was their heavy reliance on the evidence of what might be termed the professions or sub-public groups involved in the mental health field. As the twentieth century drew on, the newly emerging professions and organisations also sought to make their voices heard. The 1877 committee took evidence from psychiatrists and former patients, generally on an individual basis. By 1926, these two groups also competed with charitable organisations, such as the Mental After Care Association, the Central Association for Mental Welfare and the National Council for Mental Hygiene. More doctors gave evidence under the auspices of organisations such as the Medico-Psychological Association, the British Medical Association and the Mental Hospitals Association, as well as in an individual capacity. The National Asylum Workers' Union submitted evidence on behalf of mental nurses while former patients were represented by the National Society for Lunacy Reform. By the 1957 Report, other organisations such as the Association of Psychiatric Social Workers competed to persuade the Committee to incorporate their views. Thus the reports of successive government committees might be seen as balancing and adjudicating on the differing and sometimes competing views of an ever increasing number of specialised organisations and professions, all seeking to persuade the government to protect their views, work and beliefs. Even the Committees were partially constituted by members of these different organisations. Like Kathleen Jones' work, which has been structured around the legal changes in the field of mental illness, I could have planned my thesis around the interactions of different organisations surrounding legal developments.²³ However, I have chosen to focus on specific sub-public

²³ K. Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th*

organisations to enable me to examine their sphere of influence and work outside of legislation.

3: Representation and Mental Disorder

Previous studies of the representation of mental illness have largely examined how mental disorder has been depicted visually and fictionally. Sander Gilman, for example, examined how visual representations of mental illness that focused on distinct types of physical appearance, mannerisms and dress have helped to separate the mentally ill from the world of the sane observer.²⁴ These representations, Gilman argued, are projections of the fear experienced by sane members of society that they too could collapse into madness. By representing the mentally ill as instantly recognisable and distinct, society is able to maintain its boundaries between sane and insane. Elaine Showalter, meanwhile, sought to undertake a feminist history of psychiatry by examining how madness was represented as a female malady, arguing that to understand psychiatric discourse in the nineteenth and twentieth centuries, we need consider the broader cultural framework

Century to the 1990s (London, 1993).

²⁴ S. L. Gilman, *Disease and Representation: Images of Illness From Madness to AIDS* (1988, London, 1994); S. L. Gilman, *The Face of Madness: Hugh W. Diamond and the Origins of Psychiatric Photography* (New York, 1976). In a similar vein, Mark Jackson has examined how photography was used to represent the mentally deficient as visibly distinct, and the social and political purposes this served. See M. Jackson, 'Images of Deviance: Visual Representations of Mental Defectives in Early Twentieth-Century Medical Texts', *British Journal for the History of Science*, 28 (1995), pp. 319–37.

within which ideas about femininity and insanity were formed.²⁵ Gilman and Showalter drew their material from the world of fine art, literature and the writings of psychiatrists, which, while yielding interesting results, focus upon a rather narrow, elite section of society.

Lindsay Prior's study of the social organisation of mental illness examines the extent to which mental health professionals have been involved in the creation of representations and the impact these have had on the organisation of mental illness. Prior argued that representations of mental illness are created by people who have been involved in describing and treating mental disorder, who in the course of their labours produced beliefs and things such as buildings, disease classifications, textbooks and legal measures, that defined the nature of mental distress and led to mental illness being organised in a particular way.²⁶ These organisational structures then reinforced the representations that created them in the first place, and helped to define the experience of being ill. Prior's work provides an interesting way to think about the relationship between representation and the actual system through which mental illness is managed and experienced. However Prior, who based his work on an examination of professional

²⁵ E. Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980* (1985, London, 2001).

²⁶ L. Prior, *The Social Organisation of Mental Illness* (London, 1996). Prior defines his use of representation pp. 5–12 and 193–4. Research on the significance of asylum architecture, one of the 'things' created by mental health workers which served to define the nature of mental illness, was recently presented at a conference in Oxford Brookes: 'Space, Psyche and Psychiatry: Mental Health / Illness and the Construction and Experience of Space, 1600-2000', 13–15 December 2002.

representations, acknowledged that different types of representation might be generated from other sources, such as the mentally ill and the lay public.

All these works use representation as a term to connote ‘an image, likeness or reproduction of a thing, e.g. a painting or a drawing’.²⁷ However, my thesis focuses on two different definitions. As this is a study of public debate and the representation of people’s concerns, it will investigate whose interests groups represented when they created specific images of mental disorder, and whether mental health service users were enabled to represent their own interests without the intervention of a third party.²⁸ The thesis also examines representation as ‘a statement made by way of allegation or to convey opinion’, by which I shall illustrate how specific groups represented mental illness to other groups within society, and the motivations that underpinned these representations.²⁹ Occupational or professional motivations need to be considered as they might lead groups to focus on their own personal concerns; at other times individuals might be motivated by a professional ethic to work for and represent the interests of those they served. Julian Le Grand has recently suggested that while the welfare state was built on the assumption that the individuals who worked within it were driven by a professional ethic to serve only the interests of their patients, it was later recognised that many workers had their own agendas that were sometimes linked to their personal

²⁷ This is the second definition of the word ‘representation’ given in J. Pearsall and B. Trumble (eds), *The Oxford English Reference Dictionary* (Oxford 1996). Quoted on p. 1223.

²⁸ This is taken from the first definition of the word ‘representation’ given in *ibid.*: ‘The act or an instance of representing or being represented’.

²⁹ This is the third definition of the word ‘representation’ given in *ibid.*

conditions, and sometimes in opposition to government policy. Later governments have assumed that workers would be driven essentially by selfish motivations, a view which may obscure workers' concerns with patient welfare. Assumptions that workers might be driven solely either by selfish or altruistic motivations, he argues, can be equally misleading.³⁰

3.1: Representing Public Representations of Mental Illness?

It became clear to me as I started to research the records of groups involved in mental health, that all believed in the existence of a public which had definite ideas about the nature of mental illness. However, it was far less certain where this public could be located. To complicate matters further, organisations' ideas about who constituted the public and what the public believed changed over time. While I contest the existence of 'the public' as an entity in the period 1870-1970, the sub-public organisations examined in this thesis were convinced of its existence and wrote frequently about what they believed the public felt or did regarding mental illness. It is important, however, not to read these views of the sub-public groups regarding public opinion at face value as reflections of public opinion.

David Cantor, in an article about the Empire Research Council, focused his examination not on the public as described by the charity, but on how the charity

³⁰ J. Le Grand, 'So You Think Public Sector Staff are Knights not Knaves? Think Again', *Guardian, Society* supplement, 17 September 2003, p. 11.

perceived and represented the idea of the public.³¹ Cantor explained how the charity in the 1930s depicted the public as a mass single entity, prone to emotionalism and easily distracted, who held inaccurate beliefs regarding rheumatic diseases and remained apathetic about the issue. This image served to define the Empire Research Council in relation to the emotional, apathetic public as rational, enlightened people who sought to lead the public and manage their emotions for the general good. The representation of the public was subject to some modifications in the 1960s, as the decline of large donations from businessmen led the charity to pitch their fundraising at increasingly differentiated groups, reconceptualising working-class individuals who donated as rational and occasionally enlightened. To appeal to a broader base, the charity used statistics to suggest that everyone was at risk from rheumatic diseases, deploying volunteers and individuals suffering from the disease to campaign against what they saw as continuing public ignorance and apathy. The old concept of the public as an undifferentiated mass gradually gave way to the notion of a community or people who were all potentially at risk from the disease. However, despite these changes, Cantor argued, the Empire Research Council continued to talk about the public as a singular category, which remained ignorant and apathetic, although for a variety of reasons. Cantor reminds us that the Empire Research Council was only one of many organisations that sought to define public ignorance and apathy in a style that advanced their own interests, that ‘they might portray themselves as representing the public and its interests, but they also represented

³¹ D. Cantor, ‘Representing “the Public”’: Medicine, Charity and Emotion in Twentieth-Century Britain’, in Sturdy (ed.), *Medicine, Health and the Public Sphere*, pp. 145-68.

their own interests through the public'.³²

Perhaps then, this thesis is less a study of public representations, and more a study of how mental health groups represented public representations of mental illness. However, as I argue that the public sphere in the era 1870–1970 was largely centred round such sub-public groups, it is perhaps here that we find the closest thing approximating to public representations of mental illness. By default, because these groups had (to varying degrees) the ability and desire to access the media, these representations of the public were often accepted as public representations of mental illness. If the sub-public groups examined in this thesis shared the Empire Research Council's view of the public as ignorant and apathetic, one might expect this to inhibit their efforts to enable the public to participate. After all, how could ignorant people, whose reasoning was subject to their emotions, be expected to participate in a rational critical discussion. Cantor's article also reminds us that the way in which sub-public groups conceptualised the public might change significantly over time. This could lead to broader (or indeed narrower) groups of people being judged fit to participate in decisions. It is also worth considering if, in the field of mental illness, sub-public organisations slowly began to conceptualise everyone as belonging to a community affected by mental ill health, rather than seeing the population divided between an enlightened professional community of mental health workers, the mentally ill, and an ignorant public.

³² *Ibid.*, p. 161.

4: Mental Illness and Society, 1870-1970

Reasons for examining the era 1870 to 1970 become more apparent if it is asked whether it would have been possible to undertake a study into changing public representations of mental illness in the era 1770 to 1870. Mental disturbance was more likely to be viewed in this earlier time as a private matter coming under the jurisdiction of families or perhaps local communities rather than a public matter requiring public solutions.³³ It could then be argued that a public sphere or sub-public spheres interested in debating mental illness as a matter of public rather than private concern only arose in the nineteenth century. Indeed, the term mental illness would be an anachronism if applied back to the era 1770–1870, when mental disturbance, although still recognised, was not necessarily seen as a condition requiring medical attention. A specialised profession of doctors with expertise in mental disorders was struggling to be acknowledged as the rightful custodian of the mad in 1870, let alone in an earlier era.³⁴ While private mad houses began to emerge in the eighteenth century,³⁵ treatment within an asylum on the basis that mental disturbance was an illness amenable to medical intervention only became the primary course of action in the nineteenth century, when a series of legal measures culminated in the

³³ For details of systems of pre-asylum care, see G. N. Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (Cambridge, Massachusetts, 1994), pp. 5–21.

³⁴ A. Scull, C. MacKenzie and N. Hervey, *Masters of Bedlam: The Transformation of the Mad-Doctoring Trade* (Chichester, 1996). See Chapter One, 'the Transformation of the Mad-Doctoring Trade', pp. 3–9.

³⁵ See W. Parry-Jones, *The Trade in Lunacy: A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries* (London, 1972).

Lunatics Act of 1845.³⁶ The idea of a community of mental patients with a shared experience of confinement within an asylum that is explored in Chapter Five cannot really be projected back on to earlier individuals, even if their behaviour did lead them to be controlled.³⁷

Mad people, Andrew Scull argued, were seen in the mid-eighteenth century as part of a larger group of indigent individuals whose problems could be managed within family and community settings. By the mid-nineteenth century, he suggested, the mad had been demarcated, diagnosed and segregated within asylums.³⁸ This argument has been moderated by historians who have examined how forms of care in the community persisted throughout the era of the asylum, often made possible by the willingness of families to provide care.³⁹ However, more individuals would have experienced mental

³⁶ For a thorough account of lunacy legislation in the nineteenth century, Kathleen Jones' work is particularly helpful. See Jones, *Asylums and After*.

³⁷ Allan Ingram's edited volume of four eighteenth-century pamphlets written by individuals who experienced mental distress suggests that they experienced their mental disturbance differently from individuals in the nineteenth century. This is discussed in further detail in Chapter Five. A. Ingram (ed.), *Voices of Madness: Four Pamphlets, 1683–1796* (Stroud, 1997).

³⁸ This is the line of argument put forward in A. Scull, *Museums of Madness: The Social Organisation of Insanity in Nineteenth-Century England* (1979, London, 1982). Scull moderated his argument in later works in light of later research that stressed the continuing importance of family care and intervention. See A. Scull, 'Rethinking the History of Asylumdom', in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society, 1800–1914: A Social History of Madness in Comparative Perspective* (London, 1999), pp. 295–315.

³⁹ Perhaps the most notable example of this revisionist work is P. Bartlett and D. Wright (eds), *Outside the*

disturbance from within the walls of the asylum, while emerging organisations such as charities, psychiatric social workers and psychiatric nurses began to supplement familial provision.

I have chosen to use 1870 as the beginning point of my examination. By 1870, according to Habermas' account, the public sphere of rational-critical debate had collapsed. The professionalisation of society was underway and the relationship between citizen and state was about to undergo major transformations. Medical historians and sociologists such as Andrew Scull, meanwhile, have argued that the early therapeutic promise of asylums was being questioned by this time, as psychiatry and the popular press began to register concern at the growth of insanity and the warehousing of incurable cases.⁴⁰ During the period in which this study takes place, the treatment of the mentally ill became the domain of growing numbers of professional groups and organisations.⁴¹ The

Walls of the Asylum: The History of Care in the Community 1750–2000 (London, 1999). David Wright has drawn historians' attention to the role played by families in securing the discharge of their relatives from asylums and providing care in the nineteenth-century: See D. Wright, 'The Discharge of Pauper Lunatics from County Asylums in Mid-Victorian England: the Case of Buckinghamshire', in Melling and Forsythe, *Insanity, Institutions and Society*, pp. 93–112. Meanwhile, Louise Westwood's research suggested that forms of non-institutional care continued to be pioneered in the first half of the twentieth century, particularly for cases labelled as borderline or mentally defective: L. Westwood, 'Avoiding the Asylum: Pioneering Work in Mental Health Care, 1890–1939' (PhD thesis, Sussex University, 1999)

⁴⁰ Scull, *Museums of Madness*, pp. 186–253.

⁴¹ For an account of twentieth-century developments within the mental health services, see Jones, *Asylums and After*. Phil Fennell has also analysed developments in psychiatry in the twentieth century from the perspective of the ethics of treating people without their consent: see P. Fennell, *Treatment Without*

management of public asylums, which had initially fallen under the control of local authorities, was later redesignated a concern of the Ministry of Health and was transferred to the National Health Service (hereafter NHS). Many psychiatrists sought a closer alignment to general medicine, seeking to assimilate their work by developing physical methods of treatment. Other psychiatrists drew on psychoanalytical ideas to explain and treat mental disturbance. Moreover, the focus began to shift from the mentally ill treated within the asylum to efforts to improve the mental health of the general population. In the work of child guidance, psychiatric social work, social psychiatry and anti-psychiatry, professionals began to turn their attention from the disturbed individual to their familial and social networks.

My examination ends in 1970, as the system of hospital care and treatment was on the decline and new ways of managing the mentally disordered were being implemented. Thus, my study takes place against the backdrop of the asylum, although the thesis explores the ideas of groups situated outside as well as inside the asylum. This era also

Consent: Law Psychiatry and the Treatment of Mentally Disordered People Since 1845 (1996, London, 2001). Edward Shorter's account discusses the new treatments developed by psychiatrists through the nineteenth and twentieth centuries: see E. Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York, 1997). Several essays in Bartlett and Wright (eds) *Outside the Walls of the Asylum* discuss the development of community care in Britain and the impact it had for different groups of patients. For an account of developments within asylums, and the effects these had on patients and staff, see D. Gittins, *Madness in its Place: Narratives of Severalls Hospital, 1913–1997* (London, 1998). A comparative analysis of post war British and Netherlands developments in the fields of mental health, psychiatry and anti-psychiatry can be found in M. Gijswijt-Hofstra and R. Porter (eds), *Cultures of Psychiatry and Mental Health Care in Postwar Britain and the Netherlands* (Amsterdam, 1998).

falls within the period examined by Showalter, enabling me to explore her contention that mental illness was represented as a feminine disorder. The changes in the representation of the mentally ill which took place once the process of hospital closure was underway would perhaps require a thesis in themselves. Moreover, some useful work on the representation of mental health service users in the post-asylum era and the impact these representations have had on users, their families and service providers has already been undertaken. Peter Barham has illustrated that the shift from institutional to community care has not been accompanied by a shift in the status of mental health service users from patient to citizen.⁴² Indeed, the shift from hospital to community care, Matt Muijen has argued, was accompanied by a shift from stories of the abuse suffered by patients in institutions to stories of the violence perpetrated by such users once in the community.⁴³

Media representations of people affected by mental illness as violent in the 1990s have been examined by Greg Philo and other researchers in the Glasgow media group, who noted that such depictions were highly compelling and had a negative impact on users, who experienced ostracisation as a result. The Glasgow group also noted that mental health service users continued to experience difficulties in gaining access to the media in order to represent themselves.⁴⁴ Sarah Payne, meanwhile, has argued that government policy regarding people affected by mental disorder has been shaped in recent times not by perceptions of the needs of the mentally ill but by perceptions of the

⁴² P. Barham, *Closing the Asylum: The Mental Patient in Modern Society* (London, 1997).

⁴³ M. Muijen, 'Scare in the Community: Britain in Moral Panic', in T. Heller, J. Reynolds, R. Gomm, R. Muston and S. Pattison (eds), *Mental Health Matters: A Reader* (London, 1996), pp. 143-55.

⁴⁴ G. Philo (ed.), *Media and Mental Distress* (London, 1996).

risk posed by such individuals to the community. Thus, young men are more likely to be referred to hospital-based psychiatric services while women were more likely to be the recipients of community based services.⁴⁵ As risk management became the primary concern of government policy, Trevor Turner argues, the private madhouse re-emerged as the (expensive) solution to contain dangerous people in the absence of the asylum.⁴⁶ The representation of the mentally ill as violent and disturbed - and usually male - is not, however, an entirely post 1970 phenomena, as is suggested in this thesis.

5: Organisation and Objectives

Starting from the perspective that in the late nineteenth and twentieth centuries, the public sphere if it existed at all was constituted in multiple publics, I have chosen to base my thesis around an examination of several sub-public groups who were involved in the mental health system, to see what kinds of representations of mental illness they sought to promote and why. This thesis has drawn mainly on English records, although records from Scotland have been studied where relevant.⁴⁷ By focussing on several groups, I hope to show the diversity of representations which circulated at any given moment, the

⁴⁵ S. Payne, 'Outside the Walls of the Asylum? Psychiatric Treatment in the 1980s and 1990s', in Bartlett and Wright, *Outside the Walls of the Asylum*, pp. 244–65.

⁴⁶ T. Turner, 'The Return of the Private Madhouse: The Rise and Fall of Community Care in Britain over the Last 50 Years', paper given at the Anglo-Dutch-German Workshop, 'Social Psychiatry and Ambulant Care in the Twentieth Century', 4–6 July, 2002.

⁴⁷ For a recent analysis of care for the mentally ill in Wales, see P. Michael, *Care and Treatment of the Mentally Ill in North Wales 1800–2000* (Cardiff, 2003).

interrelationships between the groups and the impact this had on representations of mental illness, and the reasons for the varying success different groups achieved when trying to promote their views. The representations that circulated at any particular time were linked to the given situation within the mental health field. In a series of recent articles, Nick Crossley has sought to explain how change within the field of mental health occurred. Crossley has examined three different phases within the post-war mental health movements: the development of the National Association for Mental Health (hereafter NAMH), the growth of the anti-psychiatry movement and the emergence of the mental health user movements.⁴⁸ Crossley argued that these movements emerged in specific contexts, altering and developing in relation to broader social structures and changes, often as a legacy having changed the mental health services or created the intellectual space for a later movement to develop. Drawing on Pierre Bourdieu's work on social movements, Crossley argued that mental health movements fought their battles in a number of different fields – psychiatry, law, parliament and media – in order to achieve their goals. Mental health movements, Crossley argued, might have the skills required to play the game in one field, but not another. Crossley also applied Bourdieu's notion of symbolic violence – the ability of one group to impose ideas upon another without discussion, by grounding their arguments in indisputable fact. For Crossley, the varying levels of social power wielded by mental health movements, or the sub-public groups,

⁴⁸ N. Crossley, 'Transforming the Mental Health Field: The Early History of the National Association for Mental Health', *Sociology of Health and Illness*, 20 (1998), pp. 458–88; N. Crossley, 'R. D. Laing and the British Anti-Psychiatry Movement: A Socio-Historical Analysis', *Social Science and Medicine*, 47 (1998), pp. 877–89; N. Crossley, 'Fish, Field, Habitus and Madness: The First Wave Mental Health Users Movement in Great Britain', *British Journal of Sociology*, 50 (1999), pp. 647–70.

who sought to achieve their goals, circumvented the democratic potential of full participation and debate.

This study could have been expanded enormously by a consideration of more sub-public groups, such as the Board of Control, psychologists, or the National Council for Lunacy Reform. However, I have chosen to focus in this study not on the totality of representations that circulated about mental illness, but why a select group of organisations, chosen as case studies, might have sought to promote a particular representation, and the factors that could have aided or impeded the wider diffusion of these representations. Some organisations, such as the National Council for Lunacy Reform, were ruled out because the remaining records were insufficient to shed light on the motivations that led them to represent mental illness in a particular fashion. Other organisations, which would have made interesting case studies, have been left out because they were already the subject of existing research and considerations of space limited what could be examined.⁴⁹

My examination begins within the space of the asylum and gradually disperses outwards towards the more general community, the people most likely to be viewed by the sub-public groups as the general public. The thesis commences by examining

⁴⁹ For example, Nicholas Hervey's PhD thesis has examined the motivations and beliefs that under laid the actions of the Board of Control. See N. Hervey, 'The Lunacy Commission 1845–60: With Special Reference to the Implementation of Policy in Kent and Surrey' (PhD thesis, University of Bristol, 1987). Surviving organisational records for The National Society for Lunacy Reform, an organisation that represented patient's interests in the 1920s, consist of three minute books held by MIND.

psychiatrists, the group whom historians have examined most frequently with regard to the public, and also the group who achieved most recognition as a profession. The research for the first chapter has been based upon the *Journal of Mental Science*, established by the Medico-Psychological Association to represent the interests of psychiatrists. I have also examined how individual psychiatrists sought to promote their own interests to a public audience in popular books. Psychiatry was a largely male-dominated occupation, which based its demands for a protected sphere of work on its claims to a specific, medically based knowledge, and frequently sought to expand its sphere of influence. Even so, as we shall see in Chapter One, they habitually encountered opposition and challenges that blocked their ambitions from other groups within society. In the second Chapter, I consider the representations of mental illness put forward by the National Asylum Workers' Union (hereafter NAWU).⁵⁰ Mental nursing has been examined in a few books, although these works had the aim of filling a gap in the historiography rather than relating the occupations to any broader issues.⁵¹ I have used both the *NAWU Magazine*, a publication largely intended for union members, and internal records of the organisation, to describe the representations of mental illness put forward, and whose interests they represented. This organisation represented an occupation that was often split between its female and male members, which vacillated

⁵⁰ Subsequently becoming the Mental Hospital and Institutional Worker's Union (hereafter MHIWU) in 1931, and later the Confederation of Health Service Employees (hereafter COHSE) in 1946, following a merger with the Hospital and Welfare Services Union.

⁵¹ P. Nolan, *A History of Mental Health Nursing* (London, 1993). A different approach is adopted by Mick Carpenter, who examined the unionisation of psychiatric nurses: M. Carpenter, *Working for Health: The History of the Confederation of Health Service Employees* (London, 1988).

between promoting itself as a nursing profession or the keepers of dangerous inmates, that sometimes empathised and promoted the interests of the patients, but at other times focused solely on its economic concerns. Attendants, or nurses as they were later known, had to bargain from the position of a low status, insecure and stigmatising occupation.

Psychiatric social workers (hereafter PSWs), the subject of my third chapter, had more of a claim to expert knowledge and professional status than psychiatric nurses, and forged a link between the patient in hospital and the broader community.⁵² I have compared the ideas about mental illness and its treatment that they expressed in their journal, the *British Journal of Psychiatric Social Work*, with the difficulties experienced by their Public Relations Sub-Committee in sharing their ideas with the public. Arguably they may have been hindered in their professional aims by the predominantly female composition of their occupation. In Chapter Four, the representations emanating from a charity, the MACA, are examined. The internal records of the MACA have been studied so that the diverse motivations generated by the disparate membership of the charity might be taken into account. I have also considered the particular remit of this organisation and what concerns might have prompted the charity's particular representations of mental illness as put forward in their promotional and public literature.

The representations of mental disorder advanced by mental health service users are considered in Chapter Five. The *Morningside Mirror*, a newspaper largely written by

⁵² An outline of the development of the occupation can be found in N. Timms, *Psychiatric Social Work in Great Britain (1939–1962)* (London, 1964).

patients at the Morningside Asylum in Edinburgh, was compared to retrospectively written published accounts by former asylum patients to illustrate how questions of audience, identity, health service care structure and the purpose of narrative all interacted to affect the types of stories users might tell about their experiences. I had initially planned to include a chapter on representations of mental illness that had occurred in the general, non-specialised press. However, as the research progressed, it appeared that many mental health stories that emerged in the general media in fact sprang from interested sub-public organisations that sought to by-pass any genuine debate by appealing directly to the government for action under the guise of public opinion. These stories are discussed in the chapters dealing with the sub-public groups, as they illustrate the operations and impacts of these organisations. Instead, I turn in Chapter Six to consider what factors underpinned the BBC coverage (or non-coverage) of mental health issues, by examining the BBC written archives. This chapter also examined the substantial impact that some sub-public groups could have on BBC coverage, such as the NAMH and psychiatry, while other groups, such as PSWs, had less power to get their opinion transmitted. It is hoped that by examining these different sub-public groups, the reasons why particular representations of mental illness were generated and circulated will become more explicable.

Chapter One: Psychiatry and the Medico-Psychological Association

1: Introduction

Historians writing about psychiatry in this era tend to depict it as the profession most able to define ideas about mental disorder in the public mind. Thus Andrew Scull, Charlotte MacKenzie and Nicholas Hervey argued that by 1900, psychiatrists had

Successfully constituted themselves as the public arbiters of mental disorder, the experts in its diagnosis and disposal. They created a professional organisation to defend and advance their interests and edited journals and wrote monographs to provide a forum for transmitting (and giving visible evidence of) the body of expert knowledge to which they laid claim. During Victoria's long reign, they increasingly dominated public discourse about insanity.¹

German Berrios and Hugh Freeman have also argued that the Medico-Psychological Association (hereafter the MPA) was an influential voice in the nineteenth-century debate regarding mental illness, acting as a broker between popular and official sentiments.² It is important to recognise, however, that psychiatry faced constraints from both within and outside the profession when it attempted to popularise its views. These constraints will be explored in this chapter.

¹ A. Scull, C. MacKenzie and N. Hervey, *Masters of Bedlam: The Transformation of the Mad-Doctoring Trade* (Princeton, 1996). Quoted on p. 7.

² G. E. Berrios and H. Freeman (eds), *150 Years of British Psychiatry, 1841–1991* (London, 1991), p. ix.

This chapter will examine the type of forum the MPA provided for a public debate about the nature of mental illness, a subject that can only be understood if psychiatrists' perceptions of the public are considered. It is thus necessary to examine what views psychiatrists believed the public harboured about the profession and the mentally ill, and whether efforts were made to destigmatise mental illness, or psychiatry; in other words, to explore whether the MPA sought to represent their own interests or those of the mentally ill. To examine the success of the MPA as a sub-public sphere with democratic potential, the chapter will also ask if the MPA sought to create an open debate with the public, where individuals could participate on an equal footing, and if not, to suggest what factors inhibited the MPA. The chapter will examine the role that psychiatrists believed the public could play in mental health and whether the MPA hoped to rouse public opinion to lobby for reform. The activities of the MPA will then be compared with the records of individual psychiatrists to see if their efforts to monitor and exploit the media for their own ends evolved from a belief that the MPA had failed to communicate with the public. This section will examine how the public were depicted, whose interests the individual psychiatrists sought to represent in their activities, and what role they envisaged for the public. In addition to works by Montagu Lomax and R. D. Laing that urged the public to challenge the psychiatric establishment,³ this section

³ R. D. Laing, *The Divided Self* (1960, reprinted with new preface, 1965, London); M. Lomax, *The Experiences of an Asylum Doctor: With Suggestions for Asylum and Lunacy Law Reform* (London, 1921). The impact of Lomax's book is described in K. Jones, *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s* (London, 1993), pp. 128–30. Laing's influence on the anti-psychiatry movement is described in D. Tantam, 'R. D. Laing and Anti-Psychiatry', in H. Freeman (ed.), *A Century of Psychiatry* (London, 1999), pp. 202–7.

will also consider some of the less controversial books published in England in the 1950s and 1960s, which sought to reassure their readers about the nature of mental illness.⁴ These books were specifically written and published for the general public, with the aim of describing what mental illness was and how the psychiatric profession sought to treat it.

2: A Brief History of Psychiatric Organisations in Britain

The first professional association of psychiatrists, the Association of Medical Officers of Asylums for the Insane, was formed in 1841, becoming the MPA in 1865.⁵ In 1926, the MPA became the Royal Medico-Psychological Association, finally becoming the Royal College of Psychiatrists in 1971.⁶ The question of membership was raised as early as

⁴ P. Hays, *New Horizons in Psychiatry* (1964, London, 1967); D. Stafford-Clarke, *Psychiatry To-day* (1952, London, 1963); H. Yellowlees, *To Define True Madness: Commonsense Psychiatry for Lay People* (1953, London, 1955).

⁵ For a detailed account of the establishment of the Association of Medical Officers of Asylums and Hospitals for the Insane, and its transformation into the MPA, see E. Renvoize, 'The Association of Medical Officers of Asylums and Hospitals for the Insane, the Medico-Psychological Association, and their Presidents', in Berrios and Freeman (eds), *150 Years of British Psychiatry*, pp. 29–78.

⁶ To simplify matters, the MPA/RMPA has been referred to throughout this chapter as the MPA as the change in title does not appear to have marked a radical transformation of the organisation. The transformation from the RMPA to the Royal College was not easy, as John Howells, who helped establish the College and has since written about his experiences, discovered. The Royal College of Physicians claimed to represent all doctors, including psychiatrists, and thus did not see the need for a Royal College of Psychiatrists. Howells suggested that the formation of a College for psychiatrists took so long because of

1871 when propositions put forward at the general meeting sought to challenge the existing regulations that limited membership to those practising psychiatry. J. Batty Tuke's proposition would have enabled non-specialist medical practitioners, legal practitioners and possibly even the lay public to join the MPA. Tuke hoped his motion would challenge the stigma attached to the treatment of mental illness within asylums and establish support for psychiatry amongst the general medical profession

By increasing our membership from the ranks of the medical public, we should secure most important sympathy and co-operation in our work, and by drawing towards us members of the general public, we would help to dissipate the superstitions which still hang about lunacy and lunatic asylums. Through the influence of our Journal, we would diffuse a knowledge of the dire diseases we are called on specially to treat.⁷

Tuke's proposition to widen membership and increase interaction with the public sphere was rejected by the AGM.

The *Asylum Journal of Mental Science* (hereafter the *JMS*) was established in 1853. Its functions were twofold. On the one hand, the *JMS* was envisaged as a forum for the debate and exchange of ideas within a dispersed profession: 'a medium for the

the stigma still attached to the mentally ill, which was projected onto the psychiatrist by association. See J. G. Howells, 'The Establishment of the Royal College of Psychiatrists' in Berrios and Freeman (eds), *150 Years of British Psychiatry*, pp. 117–34.

⁷ 'Proceedings of the 26th AGM of the MPA', *Journal of Mental Science* (hereafter the *JMS*), 17 (1871–72), pp. 438–65. Quoted on p. 445.

publication of its results, for the interchange of thought amongst those engaged in it'.⁸ Simultaneously, the *JMS* was thought to communicate the ideas of the profession to a wider audience, to 'make an otherwise clapperless bell articulate'.⁹ However, despite these ideals, which conformed to Nancy Fraser's ideal of a sub-public sphere,¹⁰ debate often took second place to a didactic defence of psychiatric practice. Editors of the *JMS* often believed they should use their position to protect the profession from unjust criticism. In 1878, Thomas Clouston claimed 'the *JMS* would fail in its duty to the members of the MPA, and to the public, were it not to defend these great hospitals, provided by the charity of the nation, from charges calculated to do them and their unfortunate inmates great harm in the eyes of the public'.¹¹ Clouston was referring to evidence given by Harrington Tuke, himself President of the MPA in 1873, to the Dilwyn Committee in which Tuke had claimed the rate of recovery was much better in private than public asylums. The *JMS* had struck back by pointing to a suicide and the low rates of recovery in Tuke's own private asylum. This illustrates well that, in its early years, the

⁸ J. Crichton-Brown, 'Presidential Address', *JMS*, 24 (1878–79), pp. 350–72. Quoted on p. 369.

⁹ D. Hack Tuke, 'Presidential Address', *JMS*, 27 (1881–82), pp. 305–42. Quoted on p. 342.

¹⁰ See N. Fraser, 'Rethinking the Public Sphere: A Contribution to the Critique of Actually Existing Democracy', in C. Calhoun (ed.), *Habermas and the Public Sphere* (Cambridge, Massachusetts, 1999), pp. 109–42. Sub-public spheres on the one hand 'function as spaces of withdrawal and regroupment; on the other hand, they also function as bases and training grounds for agitational activities directed towards wider publics'. Quoted on p. 124. The idea of the sub-public sphere is discussed in the introduction.

¹¹ T. Clouston, open letter in reply to Harrington Tuke's complaints that the *JMS* had dealt unfairly with the evidence he had given before the Dillwyn Committee, *JMS*, 24 (1878–79), pp. 335–43. Quoted on p. 336.

JMS was just as often a site of inter-professional strife as a united voice for professional development, a fact noted by Crichton-Brown in his presidential address of 1878.

Our speciality has been in the din of battle from its beginnings. It has had to protect itself against assailants on all hands. Beset by jealousy and suspicion from without, and perturbed by internecine feuds, it has had to fight out the great battles of non-restraint, of moral treatment and of medical supremacy.¹²

Crichton-Brown was echoing the pleas of Thomas Lawes Rogers, President in 1874, who told fellow members that ‘isolated more or less as we are, often viewed with unfriendly eyes by the public, and criticised by hostile press, there is more necessity for unity amongst ourselves. Let there be no jealousy between ourselves’.¹³ This correlates well with Trevor Turner’s research on the public profile of the MPA between 1851 and 1914. Turner depicted an association with no clear role, laden with stigma and in constant danger of being swallowed up or rendered irrelevant by the British Medical Association, which had its own psychological section. Examining the criticism emanating from within the profession, Turner concluded that up until 1914, the MPA was ‘an introverted body, whose members only gave it partial allegiance’.¹⁴ Faced with internal dispute and overshadowed by more traditional and respectable organisations, Turner argued that the MPA played no role as an association in campaigning on issues such as alcoholism. In his view, the MPA failed to enter into a public debate or adopt a reformist approach.

¹² Crichton-Brown, ‘Presidential Address’, p. 350.

¹³ T. L. Rogers, ‘Presidential Address’, *JMS*, 20 (1874–75), pp. 337–51. Quoted on p. 351.

¹⁴ T. Turner, “‘Not Worth Powder and Shot’: The Public Profile of the Medico-Psychological Association, c. 1851–1914”, in Berrios and Freeman (eds), *150 Years of British Psychiatry*, pp. 3–16. Quoted on p. 14.

Having undertaken a survey of one hundred years of the *JMS*, it appears that the profession devoted very little time or space to public relations. While the *JMS* acted as a space to communicate developments in therapies, the problems posed by a perceived lack of public awareness and efforts to combat this by attempting to communicate more positive images of mental illness to the public are striking because of their scarcity. Despite the fact that many of the therapeutic strategies or theories of social causation adopted by MPA members required contact and collaboration with the wider community, the *JMS* rarely discussed how this was to be achieved. Discussions about the public and public ideas of mental illness were generally limited to complaints that the public was prejudiced against the mentally ill and those who treated them. Few attempts were made to verify the accuracy of this belief or even define whom the public consisted of.

In 1963, the *JMS* changed its title to the *British Journal of Psychiatry*. This was a significant alteration, mapping out the changing – and increasingly curtailed - scope of the journal. The term ‘mental science’ had been coined by the first editor, Sir John Charles Bucknill, who envisaged a broad scope of enquiry, covering ‘mental physiology and pathology, with their vast range of inquiry into insanity, education, crime, and all things which tend to preserve mental health or to cause mental disorder’.¹⁵ As the editorial explained, ‘Today this vast range of inquiry is being pursued by workers belonging to many disciplines, while psychiatry has become the recognised term

¹⁵ ‘Editorial’, *British Journal of Psychiatry*, 109 (1963), p. 1. The author of the editorial was probably Alexander Walk, then editor-in-chief.

everywhere for the branch of medicine which deals with mental health and with all kinds of degrees of mental disorder'.¹⁶

Those responsible for editing the *JMS* to a certain degree controlled the way in which psychiatry represented itself to the world. It was therefore rather surprising that Henry Maudsley became co-editor of the *JMS* in 1863, only leaving in 1878 after moves made in the previous year by his brother-in-law Thomas Harrington Tuke to oust him from the editorship of the *JMS*. Tuke claimed that under Maudsley, the *JMS* did 'not represent the majority of the Association',¹⁷ and indeed his position as editor enabled him to establish himself as 'the dominant voice in the profession – rather anomalously in some respects because he lacked a position at the head of a public asylum or of a sizeable private institution'.¹⁸ In 1871, Maudsley served as President of the MPA. Amongst other editors of the *JMS*, Daniel Hack Tuke and George H. Savage, who served as editors from 1880 to 1895 and 1878 to 1894, and Presidents of the MPA in 1881 and 1886 respectively, were both heavily involved in the work of the MACA, discussed in Chapter Four. Meanwhile, John R. Lord, a leading character in the mental hygiene movement, appeared as an assistant editor of the *JMS* from 1900 until 1911 and then acted as editor in chief from 1911 until his death in 1931. Lord, a member of the General Nursing

¹⁶ *Ibid.*, p. 1.

¹⁷ Harrington Tuke, 'Report of the 32nd AGM of the MPA', *JMS*, 23 (1877-78), pp. 420–49. Quoted on p. 428.

¹⁸ For more information on Maudsley's role as editor, see A. Scull and C. Mackenzie, 'Degeneration and Despair: Henry Maudsley (1835–1918)' in Scull, Mackenzie and Hervey, *Masters of Bedlam*, pp. 226–67. Quoted on p. 233.

Council, the Child Guidance Council and a founder member of the International Committee for Mental Hygiene, served as President of the RMPA in 1927. Alexander Walk, assistant editor of the *JMS* in 1930 continued to sit on the editorial board until at least 1967, by which stage he was editor in chief. Walk's remarkable span of at least 37 years as editor was crowned by a year as President of the RMPA in 1961. For many years, Walk worked alongside G. W. T. H. Fleming, who became one of the editors in 1931 when Lord died and was elected editor in chief in 1938, holding this position until his death in 1963. Fleming's obituary in 1963 claimed 'he devoted himself to the task of enhancing the prestige of the journal and of using it as an instrument to raise the standard of scientific psychiatry in this country'.¹⁹ Fleming, like so many of the journal's editors, was rewarded by election to the presidency of the RMPA in 1953. While these details may seem trivial, it is important to recognise that the editors exercised considerable control over the contents of the *JMS*, enabling a few men to dominate the public organ of the profession. For example, much of R. D. Laing's work was turned down for publication by the *British Journal of Psychiatry*, leading him to publish elsewhere in more radical journals.²⁰

¹⁹ Obituary of G. W. T. H. Fleming, *British Journal of Psychiatry*, 109 (1963), pp. 2–3. Quoted on p. 2.

²⁰ See N. Crossley, 'R. D. Laing and the British Anti-Psychiatry Movement: A Socio-Historical Analysis', *Social Science and Medicine*, 47 (1998), pp. 877–89.

3: Mental Illness, Stigma and the Public

As Turner suggests, the profession's awareness of its own lack of authority when compared to other medical organisations, and its belief that stigma surrounded mental illness and those who treated it in the public mind, inhibited its attempts to open a debate with the public. Indeed, Thomas Lawes Rogers suggested in 1874 that 'the subject of insanity is with the profession, almost as much as with the public, a subject to be avoided, unless, indeed, when some fault, either real or imaginary on the part of those who spend their lives in working for the benefit of the insane, brings asylums in sensational form before the public'.²¹ A desire to avoid entering into futile debates was also emphasised by Crichton-Brown who argued 'it is hopeless to attempt by any amount of inquiry to pacify half-cured lunatics, or crack-brained enthusiasts, to conciliate the irreconcilables who must have a grievance, or to tranquillise the busy-bodies who think themselves. Life is too short for the education of idiots'.²²

Psychiatrists writing in the *JMS* often complained that public prejudice towards mental illness and those who treated it was fed by negative comments from the general medical press. The *Lancet* commission reports on the care of the insane was attacked bitterly in a *JMS* review of 1877, which claimed medical press coverage 'combining real

²¹ Lawes Rogers, 'Presidential Address', p. 337.

²² Crichton-Brown, 'Presidential Address', p. 351.

ignorance and popular prejudice with a lofty affectation of knowledge in its hostile criticism in a way we never remember to have seen exhibited towards any other department of the profession'.²³ In 1871, the *JMS* attacked an article that appeared in the *British Medical Journal* entitled 'A Social Blot', deriding the piece as 'inspired by the sensationalist spirit of the worst sort of writing in the daily press'. Psychiatrists belonging to the British Medical Association wrote to protest, claiming the article would tend to 'make the separation between the speciality and the general body of the profession still greater than it is at present, and strengthening popular prejudices which are injurious to the true interests of the insane and of the medical profession'.²⁴ In this instance, as in many others, psychiatrists argued that the welfare of the mentally ill was intrinsically bound up with the public image of psychiatry, so that the interests of the mentally ill could only be represented if those of the psychiatrist were considered first. Criticism could come also from within the profession. Henry Maudsley's highly critical 1871 presidential address has been described by Scull and MacKenzie as 'a sustained assault on the *raison d'être* of the speciality as it then perceived itself, a slaughter of sacred cows that undoubtedly left his audience squirming in their seats'.²⁵ Dr Woods felt that such stringent criticism emanating from within the profession could only further damage the MPA in the eyes of the public.

²³ Anonymous, reviewing J. Mortimer Granville's book, *The Care and Cure of the Insane. Being the Reports of the "Lancet" Commission on Lunatic Asylums, 1875-76-77* in *JMS*, 23 (1877-78), pp. 393-6. Quoted on p. 393.

²⁴ 'Occasional Notes of the Quarter: A Social Blot', *JMS*, 17 (1871-72), pp. 230-4.

²⁵ Scull and Mackenzie, 'Degeneration and Despair', p. 238,

A mad physician is a dangerous character and if we find in our own class men who are occupying high positions, saying anything to encourage the popular notion that we are unworthy of the trust that is reposed in us, I think we ought to try to set ourselves right.²⁶

‘We can hardly be surprised at the unreasonable manner in which the subject is treated by the lay press’, argued Lawes Rogers, ‘when we find the medical journals following the same line’.²⁷

Many writers in the *JMS* complained that mental illness and asylums were unfairly stigmatised, suggesting that this public prejudice arose from public ignorance. ‘There is a class who are profoundly ignorant of the whole matter, and never saw a lunatic in their lives – would much rather not see one’, claimed G. Fielding Blandford, ‘yet who are entirely convinced that patients are still barbarously ill-treated in asylums, and for that reason wish the latter to be swept away’.²⁸ However, some members of the MPA felt that contact needed to be made with the public, perhaps to address this ignorance and inculcate positive views of psychiatry. Daniel Hack Tuke, in his presidential address, claimed ‘we should be strangely faithless to our mission, if we did not endeavour to enlighten the community in the doctrines of true psychological science’.²⁹ This desire to involve the public in issues of mental health and illness seemed

²⁶ Dr Woods, ‘Proceedings of the 26th AGM of the MPA’, *JMS*, 17 (1871–72), pp. 438–65. Quoted on p. 458.

²⁷ Lawes Rogers, ‘Presidential Address’, p. 340.

²⁸ G. Fielding Blandford, ‘The President’s Address’, *JMS*, 23 (1877–78), pp. 309–24. Quoted on p. 320.

²⁹ Hack Tuke, ‘Presidential Address’, p. 341.

to be restricted to educating the public to the profession's beliefs: as Bucknill put it, 'there are two kinds of public opinion, the one morbid and irrational, the other sound and intelligent. The latter is based, indeed, upon the efforts made by scientific men themselves to create enlightened public opinion on this subject'.³⁰ Enlightened public opinion did not, for Bucknill, entail rigorous debate but the absorption of given information. Bucknill sought to preclude discussion by claiming that psychiatric knowledge was indisputable fact rather than opinion, debarring lay people from participating in debate. In G. Douglas McRae's judgement, 'the public are already very strongly prejudiced against asylums and asylum treatment...public ignorance is the stigma – and I think we ought to stand up more firmly for our asylums and get the public to understand what work we really do. I do not think we ought to leave the public under the impression that the mental specialist is a man who deals with chronic dangerous lunatics.'³¹ An occasional note of 1922 commented on the furore created by Montagu Lomax's expose of asylum conditions, suggesting that public attention could only be attracted through sensationalist journalism.

As an actual fact, it was the public that needed awakening and not the mental services; and just as it has happened in other matters, a crusade of exaggeration, calumny, and alarm has done as much, perhaps even more, to stimulate the present revival of public interest in the welfare of the insane than legitimate propaganda based on hard fact and careful thought.

³⁰ 'Occasional Notes of the Quarter: The Annual Meeting and Dinner', *JMS*, 27 (1881–82), pp. 401–2. Quoted on p. 402.

³¹ G. Douglas McRae, 'Annual General Meeting of the MPA', *JMS*, 68 (1922), pp. 423–58. Quote p. 434.

However, the arousal of public interest – even if negative – was still welcomed.

The mental hospital medical and nursing services have for years been subjected to suspicions, neglect, discouragement, even thinly disguised aversion, so much so that they have developed a hide of almost armadillo-like texture. A further instalment, even of an extra virulent variety, is of small matter if thereby the public can be brought to give more constant and serious thought in the work of mental hospitals and the welfare of the insane.³²

In this instance, the *JMS* represented the public as an anonymous mass, whose interests were only swayed briefly by sensationalism and who were unable to think seriously about important matters.

Public awareness of mental health issues was deemed essential to halt the increase in mental illness. J. F. Duncan argued in 1875 that ‘the only part medical men can take in trying to prevent the spread of any disease is to enlighten the public mind upon the subject, by disseminating correct views as to the nature of the disease, its ordinary causes, and the best means of counteracting their operation’.³³ Public opinion – of the ‘correct’ kind – could also counteract institutionalism, J. R. Lord argued in 1923.

Mental hospitals should, as far as practicable, be thrown open in the same spirit as are the general hospitals, and the cleansing and stimulating influence of a

³² Anonymous, ‘Occasional Note: The Trend of Psychiatry in England and Wales’, *JMS*, 68 (1922), pp. 171–5. Quoted on p. 172.

³³ J. F. Duncan, ‘Presidential Address’, *JMS*, 21 (1875–76), pp. 311–38. Quoted on p. 316.

correctly informed public opinion brought constantly to bear upon mental hospital care and treatment.³⁴

The view that the MPA needed responses from the public in order to advance was not unanimous. W. R. Dawson argued 'progress has come entirely from within. It has not come from officious criticism on the part of busybodies who think they know better than the men who have studied the subject for a lifetime'.³⁵ In 1957, President R. W. Armstrong was still reflecting on the failure of the profession to educate the public.

When we turn to our achievements in educating the public I am less happy. Most of my senior colleagues will share my feeling that all our conscientious efforts over a period of years to inform the public about our work and our psychiatric hospitals have been somewhat unrewarding. If we make painful progress with a series of carefully prepared television programmes³⁶ it is only to slip further back into ignorance and prejudice as a couple of patients from Rampton make the headlines of the daily newspapers with their foolish exploits...The public must be wooed and enticed with entertainment and buns or they will stay away for the

³⁴ J. R. Lord, 'Lunacy Law and Institutional and Home Treatment of the Insane', *JMS*, 69 (1923), pp. 155–62. Quoted on p. 159.

³⁵ W. R. Dawson, 'AGM of the MPA', 1922, p. 438.

³⁶ This is probably a reference to the BBC television series 'The Hurt Mind' which was shown in 1957. This series is discussed in Chapter Six.

rather interesting reason that we have nothing very sensational in the line of padded cells or Snake Pits to show them.³⁷

In summary, reflections on public opinion in the *JMS* were common in the period 1870–1930 but declined from the middle of the twentieth century. This might in part be explained by the disappearance of the ‘Occasional Note’ articles from the 1920s. These provided a space for the editors to comment on issues affecting the profession, in particular instances where it was felt that psychiatrists had been unfairly slandered. The *JMS*, which in the mid-nineteenth century had the character of a trade paper, appears to have become more academic, articles concerning therapies predominating, with very little space devoted to professional issues. This may have been an attempt to remove the tarnish of commerce and portray psychiatry as an expert, disinterested profession. It is difficult to contest Trevor Turner’s claim that the MPA was an introverted organisation; if anything, it became more introverted over time. The profession believed that violence and scandal were more likely to grab headline news than the progress of the profession, and on the occasions that the *JMS* did see fit to address the problems facing the profession as a result of hostile public opinion, the inculcation of the ‘correct’ views was urged instead of the desirability of stimulating debate amongst the public. Despite the interface they could have created, the *JMS* failed to open a debate with the public. This failure becomes more explicable if we consider the MPA’s perception of the public as an undistinguished mass resistant to careful and responsibly given information, whose

³⁷ R. W. Armstrong, ‘Education in Psychiatry: Presidential Address’, *JMS*, 103 (1957), pp. 691–8. Quoted on p. 695.

attention could only be momentarily attracted by sensationalist journalism. Not only was it difficult to interest such a public in mental health issues, they would be incapable of participating on an equal footing in any debate on mental illness. Even if the MPA had believed the public to be capable of debate, it is uncertain whose interests it would have sought to represent. The organisation's claims that mental illness could only be destigmatised if psychiatry could first achieve public respect and recognition as a disinterested profession often led the mentally ill to be largely overlooked on the occasions when the MPA did seek to reach out to the public.

4: Monitoring Media Representations: The Royal Edinburgh Asylum Press Cuttings Books

One way to explore whether psychiatrists faced as much hostility as the MPA claimed they did is to examine how individual psychiatrists reacted to press coverage of mental illness and related issues. It is then possible to examine how psychiatrists might seek to rectify this hostility through their own ventures into the media. The series of press cuttings books kept by the medical superintendents of the Royal Edinburgh Asylum (hereafter REA) from 1863 until 1938 suggest what particular topics of press coverage were of special concern or interest to psychiatrists.³⁸ David Skae initiated the cuttings books and the habit was continued by Thomas Clouston from 1873 and then George M.

³⁸ Lothian Health Service Archives, Press cuttings books volumes 1-8, 1862-1938, LHB7/12/1-8. I have not included the archival reference for articles from the cuttings books for which it has been possible to attribute the paper, title and date of publication.

Robertson, following Clouston's retirement in 1908. The material might be divided into areas that were probably of concern to most psychiatrists, and those that reflected the special or local interests of the compiler. It is a sign of the problems facing the profession that no single term was used to describe doctors who worked with the insane in the late nineteenth century, with terms such as alienist, medico-psychologist, medical superintendent and lunacy or mental expert all being deployed. To simplify matters, I have used the term 'psychiatrist' in my discussion of the articles from the cuttings books, aware that the employment of a single, and current term, is somewhat anachronistic and does imply more uniformity than existed at the time.

4.1: Areas of General Concern to Psychiatrists

Many articles that criticised the specialism of psychiatry and the system of asylum care can be found pasted into the books. These articles attacked the demedicalised treatment provided within asylums, accusing psychiatrists of being no more qualified to treat the insane than a general medical practitioner, if not less so. These accusations, combined with suggestions that psychiatrists' motivations may have been more mercenary than medical, threatened to undermine the professional identity that psychiatrists sought to cultivate.³⁹ Like other professional groups emerging in the nineteenth century, Scull

³⁹ For some example of articles that fell within this category, see 'Hospitals for the Insane', *The Times*, 19 July 1869; *The Times*, 3 September 1888, Press Cuttings Vol. 3, 1885-89, p. 183; *Edinburgh Evening Courant*, 21 January 1870, Press Cuttings Vol. 1, p. 202; 'Scots Asylums', *Scots Observer*, 27 September 1890; Article from unnamed, undated paper concerning the increase in insanity figures, Press Cuttings Vol. 1, p. 209; 'Medical Evidence in Cases of Lunacy', Letter from K. N. MacDonald to the *Fifeshire Journal*,

argues, psychiatrists sought not only an economic reward but also social status, and 'behaviour that was crassly materialistic and self-interested...might serve to advance an occupation's economic interests but threatened to prove fatal to its social aspirations'.⁴⁰

Another substantial group of articles pasted into the cuttings books dealt with the incursion of psychiatrists into law courts. The insanity defence offered psychiatrists in the late nineteenth century an arena to promote their profession and their unique scientific expertise.⁴¹ Not only did the legal profession frequently contest their expertise, but psychiatrists also often disagreed amongst themselves in this public arena. This undermined psychiatrists' claims to be the guardians of indisputable scientific knowledge. Most of the press cuttings in this category mocked the psychiatric theories advanced in court, accusing psychiatrists of medicalising criminality and enabling murderers to escape just punishment.⁴² Many articles pasted in the cuttings book dealt with concerns that individuals had been wrongfully confined within asylums.⁴³ Under the

19 June 1879.

⁴⁰ Scull, MacKenzie and Hervey, *Masters of Bedlam*, p. 6.

⁴¹ R. Smith, 'The Boundary Between Insanity and Criminal Responsibility in Nineteenth-Century England', in A. Scull (ed.), *Madhouses, Mad-Doctors and Madmen: The Social History of Psychiatry in the Victorian Era* (London, 1981), pp. 363–84.

⁴² For examples of articles in the cuttings books which dealt with the intervention of psychiatrists in legal cases see *The Times*, 7 December 1881, Press Cuttings Vol. 1, pp. 440–1; 'The Plaything of Science', *National Observer*, 13 August 1892, 'A Merry Medico', *Punch*, 17 January 1885; *The Times*, 7 December 1881, Press Cuttings Vol. 1, pp. 440–1.

⁴³ For examples of the concerns expressed in the press about wrongful confinement see 'Mad, and Yet Not Mad', unnamed Dundee paper, possible the *Dundee Advertiser*, 7 December 1866. Press Cuttings Vol. 1,

Lunatics Act of 1845, a pauper patient required one medical certificate stating that the patient was insane and a magistrate's order, while private patients needed two medical certificates.⁴⁴ The legal responsibility for certification, while a mark of the scientific credibility of the profession, placed psychiatrists open to charges of wrongfully confining individuals, often in collusion with malevolent relatives, in return for financial reward. However, as both Michael Clark and Peter McCandless have argued, while Victorians remained horrified at the idea that a sane man or woman could be locked away in a madhouse, they remained equally concerned that the insane should not remain at large and relied upon psychiatrists to police the boundaries of Victorian morality and treat those who transgressed them as insane.⁴⁵ This potentially placed psychiatrists in the

pp. 304–5; *The Times*, 10 April 1884, Press Cuttings Vol. 2, p. 76; 'Strange Adventure in a Lunatic Asylum', Untitled paper, Press Cuttings Vol. 2, p. 5. A defence of certification can be found in the following two articles: Letter from Dr. Forbes Winslow, *The Times*, 3 January 1883; *The Times*, 3 August 1885. Press Cuttings Vol. 3, p. 23. For examples of concerns expressed in the twentieth century about wrongful confinement, including the confinement of shellshock cases, see Justice Lush, cited in 'Lost his Liberty: Sane Man Kept in Asylum for Nine Years - Doctors to Pay £25,000', *News of the World*, February 1924, Press Cuttings Vol. 7, p. 231; Letter from Fiat Justitia regarding nerve-shaken soldiers, *Nation*, 14 October 1916; 'Manufacturing Madness', *John Bull*, [1918] Press Cuttings Vol. 7, p. 11.

⁴⁴ For more details of the certification requirements under the 1845 Act and their revision under the 1890 Lunacy Act, see Jones, *Asylums and After*, p. 90 and p. 108.

⁴⁵ M. J. Clark, 'Law, Liberty and Psychiatry in Victorian Britain: An Historical Survey and Commentary, c. 1840-1890', in L. de Goei and J. Vijselaar (eds), *Proceedings of the First European Congress on the History of Psychiatry and Mental Health Care* (Utrecht, 1993), pp. 187-93 and P. McCandless, 'Liberty and Lunacy: The Victorians and Wrongful Confinement', in Scull (ed.), *Madhouses, Mad-Doctors and Madmen*, pp. 339-61

unenviable position of potentially endangering public safety in two ways, either by unjustifiably certifying a sane individual or by failing to certify an insane individual. Moreover, as McCandless noted, press criticism on the topic was forthcoming because most Victorians believed there was a definite distinction between the sane and insane and that it was relatively easy to determine this, leading to suspicion of psychiatrists who could not agree about an individual's mental state.⁴⁶ The suggestion that psychiatrists could profit from incarcerating the sane again posed a challenge to the professional, altruistic image they sought to create.

An examination of the articles preserved in the cuttings books from the last two decades of the nineteenth century enables the assessment of the claims made in the *JMS* that public prejudice towards psychiatry stemmed from the dismissive way that general medical practitioners treated the profession. General doctors wrote a significant number of the articles. As in the general media coverage, much of the medical press coverage attacked the scientific basis and claims to expertise made by psychiatrists. Psychiatrists were frequently represented by doctors as ridiculous figures, stupid, lazy despots whose job description lay closer to that of a hotel manager than a medical professional. Many psychiatrists, and the MPA as an organisation, sought closer links with general medicine and on this foundation attempted to lay claim to a scientific basis for their profession. However, general medical professionals, who mocked the supposed expertise of psychiatrists, did not reciprocate their desire for closer links. General doctors were

⁴⁶ McCandless, 'Liberty and Lunacy', pp. 340-1.

perhaps keen to maintain a favourable profile in the public mind and not be tarred with the stigma surrounding psychiatry.⁴⁷

The open disputes and rifts between MPA members cannot have helped the negative portrayal of psychiatry in the medical press. After a series of letters exchanged between prominent psychiatrists John Charles Bucknill and George Savage in *The Times* regarding the use of mechanical restraint in Bethlem, Bucknill wrote that Savage ‘rebukes me for writing to *The Times*, and like the inconsistent lady who consented, he says “I decline altogether to discuss medical questions with Dr. Bucknill in public papers” even while he is actually discussing them’.⁴⁸ Both men seemed aware of the potential damage to the public image of psychiatry that could be caused by a public dispute, yet neither seemed willing to back down for the sake of professional unity. Bucknill, indeed, as Andrew Scull and Charlotte Mackenzie have noted, had some prior experience as a critic of asylum practice, having authored a series of attacks on private asylums in the *British Medical Journal* in 1879.⁴⁹ The very public disagreements between psychiatrists in the high profile arenas of the courtroom, the press and even within their

⁴⁷ For examples in which doctors criticised the work of psychiatrists, see *Medical Times*, undated, Press Cuttings Vol. 2, p. 100; ‘Lunacy Work’, *Medical Press*, 21 November 1888; ‘Letters to Undistinguished Persons IV: The Superintendent of a Lunatic Asylum’, *Medical Times*, 20 June 1885. There was also one case in which a nursing paper attacked psychiatrists’ attitudes towards their patients. See ‘Brutality V. Science’, *Nursing Record and Hospital World*, 30 July 1898, p. 83.

⁴⁸ Dr Bucknill, ‘Mechanical Restraint of the Insane’, *The Times*, 25 August 1888.

⁴⁹ ‘Chapter Seven: From Disciple to Critic: Sir John Charles Bucknill (1817-1897)’, in Scull, Hervey and MacKenzie, *Masters of Bedlam*, pp. 187-225

own journal can hardly have created the image of a medical profession grounded in objective scientific knowledge. The disagreements in court, combined with the continual furore over wrongful confinement, also served to reinforce the image of lunacy as a trade rather than a profession in the public mind.

4.2: Articles Reflecting the Personal Interests and Concerns of Clouston and Robertson

The character of the cuttings books not only reflected the more general concerns of psychiatrists, but also issues that were of local or personal interest to the compilers. Thus, a handful of articles dealt with complaints of wrongful confinement within the REA,⁵⁰ and the furore created by plans to extend the asylum grounds in 1889.⁵¹ Moreover, both Clouston and Robertson used the press to advocate their own particular areas of interest, and widely collected references to their work made in the press. These interests often reflected areas in which psychiatry could potentially expand its influence outside the asylum. Thus, Clouston clipped newspaper reports on his speeches about the dangers of higher education to the female constitution,⁵² while also pursuing his concerns regarding

⁵⁰ See for example 'Morningside Lunatic Asylum: Startling Story', *Town (Officer?)*, June 1904, Press Cuttings Vol. 6 – the pages in this volume are unnumbered; *Evening Dispatch*, 15 March 1888, Press Cuttings Vol. 3, p. 154.

⁵¹ For examples of articles on this topic, see 'The Royal Morningside Asylum', *Lancet*, 26 January 1889; *Scottish Leader*, 23 January 1889, Press Cuttings Vol. 3, pp. 241–2; Letter from 'Colinton Road', *Scottish Leader*, 12 January 1889; *Scottish Leader*, 28 January 1889, italics in original text, Press Cuttings Vol. 3, p. 252; Letter from J. S., *Scottish Leader*, 25 January 1889.

⁵² See, for example, *Evening News*, 15 November 1882, Press Cuttings Vol. 2, p. 42; *Evening News*, 18

alcoholism within the press. Clouston argued that the special expertise psychiatrists had developed ‘throws a tremendous responsibility on our profession towards the public in regard to the alcohol question’,⁵³ thus attempting to stake out a wider public role for himself outside the walls of the asylum within the community, on the basis of his expert psychiatric knowledge. However, the ‘profession’ to which Clouston here referred would appear to be not psychiatry but doctors generally, as the letter appeared in the *Lancet*, and not the *JMS*. Perhaps this reflected Clouston’s ambitions to be seen as a respected member of the general medical community rather than just as a superintendent of an asylum. It might also indicate Clouston’s belief that the MPA lacked the influence or will to push for legislative reform.

Robertson, meanwhile, became involved in a newspaper debate about the dangers of spiritualism and spiritual healing.⁵⁴ However, the popular press was not always a

November 1882, Press Cuttings Vol. 2, p. 43. The press coverage of Clouston’s speeches gave rise to a different debate on the dangers of overtaxing girls and boys. See ‘Dr Clouston’s Protest’, *Express*, 18 November 1882; Letter from Flora Stevenson, *Scotsman*, 20 November 1882; Letter from Sophia Jex-Blake, *Scotsman*, 27 November 1882; ‘Edinburgh Health Society: Dr J. Batty Tuke on Brain Health’, *Scotsman*, [1] December 1882, Press Cuttings Vol. 2, p. 48.

⁵³ Dr. Clouston, ‘The Duty of the Profession in Regard to Legislation for Alcohol Excess’, *Lancet*, 16 April 1901, Press Cuttings Vol. 5.

⁵⁴ Robertson warned that the growth of spiritualism was feeding the populations of asylums. See ‘Spiritualist “Dreams”. Mental Expert’s Warning of Perils of the Cult’, *Evening Standard*, 25 February 1920. Robertson also generated substantial press coverage when he launched an attack in 1923 on the Reverend R. C Griffith, a vicar from Norwich who claimed that cancers could be eliminated within twenty minutes of a spiritual healing.

successful way to communicate ideas to a wider audience. When asked to give the Maudsley Lecture in 1926,⁵⁵ Robertson used the opportunity to voice his opposition to sterilisation of the mentally ill, and his conviction that psychiatrists should become more involved in preventative work in the community.⁵⁶ These arguments were overlooked by the popular press, which simply reported Robertson's findings that single men were more at risk of insanity than their married counterparts.⁵⁷

As the press cuttings books illustrate, both Clouston and Robertson felt that the MPA and *JMS* provided an inadequate forum and organisational basis from which to reach the public. Seeking to disassociate themselves from the tarnished image of the trading mad-doctor, running his asylum with an eye to management rather than medicine, both men reached out to broader sections of the community through the campaign for

⁵⁵ A Maudsley Lecture was one of the few means by which the MPA tried to establish contact with the public. A lecturer was appointed every year to popularise psychiatric ideas.

⁵⁶ The only report of Robertson's speech which mentioned his advocacy of a preventative role for psychiatrists was 'The Prevention of Insanity - a Preliminary Survey of the Problem', *Lancet*, 17 July 1926. 'In the opening up of preventative channels a great responsibility rests on practising psychiatrists. It is futile lament that those of unstable equilibrium turn elsewhere for help – to the quack, to the charlatan, to the barren ritual of the latest cult. The blame for this state of affairs must be shared by the psychiatrist. For too long he had sulked in his cave; now he must come out in to the marketplace and offer his wares to all who need them. He must not confine his interests to his duties in the mental hospital. He must co-operate with the general practitioner and get in touch with the outer world...'

⁵⁷ W. Stephson, 'Bachelordom and Longevity', *Clarion*, 30 July 1926. This story was also reported in the *Westminster Gazette*, the *Evening Standard*, the *Morning Post*, *The Times*, the *Daily Telegraph* and a raft of local and international papers, and dutifully pasted into the clippings book.

mental hygiene, seeking to attract the interests of the broader medical profession and the public.

5: Writing for the Public: Popular Psychiatry Books, 1921-70

We have seen in the previous section how Clouston and Robertson sought to advance their careers through their involvement in the mental hygiene movement in the 1920s. Other psychiatrists also pursued their interest in the media, seeking to reach the public through popular books on psychiatry. This section will examine what motivated psychiatrists to write these books, what they hoped to accomplish by writing for a public audience and what methods they used to try and achieve their aims. It will also address how the authors represented mental illness and the public. The early twentieth century witnessed a rise of popular publications on psychology and psychoanalysis,⁵⁸ although psychiatry itself, Roy Porter argued, took longer to shake off the unappealing spectre of the asylum and its mad inmates, to appeal to broader sections of the public.⁵⁹ The development of the mental hygiene movement, a collaboration that involved psychiatrists, social workers, doctors and psychologists, may have begun to change this

⁵⁸ See M. Thomson, 'The Popular, the Practical and the Professional: Psychological Identities in Britain, 1901–1950', in G. C. Bunn, A. D. Lovies and G. D. Richards (eds), *Psychology in Britain: Historical Essays and Personal Reflections* (Leicester, 2001), pp. 115–32; D. Rapp, 'The Early Discovery of Freud by the British General Educated Public, 1912–1919', *Social History of Medicine*, 3 (1990), pp. 217–43.

⁵⁹ R. Porter, 'Two Cheers for Psychiatry! The Social History of Mental Disorder in Twentieth Century Britain', in H. Freeman and G. E. Berrios (eds), *150 Years of British Psychiatry Volume II: The Aftermath* (London, 1996), pp. 383–406.

state of affairs. The movement first emerged in America following the publication of Clifford Beer's widely read account of his experiences as an asylum patient in *A Mind that Found Itself*.⁶⁰ In 1922, the movement took root in England with the formation of the National Council for Mental Hygiene. The agenda of the mental hygienists shifted the focus away from the mentally ill and towards the tasks of preventing illness and preserving mental health in community settings.⁶¹ In order to achieve their goals, mental hygienists needed to effect changes in family life and social conditions and thus required the participation of the public. However, the extent to which mental hygienists sought an open discussion with the lay-public is subject to question. In his analysis of Thomas Clouston's 1906 work, *The Hygiene of the Mind*,⁶² Nick Crossley argues that although the book was permeated with middle-class values and prejudices, Clouston claimed his argument drew on incontestable fact rather than opinion, thus precluding the possibility of debate and contestation by a lay readership.⁶³ Clouston's work was probably aimed more at fellow mental health workers rather than a lay audience; indeed, the most popular and widely read work of the movement was Beers' account of his experiences as a patient, not a book by a professional. Nevertheless by the mid twentieth century, 'a

⁶⁰ C. Beers, *A Mind that Found Itself: An Autobiography* (London, 1908).

⁶¹ For details of the growth of the mental hygiene movement, see C. Unsworth, *The Politics of Mental Health Legislation* (Oxford, 1987), pp. 128–31.

⁶² T. Clouston, *The Hygiene of the Mind* (London, 1906).

⁶³ N. Crossley, 'Transforming the Mental Health Field: The Early History of the National Association of Mental Health' *Sociology of Health and Illness*, 20 (1998), pp. 458–88. For an analysis of Clouston's book, see pp. 466–8.

concern with mental health began, slowly but decisively, to percolate beyond the asylum walls into the very pores of society at large'.⁶⁴

One of the earliest psychiatrists who transcended the division between psychiatry and the popular media was James Crichton-Browne, whose popular publications included such works as *The Doctor Remembers*, *The Doctor's Second Thoughts*, *From the Doctor's Notebook*, *Stray Leaves From a Physician's Portfolio* and *Burns, From a New Point of View*.⁶⁵ However, as Michael Neve and Trevor Turner have noted, Crichton-Browne was 'surprisingly unforthcoming' about his own profession in his popular books.⁶⁶ Thus in his collection of essays, *Stray Leaves*, Crichton-Browne dealt briefly with dreamy mental states and brain rest before examining more literary topics, such as the Brontës, Shakespeare, Burns and Sir Walter Scott. Meanwhile, *A Doctor Remembers* was not an autobiography of Crichton-Browne's experiences as a psychiatrist, but a compilation of his reminiscences of famous men and incidents from the Victorian era. Crichton-Browne seemed motivated to write by his concern that his side interests were saved for posterity, 'rescued from the oblivion of bygone magazines'.⁶⁷ 'Most physicians', he claimed (the choice of word identifying him with the general medical

⁶⁴ Porter, 'Two Cheers for Psychiatry!', p. 393.

⁶⁵ J. Crichton-Browne, *The Doctor Remembers* (1932, London, 1938); *The Doctor's Second Thoughts* (London, 1931); *From the Doctor's Notebook* (London, 1937); *Stray Leaves from a Physician's Portfolio* (London, 1938); *Burns, From a New Point of View* (London, 1926).

⁶⁶ M. Neve and T. Turner, 'What the Doctor Thought and Did: Sir James Crichton-Browne (1840-1938)', *Medical History*, 39 (1995), pp. 399-432. Quoted on p. 417.

⁶⁷ Crichton-Browne, *Stray Leaves*, p. vii.

profession), 'are peripatetics and stroll from time to time from the professional Lyceum into the shady walks that branch out of it in so many directions'.⁶⁸ If judged by his popular writing, Crichton-Browne would appear to have spent very little time in the professional Lyceum at all. His avoidance of the topic of mental illness when writing for a public audience might be explained by two factors. On the one hand, given the stigma that the MPA felt was attached to psychiatry in the public mind, Crichton-Browne may have felt it necessary to ignore the subject in his popular work. Given the difficulties psychiatrists experienced trying to persuade the public that their occupation was respectable, Crichton-Browne may have sought to present himself as a cultured gentleman in order to challenge perceptions of insanity as a dirty trade. In her analysis of Henry Maudsley's *Physiology and Pathology of the Mind*,⁶⁹ a book that was devoted to the discussion of insanity, Helen Small examined how Maudsley privileged fictional examples of insanity over scientific learning on the subject. 'The repeated emphasis on medicine as a creative art', argued Small, 'indicates considerable social ambition on the part of a man who cultivated an extensive aristocratic clientele, and who fought to protect the gentility of his profession'.⁷⁰ We might perhaps ascribe Crichton-Browne's free-ranging popular writings as an attempt to promote himself to the public outside the narrow sphere of the MPA, and as an attempt to professionalise psychiatry as a gentleman's occupation, requiring literary and social attributes as well as scientific knowledge.

⁶⁸ *Ibid.*

⁶⁹ H. Maudsley, *The Physiology and Pathology of the Mind* (London, 1867).

⁷⁰ H. Small, "'In the Guise of Science": Literature and the Rhetoric of Nineteenth-Century English Psychiatry', *History of the Human Sciences*, 7 (1994), pp. 27-55. Quoted on p.45.

Another doctor writing for the public in the 1920s had no hesitation in laying before the public gaze what went on within asylum walls, perhaps because he identified himself primarily as a physician rather than a psychiatrist. Montagu Lomax's 1921 exposé, *The Experiences of an Asylum Doctor with Suggestions for Asylum and Lunacy Law Reform*, was concerned less with advancing a particular representation of mental illness to the public than familiarising its readers with what Lomax saw as the prison-like conditions within asylums. Aiming to reform the system of asylum administration, Lomax described the appalling conditions in which patients were kept, arguing that the insane were not 'dangerous wild beasts' but intelligent people with feelings who were painfully aware of their surroundings, which had 'a very real influence on their health and happiness and their chances of recovery'.⁷¹ In his final chapter on what might constitute an ideal asylum, Lomax summarised his main criticisms of the asylum system as he had found it:

I saw these unhappy inmates confined at times for weeks together in pitch-dark, ill-smelling, mostly unheated, and locked-up cells. I saw them exercising in what were practically prison yards... in quasi-convict garb...subjected to a rigid and callous discipline. I saw them fed on ill-selected, innutritious, dirtily served and badly cooked food. I saw them suffer and die from various physical diseases, contributed to, if not actually caused by, the conditions of their asylum life...I saw others systematically purged and drugged as an added means of punishment

⁷¹ M. Lomax, *The Experiences of an Asylum Doctor with Suggestions for Asylum and Lunacy Law Reform* (London, 1921). Quoted on p. 253.

and restraint...I saw ex-service patients placed in asylums who should never have been put there, and other cases detained for years who, in my opinion, were fit for their liberty.⁷²

By itself, Lomax's book may not have had a significant impact. However, public feeling about asylum treatment had been stirred by the treatment of ex-service patients as pauper lunatics, and Lomax was able to tap into the emotion generated by this issue. Lomax's account was no doubt shaped by earlier critiques of asylum treatment that had appeared in the media, and itself provided the template for subsequent media exposés. Robertson's cuttings book contains several articles from *Truth*, the *New Statesman* and the *Fortnightly Review* that examined Lomax's allegations, or made their own investigations after reading Lomax's account. It also contained an article by a general doctor, Albert Wilson, published by the *Evening Standard*. Wilson praised Lomax for daring to give the public 'the naked truth' by revealing how treatment and conditions were compromised by parsimony. 'It is for the public to move and see to improved laws and systems', Wilson argued. However, after expressing his sympathy for the 'poor things' in the asylums, Wilson argued that Lomax's reforms had not gone far enough and proceeded to make a suggestion that must at the time have been rather original:⁷³

There are many put in asylums who might as well be put in their graves. Why not? Twenty-five years ago I put a lad of eighteen in an asylum. He has no

⁷² *Ibid.*, p. 251.

⁷³ Similar arguments were also used to support the 'euthanasia' of German psychiatric patients under the Nazi regime. See M. Burleigh, *Death and Deliverance: 'Euthanasia' in Germany 1900-1945* (Cambridge, 1994).

pleasure in life...he will never come out or regain his reason...Why not painless extermination? Morphia or carbonic oxide gas when in normal sleep. That would represent the highest and noblest Christian ethics. But the people have to be educated up to it. Which is the kinder - to herd these sufferers, or, when a case is hopeless, to relieve him or her of his suffering.⁷⁴

Wilson claimed to be an advocate of psychiatry, yet his support for Lomax's criticisms of asylums in a nation paper and his suggestion that asylum inmates were in need not of curing but killing undermined psychiatry's claims to be a medical profession treating a curable illness. Wilson's article exemplifies how the subsequent press coverage of psychiatrists' popular works might diverge greatly from the original intentions of the author.⁷⁵

To achieve reform, Lomax believed that one had to address not the medical profession but the public. 'All reforms of public institutions depend in the last resort upon the rousing of public opinion', claimed Lomax. 'It is not enough for specialists and experts to be satisfied of the necessity for reform; it is for the public itself to take the lead. But to do this the facts must be known.' Thus the aim of his book was 'to supply the facts and give the reasons, and thereby enable the public to form a judgement and take action accordingly'.⁷⁶ This was not an entirely alien concept to the MPA who, as we have

⁷⁴ A. Wilson, 'Critic of English Asylums: A Doctor's Book on Alleged Evils and Abuses: Can our System be Reformed? By Albert Wilson, M.D.' *Evening Standard*, 26 July 1921, Press Cuttings Vol. 7, pp. 88-90.

⁷⁵ The suggestion that psychiatry might deal with its more hopeless cases by killing them resurfaced in the debate surrounding mental deficiency in the 1930s, which is discussed in Chapter Two.

⁷⁶ Lomax, *The Experiences of an Asylum Doctor*, pp. 13-14.

seen, sometimes argued that it would take the weight of public pressure before the government would act to reform the mental health services and improve resources. For Lomax, the public were humane people at heart, just ignorant of the true state of affairs; once they were made aware of the terrible conditions within asylums they would push for reform. The opportune timing of the book caused enough of a stir to prompt an investigation by the Board of Control, which dismissed his allegations and discovered in the process that Lomax had been responsible for prescribing 253 of 333 doses of the purgative croton oil between October 1917 and March 1918. Lomax's allegations also impelled the Minister of Health to appoint a committee to investigate on conditions in 1922, while a Royal Commission was appointed in 1924, whose recommendations were partly met in the Mental Treatment Act of 1930. Thus the work of a marginal member of a sub-public group, coinciding with a more general concern about conditions faced by ex-servicemen, created enough of a public furore to propel the government into action.

During the 1950s, significant changes had an impact on the psychiatric services, which had been brought under the control of the Ministry of Health by the 1946 NHS Acts. Psychosurgery and ECT had been developed in the 1930s and 1940s, while drug therapy was expanded by the introduction of largactil in 1953, leaving psychiatrists a wide range of therapeutics at their disposal. Some hospitals in this era experimented with the opening of previously locked doors and attempted to apply the model of the therapeutic community to their institution,⁷⁷ while day hospitals were pioneered as an

⁷⁷ Denis Martin, for example, described how he transformed Claybury hospital into a therapeutic community in the 1950s. D. V. Martin, *Adventures In Psychiatry: Social Change in a Mental Hospital*

alternative to residential care. Media coverage of psychiatry was boosted by the decision of the BBC to make the series 'The Hurt Mind', discussed in Chapter Six. These changes in practice were met with legislative reform, as the recommendations of the Royal Commission on Mental Illness and Mental Deficiency (1954-57) led to the 1959 Mental Health Act, which abolished the Board of Control, removed many of the formalities of voluntary treatment and enabled local authority health services to establish voluntary services.⁷⁸

Two books written in the early 1950s, before some of these events had taken place, sought to enlighten the general public about mental illnesses and their treatments. David Stafford-Clark, who also participated in BBC radio programmes on mental health issues, published his work *Psychiatry To-day* in 1951. Reprinted by Penguin, the book had sold over 130,000 copies and been translated into several languages by 1963. The book was 'specially written' for the general public,⁷⁹ but was equipped with some of the trappings of an academic publication, a glossary and index. Stafford-Clark did not distinguish between the general public and the psychiatrist in his writing, talking instead of 'normal people', 'we'. He also attempted to rationalise the fear and disregard he believed had been historically felt by people towards the mentally disordered. 'Why do normal people find it so hard to accept and understand the mentally ill?' asked Stafford-

(Oxford, 1992)

⁷⁸ For an overview of these developments, see Jones, *Asylums and After*, 'Chapter Nine: New Services for a New Age', pp. 141-58; P. Fennell, *Treatment Without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People Since 1845* (London, 1996), pp. 129-69.

⁷⁹ Stafford-Clark, *Psychiatry To-day*. The quote is from the back cover of the 1963 edition.

Clark. 'A refusal or inability to accept some or all of the demands of reality is characteristic of such patients, and it is this above all that separates them from their fellow men'.⁸⁰ Stafford-Clark was careful not to attack his readership by deriding their prejudices as foolish and setting himself apart from them. His book discussed normal and abnormal behaviour, its causes and treatments but also examined broader, more contentious issues, such as the place of psychiatry within general medicine and the wider applications of psychiatry:

Psychiatry has much to offer, as we have seen, in the sphere of human relations; it has contributions to make to man's happiness and security in childhood, in adolescence, in work, in marriage, in sickness and in health. It is a useful tool in sociology and in anthropology, it has something to bring to the appreciation of art and literature, and to the interpretation of some aspects of philosophy and religion.⁸¹

Stafford-Clark was seeking to expand and broaden the horizons, prestige and career options open to those who trained as psychiatrists, by associating the profession less with sickness than with health and cultural pursuits.

However, when Stafford-Clark began to address the social problems mental illness posed, the inclusive manner he had previously used to address his readers changed: 'In essence', he claimed, 'it is still the problem of an attitude of mind on the part of the public, who in turn must look for leadership to members of my own

⁸⁰ *Ibid.*, pp. 11-12.

⁸¹ *Ibid.*, p. 297.

profession'.⁸² Indeed, by his last chapter Stafford-Clark had become rather didactic, urging an unequal relationship between the educated psychiatrists and ignorant mass of the public 'The public as a whole need to be taught the truth about psychiatry...they need to be helped to overcome the shame and fear which have dogged the whole concept for mental illness for centuries...'⁸³. If psychiatry was a source of stigma, he suggested, then the fault lay with the public. This line of argument was rather different to that urged by Lomax thirty years earlier, who had believed that once furnished with the facts, the public could more successfully bring about change than medical superintendents.

Henry Yellowlees first published his popular psychiatry work, *To Define True Madness*, a year after Stafford-Clark's book was released.⁸⁴ Unlike some popularisers, Yellowlees had spent twenty seven years working within mental hospitals, and hoped to inform and enlighten the 'lay public' by giving readers 'a fuller and clearer understanding of a few of the disorders with which psychiatry deals', choosing to focus on those topics 'about which public feeling has rather outstripped public understanding'.⁸⁵ His book discussed depression, psychological theory, hypnosis and the relationship between law and medicine. A key area of concern for Yellowlees, which may have motivated him to write his book, was the public attitude towards psychiatry and what he described as the 'mutual misunderstandings' that existed between the psychiatrist and the layman.⁸⁶ While

⁸² *Ibid.*, p. 268.

⁸³ *Ibid.*, p. 297.

⁸⁴ Yellowlees, *To Define True Madness*.

⁸⁵ *Ibid.*, p. ix, and inside cover.

⁸⁶ *Ibid.*, p. ix.

this term might imply equal blame for the state of affairs, Yellowlees laid most of the blame at the door of the public. Yellowlees was, however, concerned that psychiatry, ‘a unique combination of science and art’ was passing into decline at the time he wrote, ‘because it is at the mercy of its amazing technique and its art has evaporated almost to vanishing point’.⁸⁷ Perhaps fuelled by the approach of psychiatrists such as William Sargant, who advocated ‘practical rather than philosophical approaches to treatment’,⁸⁸ Yellowlees bemoaned the decline of clinical expertise at the expense of ‘empirical’ new treatments, rather as Maudsley had in the nineteenth century. He also blamed media coverage of mental health issues for not only illustrating the misunderstandings between the public and psychiatry, but for doing ‘much to maintain it’.⁸⁹

The book bewailed the low esteem with which psychiatrists were regarded, as ‘the butt and laughing stock of a majority of both the medical profession and the general public’:

Beyond all doubt, psychiatry holds a lower place in public regard than any other branch of medicine. The psychiatrists on the stage, on the screen, and in modern ‘literature’ is even ceasing to be the malevolent wizard of a few years ago and has largely become nothing more than an idiotic and incompetent figure of fun. Much more serious than this is the attitude of persons in official positions...many illustrations could be given of the contemptuous attitude to psychiatry of the Press

⁸⁷ *Ibid.*, p. 13.

⁸⁸ W. Sargant, *The Unquiet Mind: The Autobiography of a Physician in Psychological Medicine* (London, 1967), p. vii.

⁸⁹ Yellowlees, *To Define True Madness*, p. 25.

the Church, the Bar, the Bench and, for that matter, a very large proportion of the medical profession itself. Is it, then, any great wonder that the man in the street, and the club, and the pub, takes his tone from his seniors and leaders?...The responsibility of those who have power to influence public opinion in various ways is correspondingly heavy.⁹⁰

Yellowlees perceived psychiatry as a profession beset on all sides, distinguishing between an elite 'public', composed of professionals, and the man-in-the-pub public, who copied their betters. He blamed this dismissive attitude on public ignorance, and reiterated the common complaint of psychiatrists that many people held 'a strange conviction that there is really nothing to know in psychiatry beyond what any ordinary person absorbs naturally by the age of twenty-five'.⁹¹

Yellowlees was very dismissive of the general public, even questioning 'whether anything can or should be done to put them in a position to grasp just the very rudiments of the subject'.⁹² He mocked the 'man in the street' (by implication, the lower order of the public) - the very person likely to buy his own book - who 'goes to a secular bookseller, acquires some popular works on what the late Professor Mapother called 'Parlour Psychology', and placidly maintains his proud position as the "local" authority on Psychiatry without Tears'.⁹³ 'We cannot stop people talking about psychiatry: cannot we

⁹⁰ *Ibid.*, pp. 1-2.

⁹¹ *Ibid.*, p. 2.

⁹² *Ibid.*, p. 3.

⁹³ *Ibid.*, p. 3.

get them to talk sense about it?' the doctor asked.⁹⁴ However, if this was Yellowlees' aim, one wonders if he might not have alienated his potential readership, despite his efforts to get the reader on to his side in opposition to the ignorant public. Distinguishing between physiology and pathology, Yellowlees commented that 'the reader who has grasped even this elementary point is entitled to feel that he has already progressed a good deal further than the average layman in his understanding of the subject'.⁹⁵ If this was praise, it did not stretch very far. Similarly, at the end of his first chapter, Yellowlees wrote

The reader who has found it hard to grasp, or even merely boring and dull, is advised to proceed no further, but anyone who has read so far with even ordinary interest and understanding, can read what follows with the pleasing certainty that at last he has some idea of what a psychiatrist is talking about, and with an increasing realisation that, far from being 'all rubbish', psychiatry is a study of enormous importance and most fascinating interest.⁹⁶

The book would enable its reader to 'think and talk intelligently about psychiatry', but only 'if he will allow it to teach him to do so'.⁹⁷ Concerned about public disregard for the profession, Yellowlees sought to impose his views upon his readers as facts not opinions to be disputed, and seemed to have little interest in opening up a debate. The book tells us more about Yellowlees' perceptions of the public, than about what the public actually thought about psychiatrists and the mentally ill.

⁹⁴ *Ibid.*, p. 4.

⁹⁵ *Ibid.*, pp. 7-8.

⁹⁶ *Ibid.*, p. 12.

⁹⁷ *Ibid.*, p. 26.

William Sargant, a prominent psychiatrist whose involvement in the making of the first major BBC documentary on mental illness is discussed in Chapter Six, chose to publish his autobiography in 1967. His stated purpose was to ‘describe the fascinating progress that has taken place during the last thirty years in the discovery of medical and surgical approaches to the treatment of the mind of man’, although the book no doubt was also intended to celebrate Sargant’s achievements and could be described as an example of ‘heroic’ medical writings in which often drastic treatments were pioneered by the heroic doctor.⁹⁸ Sargant, a vocal advocate for physical therapies, described the changes that had taken place from his own personal perspective, urging readers to ‘continue along the road of practical rather than philosophical approaches to treatment’.⁹⁹ Although indexed and referenced, Sargant’s book was written in an accessible style and appears to have been aimed at the general public. Like Yellowlees, Sargant felt that for many laymen, ‘psychiatry and psychological medicine have too often become the subject of fear, anger or laughter’.¹⁰⁰ Sargant sought to tackle this by trying persuade his readers that, far from being a disorder that affected an isolated group of individuals, everyone was potentially at risk from mental illness. He argued that the public were heavily involved in the problems arising from mental illness, citing statistical figures of illness

⁹⁸ Sargant, *The Unquiet Mind*, p. vii. Sargant held a number of high profile positions, acting as Registrar for the RMPA and President of the Section of Psychiatry of the Royal Society of Medicine. Heroic accounts of the history of medicine usually focus on the heroism of the doctor who pioneered the treatments, not the patients who underwent them.

⁹⁹ *Ibid.*

¹⁰⁰ *Ibid.*

rates and hospital beds to persuade his readers that mental illness was a subject of concern to everyone, which deserved better funding.

R. D. Laing's first book *The Divided Self* dealt with the nature of schizophrenia, a disorder that by the mid-1950s was assuming a prominent position within psychiatry as a 'test subject' to examine different strands of psychiatric and psychotherapeutic practice.¹⁰¹ Laing sought 'to make madness and the process of going mad comprehensible', arguing that schizophrenia could be understood as a form of personal alienation.¹⁰² Now seen primarily as an anti-psychiatry text, Tavistock originally published the book in 1959, mainly for other psychiatrists. Although Laing would later distance himself from his former colleagues, Jonathan Andrews argues that his early work and ideas should be understood in the context of the research projects on schizophrenia that he participated in at Gartnavel Royal Hospital.¹⁰³ Nick Crossley suggests that Laing was attempting to change the field of psychiatry from within when he wrote the book, by drawing on philosophical theories and progressive ideas within psychiatry, such as the importance of

¹⁰¹ J. Andrews, 'R. D. Laing in Scotland: Facts and Fictions of the 'Rumpus Room' and Interpersonal Psychiatry', in M. Gijswijt-Hofstra and R. Porter (eds), *Cultures of Psychiatry and Mental Health in Postwar Britain and the Netherlands* (Amsterdam, 1998), pp. 121–240. Quote from Cameron and Esterson, 'Psychotherapy with a Schizophrenic Woman', *Psychiatric Quarterly*, 32 (1958), pp. 304–17. Cited in Andrews, 'R.D. Laing in Scotland', p. 134.

¹⁰² R.D. Laing, *The Divided Self: An Existential Study in Sanity and Madness* (1959, London, 1965). Quote from the Preface to the Original Edition (1959).

¹⁰³ Andrews, 'R.D. Laing'.

the social environment.¹⁰⁴ However, the *British Journal of Psychiatry* rejected Laing's later articles as he increasingly found himself marginalised from psychiatry.¹⁰⁵

Seeking a different audience for his work, Laing placed his articles in the *New Left Review* and republished *The Divided Self* through Pelican. In the new preface to the reissue, Laing made different claims about schizophrenia and psychiatry, aiming the work at a different audience. Mental illness was now represented as the transcendence over a repressive, one-dimensional society. Psychiatry, instead of aiding this transcendence, was all too often 'a technique of brainwashing', the restraints of old having been replaced by 'the more subtle lobotomies and tranquilizers that place the bars of Bedlam and locked doors *inside* the patient'.¹⁰⁶ Laing tried to situate the book within the broader counter-culture, linking his arguments to critiques of industrialisation, nuclear weaponry and racism. 'A man who says that Negroes are an inferior race may be widely respected', he wrote. 'A man who says his whiteness is a form of cancer is certifiable'.¹⁰⁷ Moreover, the book was not just relevant to those interested in mental illness; normal people would benefit too because, Laing argued, 'our "normal" "adjusted" state is too often an abdication of ecstasy, the betrayal of our true potentialities'. It was only those individuals with 'an insistent experience of other dimensions' who escaped 'the pervasive

¹⁰⁴ Crossley, 'R.D. Laing'.

¹⁰⁵ Although Crossley does note that many of Laing's early articles were also rejected by the *British Journal of Psychiatry*. *Ibid.*, p. 882.

¹⁰⁶ Laing, *The Divided Self*, preface to the Pelican Edition. Italics in original text.

¹⁰⁷ *Ibid.*

madness that we call normality'.¹⁰⁸ Although Laing continued to support his arguments by claiming expertise through his qualifications in psychiatry (his qualifications, research and positions held continued to be listed in the front of the pelican edition) he not only opposed but also distanced himself from psychiatry. As both Colin Jones and Nick Crossley have noted, Laing's work formed part of the broader counter-culture and was embraced by people seeking personal development.¹⁰⁹ As a consequence of Laing's personal motivation to find a field that accepted his work after his ideas were rejected by the mainstream of psychiatry, a much larger and diverse group of people read his works. However, it is debatable whether this led to a growth of interest in the rights of the mentally ill.

6: Conclusion

When addressing the contribution made by psychiatry towards public representations of mental illness, one starting point would be to explore the extent to which the MPA operated as a democratic sub-public sphere. Undoubtedly the organisation enabled members to discuss ideas amongst themselves, withdrawn from the pressures of the external world, both within national and local meetings and within the pages of the *JMS*. Even within the journal, though, not everyone was afforded equal access. Individual editors appear to have been responsible for large sections of the journal, while other

¹⁰⁸ *Ibid.*

¹⁰⁹ C. Jones, 'Raising the Anti: Jan Foudraine, Ronald Laing and Anti-Psychiatry', in Gijswijt-Hofstra and Porter (eds), *Cultures of Psychiatry*, pp. 283–94; Crossley, 'R.D. Laing', pp. 884–6.

psychiatrists experienced difficulties getting their work published. This may have made the *JMS* unrepresentative of the interests and concerns of the majority of psychiatrists. The functioning of the MPA as a democratic sub-public sphere is problematised further when it is considered whether it provided a base from which psychiatrists could spread their views to a wider audience. Indeed, while the MPA functioned admirably as a space of withdrawal, efforts to target the public, or even discussions of whether it was worthwhile trying to communicate with the public, virtually disappeared from the *JMS* by the mid-twentieth century. This can in part be explained by the MPA's perception of the public, which did not appear to be subject to much alteration throughout the period. Ignorant, resistant to the careful efforts of psychiatrists to educate them and yet strangely prone to sensationalist reporting, the public as envisaged by psychiatrists were not capable of participating in a debate about the care of the mentally ill even if it was possible to gain their attention. Thus, while it was sometimes acknowledged that public opinion might be a helpful thing if it could stimulate the government to improve conditions of work and the prestige of psychiatry, psychiatrists believed this opinion should be created by the absorption of knowledge passed from psychiatry to the public. These views were still being expressed in the popular psychiatry books of the 1950s. Another factor that inhibited psychiatrists from entering into a debate with the lay public was their view that psychiatric practice was firmly grounded not on opinion or belief but on incontestable scientific fact. A logical consequence of this belief was that the lay public, who were not privy to this specific expertise, were unqualified to contest psychiatric practice. This argument may not have carried much weight to lay commentators who saw psychiatrists frequently contesting these supposedly indisputable

facts amongst themselves in court. Finally, one other reason why the MPA and the *JMS* began to discard their concern with public opinion should be considered, even if individual psychiatrists continued to view the topic as an area of legitimate interest. As psychiatry sought to increase its prestige as a legitimate profession, overt anxiety regarding public opinion and hostility may have been seen as detrimental to the image of a disinterested profession dedicated to helping those affected by mental illness. Of course, the MPA was not the only forum in which psychiatrists could voice their interests and some individual psychiatrists participated in other sub-public spheres in order to raise their concerns, as will be seen in other chapters of this thesis.

Psychiatry was the first professional group that developed specifically to cater for the care of the mentally ill, but was arguably not the first group to represent the interests of the mentally ill. This chapter has sought to address whose interests the MPA and individual psychiatrists represented when they did try and communicate their views by examining both the anxieties expressed within the *JMS* and the types of press coverage that Clouston and Robertson preserved within their press cuttings books. These examples show that psychiatrists, both collectively and individually, were more concerned by press coverage that attacked psychiatry as a dedicated, moral profession that drew on special expertise than coverage that represented mental illness in a negative light. Although they argued that it was necessary to advance the prestige of psychiatry before the problems faced by the mentally ill could be addressed, psychiatrists appear to have been more concerned to advance the professional image of psychiatrists than the social position of the mentally ill. After all, psychiatrists rarely argued that it was necessary to destigmatise

mental illness before the prestige of psychiatry could be enhanced. Thus even when they did seek to address the lay public, psychiatrists often sought to create more positive representations of psychiatry rather than of the mentally ill. Potentially, if psychiatrists' main aim was to advance their professional status, this strategy may not have been entirely successful, because if they conformed to the true image of the professional they would be more dedicated to the lives of their patients than their own economic and social rewards.

The failure of psychiatry to alleviate the stigma attached to mental illness and the asylum can be viewed as a consequence of their strategy to improve their professional status. Even though this study has taken place against the backdrop of the asylum, many psychiatrists sought to escape from the confines of the asylum walls, a system of care which was being questioned as early as 1870, to work towards mental health within the community where they could have a more prestigious and influential role. Although many psychiatrists no doubt genuinely believed that the development of this field of work was the best way to tackle mental illness by preventing their occurrence in the first place, it is nevertheless ironic that the asylum and the mentally ill, who had given birth to and justified the profession of psychiatry as a field of medical expertise, was seen to pose such a stumbling block to the realisation of a professional identity for psychiatry. As a consequence, while seeking to increase their prestige, psychiatrists seem to have lost sight of the mad. In their efforts to destigmatise minor forms of mental distress, psychiatrists may have inadvertently increased the stigma attached to more severe forms of mental disorder.

Chapter Two: The National Asylum Workers' Union

A male nurse stood at the Pearly Gates,
His head was bent and low
He meekly asked the man of fates,
Which was the way to go,
'What have you done?' St Peter said,
'To seek admission here.'
'I've been a mental nurse for many and many a year.'
St. Peter opened wide the Gate and smiled at him as well,
'Come in,' he said, 'and choose your Harp,
You've had your share of Hell'.¹

Over the past twenty years, psychiatry has been a major area of investigation for historians. Yet, as Peter Nolan notes, nurses have been 'allocated only a marginal role in the pages of history despite having had the most intimate therapeutic role in relation to the mentally ill'.² Recognising the substantial contact psychiatric nurses had with the mentally ill, this chapter examines how nurses portrayed the mentally ill in their journal, asking if nurses prioritised the representation of their own interests or those of their patients.

¹ R. S. Cook, 'At Heaven's Gate', *Health Services Journal*, 1 (December 1948), p. 10.

² P. Nolan, *A History of Mental Health Nursing* (London, 1993), p. 1.

The chapter commences with a brief history of the National Asylum Workers' Union (hereafter the NAWU), before examining how the Union journal might be viewed as a forum for the representation of mental illness amongst asylum attendants.³ Throughout the period under study, the occupational concerns of psychiatric nurses seem to have affected the manner in which they chose to represent the mentally ill. The research indicates that initially the interests of the male nurses dictated the representation of the patients. The chapter explores the slow emergence of the patient voice in the journal and examines how Union members represented patients categorised as mental defectives. The attempts of the Union to remodel its profession along the lines of general medicine in the 1930s and 1940s are then examined and it is suggested that this development led the Union to focus more upon the interests of the patients. Finally, it is argued that the closure of mental hospitals proposed by Health Minister Enoch Powell in 1961 led to a new professional crisis and provoked individuals within the Union to again stigmatise those in their care.

1: A Brief History of the NAWU⁴

The formation of the NAWU in 1910 was a reaction to the poor working conditions faced by asylum attendants. Attempts were made in the 1890s by medical superintendents to

³ The title of the Union's journal changed several times in the period under study, reflecting changes in the Union's title and composition. For clarity, I have largely referred to the Union's paper as the journal in the text, listing the exact title in the footnotes.

⁴ A detailed history of the progress of the NAWU can be found in M. Carpenter, *Working for Health: The History of the Confederation of Health Service Employees* (London, 1988).

contain staff discontent within the employer-led Asylum Workers' Association. This organisation idealised the professionalism of asylum staff while failing to address the low wages and long hours that were the major cause of unrest.⁵ The failure of the Asylum Workers' Association to secure a non-contributory pension for asylum workers in the Asylum Officers' Superannuation Act of 1909 provided a final incentive for the formation of a trade union in 1910 by delegates from five asylums. The fledgling NAWU capitalised on attendants' discontent with the Superannuation Act and the gulf between the salaries of medical superintendents and attendants, successfully attracting many former Asylum Workers' Association members to its ranks.

By 1913 the membership of the NAWU stood at 7,900. Herbert Shaw, an attendant at the Wakefield Asylum, was appointed as Assistant General Secretary in 1911 after being dismissed from his post for Union activities. Shaw, who does not seem to have been involved in trade union activity outside of the NAWU, remained editor of the Union's journal until his retirement in 1946. George Gibson was elected as General Secretary in 1913, retaining his post until 1948. Gibson was a man of broad interests, of which psychiatric nursing was just one. He was widely involved in the trade union movement, serving on the Trade Unions Congress (hereafter TUC) General Council from

⁵ A survey conducted by the NAWU of 31 mental hospitals in 1912 revealed the working week of attendants to be in excess of seventy hours, in some cases more than eighty or ninety. Cited in M. Carpenter, 'Asylum Nursing before 1914: a Chapter in the History of Labour', in C. Davies (ed.), *Rewriting Nursing History* (London, 1980), pp. 123-46.

1928 and acting as TUC Chairman in 1940.⁶ Gibson's impact on the Union was perhaps matched by that of Claude Bartlett, who was elected President in 1926 and remained in his position until 1962. Throughout his presidency, Bartlett remained a mental charge nurse and, with the exception of the chairmanship of the TUC in 1959, restricted his activities to the field of health care. Bartlett was one of the most prominent voices calling for the amalgamation of the health services trade unions into the Confederation of Health Service Employees (hereafter the COHSE). He was also a member of the Royal Commission on Law relating to Mental Illness and Mental Deficiency, whose recommendations were incorporated into the Mental Health Act of 1959.

The first ten years of the Union marked a flurry of strikes, fluctuating membership and the establishment of Joint Conciliation Committees, to negotiate wages and conditions between the NAWU and the Mental Hospitals Association. The 1920s saw a weakening of the Union's position, as many asylums used a failed strike at Radcliffe in 1922 to cut salaries of attendants: membership fell from around 18,000 at the end of 1920

⁶ Gibson also served on the Overseas Settlement Board, the National Savings Committee, the Children's Overseas Reception Board, the Lancashire Industrial Development Council and the National Investment Council. He resigned from his COHSE appointment to become the chairman of the NorthWest Electricity Board for four thousand pounds a year. Implicated in the Lynskey Tribunal of Inquiry in 1947 for using his official powers to assist his friend Sidney Stanely to set up a business in expectation of personal gain, Gibson resigned from his public posts and died in 1953, largely ignored by his former colleagues at the TUC. Said to be a witty, imposing and eloquent speaker with imperialist views, Gibson was honoured by his former nursing colleagues in the Confederation of Health Service Employees, who paid tribute to 'his vision and drive which enabled him to win such notable reforms for mental hospital and institution workers - and for patients too'. C. Bartlett, quoted in the *Health Services Journal*, 6 (1953) p. 4.

to 10,600 in 1926. By August 1930, when the NAWU renamed themselves the Mental Hospital and Institutional Workers' Union (hereafter the MHIWU), membership had increased to 12,488. During the 1930s, pay and hours only slowly improved as unemployment throughout the country remained high, but by 1942 the Union had 24,078 members.⁷ In 1943, the Rushcliffe Committee report established a national scale of wages for nursing and in 1946 the MHIWU federated with the Hospitals and Welfare Services Union to form the COHSE, with a combined membership of 40,000. Unrest stirred again in the 1950s as recruitment to mental nursing declined and the COHSE struggled to negotiate better rates of pay and less overtime for mental nurses, organising demonstrations. In 1955, the COHSE members picketed the Mental Health Exhibition, which was intended to tour the country, promoting the NHS. Health Minister Enoch Powell's plans to run down many of the mental hospitals in 1961 led to heightened anxiety among many psychiatric nurses who feared losing their jobs.

2: Using the Journal as a Source

The NAWU was a product of the poor working conditions of asylum workers in 1910. It is not surprising to find that its objects, as listed in the front cover of the journal, were orientated towards working conditions, not conditions for patients:

Objects - to obtain by legislation improvement of the status of asylum workers, reasonable hours of duty and of freedom, fair rates of wages, abolition of

⁷ For a history of mental nurses' trade union activities, from the NAWU to the Confederation of Health Service Employees, see Carpenter, *Working for Health*.

vexatious restrictions and other grievances, and a better regulation of the relations between employers and employed; and to assist members if wrongfully dismissed, and to provide legal aid when necessary, and to promote the welfare of asylum workers generally.⁸

The journal in its early format was strongly socialist, fighting for its subscribers as members of the working class and attacking authority figures, especially superintendents, whom they viewed as over paid and over privileged. Membership of the rival Asylum Workers' Association was seen as class betrayal. As the situation of asylum staff slowly improved, the Union extended its horizons to incorporate other aspects of their work apart from their salaries, and the conditions in which the asylum patients lived came under closer scrutiny.

The content, format and distribution of the journal underwent radical changes from the formation of the NAWU in 1910 up into the 1960s. Initially intended to cater for under 8,000 mostly male asylum attendants, in 1946, the journal began to incorporate the concerns of the former Hospitals and Welfare Services Union. By 1963, membership of the COHSE (and readership of the journal) stood at 67,000, reflecting for the first time a predominance of women members.

This chapter examines the representation of the mental patient around three groups of issues: first, the early struggles of the Union for recognition and the issues arising with the 1930 Mental Treatment Act; second, the period around the Second World

⁸ *NAWU Magazine*, 1 (October, 1912).

War, establishment of the NHS and foundation of the COHSE, and finally the period from the Mental Health Act of 1959 to 1963. All these periods can be viewed as landmarks in the treatment of mental illness in the twentieth century: this chapter examines how these events affected the way in which a psychiatric nursing union represented users of the mental health services.

The Union's journal was described as the official organ of that body, created to represent the views of the organisation to its readership. Most of the time, that readership would consist of its members, although contributions to the journal from MPs, doctors and pressure groups indicate that individuals outside of the Union were reading its publication. A debate on the format and distribution of the journal in 1934 suggests that Union members were aware of its limitations. 'Onlooker' (Mr H. Noble) notes that those who 'mattered' - presumably other people with an interest in mental health care - could get hold of a copy but 'as for the "general public", in so far as this refers to newspaper readers I do not think there is much scope for distribution. Is there, for instance, anyone who, not directly interested, would buy the "Draper's Record".' Noble suggested that a series of talks could be given at local clubs by Union members on issues affecting mental nurses.⁹ Perhaps then the journal could be seen as a forum for debating and defining issues that could then be publicised by individuals outside of the journal.

'A Satisfied Reader' ridiculed the idea that the journal could exert a wide influence: 'Apparently some of your members labour under the delusion that a small and

⁹ *MHIWU Journal*, 23 (January, 1934), p. 14.

necessarily technical Journal such as ours can have an effect on public opinion outside the service.’¹⁰ The representation of the public in the pages of the journal as an ignorant mass in need of enlightenment reflected not so much the actual state of public opinion but the union’s perception of public opinion regarding mental illness and its treatment. For example, A J. Goundry used the correspondence column in the *MHIWU Journal* in 1931 to express his concerns that the attitude of the ‘general public’ to mental nursing was outdated and ill informed. ‘What an eye-opener for the outside public if the arduousness and extreme difficulty of the work...could be put before it by a noted journalist of the press. The general public does not know enough of the more difficult type of nursing - mental nursing. As a matter of fact, a distorted view is often held...’.¹¹

Assigning authorship to articles within the journal is problematic. Apart from the very first issues edited by the Rev H. M. S. Bankart (until his resignation in 1913), the journal was edited by the Assistant General Secretary Herbert Shaw, probably until his resignation in 1946. The editor of the journal from this point is unclear: in 1963 the journal advertised for a full time journal editor and publicity officer. Some articles were contributed by members of the National Executive Council (hereafter NEC) to explain policy to the members, other articles were contributed by members of the branches. Still more were reports of mental health issues clipped from other publications and reprinted in the journal. The correspondence column also provided another forum for views,

¹⁰ *Ibid.*, p. 15.

¹¹ *MHIWU Journal*, 20 (March, 1931), p. 3.

although controlled by the editor. Thus the reaction to what Union members perceived as public opinion regarding mental illness was diverse.

3: Patients Viewed from Male Nurses' Perspective

Cutting nails, chronic males,

Courtyard evolution:

You bet you can get 'bumped off' at

A mental institution...¹²

Early representations of asylum patients were haphazard, usually deployed by the Union to advance conditions of attendants, and not those in their care. Not that an outwardly hostile attitude to the patients was taken: an article ironically entitled 'A Patient's Paradise' described the hard physical labour expected from patients and the poor food they received in return. A further article in the same issue described the poor food given to patients because medical superintendents preferred to spend money on the outward appearances of the asylum, inciting Herbert Shaw to make a sardonic comment: '[Why do the patients need good food? They aren't Superintendents.- Editor].'¹³ The very first editorial of the journal commented: 'we seriously maintain that if the Lord Chancellor and the Lunacy Commissioners are sincerely anxious for the welfare of the patients, the

¹² From 'The Song of the Charge' by a correspondent from Fishponds, *MHIWU Journal*, 23 (August, 1934), p. 6.

¹³ *NAWU Magazine*, 2 (May, 1913), pp. 65–67.

very first thing to which they should turn their attention is to see to it that the conditions of asylum service are such as to attract and retain the best types possible of men and women...they allow the public money to be wasted...in giving medical superintendents huge salaries.’¹⁴ Dingwall, Rafferty and Webster note that early in the twentieth century, asylum attendants in the pauper asylums ‘shared the conditions of the patients. Both were equally subject to the same complex web of rules and to the expectation of automatic and unquestioning obedience.’¹⁵ These early critiques on behalf of the patients may indicate how the poor working conditions of attendants led them to sympathise with the patients.

A more usual strategy adopted by the NAWU at this time to obtain improved conditions and pay, however, was to focus on the unpleasantness of the patients. Complaining of the visiting committees of asylums in 1912, the writer noted ‘asylum staffs have quite enough to do to attend to the antics of deluded and degraded “mental-deficients” and moral perverts under them’.¹⁶ Frequently, the nurse was described as having to ‘manage’ or pacify these difficult patients through an astonishing array of

¹⁴ *NAWU Magazine*, 1 (October, 1912), p. 3.

¹⁵ L. Dingwall, M. Rafferty and C. Webster, *An Introduction to the Social History of Nursing* (London, 1988), p. 127.

¹⁶ *Ibid.*, p. 9. The reference to moral perverts was perhaps an allusion to the category of ‘moral imbeciles’, described in the standard mental nurses’ handbook as ‘persons who from an early age display some mental defect coupled with strong, vicious, or criminal propensities on which punishment has little or no detrimental effect’: MPA, *Handbook for Attendants on the Insane* (London, 1908), p. 216. By adding the term ‘pervert’ onto the phrase, the writer managed to convey an impression of sexual depravity, perhaps reflecting how some nurses viewed this category of patient.

personal qualities. 'The staffs at asylums', argued one correspondent in 1913, 'have to exercise...the caution of a lion tamer, the cunning of Sherlock Holmes; they have to cajole, wheedle, threaten, persuade, fascinate, charm, captivate, pacify, soothe, calm, appease, relieve, discipline, coax and humour the patients'.¹⁷ In this article, the patient was represented as alien, foreign, devious and different from normal people, in need of management. This idea of how to handle patients could have been drawn from attendants' training: in the main text for training attendants, the terms 'nursing' and 'management' or 'control' of patients appear to be interchangeable.¹⁸ The use of the metaphor of a lion tamer adds an air of animality to the inferred description of the patient. Nor had things radically changed by 1929 in a description of the job of the mental nurse, when it was claimed that 'her patients may be unpleasant, abusive, filthy in habits and language, or ungrateful, suspicious, unwilling and resistive...her sympathy, kindness and tact must be abundant to overflowing for a mental patient...is amenable to nothing else...'.¹⁹

Arguments were put forwards in the journal that attendants' calls for better wages and conditions were justified due to the violent and anti-social behaviour of the patients. An attendant's response in the correspondence section to an earlier 'joke' article about the slothful life of the asylum attendant bitterly attacked his work, and the patients at the heart of his job:

¹⁷ *NAWU Magazine*, 2 (May, 1913), p. 3.

¹⁸ MPA, *Handbook for Attendants on the Insane*, pp. 335-6.

¹⁹ *NAWU Magazine*, 18 (March, 1929), p. 2.

We have such fun, washing and dressing the patients, often belching in one's face and worse...in some asylums...they have an endless amount of fun provided by patients wandering round the table, falling in fits, and occasionally throwing a spittoon onto the table...then...the bedding of the patients. Oh! The fun we have; it makes our sides split - undressing, bathing, pulling, struggling; it really is delightful. Then sometimes we get a black eye, a kick on the shin, or a tooth or two knocked out.²⁰

In this article, the writer did not depict the patients as ill, but as violent and anti-social. An article from 1928, meanwhile, responded to allegations of staff brutality by reporting how an attendant had been attacked by a patient:

The nurse was knocked unconscious and the patient lifted the chair to strike another, and perhaps, a fatal blow, when the patient playing cards sprang to the rescue...The nurse had to have six stitches in his head...These are the everyday 'emoluments' of the mental nurse which are not advertised by those critics of the service whose principal concern is to expose the alleged 'brutality' of the mental nurses.²¹

In this article, two conjectures were placed in the account; that the next blow from the patient would perhaps have been fatal, and that such events were 'everyday'. These phrases help shift the meaning of the story to fit the desired conclusion - that any

²⁰ *NAWU Magazine*, 2 (May, 1913), p. 2.

²¹ *NAWU Magazine*, 17 (March, 1928), p. 9. This article was satirically entitled 'More "Emoluments"', a reference to the earlier tradition of paying part of the attendant's wages in goods or services.

individual undertaking such work deserved better conditions and pay, not because they were skilled professionals but because they managed dangerous, violent inmates.

In 1920, violent and anti-social patient behaviour was emphasised and given a specific meaning by the NAWU in a battle reflecting the composition and power structure within the organisation. Although by the end of 1920 women's membership had increased to almost 46 per cent of the total membership,²² the NEC delegates to the annual conference and branch executives were almost entirely male. It also appears that the authorship of the journal was dominated by men. Women's employment on the male wards of mental hospitals, a practice introduced during the war to combat the shortage of manpower but continued by some medical superintendents afterwards,²³ met with disapproval from men within the Union. The gender imbalance of power within the Union became clear as men, deploying the journal, attempted to contend that their view was held throughout the Union by men and women.

Virtually every month in 1920, the issue of women nursing on male wards was attacked through the auspices of the journal. Arguments focused on the 'depraved' behaviour of male patients and the supposed vulnerability of female nurses to violent

²² Carpenter, *Working for Health*, p.75.

²³ The system was advocated by some psychiatrists, most notably George M. Robertson, who argued that the insane were ill rather than deviant and thus required the attention of female nurses, naturally skilled at nursing because of their mothering instinct, rather than male attendants to control their antics. This formed part of Robertson's plan to 'hospitalise' the asylum. See G. M. Robertson, 'The Employment of Female Nurses in the Male Wards of Mental Hospitals in Scotland', *JMS*, 62 (1916), pp. 351-62.

attacks from male patients. In a long article in the January edition, Secretary George Gibson quoted from the *Handbook for Attendants Upon the Insane* all passages relating to 'self indulgence', 'indecent conduct', 'filthy and dirty habits' and dangerousness posed by (male) patients to (female) staff to condemn the 'revolting' and 'degrading' system of female nursing of male patients. '...And it must not be forgotten that many seemingly quiet patients are, at times, liable to become dangerous to themselves and others.'²⁴ Taking these quotes out of context, stacking them next to each other, adding differentiating type fonts and sarcastic comments, and attaching them to an agenda all helped to create a stigmatising image of the male patient and the female nurse who would choose such a job:

' . 344- ...Bad sexual practices are, unfortunately, *common among the insane*, and ought to be prevented as far as possible. The possibility of *any* patient indulging in bad habits should be borne in mind, *and a constant watch for signs should be kept up.*'*

**Surely a nice occupation for a girl?*²⁵

As the quote was placed in an article on male patients, the reader would automatically assume that the quote referred to male patients only, although it was actually gender free. Moreover, by choosing to emphasise the words 'common among the insane', Gibson tainted all male patients, while the aside comment, by implication, attacked the reputation of any woman who chose to undertake the work. Instead of allowing women or 'girls' to

²⁴ *NAWU Magazine*, 9 (January, 1920), p. 8.

²⁵ *Ibid.*, italic type in original text. Starred comment by George Gibson.

Speak out against the practice (because, perhaps, he could not find any willing to), Gibson used paternalistic language to speak for them:

There is no medical superintendent, nor any male member of the Board of Control, who would *permit* wife or daughter to undertake such work, and having equal *reveration* for all women, I protest emphatically against the employment of female labour in the male lunatic wards of the asylums.²⁶

The NAWU actively encouraged its members to send copies of the articles to the local press, and suggested that branches contact local associations of discharged soldiers and sailors to 'acquaint them with the fact that the continuance of this system of female nursing in asylum wards is depriving many ex-servicemen of the opportunity of securing employment in a public service'.²⁷ This strategy met with some success. In Wakefield, a joint protest was organised between the NAWU and the local ex-servicemen's branch, which stressed both the unsuitability of women for the work, and the fact that their employment in male wards was depriving discharged servicemen of work. *John Bull* also picked up on the story, attacking the practice of female nursing in male wards after reading the NAWU journal 'in whose columns the revolting nature of the duties involved are emphasised with lurid force'.²⁸

The NAWU centred their arguments about female nursing of male patients on a particular view of the nature of insanity. For George Robertson and other psychiatrists,

²⁶ *Ibid.*, p. 9. Italic type in original.

²⁷ *Ibid.*, p. 8.

²⁸ *NAWU Magazine*, 9 (February 1920), p. 9. Reprinted from *John Bull*, issue and page numbers not given.

the insane were sick patients who would respond to the maternal instincts of skilled female nurses by exercising restraint and self-control. However, in the view of Gibson and his colleagues, they were in fact violent, anti-social misfits. The only effect that the female touch would have on such patients would be an increase in their violent and sexually depraved behaviour. Moreover, female nurses who engaged in such work were not viewed as professional and skilled hospital nurses, but instead as morally degraded by the dirty work they had undertaken. Throughout the year, the male writers on the journal launched an unremitting campaign to remove women from male wards by attacking the character of such female nurses and labelling male patients as violent and sexually depraved.

The *Nursing Times*, a paper dominated by women, was cited in opposition to the NAWU. It was quick to see a different side to the argument: 'we confess to a feeling of great distrust when we hear of complaints by male attendants in asylums of the "demoralising" influence of women nurses in male wards. Why this solicitude for the women?...Not a single complaint of any kind has been made by the female nurses.'²⁹ The NAWU failed to find any female nurses to censure the system, although several wrote in attacking the Union for criticising the character of such female nurses, accusing the men of 'selfishness and jealousy', and of branding the profession a degradation.³⁰ The Union also linked recovery rates and a patient suicide to the practise of female nursing on male

²⁹ *NAWU Magazine*, 9 (February, 1920), p. 2. Reprinted from the *Nursing Times*, issue and page number not given.

³⁰ *Ibid.*, p. 11.

wards, effectively attacking the nursing standards of their female members. One female critic perceptively commented on the harmful stigmatisation of male patients that the NAWU was undertaking: 'It is an insult to a great number of patients to infer that all mental cases are depraved.'³¹ However, while the existence of a counter-discourse amongst attendants should be acknowledged, it is also important to recognise that this alternative view may not have had much influence.

When the depiction of male patients as violent and sexually perverted was no longer in accordance with the new representations of the mentally ill that the Union were trying to establish, the image gradually disappeared from view. This confused long serving mental nurse C. H. Bond, writing in 1948, who was shocked that a reversal of Union policy had taken place at the previous annual conference: 'Surely some of our old London District Council members remember the evidence produced by female mental nurses before the London County Council Mental Hospitals Committee, referring to the degradation being imposed upon females nursing male mental patients?'³² The issue finally died away in 1959, when a motion to bar women from nursing in male wards was overturned at the annual conference. Proposer Mr Higgins claimed 'a female nurse working on male wards would be a witness to degrading scenes by chronic patients'. However, this image of the patient was seen as embarrassingly dated and a threat to the professional image the Union was then trying to create to most of those present, Mr Barry

³¹ *NAWU Magazine*, 9 (September, 1920), p. 14.

³² *Health Services Journal*, 1 (January, 1948), p. 10.

describing the resolution as 'restrictionist and...as obsolete and outmoded as the padded cell or straitjacket'.³³

Parallel to the debate over the issue of women nursing on male wards, the NAWU discussed the allegations of cruelty by attendants made in the journal *Truth* by a former patient who had been invalided from service after a nervous breakdown. This article belonged to the genre of tales of wrongful confinement and violent staff that had figured so prominently in the *Pall Mall Gazette*.³⁴ However, the story attracted more attention as it was written not by an ordinary discharged patient but by an individual who had been treated for shellshock. The article in *Truth* depicted the mental hospital as a place of incarceration where 'inmates' were 'detained' by 'brutal and ignorant warders' or 'gaolers'.³⁵ The writer of this article based his argument on the contention that insanity was a form of sickness that would respond to medicalised treatment in hospital settings. In the article, the writer depicted shell-shocked cases as patients suffering from an

³³ *Health Services Journal*, 12 (July-August, 1959), p. 23.

³⁴ For examples of wrongful confinement articles, see 'Legal Difficulties in Cases of Alleged Lunacy', *Pall Mall Gazette*, 8 June 1870; 'Certificates of Lunacy', *Pall Mall Gazette*, 31 May 1870. For examples of tales of staff cruelty, see 'The Treatment of Lunatics: its Known and Permitted Horrors', *Pall Mall Gazette*, 15 January 1870; C. Reade, 'How Lunatics' Ribs Get Broken', 20 January 1870; 'In a Lunatic Asylum', *Pall Mall Gazette*, 9 May 1870.

³⁵ Anonymous, 'Army Mental Hospitals: A Little Light on a National Scandal', *Truth*, 87 (January 1920), pp. 95–97. Quoted on pp. 96, 97. The author described the mistreatment of shellshock patients, but argued that the same conditions applied to pauper lunatics who were cared for in the same institutions by the same staff.

incipient stage of mental disease who needed to be restored to health. Violence was abundant again in this narrative: yet here, the violence was ascribed not to the sick patients but to the male attendants. The author of the piece referred to the 'variety of forms of physical violence' used by attendants to control patients. Those described in the article included throttling, half drowning, hitting the back of the patient's head against the floor, and what the author referred to as 'obscene methods of torture the nature of which I can only leave to the imagination of the reader'.³⁶ These allegations of cruelty were restricted to male nurses. The author argued that 'it is by no means certain that women nurses would not be quite capable of looking after many, if not the majority, of the cases, and that patients would not be better off in their hands'.³⁷

In February 1920, the NAWU responded to the allegation in their journal in an article entitled 'Truth and Exaggeration'. The Union rejected the allegations, pointing out that nurses faced severe penalties for assaulting a patient, and arguing that patient testimony was unreliable. Despite denying the allegations, the NAWU writer felt it necessary to provide some excuses for poor nurse behaviour, citing 'the provocation which may be received...maybe only those who have been engaged in attendance upon the insane can fully appreciate'.³⁸ The NAWU also blamed 'the confinement of nurses within asylum walls in the atmosphere of insanity for 80 to 100 hours per week'.³⁹ The NAWU response failed to stem the tide of people writing to *Truth* with their own

³⁶ *Ibid.*, p. 97.

³⁷ *Ibid.*, p. 96.

³⁸ "'Truth" and Exaggeration: Mental Hospital Treatment', *NAWU Magazine*, 9 (February 1920), p. 6.

³⁹ *Ibid.*, p. 6.

allegations of neglect and abuse suffered at the hands of asylum nurses, in spite of a NAWU publicity stunt, when George Gibson invited a journalist from the *Sunday Chronicle* to look round another military mental hospital and report favourably on it.⁴⁰ The focus of reports in *Truth* remained upon the discharged servicemen contrasting 'admirable hospitals' in Kensington where 'the nursing was in the hands of skilled women nurses' with the 'dark cells and padded room of the lunatic asylum, with brutal warders cowing the unfortunate occupants by physical force, to which the NCOs and men were condemned after their nervous systems had been wrecked by exposure to an unheard-of strain'.⁴¹

The media flurry that was generated by George Gibson's condemnation of women nursing male patients illustrates how a sub-public group, motivated by professional (private) concerns, could trigger a debate on the nature of mental illness within the general media, ostensibly as a result of rational critical debate and in the interests of the general public. Treatment of the issue within the specialised media of the *NAWU Magazine* was followed by further coverage in local and general press. Perhaps what was more difficult to control was the direction and impact this might have. Diane Gittins, in her work on Severalls hospital, has discussed popular fears of the polluting powers of the mad and madness and suggests that those who worked with the mentally ill were

⁴⁰ This publicity stunt may in fact have been counter-productive, as *Truth* in a subsequent article related the story of Mrs X., who alleged that her ex-soldier husband had been subjected to brutal treatment in this same institution. See 'The Lord Derby War Hospital', *Truth*, 87 (February 1920), pp. 235–6.

⁴¹ 'The Mental Hospital Scandal', *Truth*, 87 (February 1920), pp. 183–5. Quoted on p. 183.

perceived to be contaminated by association.⁴² Male nurses writing in the journal emphasised how the polluted identity of male patients could contaminate female nurses, enforcing the stigma of the mentally ill and their carers in the public mind. Male patients, and to a lesser extent, female nurses, were used as voiceless targets, victims of harmful representations, to further the professional aims of male nurses. It is interesting that in the debate surrounding the alleged mistreatment of shellshocked patients, some of the themes that emerged in the first debate relating to touch, insanity, nursing, and violence were deployed in an article that looked at the reverse issue of men nursing men. This may reflect the observation made by Jenny Kitzinger that the way in which a topic is covered may frame the way that future similar events are discussed and represented in the media.⁴³ Factors arising from the First World War played a part in creating and shaping these debates. The shortage of available male staff promoted discussion amongst psychiatrists of the system of female nursing on male wards. Peter Barham has recently suggested that the First World War aroused public concern for the plight of the shellshocked soldiers and demands for their proper treatment as citizens and not

⁴² D. Gittins, *Madness in its Place: Narratives of Severalls Hospital 1913-1997* (London, 1998), pp. 21-24 and pp. 48-49.

⁴³ J. Kitzinger, 'A Sociology of Media Power: Key Issues in Audience Reception Research', in G. Philo (ed.), *Message Received: Glasgow Media Group Research 1993-1998* (Harlow, 1999), pp. 3-20. Kitzinger makes this point while discussing how coverage of the Cleveland social work scandal helped shape the representation of later sexual abuse / social work scandals, such as Orkney, p.10.

paupers.⁴⁴ In *Truth*, it was the figure of the ex-serviceman and not the pauper lunatic who attracted sympathy and respect. Meanwhile, the NAWU argument against female nursing was based partly on an appeal that women were depriving ex-servicemen of jobs. A contested view of the nature of insanity underpinned these stories. Insanity was viewed by some psychiatrists and the journal *Truth* as a form of illness, therefore requiring skilled, hospital-trained female nurses, imbued with maternal instincts, to treat the sick patients. The use of skilled female nurses, it was believed, would negate the risk of violence towards the male patient that was always a risk when male attendants were employed. However, for other psychiatrists and the male leaders of the psychiatric nursing trade union, insanity was portrayed as a form of social deviance and loss of control. The introduction of female nurses to male wards would only produce exhibitions of sexual deviance and violence that women would not be able to control.

Not only did these images of male patients fail to represent the interests of patients, but they also failed to serve the interests of all Union members. The balance of power between men and women in the Union was reflected in the hostility expressed towards women in positions of authority. Attacks on the character of matrons through the pages of the journal was prolonged and bitter. In 1913, a male correspondent to the NAWU journal attacked a matron who had ordered a male attendant on duty: 'this sort of thing should be put a stop to, and she should be kept in her place by the medical officer,

⁴⁴ P. Barham, 'The English Mental Patient in the Twentieth Century: Continuity and Discontinuity', unpublished conference paper from the Anglo-Dutch-German Workshop on Social Psychiatry and Ambulant Care in the 20th Century, 4–6 July 2002.

and not allowed to use her opinion'.⁴⁵ A motion appeared on the 1930 conference agenda attacking the authority of matrons over male staff in Mental Hospitals, while a lengthy attack on matrons, which extended to attack women more generally, appeared in 1942. The author blamed the poor working conditions in many mental hospitals upon matrons, arguing that 'the inability of most women to take positions of responsibility and behave with human tolerance to subordinates of their own sex was no small part of the problem'. What was allegedly written in defence of victimised female nurses subject to the whim of the matron was in fact an attack on female nature. Another backhanded insult was aimed at women when the writer claimed 'it is gratifying to see our female colleagues at last realising the need of organisational action', suggesting women were too slow to see the advantages beforehand. Perhaps it was unsurprising that more women at that particular branch had chosen not to join the Union.⁴⁶ An impression of female nurses' attitudes towards the MHIWU can be gleaned from a letter written in 1936 from a nurse who had been assisted in a legal case by the Union. Although she thanked the Union for the help received, the nurse added 'frankly, I had begun to begrudge paying my monthly subscription as I nursed a suspicion that female nurses were inadequately catered for'.⁴⁷ As with the male patients, who allegedly suffered at the hands of female nursing, the male executive of the NAWU claimed to represent the interests of an injured party (female nurses), only to portray them in a very derogatory light in order to gain benefit for themselves.

⁴⁵ *NAWU Magazine*, 2 (May, 1913), p. 9.

⁴⁶ *Mental Health Services Journal*, 31 (November-December, 1942), p. 23.

⁴⁷ *MHIWU Journal*, 26 (November, 1936), p. 11.

4: Representing the Interests of Staff or Representing Patient Interests?

4.1: Representing Mental Deficiency

As one of the main group of workers responsible for the care of patients diagnosed as mentally defective, the NAWU became involved in the broad debate about the social problems posed by such individuals.⁴⁸ From 1929, the journal played host to reports from Boards of Guardians and County Councils who passed resolutions urging the government to consider sterilisation of mental defectives. One such report from the West Riding County Council utilised the image of difference to justify its call. Sterilisation would ‘stop the propagation of a species which, if continued, would in time be an enormous burden to the ratepayers’.⁴⁹ The mental defective ‘species’ were depicted as an (economic) threat to the sane ratepayer. Similar concerns were expressed in the law courts. The journal reported several speeches made by judge Henry McCardie.⁵⁰ In one of

⁴⁸ For an examination of the factors which led to the emergence of mental deficiency as a social problem, and an analysis of the debates that ensued regarding potential solutions, see M. Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy, and Social Policy in Britain c.1870–1959* (Oxford, 1998).

⁴⁹ *NAWU Magazine*, 18 (August, 1929), p. 3.

⁵⁰ McCardie appears to have been a somewhat controversial figure who was convinced that ‘the consideration of social problems, as well as that of the judicial precedents, should form part of the tools of the judge’s trade...he delivered himself freely of all sorts of aphorisms on many burning topics of the day. This habit was by no means always popular.’ L. G. Wickham Legg (ed.), *Dictionary of National Biography 1931–1940. With an Index Covering the Years 1901–1940* (London, 1949), p. 559.

his pronouncements about the dangers posed by mental defectives to the community, McCardie opined:

I am appalled at the breeding of mental defectives that is going on throughout the country. It is a curse on the nation...unless steps were taken, either by greater measures of segregation or by sterilisation, the hideous process of multiplying the mentally unfit would go unchecked, and an army of mental defectives, which now numbers 400,000 would increase daily and almost hourly.⁵¹

The image of the 'army' of the mentally unfit not only suggested opposition but active danger.

Such negative imagery was not always tied to calls for sterilisation. The Board of Control was itself dubious that mass sterilisation would effectively reduce the number of mental defectives. However, a description by the Board on the nature of mental defectives stressed their anti-social nature, framing their disorder in terms of lack of social conformity and loss of self-control, not illness:

The majority of defectives cannot support themselves, many cannot resist criminal impulses, and others, though not actively dangerous, are a menace to the community, because they have no idea of truth or social obligation, and because they cannot keep themselves decently clean or observe the simplest rules of personal hygiene. Some have so little self-control that they are apt to moments of excitement to attack others and to commit crimes of violence, including arson.

⁵¹ *NAWU Magazine*, 19 (August, 1930), p. 1.

Many are sexually unrestrained or perverted, and are a constant danger to women and children. Anti-social tendencies and habits of this kind are not to be cured or even lessened by sterilisation.⁵²

This emphasis on the dangers posed by mental defectives to the safety of the community should be understood as a justification of the Board's policy of ascertaining and institutionalising as many defectives as could be detected in the community, as discussed by Louise Westwood in her DPhil thesis.⁵³ Six years later the Board of Control described mental deficiency as 'social failure' of the individual. Mr L. G. Brock, the chairman of the Board of Control, discussed the 'grave problems' entailed by 'the aggregation of the socially inefficient, estimated at 300,000'. The MHIWU cartoonist, 'Barlow', chose to depict Mr Brock's views with a full-page image of a physically deformed figure, whose featureless 'shadow' fell menacingly over Britain. This represented the belief that the mentally defective were often physically as well as mentally stunted. Barlow's decision to represent the defective as featureless emphasised the concerns that the mentally defective were difficult to identify, ascertain and segregate. By gendering the figure as male and not female, Barlow played to concerns that male defectives posed a danger to women and children. The figure was represented with palms outstretched, recalling the belief expressed by doctors, judges, poor law guardians and the Board of Control in the journal that mental defectives were socially inefficient and an economic drain on the normal population.

⁵² *NAWU Magazine*, 18 (October, 1929), p. 2.

⁵³ L. Westwood, 'Avoiding the Asylum', pp. 138ff.

OUR MONTHLY SPECIAL CARTOON.

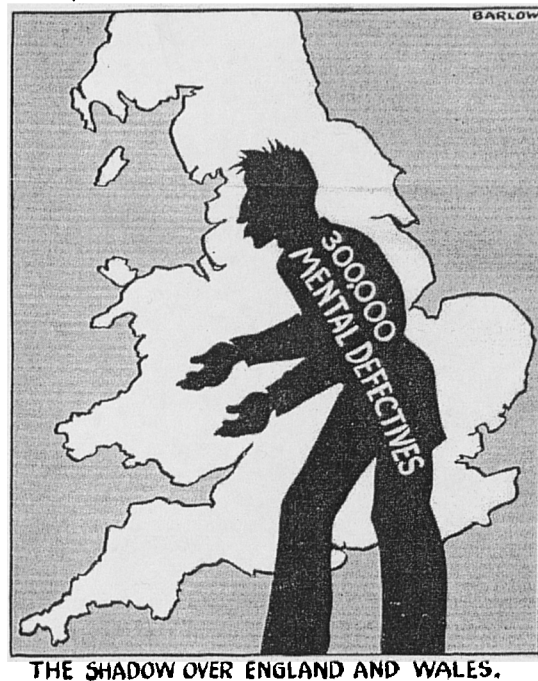


Figure 1: Barlow, 'The Shadow Over England and Wales', *MHIWU Journal*, 24 (July, 1935), p. 9.

Doctors who wrote in favour of sterilisation in the journal sometimes highlighted their duty to society. Professor John Cooke of Trinity College, Dublin argued that 'the right of the state to prevent imbeciles and hopeless degenerates from propagating their species can hardly be questioned'. In the most extreme argument which the journal chose to publish, Dr E. G. L. Goffe, a Kingston physician, was reported as saying 'As regards idiots, I cannot see any other alternative but the lethal chamber...it seems to me that such people should not be a drag on the community...it is a waste of money and energy to keep them alive'.⁵⁴ This argument was echoed in 1934 by Professor J. A. Berry, the director of

⁵⁴ *NAWU Magazine*, 19 (September, 1930), p. 2; (November, 1930), p. 5.

medical services at Stoke Park Colony in Bristol, who under the guise of humanitarianism, argued that some of those in his care should be killed:

It was difficult for anyone who saw these human mental monstrosities almost every day to understand why society took such extraordinary pains to keep them alive. 'With complete absence of all human qualities or intelligence', he said, 'they have to be clothed, fed, housed and waited on hand and foot at the nation's expense, and one wonders why. Surely a kindly euthanasia is the only really kindly treatment for this pathetic side of mental deficiency.'⁵⁵

The use of inverted commas in the title given to this piece by the MHIWU editor Herbert Shaw suggests that the Union saw Berry's humanitarian argument as a veil to hide his true interests: the article was entitled "'Kindliness' of Euthanasia'.

The first NAWU member to use the journal to comment on the sterilisation debate was Mr H. Noble, who also wrote articles on the physical improvement of Hospital buildings for the benefit of the patients, and could thus be seen as an advocate of patient welfare. Noble engaged in a debate via correspondence with Dr N. Montgomery of Storthes Hall Mental Hospital on the issues of sterilisation and economics.⁵⁶ The debate was started by Dr Montgomery, who wrote into the journal attacking the claims of those who asserted the right to sterilise the mentally deficient, making an argument that mental

⁵⁵ *MHIWU Journal*, 23 (August, 1934), p. 11. Michael Burleigh has examined how humanitarian arguments were used to justify the killing of psychiatric patients in the T4 program in Germany: M. Burleigh, *Death and Deliverance: 'Euthanasia' in Germany 1900-1945* (Cambridge, 1994)

⁵⁶ Almost certainly, this is Dr Neil Montgomery, who wrote the revised and enlarged edition of *Notes for the Mental Nurse in Training*, published by the MHIWU and still in press by 1941 (no publication date found).

defectives made an important contribution to the economy. In response, Mr Noble argued: 'the mental deficient certainly do produce one thing in abundance for which there are no buyers, viz, trouble. When they have reproduced themselves ad infinitum they will be in the majority.' In the next issue of the paper, Dr Montgomery noted that mental defectives produced:

A living, and a more or less congenial occupation for such people as Mr Noble (I presume) and myself. No doubt, were they all painlessly exterminated we should manage to pick up another job somewhere...but we are all too apt to forget that while we take the money which reaches us solely on account of the insane, we are their servants, and neither their judges nor their executioners.

Having expounded a philosophy of duty of care to those under his charge and a sense of interdependency of employee and patient, Dr Montgomery finished his letter by emphasising an element of class power.

As for sterilisation...it is sure to be tried out first on the poor, who are less capable of resisting than the rest of us, especially if they happen to be pauper imbeciles. Blessed are the poor, for they shall be rendered sterile and aseptic and innocuous, and great shall be their glory in the servile state.

It is surprising to find these sentiments of duty to the patient and awareness of class power abuse issuing from the doctor, and not the member of a working-class trade union.⁵⁷

⁵⁷ Dr N. Montgomery, *NAWU Magazine*, 18 (September, 1929), p. 16; H. Noble, (October, 1929) p. 12, and Dr N. Montgomery, (November, 1929), p. 11. The class-based concerns of the early eugenics movement in Britain have been examined by G. R. Searle, *Eugenics and Politics in Britain 1900-1914* (London, 1976), pp. 45ff.

Mr Noble's next letter suggested disillusionment with asylum work, caused perhaps by years of experience within the service:

I base my opinion solely on my observations during my service with mental cases. The large percentage that can trace their trouble (or rather, other people can) to hereditary causes, and the number who are discharged as cured but who return eventually, very often after begetting another generation of mentally deficient....⁵⁸

The next nurse to join the debate was Alec Flanagan, one of the most vocal members of the Union who frequently put forward resolutions at the annual conferences of the Union. He adopted a very different view to Mr Noble, emphasising how advocates of sterilisation had hijacked the mental nurses' journal without any protest, perhaps recognising that nurses had only started to debate the issue once the topic had been introduced by a doctor. 'Articles under the heading "sterilisation" have appeared from time to time without causing the controversy one would expect...While we of the mental nursing profession look on, others are propagating their theories...'. Noting that public health committees were lobbying the government to make sterilisation legal, Mr Flanagan commented: 'Forces are massing beneath a banner whose motto is apparently "sterilisation first; realisation afterwards"'. Having attacked the scientific basis of the arguments for sterilisation, Mr Flanagan proceeded to attack the ethical basis for sterilisation, demonstrating a humanitarian concern for those in his care:

⁵⁸ H. Noble, *NAWU Magazine*, 18 (December, 1929), p. 12.

This operation means the mutilation of an individual who surely has the right to life and bodily integrity...the defective has committed no crime by being born as such: surely, it is his misfortune, and as such he desires and needs the care and protection of his fellow beings.

Like Dr Montgomery, Mr Flanagan, a keen trade unionist, seemed aware of the class bias inherent in the proposals of the eugenicists, and empathised with the patients: 'one begins to wonder if this is not something like class legislation under a new name'.⁵⁹

Flanagan's initial letter triggered twenty responses from nine different nurses, four in favour of sterilisation and five opposed. H. C. Tusker reinforced the stigma of the 'mentally deficient' (and potentially nurses in contact with them) by emphasising their sexual depravity as an individual failing occurring at the expense of the state, and arguing that they should be compulsorily sterilised.⁶⁰ A very different approach to the issue was taken by E. Carnell, who stressed the ability to prevent and treat dementia praecox (schizophrenia): 'Mental disease is a product of a social condition, and can therefore only be explained by that condition. Insanity, like crime and prostitution, should be treated, not as an individual disease, but as a social relation.'⁶¹ Tusker had chosen to situate the problem and blame of mental deficiency within the body of the individual, suggesting that the interests of the state ran counter to the 'undesirable species'⁶² of the mentally

⁵⁹A. Flanagan, *NAWU Magazine*, 19 (December, 1930), p. 10.

⁶⁰*MHIWU Journal*, 20 (January, 1931), p. 10.

⁶¹*MHIWU Journal*, 20 (March, 1931), p. 10.

⁶²The phrase 'undesirable species' is drawn from a letter by another nurse advocating sterilisation of the mentally defective: 'Anti-Cant', *MHIWU Journal*, 20 (March, 1931), p. 11.

defective. Carnell instead de-emphasised the role of biology in mental deficiency by examining research into the social causation of schizophrenia, and suggesting that society and not the individual produced mental disorder. By using schizophrenia as an example, Carnell conflated mental deficiency with other forms of mental disorder, de-emphasising the otherness of the mental defective. These arguments against sterilisation were linked by Flanagan to an ethos of nursing that sought to restore the patient to society: 'to mention segregation as an alternative to sterilisation only shirks the other eugenic aim, the lethal chamber, and totally ignores the more humane and practical methods of socialisation'.⁶³

At least one nurse stepped beyond the issue of sterilisation to contemplate the killing of those in their care. Writing in the column 'Things We Would Like to Know', the correspondent asked 'who will have the courage to recommend the lethal chamber for those suffering from hopeless insanity accompanied with physical disease?'⁶⁴ Despite their call for the 'courageous' to come forward, the writer masked his or her identity under the pseudonym 'Iconoclast', and phrased the issue as a question, rather than proclaim themselves in favour. No responses to this query appeared in the journal.

The intervention of George Gibson on the issue of sterilisation effectively closed the debate and provided an official policy statement from the NEC. Gibson opposed the use of sterilisation, but his arguments lacked the liberalism of Carnell and Flanagan.

⁶³ *MHIWU Journal*, 20 (October, 1931), p. 12.

⁶⁴ *MHIWU Journal*, 20 (November, 1931), p. 3.

Gibson sidestepped the issue to an extent by claiming that with the current lack of undisputed facts of heredity, it would be better to play safe and not tamper with the laws of nature - a theme encapsulated by the title 'Sterilise the Unfit - When You Can Identify Them!' Gibson conveyed the impression that if it were proven that a category of patients could be sterilised with no ill effects he would be in favour: 'the test obviously must be the measure or degree of social benefit secured by sterilisation of a particular person or class of persons...segregation or detention during the reproductive period may be a better way in many cases...admittedly, society has a right to protect itself'.⁶⁵ Gibson joined Carnell and Flanagan in arguing against sterilisation, but actually deployed more of the arguments used by the proponents of sterilisation in his article. The debate regarding sterilisation was one of the few occasions where the Union discussed the nature of mental deficiency. Some writers represented mentally defective patients in a similar manner as they had represented mentally ill patients: as male, violent, sexually depraved and distinctly different from sane people. These images were not created to represent the interests of the mentally defective, but of the attendants and the perceived 'sane' society. Other writers, however, urged their colleagues to prioritise the interests of mentally defective patients and to conceive of their work as a moral duty to the less fortunate. The ramifications of the Union's debate and the eventual adoption of an official position against sterilisation may have had a significant impact on government policy. Mathew Thomson suggests that the resolution brought by Gibson to the TUC of 1934 opposing sterilisation, alongside opposition from other groups such as the Catholics, 'made it clear that powerful groups within civil society would make sure that the labour party resisted

⁶⁵ *MHIWU Journal*, 21 (July, 1932), p. 6.

any attempt to introduce sterilization'.⁶⁶ We might see these concerns with the welfare of mentally defective patients as part of a broader shift in Union policy towards the interests of the patients.

4.2: The Emergence of the Patient Voice

Early representations of patients within the journal were of voiceless, violent and deprived male patients. Representations of female patients rarely occurred, perhaps because they were seen as unable to advance the interests of male nurses. While the patients' voice was conspicuous by its very absence in the early issues of the journal, there are other instances of it being suppressed. An account of an inquest into an inmate's death in 1929 illustrates how the staff of mental hospitals could discredit patient testimony to safeguard their reputations. In this inquest, the nurses maintained that the dead patient struck an attendant, before being struck by another patient, while three patients claimed that they saw the struck attendant kick the dead patient. The doctor assured the coroner that statements made by patients were unreliable as they were readily influenced by other patients, and based on this statement, the jury decided not to hear the testimony of the patients and returned a verdict of death by misadventure. Some readers of this article may have been sceptical that the violence existed solely in the mind of the patient. Papers such as the *Pall Mall Gazette* told their readers stories of violent asylum

⁶⁶ Thomson, *The Problem of Mental Deficiency*, p. 71.

attendants who abused and sometimes killed their charges.⁶⁷ However, the unreliability of patient testimony was also given official credence in the *Handbook for Attendants on the Insane*, although linked mainly to epileptics: ‘they are unreliable, and very apt to make false accusations’.⁶⁸

Very slowly, a few patient voices infiltrated the journal. The first instance in which a patient’s account was cited with respect was the publication of *The Autobiography of David* in 1946. This was viewed with favour by the journal: ‘The anonymous author who triumphed over mental ill-health to become a staunch friend of this Union has gained an uncanny insight into the processes of mind derangement and he is generous in tribute to the powers of healing’.⁶⁹ It was perhaps unsurprising that the COHSE chose a favourable account of mental treatment to review in their journal.⁷⁰ In their August edition of the 1946 journal, ‘David’ was cited giving qualified support to

⁶⁷ For example, ‘The Treatment of Lunatics: its Known and Permitted Horrors’, *Pall Mall Gazette*, 15 January 1870; Charles Reade, ‘How Lunatics’ Ribs Get Broken: By Charles Reade’, *Pall Mall Gazette*, 20 January 1870. The Royal Edinburgh Asylum Press Cuttings books examined in the previous chapter also contained numerous articles that alleged violence carried out by attendants on patients. These stories may not have been groundless: some of the former asylum nurses interviewed by Peter Nolan recall instances where attacks by asylum nurses on patients were covered up by other medical staff. Nolan, *A History of Mental Health Nursing*, pp. 108-9 and p. 133 related incidents in which staff violence towards patients was covered up by other staff.

⁶⁸ MPA, *Handbook for Attendants*, p. 288.

⁶⁹ *Health Services Journal*, (June, 1946), p. 1. There was no volume for the 1946 *Journal*.

⁷⁰ E. Raymond (ed.), *The Autobiography of David* (London, 1946). The COHSE writer chose to cite the most flattering paragraph referring to mental nurses in David’s account.

care he had received, while arguing that the service would be better if only the government would improve the status and conditions of those who worked in mental hospitals:

Conditions can, and must, be greatly improved. The buildings, the staff (doctors have far too many patients to attend to, and so have the nursing staff), the living conditions of the nurses and their pay, provision for early treatment, money for reforms on an adequate scale - here is the ground on which we have to work and create the necessary reforms which will give the public, and particularly the patient, complete confidence in the services.⁷¹

The inclusion of David's recommendation suggests that the Union were beginning to represent the interests of patients into their fight for better conditions. Perhaps this marked the start of what Mick Carpenter has described as a 'user-centred and worker friendly approach' which UNISON, the successor organisation of the COHSE, currently supports.⁷² Two years later, David was cited again, this time to praise a nurse who had rescued a mental patient from a dangerous situation. Again, he reiterated the themes of patient-staff collaboration and the need for both 'a fuller understanding by the public of all the varied and difficult services rendered by the mental nursing staffs', and the effort 'to create a more humane public opinion towards insanity'.⁷³

⁷¹ *Health Services Journal* (August, 1946), p. 2.

⁷² M. Carpenter, *Normality is Hard Work: Trade Unions and the Politics of Community Care* (London, 1994). Quoted on p. 3, and supported by Alan Jinkinson, General Secretary of UNISON on p. 2.

⁷³ *Health Services Journal*, 1 (September, 1948), p. 19.

5: Towards a Model of General Nursing and a Patient-Centred View

An important shift with regards to the patient was taking place. Formerly at the fringe of the NAWU debates, deployed solely to highlight the pitfalls in the jobs of mental nurses, mental patients now assumed importance in their own right in the NAWU discussions. Thus, in his opening speech at the 1928 annual conference, Claude Bartlett acknowledged that while wages and conditions of work for members were the primary concern of the Union, it was also the duty of nurses to take responsibility for the welfare of the patient.⁷⁴ In addition to the usual motions relating to the pay and conditions of service of the nurses, a motion pressing for an improvement of outdoor facilities for patient recreation was passed. A further motion was passed – ‘that this conference thinks it desirable for the general public to be enlightened in regard to public mental hospitals and the treatment therein’. Arguing for the motion, Mr Dixon emphasised the need to improve the public image of the work carried out in mental hospitals. ‘At present, all the public know about mental hospitals is the worst side of them, and we think it would do much good if they were to come inside and look round.’⁷⁵

This new concern to enlighten the public about the good work being carried out in mental hospitals could be linked to changing representations of the mental health services and those working within it. In the favoured metaphor of many working within the mental health services, psychiatry was seen as the ‘cinderella’ of the health services,

⁷⁴ *NAWU Magazine*, 17 (August, 1928), p. 4.

⁷⁵ *Ibid.*, p. 20

lacking the professional status, therapeutic techniques and popular image enjoyed by general medicine. In 1920, repeated calls were made in the journal for all staff to obtain the Medico-Psychological Association Certificate so that the work might be seen as a profession rather than an unskilled occupation only concerned with its financial rewards.⁷⁶ We can perhaps here point to a growing desire for amongst psychiatric nurses that their work be regarded as a skilled profession rather than an occupation engrossed with its own economic condition.

In 1929 an unsuccessful attempt was made to change the title of the NAWU to the National Association of Mental Employees. The proposer argued:

It will raise our status. Of course, we know wherever asylums are they will still be asylums, but I think it gives us a higher standing if they are known as 'mental hospitals'. If we can get people to talk of us as 'mental hospital workers' I think it will make things a bit better.⁷⁷

The proposal failed but nine years later a virtually identical proposal succeeded, raising the same issues of public perceptions of the occupation, but voicing more positive beliefs that the change in name reflected an actual improvement in terms of treatment instead of a simple relabelling of the old asylum:

If we as a Union alter our title and do away with the false stigma of the word 'asylum', the public will more readily realise that our institutions are actually hospitals dealing with mental diseases... We shall be doing something to raise the

⁷⁶ See for example *NAWU Magazine*, 9 (January, 1920), p. 3.

⁷⁷ *NAWU Magazine*, 9 (June, 1920), p. 5.

status of the mental nursing profession and to teach the public that our profession is a real asset to the social services of the country.⁷⁸

These relabelling exercises reflected the desire of the NAWU to be recognised as a skilled medical profession, which by caring for sick patients was performing an important social service. Progress would no longer be made by pursuing the financial interests of attendants at the expense of patient interests.

These views of the NAWU mirrored attempts by medical superintendents to redefine their field of work during the 1920s, a period that represented a current of change in British psychiatric practice, with the establishment of out-patient clinics, reforms of the laws regarding hospital admission that enabled voluntary treatment and reforms within hospitals themselves.⁷⁹ By 1928, Mr L. Brock, the Chairman of the Board of Control, used the occasion of the opening of a nurses home to stress the more positive representation of mental illness and its treatment, in which he referred to:

The changed attitude of the public in recent years in relation to the curative treatment of mental disease, and contrasted present-day methods with the cruelty and violence practised in asylums in the Victorian era. He affirmed his belief that the advances in the treatment of mental disease which had already been made were only an instalment of the much greater advances which would be seen in the next few decades.⁸⁰

⁷⁸ Mr Harris, *NAWU Magazine*, 18 (August, 1929), p. 11.

⁷⁹ These developments are summarised in Jones, *Asylums and After*, 126–35.

⁸⁰ *NAWU Magazine*, 17 (June-July, 1928), p. 1.

It is not clear whether Mr Brock really believed this to be the prevalent image among the public or whether he hoped that by representing the public as enlightened he would encourage the public to view and represent mental illness more positively.

This new concern for patient welfare was formally enshrined in the Union's aims at the 1935 annual conference, when a resolution was passed binding the MHIWU 'to consider any matters relating to the care, treatment and general welfare of the patients in mental and other hospitals'.⁸¹ In 1931 the Union started to report the activities of the Mental After Care Association, a charity established to reintegrate recovered mental patients into social and economic life following their discharge from mental hospitals. The charity focused on helping former patients but adopted a paternalistic attitude towards their cases.⁸² In a report of the annual meeting of the MACA cited in the journal, the MACA President Lord Wakefield was quoted saying 'in a sense we are making good citizens, and so rendering a service to the state'.⁸³ The sympathy of the MHIWU for this approach to mental illness - patient-centred and yet not patient led or radical - was exhibited in their decision in 1931 to give an annual subscription to the charity.

In their journal, the NAWU mirrored the view that the asylum had now become a mental hospital where patients, represented as curable, would receive up-to-date treatment from a skilled profession who supported the principle of voluntary admission

⁸¹ *MHIWU Journal*, 24 (August, 1935), p. 17.

⁸² The work of the Mental After Care Association is discussed in Chapter Four.

⁸³ *MHIWU Journal*, 20 (May, 1931), p. 5.

and destigmatisation enshrined in the 1930 Mental Treatment Act. This new conception, which focused less upon the mental nurse as the over worked and underpaid servant of the asylum authorities, required a new, more sympathetic representation of the mental patient. Early representations that depicted the mental patient as distinct from sane individuals gave way to the view that any one could be susceptible to mental illness. Compare the earlier views that a nurse needed to possess multiple charms in order to keep the patient in order with the views of mental nurse Mr R. Bringloe, the runner up in an essay competition in 1946, for 'What are the Prime Essentials in Successful Mental Nursing?' 'The nurse must be able to place herself in the position of the patient, appreciate his predicament...Running counter to this is the attitude so easily developed of humouring a patient, based on the assumption that he is "mental"'.⁸⁴ It is interesting that although a male nurse wrote the piece, the nurse was gendered as female and the patient as male. This is indicative that the earlier opposition to female nursing in male wards had been abandoned by the Union at this stage in their quest for greater professional status. It might also suggest that the writer of the essay viewed the modelling of psychiatric nursing on the feminised profession of general nursing a good strategy: while psychiatric (male) nurses may have been the first group of nurses to unionise, general (female) nurses were arguably the first to professionalise their occupation. This points to the conflict experienced between pursuing economic rewards on the one hand, and seeking professional status on the other.⁸⁵ It is also important to remember that the COHSE were

⁸⁴ *Health Services Journal* (August, 1946), p. 12.

⁸⁵ As Julia Hallam argues, professionalisation of nursing developed first in the field of general nursing, which unlike psychiatric nursing was female dominated. Men, indeed, were not admitted to the general register of nurses until 1949, and were not entitled to join the Royal College of Nursing until 1960. J.

not the only organisation that claimed to represent the concerns of psychiatric nurses, and that they may have felt the need to compete with the Royal College of Nursing.

With the formation of the NHS, the MHIWU merged to form the COHSE, and the journal become host to a broader range of health concerns. Perhaps with this integration of mental health services into general medicine, both in the form of the NHS and the COHSE, it is not surprising that mental nurses approximated their work - and their patients - to a model of general medicine. In the 1946 essay competition on 'What are the Prime Essentials In Successful Mental Nursing', Mr Yarnell suggested that more general nursing training should be included in the training of mental nurses:

I think this is very necessary, otherwise the real meaning of the word 'hospital' loses its significance. The mental health of the nation is an integral part of the health system of this country. Each is complementary to the other. The mind and body are so closely associated that general and mental trained nurses should be similarly associated.⁸⁶

The reproduction of extracts from other letters from this competition helps to give an idea about the concerns and beliefs - or at least the ideals - of mental nurses regarding their profession, and how they felt it was perceived by the general public. Some letters in the competition registered anxiety that the representation of mental illness by the press

Hallam, *Nursing the Image: Media, Culture and Professional Identity* (London, 2000), p. 100.

⁸⁶ *Health Services Journal* (June, 1946), p. 7.

was dated and inaccurate, overlooking new progress. Mr G. Tiley expressed concern about the isolation of the mental hospital and its work:

In the past, these hospitals have always been erected in the most outlandish places, giving the impression that mental trouble...is a disease which must be isolated entirely from the social community...There still exists a 'fear' among the sane population of being contaminated by mental affliction and then being referred to as a 'lunatic' in the 'asylum'. I trust in the very near future sufficient public opinion will be given to these deplorable facts to dispel these fears.

This essay concentrated on the stigma still attached to mental illness. Tiley regarded outdated public opinion appertaining to the treatment of mental illness as a major threat to the status of nurses if they wished to be viewed as professionals. Tiley's use of the phrase 'contamination' suggests his fear that those unconnected with the mental health services may have believed that nurses' contact with patients somehow polluted the nurses, a popular concern that has been traced by Peter Nolan and Diane Gittins in their interviews with former psychiatric nurses.⁸⁷ Concerns about the use of outdated, derogatory terms by newspapers were expressed by Ward Sister Florence Marion Harries - Jones in her entry:

Unhappily, newspapers are only too prone to refer to a mental hospital as a lunatic asylum. The time is, however, now almost at hand when this old fashioned idea will be completely eradicated and mental nursing will be given the recognition it deserves for the skilled, highly trained and efficient profession which it has become.

⁸⁷ Gittins, *Madness in its Place*, pp. 21-24 and Nolan, *A History of Mental Health Nursing*, pp. 109-10.

Mr E. Stamp chose instead to focus upon the new conception of the patient, reflecting the shift in the twentieth century from a rigid distinction between the sane and insane, to a belief that mental health and illness were part of the same continuum:

‘But for the grace of God, there go I’, or words to that effect should be the outlook of a good nurse in a mental hospital because, as one well knows, the dividing line between sanity and insanity is a very narrow one. That depressed ‘monday morning’ feeling, if magnified, gives one a slight impression of the tortures of the average melancholic...the average patient responds to kindness, when treated as an equal.⁸⁸

In an environment (or, at least, the representation of a working environment) where a patient was constituted as an equal, an individual not too dissimilar from the nurse, the interests of patients were listened to and represented.

Joan Busfield has noted that the emergence of new physical treatment in the 1930s ‘brought psychiatry closer to other areas of medicine and helped to increase its legitimacy as a field of medical practice’.⁸⁹ In this period, the new professional role of the mental nurse and its approximation to the role of general nurse was believed to be enhanced by the new therapeutics employed in mental hospitals. The Union’s journal carried reports on the experimental use of leucotomies and E.C.T., and cited the government’s Athlone Report on nursing, which insisted ‘the medical staff now require

⁸⁸ *Health Services Journal* (June, 1946), p. 7.

⁸⁹ J. Busfield, ‘Restructuring Mental Health Services in Twentieth-Century Britain’, in M. Gijswijt-Hofstra and R. Porter (eds), *Cultures of Psychiatry and Mental Health Care in Postwar Britain and the Netherlands* (Amsterdam, 1998), pp. 9–28. Quoted on p. 16.

highly skilled mental nurses to assist...there is every justification for the recognition of mental nursing as a highly skilled branch of the profession and entitled to a worthy status.'⁹⁰ The COHSE's enthusiasm for the new therapeutics challenges Peter Nolan's argument that the physical treatments threatened to erode nursing skills by reducing nurses to the role of assistant to the doctor.⁹¹

However, in their rush to destigmatise voluntary, borderline and treatable patients, and consequently destigmatise their own profession, mental nurses may have contributed to the stigma of less treatable groups of patients, in addition to the continuing stigmatisation of the mentally deficient already examined. In 1930, it was reported that the Durham Mental Hospital was considering building an admission hospital where cases of a 'recovering type' could be received. They could then be discharged 'without coming into contact with permanent patients', who were clearly to be hidden away from the public view and 'acceptable' borderline case as they were not publicity-friendly. A report from the Derby Mental Hospital in the same year expressed the hope that many recoverable cases would go straight from the admission unit to convalescent villas without entering the main hospital at all, suggesting a similar fear of 'contagious' chronic patients.⁹² The process through which the stigma of chronic and low-grade cases was reinforced by the destigmatisation of more favourable cases has rarely been explored, although Mathew Thomson's work illustrates that efforts to advance mental health and

⁹⁰ *Health Services Journal* (February, 1946), p. 4.

⁹¹ Nolan, *A History of Mental Health Nursing*, p. 118. Nolan was discussing reactions to treatments in the 1950s.

⁹² *NAWU Magazine*, 19 (July, 1930), p. 8 and (November, 1930) p. 2.

destigmatised some forms of mental distress such as shellshock had the effect of reinforcing the stigma and reducing the resources available to more severe and chronic cases.⁹³

Many mental hospitals in the late 1940s and early 1950s began to operate the open door policy and offered weekend parole to patients. This entailed a reconceptualisation of the image of the patient as a guest or client. By 1961 glossy photos showing luxurious aspects of not private but public mental hospitals were displayed monthly, as hospitals were described as if they were hotels, and patients subsequently filling the role of guest or client. In the November and December issue of 1961, a photo depicted Londonderry Hospital's 'spacious out-patient waiting room', which strongly resembled a hotel reception.

The preceding month, a double page spread was devoted to Craig Dunain Hospital that celebrated its centenary by emphasising its modernity and comfort. Even the title, with its references to amenities, and the highlands location, is reminiscent of hotel language.

⁹³ See Thomson, *The Problem of Mental Deficiency*, p. 284; M. Thomson, 'Status, Manpower and Mental Fitness: Mental Deficiency in the First World War', in R. Cooter, M. Harrison and S. Sturdy (eds), *War, Medicine and Society* (Stroud, 1998), pp. 149-66.



Figure 2: Craig Dunain Hospital, *Health Services Journal*, 14 (September–October, 1961), pp. 12–13.

Boasting of a golf course, its ‘hotel-like annexe for the milder cases’ and ‘some of the grandest scenery in the Western Islands and highlands of Scotland’, the piece was accompanied by four images. Two showed the ‘stately gothic buildings’ and ‘Dunain House, a hospital annexe with hotel comforts’, and the other two depicted the ‘bright and spacious’ women’s lounges.⁹⁴ A striking feature of these photographs is that none of them depicted any aspect of medical care: no wards or beds were on display, no therapeutics were depicted. The only patients displayed were those sitting in the lounge, an image of normality. The Union perhaps hoped that demedicalised images such as these could destigmatise mental illness by suggesting that psychiatric patients were neither sick nor dangerous. However, these representations did conflict with the growing

⁹⁴ *Health Services Journal*, 14 (September–October, 1961), pp. 12–13.

presentations of mental disturbance as a physical illness that could appropriately be treated within a hospital.

In his presidential speech to the triennial delegate conference of 1959, Claude Bartlett expressed satisfaction at the large advances made by the Union in representing the interests of nurses as professionals:

When I compare the conditions in our mental hospitals today with those obtaining before the advent of the NHS, I often wonder whether some of my trade union colleagues are not trying to break down barriers which have long since ceased to exist. It is a far cry from the lunatic attendant of less than fifty years ago to the fully trained and qualified psychiatric nurse of today. I am naturally proud to have played some part, small perhaps, in raising a once lowly and much stigmatised occupation into a skilled and honoured vocation.⁹⁵

6: Professional Crisis and a New Stigmatisation of the Psychiatric Patient

Serious problems, however, faced the psychiatric nursing profession in 1959 and the early 1960s that undermined the COHSE's patient-centred view and suggested that the overwhelming concern of psychiatric nurses remained their working conditions. The 1959 conference passed a resolution on the Mental Health Bill expressing their concerns at inadequate funding for the proposed measures and their hope the mental nurses' skills would be utilised in the new system of community care. As psychiatric nurses became

⁹⁵ *Health Services Journal*, 12 (July-August, 1959), p. 10.

aware of the possibility that other professionals might usurp their roles and threaten their careers, the COHSE membership sought to establish their credentials to become involved in the new systems of care proposed. The wording of the resolution emphasised the COHSE's role as crusaders for the users of the mental health services and leaders of public opinion. 'For many years the confederation membership has played an important part in seeking to improve the standard of nursing and other services to those mentally ill and have attempted through this organisation to make the general public mental health conscious.'⁹⁶ The COHSE were not the only organisation that claimed to speak for the concerns and interests of psychiatric nurses, and had to compete with the Royal College of Nursing for this role.⁹⁷ Moreover, attempts by psychiatric nurses to become involved in community work were resisted by the Association of Psychiatric Social Workers. An article in 1969 acknowledged the occupational rivalry: 'there seems to be a real fear of the nurse muscling in on the social worker's job...there is still strong support in some quarters for the view that anyone can do social work provided he is interested in people'. The article continued by asserting the professional superiority of social work - 'one can expect the nurse to assail the status of the social worker, and the latter to endeavour to maintain his position'. The writer concluded that the psychiatric social worker was in most instances the worker best trained to visit patients in the community, as nurses'

⁹⁶ *Ibid.*, p. 49

⁹⁷ The Royal College of Nursing often portrayed itself as the organisation that represented the views and interests of psychiatric nurses, as in 1960 when they issued a report on the impact of the 1959 Mental Health Act and its implications for the roles of psychiatric nurses. See 'Changes Urged in Mental Nursing', *The Times*, 22 April 1960, in which it was stated that the report 'contains the views of a representative group of mental and mental deficiency nurses'.

training was limited to the management of the patient within the hospital setting.⁹⁸ However, one lecturer in nursing studies pointed out the problems of limiting psychiatric nurses' work to hospitals during a period when government policy was devoted to shutting them down: 'it seems unlikely that one can find intelligent highly motivated people of the right kind of personality to staff the hospital wards if they are barred from all work which carries more interest, more prestige and more career opportunities'.⁹⁹

Another 1959 conference resolution on the custody of dangerous mental patients suggested that 'sex perverts, psychopaths, criminal patients and some other dangerous mental patients who can easily abscond from ordinary mental hospitals' should be detained in a special secure hospital in each region. The proposer argued that if a dangerous patient absconded from a normal mental hospital and 'murdered a child or some innocent person - and we read in the press of an increase in sexual assaults and brutal crimes of this nature - then public opinion would soon put the clock back and the many would suffer for the few'. This resolution followed in the wake of a string of newspaper reports concerning the escapes of Rampton patients.¹⁰⁰ In the interests of

⁹⁸ T. Smith, 'The Role of the Psychiatric Nurse in the Community', in *The Association of Psychiatric Social Workers, New Developments in Psychiatry and the Implications for the Social Worker*, (London, 1969), pp. 40-46. Quoted on p. 40.

⁹⁹ A. Altschul, 'The Role of the Psychiatric Nurse in the Community', *New Developments in Psychiatry*, pp. 37-39. Quoted on p. 39.

¹⁰⁰ These articles mainly concerned escapes and attempted escapes from the institution, such as 'Four Rampton Patients Caught: Window Bar Cut to Aid Escape', *The Times*, 22 December 1958. In one incident, the two escaped men were found guilty of assault and robbery; see 'Rampton Men Accused:

preserving open door policies for the majority of mental patients by appeasing public opinion, this delegate suggested a new form of custodialism for certain categories of patients by again raising the spectre of the (sexually) violent patient. Two further resolutions at this conference dealt with concerns for the safety of staff if prisoners were admitted to ordinary mental hospitals.¹⁰¹

The other bone of contention for the COHSE members was the announcement by Health Minister Enoch Powell of the proposed closure of 75,000 hospital beds over a period of fifteen years, made in 1961. The COHSE bitterly opposed this, arguing that the shortage of mental nurses would worsen as individuals would seek to leave a profession with no future, and that mental hospitals, instead of being improved, would simply be downgraded as they faced closure. Dingwall, Rafferty and Webster note that the effect of Powell's policies was liable to make mental nurses' work more onerous as the younger and least 'damaged' patients were discharged, leaving the hospitals to care for the most severely disordered and elderly.¹⁰² As morale worsened, the COHSE writers in the journal started to suggest that all grades of nurses in psychiatric units should be paid 'danger money', returning to arguments advanced by the Union soon after it had first

"Intent to Murder", *The Times*, 23 January 1957 and 'Prison Sentences on Rampton Men: Judge's Concern with Protecting the Public', *The Times*, 5 March 1957. In 1958, it was reported that a nurse had been assaulted; see 'Ministry Statement on Rampton Incident: "No Question of Mass Break-Out Attempt"', *The Times*, 21 May 1958. In 1963, however, a student nurse was alleged to have assisted a patient to escape; see 'Rampton Escape Aided by Nurse', *The Times*, 10 August 1963.

¹⁰¹ *Health Services Journal*, 12 (July-August, 1959), p. 46.

¹⁰² Dingwall, Rafferty and Webster, *The Social History of Nursing*, p. 139.

formed which based demands for better wages on the violence of the patients.¹⁰³ An article in the 1961 July-August edition of the journal raised alarms about attacks on mental hospital staffs, which was claimed to have resulted from Powell's policy of only placing psychiatric patients into Broadmoor, Rampton and Moss Side as a last resort: 'it may be a counsel of perfection for the report to say it is wasteful to provide security precautions for patients who do not need them but nurses who have been attacked by informal patients who seemed harmless will need to be convinced'.¹⁰⁴ This piece again portrayed some patients as violent and a danger to be contained. An article in the journal for July-August 1963 told a 'classical case' of a man sent to a mental hospital from the law courts, and admitted as an informal patient: 'he left the hospital, went home and assaulted his wife. He decided to return to the Hospital, but got drunk before he arrived. He attacked the staff nurse in charge and left, only to be returned to the same ward by a probationer officer...'.¹⁰⁵

Anger at Powell's policies led to a damaging image of psychiatric patients in an article of September-October 1961, in which Powell was dubbed the executioner and the policy of discharging patients from hospitals on prescriptions was viewed as the creation of a nation of drug addicts. Mr Thomas wrote:

In 1954, 54,000 patients were admitted to our mental institutions. Today the figure is 90,000, of which 80,000 are discharged and returned to the community.

¹⁰³ Correspondence from E. Buck and W. D. Chanbelen, *Health Services Journal*, 14 (March-April, 1961), pp. 21-22.

¹⁰⁴ General Secretary, *Health Services Journal*, 14 (July-August, 1961), p. 2.

¹⁰⁵ *Health Services Journal*, 16 (July-August, 1963), p. 2.

Do not delude ourselves with the idea that this great mass of patients goes home cured or even half cured. The truth is that a large number leave behind them a trail of violence, robbery, assault, rape and murder.¹⁰⁶

In this article, psychiatric patients were represented as violent criminals. Mr Thomas was probably concerned that the growth of out-patient care at the expense of care within mental hospitals was a threat to his job and the future and status of the profession. However, his attack stigmatised some patients as violent criminals and suggested that the role of the psychiatric nurse was to act as custodian to violent deviants.

Nor did the situation improve by the end of the 1960s. Indeed, the furore created by Barbara Robb's exposé of the ill treatment of elderly patients in her book *Sans Everything: A Case to Answer* led to investigations of nursing practices at many mental hospitals.¹⁰⁷ Although a subsequent White Paper dismissed most allegations,¹⁰⁸ the COHSE complained of a 'witch hunt atmosphere' and derided Robb's book as 'Knock Everything'.¹⁰⁹ Even the Royal College of Nursing, which tended to focus less on the working conditions of nurses than the Union, chose the occasion of their 1970 conference to attack psychiatric nurses' conditions of work. Although the Chairman of the Psychiatric Committee claimed that nurses were demoralised 'by not being able to

¹⁰⁶ *Health Services Journal*, 14 (September-October, 1961), p. 8

¹⁰⁷ See Geoffrey Smith, 'Tyranny Over the Unloved Old', *The Times*, 3 July 1967; 'Mental Nurse to go After Inquiry', *The Times*, 4 November 1967.

¹⁰⁸ 'Hospitals Cleared of Cruelty', *The Times*, 10 July 1968.

¹⁰⁹ 'Mental Hospitals Staff Defended: "Witch Hunt Atmosphere"', *The Times*, 20 June 1968.

provide the service they wished for their patients', he subsequently shifted his attack to suggest that the patients posed the main limitations to nurses' work. Nurses, he claimed:

Serve when they are spat at, kicked scratched and bitten, they serve as they separate patients locked in fights as they ward off physical assaults on themselves. They tolerate verbal abuse and serve as they retrieve towels, socks and other clothing from lavatory pans. And they serve as they climb on slippery roofs to bring patients back to safety.

Another resolution at the conference re-established the division between mentally and physically ill patients, as delegates voted to ensure as a matter of policy that the two groups of patients were not placed in the same ward.¹¹⁰

7: Conclusion

This study of the inter-relationship between the private/professional interests of the NAWU and the representations they created of mental patients suggest that such images were largely determined by nurses' working conditions. Established to combat the long hours, low wages and poor conditions of their work rather than to promote psychiatric nursing as a skilled profession, the NAWU initially felt that in order to represent the interests of its members it did not need to concern itself with patient welfare. Images of patients, when they did occur, were more incidental, added into the journal to prove an argument. These representations of the violent or sexually depraved male patient were often detrimental to patient interests, perhaps damaging the public image of the mental

¹¹⁰ 'Mental Nurses Demoralised by Conditions', *The Times*, 19 October 1970.

patient, and by association, psychiatric nurses. The difference between the sane and the insane was stressed in the journal, especially with reference to mentally defective patients, and used as a justification to silence the patient voice. The balance of power between men and women within the Union also informed the debates and the interests represented within the journal, acting to silence the views of female members.

During the 1930s, 1940s and 1950s many of the Union's initial goals were achieved. The status of the occupation rose as new legislation and therapeutics enhanced the image of the patient and the environment in which they were cared for. Psychiatric patients were no longer seen as necessarily dangerous or fundamentally different from the sane. As the material condition of mental nurses improved they were able to fight for a humanisation of the patient. No longer used as a tool to represent nurses' discontent, the representation of patients' interests had become a major focus of the MHIWU's campaigning in its own right, although the collaboration between nurses and patients envisaged by 'David' was never fully realised in the period under study. This process was accelerated with the formation of the NHS and the amalgamation of the MHIWU with other health service employee unions to form the COHSE. Nurses sought to challenge harmful and outdated images of the mental patient, hospital and nurse. Concern no longer focused on improving the conditions of hospital workers but on raising the image and status of the occupation to that of a medical profession.

By 1959, new legislation promised the destigmatisation of mental illness and its integration into a community from which it had long been separated. However, Enoch

Powell's proposed closure of the mental hospitals and attempts to have criminal patients treated in mental hospitals challenged the new conceptualisation and representation of the psychiatric patient, removing less damaged and more rewarding patients. As the profession came under threat and became demoralised, concern with patient welfare diminished and nurses' self-interest again rose to the fore. Earlier images resurfaced of the violent and depraved patient who threatened the safety of the mental nurse. While acknowledging the frustration that many psychiatric nurses must inevitably have felt working in a career that appeared to offer no future, in buildings that were decaying and amongst less and less promising cases, it is difficult not to argue that throughout the period under study, the NAWU's main concern remained consistently the representation of staff not patient interests. This perhaps explains why, in the Union's journal, sympathetic representations of the mentally ill and the representation of patient interests failed to progress.

Chapter Three: Psychiatric Social Workers

Psychiatric social work as a trained profession and the Association of Psychiatric Social Work (hereafter the APSW) were initiated in 1929. In 1970, the APSW and its 1,550 members were absorbed into the British Association of Social Workers and the specialised university training that had previously distinguished psychiatric social workers (hereafter PSWs) from their fellow social work colleagues was assimilated into the new generic training for all social work. This chapter will explore whether this relatively small group of workers was able to contribute to public ideas about mental illness, examining if their dual role within both institutions and the community enabled them to develop a unique perspective towards mental illness. The chapter will also examine whether PSWs sought to represent the interests of the mentally ill alongside their own interests, and the mechanisms the profession used to try to communicate its ideas to a broader public.

The first section of this chapter will explore the constitution of the APSW as a sub-public sphere, in which a specialised group of workers could debate ideas about mental illness among themselves. It will be argued that the representations of mental illness produced by PSWs within this internal sphere changed from the idea that mental illness was a problem affecting only dysfunctional individuals to a growing belief that mental disorder could result from social conditions. Treatment ideals correspondingly shifted from attempts to effect change within the sick individual and thus enable them to conform to society, to efforts to bring about change within the social networks that had

made people sick. These changing images of mental illness reflected the growing belief that PSWs should be championing the interests of their clients, not the interests of society or the state.

The second part of the chapter explores the APSW's efforts to participate in and shape a public debate about mental disorder and its treatment through an examination of the APSW's Public Relations Sub-Committee (hereafter PRSC). This section will ask what the APSW sought to achieve through its encounters with the media and whether their primary objective was the advancement of patient or professional interests. It is also important to explore here the APSW's perception of the public and whether this had an impact on the way the organisation sought to engage with a broader audience.

1: Who PSWs Were: Background Information and Professional Ideals¹

1.1: History of Psychiatric Social Work

The origins of psychiatric social work can be found in the activities of earlier charitable organisations that worked with the mentally disordered and their families within community settings, often seeking to remedy people's difficulties by providing solutions to their economic problems.² Another factor that influenced the development of

¹ For a more thorough account of the history of the profession, see N. Timms, *Psychiatric Social Work in Great Britain 1939-1962* (London, 1964).

² For example, the MACA, the subject of the next chapter, deployed lady volunteers to visit its charity cases in their homes or places of work to check on the progress of their recipients and resolve any difficulties

psychiatric social work was the growing acceptance of psychological explanations for people's behaviour and problems, and the emergence of the mental hygiene movement, which sought to prevent mental illness from occurring by tackling the underlying causes.³ The influence of the mental hygiene movement can be seen in the first object listed in the APSW constitution: 'to contribute towards the general purposes of mental hygiene'.⁴ One aspect of this movement was expressed in the growing interest in the 'problem' child, exemplified in the work of educational psychologist Cyril Burt who was employed in

with their employers. As will be seen in Chapter Four, the primary aim of the MACA was for many years to enable its cases to gain employment. The Central Association for Mental Welfare (founded in 1913 as the Central Association for the Care of Mental Deficiency) was also engaged in work with the mentally disordered within the community. Their work is discussed in L. Westwood, 'Avoiding the Asylum: Pioneering Work in Mental Health Care 1890–1939' (DPhil thesis, Sussex University, 1999).

³ The role of the mental hygiene movement in the emergence of psychiatric work is discussed in K. Woodroffe, *From Charity to Social Work in the United States and England* (London, 1962), pp. 124–39.

⁴ 'The APSW Report for the Year 1936 (With Foreword on the Years 1930–5)', p. 5, MSS.378/APSW/2/1/1; APSW Annual Reports 1930/36–69, MSS.378/APSW/2/1-35. All APSW archive sources consulted for this chapter are held at the Modern Records Centre, University of Warwick. The Annual Reports appeared in printed pamphlet form in the years 1930/36 to 1944/46 and 1954/55 to 1970. The Reports produced in between these dates that are available in the archive are in typescript form. It is difficult to judge how widely the Reports were distributed, although as they cannot be found on the British Library Catalogue, I have chosen reference them as archived sources. They were probably only distributed amongst PSWs. Throughout their existence, the APSW remained involved in the mental health movement. Their first Annual Report noted that representatives of the APSW sat on the National Council for Mental Hygiene, while in the Second World War, the APSW was a member of the Mental Health Emergency Committee. Representatives served on the Provisional National Council for Mental Hygiene and subsequently the National Association of Mental Health.

1913 to investigate cases of difficult children in London schools and to carry out treatment. This paved the way for the development of child guidance clinics (hereafter CGCs) in which PSWs were to play a significant role.⁵ Professional training for social workers in psychiatric fields was first developed in America in 1914 at the Boston Psychopathic Hospital: by 1918, the Smith College offered the first course for training in psychiatric social work.⁶ PSWs became part of the team in the newly established CGCs, funded by the Commonwealth Fund with the aim to prevent juvenile delinquency. When the Commonwealth fund agreed to finance the establishment of CGCs in Britain, they stressed the need to train social workers in a university setting.

In 1929, the London School of Economics established the Mental Health Course to train social science graduates with some experience in social work in psychiatric social work. The APSW was also formed in 1929 with seventeen members. It had no control over the training of PSWs but recognised graduates of the mental health course as members if they paid the subscription fees. By 1944, only 257 people had qualified as PSWs, and not all of these people were using their qualification to work as a PSW. Approved courses then started in Edinburgh (1945), Manchester (1947) and Liverpool (1954). From 1958, students who had qualified through generic courses were accepted as members of the APSW, provided they undertook an additional psychiatric placement.

⁵ A discussion of Burt's significance in the formation of child guidance clinics can be found in D. Thom, 'Wishes, Anxieties, Play and Gestures: Child Guidance in Inter-War England', in R. Cooter (ed.), *In the Name of the Child: Health and Welfare, 1880–1940* (London, 1992), pp. 200-19.

⁶ For more information on the development of psychiatric social work training in America see E. Lunbeck, *The Psychiatric Persuasion: Knowledge, Gender and Power in Modern America* (Princeton, 1994), pp. 35-45.

Initially, more PSWs were employed in the field of mental hospital work than in CGCs, although the disparity was later evened out as the child guidance service developed. The field of community care was slow to develop, only really equalling the other two fields by 1969.⁷ In 1962, the number of trained PSWs had reached 1,202, of which 136 were men.

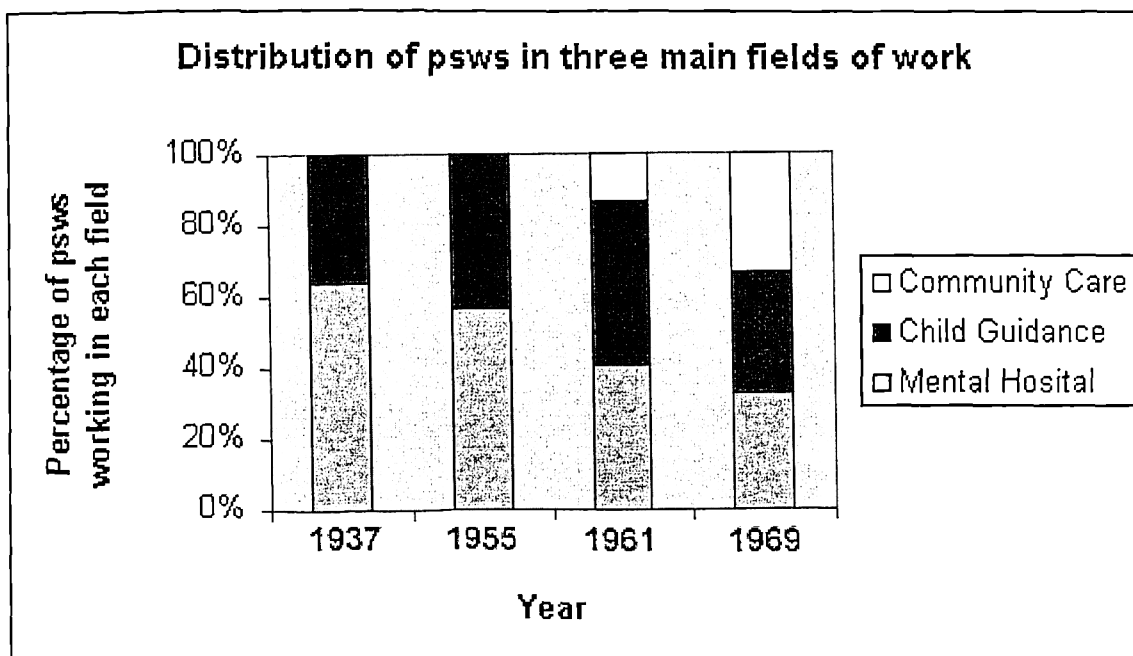


Figure 3: Distribution of PSWs in Three Main Fields of Work, 1937–69. Figures for the years 1937, 1955 and 1961 are drawn from data in Timms, *Psychiatric Social Work in Britain*, pp. 69–70. The figures for the year 1969 are drawn from ‘The APSW Annual Report 1969’, p. 17, MSS.378/APSW/2/1/35.

⁷ A thorough examination of the numbers of PSWs entering different fields of work and their geographical location can be found in Timms, *Psychiatric Social Work in Britain*, pp. 66–89. The chart illustrates only the main trends in the employment of PSWs: not all qualified PSWs went in to these three fields of work and Timms should be consulted for more details of other sectors of employment for PSWs.

1.2: The Work of PSWs and their Professional Identity

The main role of the PSW in the mental hospital setting was often seen to be the taking of the social history. The kind of information gathered in these early social histories included the patient's social background, hereditary conditions, their physical and intellectual development, experiences, a study of their personality before the illness developed and what led up to the present situation.⁸ PSWs viewed their function of taking the social history as a very important aspect of their work, not just for the information it would give to the psychiatrist about his case, but as Margaret Ashdown explained to an audience of psychologists and psychiatrists, the PSW in the patient's home should try 'to lift the patient's case out of the atmosphere of bewilderment and fear, blame and recrimination, so that he can be regarded as simply a sick person to be helped'.⁹ PSWs working in mental hospitals may have placed such a high value on the social history, as it was this task that distinguished them from other mental health workers as a skilled, specialised profession. The other functions of the PSW working in the mental hospital were perhaps not that different from her predecessors working for the MACA: to help the patient to readjust following his discharge from hospital, to persuade him to join a social club and to help the patient find work.¹⁰

⁸ M. Ashdown, *The Role of the PSW: An Address Delivered Before the Medical Section of the British Psychological Society on February 26th 1936*, p. 7, MSS.378/16/4/1; APSW Publications 1932–70, MSS.378/16/4/1-20. This pamphlet gives no date or place of publication.

⁹ *Ibid.*, p. 8.

¹⁰ For a detailed overview of PSWs' activities within mental hospitals, see Timms, *Psychiatric Social*

Early practice in CGCs was largely based around casework interviews between the PSW and the mother of the child referred. These interviews were influenced by psychoanalytical ideas: namely that the behaviour of the mother could only be understood if unconscious motivation, often extending back to childhood, was taken into account. This particular approach suggested that the mother had caused her child's disorder by her faulty handling of the child, perhaps resulting from her own unresolved problems.¹¹ PSWs debated whether the PSW in this situation was providing advice, or undertaking psychotherapy to resolve the problems of the individual mother, suggesting that a desire to be recognised as a professional was a priority. Editor Margaret Ashdown questioned in the *British Journal of Psychiatric Social Work* (hereafter the *BJPSW*) whether PSWs, in their efforts to represent their own professional interests, had failed to represent the interests and needs of their patients.¹² This point was made more forcefully by Dr T. A. Ratcliffe at a paper he gave to an APSW general meeting: 'has a tendency grown up to regard the less intensive forms of therapy and casework as somehow inferior; and, with it, a danger that the intensity of the therapy attempted will be governed more by the training level - and dare we say the professional ambitions - of the therapist or caseworker, than by the level of therapy which is most appropriate to the client's needs and capacity?'¹³

Work, pp. 110–9.

¹¹ For a detailed overview of PSWs' work in CGCs, see Timms, *Psychiatric Social Work*, pp. 90–109.

¹² M. Ashdown, 'Editorial', *BJPSW*, 1 (1950), pp. 3–7. Discussed on p. 7. All articles cited from the *BJPSW* are from the 1968 reprints by Swets and Zeitlinger N. V. Amsterdam.

¹³ T. A. Ratcliffe, 'Relationship Therapy and Casework', *BJPSW*, 5 (1959), pp. 4–9. Quoted on p. 4.

Ratcliffe, of course, belonged to his own profession whose special area of expertise he may have been trying to protect.

The APSW frequently endorsed collaboration with other organisations. Cooperation, however tended to be a one-sided process. PSWs argued that their post-graduate university qualification fitted them to train and supervise psychiatric nurses, mental welfare officers, health visitors, child care officers and the probation service; occupations that might have resented the claims of PSWs to have any authoritative knowledge regarding their work. The APSW sought to maintain its own professional status against the suggestion of the Cope Report that PSWs should be registered as medical auxiliaries: 'the first concern will be with the designation of medical auxiliary and the effect of that upon the status of PSWs as professional social case workers with their training based at a university'.¹⁴ Indeed, at times PSWs argued that their specialised expertise qualified them as professionals to elucidate doctors on certain issues. In 1955 the APSW suggested that PSWs might be involved in the training of medical undergraduates who they felt 'learnt very little about social and psychological factors in health and illness, let alone in mental illness'.¹⁵ The APSW's first constitution, contained within their Annual Report for 1936, concisely expressed the dual function of the organisation. While, as the first object expressed, the APSW sought to promote mental health, the second object aimed 'to raise and maintain professional standards, and to

¹⁴ 'The APSW Annual Report 1951-52', typescript, p. 5, MSS.378/APSW/2/1/17.

¹⁵ 'The APSW Annual Report 1955', p. 16, MSS.378/APSW/2/1/21.

encourage the employment of fully trained workers at adequate salaries'.¹⁶ This latter issue posed a persistent problem for the APSW, whose largely female members were paid less than psychologists and psychiatrists. The value placed on the PSW post-graduate qualification was not always appreciated. In June 1950, for example, a protest ensued when an advertisement was placed for a PSW, or alternatively, an untrained worker at a higher salary.¹⁷

Recognising the potentialities in the 1959 Mental Health Act to expand and improve the status of psychiatric social work, the APSW gave a guarded welcome to the legislation. 'The Bill could achieve little without the allocation of adequate finance and staff', wrote the *Daily Telegraph*, citing the APSW. 'Indeed, without them the Bill could make the situation worse rather than better...PSWs had a vital part to play. But there must be better recognition of their professional status.'¹⁸ Approval of the Act was qualified by the APSW's demands for more community services and a better status for social workers. However, government support for psychiatric social work was not wholehearted. In a House of Lords debate on the Youngusband Report on social work in 1960, former Professor of Social Studies at London University, Barbara Wootton, criticised 'the growing practice of giving people in trouble "pseudo-psychology" instead of practical help...many social workers were encouraged, when faced with a simple practical economic problem, to search for some profound disturbance underneath'. Lord

¹⁶ 'The APSW Annual Report for the Year 1936', p. 5.

¹⁷ 'APSW Chairman's Report 1950-51', typescript, p.3, MSS.378/APSW/2/1/15.

¹⁸ "'Revolution" in Mental Care: Bill Welcomed', *Daily Telegraph and Morning Star*, 23 March 1959.

Pakenham, speaking in the same debate, also touched on the issues of the value of a trained PSW and concerns that PSWs were meddlers: 'what generated so much heat was the question whether there was such a thing as a professionally qualified social worker as distinct from someone with good sense and a wealth of experience'.¹⁹ Psychiatric social work was funded through the state so to hear government representatives question the expertise upon which PSWs staked their claims for professional status must have been disheartening.

2: Internal Debate: From Representing the Mentally Ill as Maladjusted Individuals to a Social View of Mental Illness

2.1: Forums for Internal Debate

One key function of a sub-public sphere, according to Nancy Fraser, is its ability to offer members of a marginal group a forum for the exchange and debate of ideas.²⁰ The APSW achieved an internal forum for debate amongst its members both through meetings and its journal. General meetings, which over time revolved increasingly around the specific issues facing PSWs, provided one place in which members could exchange views. The development of local branches expanded this forum outside its original London setting, enabling members throughout the country to debate professional issues. The APSW also

¹⁹ 'Distrust of Psychiatry: House of Lords', *Daily Telegraph and Morning Post*, 18 February 1960.

²⁰ N. Fraser, 'Rethinking the Public Sphere: A Contribution to the Critique of Actually Existing Democracy', in C. Calhoun (ed.), *Habermas and the Public Sphere* (Cambridge, Massachusetts, 1992), pp. 109–42.

had a number of sub-committees that dealt with areas such as the management of the *BJPSW* and other APSW publications, relations with other professions, training standards, salaries, and public relations. These committees were accountable to the APSW and the membership. The Public Relations Sub-Committee, for example, believed that a public image could only be agreed through active internal debate. Arguing for the need for annual meetings, the committee felt this was the best way 'in which the complications, inhibitions, internal politics and other differences of the general membership, in other words, the very things, in the sub-committee's view, that stood in the way of the development of a clear and united aim in public relations, could be expressed, discussed and possibly resolved'.²¹

The *BJPSW* was established in 1947, under the auspices of the APSW Publications Sub-Committee. 1,000 copies of the journal were printed in 1947 and 1948, reduced to 600 copies of the 1949 journal when it became clear that the APSW had over 200 copies left of each of the previous journals: membership of the APSW only stood at 398 by the end of 1948. From 1950, copies of the *BJPSW* were distributed to all subscribing members of the APSW. The remit of the journal was initially to 'provide a vehicle for exchange of ideas regarding the methods of psychiatric social work. It will therefore be mainly of interest to a limited number of clinical workers.'²² Organised through the central executive of the APSW, it was hoped that the issues discussed in the

²¹ APSW PRSC meeting minutes 21 April 1961, p. 2, MSS.378/APSW/14/1/32; APSW Public Relations Sub-Committee, 1957-63, MSS.378/APSW/14/1/1-41.

²² 'APSW Annual Report 1946-47', typescript, p. 7, MSS.378/APSW/2/1/9.

BJPSW would be debated in general meetings and branch meetings, linking the central structure of the APSW with its branch members.²³ By 1949, editor Margaret Ashdown was hoping that the journal might help publicise the achievements of the APSW to related professions: ‘perhaps the journal can be used as a whispering gallery, by means of which our voices, which some of us feel to be so feeble, can be made to carry to our professional neighbours, without fear or strain’.²⁴

2.2: Maladjusted Individuals

In the early years, PSWs frequently represented their patients as individuals whose sickness evolved from their own lives and who needed to be helped by a PSW to adjust back to society. Kathleen Woodroffe has argued that in the 1920s and 1930s, social workers jettisoned their earlier concern with problems in the social environment that might impede individual adjustment, arguing that with the shift from an economic to a psychological approach to people’s problems, ‘the individual became the centre of stage...in the post-war years, it was assumed that if adjustment was not achieved the individual was to blame’.²⁵ Much of this work appears to have been with poorer clients, implied by the emphasis sometimes placed on the need to make the patient assume social

²³ ‘One would have to leave discussion of the contents of the journal to meetings of the Association, especially to branch meetings, sub-committees and to more informal groups...one may hope the journal and the meetings of the Association will constantly result in stimulating the interest and initiative of the members’. M. Ashdown, ‘Introduction’, *BJPSW*, 1 (1947), pp. 3–7. Quoted on p. 6.

²⁴ M. Ashdown, ‘Editorial’, *BJPSW*, 1 (1949), pp. 3–6. Quoted on p. 3.

²⁵ Woodroffe, *From Charity to Social Work*, p. 132.

responsibilities and to become a useful citizen. This attitude, for example, is clear in a case study prepared by the APSW in 1932. By resolving the difficulties of R.D., a married man with children, the APSW considered that 'apart from the hope of relieving a distressing personal situation, R.D. seems essentially capable of contributing, as an intelligent and responsible citizen, to the community on which he has so long parasitically depended'.²⁶ Fifteen years later similar ideas were cited in the *BJPSW*: 'We have to help the patient to assume social responsibilities for himself, his family and the community, to bear strains and pressures'.²⁷

Within CGCs, PSWs argued that children's problems usually stemmed from some imbalance of the mother. Margaret Tickler suggested that the mother's role in a CGC could vary: 'there are mothers who will be treated only in their role as parent, and with whom work will be confined to the mother-child relationship. And there are mothers who will be regarded as patients in their own right.'²⁸ PSWs working in CGCs may have sought to glorify their work as psychotherapeutic treatment with a patient (the mother), as psychotherapy, but a contradiction lay in the fact that it had been the child, and not the nominally healthy mother, who had been referred to the clinic with problems. Betty

²⁶ 'Psychiatric Social Work and the Family by the APSW Part II Illustrative Material: A Study in Preparation for the Second International Conference on Social Work', p. 7, MSS.378/APSW/16/4/3. This pamphlet was produced for a conference held in 1932.

²⁷ G. Hamilton, *Theory and Practice of Social Case Work* (London, 1940), quoted in P. Armstrong, 'Aspects of Psychiatric Social Work in a Mental Hospital', *BJPSW*, 1 (1947), pp. 36-44. Quoted on p. 44.

²⁸ M. Tickler, 'Indications for Successful Work with Parents in a CGC', *BJPSW*, 1 (1947), pp. 80-84. Quoted on p. 82.

Joseph's psychoanalytic approach allowed her to overlook this potential drawback. 'One tends to find in working with mothers and babies, that one is really handling the situation as if one were dealing with one person not two', she wrote. 'If one feels that a mother and a young child are essentially emotionally one, then if one can alter, ever so little, the feeling in the mother, this fact will show itself in her child.'²⁹ However, an attack was launched upon those PSWs who engaged in psychoanalytic treatment interviews from a group within the APSW concerned with the social.

The course of our future development depends upon our present choice, whether we chose to extend our knowledge of and skill in therapeutic relationships to the neglect of our other interests and abilities, or whether we reorientate both our knowledge and our skill around a new conception, which is probably the rediscovery of an old concept of our function as social workers who are students of social life.³⁰

2.3: A Social View of Mental Illness and Psychiatric Treatment

If the focus on the treatment of individuals and their problems through psychoanalysis was largely prescribed by PSWs working in CGCs, the impetus to adopt a more social view of psychiatry came mostly from PSWs working in the mental hospital and local authority field. While PSWs in CGCs were 'working in a setting where prognosis for patients was on the whole better and in which the emphasis was on preventative work',

²⁹ B. Joseph, 'A PSW in a Maternity and Child Welfare Centre', *BJPSW*, 1 (1948), pp. 30–45. Quoted on p. 34.

³⁰ F. E. Waldron, 'The PSW's Professional Standing', *BJPSW*, 1 (1948), pp. 10–17. Quoted on p. 17.

the mental hospital PSW was faced with an 'overwhelming...amount of incurable illness'. Her colleagues working in the field of community care, meanwhile, were 'likely to find that a high proportion of "hopeless" cases will come her way - semi-stabilised psychotics, chronics of all descriptions, psychopaths, epileptics, dullards - until the local authority office may even be regarded as a sort of benevolent dustbin'.³¹ These were the type of cases that psychiatrists involved in mental health and social psychiatry, or those seeking to transform the image of their asylum from a custodial institution to a curative hospital, might have wished to distance themselves from. It was believed that the stigma of such chronic cases might prejudice the public against mental health schemes or from voluntarily entering mental hospitals. Indeed, in the 1930s many new admission blocks and convalescent villas were built by asylums with the aim of removing any possible contact between permanent and voluntary patients.³² However, it was precisely these cases, deemed hopelessly incurable by psychiatry, which PSWs working in mental hospitals and for the local authorities tried to help by a social rather than a medical approach. Both in mental hospitals and in local authority settings, PSWs moved away from their original primary function as a link with the parents and relatives of the patient, to work directly with the patient. Perhaps by working with cases largely shelved by the medical profession, PSWs were able to demarcate their own professional domain.

³¹ K. I. Jones and P. M. Hammond, 'The Boundaries of Training', *BJPSW*, 1 (1948), pp. 172-7. Quoted on pp. 173-4.

³² Voluntary treatment at a mental hospital was legalised by the 1930 Mental Treatment Act. In the same year, Durham Mental Hospital considered building an admission hospital where cases of a 'recovering type' could be treated without 'coming into contact with permanent patients'. *NAWU Magazine*, 19 (July, 1930), p. 8.

For PSW Margaret Eden, who worked in observation wards and short stay treatment units, this social approach to psychiatry was ‘concerned with the way in which social events cause, exacerbate, minimise or prevent the manifestations of illness...about the interaction of social and clinical events’.³³ PSWs who adopted this approach pushed for further research into the emotional, sociological and environmental factors in mental illnesses.³⁴ Margaret Ashdown suggested that the tactic of treating the patient within a network of other people was a professional skill distinct to PSWs. ‘Some of us would argue’, she wrote, ‘that one of our functions in psychiatric social work is to attempt to individualise the various components of a patient’s human environment and to see the situation through their eyes as well as through the patients, so that we may be able to supplement the greater “single-pointedness” towards the patient demanded by the psychiatrist’.³⁵

Viewing the patient as part of a wider social network, PSWs working in mental hospitals were more likely to conceptualise and work with the mentally ill person within a wider public setting. This process was accelerated by the more general moves to treat the patient in the community arising from criticism of asylum care, new treatment methods, attempts to economise on care and the increasing provision of facilities for the

³³ M. Eden, ‘A Short Stay Psychiatric Treatment Unit’, in the APSW, *New Developments in Psychiatry and the Implications for the Social Worker* (London, 1969), pp. 6–11. Quote on p. 8.

³⁴ Armstrong, ‘Aspects of Psychiatric Social Work’, discussed pp. 43–44.

³⁵ M. Ashdown, ‘Editorial’, *BJPSW*, 1 (1948), pp. 3–9. Quoted on p. 8.

mentally ill within the community.³⁶ PSWs suggested that treatment in hospital was just an interlude in a patient's illness, and that the role of the PSW lay in preparing the patient for a future outside the hospital rather than their care within the hospital.³⁷

The social outlook held by many members of the APSW led them to hold more reserved views about the success of medical treatments. Thus Madelene Crump in her work with cases who had been treated with largactil, found that many patients had lost contact with their families during their hospitalisation and had to come to terms with their loss. Mary Lane, who worked with leucotomised patients and their families, found that patients whose operations were judged a medical success were often rejected by their families.³⁸ By examining the impact on entire family groups, Lane suggested that decisions about treatments should be shared with family members. She also questioned the success of physical treatments to improve the life of the patient, emphasising that illness had an impact not just on the patient but their broader social network.

PSWs working in mental hospitals found themselves coping with the social

³⁶ A valuable discussion of the various factors that paved the way for community care can be found in J. Welshman, 'Rhetoric and Reality: Community Care in England and Wales, 1948-74', in P. Bartlett and D. Wright (eds), *Outside the Walls of the Asylum: The History of Care in the Community 1750-2000* (London, 1999), pp. 204-26.

³⁷ M. Eden, 'A Modern Observation Ward and the PSW', *BJPSW*, 3 (1955), pp. 13-18. Quoted on p. 18.

³⁸ M. Crump, 'Social Aspects of Physical Treatment in Mental Illness', *BJPSW*, 5 (1959), pp. 19-25; M. A. Lane, 'The Effect of Leucotomy on Family Life', *BJPSW*, 3 (1956), pp. 18-24. Both these articles give detailed case histories.

problems of patients who had undergone physical treatments. Those who worked in the field of community care faced a different problem, finding that many of their cases were beyond the help of psychiatric medicine. Michael Power, who worked in community care, discussed the problems that the limited power of medicine posed for him:

Often there *is* nothing to be done. The person with chronic schizophrenia or a psychopathic state whose symptoms frustrate generations of social workers is a constant problem...it is a bone of contention that hospitals all too easily label a patient as chronic, and then pass the responsibility back to the social agencies serving the area to deal with as best they can. We frequently meet resentment amongst relatives and social workers because the hospital has failed to cure the patient. It is difficult for them to understand intellectually and accept emotionally the limitations of psychiatry, because of a natural tendency to regard specialists and hospitals as omnipotent and refuse to accept knowledge as limited and incomplete.

Power continued 'often there is a great deal to be done, but socially rather than medically'.³⁹

2.4: Psychiatric Social Treatment

Margaret L. Ferard, in an early article on her work with paranoid schizophrenics outside of the mental hospital, coined the phrase 'psychiatric social treatment', to distinguish her

³⁹ M. Power, 'Community Care: A New Service', *BJPSW*, 3 (1956), pp. 4–10. Quoted on p. 7. Italics in original text.

work from psychiatric treatment carried out primarily from a medical standpoint.⁴⁰ Ferard's approach to schizophrenia was focused on assessing and optimising the patient's degree of mental health, instead of concentrating on their illness. When working with chronic schizophrenics, Ferard attempted to

Help the patients to the best social adjustment which their symptoms permit. Psychiatric social treatment interpreted in this way is not concerned with 'curing' mental illness, nor even necessarily with trying to reduce symptoms, it is less ambitious, frankly palliative, and more directed to assessing the degree of health than a degree of ill health.⁴¹

An important aspect of Ferard's task was assisting her cases to gain work. Employment gave the patients more independence and removed them partially from any domestic tensions in the family. It also seemed to be an important criterion Ferard used to measure the social adjustment of her cases. E. F., for example, found work for himself in a bakery, as he believed that influences reflected from aeroplanes and arranged by the hospital authorities caused him to make mistakes in his previous clerical occupation. He was judged to no longer require compulsory treatment for his illness and was thus discharged from certification after Ferard decided 'he had been earning his own living, was less disturbed by his symptoms and assumed a tolerant aloofness towards other people'.⁴²

⁴⁰ M. L. Ferard, 'Notes on the Psychiatric Social Treatment of Mental Hospital Patients: Four Paranoid Schizophrenics', *BJPSW*, 1 (1947), pp. 45–56. Quoted on p. 45.

⁴¹ *Ibid.*, p. 54.

⁴² *Ibid.*, p. 53.

Ferard's emphasis on maximising the healthy aspects of her cases and restoring their social functioning was developed further by PSW Eugene Heimler in his attempts to help the mentally disordered into employment. Heimler was a Hungarian Jew who had survived internment at Auschwitz and Buchenwald. Leaving Germany in 1947, Heimler trained to be a PSW at the London School of Economics. Heimler believed he had learnt from his experience the emotional significance of satisfying work, and the corrosive effect which purposeless labour had on the personality.⁴³ He claimed 'a satisfactory job is the best psychotherapist' and argued that given the conditions that suited them, for example understanding employers, people with apparently crippling delusions could lead normal lives.⁴⁴

Heimler had the opportunity to test his theories when in 1954 he led a project in Hendon, Middlesex, to attempt to bring the unemployed back to work through the combined efforts of their families, of society, and of PSWs. The National Assistance Board referred cases to Heimler who exhibited emotional problems. Heimler found that many of these 'work-shy' clients had deep-rooted emotional difficulties and were unable to utilise their energies in work until these problems were examined. The PSW had to help release the client's ability to work. The scheme was expanded from its initial thirty-one cases to 301 by

⁴³ In his book he describes taking part in a 'mental health' experiment in Troglitz concentration camp which involved moving sand from one end of a factory to the other and then moving it back again. This 'meaningless task' dramatically increased the suicide rate. Described in E. Heimler, *Mental Illness and Social Work* (Harmondsworth, 1969), pp. 107-8.

⁴⁴ C. Driver, 'Concentration Camp Graduate', *Guardian*, 8 April 1961.

1956. Around half of these cases had never seen a psychiatrist and were referred to prevent further problems.⁴⁵

Heimler drew on psychoanalytic theory to argue that the present could be utilised as a therapeutic tool to induce the patient to adopt a new pattern of functioning that would assist him to feel differently about the past. 'Satisfaction can alleviate past frustrations...the past influences the present, but the present also influences the past.'⁴⁶ Heimler recognised the problems that might block a case from being able to work and the emotional significance satisfactory work could hold for a client. He extended his analysis to a study of the relationship between an individual's satisfaction levels and their ability to function socially, arguing that social isolation, prevalent amongst the elderly, might also increase an individual's sense of purposelessness and induce mental distress.⁴⁷ Assisting the elderly to find a purpose in life and satisfactions through hobbies and useful occupations, he believed, should combat this isolation.

Convinced that a sense of purposelessness and futility caused people to breakdown unless counterbalanced by their satisfactions in life, Heimler created a Social Function Scale test. This measured the client's levels of satisfaction in the areas of financial security, sexual satisfaction, satisfaction through family relationship, satisfaction through friendship, satisfaction through work and hobbies. Low satisfaction level scores indicated a patient's

⁴⁵ Heimler, *Mental Illness and Social Work*, 111-7.

⁴⁶ *Ibid.*, p. 119.

⁴⁷ *Ibid.*, pp. 54-55.

inability to function adequately in a social setting. Heimler's work was important in two ways.⁴⁸ By embracing the ability of the present to change the way a person may feel about negative events in the past, Heimler's approach could be viewed as therapeutically optimistic and constructive. Heimler also partially severed the link between mental illness and the ability of an individual to function adequately in their community. As Heimler explained to journalist Christopher Driver, 'people who were revealed to be hopelessly neurotic when scored by Doctor Eysenck's Maudsley personality inventory could score correspondingly high on "social functioning". Their satisfactions, it seemed, could counterbalance their sickness.'⁴⁹

It was not just outside the walls of mental hospitals that PSWs sought to maximise the health of their cases. Changes within the hospital were also taking place. Madelene Crump described how the days of the isolated and self-contained hospital were fading: 'Doors - and gates - are being opened. Some hospitals are concentrating on extending outwards into the community; others are bringing the community in.'⁵⁰ Initially the uniqueness of the PSW in the mental hospital had been her role on the fixed boundary between hospital and community. Now PSWs found that the boundary itself was being dissolved - in theory at least. One major innovation within the hospital was the ideology of the therapeutic community that many hospitals were trying to adapt for their circumstances. Crump, in 1959, claimed that 'the mental hospital is in the process of

⁴⁸ *Ibid.*, pp. 122-9.

⁴⁹ C. Driver, 'Testing Social Normality', interview with Eugene Heimler (possibly from the *Guardian?*), MSS.378/APSW/14/4:122; APSW and the Press: Press Cuttings 1955-65, MSS.378/APSW/14/4/1-125.

⁵⁰ Crump, 'Social Aspects of Physical Treatment', p. 19.

becoming a real community, whose aim is not merely to achieve the absence of disease, but to include in a social process, which fosters healthy ways of living and thinking, patients who have in varying degrees withdrawn from participation in their normal everyday world'.⁵¹ By maximising the healthy aspects of patients, hospitals were able to reduce the amount of physical treatments given to patients.

Both the social approach to psychiatry and attempts made to maximise the mental health of patients sought to enable as many patients as possible to function as well as possible within the community. For the more damaged patients, changes within the mental hospital itself and the growth of day hospitals sought to bring the community into the hospital and break down the boundaries to the outside world. A career pamphlet for would-be PSWs argued that 'the increasing provision of out patient facilities and care in the community for the mentally sick has enabled many potential and ex-patients to remain out of hospital, usefully employed, and relatively well adjusted to their environment'.⁵² However, one consequence of a social approach was that mental deficiency, which was believed to have a more physical basis than mental illness became increasingly excluded by PSWs. Mental deficiency had never been a popular area of work for PSWs. However, the later focus on emotional family disorders could only have deprioritised mental deficiency work still further. F. Joan Todd, a PSW engaged in work with the mentally deficient, wrote a rare article in the *BJPSW* trying to emphasise the

⁵¹ *Ibid.*, p. 19.

⁵² 'Psychiatric Social Work as a Career', pamphlet printed by the APSW before 1959, p. 1, MSS.378/APSW/16/4/17.

constructive and progressive nature of her work. Todd described the wide range of clinical types the term defective could cover before claiming 'the rate of discharge after successful licence is much greater than many people realise. With the new attitude to mental deficiency which is current at the present time, more and more emphasis is being placed on returning patients to the community.'⁵³

Within the child guidance clinics too the emphasis was shifting from deeply disturbed children to more normal children. Deborah Thom has noted that the focus of the CGCs shifted after their inception from 'dangerous children' to 'children in danger'.⁵⁴ An article in *Mother* in 1961 sought to dispel prejudice against CGCs by remarketing them as places that treated normal children. CGCs, the article claimed, 'deal essentially with normal children...The whole aim of the work carried out in such clinics is to keep normal children normal.'⁵⁵ An article printed the following year in *Good Housekeeping* also advertised the work of CGCs to its middle class readership and sought to dispel prejudice. The types of problems discussed in the article such as thumb sucking and bed-wetting were less disturbing than those described by PSWs in early articles. Even the writer of the article acknowledged the change in direction of the clinics. 'Originally it

⁵³ F. Joan Todd, 'Psychiatric Social Work in a Mental Deficiency Hospital - First Impressions', *BJPSW*, 3 (1956), pp. 25-27. Quoted on p. 27.

⁵⁴ Thom, 'Wishes, Anxieties, Play and Gestures', p. 200.

⁵⁵ 'When Parents Can't Cope', *Mother*, February 1961, exact page reference unknown, MSS.378/APSW/14/4/58.

was the unruly ones who were sent to the clinics. Today, quite as often, it is the too-quiet child who comes for help.’⁵⁶

2.5: Using Casework to Treat Sick Middle-Class Families

By 1969, Margaret Eden wrote that PSWs ‘no longer take social histories as such but assess family relationships, attempting to identify and define problems with a family with a view to relieving its tensions. They may treat the family as a group.’⁵⁷ This approach was typified by E. M. Goldberg’s examination of the family dynamics in cases where a son was being treated for schizophrenia. Goldberg believed that schizophrenia might emerge in genetically predisposed individuals but felt that stressful social environments could precipitate the illness. She suggested that the social worker should attempt to modify these environmental stresses by working with the patient’s family or by recommending that the patient not be placed back with his family. ‘We cannot expect patients to complete their recovery’, Goldberg argued ‘in the environment (mostly unaltered) which has helped to make them ill’.⁵⁸ There are similarities between Goldberg’s work and *Sanity, Madness and the Family*,⁵⁹ in which the interactions between family members were studied in an attempt to make the experiences and behaviour of the schizophrenic member of the family socially intelligible. However,

⁵⁶ E. Elias, ‘Please, Can You Help Me?’, *Good Housekeeping* (March, 1962) p. 89.

⁵⁷ Eden, ‘A Short Stay Psychiatric Treatment Unit’, p. 11.

⁵⁸ E. M. Goldberg, ‘Parents and Psychotic Sons’, *BJPSW*, 5 (1960), pp. 184–94. Quoted on p. 186.

⁵⁹ R. D. Laing and A. Esterson, *Sanity, Madness and the Family: Families of Schizophrenics* (1964, London, 1970).

Laing and Esterson concluded from their research that the schizophrenic family members they had studied were 'struggling to make sense of a senseless situation' created by other family members.⁶⁰ Goldberg believed that in the absence of the father, a pathogenic situation sometimes emerged in which the patient and parent might be locked together in a common sickness. This situation could not be treated by a psychiatrist who often 'sees the parent as a harmful agent who has contributed and is still contributing to his patient's illness. The parent is almost his enemy, who not infrequently is trying to sabotage his work in many irritating ways.' Goldberg argued 'the fact that we are social workers, with one foot in the community, and not doctors who deal mainly with the sick in hospitals or clinics may help to stimulate the healthy forces in the relatives'.⁶¹ Eugene Heimler, who worked in community care, often found that the individual who was referred to him was often not the most disturbed member of a family and that casework needed to be directed to the entire group. Heimler believed that the breakdown of a member of the family could reflect the psychopathological problems of the whole family that might need to be treated in casework.⁶²

PSWs working with families adopted a psychodynamic approach, attempting to resolve emotional difficulties in increasingly middle-class, nuclear families. This interest in preserving and working with the nuclear family was also exhibited in the activities PSWs engaged in outside of the work time: the 1953-54 APSW Annual Report noted that

⁶⁰ *Ibid.*, p. 265.

⁶¹ Goldberg, 'Parents and Psychotic Sons', p. 193.

⁶² *Ibid.*, p. 24. *Italics in original text.*

PSWs had served on the Family Discussion Bureau, Family Service Units, Family Welfare Association and the Marriage Guidance Council.⁶³ In 1969, an APSW conference noted that PSWs were moving away from casework with individuals and developing new techniques of work with various groups, including the family and the therapeutic community.⁶⁴ It might be argued that PSWs' interest in group dynamics led them to adopt a less patient-centred approach than psychiatrists. In a letter to *The Times* in 1963 Irene Spackman wrote

We have to recognise that some patients coming home...still entertain delusions or behave in a way which may cause great suffering to spouse and children...This community mental health service cannot be purely patient-centred, but has the more difficult task of balancing up the mental health needs and risks of all members of the family.⁶⁵

2.6: Adaptation, Individual and Society

When considering their duties, PSWs frequently balanced the needs of their clients - private individuals - with the wider common good of the public. This divided PSWs' loyalty. Thus PSWs working in child guidance felt that 'the social worker, notwithstanding her appreciation of the motivation of the client's particular demands and

⁶³ 'APSW Annual Report 1953-54', typescript, p. 7, MSS.378/APSW/2/1/19.

⁶⁴ M. Thomas, 'Conclusions', *New Developments in Psychiatry*, pp. 52 - 54.

⁶⁵ I. B. Spackman, letter to the editor of *The Times* on 16 Sept. 1963, published in *The Times*, MSS.378/APSW/14/3/105a; APSW and the Press: Press Correspondence 1955-65, MSS.378/APSW/14/3/1-111.

denials, remains a positive figure, making implicitly, in her role of representative of the community, demands of her own'.⁶⁶ F. E. Waldron, while trying to focus PSWs' attention more on the 'social' aspect of their work, argued that PSWs had a 'double allegiance': 'it is as qua social worker, that is, professionally, that we are doubly committed. We can never give the final consideration to our patient's problem when he is clinically isolated, and we cannot cure him at the expense of society. We have, then, a tradition of service to the individual and to society. A social worker is a social servant.'⁶⁷ In a paper given to the psychiatric session of the BMA in 1950, E.L. Thomas made similar arguments about the 'distinctive' role of the PSW in

The counter-poising of its two aspects - the inner, that which is orientated to the patient, his personal troubles and his particular needs, and the outer, concerned with the obligations imposed by society and the inter-relatedness of members of his circle...if the social worker can avoid both an identification with the patient in his battles with authority and at the same time refrain from becoming a watchdog of the community, she can, I think, have a useful function in easing points of friction...her concern for a patient's optimal readjustment cannot be pursued to the point of jeopardising the welfare of others.⁶⁸

Molly Harrington, a PSW who worked in a borstal institution, believed she should represent the interests of the social forces that had committed her clients to the borstal. 'I

⁶⁶ L. A. Shaw and F. E. Waldron, 'Social Workers' Interviews', *BJPSW*, 1 (1947), pp. 8–15. Quoted on p. 9.

⁶⁷ F. E. Waldron, 'The Meaning of the Word "Social" in Psychiatric Social Work', *BJPSW*, 1 (1949), pp. 7–17. Quoted on p. 12.

⁶⁸ E.L. Thomas and K. M. Lewis, 'Papers on the Role of the Psw Given to the AGM of the Psychiatric Session of the BMA in 1950', *BJPSW*, 1 (1950), pp. 18–24. Quoted on p. 22.

myself have come to feel that a worker “inside” must start with an acceptance of...the present stage of social opinion and, above all, of the work of the people operating the system - having, in short, a caseworker’s approach rather than a reformers.’⁶⁹

In the early years of their profession, PSWs expected the patient to adapt to society, and not the other way round. The PSW was not expected to challenge the social order that their client may have fallen foul of. Gradually, however, the onus upon the patient or client to adapt himself to society shifted, perhaps as a result of the development of psychiatric social treatment. In a careers pamphlet printed in 1960, psychiatric social work was described as ‘a branch of social case work which is concerned with helping disturbed people and society adapt themselves to one another’.⁷⁰ The PSW’s role was now to mediate between the interests of the private individual and the wider public. The most sustained attack on the idea that the mentally disordered individual should strive to adapt himself to society was launched in a 1963 APSW conference. In the annual report for the year, the chairman, Irene Spackman, refuted the earlier stance of Molly Harrington. ‘Attention has been focused upon the responsibility of the social worker for influencing social policy. We have been reminded that casework is not a panacea for all social ills.’⁷¹ A report of the APSW conference in *New Editor* complained that people could not be expected to adapt to society if society failed to provide adequate resources.

⁶⁹ M. Harrington, ‘Psychiatric Social Work in a Borstal Institution’, *BJPSW*, 1 (1950), pp. 40–42. Quote on p. 40.

⁷⁰ ‘A Career as a Psychiatric Social Worker’, Folded A4 information sheet, printed 1960 or 1961, MSS.378/APSW/16/4/14.

⁷¹ ‘The APSW Annual Report 1963’, p. 7, MSS.378/APSW/2/1/29.

This critique of inadequate resources for people already disadvantaged by mental illness was followed by an attack on a social policy that sought to fracture the PSWs' approach to the sick family rather than the sick individual.⁷² In the original draft for this piece, PSW Jean Nursten reported

It was thought that casework skills are misused and may be brought into disrepute when the aim is to adjust clients to situations which really require social action on a larger scale...The members of the conference thought that social workers' responsibility lay in effecting change in the client and in society.⁷³

3: External Representations

3.1: The PSW as a Representative of Mental Health in the Community

The question of the PSW's role in the community was a topic of discussion from early in the profession's history. In 1936 Margaret Ashdown asked 'whether the PSW has not a special responsibility to the community at large, as representing a certain attitude to mental and nervous disorder. The function will, indeed, be almost forced upon her by her position and title, but she will probably be most effective if she does not carry a banner

⁷² From unnamed, undated paper, 'Social Work: Who's Out of Step?', MSS.378/APSW/14/4/120. Judging from the phrasing of this article, it appears to be the one sent by PSW Jean Nursten to the editor of *New Society* reporting on the APSW conference 'Psychiatric Social Work: Developments in Training and Practice', held in Manchester from 8-13 September 1963, MSS.378/APSW/14/3/106a. Nursten entitled her piece 'A Question of Adjustment'.

⁷³ Nursten, 'A Question of Adjustment'. Underlining in original text.

and is not too vocal.’⁷⁴ Ashdown may have down played the extent of the PSWs’ role as this paper was presented before the psychologists in an early stage of the development of psychiatric social work and the purpose may well have been to ‘sell’ the occupation to allied professions without encroaching on their field of work. In the second issue of the *BJPSW* in 1948, PSWs started to embrace more enthusiastically their role within the community. Pauline Shapiro believed that the PSW had a dual function as a therapist and educationist and as a carrier of psychiatric concepts and attitudes: ‘She is confronted by the therapeutic needs of the patient and the social values and demands of the community. Is it not perhaps specially important that she should accept more consciously her function as educationist at this time of new legislation reflecting new social values and needs?’⁷⁵ This move to a more active position had been consolidated by 1959, when a careers pamphlet described psychiatric social work as being ‘particularly concerned with the promotion of mental health in individuals and the community’. This pamphlet also stressed ‘the public relations aspect of being able to put across the mental health “approach” to those not immediately interested’.⁷⁶

3.2: The Public Relations Sub-Committee

The PRSC was inaugurated in 1957 after the BBC programme ‘The Hurt Mind’ was broadcast, when it noted that ‘the Committee felt that this had been a much needed and

⁷⁴ Ashdown, ‘The Role of the PSW’, p. 19.

⁷⁵ P. C. Shapiro, ‘Some “After-Care” Patients in Rural Areas’, *BJPSW*, 1 (1948), pp. 51–70. Quoted on p. 70.

⁷⁶ ‘Psychiatric Social Work as a Career’, pamphlet produced by the APSW between 1950 and 1959. Quoted on p. 1 and p. 5, MSS.378.APSW/16/4/16.

excellent attempt at a difficult subject, but pointed out that the whole field of psychiatric social work was barely mentioned'.⁷⁷ Initially the PRSC set out to monitor the press, radio, television and other publications in order to correct inaccuracies and provide constructive comment. They also hoped to produce material publicising the profession and to get the branches involved in collecting and replying to the press.⁷⁸ It should be noted that from the outset the PRSC were mainly concerned with the profession of psychiatric social work, and that general issues regarding mental health and illness were further down, or even incidental, on their agenda. The PRSC asserted that 'the work of this committee differed subtly from that of other committees in so far as any results represented, or should do so, the public face of the Association.'⁷⁹ For the historian, this body provides a link between the internal debate regarding mental illness within the association, and the ideas that the APSW sought to promote outside their professional sphere, although individual PSWs no doubt used their involvement in other organisations such as the NAMH to promote mental health and psychiatric social work.

Several factors handicapped the PRSC's effectiveness. Virtually all the members serving on the committee also had full time jobs as PSWs, and it became clear that APSW members were not eager to participate. A meeting with branch members noted that people were being 'bludgeoned' into taking office because there was no one else who

⁷⁷ Meeting of the PRSC of the APSW on 7 February 1957, p. 2, MSS.378/APSW/14/1/3. The making of 'The Hurt Mind' is discussed in detail in Chapter Six.

⁷⁸ From the APSW PRSC terms of reference, MSS.378/APSW/14/1/1.

⁷⁹ APSW PRSC meeting minutes 21 February 1961, p. 3, MSS.378/APSW/14/1/31.

would.⁸⁰ Judging from the meeting minutes, serving on the PRSC could be a disappointing experience. The problem of the 'boundary identity' of PSWs proved exceptionally difficult for the PRSC, who felt their first main objective lay in producing 'a good definition of the functions of a PSW'.⁸¹ The APSW executive looked to the PRSC to communicate to the public the role of the PSW and the viewpoint of the APSW, as 'it was felt that as a professional body it had a definite viewpoint to put across'. However, the passage continued 'This still holds good, even though there is within the Association a wide range of opinion on certain subjects'.⁸² Not only did a boundary identity lie in the way of producing a clear description of psychiatric social work, it also made it more difficult for the PRSC to visually represent their work. A PSW reporting on her experience in an exhibition in 1955 noted 'psychiatric social work is insuperably unpictorial. No uniforms, no badges, no exhibits, not even a photo could really demonstrate what we do, unless, as one of us gloomily observed, it were a photo of a woman on a wet day knocking at a door.'⁸³ When the PRSC were attempting to create their first poster, they 'realised how hard the idea was to represent'.⁸⁴ The executive expected the PRSC to provide clear descriptions of psychiatric social work while acknowledging that no such clear-cut picture existed. The impossibility of this task fell on the PRSC. At one disheartening meeting the secretary wrote

⁸⁰ APSW PRSC and representatives from branches, meeting minutes 23 October 1959, p.3, MSS.378/APSW/14/1/24.

⁸¹ APSW PRSC meeting minutes 16 May 1958, p. 2, MSS.378/APSW/14/1/12.

⁸² APSW PRSC meeting minutes 14 March 1957, p. 2, MSS.378/APSW/14/1/4.

⁸³ R. Morrison, 'Reflections on an Exhibition', *BJPSW*, 3 (1955), pp. 32–35. Quoted on p. 32.

⁸⁴ APSW PRSC meeting minutes 25 July 1958, p. 1, MSS.378/APSW/14/1/15.

There was a feeling that members were not clear about their function and felt that they had not been given a function. It was pointed out, however, that...the sub-committee was established to work out its own function. The fact that a number of its ideas to date had either not worked or had been refused did not mean it was useless. Any feelings of discouragement or exasperation lay within the sub-committee and not elsewhere.⁸⁵

In a meeting of the APSW PRSC with Miss McClenan of the public information department of the NAMH, Miss McClenan 'made a plea for frankness':

The APSW tends to be an ivory tower, maintaining a language so esoteric that the function of the PSW is incomprehensible to the ordinary lay mind. A clear but simple definition of what a PSW is and does has never, to her knowledge, been made public. Because this is so, there is sometimes the tenancy to regard the profession as a phoney one.⁸⁶

3.3: Ignorance of the Press and Public

The PRSC believed they had to battle against widespread press and public ignorance and apathy about psychiatric social work. Noel Timms' account of the profession, published in 1964, was written largely to inform his readers who PSWs were and what they did. In his introduction Timms cited a pilot survey into public knowledge of, and attitudes to,

⁸⁵ APSW PRSC meeting minutes 21 January 1961, p. 2, MSS.378/APSW/14/1/30.

⁸⁶ APSW PRSC meeting minutes, 10 July 1959, p. 1, MSS.378/APSW/14/1/21. Apparently the PRSC 'took this most welcome frankness on the chin'.

social work and the social services. 75 per cent of the sample interviewed had not heard of PSWs while 80 per cent could not say what they did. Most of the remainder thought that PSWs were engaged in the actual treatment of mental patients.⁸⁷ At a meeting of the PRSC, guest speaker George Burden, General Secretary of the British Epilepsy Association and a PSW, suggested 'the public at large had a very dim view or even no view at all, of what social work was, and this was even more so as far as psychiatric social work was concerned'.⁸⁸

Ignorance of the functions of PSWs was believed to extend into, and perhaps emanate from, the press. The PRSC initially focused on sending letters to the media to correct misrepresentations of PSWs and to attack omissions of PSWs' work. Mrs Finch, the chair of the committee, commented to the chair of the medical committee established to advise the BBC that 'it was felt to be misleading to show doctors functioning by themselves in programmes without any mention of other professional and technical staff'.⁸⁹ She also wrote to *Guardian* television critic Mary Crozier complaining 'we feel it is impractical and even petty to keep writing letters of protest when, for instance, a PSW is shown on the BBC doing nothing more than getting into bed with a psychiatrist or

⁸⁷ Timms, *Psychiatric Social Work*. Timms claimed that his book was 'designed to answer certain questions: who are PSWs? What do they do? Are they "half-baked" or adequately trained?' (p. 1). The survey is cited on pp. 7-8. It is interesting that Timms cited the answer of respondents that psws were engaged in treatment of patients as wrong, given that several PSWs had described their work in the *BJPSW* as psychiatric social treatment.

⁸⁸ APSW PRSC with branch representatives meeting minutes 23 October 1959.

⁸⁹ APSW PRSC meeting minutes, 29 September 1961, MSS.378/APSW/14/1/35.

removing a coat from her back to put it on that of a patient'.⁹⁰ Mrs Finch's grievances may have resulted from the BBC's reliance on doctors and psychiatrists for advice when creating programming, which is explored in Chapter Six in the case of 'The Hurt Mind' series.

3.4: Selling Psychiatric Social Work

Perhaps recognising that they could do little to stop misrepresentations of their occupation, the PRSC increasingly sought to produce and circulate positive images of their work as a skilled profession. 'The first step to be taken was the development of a conviction that psychiatric social work should be sold - that it was worth selling', Mr Burden decided in a PRSC meeting.⁹¹ PSWs were selling to several different audiences. They needed to persuade potential employers that a PSW could be a useful and productive member of the team. They needed to reassure potential consumers - especially mothers of children referred to child guidance clinics - that their work was helpful. They wanted the general public to be more informed and positive about psychiatric social work. The main emphasis of their campaign was, however, towards potential recruits. Some members of the APSW questioned whether the profession should be seeking to promote its services at all. A branch representative from Scotland argued 'it seemed

⁹⁰ Letter from Mrs Finch to Mary Crozier, 12 October 1961, MSS.378/APSW/14/3/84.

⁹¹ G. Burden, APSW PRSC meeting minutes 23 October 1959.

futile, if not worse, to paint glowing pictures of what the profession could do when the supply of workers was so limited as to preclude fulfilling it'.⁹²

One of the first tasks of PSWs was to sell their profession to psychiatrists. As Peggie Armstrong commented in the first issue of the *BJPSW*, 'it is true to say that social workers needed the help of psychiatrists long before psychiatrists were prepared to acknowledge that they needed lay assistance in the form of trained and skilled PSWs'.⁹³ A pamphlet produced by the APSW in 1943 attempted to sell PSWs to potential employers, emphasising how the PSW could assist the psychiatrist. In regard to training, the pamphlet noted 'emphasis is placed on the importance of this training to ensure full professional cooperation between social worker and the medical staff'. Another passage suggests the PSW could act as an assistant or auxiliary, suggesting the PSW 'may also be able to assist in research by such means as following up...a group of patients'.⁹⁴ However, the APSW's concern that registration of university trained PSWs as medical auxiliaries under the Cope Report would damage their chances of having psychiatric social work recognised as a specialised profession led PSWs to distance themselves from this earlier role. Increasingly in the internal debate of the profession, PSWs sought to emphasise the social aspect of their work in order to bolster their claims of distinct professional expertise. In 1956, the APSW attacked the BMA for the evidence they had given to the Working Party on Social Workers: 'It would seem that when the doctors emphasise so

⁹² APSW PRSC meeting minutes, 23 October 1959.

⁹³ Armstrong, 'Aspects of Psychiatric Social Work', p.36.

⁹⁴ 'Psychiatric Social Work in Mental Hospitals', APSW pamphlet printed around 1943, p. 3, MSS.378/APSW/16/4/7.

much “a real sense of vocation” and so little the acquisition of skills, they are perpetuating in the social field a state of affairs which would not be accepted in their own profession’.⁹⁵

The APSW sometimes sought to promote their services to potential service users, although the value of this was debated. In 1958, the PRSC debated whether or not to contribute an article on psychiatric social work with the mentally deficient to *Parent’s Voice*. ‘It was felt that as so few PSWs were working in this field it might be unwise to do anything which would stimulate too great a demand’, they explained, although finally an article was contributed by Joan Todd.⁹⁶ A more sustained attempt was made to promote the work of CGCs. Elizabeth Brown commented on the problems facing the mother which needed to be addressed: ‘after the child has been referred to the clinic, the mother may have to face other problems, such as relatives and friends, who, full of prejudice and the colourful propaganda of some recent films, paint to her a grim picture of what will happen to her child once he gets into the power of a psychiatrist’.⁹⁷ A couple of articles appeared in magazines for mothers tackling the stigma surrounding treatment and emphasising the normality of CGCs. An article in *Mother* wrote ‘whenever they hear the word “psychiatrist” some people immediately think of mental disease...even to have

⁹⁵ Letter to BMA, printed in *British Medical Journal*, MSS.378/APSW/14/3/3.

⁹⁶ APSW PRSC meeting minutes 22 January 1958 and 13 February 1958, MSS.378/APSW/14/1/8-9. This reticence may also be linked to the APSW’s concern that work with the mentally deficient was of a lower status.

⁹⁷ E. Brown, ‘The Preparation of Parents for Treatment in a CGC’, *BJPSW*, 1 (1948), pp. 46–50. Quoted on p. 46.

psychiatric treatment, however simple, at an ordinary clinic in a general hospital, seems to them to carry a kind of stigma. They wouldn't want the neighbours to know...CGCs deal essentially with normal children'.⁹⁸ An article in *Good Housekeeping* the following year also sought to emphasise the normality of CGCs: 'what a long way this idea has travelled since that day, thirty years ago, when so many viewed the first clinic with suspicion! Even ten years back the very thought of "taking him to the clinic" amazed the neighbours in my district.'⁹⁹ By focussing on normal and respectable families, PSWs may have deprioritised those with more severe mental disorders. While articles approved of by the PRSC did tackle community care they do not seem focused on advertising these services to those who might need them but rather to reassure the public that PSWs were engaged in useful, skilled work.

However, the main focus of the PRSC was to sell psychiatric social work as a career to potential recruits. Sometimes the career would be aimed at young 'ladies' and placed alongside jobs such as psychologists, assistant matrons and housemother in children's residential homes, emphasising that the work could be with children - despite the fact that most PSWs working in CGCs worked with the parents and not the children.¹⁰⁰ Such an approach often emphasised the 'vocational' aspect of the work, stressing the moral probity and thus professional nature of PSWs. An article in 1959 claimed 'PSWs have an intense vocational spirit - their training is long and arduous and

⁹⁸ 'When Parents Can't Cope'.

⁹⁹ ' "Please, Can You Help Me?"'

¹⁰⁰ This strategy was adopted in *The Times* on 20 November 1958.

depends upon specialised practical and theoretical courses at a university'.¹⁰¹ An internal letter between members of the PRSC described their approach to selling the career of a PSW, made in consultation with public relations advisors:

At our small meeting we decided that at the moment we were 'selling' a career, with an eye to recruitment, to those above school leaving age, i.e. the 18s and also men and women of 25-30...They suggested that it might be worth while to contact Furzedown and Hillcroft colleges as this would touch people who already knew that they wanted to try some other more interesting occupation if possible and were prepared to suffer financial hardship to achieve it...they emphasised that to attract peoples' attention we should have to write some slightly different articles with some emotional appeal relating to what we get out of psychiatric social work, as it is obvious that we must get something as it isn't financially rewarding.¹⁰²

A 1951 pamphlet advertising the career focused on the unique status of the PSW: 'the PSW is a social therapist, whose previous training and experience in social work combined with additional training in the field of psychological medicine, give her a special role to play in the investigation and treatment of patients, a role which is no less important than that of the psychiatrist or psychologist'. What the pamphlet did not mention was that psychiatric social work was paid considerably less well than either of the other professions (a factor that was believed to cause the low levels of male entrants

¹⁰¹ K. Sansacre, 'The Sympathetic Ear', Untitled paper, June 1959, pp. 164-5. Quoted on p. 165, MSS.378/APSW/14/4/14.

¹⁰² Letter to Mrs Colwell from Mrs Barbara Cautrey, 5 February 1960, 'Re meeting with our public relations advisors on 4 Feb.', MSS.378/APSW/15/3/47.

into the profession), instead focusing on the ‘interesting and satisfying’ nature of the work.¹⁰³

However, representing the emotionally satisfying nature of the work could prove damaging to APSW’s attempts to improve the status and pay for the occupation as a skilled profession. Margaret Barnes wrote in to *The Times* in 1965 in response to an article on psychiatric social work as a career:

Your correspondent suggested that psychiatric social work calls for a ‘selfless character and that such workers are not likely to rate money that highly’. This image of social work is out of date and PSWs, like the medical and nursing professions, wish to have their skills recognised by adequate and fair remuneration.¹⁰⁴

Like psychiatric nurses, PSWs had to tread a line between demanding professional recognition and money or emphasising the vocational aspect of the job and the satisfaction to be gained in helping patients. In 1956 the APSW chairman, Mary Lane, claimed ‘professionalism sometimes means that the members of the profession are losing sight of real values, but in its best sense it should mean a growth of corporate feeling and ethical responsibility towards those whom the profession serves’.¹⁰⁵

¹⁰³ C. Hay-Shaw (on behalf of the APSW), ‘Training for Psychiatric Social Work’, pp. 1–6. Quoted on p. 2 and p. 6, MSS.378/APSW/16/4/9. This pamphlet was probably printed in 1951.

¹⁰⁴ M. Barnes, Letter to *The Times* in response to the article ‘Open Door to Mental Health’, published 30 March 1965, MSS.378/APSW/14/3/108.

¹⁰⁵ ‘The APSW Annual Report 1956’, p. 3, MSS.378/APSW/2/1/22.

3.5: Debating with or Informing the Public?

The PRSC was established ‘to deal with public relations and watch press and radio and other activities, with a view to ensuring the right kind of publicity and initiating, where necessary, correspondence and public discussion’. While public discussion was contemplated in this early definition of the PRSC’s role, it was expected to be led by the APSW, who were presumably hoping for an opportunity to distribute the ‘right’ publicity.¹⁰⁶ In one of the more fraught PRSC meetings, ‘it was asked whether the function should be publicity and not public relations. It was felt that the terms of reference were too broad and that, possibly, things were being attempted that could not be accomplished.’¹⁰⁷ While the committee had initially hoped to encompass all mental health issues, many members felt that this proved too large a challenge for their work and argued that ‘work should be confined to the sphere of PSWs’.¹⁰⁸ In 1958 it was argued that the role of the PRSC was ‘in general “educating” the public’.¹⁰⁹ Essentially, the PRSC chose to restrict their role to represent the interests of PSWs, not the interests of the mentally ill, or even the cause of mental health. Thus discussion of mental illness became more incidental to the committee’s work, mentioned only when relevant to promoting psychiatric social work. A report in the *Guardian* on music therapy in 1962 was criticised because it ‘portrayed mental hospitals with only chronic and deteriorating patients’ not because they sought to destigmatise mental illness but presumably because

¹⁰⁶ *Ibid.*, p. 5.

¹⁰⁷ APSW PRSC meeting minutes, 21 January 1961, p. 2. Underlining in original text.

¹⁰⁸ APSW PRSC meeting minutes 16 May 1958, p. 2.

¹⁰⁹ APSW PRSC meeting minutes 7 July 1958, p. 2, MSS.378/APSW/14/1/14.

PSWs wanted to portray mental illness as a disease one could recover from and require the skills of a PSW.¹¹⁰

The internal debate of the APSW created a new representation of mental illness as a product of social problems, instead of an individual problem that risked affecting society. However, the PRSC were not trying to engage in a critical debate with the public but were trying to represent their own interests, create awareness of their work and correct misrepresentations with the hope of making their occupation seem more professional. This was to be achieved through positive publicity. Perhaps resulting from their efforts to represent their profession to broader audiences, the PRSC may as a consequence have disseminated different images of mental illness and how it might be managed within community settings. The APSW and individual PSWs seem to have been concerned about patient welfare and the lives of the clients; believing however that the public were in ignorance of what they themselves did, many PSWs may have felt that their own lack of public visibility prevented them from campaigning on behalf of patient interests. It is also probable that PSWs felt that campaigning organisations like the NAMH were a more appropriate and effective forum through which to promote their ideas about mental health to a wider audience.

¹¹⁰ APSW Public Relations Working Party meeting minutes October 1962, p. 2, MSS.378/APSW/14/1/38. The PRSC became the Public Relations Working Party in 1962 when Miss Barnes was appointed Public Relations Officer.

4: Conclusion

The APSW set itself two main objectives in its constitution. The first was to 'contribute towards the general purpose of mental hygiene' by 'affording opportunities for the sharing of ideas and experiences'.¹¹¹ The organisation set about this task by creating a number of vehicles for the discussion and debate about mental health and illness amongst PSWs, thus creating a sub-public sphere in which this new group of workers could develop their own ideas. Initially deploying the psychological theories and psychoanalytical techniques circulating in the 1920s to explain why their individual clients had failed to adjust to society, PSWs working for mental hospitals and local authorities began to adopt a social approach to the problems of their cases. This may have been an expedient response by workers faced with clients who had often failed to benefit much from conventional psychiatric practices. However, efforts to assist people to function within the community by maximising their degree of health and effecting changes in their social, family and working environments was a pioneering way of representing individuals with chronic mental health problems. PSWs, who had initially felt they should represent the interests of the state and society, increasingly believed they should be representing the interests of their cases, arguing that it was the environment that had made them sick and failed to provide adequate material support.

The other main objective listed in the 1936 constitution was 'to raise and maintain professional standards, and to encourage the employment of fully trained workers at

¹¹¹ 'The APSW Report for the Year 1936', p. 5.

adequate salaries'.¹¹² The external debate of the APSW largely focused on this objective, seeking to represent the interests of PSWs as university-trained professionals with special expertise, correcting misapprehensions about psychiatric social work and selling it to potential employers, trainees and clients. PSWs were, however, hampered by several problems in their efforts to achieve professional recognition and thus to be in a position to campaign for more positive representations of the mentally ill. A letter from Mrs Finch of the PRSC to television critic Mary Crozier in 1961 highlighted some of these obstacles:

We are accused of being in an ivory tower, we are inarticulate, our professional language is incomprehensible to ordinary people who say they simply do not know what we do that common kindness and neighbourliness cannot do...though the material with which we work is loaded with 'human interest' and eminently pictorial in a popular way, the professional process by which we accomplish our results is not.¹¹³

Like all occupations seeking professional status, PSWs had to tread a fine line between emphasising the vocational, disinterested nature of their work on the one hand and their claims for higher wages on the other. Representing psychiatric social work as an occupation requiring vocation suggested to some that PSWs were akin to voluntary workers and thus did not require the remuneration a qualified professional might expect. Moreover, the unwillingness of the APSW to clarify what psychiatric social work was and what distinguished it from other workers led other professionals and some politicians

¹¹² *Ibid.*

¹¹³ Letter from Mrs Finch to Mary Crozier, 12 October 1961.

to believe that there might not be any special expertise involved. Indeed, of the two skills that marked out psychiatric social work as an expert profession, the taking of the social history fell out of favour and casework was ill-defined and gradually adopted by other social workers. In spite of claims by the APSW that they were forging their own unique professional identity, it appears that not all PSWs were happy with their occupation. Noel Timms cited an American study of the mental health professions, which revealed that PSWs 'value psychiatry more than their own profession and many wish they were psychiatrists rather than social workers'.¹¹⁴

Although concerned with their own status as professional workers, PSWs were not unaware of their potential role as leaders of public opinion regarding mental illness. However, PSWs' beliefs that the public knew little about their work impeded their efforts to transfer their ideas about mental illness from their internal sphere to a broader public sphere. This attitude was exemplified by Elizabeth Irvine in 1958 when she considered the problems of spreading ideas about mental illness outside the confines of the *BJPSW*:

Have we not a responsibility to play a more active role than hitherto in shaping public opinion on the needs and care of the mentally ill? If we are seldom consulted or mentioned by those who broadcast on mental health...may this not be because we ourselves have a certain diffidence about public expression...which seriously impedes the communication of our special knowledge and experience on topics of public importance. Much as we welcome

¹¹⁴ A. Zander et al., *Role Relations in the Mental Health Professions* (Amsterdam, 1957), p. 41, cited in Timms, *Psychiatric Social Work*, 93.

copy for this journal, we must bear in mind that what is published here reaches only a very small and specialised public.¹¹⁵

¹¹⁵ E. E. Irvine, 'Editorial', *BJPSW*, 4 (1958), p. 3.

Chapter Four: The Mental After Care Association

When assessing shifts in public representations of mental illness in England, it is important to examine the role played by charities. Sub-public spheres that developed around particular professions struggled to represent both their own private interests and those of the mentally ill. Charitable organisations, however, replicate more closely the ideals of the public sphere, as they are created by private individuals who have (in theory) chosen to work for an area of public concern outside of the sphere of governmental control. I have focused on the oldest mental health charity, the MACA, which was formed in 1879 and still operates today. This chapter commences with a brief history of the work of the MACA and the people associated with the charity's operations. In the next section, the chapter explores how the MACA created and publicised a 'suitable case' for philanthropic aid in the late nineteenth century. This research suggests that the charity sought to promote their work and gain sympathy for their clients by applying nineteenth-century beliefs about poverty, employment and gender to their representations of suitable cases for assistance. In section three, the impact of the emerging welfare state on the direction of the charity's work is explored. I examine how the MACA carved out a role for itself in providing a 'personal touch', focusing its work upon the more chronically disordered patients. In the fourth section, the significance of the MACA's move to a more community-centred approach and the impact made by theories of psychiatric social workers is explored. Finally, in an effort to understand the mechanisms through which the MACA engaged with public opinion and sought to convey its ideas back to a broader public arena, the work of the charity's Publicity Committee is examined. This section

will ask whether the MACA attempted to initiate a debate within public circles about mental illness. It will also examine the extent to which the charity's clientele were able to represent themselves.

1: History of the MACA

To understand the forces that led to the formation of the MACA and shaped its aims, it is necessary to consider the social and economic circumstances of Britain in the late nineteenth century. The MACA developed during a period of extensive philanthropic activity, in part a response to the depression of the late nineteenth century that had led to high unemployment, low wages and subsequent social unrest. Perceptions of those seeking aid divided the deserving from the undeserving poor,¹ while poverty itself was viewed as a mark of social failure on the part of an individual who had failed to support himself. Philanthropic bodies such as the Charity Organisation Society set about their work with the aim of not simply assisting its clients, but enabling them to support themselves.²

These concerns also helped shape the work of the MACA, the first charity established to help those affected by mental disorder.³ The charity was founded in 1879

¹ See G. Himmelfarb, 'The Idea of Poverty', *History Today*, 34 (1984), pp. 23-30.

² See A. W. Vincent, 'The Poor Law Reports of 1909 and the Social Theory of the Charity Organisation Society', *Victorian Studies*, 27 (1984), pp. 343-63.

³ Little has been written to date on the work of the MACA. The archivist, Jennifer Smith, has written an outline of the available sources, and my own MA dissertation focused upon the work of the charity from its

under the name 'The After-care Association for Poor and Friendless Female Convalescents on Leaving Asylums for the Insane' by the Reverend Henry Hawkins, chaplain of Colney Hatch Asylum, with veteran campaigner Lord Shaftesbury acting as President between 1880 to 1886. In 1886, the year before the first annual report was published, the charity adopted its first constitution and appointed a Council with Dr Daniel Hack Tuke acting as chair. The charity persuaded Lord Brabazon, Earl of Meath to act as President and in the same year they employed their first paid Secretary, Mr H. Thornhill Roxby, to recruit local lady visitors to inspect clients. The aim of the charity was to provide convalescent homes for women discharged as recovered from asylums who might otherwise have nowhere else to go. The MACA also assisted former asylum patients to find employment in order to save them from the workhouse and the threat of a possible recurrence of their disorder. By 1894, the charity expanded its work to include men. In 1904, local branches of the charity were created. In these early years of the charity, successful attempts were made to attract the interest and participation of asylum medical superintendents and poor law guardians in the work of the charity. The MACA also numbered many clergymen and lady philanthropists amongst its membership.

By 1914, the MACA decided to extend its work to incorporate patients 'on trial' from asylums that were not officially recovered. In the following year, Miss Ethel Vickers replaced H. Thornhill Roxby as Secretary of the charity. She retained this

inception up until 1925. See J. Smith, 'Forging the "Missing Link": the Significance of the Mental After Care Association Archive', *History of Psychiatry*, 8 (1997), pp. 407-20. V. Long, 'The Mental After Care Association: Public Representations of Mental Illness, 1879-1925' (MA thesis, University of Warwick, 2000).

position until her resignation in 1940. The change in Secretary appears to have had a significant impact on the extent of the MACA's work. From forty-one individuals assisted in 1887, the annual number of applications had risen to 373 in 1914, a figure that had remained stable since 1907. After Miss Vickers replaced Thornhill Roxby as Secretary, the number of individuals helped started to rise rapidly. By 1916, 508 individual cases were considered, rising to 944 in 1922, 1,936 in 1927 and 4,269 in 1938. After Vicker's retirement in 1940, annual caseloads fell to 2, 509 within two years.⁴ An examination of the few surviving case files reveal that Vickers played an active role in these. In 1931, the Council paid tribute to Ethel Vickers' contribution: 'She is the Association: the two are synonymous terms... Could all those she has helped and established present themselves, the square outside would not hold them.'⁵

Through the 1920s and 1930s, the MACA continued to expand its activities, perhaps assisted by their President from 1920 to 1940, Sir Charles Wakefield, who poured significant amounts of his own money into the charity. From 1924, the MACA

⁴ Other factors such as the outbreak of the Second World War and the formation of the NAMH also had an impact upon the services provided by the MACA.

⁵ *The MACA Annual Report 1931*, p. 7. Emphasis in original text. I have listed the annual reports as published material, as they were all printed and quite widely distributed. However, as copies of the report are difficult to find, I consulted the series stored in the Mental After Care Association archives, which like the other MACA archival material consulted for this chapter are held at the Wellcome Institute's Contemporary Medical Archives Centre in London. The titles of the report varied as the name of the organisation underwent small changes, but I have chosen to standardise references to the *MACA Annual Report*. The archive references for the report in the years 1887 to 1971 are SA.MAC/B.1/1-83.

expanded its work to provide convalescence for so called 'early' care clients: individuals who were ill but who had not yet been certified. In 1933, MACA visitors started to act as social workers in hospitals, though this area of work began to decline in the late 1930s as the numbers of qualified PSWs started to increase. In the same year, the charity began to board out London County Council patients defined as 'chronic cases' who needed supervision to cope with life outside of hospital. These patients made up 101 cases in 1936, and 446 by 1940, a figure that remained stable up until 1970. From 1935, the MACA started to provide holidays for patients not well enough to leave hospital. 1,174 such individuals were helped in 1938, but the numbers quickly fell as the MACA decided to give preference to providing places for those patients leaving hospital who required permanent care.

In 1937, an attempt was made by the Feversham Committee to bring together the work of the four main charities working in the field of mental health. These were the MACA, the Central Association for Mental Welfare, the National Council for Mental Hygiene and the Child Guidance Council. The account of Priscilla Norman, who spent much of her life working voluntarily for mental health issues, suggests that early negotiations were fraught with tension:

Anybody who has ever contemplated an amalgamation of this sort will know that the emotion and hostility engendered are very strong. This time the antagonism was intense and dear Evelyn Fox's explosive temperament did not make matters any easier! She saw things clearly from her point of view, but the three other

organisations saw this move as a swallowing up of their identities by this dynamic personality.⁶

In the end, the MACA remained the only charity to dissent from the 1939 Feversham report on the Voluntary Mental Health Services, while the remaining three charities amalgamated to form the NAMH. This organisation had a different agenda and different functions to the MACA: their interactions with the BBC will be examined in Chapter Six. It seems that the MACA's dissension arose from its desire to retain its identity. In the 1946 annual report, it was reported that the MACA 'has every intention of continuing all its usual activities and that it is in no way connected with, or subsidiary to, any other organisations'.⁷

In 1940, the death of the former President and retirement of the Secretary brought in a new group of long serving officers, helping to maintain the continuity of the charity. Princess Arthur of Connaught served as President until 1949, finally replaced in 1958 by the Duchess of Kent who also worked as Patron for the NAMH. She continued to work for the charity until her death in 1965. Miss Russell, a PSW who had been appointed Assistant Secretary in 1936, took over from Miss Vickers in 1940 and held her post until 1960 when she retired and was replaced by Mrs E. Clifton. Russell was awarded the MBE in 1953. Doctor Henry Yellowlees was also an influential figure in the charity,

⁶ P. Norman, *In the Way of Understanding - Part of a Life: Lantern Slides in a Rough Time Sequence* (Godalming, 1982), pp. 63-64. Evelyn Fox was Secretary of the Central Association for Mental Welfare.

⁷ *The MACA Annual Report 1946*, p. 3.

serving as Chairman of the Council from 1938 to 1956. His involvement in the MACA probably reflected his general concern to educate the public about mental health matters.⁸

In 1948, the MACA had not made many changes in response to the NHS Acts, arguing that 'at 31st December the new Acts have barely survived their birth, and it is therefore impossible to state with any accuracy how widespread the changes will ultimately become'.⁹ However, by 1954 Yellowlees acknowledged that better provision by the welfare services for former hospital patients and the unemployed rendered many of the charities' activities obsolete and suggested more work should be undertaken with elderly, chronic patients.¹⁰ In the 1960s, the charity began to call more vocally for many more hospital patients to be cared for in the community. By the end of the 1960s, the MACA were finding it difficult to maintain their homes as maintenance grants from local authorities for patients in the charity's care failed to increase in proportion to running costs. The scope of this chapter is not sufficient to cover the change in direction made by the charity in the 1980s.¹¹

⁸ Yellowlees' popular psychiatry book, written to educate the public about mental illness, is discussed in Chapter One. See H. Yellowlees, *To Define True Madness: Commonsense Psychiatry for Lay People* (1953, London, 1955).

⁹ *The MACA Annual Report 1948*, p. 2.

¹⁰ *The MACA Annual Report 1954*, pp. 6-9.

¹¹ For a brief overview of these changes, see Smith, 'Forging the "Missing Link"', pp. 418-9.

2: Creating and Publicising a ‘Suitable Case’ for Aid in the Late Nineteenth and Early Twentieth Centuries¹²

As a non-governmental organisation seeking to provide aid to former asylum patients, the first task of the charity was to raise funds for its work from the public. Publicising the activities of the MACA was therefore essential if the charity’s work was to be carried out. An examination of this process gives us some insight into how the MACA perceived the public and created representations of mental illness that were calculated to appeal. The ways in which the MACA sought to represent its objects of aid, and the audiences it targeted in its attempts to raise money, therefore offers us a crucial insight into the interaction between the charity and the broader public. It is also interesting to examine the similarities in the discourse of the MACA and other charities, to see how its representation of the deserving charitable case drew from a common philanthropic language.

The arguments made by the charity from 1879 through until the 1920s were often interconnected. One focused on the vulnerability of friendless but respectable women. Another argument sought to restore people to their rightful place in society as wage earners. The final argument focused on the money that could be saved by the charity’s approach. One way for the MACA to publicise its work was through the case studies published in its annual reports. In the first report published by the charity in 1887, one

¹² This section contains material from my MA dissertation: Long, ‘The Mental After Care Association’, pp. 22–32.

subscriber commented that 'the list of cases read to us from the report is in itself the most efficient plea that the Association can put forward for the sympathy and support of the public with this movement'.¹³ Up until 1925, when the Propaganda Committee formed and the charity considered different methods of publicising its work, the annual report was the main form of publicity for the MACA. In 1909, the report claimed that 'although the expense of printing this report and other sundry leaflets from time to time is rather heavy, the Council wishes to state that, as it does not advertise the Association in the public press, except under special circumstances, it considers this one of the best ways of making the work known and extending its efforts'.¹⁴

In the annual reports of the charity between ten and twenty brief case studies would be included, listing details of the individual's gender, age, family background, institutional history, help given by the Association and the outcome of the case. It seems probable given the publicity function of the annual report that individual cases were selected and described in a way that represented the charity in a positive light. The cases given might not represent the 'typical' profile of the individual helped by the charity.

In a paper outlining the charity's work and aims, the first Secretary Mr H. Thornhill Roxby described the women helped by the MACA as 'governesses, highly educated ladies, quite destitute, for whom the workhouse surroundings are very

¹³ *The MACA Annual Report 1888-88*, Miss Davenport, p. 10.

¹⁴ *The MACA Annual Report 1909*, p. 10.

unsuitable'.¹⁵ The figure of the respectable governess fallen on hard times may have been a useful emblem for the charity in attracting aid. F. K. Prochaska has suggested that women preferred to contribute to causes that helped with 'pregnancies, children, servants and the problem of ageing and distressed females'.¹⁶ Thus, the MACA's focus on vulnerable respectable women may explain the extensive participation of women in the work of the charity and the fact that the majority of the subscribers to the MACA were women. Kathryn Hughes has argued that the figure of the Victorian Governess generated concern because of her marginal position on the edge of respectable society. She was a decent woman reduced to paid work, often an unmarried young woman in a sexually vulnerable position away from the protection of her family.¹⁷ In a period when feeble-minded women were constituted as an ominous eugenic threat,¹⁸ the MACA were careful to differentiate their clientele. Female MACA cases were represented as respectable and deserving individuals, whose breakdowns were attributed not to hereditary eugenic flaws but acceptable social pressures. Case studies of governesses fallen on hard times were frequent in early annual reports of the MACA. In the report for the years 1892-93, a case was given of 'a governess, daughter of an officer who is now dead; high qualifications. Was in a London Asylum. Grant of money made through the Charity Organisation

¹⁵ H. Thomhill Roxby, 'The After Care Association for Poor Female Convalescents on Leaving Asylums for the Insane', unpublished paper, p. 1. SA/MAC/A.1/2.

¹⁶ F. K. Prochaska, *Women and Philanthropy in Nineteenth-Century England* (Oxford, 1980), p. 3

¹⁷ K. Hughes, *The Victorian Governess* (London, 1993).

¹⁸ See M. Jackson, *The Borderland of Imbecility: Medicine, Society and the Fabrication of the Feeble Mind in Late Victorian and Edwardian England* (Manchester, 2000), pp. 144-8.

Society who knew the case to be thoroughly deserving.’¹⁹ This case also demonstrates how the MACA might work with related charities.

In the first report of 1887-88, the Council cited the case of a ‘very highly educated lady, quite destitute. Assisted by a gift of clothing. Has obtained situation as a governess.’²⁰ This case emphasised the respectable and destitute characteristics and introduced the second argument in favour of the charity’s work, namely the ability of the MACA to fit individuals back into an economically productive position in life. H. Thornhill Roxby emphasised this aim in a paper he wrote in 1893. He described the work of the charity as aiding women discharged from asylums with no means of existence ‘until they can again earn their own living’. Such women were ‘capable of doing good work could they only have a helping hand to give them a fresh start’. ‘It is so important’, Roxby concluded, ‘to enable these saddest of sad cases to once more take their places among the workers of the world’.²¹ In an analysis of the 481 case studies printed in the annual reports between 1897 and 1914, 80 per cent of men and 87.5 per cent of women were cited as having obtained work. Clearly, the MACA sought to differentiate their clients from the perceived social residuum of the unemployed, the hereditarily degenerate and the insane in its publicity. Hence in the 1887-88 report, a ‘respectable’ case was described where mental breakdown was ascribed to a social, not hereditary cause and the girl was placed in a suitable occupation: ‘A most respectable girl. Became ill through

¹⁹ *The MACA Annual Report 1892-93*, p. 9.

²⁰ *The MACA Annual Report 1887-88*, p. 7.

²¹ Thornhill Roxby, ‘The After Care Association’, p. 1, 9.

worry and deprivation in helping her father - a small tradesman who lost his capital. Is now in service in a house of a member of the committee.'²²

However, there remained a contradiction at the heart of the MACA attitude to their clients and work. In an early meeting, Mr Thornhill Roxby insisted that the charity 'took no cases where recovery was not certain'.²³ Nevertheless, the charity also described cases where they had sought to reform the personality of the individual through 'befriending' and personal contact, suggesting that the MACA considered their clients impaired and their personality in need of alteration. This ideology was rather similar to that of the Charity Organisation Society, described by A. W. Vincent as the 'ethical individual'; characterised by their ability to be both self-governing and self-maintaining.²⁴ A 1901 newspaper report of the charity's work cited the view of the MACA that the former asylum inmate 'cannot be trusted all at once to take up his former interests and anxieties without their effect upon his intellect being watched less any sign of irregularity should betray itself'.²⁵ While in the following year, the MACA Secretary described many former patients as 'poor and friendless, and with peculiarities in appearance and habits, weak in judgement and needing help in life.'²⁶ A case described in the 1887 report illustrates the concerns of the charity to remould the character of some of

²² *The MACA Annual Report 1887-88*, p. 7.

²³ H. Thornhill Roxby cited in unknown paper, unknown date. SA/MAC/H.2/2, Loose Press Cuttings c.1890-1991: SA/MAC/H.2/1-14, Occasional Publications and Publicity.

²⁴ Vincent, 'The Poor Law Reports of 1909'.

²⁵ Unknown paper. SA/MAC/H.2/2.

²⁶ *Guardian*, 12 February 1902.

its cases: 'A young woman from one of the metropolitan asylums. Very badly brought up; was placed in service by the Association, after having been in a cottage home. But did not give satisfaction. Was placed in a training home by the Association where it is hoped she may in time become useful.'²⁷ A case from 1917 also reiterated the charity's claim of befriending. It related 'another striking example of personal influence', describing a young woman who:

Before she went to the asylum, had been four times in prison with a very bad record. This girl, after weeks of patient endeavour, responded to the better influence brought to bear...she has voluntarily undertaken the support of her child...her situation is down in the south, away from her unsuitable friends.²⁸

The ideology of the MACA could be viewed as an extension of the Asylum's role in attempting to fit its patients back into their place in society. Peter Bartlett has examined the 'productive alliance' operating between the asylum and the poor law, arguing that the asylum was viewed primarily as a poor law institution, containing members of the 'social residuum' whose insanity was instigated by alcoholism or immorality. In this view, mental disorder was caused by a collusion of social factors and personality weakness and the asylum needed to reform the personality of the patient.²⁹ The emphasis placed by the MACA in its publicity upon restoring its clients to

²⁷ *The MACA Annual Report 1887-88*, p. 7.

²⁸ *The MACA Annual Report 1917*, p. 7.

²⁹ P. Bartlett, 'The Asylum and the Poor Law: The Productive Alliance', in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London, 1999), pp. 48-64.

employment suggests that one factor which motivated the charity may have been a desire to instil the values of labour discipline and bourgeois rationality into an unproductive workforce. This gives some support to Andrew Scull's arguments about the factors underlying the nineteenth-century process of incarceration.³⁰

The MACA may not have been able to demonstrate that all its clients were highly respectable workers who had broken down through their own fault. However, it did seek to publicise the fact that it was able to get many unproductive people into employment, thus saving the local authorities money. This was the third claim pushed in the publicity of the MACA to justify its work to a philanthropic public and was held out tantalisingly to poor law guardians. As early as 1890 the latter were being asked to join the MACA as 'much mutual good may be arrived at by co-operation between public and private bodies whose work is to benefit the poor'.³¹ The MACA offered the hope of preventing relapses and thus the necessity of sending paupers back to the asylum (the most expensive form of care for a pauper). They also held out the promise to make such individuals reliant, thus removing the need for any type of poor law support. A 1930s pamphlet urged donations from 'those who understand that patients helped and tided over this critical period of their life are a **real economy to the community**'.³² This is just one example of how the MACA interacted with state organisations to achieve its goals, a trend that accelerated

³⁰ A. T. Scull, *Decarceration: Community Treatment and the Deviant: A Radical View* (Englewood Cliffs, 1977), pp. 15-40.

³¹ *The MACA Annual Report 1890-91*, p. 6.

³² MACA pamphlet, early 1930s. SA/MAC/H.2/1, Publicity and Information Sheets c.1880-1991. Emphasis in original text.

through the charity's life. The early publicity of the MACA suggests that even in an early stage of its history, the charity was able to distinguish differentiated groups within the public and target publicity to appeal to their varied and specific interests. In turn, this approach illustrates that while the MACA may have been established with the purpose of assisting recovered mental patients, it did not always portray itself as primarily representing the interests of ex-patients and the mentally ill. The variety of other interests and concerns represented by the charity, such as concerns about the costs of maintaining paupers, a desire to raise the status of the psychiatric profession, notions of religious duty and the opportunity for women to exercise power, illustrate that even charitable organisations ostensibly concerned with public interest might fulfil a range of private interests too.³³

3: State Intervention and its Impact on Voluntary Organisations

As state provision expanded through the 1930s and 1940s, many of the functions of the MACA slowly became obsolete. At the 1954 Annual General Meeting (hereafter AGM) of the MACA, Chairman Henry Yellowlees contemplated the changes that had occurred which the charity needed to take stock of.

It is now quite unthinkable that a patient should be turned out from a public mental hospital nominally recovered but weak in body and confused in mind, without friends, without money, without employment, without adequate

³³ The range of motivations and interests that inspired MACA workers is discussed in more detail in my MA thesis. See Long, 'The Mental After Care Association', pp. 5–21.

equipment and clothing, and with only this charity to befriend him, but that happened quite often 75 years ago.³⁴

As Yellowlees pointed out, many functions formerly undertaken by the charity were by then carried out by government agencies. Labour exchanges and Disablement Resettlement Officers now found work for former patients.³⁵ The visiting and following up of clients that used to be carried out by MACA staff was by 1954 more likely to be carried out by PSWs, almoners and visitors.

What Yellowlees proposed was a radical alteration in the direction of the MACA's work and the clientele it helped in order to maintain its relevance. He argued that the charity's current work with convalescent patients, ostensibly recovered from their mental illness, met with little need. Instead, he pointed to the 'great increase in the number of harmless and quiet chronic patients, owing to the success of modern treatments in at least removing violent, noisy and aggressive symptoms in cases where full recovery is impossible'. Yellowlees argued that the shift in the charity's work was a step in maintaining its original aims: 'we think that if by caring for a chronic patient we are setting free accommodation for a recoverable one, we are surely acting in accordance with the spirit of our original constitution'.³⁶

³⁴ *The MACA Annual Report 1954*, pp. 7-8.

³⁵ The work carried out is described in K. Laurie, *Employable or Unemployable? Report on Pioneer Experimental Work Covering the Period February 6 1939 - August 1 1940* (London, 1941).

³⁶ *The MACA Annual Report 1954*, p. 9.

However, a shift to caring for the chronically disordered was a radical step for the charity to take. Council members involved in the MACA in the late nineteenth century had been anxious to demarcate the individuals they helped from such chronic patients. Early reports claimed to have declined some applicants 'as it was thought, after much consideration, that they would never be fit for the struggle of life again'.³⁷ In the second AGM of the MACA, psychiatrist G. H. Savage raised the spectre of the chronic patient

Now and again the question arose as to how often one ought to help a patient who had broken down more than once...some patients who had seemingly recovered, not infrequently broke down again, the reason being that they suffered from what was termed recurrent insanity. They had to consider whether they should pass them over in favour of sufferers who were of a more hopeful character.³⁸

Up until the 1940s, the MACA had focused in its publicity on their success in returning people back into social life, stressing that mental illness was a curable disease. Now the charity was revealing to the public gaze work with chronic, impaired patients. Yellowlees acknowledged 'nobody pretends that work for chronic patients is anything like so interesting or spectacular as work with convalescent or recoverable cases'.³⁹ The MACA could no longer sell its work on the strength of the number of people returned to economically productive employment or money saved to the community. Case studies

³⁷ *The MACA Annual Report 1888-89*, p. 4.

³⁸ *Ibid.*, p. 10.

³⁹ *The MACA Annual Report 1954*, p. 9.

printed occasionally in the annual report emphasise this shift in focus. In 1964, the MACA described the case of A.G., admitted to a mental hospital in 1950:

He first came to us for a short holiday in 1960 and has been every year since. After his holiday in 1964 an arrangement was made by the hospital for long-term care and this was arranged for him later in the year. He is still with us, unlikely ever to be independent, but gradually widening his interests.⁴⁰

In this new approach, the success of the case was measured by the ability of the patient to live as full a life as possible outside of the mental hospital.

An examination of individual and home files from 1915 through to the 1960s allows us examine the extent to which the MACA's shift in public rhetoric reflected a shift in the charity's actual practices. This material helps explore whether charity workers in dealing on a person to person level with their clients developed a new perception of the mentally ill. It also provides some evidence about the extent to which the MACA sought to represent the actual interests of its clients. In the early case files, the accounts of the convalescent home owners, the relatives, employers and the clients themselves competed to define events and work out the best course of action to be taken. The file for Alice T. stretches over nine years. It traces Alice's reception into a convalescent home in 1915 where the homeowner, Mrs Balls, took the opportunity to promote Alice's opinions to MACA Secretary Miss Vickers who appears to have overseen the case.⁴¹ Alice, like

⁴⁰ *The MACA Annual Report 1964*, p. 12.

⁴¹ Case Notes - Alice T, 1915-24, SA/MAC/G.3/34. Alice's case was also discussed in my MA dissertation: Long, 'The Mental After Care Association', pp. 44-47.

many other MACA clients, was placed in domestic service, a field of work rejected by many working-class women because of the low status and other occupations opened up to them by the war.⁴² In her first placement, Alice was unsuccessful, but Miss Vickers conceded to another potential employer that this may not have been Alice's fault: 'I think perhaps it is only that the situation is too hard for Alice or too much has been expected of her'. Alice was then placed in a boarding house, a position she chose to leave, as she did not enjoy the post. Her employer, however, had a favourable opinion, stating 'I only wish I could have kept her, she seems a very good maid and thorough'. Miss Vickers then placed Alice in February 1917 with Mrs B., who did not seem to accept the charity's rhetoric that all their clients were completely recovered. Mrs B. wrote to the MACA complaining about Alice's level of service, and Miss Vickers in turn wrote to Alice encouraging her to work hard and make 'a fresh start in life'. However, by March, Mrs B. wrote to Miss Vickers, suspecting that Alice was 'off her head'. In April, Mrs B. readmitted Alice, who had seemed depressed and threatened to jump out of a window, to Colney Hatch, expressing little interest in the fate of her former servant but plenty of grievance over the inconvenience Alice's problems had caused her: 'it has been too much expense for my poor pocket, anyhow, I'm glad and relieved she is away from my home. It has been a very unpleasant experience for me.'

⁴² Alice may have experienced less difficulty gaining employment than she would have done prior to 1914 because the large number of working-class women who left domestic service for other work available during the war created a shortage of available servants. Even after the First World War had ended, domestic service continued to be an unpopular and understaffed occupation, which may explain the MACA's decision to place so many of its female cases in service. See J. MacCalman, 'The Impact of the First World War on Female Employment in England', *Labour History*, 21 (1971), pp. 36–47.

Once back in the asylum, Alice received a letter from Miss Vickers, expressing sympathy with Alice's plight and best wishes for her recovery. Alice wrote back, expressing her wish to 'get out and earn my own living again which I am so longing to do...I am sure there is plenty of work for women now'. Alice may well have been aware of the MACA's enthusiasm for employment, perhaps choosing to represent herself as an enthusiastic worker and ideal case in her efforts to gain assistance. This mentality appealed to the MACA, who again received Alice on her discharge in October 1918. Alice was placed next with a Mrs Q., who became hostile to Alice in just over a month, demanding in February 1919 that the charity send for her as soon as possible as 'Alice has been again so defiant and rude I can no longer keep her'. Mrs Q.'s complaints were based on Alice's poor skills as a servant but Alice suggested to the charity that the hostility arose from a failure to believe in her recovery. Alice wrote to the charity protesting that Mrs Q. 'treats me as if I am silly and a lunatic I should think my place is away with the lunatics and not out in the world...I have told her I am supposed to be free now and not watched over anyway'. A neighbour of Mrs Q. took Alice in, suggesting to the charity that the dispute may have arisen over Mrs Q.'s failure to pay Alice. Perhaps Mrs B. and Mrs Q. were more concerned with trying to get good servants during a time when there was a shortage of available staff, than helping a woman who had had a mental illness. They did not appear to use the MACA's language of befriending or charity. If indeed Mrs Q. was attempting to avoid paying Alice, there is even a possibility that she hoped to take advantage of Alice's status as a former mental hospital patient. Neither of these two employers seemed to accept the charity's rhetoric that Alice had recovered.

Alice's case ended on a positive note when she was employed by Mrs Marriott, who gave money to the charity and had 'no objection taking a girl who had mental troubles'. The case notes focused on the employment of Alice, and the efforts of Miss Vickers to encourage Alice to stay in her positions. While Alice was involved in the decisions about her case and was able to express her opinions to the charity and have them taken seriously, at the same time the attitude of the charity was somewhat condescending. In 1919, MACA worker Miss Wheatley referred to thirty-one year old Alice as 'quite a nice girl' although 'just lately has proved herself rather tiresome' to a potential employer. This suggests that Alice, a grown woman whom the charity's rhetoric sought to portray as recovered, was viewed as a difficult and awkward child who needed to be placed in a suitable position by the MACA.

The way in which Alice was viewed by the charity and the extent to which they represented her interests can be compared against the representation of female clients who were placed in Eversley long stay home for elderly and chronic female patients between 1948 and 1962. A MACA social worker, Miss C. (who was responsible for visiting four MACA homes), the patients and the homeowners Mrs M. and Miss H., both qualified mental nurses, competed to define events within this file.⁴³ An examination of this file confirms that the MACA were indeed dealing with a very different type of client. Of the twenty-six women resident at Mrs M.'s house on 5 November 1953, only six were

⁴³ Mrs M., 'Eversley', Westerham 1948-62. SA/MAC/F.1/9: Files on Individual Homes 1941-62, SA/MAC/F.1/1-14.

under sixty years old and eleven were over seventy years old. The descriptions given of these women do not refer to their medical condition with the exception of four women (all under sixty years old) who were referred to as MD (mentally deficient). Instead, descriptions focused on the work carried out in the house by the women and their personalities. Celia E., for example, was described as a 'champion grumbler, arthritis etc. does nothing'. Gwen W., a mentally deficient patient, was described as 'self-satisfied. Does some polishing', while Alice S., seventy-six years old, was simply described as 'old and miserable beyond description'. Although a home register for Eversley does not appear to be in the archive it is possible to get some idea of the conditions affecting these women by looking at a comparable home for chronic male patients. Hulsewood admissions register listed diagnoses for residents such as chronic melancholia, paraphrenia, schizophrenia, anxiety neurosis and inadequate personality.⁴⁴ The deciding factor for which individuals to send to Eversley may have rested less on their medical diagnosis and more upon how 'well behaved' patients were. As the first social worker to the home, Mrs Chapman, wrote in November 1948, 'Both Mrs M. and Miss H. are inclined to be a bit difficult about the type of patient they have and do not seem to have much patience with difficult ones'.

The atmosphere in this particular home did not appear to be a particularly happy one. On 1 September 1954, Miss C. visited to find the patients 'sitting in separate and faintly hostile groups. The garden looked lovely and several patients said what a nice

⁴⁴ Hulsewood Admissions Register 1948–61. SA/MAC/F.4/15: Home Registers 1934-75, SA/MAC/F.4/1–15.

place it was but the people in it were not nice, although the matrons were and so on'. In August 1953, Miss C. commented that both matrons 'seem to have very quick tempers; they seem to get furious about quite small things'. In January 1954, she considered the methods of the matrons:

I do think they both think they are running the home very well and that their methods are the right ones, they make no secret of shouting at patients when naughty and even say it would be better if social workers gave them a good scolding too instead of appearing so sympathetic. Certainly about half the patients do seem contented: these of course are the 'good' ones who help a bit in the house or are genuinely incapable, or are just silly and thick skinned like poor Annie B.

This account suggests that at least some MACA staff continued to represent their cases as naughty children. In July 1953, Miss C. reported that the matrons used 'shouting when angry and threatening return to hospital - they say it is the only thing to do'. This tactic was still being deployed in August 1959 when the matrons remarked to Miss C. 'that Mrs W. was much better since they had told her she would have to make her own arrangements if she did not improve'. However, it was perhaps the matrons' attitudes towards the patients that coloured the attitudes of the patients to one another. In an early visit in January 1953, Miss C. saw ten of the patients privately and 'all thought all the other patients were too mental for them and each was evidently the only sensible one there in her own estimation'. Perhaps the patients expressed these views when in conversation with Miss C. as they sought to differentiate themselves from their fellow patients and represent themselves as sane. The matrons' attitude appears to have affected

Miss C.'s judgement also. In October 1955 she wrote 'they all think they should not be in this place "with this lot", and I have now taken to telling them almost as bluntly as Miss H., that they are all here for the same reason and should tolerate one another'.

Perhaps the matrons found working with chronic and elderly patients unrewarding and, failing to receive the appreciation they hoped for, were disappointed. In March 1953, Miss C. wrote 'they have a great many defectives and senile patients...a lot of the patients have to be helped in the bath, few of them seem to have any "life" in them and they do not seem to appreciate what is done for them'. In the instances where some improvement was evident, the matrons seem to have been very pleased. In August 1959, Miss C. reported that 'Mrs H. is more settled and came back from a weekend with a friend saying, "it's so nice to be home again". Matrons were compensated for all sorts of disappointments by this compliment'. Despite the radically altered clientele of the charity and the expectation that the individuals coming into Eversley would never be self-supporting, many older criteria for assessment, such as character, work and usefulness remained in currency. These assessments also drew on typical representations of femininity, focussing upon the attention individual women paid to their appearance and their willingness to undertake domestic chores. When considering the closure of the homes, Miss C. described Isabel B. as

Very clean, tidy and presentable, indeed quite pleasant in appearance. Always polite and respectable rather reserved but does at times go out with other patients. Can converse quite reasonably except when there is a question of money or payments, when she becomes stubborn to the point of idiocy but still perfectly

polite. Works quite hard and willingly cleaning stairs and passages etc, - a bit too energetic and rough, but definitely useful.

Alice H, the patient described as 'more settled' in August 1959 was regarded as a success for a chronic patient:

Has taken about two years to pull round since admission from depression, diffidence, lack of initiative, inability to make up mind, but is now a nice, friendly, quietly helpful, reliable person...She is clean, tidy, and dresses nicely, helps a bit in things like wiping the dishes, and also is reliable in taking messages, keeping an eye on a patient in bed or other socially useful things. She was promised she would go with the matrons wherever they moved to...I think she would be a nice person to have about and worth sticking a point for as she is one of our successes.

As a result of the MACA decision to care for the chronically impaired, the MACA increasingly represented itself providing a sanctuary or haven for those who would never recover sufficiently to be self-supporting. This was a view that the MACA sought to express in their publicity. An interview conducted in the late 1970s for publicity purposes by Lord Dowling with Annie, a MACA resident since 1951, directed Annie to say a specific phrase:

L. D. - Do you feel that this place represents something very valuable?

A. - Oh I'm sure it does...

L. D. - Not only to you but to others

A. - I'm sure it does, it's a haven really, really is.

L. D. - Could you say again, it's a haven really, yes this is a valuable place

A. - It really is, it's quite a haven really

L. D. - Could you make that into a statement without me talking?

A. - Well, I think its valuable for people to be in a place like this, because its quite a haven, it has been to me.⁴⁵

By representing MACA homes as a haven, the charity was differentiating itself from the service provided by the state. A 1968 appeal on ATV claimed 'there are many remaining in mental hospitals only because there are not enough homes and hostels where, with sympathy and skilled support, they can be helped to regain their self-respect and confidence in their own ability to live happy normal lives'.⁴⁶ The MACA managed to preserve a thread of continuity in their ideology by retaining a focus on the importance of the personal touch, or 'befriending', which they argued differentiated their services from those provided by the NHS. This point was made strongly in 1954 when Henry Yellowlees announced the change in the clientele to be helped: 'We remain, and have remained for three quarters of a century, unique, in that we are an entirely independent, voluntary organisation, devoted not only to psychiatric social service in general, but limiting ourselves to those aspects of it which require and demand personal contact with

⁴⁵ Making a calculation of the date of this interview based on the date of Annie's admission to the MACA home and the length of time she is said to have spent there, this interview was probably carried out as part of the 1979 appeal given on ITV London weekend television in 1979. SA/MAC/D.3/1/8, ITV Appeals: Correspondence and Scripts 1968-87.

⁴⁶ Notes for ATV Appeal, '1 in 5', 7 April 1968, SA/MAC/D.3/1/8.

individual patients'.⁴⁷ The same point was made in 1961 by Dr T. P. Rees, who stressed the unique role that could be played by a charity outside of the state, speaking of 'the great advantage of the human touch which characterises the voluntary association'.⁴⁸ A further advantage that the MACA claimed could be utilised by the charity operating outside of the state was the ability to innovate. In 1955, Sir Russell Brain, addressing the AGM, emphasised the role that the MACA could play:

You were pioneers when you first came into existence and you have the opportunity of maintaining the pioneer spirit still. A voluntary Association has a power of initiative and flexibility which the state most inevitably lacks. You can think of new ideas and try them out and then, if they are successful, persuade the state to adopt them, as, indeed, you have done in the past.⁴⁹

In 1962, Lord Feversham accredited the MACA and the NAMH of bringing about the government policy of community care. It was after all at a NAMH AGM that Enoch Powell made his speech on the closure of all mental hospitals. Lord Feversham argued:

The two associations had preached that the only people who should be in mental hospitals should be those requiring hospital treatment and he said that the state was promoting the idea, which the MACA was the first to conceive, that all who could should leave the hospitals and live and work in the community.⁵⁰

⁴⁷ *The MACA Annual Report 1954*, pp. 6-7.

⁴⁸ *The MACA Annual Report 1961*, p. 8.

⁴⁹ *The MACA Annual Report 1955*, p. 7.

⁵⁰ *The MACA Annual Report 1962*, p. 8.

Even Health Minister Enoch Powell was happy to acknowledge that charities such as the MACA could contribute something that the state could not offer:

Such voluntary organisations were not being used by officials to save trouble and expense, but to give 'that something extra'...This is part of the benefit of the intermingling of the official and unofficial. It is no criticism of the official to say that sometimes the others can do something as well, if not a little better, as the official.⁵¹

There were, however, limitations to this co-operation between charity and the state: by the end of the 1960s, the MACA was finding it difficult to maintain its homes as maintenance grants from local authorities for patients in the charity's care failed to increase in proportion to running costs. This point in itself might suggest that Enoch Powell, rather than placing the interests of the mentally disordered first when creating mental health policy, may have sought to exploit charitable provision to save trouble and expenditure.

Curiously, the private organisation set up outside of state provisions could thus lay claim to directing government policies and provision. Charities such as the MACA might be seen as ideal public spheres, formed as they are from private individuals voluntarily trying to do what is in the common good. This chapter has asked whether the interpenetration of charity and state debased this public element and inhibited democratic participation, as Habermas' argument might suggest. Geoffrey Finlayson's account of the relationship between the state and voluntary societies, however, provides another way of

⁵¹ Mr Powell speaking at the opening of a MACA hostel in Croydon. *Croydon Advertiser*, 21 April 1961.

thinking about this issue. Finlayson examined the co-operation of voluntary bodies with the state in the twentieth century arguing that voluntary organisations released energies that might otherwise have remained dormant, offering people the opportunity to participate in the public sphere and public policy free from the constraints of compulsion, at a time when they had little access to formal political structures. This enabled participants to become actively involved citizens – what Finlayson termed ‘active citizenship’ – instead of merely being entitled to services whose organisation they were excluded from – the ‘citizenship of entitlement’. People could become empowered rather than passive recipients of social entitlements. We might, perhaps, then argue that the interaction of the state and the public sphere, represented here by the MACA, in fact enabled democratic debate and participation of private individuals for the common good.⁵²

4: A ‘Social’ / Community Approach

At the AGM of the MACA in 1948, the Secretary Miss Russell, a qualified PSW, ‘stated that the MACA is the oldest organised body concerned with psychiatric social work’.⁵³ Alongside Kathleen Laurie, a trained PSW who was hired as the charity’s employment officer between 1939 to 1940, Miss Russell appears to have introduced to the charity many concepts and theories current among the psychiatric social work profession. Many of these ideas focused on the social factors that were believed to affect mental disorder.

⁵² G. Finlayson, *Citizen, State, and Social Welfare in Britain, 1830–1990* (Oxford, 1994), see especially pp. 282–6, pp. 324–5 and pp. 401–3.

⁵³ *The MACA Annual Report 1948*, p. 1.

Kathleen Laurie's work grafted onto the traditional MACA focus of employment new beliefs amongst PSWs that work could both cause mental distress and facilitate recovery. In the report she published on her work, Laurie's stated objectives seemed similar to current MACA thought. Not only would it 'show a saving of Government money', it would also help in 're-establishing people in normal life'.⁵⁴

However, Laurie's report suggested that being placed in the wrong job might lead to dissatisfaction and frustration. Skilled workers placed in a position not demanding enough might lose interest and be less effective at unskilled work than an unskilled worker. Other workers were placed into positions that were beyond their capacity. Either scenario, Laurie argued, could lead to a loss of confidence, emotional or intellectual dissatisfaction, and finally maladjustment. Laurie's work may have reflected more general concerns that the deskilling of labour entailed by new production methods and mechanisation led employees to view employment as simply a necessary means to obtain money for satisfactions outside of work. The 1931 Factory Inspectorate, for example, claimed that mechanisation had led to an increase in nervous disabilities and mental weariness.⁵⁵

While earlier MACA workers had stressed the advantages of 'suitable work' for its clients, Laurie suggested that an 'employment history' of the individual should be taken. This should uncover where difficulties in employment arose in the past, whether

⁵⁴ Laurie, *Employable or Unemployable?* p. 2.

⁵⁵ J. Stevenson, *British Society 1914 - 1945* (London, 1990), pp. 187-91.

the patient's home environment was suitable or whether a residential post would be better and establish the nature of the illness or the 'psychological motive' behind a breakdown. Laurie tackled the earlier contradiction of MACA policy that could not decide if its clients were fully recovered or in need of surveillance by the charity. Laurie argued that **'recovery and yet a certain impairment are not incompatible'**, claiming that a person could be taught to deal with their delusions. She even argued that an individual might

Have quite a dangerous or stupid attitude to one person (possibly his wife) and towards no one else. One such man is a good works foreman and is a reliable worker, but at all costs he must be kept away from his wife. His judgement on everything else in life is utterly sane and sound. To his wife he is still really dangerous.⁵⁶

Laurie's next step was to create a social treatment plan. This took account of any remaining symptoms and should remove any possible conditions that might cause them, for example by placing people whose home environment was hostile into a residential post. Laurie also stressed the importance of a tolerant and understanding employer and the need for after care for some individuals still affected by emotional or personality problems. Case four cited in Laurie's report demonstrates aspects of her approach:

A man once in specialised government work, always on night duty, is now a porter in a hospital, taking his turn as a roof spotter. His illness seemed to be the rebellion of a conscientious person's body and mind against the abnormality of his life conditions. These allowed no social amenities and very few human

⁵⁶ Laurie, *Employable or Unemployable?*, p. 20. Emphasis in original text.

contacts even with his family...his new employment had to remove these wrong conditions and provide company for him so that he could strike roots. He has an excellent character, both generally and in the army, and we used this to get him a well-paid job, allowing of contacts.⁵⁷

In this narrative, the illness was ascribed a social cause - his previous employment - which was remedied by a more suitable position. Individuals dealt with by the charity may have represented their breakdown and recovery in a similar manner to the charity, as demonstrated in a letter written by M.R. to the MACA, which was published in the report of 1942:

I am sure you will be interested to learn that a month ago I found a position in the science department of a school. Having thus got back to an activity of school and lab work, which is most essential to me, and in a lovely part of the country too, I feel very happy indeed again. Needless to say that satisfactory work has fully completed my recovery, and that nobody, not even myself, would imagine that I ever had such a breakdown, for which five years spent in Nazi Germany and two and a half more of involuntary unemployment provide some explanation after all.

The explanations underlying Laurie's project were motivated by newer theories of the social causation behind breakdowns and the therapeutic satisfactions that could be gained from work. However, her results in one aspect were strikingly similar to the people helped into employment in the First World War. Of the 285 women helped by Laurie, 220 were placed in domestic work, most of these positions being residential. This

⁵⁷ *Ibid.*, p. 30.

reflected a more general move of women into domestic service in the 1930s as other fields of work for women were hit by the depression. However, service remained an unpopular and low status occupation among female workers and the numbers engaged in domestic service fell from 1,142,655 women in 1931 to 350,000 in 1951.⁵⁸ Laurie continued the MACA tradition of equating recovery from mental illness with gainful employment. Perhaps the results of her labours were no different to the women helped than those assisted in 1914.

The MACA also took care to distinguish its work from medical treatment. In 1953, the annual report of the charity noted that

The services of an Association such as this naturally begins and ends outside the hospital precincts. That, however, does not mean that the social worker has no interest in, and never enters, the hospital where the treatment is given, but her efforts are concentrated on getting the patient back to normal living conditions after medical treatment or on preventing the necessity for treatment.⁵⁹

There seems to be an implicit criticism in this passage of the medicalisation of care for the mentally disordered. This was more explicit in the MACA's claim that the vast majority of psychiatric patients should be cared for outside of the mental hospitals. In 1950, the annual report of the charity contemplated the extension of its activities:

An Association professing to care for patients outside hospital, naturally asks itself how many of these patients could it suitably provide with other

⁵⁸ P. Horn, *The Rise and fall of the Victorian Servant* (Dublin, 1975), pp. 170, 179.

⁵⁹ *The MACA Annual Report 1953*, p. 5.

accommodation? Of a total number of 132,000 mental hospital patients, it has been estimated that 16 per cent could be adequately cared for in homes other than mental hospitals. This means that 21,000 beds are being taken up in hospital unnecessarily.⁶⁰

The MACA reacted positively to Health Minister Enoch Powell's plan to close down the mental hospitals. At the official opening of a MACA home at Croydon in 1961, MACA Chairman Mr W. King described Enoch Powell as 'a man who had seen a vision and was now seeking to make it a reality. He had removed many of the old fashioned and forbidding hospitals'. Powell, who was photographed with MACA personnel at the opening ceremony, was happy to acknowledge the MACA's role as pioneers in community care: 'he regarded the hostel as something symbolic and as an early example of coming developments in the health service'.⁶¹

While the MACA did reframe its view of mental illness as in part a reaction to social problems, Dr A. R. K. Mitchell, consultant psychiatrist at Fulbourn Hospital Cambridge, castigated their efforts in the 1969 AGM of the charity. Mitchell held out a suggestion to the MACA that they could expand the field of their work into social therapy if they successfully abandoned the illness model of mental disorder. Dr Mitchell described

⁶⁰ *The MACA Annual Report 1950*, p. 3.

⁶¹ *Croydon Advertiser*, 21 April 1961.

The 'social model' of mental illness, with its basic premise that mental disorders arise out of the interaction between individuals...As psychiatrists and others experiment with group situations and study the interaction patterns between the individuals concerned they have found that new dimensions of care could be used...Dr Mitchell ended with a challenge to our own Association. He said 'mental after care is based on the "illness model" of mental disorder. When we move out of the "mental illness model" to the "social model" I think organisations like your own are faced with the challenge of participating away from tertiary care and into the exciting field of primary care'.⁶²

Unlike the APSW, the MACA never did seem to shift away from the medical model but they did increasingly rely on people within the community to support its cases there. Convalescence had long been an essential element in the MACA's work and continued to hold a prominent place through the 1950s and 1960s. In 1959, the Chairman commented that 'the matrons and wardens had, he felt, perhaps the most important position of all in the Association as it is they who have the immediate care and guidance of the patients for whose welfare the Association exists. It was not too much to say that the fate of the patients is largely in their hands'.⁶³

For a charity that laid great emphasis upon the importance of the personal touch, it was the matrons and wardens who had the most direct and consistent contact with the

⁶² *The MACA Annual Report 1969*, pp. 6-7.

⁶³ *The MACA Annual Report 1959*, p. 7

patients. They embodied the MACA for these individuals. The matrons and wardens were linked to the charity by the visits of the MACA social workers who mediated between the patients, the matrons and the wishes of the MACA. The mediating role of the social worker could prove quite fraught when dealing with matrons who owned their homes and might not always take kindly to intervention. The file on Miss H. and Mrs M.'s home in Eversley, discussed earlier in the chapter, proved especially difficult for the social worker Miss C.⁶⁴ These matrons seemed to view their home very much as their own private property and did not take kindly to having their methods of managing the patients interfered with. In March 1953, the matrons threatened to not take any more MACA patients and in October 1954 they wrote to Miss C. complaining that she had strayed into their private quarters on a visit to their house. Miss C. had no success in trying to moderate the matrons' rather disciplinarian attitude towards the patients.

By 1967, the MACA owned ten homes of its own and employed registered mental nurses to act as matrons and wardens. These homes provided places for 247 patients, outnumbering the provision for MACA patients in privately owned homes. The MACA cited the retirement of previous matrons, new regulations affecting the running of registered homes for the mentally disturbed and the unsuitable location of many previous homes that had been far from centres of employment and out-patient clinics as reasons for this change in policy.⁶⁵ However, perhaps they also hoped to gain more control over the running of the homes by employing the matrons and wardens. The MACA sought to

⁶⁴ Mrs M., 'Eversley'.

⁶⁵ *The MACA Annual Report 1966*, pp. 6-7.

encourage interaction between the community and the residents in its new homes, claiming in its 1966 report that:

There are contacts between the homes and the local community and there have been many acts of kindness on the part of local residents...residents' friends and relatives, and interested professional people, are welcomed; we also welcome every contact with neighbours and local inhabitants but we do not present our residents to the local community as objects of special interest and concern en masse.⁶⁶

Quite how successful this integration with the community was is not clear. The social worker's home file for Northdown Road refers to an incident in April 1959 involving a patient who was returned to hospital

She [the matron] says she has not heard anything of the parents of the little girl concerned but she feels afraid to go out as the limelight is on the house from the paper! The paper did not give the actual address but she feels sure a lot of gossip must be going on, so when it came to complaints of B. through the police of course she felt much worse.⁶⁷

Local opposition to MACA homes also surfaced in Thanet in 1976 when the Council enforced the closure of homes for the mentally handicapped. Some homes were closed because they failed to meet fire safety standards but others because they were in the 'holiday zone'. The Chairman of the Council claimed 'the Council is acutely aware of the

⁶⁶ *Ibid.*, pp. 8, 20.

⁶⁷ Mrs A., Northdown Road, Cliftonville 1941-62, SA/MAC/F.1/1.

problems created by the influx of ex-mental patients into Thanet'. The matron of one of the homes blamed local opposition for the closures, stating 'I am not surprised considering the local attitude to this problem. It is a bit distressing'.⁶⁸

5: Not 'Educating the Public'

As a voluntary organisation, the MACA relied upon the charity of the public to continue and expand its work. The very existence of the organisation depended upon its ability to depict its work in a favourable manner through the right kind of media. Faced with the necessity to create some type of public image in order to survive, the MACA had the potential to actively promote certain messages about mental disorder amongst the public or to engage in a debate about mental illness. In order to examine how much of the internal debates in the charity about the nature of mental disorder and those affected by it were more widely diffused, study of the charity's efforts to publicise its work is crucial.

However, much of the archival material suggests that MACA workers, while believing that the public should be educated and become more enlightened about mental disorder, did not see themselves as the right organisation to do this, perhaps preferring to leave this task to the NAMH. In 1946, for example, the MACA annual report pronounced that 'the activities of the MACA are purely of a practical nature...it has never been its

⁶⁸ Councilor Harry Anish and homeowner Doris Pargeter quoted in the *Isle of Thanet Gazette*, 24 September 1976.

concern to organise and arrange lectures, etc; on the subject of mental illness, although recognising that such work must be done and encouraged'.⁶⁹

During the late nineteenth century and the first two decades of the twentieth century, the MACA relied heavily on the annual reports as the main form of publicity for the charity.⁷⁰ Whether this managed to convey the nature of the charity's work and its views on mental disorder accurately to the press and the public is rather doubtful. A press cutting from 1902 kept by the charity wildly distorted the character of the MACA's clientele and the charity's motivations for intervention:

The charitable organisation known as the After Care Association is in every way worthy of public support. It takes care of mentally deficient patients who are

Discharged from Lunatic Asylums

because they are no longer mad enough to be kept in them. That is to say, it provides supervision and attention for the large class of lunatics who are liable after their release from asylums to be driven mad again by the stress of daily life.⁷¹

This writer had assimilated a couple of the MACA's points – namely that some individuals would relapse after discharge without assistance and the point that some people did need to be watched over initially. However, he argued that the public should support the charity not because they were re-establishing recovered individuals into

⁶⁹ *The MACA Annual Report* 1946, p. 2.

⁷⁰ See the section 'Creating and Publicising a "Suitable Case" for Aid in the Late Nineteenth Century' for more details on the early publicity of the MACA centred on the annual reports.

⁷¹ Article from unknown paper, unknown author, 1902, SA/MAC/H.2/2. Emphasis in original text.

social life but because they were supervising lunatics and mentally deficient patients not 'mad enough' to be kept in the asylum. The main contention of the writer was that premature discharge could lead to 'many of the daily tragedies which startle the newspaper reader. A certain number of homicidal maniacs are let loose upon society every week...frequently this outburst - or rather, this recurrence - of mania means a murder, sometimes a massacre'. Clearly, this kind of article was not likely to lead to the destigmatisation of mental illness and was attempting to generate panic among its readers that discharged patients were dangerous, violent and by no means cured. The writer even claimed it was an established fact that Jack the Ripper had been an asylum inmate, unwisely discharged.

An examination of the MACA's Propaganda Committee, established in 1921 and operative until 1929, provides a helpful insight into the way that the MACA sought to raise money for the charity.⁷² In the very first meeting held in March 1921, the Committee focused specifically on advancing the cause of the MACA and not of mental welfare more generally. They aimed to get a question asked in parliament as to what support, if any, was given to the Association. Presumably, it was hoped that this would make the public aware of the charity's status as a voluntary organisation with no central state funds. Another Committee member was to approach the Bishop of London to see if he would allow papers about the Association's work to be placed in church and attention drawn to their work. This would target churchgoers as potential contributors to the

⁷² Propaganda Committee Minute Book 31 March 1921–25 February 1929. SA/MAC/C.4/4, Propaganda Committee Minutes.

charity. The final resolution of the meeting also demonstrated how the charity targeted its publicity to interested groups within the public. The Committee resolved to draw up an appeal to be distributed to the Boards of Guardians, to be followed later by an appeal to friends of patients in private institutions.⁷³

After a couple of meetings in 1921, the Committee minute book was silent until 1925, when discussions began about getting a broadcast on the BBC to publicise the MACA's work and establishing collecting boxes in mental hospitals.⁷⁴ A conference of medical superintendents was organised by the charity at the end of 1925, perhaps to persuade them to allow MACA collection boxes to be placed in their hospitals and to contribute to the MACA sale of work.⁷⁵ More appeals letters were drafted again in 1926 to be sent to interested and influential groups of people. 2000 copies were distributed to MPs, large subscribers to the Surgical Aid Association, members of the London County Council and members of the House of Lords. Another 500 copies were to be sent to members of the Mental Hospitals Association, to the clerks of the committees and chairmen of the licensed houses and registered hospitals.⁷⁶

By the end of 1926, the Propaganda Committee's business was dominated by the forthcoming meeting to advertise the work of the charity to the public, to be presided over by the Prince of Wales, then Patron of the MACA. The Committee decided to

⁷³ Propaganda Committee Meeting Minutes 31 March 1921.

⁷⁴ Propaganda Committee Meeting Minutes 15 June 1925.

⁷⁵ Propaganda Committee Meeting Minutes 20 November 1925.

⁷⁶ Propaganda Committee Meeting Minutes 23 April 1926.

approach large business such as Lloyds and the Stock Exchange for support. Invitations were sent to important people and letters sent to the press and rotary clubs.⁷⁷ After the meeting addressed by the Prince had been concluded, little remained in the minute book except a suggestion that a car should be raffled to raise money for the charity. It was suggested that the NAWU might help advertise the raffle on a countrywide basis; it seems that MACA publicity work in the 1920s was largely concentrated in London. However, the suggestion from the NAWU that the raffle should be confined to NAWU members was deemed not 'public' enough.⁷⁸

The minute book gives an idea of how, in the 1920s, the charity perceived the public and targeted its publicity to specific groups. The charity targeted specific groups – namely church goers, people who subscribed to other charities, influential people such as MPs, business men, people involved in the care of the mentally ill and people responsible for welfare services such as the Boards of Guardians. Different arguments were tailored to specific groups. The MACA suggested helping the mentally afflicted was a religious duty, that it was a unique charity catering for people unable to defend themselves, that it provided value for money. Those who were targeted were depicted as more enlightened than the general public about the problems posed by mental illness and the value of the MACA's work. An appeal targeted towards large businesses was a rational option for the MACA prior to the introduction of the NHS, as the charity could argue that their work

⁷⁷ Propaganda Committee Meeting Minutes 19 January 1927.

⁷⁸ Propaganda Committee Meeting Minutes 11 January 1929.

helped maintain a stable workforce and thus saved businesses and industry money.⁷⁹ However, to find out just how the charity sought to convey its message one needs to examine the remaining pamphlets and publications from the period.

A handout of extracts from speeches made at the AGM in 1919 bemoaned the lack of public awareness about the charity's work, focused on the inability of the mentally disordered to fight for themselves. The extracts conveyed the message that having a mental illness was so stigmatising that those who had recovered were unable to talk about their experiences:

For some reason we have not got the support we might have expected from the public, probably due to the fact that this Association does work for those who cannot ask for themselves, and their disabilities are of a kind which we cannot advertise. These people have to seek the help of an asylum, and you can quite understand that, when they are recovered and fit to go out again, they rather shrink from anybody knowing they ever had an illness which necessitated their being sent off...This is wonderful work. There is no limelight, no pictures in the papers like other societies have to help them...⁸⁰

⁷⁹ David Cantor's study of the Empire Research Council's fundraising and its perception of the public examines how the charity targeted large businesses in the 1930s, but had to appeal to broader groups of the public after the creation of the NHS, when sponsorship from industrialists dwindled. See D. Cantor, 'Representing "the Public": Medicine, Charity and Emotion in Twentieth-Century Britain', in S. Sturdy (ed.), *Medicine, Health and the Public Sphere in Britain, 1600–2000* (London, 2002), pp. 145–68.

⁸⁰ 'Extracts From Speeches At The AGM 1919', Pamphlet. SA/MAC/H.2/11.

Pamphlets produced in the 1930s combined arguments for the need for their work with an emphasis on their low running costs and the overall savings made to society. In large, bold type on the cover of one pamphlet was written '**ADMINISTRATIVE EXPENSES ONLY 8.08%**'. Towards the end of the booklet, again in bold text, the writer argued '**It is extremely doubtful whether any charity in the world has ever managed to do so much work with so low an administrative expenditure**'. Photographs in the pamphlet advertised the convalescent homes where the patients were sent. One photograph represented a home set in country grounds with a badminton or tennis net set up in the garden; the other photograph showed female patients playing croquet in a large garden. Perhaps these images of sports and the outdoors were meant to suggest that the MACA restored its clients to health through the convalescence it provided.⁸¹

A letter sent to *The Times* in 1938 by the MACA Treasurer suggested that the use of physical treatments and the provision for voluntary admissions to mental hospitals in the 1930 Mental Treatment Act should destigmatise mental disorder.⁸² However, this representation of mental disorder and its treatment, sent to a major newspaper with the aim of furthering the work of the MACA, remained contradictory. At the beginning of the letter, the Treasurer argued that certification should no longer be viewed as a shameful process, attacking 'the fear of the mentally afflicted which, except for those very few

⁸¹ MACA eight page pamphlet from the early 1930s. SA/MAC/H.2/1.

⁸² Unpublished letter to *The Times*, sent 7 November 1938. SA/MAC/D.3/1/1/6: Appeals and Fundraising: General SA/MAC/D.3/1/1/1-19.

persons who are members of mental hospital visiting committees, and medical officers, undoubtedly is present in ordinary people; only gradually is certification ceasing to be a stigma upon the family history'. However, the next statement made by the Treasurer in his attempts to promote early treatment for promising patients suggested ambiguously that certification was still viewed as stigmatising: 'How many are there who are aware that the Mental Treatment Act provides for admission to mental hospitals without certification, thus avoiding stigma, if stigma there be?' A similar contradiction emerged when the Treasurer sought to emphasise the favourable treatment given to new and promising patients at the expense of more serious or chronic patients: 'The detention of newly admitted patients in a separate admission villa, divorced as far as possible from the main institution, and the provision of convalescent villas for promising cases, are all means whereby enlightened humane treatment is being adopted'. In this letter the Treasurer viewed the developments in medical treatment within hospitals as an argument for the destigmatisation of mental illness when the MACA were never involved in medical treatment and only worked outside of the hospitals. The term used by the Treasurer to describe the mentally ill - the 'mentally afflicted' – ascribed victim status to the mentally disordered.

From 1944, the MACA began to use radio broadcasts to publicise its cause to the charitable public. The first broadcast made by the Chairman Henry Yellowlees used the story of MACA home residents in Luton who were taught to carry out some of the processes for a war factory to appeal to the listeners. MACA residents were depicted as capable of productivity and usefulness if provided with the opportunity

Imagine what it means to men and women who have just struggled out of the dark shadows of mental disease, to be assured that there is still a place and a job and a need and a welcome for them in the busy world. Once they realise, like those men at Luton, that they can still be of use, that they can still **do** something or **make** something, their self-respect returns in a flash and they hold up their heads once more.⁸³

The traditional theme of the MACA that they were helping former patients back to a socially useful and economically productive place in the community was perhaps especially relevant in the atmosphere of war. Mental illness was represented in the broadcast as an illness from which one could recover completely if given the right guidance. £1, 363, 4s 9d was raised consequently.

In 1955, another appeal was broadcast on the BBC's Week's Good Cause. Addressed again by Yellowlees, this appeal stressed the continuity between the aims of the original founder of the MACA and the work carried out in 1955.⁸⁴ In this broadcast, the Reverend Hawkins 'said that something *must* be done to befriend and re-equip ex-patients, to give them convalescent care, and thus ease and hasten their return to completely renewed usefulness and regained happiness'. 'Today', Yellowlees claimed, 'we take convalescent patients from mental hospitals and bridge the gap between discharge from hospital and full normal activity in the outside world'. The broadcast also

⁸³ BBC Appeal Broadcast made on 6 August 1944, cited in full in *The MACA Annual Report 1944*, p. 6. emphasis in original text.

⁸⁴ BBC Appeal, 8 May 1955, *The MACA Annual Report 1955*, pp. 9–11.

reiterated the emphasis placed on befriending: 'we rehabilitate – or to use our founder's simpler word, we befriend – sufferers from the saddest of all human ills'. By focusing on the aims and functions of the MACA, Yellowlees created a sense of continuity within the charity. Religious language was again used – Yellowlees described the MACA's work through the Bible phrase 'Beauty for ashes, the oil of joy for mourning, the garment of praise for the spirit of heaviness'. The appeal focused on individuals who had recovered from mental disorder. However, the newer functions of the charity that related to patients who had not recovered and would never be independent were also described. A 1961 appeal broadcast revisited familiar ground.⁸⁵ People who were affected by mental illness were described as 'victims of the saddest ill which afflicts mankind – the malady of the mind'. The philosophy of the personal touch was implicit in the description of the MACA homes: 'real homes where friendship and cheerfulness are found and hope again is born and fulfilled. Matrons and wardens become friends, comforters and guides to those under their care.' A more positive description of the care for more chronic patients appeared in this broadcast: 'although unable to fend for themselves, they are sufficiently recovered to take part in the life of a home and to enjoy its freedom'.

In 1968, the MACA ventured onto ATV television to promote their work and raise funds. The approach used was very different to the previous radio broadcasts.⁸⁶ The appeal did not use biblical texts or pleas to help the 'mentally afflicted', although the

⁸⁵ Appeals Script for the Week's Good Cause 8 January 1961. SA/MAC/D.3/1/7, BBC Correspondence 1955–87.

⁸⁶ ATV Appeal, '1 in 5', 7 April 1968, Flyer. SA/MAC/D.3/1/8.

broadcast was produced by the religious programmes department. Instead, the appeal used statistics to create a series of mental illness 'facts' and 'risks' that affected everyone. The title of the appeal, 'One in Five', referred to the number of families thought to be affected by mental illness at some stage. On a flyer for the programme, this figure was given alongside the number of women and men who would at some stage be committed to a mental hospital (one in nine and one in fourteen respectively). The statistic that 47 per cent of all hospital beds were taken up by psychiatric patient was also given. The MACA were no longer representing the mentally ill as stigmatised outcasts. Instead, they suggested to their audience that everyone was at risk from mental illness. The final wording on the flyer suggests that MACA could alleviate some of these problems if given enough funding: 'there are many remaining in mental hospitals only because there are not enough homes in which they could live happy lives if given the support and understanding they need'.

Notes of the discussion between Mrs Clifton, then Secretary of the MACA, and the head of ATV religious programmes Mr Allenby reveal that ATV were keen to have a 'peg' on which to hang the appeal.⁸⁷ The focus was on the number of hospital beds needlessly occupied by patients who could be cared for in the community if there were provisions. An interesting new aspect was the suggestion that a MACA client should be asked to take part in a discussion to help the appeal. This was clearly a departure from the earlier appeals made by the MACA, such as that in 1919, on behalf of individuals

⁸⁷ Notes on discussion between Mrs Clifton and Mr Allenby, head of religious programs on ATV, 1 January 1968. SA/MAC/D.3/1/8.

believed to be too stigmatised by their illness to speak for themselves. Indeed Mrs Clifton, when this suggestion was put to her, suggested the name of a MACA resident who had already appeared on a television programme about mental health. This suggests that the MACA had moved beyond a stage where it represented the interests of the mentally ill on their behalf, instead enabling its users to voice their own concerns. The final programme also featured still images of four MACA cases at work - a clerk, a typist, a waitress and an assembler at an engineering works.⁸⁸ Perhaps the MACA were using technology to demonstrate as they had sought to demonstrate through case studies in the earliest of their reports that their clients could be returned to work. The appeal claimed 'these people have in common the fact that they have received treatment, have recovered and are now working again with the supportive and understanding care that our hostels provide'. This appeal combined older elements of MACA appeals – notably a focus on helping people back into employment and socially useful lives – with new elements. A new focus for the charity was the suggestion that chronic patients should receive care in community homes to help them 'regain their self-respect and confidence in their own ability to lead happy normal lives'. This would also make hospital places available for patients needing medical treatment. Older, religious language about sufferers of mental illness was replaced with a set of figures urging the viewer 'that today mental health is everyone's concern'.

⁸⁸ Notes for ATV Appeal, '1 in 5', 7 April 1968, SA/MAC/D.3/1/8.

6: Conclusion

This chapter has sought to challenge Habermas' contention that the interpenetration of state and society led to the collapse of a rational-critical bourgeois debating public sphere by examining Nancy Fraser's suggestion that the multiplicity of sub-publics seeking to protect private interests could set up a more democratic form of participation.⁸⁹ Potentially groups of people previously debarred from equal participation could be enabled to bring to the agenda private issues that might exclude them and to carry them forward to a wider public.⁹⁰ The MACA might be seen as one such sub-public, indeed might conform more to a Habermasian concept of a public sphere than the professional groups examined in previous chapters. While organisations like the MPA, the NAWU and the APSW were established primarily to advance the interests of mental health professions, the MACA was established primarily to represent the interests of the discharged mental patient. Finlayson argued that charity members were participating in some kind of public sphere: 'Those who took part in such initiatives – and they included an immense contribution from women – were involved in "active citizenship"...at a time when they were, in large measure, denied access to formal political structures'.⁹¹ In the AGMs and committees MACA members debated the issues surrounding mental illness.

⁸⁹ J. Habermas, *The Structural Transformation of the Public Sphere: An Inquiry into a Category of Bourgeois Society* (1962, translated by Thomas Burger London, 1999).

⁹⁰ N. Fraser, 'Rethinking the Public Sphere: A Contribution to the Critique of Actually Existing Democracy', in C. Calhoun (ed.), *Habermas and the Public Sphere* (Cambridge, 1992), pp. 109–42.

⁹¹ Finlayson, *Citizen, State, and Social Welfare*, p. 401.

These debates were replicated on smaller, localised scales in the interactions between MACA staff, MACA clients, employers, homeowners, subscribers, local residents and social workers. However, it's important to acknowledge the very notable exclusionary limits of this particular public sphere. For most of the period under study, the very people whose interests were most affected by these debates continued to be represented as child-like patients: entitled to receive, but not to participate or contribute their own opinion except when manipulated for publicity purposes. Voluntary organisations, Steve Sturdy has argued, 'conformed only poorly to Habermas's ideals of inclusiveness, transparency and formal equality', and were often 'appropriated and privatised by particular interest groups intent on self-advancement and the pursuit of social influence'.⁹²

The representations of mental illness that the MACA sought to publicise were related to the aims and needs of the charity. Even within a charitable organisation such as the MACA, the private interests of members competed with the needs of the mentally ill to determine the course the charity would follow and the representations it would produce. Moreover, in order to fund its activities, the MACA required financial support from the public. Although those MACA members who drew up the publicity material may well have felt that the needs of the mentally ill were their primary concern, in order to appeal to potential sponsors they frequently suggested that donations to the charity would serve to represent other interests and concerns. This approach reflected the view the MACA had of the public, and of public attitudes towards mental disorder. Perhaps the

⁹² S. Sturdy, 'Introduction: Medicine, Health and the Public Sphere', in Sturdy (ed.), *Medicine, Health and the Public Sphere*, pp. 1–24. Quoted on p. 12.

main example of the surfacing of other interests can be seen in the MACA's preoccupation with employment. From the charity's inception though to the 1968 ATV 'One in Five' campaign, which showed viewers photographs of former MACA cases at their place of work, the MACA equated recovery with gainful employment, suggesting that their work could make unproductive people into industrious citizens who would not prove a burden to state resources. As a charitable organisation operating in an era of increasing government intervention in social affairs, the MACA not only had to interact with state provisions, but differentiate its services from those provided by the government in order to justify its continued operation. The representations put forward by the charity about the nature of mental illness were designed to promote the services that the charity offered at any point in time. This state of affairs led the MACA to invert the more usual shift in how mental illness was depicted. At a time when mental disorder was largely perceived as hereditary, chronic and incurable by medical profession, the MACA depicted most of its clients as suffering from a curable condition brought about by social strain. Yet in the mid-twentieth century, when psychiatry increasingly represented mental disorder as a curable illness, from which individuals could recover and resume their place within the community, the MACA began to publicise the image of the chronically ill individuals who would need permanent care, albeit outside of the hospital.

My examination of the early records of this charity, essentially in this analysis from its formation in 1879 up until 1920, situates the charity amongst other philanthropic currents and ideologies. The MACA drew on ideas of the Charity Organisation Society and the poor law when it envisaged that its clients would emerge from convalescence and

regain their social and economic place within society, supporting themselves. It was one of the 'independent agencies concerned to foster independent conduct'.⁹³ Case studies in the annual reports created stories of acceptable breakdowns amongst respectable people followed by their satisfactory resettling into work. The image of vulnerable women, in particular of the governess, was deployed especially in the very early years of the charity. When the mental disorder was thought to be linked more closely to the personality of the individual, then the ideology of 'befriending' could be applied to remould the character into a suitable worker or mother. Amongst the medical members of the charity, the belief that mental illness was a curable disease from which one could recover vied uneasily with the notion that mental disorder was hereditary and recurrent, unamenable to social or medical action. Despite the fact that in this early period the MACA were keen to promote mental illness as a disease from which one could recover, these concerns were transmitted to the public in some newspaper articles about the charity's work.

The period from 1920 to 1940 was a period of expansion and diversification for the charity. Pamphlets in the 1930s balanced the social benefit gained by the individuals helped with the utilitarian benefits of supporting a cost-effective charity that kept its clients away from public support. Appeals for help castigated public ignorance and prejudice towards mental disorder but the MACA failed to attempt to tackle this stigma. When attempting to decrease the stigma of the voluntary or early case patient the MACA may have worsened the stigma attached to more chronic patients in the public mind.

⁹³ Finlayson, *Citizen, State, and Social Welfare*, p. 77.

Appeals for help remained linked to notions of religious duty towards the mentally afflicted sufferer.

From 1940 to 1970, the MACA was forced to rethink its policies and image as other charitable organisations and the formation of the NHS began to encroach upon its traditional ground. In 1939, the Central Association for Mental Welfare, the National Council for Mental Hygiene and the Child Guidance Council linked together to form the NAMH, leaving the MACA as the only charity to withdraw from the merger. Attempts to maintain its unique identity and pioneer role in the provision of convalescent homes and employment for recovered patients came under threat from the NHS. The MACA took the bold step of abandoning much of their work among recovered clients for work with more chronic patients. By grafting this new direction onto the traditional ideologies of befriending and the 'personal touch', the MACA were able to maintain their identity and sense of continuity while retaining useful and fairly unique services. Attempts to gain donations in this period frequently stressed these continuities with older arguments while beginning to emphasise the rights of more chronic patients in a public sphere. Theories developed in psychiatric social work relating to the social causation and treatment of mental distress partially affected the views of the MACA in this period. The affect that the MACA appeared to have on the direction and ideology of state policy does seem to suggest that a voluntary society could bring some influence upon public policy. Of course, many other reasons for the policy of care in the community, ranging from financial savings, new drug therapeutics and sociological critiques of the mental hospital, provide a fuller explanation. However, the MACA (an organisation of private people)

clearly played a sizeable role in the actual care of the mentally disordered, a role that the state was meant to fulfil.

In the ATV 1968 campaign, striking divergences with earlier representations were evident. The MACA, which had for a long time shied away from educating the public, created a campaign that was based not on the figure of the friendless isolated and voiceless victim of mental disorder but on statistics. This suggested that mental health and ill health posed a risk and responsibility to everyone. Moreover, an important shift in the representation of interests had occurred. The MACA no longer sought to speak on behalf of the mentally ill and represent their interests to the public, but enabled some MACA clients to share their perspectives and experiences, and represent their own interests.

Chapter Five: Patients and the Representation of Mental Illness

1: Introduction: Mental Illness, Texts, Reality and Representation

'Madness', Roy Porter observed, 'largely involves sound out of place'.¹ Perhaps recognising this, Joseph Berke, Mary Barnes' therapist at Kingsley Hall, described why he had chosen to specialise in psychiatry:

Here was one discipline where it was still fashionable to talk to the patient, or so it seemed. On closer examination it became obvious that the reverse was true. Both the interview and treatment situations were carefully structured to prevent any genuine exchange between patient and therapist...During my clinical years it became clear to me that most psychiatrists are not only not experts in communication, but are not at all interested in what their patients have to tell them.²

While speech might mark out madness, Porter argued, psychiatrists were 'interested in speech, if at all, chiefly as *symptom*, psychiatry tended to disavow what the disturbed said as *communication*'.³ The content of patients' speech was believed to have no meaning and no significance, to bear no relation to reality. Thus, stories told by those affected by mental illness about their experiences have traditionally been excluded from the

¹ R. Porter, 'Hearing the Mad. Communication and Excommunication', in L. de Goei and J. Vijeelaar (eds), *Proceedings of the First European Congress on the History of Psychiatry and Mental Health Care* (Amsterdam, 1993), pp. 338–52. Quoted on p. 348.

² M. Barnes and J. Berke, *Two Accounts of a Journey Through Madness* (London, 1971), pp. 78, 81.

³ Porter, 'Hearing the Mad', p. 344.

psychiatric record. When, for example, in 1920, an ex-serviceman affected by shellshock launched an attack on the ill treatment he claimed he had received, the National Asylum Workers' Union denounced the legitimacy of his testimony. 'The fact that the patient was for five months in the Hospital would of itself seem quite sufficient to put anyone on his guard against accepting without reserve a series of charges made by one whose memory and judgement must of necessity leave much to be desired.'⁴ For the psychiatric profession, an individual's mental illness undermined the meaning and accuracy of anything they said. Communication with the mentally ill was deemed pointless.

Historians, however, have reasserted the value of speech and communication with those diagnosed as mentally ill. Kerry Davies has used oral testimony to examine the acceptable narratives mental health service users have deployed to represent their experiences since 1948.⁵ Davies argues that such narratives illustrate the relationship between specific individual events and a more general, historical context. She has examined how patients made use of both lay and psychiatric discourses when constructing their narratives, often incorporating fictional figures from popular culture to elucidate their experiences.⁶ Challenging the assumption that patient narratives can only be examined as individual or specific accounts, Davies outlined three narrative frames which her respondents used to shape and give meaning to their stories: narratives of loss, of survival and self-discovery, and of the self as patient. The oral histories Davies

⁴ *NAWU Magazine*, 9 (February, 1920), p. 6

⁵ K. Davies, "'Silent and Censored Travellers'? Patients' Narratives and Patients' Voices: Perspectives on the History of Mental Illness since 1948', *Social History of Medicine*, 14 (2001), pp. 267–92.

⁶ *Ibid.*, p. 274.

collected revealed a sense of community amongst mental health service users, either as part of the hierarchical community of the hospital, or, later on, as members of a user community, quite distinct from psychiatry.⁷

The ‘cultural turn’ in history has led academics to investigate more thoroughly how texts function, prompting historians to examine written accounts of the mentally ill, to listen to what those described as mad have said, in the hope of enriching social history. As cultural historian Roger Chartier reminds us, ‘no text, even the most apparently documentary, even the most “objective” (for example, a statistical table drawn up by a government agency), maintains a transparent relationship with the reality that it apprehends’. The relationship of the text to reality is mediated by what Chartier terms ‘construction procedures’, through which the beliefs and ideas of the writer, and the stylistic rules of the particular genre of writing shape the text.⁸ An appreciation of the construction procedures that shaped the writings of both psychiatrists and patients helps to level the historical discrimination against using the writings of the mad as a source. Lindsay Prior suggested that ‘the ways in which we organize care and treatment for psychiatric disorders serves both to reflect and constitute what such disorders are’.⁹ In his book, *The Social Organisation of Mental Illness*, Prior argued that the seemingly objective texts created by psychiatry, such as classificatory asylum admissions tables, revealed not so much what mental illness actually was, but what theories psychiatrists

⁷ *Ibid.*, pp. 276–89.

⁸ R. Chartier, *Cultural History: Between Practices and Representations* (Padstow, 1988), p. 43.

⁹ L. Prior, *The Social Organisation of Mental Illness* (London, 1993), p. 1.

held about mental illness. 'We may say that representations of mental illness are nothing less than theories realised', wrote Prior. 'Hospital architecture, for example, expresses and realises specific theories of psychiatric disorder'.¹⁰ Although the narrative of a patient may not reflect an objective reality, the texts produced by psychiatry were also only a subjective reflection of psychiatrists' theories and beliefs about mental illness.

While speech and the written word might both communicate to an audience something of a person's experience of mental illness, both as an individual and as part of a community, it is necessary to examine how writing functions differently from speech. Michael Roper has examined the psychological role writing might play for an individual, challenging suggestions that narratives are shaped solely through narrative forms and social practices.¹¹ Writing, he argues, is a different process from speech, a solitary occupation removed from interaction with other people, in which the author's thoughts remain unchallenged, allowing a space for reflection. It can also fulfill psychological purposes, allowing the author to make disturbing events more meaningful and to create an image of the self that is acceptable.¹² Roper examined the unsent letters of a management expert, Lyndall Urwick, which were written at times of stress in his life. Using Melanie Klein's belief that projective identification forms a key defence mechanism people use to protect their psyche, Roper examines how Urwick used his unsent letters as an opportunity to split off aspects of his personality that threatened his

¹⁰ Prior, *Mental Illness*, p. 16.

¹¹ M. Roper, 'Splitting in Unsent Letters: Writing as a Social Practice and a Psychological Activity', *Social History*, 26 (2001), pp. 318–39.

¹² *Ibid.*, pp. 319–20.

sense of self. These threatening characteristics were then projected onto other people.¹³ The experience of certification, compulsory detention and treatment within an asylum was a disruptive experience that could pose threats to an individual's sense of self. As such, we should examine not just how the narrative and social structures shaped the experiences of writers who had experienced mental disturbance, but the psychological motivations that drove them to express themselves in particular ways.

Another way of thinking about the narratives of people diagnosed as mentally ill is to examine their writing in the context of broader cultural beliefs. Porter suggested that 'the delusions of the mad, the myths of psychiatry and the ideologies of society at large all form part of a common ideological fabric'.¹⁴ While psychiatrists constituted themselves as the voice of reason, casting the patient voice into the opposite role, the narratives of the two groups often converged. 'The mad and the mad-doctors are often saying intriguingly comparable things about agency and action, rights and responsibility, reason and nonsense,' Porter argued, 'although applying them in fundamentally reversed ways'.¹⁵ Although psychiatry was keen to proclaim itself as a scientific discipline based on truth and observation, some asylum inmates argued that psychiatric practice was simply the realisation of unproven theories. The growth of the psychiatric domain in the nineteenth and twentieth centuries encompassed increasing numbers of people within its ever-expanding categories of illness. Porter's study of patient narratives revealed that

¹³ *Ibid.*, pp. 320–37.

¹⁴ R. Porter, *A Social History of Madness: Stories of the Insane* (London, 1999), p. 4.

¹⁵ *Ibid.*, p. 4.

some thought psychiatry itself mad – ‘it rendered others the victims of its own delusions, by conjuring up its own fantasy world of the mad. Once you had been forced to act out the role of patient in this fantasy...once you were confined in the asylum, you were allowed to escape only if you played your part to the letter’.¹⁶

This chapter will examine, first, how an asylum magazine might function as a space in which a sub-public group of people with specific concerns, in this instance the certified insane, could debate issues and promote a sense of community and identity. The case study for this research has been the *Morningside Mirror* (hereafter the *Mirror*), a magazine published at the Royal Edinburgh Asylum at Morningside (hereafter the REA). The REA, which opened in 1813 as a voluntary hospital, catered for both pauper and private patients. The chapter will examine if the *Mirror* provided a forum in which those certified as mentally ill could debate and challenge conventional concepts about their identity, just as Davies’ research into the oral testimonies of more recent mental health service users uncovered a patient or user community in opposition to psychiatry. The second part of the chapter examines a few of the published autobiographies written by people who were treated within asylums, which were intended for a popular audience. These non-fictional works all relate to experience of psychiatric treatment and care received in Britain over the course of the twentieth century. We can perhaps read the stories written by former asylum patients as attempts to communicate the disruptive and isolating experience of mental illness to the wider community, trying to reintegrate themselves and their experience back into the cultural setting.

¹⁶ *Ibid.*, p. 23.

This chapter will consider how patients sought to re-establish identities under threat by writing. The process of certification and internment in an asylum threatened people's identities as citizens, workers and family members, substituting a societally imposed identity of madness. It remains difficult, Peter Barham argued in 1992, for people diagnosed with mental illnesses to go 'against the grain of established cultural sensibilities in which identities are judged to be irrevocably tainted or spoiled by a diagnosis of mental illness'.¹⁷ This chapter will consider how people sought to define themselves through writing and what purposes they hoped to achieve. It will examine how patients sought to represent themselves in differing ways to multiple audiences. While notions of madness were imposed upon patients by psychiatry, this chapter will examine how certified people sought to contest and challenge their given identities, and will ask how much control patients had in the fashioning of their identity.

Psychiatry's right to identify and segregate the mad did not remain unchallenged. Public concerns about the wrongful confinement of sane individuals in asylums and false pleas of insanity entered in murder trials were arbitrated in law courts, where the legal profession often successfully challenged psychiatry's right to define and treat the insane.¹⁸ Meanwhile, an organisation consisting mainly of former asylum patients, the

¹⁷ P. Barham, *Closing the Asylum: The Mental Patient in Modern Society* (London, 1992), p. 59.

¹⁸ For further information on public concerns about wrongful confinement, see P. McCandless, 'Liberty and Lunacy: the Victorians and Wrongful Confinement', in A. Scull (ed.), *Madhouses, Mad-Doctors and Madmen: the Social History of Psychiatry in the Victorian Era* (London, 1981), pp. 339–61. These issues are also discussed in Chapter One.

Alleged Lunatics' Friend Society, was founded in 1845. This society campaigned for improvements in the way patients were treated and sought to bring about changes in the lunacy laws to reduce the risks of unnecessary confinement and improve the conditions within asylums.¹⁹ The Alleged Lunatics' Friend Society attempted to prevent psychiatry from expanding definitions of insanity to include those that 'encroached on the borders of eccentric, immoral and even criminal behaviour'.²⁰ While the Society disbanded in 1865, further organisations advocating patient rights were established.²¹ However, organised mental health service users movements, which should be distinguished from charitable or pressure group organisations set up on behalf of the mentally ill, post date the period 1870–1970, becoming visible in the late 1970s and 1980s. Such movements, which enabled people to define themselves as 'survivors' rather than 'mental patients', may be one way in which 'the former mental patient may learn to reappropriate his or her identity'.²² The development of mental health user movements has been charted by Nick Crossley, who suggests that the movement emerged when it did because the earlier critiques of anti-psychiatrists altered the mental health field and created the impetus to re-

¹⁹ For an account of the society's life, see N. Hervey, 'Advocacy or Folly: The Alleged Lunatics' Friend Society, 1845-63', *Medical History*, 30 (1986), pp. 245–75.

²⁰ *Ibid.*, p. 275.

²¹ Hervey lists the Lunacy Law Reform Association, founded in 1873 and led by Louisa Lowe, a vicar's wife consigned to an asylum because of her spiritualist beliefs. This organisation ceased to operate around 1885 and I have been unable to find any archives relating to its work. The National Society for Lunacy Reform, founded in 1920, played a role in instigating the 1926 Royal Commission. It is unclear whether this organisation consisted chiefly of former patients or not. *Ibid.*, p. 245, footnote 3.

²² Barham, *Closing the Asylum*, p. 116.

imagine the status and role of the mental patient.²³ This chapter will examine whether writing produced by those diagnosed as mentally ill created a sense of community and allowed patients to refashion their identities.

2: Internal Debate

2.1: Background Research on the Morningside Mirror

Established in 1845, the *Mirror* appeared on a monthly basis in the format of a broadsheet newspaper and was edited by the assistant doctors and the chaplain of the REA. The research on the *Mirror* undertaken for this chapter was based on sampling the first two numbers of the *Mirror* for every other year, sometimes following up items from there into other issues. There are gaps in the issues that remain. Copies from 1912 to 1935 are missing, as are those from 1947 to 1959. Michael Barfoot and Allan Beveridge, who have undertaken research on the *Mirror*, suggest that the level of patient involvement was very high, both in the printing of the paper in the asylum's workshop and in its content. Not only did patients contribute the vast majority of the material in the *Mirror*; they were also heavily involved in editing it.²⁴

²³ N. Crossley, 'Fish, Field, Habitus and Madness: the First Wave Mental Health Users Movement in Great Britain', *British Journal of Sociology*, 50 (1999), pp. 647–70.

²⁴ M. Barfoot and A. Beveridge, "'Our Most Notable Inmate": John Willis Mason at the Royal Edinburgh Asylum, 1864–1901', *History of Psychiatry*, 4 (1993), pp. 159-208. See p. 172.

Topics written about in the magazine shifted over time, reflecting change within the hospital. Early issues discussed the sports competitions, making special reference to curling matches. Lectures given to groups of the patients were discussed: these encompassed many themes but predominantly related to travel in other countries. The plays, concerts and balls that the patients attended were also written up. Studying these accounts, an interesting change in terminology can be discerned. At first referred to as ‘inmates’,²⁵ those attending the balls were later described as ‘patients’²⁶ and then ‘guests’ or ‘dancers’.²⁷ The *Mirror* contained stories, poems and essays, written mainly by patients, that principally covered historical, literary and musical subjects and very rarely mentioned the subject of mental illness. Initially the *Mirror* was sold in bookshops in Edinburgh but at some stage the outside circulation ceased and it became entirely a house magazine for inside circulation. Only a couple of copies were then distributed outside the asylum, and these were sent to subscribers who had once themselves contributed to the *Mirror*. By 1960, the *Mirror* was being edited by a group of patients and staff in occupational therapy and no longer resembled a professional newspaper in appearance. Its purpose by this stage may have been more therapeutic. The articles that appeared in the 1960s issues of the *Mirror* – about working outside the asylum, a series of recipes for individuals in bedsits, and accounts of patients’ holidays – reflected the fact that patients were moving in and out of the hospital more rapidly by this time. By the 1960s, increasing numbers of articles in the *Mirror* covered the affairs of the staff in the asylum.

²⁵ *Morningside Mirror*, XXV (1870), p. 32

²⁶ *Morningside Mirror*, LVIII (1903), p. 2.

²⁷ *Morningside Mirror*, XCV (1938), p. 9.

This may have reflected the growing influence of the ideal of the therapeutic community, which necessitated a curtailment of hierarchical power structures and the opening up of communication amongst all who lived and worked in the hospital. The increasing amount of space given over to staff affairs may have resulted from a growing belief that nurses had an important therapeutic role to play. It also emphasised the belief that and all those who lived and worked in the hospital were part of the same community.²⁸ In 1965, the administration of the *Mirror* was taken over by teenage patients and was given a new format.

2.2: Purposes of the *Mirror*: A Place in Which to Vent Grievances

In 1893, outgoing *Mirror* editor Dr Robertson, who later returned to the asylum as Medical Superintendent, defined three main purposes of the *Mirror*. It was there, in his view, to entertain its readers, to provide a record of the life of the community and to provide a creative outlet for those so inclined.²⁹ For many of its contributors, however, the primary purpose of the *Mirror* appears to have been the space it offered for patients to voice their grievances. A. M. wrote to the editor of the *Mirror* in 1891 with a list of suggested improvements for the asylum that included an attack on the compulsory detention of patients and a request for private clothing and possessions to be allowed to

²⁸ For more information on the development of the therapeutic community, see D. W. Millard, 'Maxwell Jones and the Therapeutic Community', in H. Freeman and G. Berrios (eds), *150 Years of British Psychiatry Volume II: The Aftermath* (London, 1996), pp. 581–604.

²⁹ *Morningside Mirror*, XLVIII (1893), p. 12.

all patients.³⁰ In 1897, a female patient used the columns of the *Mirror* to vent her grievances at her former employer who had refused to give her a good reference thus keeping her out of work.³¹ In the same year N-V-N, who designated himself ‘Emperor of the Entire World’, launched a bitter attack on a fellow patient: ‘he is more trouble and annoyance than all the rest of the fifty-three patients out together. He is...the meanest, hardest and most troublesome animal in existence.’ The following month, the accused patient used the *Mirror* to respond and defend himself.³²

Another negative view of the asylum routine and its inhabitants can be gleaned from a letter written by a patient to his wife, which was published in the *Mirror*.³³ ‘My dearest wife – I will write to you every day, and until I get away from this noxious, foul smelling, stinking, abominable, hateful, cruel, diabolical, and most d-e h-l upon earth that the mind...could contemplate.’ The author described his fellow inmates in rather derogatory terms, as if to distance himself from them:

It is a moving, touching, and most affecting spectacle to observe the voracity of the guests, and the velocity, and I might say ferocity, with which victuals are

³⁰ *Morningside Mirror*, XLVI (1891), p. 67.

³¹ ‘An Autobiography: Or, My Late Mistress: A Warning to Servants and Others in Search of Situations in Large Towns and Cities in England, Scotland and Ireland’, *Morningside Mirror*, LII (1897), pp. 2–4.

³² ‘One of Our Celebrities Described by Another’, *Morningside Mirror*, LII (1897), p. 6. The rebuttal of the charges appeared on p. 14.

³³ ‘A Psychological Study: Impressions of an Asylum (A Humorous Patient’s Letter to His Wife)’, *Morningside Mirror*, XLII (March, 1887), pp. 20–21. It is possible that this letter was written as fiction for the *Mirror*.

dispatched. The yells of some of the more playful inmates form a pleasing concert, mixed with 'caller herrin' from some larky fishwife, and the 'Damn-your-eyes, you've taken my bread', of some male maddy.

The standard of food came in from criticism by the author. 'I have not eaten an egg nor beefsteak. Eggs, I presume, are too expensive...or perhaps they may be deemed by a potential lunacy board detrimental or too luxurious for a pauper constituency, so I've had none.' The types of work that the patients were expected to do were also ridiculed. 'But as for work, Lord bless you, my dear, only fancy your husband a navvy one day, a pigsty man another, a gatherer of weeds another, a scrubber of floors another, a maker of beds and washer out of chamber ware another, and you will have a tolerably correct idea of his situation.' Finally, the writer expressed his desire to leave the asylum: '...heaven, my dear, to be in Auld Reekie again, even in my last box, seems a dream to me'.

The inclusion of this piece in the *Mirror* is rather unusual, as it had been intended for an outside audience, and not fellow patients. This may explain why, in addition to many of the usual grievances aired by the patients – the restrictions placed on letter writing and the type of work patients were expected to do – the author was very critical of his fellow inmates. Far from being talented poets or skilled sportsmen, the patients were targeted as a butt for his jokes. The author was probably trying to distinguish himself from the madness that surrounded him, in an attempt to re-establish his sense of identity as a sane man.³⁴

³⁴ The letter may have been written as a fictional piece for the *Mirror*.

Some criticisms of the hospital rules and regimes continued to surface throughout the twentieth century. A cartoon from 1963, entitled 'two sides to everything', showed a door, with the sign 'staff complaints here please' placed above a letterbox. On the other side of the door, the cartoonist drew a waste paper basket.³⁵ In 1964, the report of the West House Patients' Improvements Committee raised such issues as insufficient margarine on the bread, a broken off door handle on one of the dining rooms that needed to be replaced and the desirability of a table tennis table.³⁶ Five years later, one disaffected inhabitant of the asylum used the editorial column of the *Mirror* to launch a rather more searing attack on the hospital system. Judging by some notes written on to the copy in the archive, it appears that a student nurse wrote this column

It would be naive indeed to believe that this or any other psychiatric hospital exists solely for the benefit of the patients but unless the seething discontent which pervades this establishment is identified, openly expressed, honestly examined and positively rectified, there will soon be no benefit accrued to anyone.

In two years, I have seen in myself and in many of my colleagues optimism, expectancy and enthusiasm turn, at times, into bewilderment, pessimism, and despair where, of course, there hasn't been a prior adjustment to the prevailing

³⁵ 'Morningside Mirror' (October, 1963), p. 2, LHB7/13/22. By the 1960s, the 'Morningside Mirror' was no longer produced as a newspaper, instead it appeared more informally as typescript on coloured paper. I have thus given the archival reference for these later editions.

³⁶ 'Morningside Mirror' (March, 1964), p. 12, LHB7/13/23.

situation in barren careerism, foetid cynicism or schizoid resignation. Frustration is impotently, furtively and daily expressed in duty rooms, coffee rooms and dining rooms, anywhere, in fact, that cretinous cowardice will permit this feeling to be expressed without fear of reprisal.

The effect and cause remain the same – a gigantic double-bind situation in which nothing changes, nothing improves and nothing evolves but therapeutic impotence, administrative incompetence and sickening confusion. A vicious circle, indeed, is this to be caught up in and beyond the credibility of anyone who has not experienced it. Those of us who have, may well consider continued optimism to be indicative of psychopathy.³⁷

This column appears to be strongly influenced by the anti-psychiatry ideas that were circulating in the late 1960s. The author attributed acceptance of the current situation to ‘schizoid resignation’, and ‘psychopathy’, deploying the language descriptive of mental illness but subverted it by assigning the madness to the asylum authorities. Perhaps the fact that the writer appears to have been a nurse, and not a patient, illustrates the extent to which those locked into the system for mental illness shared a common language, common concerns and anxieties. It is clear that by this stage the *Mirror* was not being so closely monitored by the asylum authorities. Clearly the author of the column had gone beyond permissible criticisms of the REA: following this issue, Dr Affleck

³⁷ ‘Morningside Mirror’ (January, 1969), p. 1, LHB7/13/29.

began to edit the *Mirror* and commenced the next month by issuing an apology for the previous month's column.³⁸

2.3: A Forum in Which to Fashion an Alternative Identity

The *Mirror* also provided a place for a small number of patients to forge an alternative identity for themselves than that of mental patient. The activities of the Asylum Literary Club were regularly reported in the *Mirror*. This club consisted both of staff and patients, and members took it in turns to present papers, thus levelling some of the hierarchy within the hospital. A poem of 1885 lauded the talent of the literary club, perhaps an attempt by some patients to separate themselves from the asylum and to define themselves in a different light:

Hurrah! Hurrah! For the R.E.A.
And the Literary Club so grand;
Where you will find, my shrewd wise men,
A better in all the land.

The Morningside College is nothing to us,
Nor Merchiston's ancient renown
Our C. and our K., and our S. and our T.
Could beat all the town and the gown.³⁹

³⁸ 'Morningside Mirror' (February, 1969), p. 1, LHB7/13/29.

³⁹ 'Our Literary Club', *Morningside Mirror*, XL (1885), p. 35.

The creation of a more meaningful, humanising and valued identity than that of a pauper lunatic was also a prominent concern in 1878, when the *Mirror* received a letter from the *Meteor*, a paper produced by the Alabama asylum. The *Meteor* complained that too much space was reserved in the *Mirror* for long articles on Tennyson. They wanted to read accounts of local affairs, details of how many patients were in the asylum and how they were supported.

Fancy anyone preferring to know how we are 'supported' to reading that most brilliant article of ours on the poet laureate, - a production, we have no hesitation of saying, unequalled as a criticism for its ingenuity and perspicuity. Tennyson's real meaning was unknown until that critique appeared. The poet has himself acknowledged this... As regards the commonplace into which his mind seems set on, we beg to inform him that our numbers at present are one or two over ten million; that we are supported by the Empress of the Universe, who lives among us; that more Kings, Emperors, gods of the first class; lords, authors, prophets, artists, inventors, and great men of whom the world was not worthy; live here than anywhere else in creation.⁴⁰

This exchange of letters suggests there existed some interaction between the multiple sub-public patient spheres created by different asylum populations, although it also points to some variations in the goals of the papers. The *Meteor*, which may have been more closely monitored and controlled by the asylum staff, appears to have been

⁴⁰ 'A Capacious Critic', *Morningside Mirror*, XXXIII (1878), p. 12.

concerned with the day to day running of the asylum. The *Mirror*, however, offered some asylum patients a forum in which to forge a different identity for themselves than that of mental patient, a place to discuss literary genius, foreign places and historical events and to escape the reality of asylum life. Not only did the *Mirror* help patients to refashion their identity; it also promoted the idea that mental illness was a positive attribute and that those within the asylum were in some sense superior to the sane outside. These ideas were given some credence by psychiatrists who sometimes argued that creativity and insanity were linked.⁴¹ The extent to which the *Mirror* offered patients the opportunity to refashion their self-image in this manner must have been limited however. Editorials throughout the years frequently bewailed the lack of contributors and it appears that a very few people may have written the vast majority of most issues of the *Mirror*.

⁴¹ Henry Maudsley, for example, used this argument in 1871 to argue against the prevention of marriage amongst people with a predisposition to mental illness. See H. Maudsley, 'Presidential Address', *Journal of Mental Science*, 17 (1871), pp. 311–32. Quoted on p. 317. 'Mankind is indebted for much of its originality and for certain forms of genius to individuals who themselves, or whose parents, have sprung from families in which there has been some predisposition to insanity. They often take up the bye-paths of thought, which have been overlooked by more stable intellects, and, following them persistently, discover new relations of things; or they discover special talents or energies which they discharge in originalities, or perhaps even eccentricities of action...and the world is notably the gainer by their existence.' Links between madness and creativity continue to be out advanced by modern commentators, such as psychiatrist Kay Redfield Jamison, who is herself affected by manic depressive illness. In her book, *Touched with Fire*, Jamison retrospectively diagnosed mood disorders in British poets and compared levels of disturbance amongst contemporary writers with a control group. K. Redfield Jamison, *Touched With Fire: Manic Depressive Illness and the Artistic Temperament* (New York, 1994).

The pastime of curling was obsessively written up, occupying large sections of early editions of the *Mirror*. This too seemed to have acted as a levelling force on the asylum and operated as a space where the asylum population – doctors and patients – could come together on an equal footing. Doctors were frequently defeated by patients in matches and the asylum team was often able to triumph over local teams. The nature of the sport made doctors who participated in it an object of mirth, as in an article from 1879:

Just watch that ‘tall wise – looking man’, who yesterday might have been seen in all the glory of official headship of his department striding along with his wand of office in his hands, a terror to all evil-doers...It cannot be that the uncanny looking mortal whom we see today on the ice is the same. He is unkempt and strange. He wields a monstrous broom, with which he now frantically sweeps the clean ice, already as smooth as glass...and if you have any doubt that the man is clean crazy and beside himself, just listen for a little to him. No patient in the padded cell was ever so incoherent.⁴²

This is yet another instance in which images of madness were subverted and applied to those conventionally viewed as sane. By the start of the twentieth century, curling slowly began to be displaced by other sports, such as cricket. In a 1960s edition of the *Mirror*, an archive account of the sport was included as a historical curio.⁴³

⁴² *Morningside Mirror*, XXXIV (1879), p. 5.

⁴³ LHB7/13/22 ‘Morningside Mirror’ (July, 1963), p. 7.

An obituary for a patient printed in the *Mirror* in 1942, made no reference to his mental disorder, listing instead the variety of activities he took part in at Morningside, which helped define who he was for his fellow inmates.

What happy memories we all cherish at West House of Peter, of his noble yet gentle character; and especially will he be remembered in the gardens. What a good memory he had for reciting or singing, and in the church he needed no bible or Psalter, as those who knew him intimately remember his early blindness. His many contributions of poetry to the *Mirror* will be eagerly sought out and re-read enjoyably, for their undoubted fine finish and moral worth, by his many admirers.⁴⁴

2.4: The Secret Society of Certified Lunatics

In a rather different vein, one anonymous contributor used the *Mirror* to describe the antics of a secret society operating within the asylum. Accounts of the doings of the Secret Society of Certified Lunatics (hereafter SSCL) were published annually in the *Mirror* between 1898 and 1900. Written in a joking manner, it is unclear whether the stories appertained to events that happened within the asylum or were simply fictional stories written to amuse. However, the stories are interesting as they contested the nature of mental illness and the purpose of the asylum. According to the author the SSCL came into being as:

⁴⁴ *Morningside Mirror*, XCVIII (1943), p. 6.

Parliament had just met to adjust the affairs of the country. Discussing it among ourselves in the gallery the morning after we agreed that the meeting illustrated two things. In the first place that there were things in the world that should be put right, and secondly, that the mode of setting things right was by talk.... It was also the opinion of the SSCL that affairs in our little community were fast going to the dogs, and that the only way to set them right was the parliamentary one of full discussion.⁴⁵

The patients thus decided to establish an emancipatory movement, a forum in which to debate issues that concerned them all – mimicking the actions of a public sphere. Using the opportunity of the attendants' ball when 'the common enemy would early and unanimously retire', the patients had to decide on a topic of debate. After considering issues of food, dress, amusement and detention, the patients agreed to debate 'were the doctors themselves *simple* or *dangerous* lunatics?' This question reversed the common understanding that the patients were insane and the doctors were qualified to diagnose and treat this.

Mr A. believed that the psychiatrists' trappings of knowledge – their professional association and knowledge of Latin - marked them out as dangerous lunatics. 'He heard they were an association by themselves, that they were acquainted with foreign tongues, two marks of danger'. Mr E. also asserted that doctors were dangerous lunatics. 'He knew them to be dangerous because they had stopped his grog, a mean thing to do'. Mr F.

⁴⁵ 'A Surprising Movement', *Morningside Mirror*, LIII (April, 1898), pp. 25–27. Quote p. 25.

also cited the doctor's desire to spoil the fun of patients as a reason to describe them as dangerous.

He had found a knife in the pocket of one of the attendant's trousers hanging in his bedroom. He had used it for his own amusement. He had ripped up a sofa and two chairs, when one of those fellows came in. Would you believe it?... He had deprived him of the toy he had found and stopped his liberty. Could there be stronger proof of dangerous lunacy than that?

Mr G. claimed that the doctors were not dangerous but simple lunatics. 'He himself had only that morning called Dr C a d-d to his face. The doctor simply laughed and passed on. Now it appeared to him that that conduct was more compatible with a simple type of lunacy than a dangerous one. If the doctor had called him a d-d fool he would have knocked him down'.⁴⁶

The meeting was drawn to a close when one patient, Mr J., deployed conventional wisdom, ending the reversal of given knowledge about mental illness. He suggested that 'before they discussed the question of whether the doctors were simple or dangerous lunatics, they must first settle whether they were lunatics at all... For himself, he did not think they were lunatics, but very sensible and well-informed persons indeed'. 'It was evident to all of us', wrote the narrator, 'that his mind was unhinged'. Mr J. was labelled a fool as his observations were 'in the teeth of the facts'.⁴⁷

⁴⁶ *Ibid.*, p. 26.

⁴⁷ *Ibid.*, p. 27.

A year later, further doings of the SSCL were reported in the *Mirror*. Stifled by the presence of the treacherous Mr J., who had had the temerity to suggest that the doctors were not in fact insane, the society was revived once he had been discharged.

How we laughed when we heard of it! Anyone who had read the account of our last year's proceedings could see that he was the only insane person present. That he should be discharged while we other perfectly sane persons were kept, afforded strong support for both sides in our celebrated debate, 'are the doctors themselves simple or dangerous lunatics?'⁴⁸

Within this piece, the author continued to reverse the conventional wisdom that the patients were insane and those who cared for them sane. Referring to the attendants, or the 'common enemy', the author wrote 'absurd though it seems, these fellows think we need supervision and protection at their hands. As a matter of fact, it is we so-called lunatics that supervise and protect them.' The patients used their meeting, again held on the night of the attendants' ball, to debate the question, 'what is insanity?' The first speaker decided it was 'merely a matter of opinion. A doctor thought his patient was insane, the patient thought the doctor was insane. Who was to decide?' To which Mr B. remarked that 'although it was difficult to say who should decide, there was no doubt about who did decide'. Here, the writer seems to have reflected popular concerns that powers to certify people should not be placed in the hands of doctors. Mr C. questioned the existence of insanity itself, claiming the whole thing was 'humbug'.⁴⁹ However, to

⁴⁸ 'The Surprising Movement', *Morningside Mirror*, LIV (January, 1899), pp. 1-3. Quoted on p. 1.

⁴⁹ *Ibid.*, pp. 1, 2.

deny the existence of insanity was to deny that doctors were lunatics, as Mr D. pointed out. It was Mr E. who resolved the issue.

There was lunacy, dangerous lunacy, but it was all outside. Any person that has access to a newspaper knew and could see for himself that the world was not only wrong but mad. For himself, he felt glad and proud to be where he was. To be considered *different from the rest of the world* when all admitted that the world was mad was surely to prove conclusively the sanity of all the members of our little society. It might not be the opinion of the doctors, but the doctors belonged to the world, and *ergo* were themselves mad.⁵⁰

The ideas expressed here that the asylum harboured a society of individuals superior than those in the world were reflected elsewhere in the *Mirror*, in its reports of the literary club and curling matches.

The final report of the SSCL appeared in the 1900 volume of the *Mirror*. 'I take up my pen on this occasion a proud man', wrote the author. 'Hitherto we have had only to record fond hopes, eager anticipations. Now we record events. We have passed the rubicon, tasted reality'. According to the account, 'one of the certified who had enjoyed the privilege and enlightenment of our company for six months, and who it was now rumoured was about to leave us', suggested that the SSCL was too theoretical. 'There was a want of practicality in our efforts. A movement that confined itself to mere theorising was bound to die. A living movement always eventuated into action.'⁵¹

⁵⁰ *Ibid.*, pp. 2–3.

⁵¹ 'The Surprising Movement', *Morningside Mirror*, LV (February, 1900), pp. 9-13. Quoted on p. 9.

While an inmate here, he had noticed that all the sanity was on the side of the certified, and all the insanity on the side of the uncertified. If therefore, we could transpose the duties and responsibilities of the two sections even for the shortest period of time, we should demonstrate the superior administrative capacity of the certified over the uncertified. Who knows what might be the result? The government might make asylums self-governing, applying the democratic idea, and allow the majority to rule. We would let the doctors and staff, the whole uncertified, enjoy their pleasure and salaries at full measure, and with the utmost zest. Indeed, the knowledge that responsibility had ceased to rest on their shoulders would remove a load of care from the official mind, and make them happier and better...

In short, an entire reversal of the asylum system was proposed. Bitterness at their experience as asylum inmates could be deduced as patients, when considering which person should be the subject of their experiment, gave names 'indicative of dislike rather than affection'. The narrator's suggestion that Dr C- (undoubtedly Dr. Clouston, the Superintendent of the REA from 1873 to 1911), 'our worthy chief', should be the first subject of the experiment, was agreed upon.⁵²

The patients again waited until the night of the attendants' ball before phoning the hall keeper and asking that the doctor be sent up to the ward. Once the doctor entered the ward, he was pounced upon, restrained, and his keys removed. 'At last when calmness – I mean stillness was restored, I advanced with a professional air, "What is all this about. Is

⁵² *Ibid.*, p. 10.

this the new patient?” Chorus “Yes sir, it’s the new patient, and a precious rough one he is, he nearly beat us.” Despite the fact that it had been the patients who had attacked Clouston, when in the role of ‘attendants’, the patients attributed the violence to Clouston, who had simply tried to defend himself. This might have reflected patient complaints of brutal attendants. Clouston was then put through a mock admissions procedure.

When he entered the sitting room I asked what his name was. One of our members informed me that his name was John Jones; that he had just been sent in as a dangerous lunatic; that he had spent the greater part of his life in asylums; and that one of his funniest delusions was that he was Dr C-, the head of one of the largest asylums in the country.

When this last delusion of poor Jones was mentioned great was the amusement of our company. Indeed so contagious is laughter, that poor Jones chimed in and laughed with the best of us.

When the patient recovered, he said, resuming a grave tone ‘you know very well who I am, and that I am Dr C-, and that you will smart for this stupid and cruel joke tomorrow.’⁵³

It is interesting that from this point in the narrative, Clouston was referred to as Jones, both when he was spoken to in the story, but also when described retrospectively by the storyteller – ‘poor Jones chimed in with the rest of us’.

⁵³ *Ibid.*, pp. 11, 12.

The admissions and treatment procedure that Clouston was put through in the story displayed some knowledge of medical discourse and practice amongst the patients. The patients in the mock admission and treatment subverted this knowledge by applying the treatment to a 'sane' subject in order to make them admit delusions, and mixing it with violence. 'We have established in this institution a new method of enlightened care. You are, happy individual, the first recipient of it. One of the means of the cure is the inculcation of truthfulness. Your name, you have heard, is John Jones. I desire you to assert it.' In order to coerce Clouston into admitting that he was, indeed, John Jones, the patients twisted his cravat, strangling him. They also pricked his rear with a pin and filled his mouth with soap and water, until he renounced his 'delusion' that he was head of an asylum. Medicalising the procedure, one patient took his pulse and temperature, pronouncing them to be too high. The narrator wanted to shave Clouston's head in order to 'draw the inflammation from the brain', but under protest from Clouston and the other patients, only a cold shower was given. 'Then informing him that the first stages of the cure were passed through, and that what he required was a good night's rest, we pushed him into the strong room and locked him up.' This last action represented patients' dislike of the use of padded cells.⁵⁴

Having kidnapped the medical superintendent, physically threatened him and locked him up overnight, the members of the SSCL 'had seen enough of the realisation of their ideal', and no more was heard from them.⁵⁵ The historian is left wondering whether

⁵⁴ *Ibid.*, pp. 12, 13.

⁵⁵ *Ibid.*, p. 13.

indeed a ward of patients kidnapped their medical superintendent. If so, Clouston cannot have viewed the incident in a particularly serious light if he allowed the *Mirror* to print the details. The articles fall into a tradition of writing within the *Mirror* that posited the members of the asylum as a select society of gifted individuals, unsuitable for the rigours of the world. It appears that humour and satire provided an acceptable means through which patients could attack their treatment and challenge the figurative power of psychiatry: psychiatrists were, after all, often the butt of popular jokes in the nineteenth and twentieth centuries. The humour of the piece was self-referential, self-mocking, as the attributes of insanity formed the basis of the jokes, and the burden of the joke often fell upon the figure of the patient. However, the humour was derived from the reversal of distinctions between sanity and insanity, which raised serious questions about the rights of doctors to detain people. By making Clouston undergo the rituals facing the newly admitted patient, even if only fictionally, the *Mirror* was again acting as a forum in which social distinctions → and distinction between the sane and insane – could be levelled. The mock ‘admissions’ procedure that Clouston was described as undergoing, while farcical, probably represented grievances the patients had about the way in which they were treated. However, the power of this attack was tempered by the fact that the article had only been published because Clouston and the assistant psychiatrists had allowed it to be. Moreover, the impact of these critiques, due to the restricted readership of the *Mirror*, did not extend beyond the asylum walls.

An examination of the *Mirror* thus illustrates how it acted as a space in which a subordinated social group (the mentally ill) were able to forge an identity that ran counter

to that promoted by psychiatry. In some ways the title of the paper proved surprisingly apt. Patients frequently held up the *Mirror* as a mirror on sanity and insanity, reflecting commonly held beliefs about madness, only in reverse. Peter Barham argues that the psychiatric profession in the nineteenth century dehumanised the insane by promoting the image of chronic and degenerative mentally ill individuals, fit only for custody in the sealed off world of the asylum. By the end of the nineteenth century, Barham argues, 'the relationship between mental patient and society has been all but severed and the mental patient isolated from ordinary understanding: in place of painstaking efforts at dialogue we find elaborate structures of excommunication'.⁵⁶ Even the mental health service users of today, Barham suggests, are identified as mental patients rather than people who are not integrated into society. People certified as insane felt their usual identity as citizens threatened by the identity of madmen placed upon them by society. Within the *Mirror*, patients sought to re-establish identities more acceptable to themselves. Writing became a way in which patients could define themselves. It is, perhaps, not surprising that patients at the REA used the *Mirror* as a place in which to express their literary abilities and forge a different identity for themselves.

⁵⁶ Barham, *Closing the Asylum*, p. 77.

3: Patient Narratives not Intended for a Public Audience

3.1: Letters Written by Patients at the REA

In this section, a few of the letters written by patients at the REA in the 1880s and 1890s that have been retained in the casebooks will be examined. These letters were retained under the 1866 Scottish Lunacy Act, which allowed medical staff to open and withhold letters deemed to be unsuitable. Allan Beveridge and Michael Barfoot have previously examined these letters in a series of articles.⁵⁷ Beveridge has noted several advantages this type of source offers to the historian. Unlike retrospective accounts written by patients after their recovery or release from hospital, letters written from within the asylum are more direct and immediate, conveying more vividly patient's experience of the institutional regime.⁵⁸ One other difference can be noted which is not mentioned by Beveridge. While the *Mirror* was written for the internalised sphere of the asylum patients, and published accounts written retrospectively by former patients were aimed at the general public, the letters examined here are those neither intended for their fellow inmates or for the eyes of the general public; they were in fact more private letters. Clearly, the intended audience of a text shapes how an account is written. In this section a

⁵⁷ See M. Barfoot and A. Beveridge, 'Madness at the Crossroads: John Home's Letters from the Royal Edinburgh Asylum, 1886-87', *Psychological Medicine*, 20 (1990), pp. 263-84; Barfoot and Beveridge, "'Our Most Notable Inmate'"; A. Beveridge, 'Voices of the Mad: Patients' Letters from the Royal Edinburgh Asylum, 1873-1908', *Psychological Medicine*, 27 (1997), pp. 899-908; A. Beveridge, 'Life in the Asylum: Patients' Letters from Morningside, 1873-1908', *History of Psychiatry*, 9 (1998), pp. 431-69.

⁵⁸ Beveridge, 'Life in the Asylum', p. 431.

letter written by a MACA case to the charity will also be examined. The charity again represents a different audience to that of the medical superintendent, thus affecting what the patient chose to write.

Many of these letters suggest that patients felt life within the asylum thrust their activities into a very public sphere thus depriving them of their right to privacy. These grievances can be seen in the avalanche of letters sent to Clouston by Jemima M. / B., a widow who ran a boarding house and who had been admitted to Morningside in 1894 as a pauper patient because of her delusions that her husband was still alive and that she was being poisoned. In her letters, in which she referred to herself in the third person, she complained of being confined in the asylum, thus depriving her of her business and home comforts.

Dr Clouston has no right whatever to keep Mrs John B. shut up in this building she has her own home to get to and there is no reason why she should not be in her own home; she had lodgers before she even saw the inside of the REA (well for her if she had never seen it) and if she were out of this place would get them again.⁵⁹

Unhappy about her confinement within the asylum, Jemima also protested about the loss of her own clothes and possessions. On February 18th 1895 she wrote to Clouston complaining:

Again and again I have asked for my own clothes but you have not even had the grace to acknowledge my request...I require the clothing to which I have been

⁵⁹ Female Casebook Volume 60, 1893 LHB7/51/60.

accustomed... Now would you wife agree to be stripped of her jewellery etc all for nothing yet that is what has been done to me. Also my private papers taken from me.

Jemima also protested that she was not treated respectfully, resenting the status of pauper lunatic and desiring to be in control of her own life again. 'Will Dr Clouston please remember that Mrs John M. is neither a town's servant nor yet a servant of the R. E. Asylum has no wish to be either; will not be bound hand and foot', complained Jemima in one letter, as she attacked the work pauper patients were meant to do around the asylum. As an independent woman who ran her own business outside of the asylum, Jemima appears to have found the status of pauper patient – and the uniform and domestic chores this entailed – galling. In another letter, Jemima seems to have struggled with the lack of dignity and respect accorded to certified patients, as she warned Clouston 'you must remember that I am not a child to have tricks of this kind played upon not either for scientific or other purposes'. Jemima clearly did not perceive herself to be insane or sick and in need of asylum treatment. After the secretary of the St. Cuthbert's Association for Help turned down her pleas for assistance, Jemima replied angrily 'Mrs John B. has no wish to be in the care of those in charge of this place longer than she can herself..Once she is out of this place she can take care of herself'. Jemima was discharged recovered in April 1895, although she continued to write to Dr Clouston after her discharge, complaining of her treatment within the asylum. In his research, Beveridge has noted that of a total of 879 letters written by patients from Morningside between 1873 and 1908 that survive, 227 – the largest category – were written to Clouston. Beveridge

provides some suggestions for the motivations that underlay letters such as those written by Jemima:

Prompted by the unequal nature of the doctor-patient interview, some inmates sought to redress the balance by writing long letters in which they tried to explain themselves. The letter afforded the inmate a more attractive arena in which to joust with Clouston: he was not constrained by time and was not prey to a volley of medical enquiries and demands; the patient was thus able to set the agenda. In addition, he was able to adopt a register which related to Clouston on equal terms or even as his superior.⁶⁰

Moreover, Scottish superintendents, unlike their English counterparts, had the power to discharge patients they considered to be sane without any bureaucratic constraints. This provided further motivation to write to Clouston for any patient wishing to be discharged.

Beveridge's examination of the patient letters revealed that many patients depicted their fellow inmates in an unfavourable light. Louis G, quoted at length by Beveridge, thought of his fellow inmates as 'poor unfortunates, vile and filthy only a shade removed from the beasts of the field'.⁶¹ In a letter to his mother, he described

Old Codgers in every state of decay share the table with me and have long beards – a circumstance that doesn't contribute to neatness you see the beasts with their beards reeking of soup and broth and we have no napkins at breakfast or supper

⁶⁰ Beveridge, 'Life in the Asylum', p. 449.

⁶¹ Letter by Louis G. to his uncle, 2 March (no year), REA Case Book LHB7/51/50, p. 63 Cited in *ibid.*, p. 451.

the poor devils take their hands and wipe off the bits of vegetables and meat and use the tablecloth, for further final cleansing of their hands.⁶²

For Louis, the other patients were not people to be emphasised with but 'poor unfortunates', which he could distance himself from and even use as a target of humour. Meanwhile, George R expressed his shock that he was not being differentiated from the other inmates, whom he portrayed as dangerous, writing 'you would be sorry if you could see me, sitting all day on the end of the seat, among a lot of men you would almost be frightened to meet in the street...I am getting no special treatment at all'.⁶³ As Beveridge suggests,

It was important for some patients to distance themselves from the other residents, for, to see themselves as a member of this human zoo, was too damaging to their already shaken sense of identity. Patients tried in different ways to separate themselves mentally from their Asylum counterparts: they might identify with Asylum staff or with the more proposing of their fellows; or they might abuse their co-residents as 'lunatics' or 'madmen'.⁶⁴

We can also perhaps explain the different representations of their fellow patients put forward in letters and the *Mirror* by considering the audience the text was written for. Many patients who wrote letters to their relatives and doctors were attempting to prove their sanity and thus sought to differentiate themselves from the human mass of madness surrounding them, perhaps by perpetuating negative images and stereotypes of mental

⁶² Letter by Louis G. to his mother, REA Case Book LHB7/51/50, p. 63. Cited in *ibid.*, p. 451.

⁶³ Letter by George R. to Nellie, 15 January 1904, REA Case Book LHB7/51/84, p. 119. Cited in *ibid.*, p. 438.

⁶⁴ *Ibid.*, p. 451.

illness. The *Mirror* was specifically produced for the internalised sphere of the asylum, and many of its contributors were happy to belong to the community of madness, most notably in the tales of the SSCL, which perhaps provided them with an acceptable sense of identity.

3.2: John R.'s Letter, 1915⁶⁵

In 1915 asylum patient John R. wrote to the MACA asking for assistance to be discharged, having been helped previously by the organisation. In his narrative, John related how his life has been plagued by the ability of other people to read and voice his thoughts and fears: strangers across the country were privy to information regarding John and spread malicious rumours regarding his morality. These comments and 'remarks about me everywhere, grew in intensity, until at last, people in the street were shouting out something about the blind maker, which sounded like "acts and sciences in the brains of a blind maker"'.⁶⁶ John found this phenomenon to be frightening, commenting 'just imagine for yourselves the horror of it, hearing different things said, which, if not actually the very thing passing through one's mind at the moment, was something like a natural corollary of whatever I was thinking of at the moment'.⁶⁷ Because he described

⁶⁵ Letter from patient, Cane Hill Asylum, 1915. Contemporary Medical Archives Centre, the Wellcome Institute Library, London, SA/MAC/G.3/41. This letter has been discussed in my MA dissertation: V. Long, 'The Mental After Care Association: Public Representations of Mental Illness, 1879-1925' (University of Warwick, 2000), pp. 37-43.

⁶⁶ *Ibid.*, p. 65.

⁶⁷ *Ibid.*, p. 92.

the voices he heard to officials in institutions, John was repeatedly certified. It was his capacity to hear these voices that constituted John's madness for the asylum officials. From his initial committal to an asylum between 1906 and 1907 to the writing of his letter in 1915, John R. visited a police station four times believing himself to be wanted by the police. He was committed to an asylum four times and was admitted to an infirmary twice. John was an inmate at a workhouse on two occasions, was received into a Salvation Army home and was helped twice by the MACA. In between these periods of institutional care, he wandered round the countryside at regular intervals, undertaking occasional work. John apparently received very little assistance from his family (his wife left him in 1906 and his mother and sisters, who figured in the comments he heard, broke contact with him). He was, however, repeatedly helped by one of his employers, Mr. Morton, who offered him work at least six times, despite John's tendency to quit his job and wander round the countryside. It was Mr. Morton who visited John in Horton Asylum, demonstrating a perceptive awareness of his employee's problems, saying 'that I had attached too much importance to what people said, and allowed it to worry me too much'.⁶⁸ What John's narrative recreates is a wide, multi-faceted care network, within which the MACA interacted with other groups and organisations to provide support for individuals who may have had ongoing mental problems and recurrently be admitted to asylums. Despite the MACA's move towards care for convalescent individuals and early cases in the last decade of study, John R.'s experience still does not conform to the image repeated in the charity's literature of the former asylum patient successfully restarted in life with few further problems.

⁶⁸ *Ibid.*, p. 86.

Useful because it provides details of John's movement between different institutions, the narrative also gives an interesting account of how John viewed his mental problems and how he tried to represent himself to the MACA in order to extract help. It is quite striking that John used the same discourses as the MACA. At the start of his narrative, John assured the charity that he was now 'perfectly sane and well', 'bright and useful' and that if discharged from the asylum, he would be 'quite able to fight my own battles'.⁶⁹ These phrases help construct the image of the now sane, self-supporting individual that the charity sought to create in its case studies, as discussed in Chapter Four. Adverts placed by the charity seeking employment for its cases assured potential employers that the individuals were now 'quite strong and well'. The military language used by John was also present in MACA literature: in the 1891-92 report of the council, the charity described how it had refused help to individuals who 'would never be fit for the struggle of life again'.⁷⁰ Early in his narrative, John claimed to have supported his brother for a few months, who had been abandoned by his wife due to his alcoholic habits, before becoming responsible for a while for his mother and convalescent sister. This identified John to the charity as a dependable family man who took care of his relatives when he could, making his abandonment by his family seem doubly unjust.

⁶⁹ *Ibid.*, pp. 1, 9, 3.

⁷⁰ *The After Care Association for Poor Female Convalescents on Leaving Asylums for the Insane, Report of the Council 1891-92*, pp. 4, 5.

John also sought to represent himself as a moral man, an image he constantly undermined. He depicted himself as an honourable husband who attempted to support his wife even after she had left him, repeatedly denying early involvement with prostitutes and claimed that for a long time he was ‘practically a teetotaler’.⁷¹ Yet, his narrative related episodes of drunkenness, abandonment of work and soliciting of prostitutes, while his delusions and concerns revolved around his sisters, prostitutes and masturbation, presumably topics that the MACA would wish to avoid. John did attempt to justify his behaviour, usually by blaming the comments made by other people for his actions: these comments ‘were largely responsible for the behaviour that followed’, explained John on one occasion of drunkenness and solicitation, or, another time, ‘as a result, I drank to excess’, while a further episode of soliciting a prostitute was described as ‘absolutely brought about through this “baiting”’.⁷²

Clearly, while John was aware that other people viewed this ‘baiting’ as a problem, he did not perceive it as the root of his mental illness, simply as something that happened which led him to unfortunate action. John constructed his own ‘acceptable’ breakdown in the narrative from which he recovered. This breakdown occurred after twenty-three weeks of unemployment and rough living: ‘I broke down utterly, mentally...I have a vague recollection of wandering about on the Great Northern Railway...giving my name as Lord Bradley...I had invented a flying machine, and was

⁷¹ Letter from patient, 1915, pp. 27, 33.

⁷² *Ibid.*, pp. 41, 46, 51.

going to be knighted by the King, and all sorts of rot passed through my brain.’⁷³ John recognised these temporary delusions as ‘madness’. In his narrative, his restoration to sanity was rapid. Upon being told that he was in a lunatic asylum, ‘the whole fabric of majesty collapsed. I emerged from the bathroom virtually a sane man’.⁷⁴ However, John did not view the comments made by strangers about him as a delusion, a product of his madness, and was clearly puzzled when a doctor suggested this to him. ‘When I spoke to Dr Lord at Horton over two and a half years ago, he told me, that such a thing as “persons being able to tell what I was thinking of” was impossible. Naturally, I am **forced** to accept his decision, as I want my discharge, but that will not prevent me from so conducting myself, that I shall not give unnecessary offence.’⁷⁵ In the debate over his sanity, John and Dr Lord disagreed over the nature and meaning of this mind reading: for John, it was an unfortunate fact that he must learn to live with, for Lord it was delusional and evidence of John’s insanity. Despite his attempts to fashion a respectable identity for himself as a sane man, and persuade the MACA that he was the model case, John’s narrative contains several elements that ran sharply against the ethos of the charity: alcoholism, persistent mental problems and extra-marital sexual involvement. Although helped in the past, it seems unlikely that his request for the charity to secure his discharge from the asylum would have met with much success as the MACA in this period reserved their aid for cases either discharged by the asylum, or at least on trial.

⁷³ *Ibid.*, p. 30.

⁷⁴ *Ibid.*, p. 31.

⁷⁵ *Ibid.*, p. 111. Emphasis in original text.

4: Public Narratives: Using Narratives to Rework Identity

To examine the accounts of their experiences that former patients wrote after leaving the asylum, we need to understand why they wrote, how the structure of the narrative might shape what could be said, and how it was said. Mike Bury's recent discussion of how illness narratives can be analysed provides some useful thoughts to the historian.⁷⁶ Bury sees illness narratives as forums in which the private spheres of experience are connected to public forms of knowledge, reintegrating authors into their cultural world.⁷⁷ 'Personal narratives', he writes, 'are means by which the links between body, self and society are articulated'.⁷⁸ Narratives help people to restore meaning to life when this is under threat through the disruptions posed by illness, enabling individuals to reshape their narrative in an attempt to maintain a sense of identity or moral character. Illness narratives also provide some balance or counterweight to the authoritative 'grand narrative' of the medical profession. We can perhaps then read the stories written by former asylum patients as an attempt to communicate the disruptive and isolating experience of mental illness to the wider community, trying to reintegrate themselves and their experience back into the cultural setting. These narratives have thus primarily been examined to see how they connect private experience to representations of mental illness within the public sphere. When considering how these stories of mental illness differ from those written by asylum inmates, the motivations that underlay their creation should be considered.

⁷⁶ M. Bury, 'Illness Narratives: Fact or Fiction?', *Sociology of Health and Illness*, 23 (2001), pp. 263–85.

⁷⁷ *Ibid.*, p. 268.

⁷⁸ *Ibid.*, p. 281.

Accounts in the *Mirror* were written for an audience of fellow patients but published autobiographical accounts were written for the general public, perhaps prompting the writer, now presumed to have recovered, to distance themselves from the ‘otherness’ of mental illness, attempting to reintegrate themselves back into the community.⁷⁹

4.1: Narratives Written to Attack the Asylum System

I have focused in this section on an analysis of three British non-fictional autobiographies. One of these accounts was written to defend the author’s sanity and to attack the asylum system. The other two accounts more openly discuss the experience of mental illness and situate it within the context of the authors’ lives. This rather narrow analysis should be considered against the broader historiography of patient narratives.⁸⁰ The 1910 autobiography of Marcia Hamilcar, *Legally Dead*, illustrates how some former

⁷⁹ I have chosen to exclude an analysis of fictional accounts, which provided a means particularly for female authors to make their experiences of mental illness meaningful, because these works have received significant attention from academics. In *The Madwoman in the Attic* authors Sandra Gilbert and Susan Gubar explored the emergence of the oeuvre of female writing in the nineteenth century. While few nineteenth-century women writers openly challenged patriarchal structures, Gilbert and Gubar argued that in addition to their heroines, many created mad and rebellious characters onto whom they could project their anger. See S. M. Gilbert and S. Gubar, *The Madwoman in the Attic: The Woman Writer and the Nineteenth-Century Literary Imagination* (London, 1984). Elaine Showalter also considers the genre of fiction in E. Showalter, *The Female Malady: Women, Madness and English Culture 1830–1980* (1987, London, 2001).

⁸⁰ For a more detailed analysis of a broader range of patient autobiographies encompassing accounts from different countries written in different eras, see Porter, *A Social History of Madness*.

patients sought to refashion events in an attempt to provide meaning to their experiences and reclaim their identity as a sane citizen.⁸¹ Hamilcar claimed that her story was ‘a true, plain, unvarnished tale’,⁸² but it is clear that she hoped to redress grievances in her book. Not only did she aim to tell her readers about her actual experiences, but she also hoped to illustrate ‘how the law facilitates the immuring of an obnoxious member of a family, or anyone, in an asylum, whilst it places almost insuperable obstacles in the way of his or her discharge’.⁸³ Hamilcar used her first two chapters in an attempt to raise public consciousness about the plight faced by the insane. She wrote indignantly on behalf of the insane, arguing they should be treated more humanely, yet she was careful to distance herself from them.

I shall always maintain that I was never insane. I was overworked and overwrought, and I grant that I had lost the proportion of things, which led me to take an exaggerated view of recent occurrences, and that for a time, which did not exceed one month, I suffered from simple mental depression, but this ought not to have sent me to an asylum.⁸⁴

⁸¹ Hamilcar’s novel belongs to a tradition of autobiographies stretching back to the eighteenth century which were written to attack the wrongful confinement of the author and demand better legislation and facilities for the insane. An earlier example of this genre can be seen in L. Lowe, *The Bastilles of England* (London, 1883).

⁸² M. Hamilcar, *Legally Dead: Experiences During Seventeen Weeks’ Detention in a Private Asylum with an Introduction by Dr. Forbes Winslow* (London, 1910), p. 17

⁸³ *Ibid.*, p. 17.

⁸⁴ *Ibid.*, pp. 67–68.

Hamilcar sought to create some meaning from her experiences by attempting, in her book, to stimulate a public debate about the care and treatment of the mentally ill, and to open newspaper columns to the subject. She was careful, however, to reconstitute her identity in the story as a sane woman.

Hamilcar related how she had undertaken extra work in order to counter her financial problems, which had resulted in a breakdown. She described feeling despondent prior to Christmas, concerned that she might not be able to afford to keep her home. 'I began to take a most disparaging view of myself and my possessions,' wrote Hamilcar. 'I had, as it were, lost the proportion of things; my mind was out of joint, and I was physically too exhausted to right it myself.'⁸⁵ Her sisters chose to place her in a nursing home in which Hamilcar claimed she was made into a lunatic by the ill treatment she received. After five weeks spent in the nursing home, Hamilcar was certified as insane and sent to a lunatic asylum, bitter that her version of what had occurred in the nursing home was disbelieved. 'So unfortunately true is it', wrote Hamilcar, 'that a patient suffering from the very mildest form of mental disease is at once condemned as incapable of making a true statement, or of speaking the truth'.⁸⁶ Although Hamilcar claimed to feel pity towards the patients in the asylum, she also sought to distance herself from those she felt to be truly mad. 'The other patients, some of whom were dreadfully disfigured and

⁸⁵ *Ibid.*, p. 89.

⁸⁶ *Ibid.*, p. 69.

most repulsive in appearance at first sight, took not the slightest notice of me; but I looked upon these poor creatures with horror'.⁸⁷

Hamilcar's account ended with a chapter that cited Clifford Beers' arguments for reform in America,⁸⁸ arguing that similar reforms should be adopted in England to protect the legal status of the mentally ill and allow them to complain about abuses they had suffered. Yet she never described herself as mad, carefully distinguishing her problems, and those of a few other patients, from the pitiable yet repulsive patients she described. Other former patients whose lives had been disrupted by their committal to a psychiatric institution, such as the anonymous author of an article published in the *Forum and Century* in 1938,⁸⁹ also reworked the story of what happened to them in a way that was acceptable to their self-image, helping the writers as they sought to reintegrate themselves back into the community.

4.2: Using Narratives to Describe Experiences of Mental Illness as a Product of Life

People who had described their experiences of what they viewed as wrongful confinement appear to have focused specifically on this period in their lives. Other former patients, who admitted that they were affected by mental difficulties, used their narratives as a place in which to situate their experiences of mental illness within the

⁸⁷ *Ibid.*, pp. 161–2.

⁸⁸ C. Beers, *A Mind that Found Itself: An Autobiography* (London, 1908).

⁸⁹ Anonymous, 'They Said I Was Mad', *Forum and Century*, 100 (1938), pp. 231–7.

broader framework of their lives. This might have enabled former patients to counter a psychiatric tradition that was largely uninterested in a patient's life outside of treatment.

The Autobiography of David, published in 1946 by Victor Gollancz, intertwined details of the author's mental troubles with an account of his life and work. The book was praised by the MHIWU for detailing the problems that nurses experienced in their work. David traced the emergence of his mental troubles to his initial experience of agoraphobia when aged thirteen. David's first hospitalisation occurred while he was living in Canada and doing temporary work.⁹⁰ David entered Toronto hospital, being transferred from the general ward to a ward for nervous diseases, where he received electric treatments and tepid baths. Failing to improve after these treatments, David was moved to a mental hospital, where he steadily became worse, depicting the hospital as a place in which both staff and patients could be violent.

There were bars on all the windows and no segregation of patients of any kind...patients raced each other up and down wards, jumping over beds...shocking scenes were a fairly frequent happening. The patients were often noisy and quarrelsome and sometimes fought with attendants. I saw a young boy of seventeen thrashed with an attendant's belt...about a week later at tea one man stabbed another in the neck.⁹¹

⁹⁰ Anonymous, *The Autobiography of David*, edited by Ernest Raymond (London, 1946), p. 55.

⁹¹ *Ibid.*, p. 56.

Following his discharge from the hospital, David was deported from Canada and went home, remaining in what he described as a state of 'acute neurasthenia'. Moreover, he found that his neurasthenia and agoraphobia had become complicated by a 'fresh horror', a desire to expose himself. 'For about a year I never went out of doors without the fear that I might expose myself,' David wrote. 'The acuteness of this agony that this cost me was probably greater than any of my other dreads, for it involved downfall in every field, mental, moral and physical.'⁹² In 1908, while undergoing what he referred to as a 'nervous turn', David exposed himself and was arrested for indecent conduct. Instead of being prosecuted in court, he was certified and sent to an asylum. David was therefore admitted for psychiatric treatment not specifically because of the severity of his mental illness, but because he had caused a social problem. David found life in the asylum a threat to his privacy and identity as an individual. Even as he walked up the driveway, he felt 'an overpowering sense of my own helplessness and insignificance'. He found solace talking to an attendant, explaining:

I had an intense desire for 'sane' company...but at night with more than a hundred insane people round one – people with whom one could not get any real contact – the 'insanity' seemed to become a sort of collective cloud hanging over all of us so that any individual variation was lost, and your own self merged into the general lunacy.⁹³

⁹² *Ibid.*, p. 59.

⁹³ *Ibid.*, pp. 61, 62.

In this instance, David had been compulsorily admitted to hospital, and not through choice. This may explain his attempts to distance himself from the rest of the patients, whom he identified not as people affected by mental illness but patients whose whole identity could be encapsulated by illness.

For twelve months I had to live with men in every phase of mental disease and trouble, from the congenital idiot slavering away in his chair – a terrible monstrosity unable to feed himself – to the highly-strung victim of some unhappy love affair, biting his nails in an anguish of melancholy. The general paralytic, the degenerate, the religious maniac, the feeble-minded, and the imbecile were my companions. I do not think of them with horror or antipathy now, though at the time it was not easy to repress repulsion...the frequent scenes of horror inside the institution were always a nightmare to me: patients at times snarling like dogs, warders fighting with maniacs, the contortions of epileptics; the continuous moaning of those afflicted by melancholy as they passed up and down, never at rest, wringing their hands; and the horrible laughter of the exalted as they proclaimed themselves to be emperors and kings.⁹⁴

David displayed revulsion for the surrounding patients, who were labelled either as popular stereotypes or psychiatric classifications. In particular, the description of the idiot ‘monstrosity’ and the patients snarling ‘like dogs’ acted to dehumanise the patients. This stay in hospital lasted for just over a year.

⁹⁴ *Ibid.*, pp. 62–63.

David continued his story by describing his emerging career in journalism, his continuing difficulties with agoraphobia and the desire to expose himself. He attempted to control his agoraphobia by self-suggestion and then sought assistance from a psychoanalyst, who told him that his agoraphobia might be incurable. 'All hope had been taken away from me', David wrote. 'I am not suggesting that the psychoanalytical attitude was necessarily wrong – but its effect on me was devastating.'⁹⁵ After this experience, David became fatalistic, no longer believing that he himself was able to effect a change in his condition. Resigning from his post on the paper due to a disagreement regarding its political stance in the lead up to the Second World War, David gave himself over to peace work and got married. As his peace initiative faltered, David felt his health give way and entered a mental hospital as an uncertified patient.

Reflecting on this experience, David expressed concern about the lack of effective communication. Between patients and attendants, he felt that the background of fear and suspicion prevented any natural relationship from forming. David gave as an example an anecdote told by the chief ward attendant, in which it was clear that the meanings of the story were very different for the teller and the listener:

The chief ward attendant told me today that Drs P. and Q. had had more suicides during the last six years than their predecessors had in twenty-one years. This was just 'bad luck' he said (for the doctors, he meant), and he quoted the case of a man who had climbed up the face of an apparently unclimbable wall – getting his toes in the cement between the bricks – and then threw himself on to the stone

⁹⁵ *Ibid.*, pp. 112, 114.

floor, dashing out his brains. ‘Who could have expected that?’ said W. in a tone that implied that the patient had taken an unfair advantage.⁹⁶

Patients, meanwhile, were at times capable of talking to each other in a friendly way at the table, but would ‘then relapse again into their various obsessions’.⁹⁷ ‘The insane are surely the most lonely people in the world’, David argued. ‘The victims of other diseases can explain or find some contact with their fellow men and women, but from the very nature of their illness, the insane are shut out from all communication to others of what is happening to them.’⁹⁸ Moreover, the problems faced by those affected with mental health problems were exacerbated by public ignorance about the nature of mental illness. As one patient complained to David, ‘I wish I had never come here. It makes me feel like I’ve been branded – branded as something apart; never the same as other people again’.⁹⁹ David claimed that his purpose in writing was to set forward his experiences in the hope that they might be of assistance to others, ‘to the helpless insane especially, who could not speak for themselves’.¹⁰⁰ However, in order perhaps to preserve his own identity, David at times in his narrative depicted his fellow patients as repulsive, dehumanised objects with which it was impossible to communicate, perhaps perpetuating the belief that the insane were silent.

⁹⁶ *Ibid.*, p. 151

⁹⁷ *Ibid.*, p. 149.

⁹⁸ *Ibid.*, p. 152.

⁹⁹ *Ibid.*, p. 156.

¹⁰⁰ *Ibid.*, p. 14.

Despite being entitled *Inside the Asylum*, only twenty-one of 115 pages in John Vincent's account, published in 1948, referred to the time he had spent in an asylum.¹⁰¹ His description of time spent in the asylum came towards the end of a narrative about his life in which the onset of mental disorder was portrayed as slow and insidious, first developing in Vincent's childhood. Vincent suffered from what he described as 'long periods of black depression', tending to recall painful events in the past through stimuli in the present. In his account, his father was depicted as a cruel and unloving, 'a morose and ill-tempered man who was an object of fear to his family and wife,' while his mother was described as weak and incompetent, 'a feeble reed upon which to lean in any difficulty'.¹⁰² Vincent believed his family were instrumental in the development of his mental problems, claiming 'my father talked to me of the cruelty of his own father, and I then realised that my father was merely inflicting upon me what he had had to suffer himself.'¹⁰³ Moreover, the family adopted what he viewed as a Victorian attitude towards sex:

The relationships between the sexes were not a high, holy and splendid thing. They were something furtive, unclean and unspeakable. I now have to write of the hours of mental and physical agony which were mine through the false secrecy of my parents. The pages which follow need not have been written if some kindly and understanding person had explained things to me at an early date.¹⁰⁴

¹⁰¹ J. Vincent, *Inside the Asylum* (London, 1948). See pp. 83–103 for Vincent's account of time spent in the asylum.

¹⁰² *Ibid.*, pp. 26, 31.

¹⁰³ *Ibid.*, p. 30.

¹⁰⁴ *Ibid.*, pp. 57–58.

Vincent took up work as a Methodist preacher and married, but found himself impotent. His personal problems were exacerbated during the Second World War, when his stance as a conscientious objector led to the social ostracisation of himself and his wife. Forced to undertake farm work and subject to abuse from other people, Vincent's depression increased. 'I knew I was seriously ill mentally', wrote Vincent, who by this time attempted to explain his difficulties with his wife to doctors, only to be brushed off by doctors who told him he was off colour or run down.¹⁰⁵ In despair, Vincent contacted a local rector who put him in touch with a psychoanalyst. This suggests that, to some extent, Vincent was an informed consumer of mental health services, although the cost of the treatment forced him to abandon it and his review of its benefits was rather sardonic.

I agreed to do this although, when he mentioned the sum of money involved, I realised that even if I failed to benefit from the treatment, another person would... No doubt if I had continued the treatment for fourteen or fifteen years I should probably have been well on the way towards a cure, and possibly by the end of my life the treatment would have terminated successfully.¹⁰⁶

Vincent was by this stage employed by two doctors to provide secretarial support for their medical practice. These doctors displayed a lack of interest in nervous problems and when told about Vincent's impotence viewed it as an unimportant matter. They did however put Vincent in contact with the head of the local mental hospital, which admitted him.

¹⁰⁵ *Ibid.*, p. 73.

¹⁰⁶ *Ibid.*, p. 76.

In Vincent's account, the routine and silence of the hospital came in for criticism. Forced to go to bed on his arrival, as part of the standard hospital procedure, Vincent became irked by the lack of communication and lack of privacy. Interviewed later by another nurse, Vincent explained how the nurses could talk, yet not communicate with the patients. He also gave a sense of the hierarchical power structures operating in the hospital that formalised interaction between nurses and patients.

I suddenly became aware of a man standing beside my bed. He was wearing the blue suit of the male nurses...I said 'good morning'. He made no remark and continued to stand and stare at me. I rolled over so that my back was towards him. Then he sat on the edge of my bed and asked me questions. His manner did not make me responsive. He seemed to be the symbol of authority, of all the authority I had ever known, of the authority against which I had been a rebel all my life.¹⁰⁷

Upon entering the common room, Vincent found that the patients were more willing to communicate with him: 'one or two of them greeted me cheerfully', he wrote.¹⁰⁸ Perceiving himself as mentally ill, Vincent was able to relate to his 'fellow patients' without distancing himself from them.¹⁰⁹ 'Most of us retained a vestige of humour', wrote Vincent, 'and there were a few stock jokes about asylums, lunatics and kindred subjects which usually raised a laugh'.¹¹⁰ This kind of self-referential humour and mockery was also evident in some of the *Mirror* articles discussed earlier.

¹⁰⁷ *Ibid.*, p. 91.

¹⁰⁸ *Ibid.*, p. 91.

¹⁰⁹ *Ibid.*, p. 93.

¹¹⁰ *Ibid.*, pp. 95–96.

Unlike earlier accounts by writers who recounted the disruption wrought on their lives by involuntary confinement, Vincent found that most of his fellow patients did not complain of being in the asylum. It is important to recognise the impact that voluntary admissions, introduced under the 1930 Mental Treatment Act, had. Vincent chose to enter an asylum and was able to have some control over his treatment. In addition to the administration of drugs, Vincent had an analytical interview with the doctor every two or three days. It is worth bearing in mind that at this time, there were only four psychiatrists for a patient population of thirteen hundred, and that Vincent might well have been a privileged patient and had an unusually good experience of the asylum. Vincent credited these interviews with the cure of his sexual impotence. Rather than emphasising the problems of the asylum, Vincent was keener to stress the problems caused by popular prejudice towards those who had received asylum care.

What of those who do leave the asylum? They will forever bear a stigma. They will be regarded with suspicion by work mates and even by loving relatives. Prospective employers will shake their heads as the gap in the record is explained...it is most urgently necessary that the public should be educated to understand and sympathise with mental disorders.¹¹¹

After leaving the asylum, Vincent sought to resume his work as a minister, but was turned down by the church. His attempts to receive training for another profession were also rejected by employers suspicious of his stay in an asylum. Moreover,

¹¹¹ *Ibid.*, p. 18.

inhabitants of his village heard about his stay in the asylum and Vincent found himself subject to mockery and abuse.

Boys tapped their foreheads as I walked past and shouted derogatory and abusive epithets after me in the street...I started to lie awake and think of the jeering boys and the coarsely grinning women. I stayed indoors because I could not endure these torments...sometimes little children shouted remarks which I knew could only have been repetitions of things which their parents had said.¹¹²

Vincent used his narrative to situate his experiences of mental troubles within the broader story of his life, believing that his problems stemmed from psychological and social causes. He depicted himself as actively seeking out treatment for his troubles and hoped that by writing popular prejudice towards mental illness might be challenged. The preface, written by Vera Brittain, stated the need for the reform of psychiatry, thus giving Vincent's work a broader purpose. Moreover, Vincent used his account to challenge ideas that his life had been inadequate. 'To many people this will be the record of miserable failure', wrote Vincent. 'I know that I have succeeded. I will never become a cog in an industrial machine, nor a number in a conscript army.'¹¹³ The narratives of David and Vincent suggest beliefs that networks of social relations might trigger mental illness had spread from the narrow field of mental health activists and PSWs to some individual sufferers. Family also played a substantial role in Mary Barnes' 1971 account of her

¹¹² *Ibid.*, p. 106

¹¹³ *Ibid.*, pp. 114-5.

journey through madness.¹¹⁴ Viewing her madness as a product of the destructive relationships and communication between family members, Barnes turned to Laing's psychotherapeutic community at Kingsley Hall, where she experienced her madness as a positive, purifying force on her life. 'My madness uncovered more clearly and revealed the faith within me. Going through madness is a purification, it brings me nearer to God, to myself, helps me to a more conscious awareness of God, to a fuller participation in the sight of God.'¹¹⁵ This may have made it more acceptable for Mary to write about her mental problems.

5: Conclusion: Dialogues and Silences

This chapter has explored how patients and mental health service users have sought to represent their experiences of mental distress, suggesting that writers used different media to address different audiences, representing their experiences in a variety of ways to achieve different goals. Sometimes, individuals sought to represent the collective interests of mental health service users. In other circumstances, writers castigated fellow patients in their efforts to advance their own interests and be perceived as a sane member of society once more. The chapter has focused primarily on what patients and mental health service users have written about their experiences. This is not because I wish to undermine the value of oral testimony, but because the main way in which patients have

¹¹⁴ Barnes and Berke, *Two Accounts*.

¹¹⁵ *Ibid.*, p. 351.

sought to communicate their experiences to a wider audience, and thus potentially change public views about mental illness, has been through retrospectively written accounts and autobiographies.¹¹⁶

My examination of the *Morningside Mirror*, an internal paper written largely by certified patients whose intended readers were also mainly certified patients, illustrates the importance of the audience in determining what a person might choose to write. The *Mirror* constituted a limited sub-public sphere for patients in which they could engage in debate with other patients, although its potential as a sphere of debate was limited both by the small number of patients who contributed, and the involvement and control exercised by staff members. Other asylum newspapers existed for the patients, and the limited correspondence between the *Mirror* and the Alabama Asylum's paper the *Meteor* suggests that some interaction between these multiple patient sub-publics may have existed. Within the *Mirror*, a relatively small number of patients took the opportunity to vent their grievances at the asylum regulations and regime, while other patients chose to forge an alternative identity for themselves than that of mental patient, promoting the idea that the community of certified patients within the asylum were in some respects superior to those outside. These aims were most successfully advanced in the numerous satirical

¹¹⁶ Oral testimony has proved valuable to historians examining other questions and issues. Diane Gittins, for example, has combined oral history from former patients, nurses and psychiatrists to reconstruct the life experiences of those who lived in Severalls hospital while Kerry Davies has used patients' oral testimony to expand and challenge our understanding of the history of mental illness in the second half of the twentieth century. D. Gittins, *Madness in its Place: Narratives of Severalls Hospital, 1913–1997* (London, 1998) and Davies, 'Silent and Censured Travellers?'

articles that reflected a mirrored view of madness and sanity, inverting notions of sane and insane behaviour to mock staff members and figuratively challenge the power and arguments of psychiatry. Most notably, the series of articles on the SSCL created a sense of community amongst mental patients, allowing them to forge their own oppositional identity and discourse. Humour was thus a powerful tool, but ultimately control over the *Mirror* lay in the hands of the doctors who could and did, at least on one occasion, reassert their authority over the paper. Meanwhile, the impact of patients' satire within the *Mirror* extended no further than the limited circulation of the paper itself.

The belief that people labelled mentally ill have in the past been silenced has been exploded as a myth by historians such as Roy Porter, who have pointed to the large number of published autobiographies written by such people. However, it is important to consider what limitations might have been placed upon an author who had been labelled as mentally ill. We can get some idea of these limitations by examining Allan Ingram's edited volume of four seventeenth- and eighteenth-century pamphlets written by people deemed to be mentally ill at some stage in their lives. Of the four writers, only one, Hannah Allen, believed that she had been mad, and used her pamphlet to describe the reasons for her mental illness.¹¹⁷ She was also the only writer who was not confined in a madhouse. The other three writers – Alexander Cruden, Samuel Bruckshaw and William Belcher - who denied that they had ever been mad, used their narratives to complain of

¹¹⁷ Hannah Allen, 'A Narrative of God's Gracious Dealings With that Choice Christian Mrs. Hannah Allen', in A. Ingram (ed.) *Voices of Madness: Four Pamphlets, 1683–1796* (Stroud, 1997), pp. 1–22.

the treatment they had received in madhouses.¹¹⁸ Ingram lists several reasons why Allen may have escaped incarceration while her fellow authors did not. Allen had a supportive family network able to take care of her while her fellow writers did not and as a widow, she was less in the view of the public. However, Ingram reminds us not to overlook the development of institutional ways of dealing with madness that emerged in the eighteenth century. Allen, the only one of the four authors to write in the seventeenth century, simply did not live in a period when mental illness was subject to institutional confinement and care. She was thus able to write about her experiences of madness without the fear that by doing so, she would be subject to compulsory detention.

By 1739, when Alexander Cruden wrote, ‘not only did madness come to loom much more largely in the public imagination, but the mechanisms for treating it, including medical specialisation and provision of places of confinement, became much more expected and promoted’.¹¹⁹ Describing one’s madness and making it public became a somewhat risky enterprise if the author did not wish to be confined against his or her will, or continue to be so confined. Moreover, people may have been less inclined to listen: Jonathan Andrews and Andrew Scull, in their recent examination of John Monro’s 1766 casebook, argued that while he sought to engage his patients in conversation in order to discover any events or behaviour that might have precipitated their disturbance,

¹¹⁸ A. Cruden, ‘The London-Citizen Exceedingly Injured’, (1739), S. Bruckshaw, ‘One More Proof of the Iniquitous Abuse of Private Madhouses’, (1774), and W. Belcher, ‘Address to Humanity: Containing, a Letter to Dr. Monro; a Receipt to Make a Lunatic, and Seize his Estate; and a Sketch of a True Smiling Hyena’, (1796), in Ingram, *Voices of Madness*, pp. 23–74, 75–126, 127–36.

¹¹⁹ Ingram, *Voices of Madness*, p. xii.

Monro 'was not disposed to place much credence in the stories he heard from what were, for him, evidently suspect sources'.¹²⁰

Madness, Michel Foucault argued, was once believed to have meaning, a wisdom of fools who possessed forbidden knowledge of the fall of mankind. In his book *Madness and Civilisation*, Foucault examined how this view of the mad as possessors of knowledge disappeared, replaced by a view of madness as sickness. 'As for a common language', he wrote, 'there is no such thing; or rather, there is no such thing any longer':

The constitution of madness as a mental illness, at the end of the eighteenth century, affords the evidence of a broken dialogue, posits the separation as already effected, and thrusts into oblivion all those stammered, imperfect words without fixed syntax in which the exchange between madness and reason was made. The language of psychiatry, which is a monologue of reason about madness, has been established on the basis of such a silence.¹²¹

The practice of confinement, Foucault argued, was inspired by a desire to separate reason from unreason. By the eighteenth and nineteenth centuries, the mad were no longer believed to be the possessors of any truth or knowledge. Communication with the mentally ill ceased, and their physical segregation from the community in asylums was matched by a disregard for their attempts at communication.

¹²⁰ J. Andrews and A. Scull, *Customers and Patrons of the Mad-Trade: The Management of Lunacy in Eighteenth-Century London with the Complete Text of John Monro's 1766 Case Book* (London, 2003). Quoted on pp. 107–8.

¹²¹ M. Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason* (London, 1967), pp. xii–xiii.

Thus, of the two genres of autobiographical writing by the mad which Porter identified, spiritual autobiographies, which sought to make sense of the experience of madness within a religious or mystical framework, seem to have flourished before and after the era of mass confinement of the mad, when the idea that the experience of mental illness might lead to spiritual insight was more commonly held. The second genre Porter referred to, works of aggressive self-justification that were written to attack enemies and vindicate the author,¹²² appear to have predominated amongst the accounts published by British authors between 1870 and the mid-twentieth century. Thus Hamilcar used her narrative to fight against compulsory treatment and neglect of the insane, and was careful to separate herself from her fellow patients, frequently depicted as bestial and silenced. Even Clifford Beers, who acknowledged in his account that he had been insane and campaigned to advance mental health, sought to distance himself from the mentally ill once he had been discharged. As Porter argues, Beers appeared to have distinguished between the 'deserving' and 'undeserving' mad, believing that his own disturbance had been a natural outcome of nursing his brother and that he himself had brought about his own cure through the exercise of will power and self-help.¹²³ The space for writers to document their inner experiences of mental illness to a wider audience was circumscribed. Writing to a wider audience might have provided a means for former patients to re-establish their threatened identities as sane citizens. It did not appear to have provided them with an opportunity to challenge popular views of mental illness or

¹²² Porter, *A Social History of Madness*, pp. 36–37.

¹²³ *Ibid.*, pp. 195 – 196. Quoted on p. 196.

advance an acceptable identity as a person affected by mental illness. The frequent derogatory comments aimed at other patients may have reflected a desire of former patients to split off disturbed aspects of their behaviour that threatened their reintegration into the community by projecting it on to other patients. It is important to distinguish between those people whose writing displayed what we might see as signs of mental disturbance yet who did not themselves address or acknowledge their experience of mental illness, with those people who did actually write about mental illness. We might read John R.'s letter, which referred frequently to the voices that he heard, as a story of his mental disorder. For John, however, the voices were a part of his reality, and apart from his description of a brief breakdown that he suffered, his letter provides a story of his life, not his experiences of mental illness.

It was only after 1930, when the Mental Treatment Act began to break the link between mental illness and compulsory treatment that authors could begin again to describe their experiences of mental illness as a positive rather than shameful experience that had enriched their lives. Mental illness was no longer necessarily viewed as a disruptive experience that threatened the identity of an individual as a citizen. This may have been related also to new theories for the causation of mental illness and its treatment. Theories concerning the hereditary nature of mental illness declined as increasing attention was paid to social and familial causes of mental distress. It may have been easier and less shameful for writers to describe experiences of mental illness that were linked to upbringing and society rather than a defective heredity. Psychoanalysis may also have encouraged writers to discuss their experiences of mental illness. It is

noteworthy that both David and John Vincent, whose accounts incorporate elements of both genres of autobiography, received psychotherapy. The emergence of the anti-psychiatry movement in the 1960s and 1970s may have also made the public more receptive to people's accounts of their experiences of mental illness. R. D. Laing's work reasserted older beliefs that those who experienced mental illness were undergoing some kind of spiritual awakening. By the time he revised *The Divided Self* in 1965, Laing viewed mental illness as a positive and liberating force that psychiatry should not be seeking to repress. 'I would wish to emphasise that our "normal" "adjusted" state is too often the abdication of ecstasy, the betrayal of our true potentialities, that many of us are only too successful in acquiring a false self to adapt to false realities.'¹²⁴ In 1971, when Mary Barnes wrote about her experience of mental illness, it is noteworthy that not only was she, like Hannah Allen, largely treated outside of the asylum – indeed, she lived in the therapeutic community as Kingsley Hall which Laing ran,¹²⁵ but, also like Allen, she was able to view her madness as a positive purifying experience that brought her closer to God and revealed truth.

It remains debatable, however, whether mental health service users in the post 1970s environment are able to easily relate their experiences of mental illness to a public audience. The emergence of mental health service user movements provided a new forum in which those affected by mental illness could discuss their experiences, although the

¹²⁴ R. D. Laing, *The Divided Self: An Existential Study in Sanity and Madness* (1959, London, 1965), p. 12.

¹²⁵ Debaring one earlier hospitalisation that did not form part of her narrative of treatment and recovery. Barnes and Berke, *Two Accounts*, pp. 49–53.

continual stigma and isolation of people with mental health problems might inhibit users' wishes to discuss their experience of mental illness outside of these sub-public spheres. It is also worth considering whether the resurgence of genetic and biological ideas in psychiatry, which displaced theories of social causation advanced in the 1960s and 1970s, have increased the stigma of mental illness. Mental illness is no longer attributed to wider social problems or a failure to communicate, but is situated inside the physiology of the sufferer who continues to be viewed as a mental patient rather than a person affected by mental illness. As Peter Barham suggested in his 1992 work, *Closing the Asylum*, mental health service users are still not viewed as citizens with whom we should engage in dialogue. They continue to be seen as individuals with flawed identities who remain marginalised in society despite their physical relocation from the asylum to the community.¹²⁶ This might make it difficult for mental health service users to share their experiences of mental disorder with a wider audience.

¹²⁶ Barham, *Closing the Asylum*.

Chapter Six: Representations of Mental Illness in the General Media: the BBC

1: Introduction: Is the Media an Expression of or Hindrance to the Public Sphere?

In the previous chapters, this thesis has examined how individual sub-public groups have sought to alter perceptions regarding mental illness and its treatment by utilising the media. This chapter will examine the interactions between sub-public groups and the media from the perspective of a media outlet. Using the BBC as an example, the chapter will explore the factors that shaped and constrained the BBC, leading it to cover certain aspects of mental health and illness, interacting with some sub-public groups but not others. An examination of the BBC's programming and the motivations that drove the BBC to cover issues of mental health and illness from its inception until 1970, seems particularly salient given recent critiques by sociologists and historians about the failure of television to fulfil its democratic potential. Television and the mass media have the capacity to reach and inform huge audiences, yet sociologist Pierre Bourdieu claimed that television 'poses a serious danger for all the various areas of cultural production...I think that television poses no less a threat to political life and to democracy itself'.¹ The constraints of the journalistic field, Bourdieu argued, transformed what was potentially a democratic sphere of debate and information into a place of entertainment. The constant pressure for audience ratings, the pressure to dramatise events and to cover the extraordinary, the limitations of time and the internal circulation of information within the journalistic field all operated to stifle debate and information. Consequently, the coverage

¹ P. Bourdieu, *On Television and Journalism* (London, 1998), p. 10.

of serious political events by television stations and newspapers was affected by these same pressures of the journalistic field. 'To justify this policy of demagogic simplification (which is absolutely contrary to the democratic goal of informing or educating people by interesting them)', Bourdieu argued, 'journalists point to the public's expectations. But in fact they are projecting onto the public their own inclinations and their own views.'² The search for entertainment even within the political sphere, tended to focus news stories towards scandals. One consequence of this style of news reporting was to depoliticise events, dividing the public from politics. 'The journalistic field', Bourdieu argued, 'represents the world in terms of a philosophy that sees history as an absurd series of disasters which can be neither understood nor influenced'.³ Bourdieu's thesis that the mass media, constrained by the forces of the journalistic field, stifles public debate, fail to inform viewers and thus help to separate the public from involvement in the public sphere, was based on an analysis of recent media activity. This chapter will explore whether the BBC succumbed to such pressures when producing programming on mental health and illness, thus potentially increasing fear in the public rather than mobilising opinion for political reform.

The power of television to determine representations of mental distress was not a significant factor until the mid-twentieth century. However, the press has also been subjected to critiques that it has subverted the public sphere. Once 'the public sphere's

² *Ibid.*, p. 3.

³ *Ibid.*, p. 8.

pre-eminent institution',⁴ Habermas argued that the eighteenth- and early nineteenth-century press evolved from being 'mere institutions for the publication of news' to 'carriers and leaders of public opinion',⁵ in which the rational-critical debate of private people functioning as a public outweighed commercial concerns. However, Habermas suggested that in the 1830s the 'establishment of the bourgeois constitutional state and the legalisation of a political public sphere'⁶ enabled the press to relinquish its political stance to pursue commercial gains. As technological and organisational advances in the printing of papers required increasing funding, papers became capitalist undertakings, 'enmeshed in a web of interests extraneous to business that sought to exercise influence upon it'. 'The press (until then an institution of private people insofar as they constituted a public) became...the gate through which privileged private interests invaded the public sphere'.⁷ As a result, the public sphere began to be transformed from a public sphere of rational-critical debate amongst private people into a sphere of advertising in which public debate 'gets shaped by the mass media to begin with'.⁸

Habermas' account of the transformation of the press from an institution that allowed private people to communicate as a public to a commercialised institution has been supported by James Curran's more detailed historical research on the growth of the

⁴ J. Habermas, *The Structural Transformation of the Public Sphere: An Inquiry into a Category of Bourgeois Society* (1962, translated by T. Burger, Cambridge, 1999), p. 181.

⁵ *Ibid.*, p. 182.

⁶ *Ibid.*, p. 184. The 1832 Reform Act in Britain enfranchised many members of the middle class.

⁷ *Ibid.*, p. 185.

⁸ *Ibid.*, p. 188.

British press. Curran's revisionist work has challenged the view that 'the British Press is one of the great instruments of liberty, an independent fourth estate, the vital defender of public interests',⁹ suggesting that there has been no 'close correlation between press and public opinion'.¹⁰ As the printing technologies for newspapers became more advanced in the 1860s and 1870s, production costs rose and increasing amounts of money were needed to establish newspapers at a profitable circulation level, gradually placing newspaper ownership and control out of the hands of the working classes. Papers began to rely on money from advertisers for their revenue, and were in turn able to cut their cover prices. However, left-wing publications were discriminated against by advertisers both because of political prejudice and because it was believed that the working classes were not sufficiently affluent to be good consumers. Left-wing papers were only able to survive if they moved up market to attract advertisers or attracted only a small readership and were supported by donations.

The political implications of the commercialisation of the press were significant, Curran argued. Class conflict was minimised and readers were encouraged to identify with the main political parties of the middle classes and the social system. As newspaper ownership was conglomerated under the press barons in the 1920s and 1930s, the pressure to expand audiences led to an increase in human-interest stories believed to appeal to undifferentiated audiences, at the expense of coverage of public affairs and

⁹ J. Curran and J. Seaton, *Power Without Responsibility: The Press and Broadcasting in Britain* (London, 1997), p. 1.

¹⁰ *Ibid.*, p. 29.

political events. Moreover, the framework within which most papers selected and represented stories, like late twentieth-century television and the press, also served to depoliticise their readers.¹¹ After a temporary resurgence of political coverage during the years of the Second World War, the popular press became increasingly depoliticised as they sought to staunch the loss of circulation by increasing coverage of human-interest stories.

The work of the Glasgow media group on the sociology of media power and the coverage of mental health issues by the media in the 1990s in many respects supports Bourdieu's thesis.¹² Researchers within the Glasgow media group have challenged other sociological works that have stressed the capacity of audiences to resist media messages. Basing their research around focus groups, researchers found that the media constituted a source of information for people, who proved able to reproduce particular aspects and the language of stories. An examination of media content and the reception of media messages also demonstrated that the media created certain associations, for example

¹¹ Curran, for example argued that most national newspapers 'portrayed the 1926 General Strike as a conflict between a minority and the majority. By framing the dispute in this way, they detached strikers from their class base and obscured the true nature of the conflict...A similarly persuasive and traditionalist framework was deployed in explaining the recession. It was widely portrayed as a 'natural catastrophe', comparable to a hurricane or a flood. In this way, the appropriate response was defined as national unity in the face of a common calamity rather than radical new policies.' Curran, *Power Without Responsibility*, pp. 52-3.

¹² See, for example, G. Philo (ed.), *Message Received: Glasgow Media Group Research 1993-1998* (Harlow, 1999) and G. Philo (ed.), *Media and Mental Distress* (Harlow, 1996).

linking mental illness to violence. Moreover, the focus groups revealed that people frequently used the mass media as a reference point to justify or explain their opinions or beliefs. Indeed, on most of the subject areas that the Glasgow media group had examined, researchers had found that ‘personal experience was a much stronger influence on belief than media content’. However, when examining how media coverage of mental illness was received, they found ‘cases in which this pattern was reversed’.¹³

An example of the Glasgow media group’s work illustrates how the constraints of the journalistic field could have a negative impact on the representation of mental illness within the media, which subsequently affected the lives of mental health service users. Lesley Henderson’s examination of television accounts of mental illness suggests that the constraints of what Bourdieu termed the ‘journalistic field’ do impact on how mental distress is depicted.¹⁴ Henderson argued that the constant pressure for audience ratings led many producers to prioritise entertainment over education, packaging stories to entertain and thus retain audiences. This could result in inadequately researched stories that inaccurately depicted mental illness. These constraints affected documentaries too, where a concern to depict the events in an interesting manner might give the impression that people moved rapidly from illness to health, a representation that could have a negative impact upon individuals experiencing distress who do not recover so rapidly. Moreover, the difficulties of creating dramatic television to depict recovery and mental

¹³ *Ibid.*, p. 103.

¹⁴ L. Henderson, ‘Selling Suffering: Mental Illness and Media Values’, in Philo (ed.), *Media and Mental Distress*, pp. 18–36.

health might sway the balance of the documentary towards the representation of illness and crises. The impression that service users were able to regain control over their lives might be further undermined by the pressure placed on producers by those higher up in the network to tell the patients' stories through voice over rather than letting them tell it themselves. As one producer complained to Henderson, 'I felt that would give the impression that these people couldn't speak for themselves'.¹⁵

For the Glasgow media group, the representations of mental illness that circulated in the media matter. They were writing in the early and mid 1990s, when government policy was focused on providing care for the mentally ill within the community.¹⁶ Hostile public attitudes towards those with psychiatric disorders, arising from inaccurate media depictions linking violence and mental illness, was believed to threaten the integration of health service users. The silencing of health service users by a media constrained by the practices of the journalistic field stopped them from participating in the creation of positive representations of mental distress and recovery. Moreover, Greg Philo argued, the stigma arising from negative portrayals of mental illness may have a subsequent negative impact upon family relationships, social networks, services for the health service

¹⁵ *Ibid.*, p. 32.

¹⁶ Although this policy may soon be undermined by the draft mental health bill, currently under consultation, which plans to widen the powers to forcibly detain people perceived to be dangerous and extend compulsory treatment to patients within the community. See for example D. Batty, 'Mental Health Bill Sparks Human Rights Fears', *Guardian*, 11 November 2002.

users and users themselves, who may be dissuaded from seeking help.¹⁷ An analysis of media content carried out by the group in 1993 revealed that the bulk of media content:

Situates mental illness in the context of violence or harm and represents the public as 'potential victims of random mania'. Such representations can clearly affect audiences. They can alter perceptions of the 'dangerous' nature of mental illness as well as affecting beliefs about the risks of random attacks by the 'maniacs' who are presented as populating the world.¹⁸

The impact of this coverage is heightened by the fact that positive representations of mental distress are generally situated in low impact media. Thus it appears that certain types of mental illness such as schizophrenia and psychopathy, due to their media associations with violence, may receive more media coverage than other types of mental distress.

Through a series of case studies, the thesis has attempted to illustrate how and why different categories of illness, age and gender of patient became news in media coverage from 1870 to 1970. It has been my contention that many of the news stories about the mentally ill which attracted press coverage initiated from the sub-public spheres with a private interest in mental disorder, some of which have been examined in this thesis. These groups, which had a particular interest in mental illness, may have helped make the topic one of general concern, perhaps initiating more systematic coverage by

¹⁷ G. Philo, 'Users of Services, Carers and Families', in Philo (ed.) *Media and Mental Distress*, pp. 105–14.

¹⁸ G. Philo, G. McLaughlin and L. Henderson, 'Media content', in Philo (ed.), *Media and Mental Distress*, pp. 45–81. Quoted on p. 80. The quote cites a headline from the *Herald*, 13 April 1993.

the media. To understand these representations of mental disorder, it is necessary to understand what motivated the sub-public groups to seek press attention. Thus, in Chapter One, we saw how Clouston and Robertson initiated press stories that assessed the risks posed to mental health by alcoholism, women's education, and the unmarried state. Clouston and Robertson, it was argued, were seeking to move out of the marginalised and stigmatised profession of asylum superintendent, and sought to promote psychiatry as the profession most fitted to promote mental health amongst the community, rather than simply to treat mental illness within the walls of the asylum. Asylum nurses, however, played on notions of danger and perceptions of risk, suggesting in stories about female nursing of insane patients that the mentally disturbed were not medically sick but socially deviant. This representation arose from a concern that female nurses might oust male nurses from their jobs, and an attempt to claim better remuneration on the grounds that the work was dangerous, rather than skilled. Patients retaliated with stories of wrongful confinement and abuse suffered at the hands of the attendants, seeking to reintegrate themselves back into the nominally sane world by re-establishing their identity. Needing to co-operate with the state in order to maintain a unique and relevant function, the Mental After Care Association promoted mental disorder as a curable disease arising from social hardship at a time when many psychiatrists believed it to be hereditary and incurable, before shifting their focus on to incurable cases at a time when many mental health workers emphasised the curability of the condition with new treatments. While all the sub-public groups examined felt that positive publicity would advance their cause, not all achieved the same access to the media. PSWs were unsuccessful at promoting representations of the mentally ill, perhaps too preoccupied by their own lack of public

recognition, and maybe lacking the requisite skills to compete in the field of the media. Thus their representation of mental disorder as a problem arising from faulty social relationships remained internalised within the *British Journal of Psychiatric Social Work* and failed to reach a wider audience. However, to understand how stories were circulated and why some were more successful than others, it is helpful to examine how the media operated.

2: The BBC: Representing Mental Illness and Educating the Public 1950-1970

In order to contextualise the BBC's coverage of mental health issues in the era 1950-1970, it is worth briefly examining the principles that inspired its conduct. Although Habermas argued that the democratic function of the press in the nineteenth and twentieth centuries became subverted by commercialised overtones, Paddy Scannell has argued that the BBC in its early years was guided by the principle of broadcasting in the public interest, believing that it should focus on educating and enlightening the public, rather than entertaining its audience.¹⁹ It was hoped that BBC programming could improve the moral tone of its audience and bring together different classes. The first Director General, John Reith, also hoped that the BBC might enrich democracy in Britain. Rather as the eighteenth and nineteenth century press had arguably increased democratic potential by offering its readership access to information and a forum for debate, Reith hoped that the BBC could offer its listeners more information from which to form their own opinion and

¹⁹ P. Scannell, 'Public Service Broadcasting: The History of a Concept', in A. Goodwin and G. Whannel (eds), *Understanding Television* (London, 1990), pp. 11-29.

make decisions, in effect fulfilling some of the functions of a public sphere.²⁰ This mission may have been undermined by the difficulties the BBC experienced in gaining independence from the government. This was as true in the field of health broadcasting as any other, as Anne Karpf has documented in a series of disputes between the Ministry of Health and the corporation in the 1930s and 1940s.²¹ By the mid-1950s, the BBC found its monopoly being challenged by the establishment of commercial television. It was at this point too that Scannell argues the BBC began to gain political independence from the government.²² We need to consider the development of mental health broadcasting against the backdrop of the ideal of educative, democratic public service broadcasting, and also the growing independence from government. Changes in the field of mental health care no doubt made the topic more suitable for coverage by the BBC, in particular the increasing amenability of mental illness to treatment and the reconceptualisation of mental disorder as an illness affecting patients to be treated in NHS hospitals rather than a disorder affecting paupers to be confined within asylums.

The BBC devoted very little coverage to issues of mental health and illness before the mid-1940s. This seems to be because they felt that an appropriate 'climate' in which these programmes would be received did not exist before then. It may also have resulted partly from the belief that, prior to the 1940s, little effective treatment for mental illness was available. Anne Karpf suggests that programming in the 1930s and 1940s centred on

²⁰ *Ibid.*, p. 14.

²¹ A. Karpf, *Doctoring the Media: The Reporting of Health and Medicine* (London, 1988), pp. 38–43.

²² Scannell, 'Public Service Broadcasting', pp. 24–25.

health rather than medicine, reflecting the lack of free medical care available. This certainly appears to be the case in regard to mental illness, where the few radio programmes dealt with topics relating to mental health rather than illness. There were a few isolated radio programmes in the 1930s dealing with the nervous system and 'nerves', such as that given in 1939 by Dr Critchely McDonald on the 'Change in Life' in women. This programme referred euphemistically to the possible 'bodily and nervous troubles' which might afflict a woman, reassuring listeners that difficulties arising from the 'change in life' were uncommon and were 'not in themselves serious symptoms...indeed they respond very quickly to treatment'. 'People often imagine that severe mental breakdown is likely to develop in women who are passing through the critical years', Critchely told his audience, before reassuring them that 'medical men who have collected data and studied the numerous facts and figures on this subject, can confidently contradict this superstition'.²³ This programme did not deal with mental illness, instead seeking to reassure female listeners who may have developed 'erroneous' beliefs about the severity of the menopause that 'medical men' knew best. Thus, the programme could be seen to fall into the category of health promotion rather than medical care.

The first time that the BBC sought to grapple with covering issues relating to mental illness as opposed to mental health seems to have been in 1942, when they were

²³ 'Your Own Health: Nervous Disorders by a Neurologist' Dr. Critchley MacDonald, BBC Written Archives Centre (hereafter BBC WAC), B/C 19: 5.19.39, Radio Film T101 CRE-CRO.

requested to promote mental nursing. This posed problems for the Director of Talks, John Pringle:

Since there has long been a complete corporation avoidance of references in the programme to the mentally diseased and their treatment, no programme 'frame' exists for an isolated talk on this extremely difficult subject...I cannot myself feel that a light entertainment programme would make a very happy setting for such a talk. I suggest that a reference to mental nursing might be discretely fitted in to a general talk on nurses and nursing.²⁴

Not all BBC staff agreed that mental nursing should be marginalised in this way. In an internal memo sent on 5 February 1942, it was noted that 'Mr Frere had been informed that the suggestion was now for reference to mental nursing to be included in a talk on general nursing, and he was very anxious that the earlier idea – a talk or interview showing that mental nursing was not just caring for wild creatures – should be revived.'²⁵ However, this enlightened attitude towards mental nursing was not shared by the C. (N.C.), who by 6 February was losing his patience with the issue: 'If these papers come back to me again I shall want one of these ladies for professional purposes. For heaven's sake let's have a talk about the whole adjectival lot. Include a reference to the mental ones...and let's forget about it'.²⁶ When the BBC was again asked to promote mental

²⁴ BBC internal memo from John Pringle, 1 January 1942, BBC WAC R51/219, Talks Health: Mental Health 1941–54.

²⁵ BBC internal memo from Mr Ryan, 5 February 1942, BBC WAC R51/219.

²⁶ BBC internal memo from C.(N.C.), 6 February 1942, BBC WAC R51/219. BBC memos and correspondence frequently abbreviated staff titles. However, it is not always clear to what the abbreviations, such as C.(N.C.) referred. I have left these abbreviations as they were given.

nursing in 1943, it was suggested that an appeal could be made on the grounds that mental nursing 'is a dignified type of nursing now (with all its drawbacks on the messy side), demanding a high standard of surgical care, treatment after operations, etc'.²⁷ The corporation still did not seem sure if mental nursing (and by extension, mental illness) was a respectable profession concerned with treating illness, or something more 'messy' and shameful.

A flood of applications to broadcast about mental health from ex-patients in 1951 and 1952 led Isa Benzie to raise the issue of how the BBC should handle such applications, and programming about mental illness more generally, with her colleagues.

From time to time also, over the years, members of the medical profession let us know of their conviction that at some time we should put out talks about mental illness, particularly about the desirability of a change of attitude on the part of the public towards (a) mental illness in general and (b) voluntarily entering a mental hospital in particular...We have not done nothing, but we have not done much. So far, to have not done much I think has been quite correct; it is a matter of one's feeling about what I call the social climate; but, as I have mentioned, the social climate is changing and therefore, I believe, the time has come to plan the inclusion on the programmes of material falling doubtless under the 'rubric' health education.²⁸

²⁷ BBC internal memo from Geoffrey Grigson to Miss Quigley, 24 June 1943, BBC WAC R51/219.

²⁸ Letter from Miss I. D. Benzie to chief assistants Donald Boyd, John Green, the Editor of Woman's Hour and Mr Thornton, AOT, 27 November 1952, BBC WAC R51/219.

Many of the early BBC programmes that dealt with the issue of mental illness were in fact unsolicited scripts from former mental hospital patients describing their experiences. The BBC seemed uncertain as to how to classify these programmes. Seeking a basis on which to plan future material, the BBC carried out audience research in 1956 to assess how receptive viewers would be to a television programme on mental illness. Three quarters of the 180 viewers sampled distinguished between mental illness and insanity, believing the former to be caused by environmental factors and to be largely curable, while the latter was thought to be the product of heredity, and to be more serious and incurable. More than half the people sampled claimed to know someone who was mentally ill while two in five had seen a film on mental illness. In many instances, this was *The Snakepit*. The sample provided a large mandate for a television programme on mental illness, although one in ten interviewed opposed as they felt 'it would be too depressing or morbid' while another one in ten believed that such a programme 'might itself produce mental illness'.²⁹ These fears about the potential impact of a programme upon viewers perhaps echoed the concerns surrounding the release of *The Snakepit* in British cinemas seven years earlier. Michael Shortland, in his analysis of the reception of this film in Britain, notes that it proved very controversial, with many papers expressing concerns that *The Snakepit* could have a dangerous impact upon its viewers. Indeed, several national newspapers reported that a woman had been driven mad after seeing the film.³⁰

²⁹ BBC Audience Research Report, 12 November 1956. Quoted on p. 5. BBC WAC S322/117/3, Adams, Mary (Assistant Controller Mental Health including the Hurt Mind).

³⁰ M. Shortland, 'Screen Memories: Towards a History of Psychiatry and Psychoanalysis in the Movies', *British Journal for the History of Science*, 20 (1987), pp. 421–52.

2.1: Purposes of Mental Health Broadcasting

As the BBC started to incorporate mental illness programming into its schedules, staff members began to question its purpose. Generally, it was felt within the corporation that programming should aim to reassure the public about the treatment available within mental hospitals and destigmatise mental illness: to inform the public and correct misapprehensions, not to encourage debate. However, this position was not unproblematic. Isa Benzie's memo of 1952 on the subject expressed concerns that coverage of ex-patient accounts at the expense of more planned, officially sanctioned programming, might be seen as an abdication of the BBC's 'becoming position', in which the BBC discussed what 'most needs talking about' (in the eyes of officials). She noted that the BBC was expected to help, and that 'the particular help these days, in the eyes of authority, lies of course in reducing the cost of the NHS'.³¹ Benzie questioned whether the BBC should promote hospital treatment for mental illness if the government was seeking to make savings. Moreover, Benzie believed that 'the branch of medicine dealing with deranged persons is in a fairly base and backward state, and I take it that it will be no part of our duty at any time to oblige persons outside by pretending things are better than they are'.³²

³¹ Letter from Miss I. D. Benzie to chief assistants Donald Boyd, John Green, the Editor of Woman's Hour and Mr Thornton, AOT, 27 November 1952, BBC WAC R51/219. Underlining in original text.

³² *Ibid.*

Sometimes staff within the BBC felt they should expose the 'real' conditions within mental hospitals, by which they generally meant failures and shortcomings. These aims could come directly into conflict, as can be seen in the making of a regional programme on mental hospital services in Northern Ireland. Believing that conditions within mental hospitals in the region had improved significantly, producer Diana Hyde submitted her proposal:

One of the main problems now is the difficulty of educating the public in the matter of mental health. Ignorance on the subject is almost universal, and what knowledge there is, is largely distorted and unrelated to facts. Fears of being 'put away' and of the stigma attached to mental disorders and diseases prevent people from going forward in the early stages when cure is likely...films such as *The Snakepit* do great disservice by seeming to confirm the false ideas prevalent.³³

Hyde aimed in her proposed programme to educate the public, breaking down stigma by correcting misapprehensions. She seemed to perceive the public as an undifferentiated mass, ignorant and unreasonably prejudiced against the mentally ill and mental hospitals. However, part way through her research for the programme, Hyde was forced to reassess her criticism of public prejudice.

I have had to modify my views since meeting Dr Malligan and Dr. McAuley.

Before this I was quite convinced that the reasons for the fear and concealment of

³³ Memo from O.P. Diana Hyde to H.N.I.P., August 15 1955, for programme suggestion, 'Within Our Province', BBC WAC N14/6/7/1, Mental Illness 1955–60. Hyde's programme, 'Within our Province: The Sick Mind', was aired on 11 December 1956 on the Northern Ireland Home Service, receiving an audience of 3 per cent of the Northern Ireland adult population, according to the BBC Audience Research Report.

mental illness were almost entirely due to ignorance of the facts. I now see that a medical history which reveals a mental illness can be a serious drawback to an individual and his or her family where work, marriage, career and emigration are concerned. In other words, I must modify my attitude to the public attitude, which is not necessarily the result of ignorance, but also to a perfectly reasonable fear of the consequences....³⁴

While carrying out her interviews for the programme, Hyde also found that not all residents of the mental hospitals shared the views she sought to promote, and rather than leave in any critical material, she appears to have cut interviews to advance her chosen presentation. This excerpt from an interview was marked 'ok to leave':

D.H. - Are you happy here?

Woman - Oh, yes very.

D. H. – Do you feel you're getting better?

Woman – Oh definitely, decidedly.

However, written in the left-hand side of the next section of the interview was 'NO. NO'.

D. H. – Would you rather be here or anywhere else?

Woman – I think...(unintelligible, breaks down)...well I am very...I certainly would rather be out of it.

Dr. Donnan – You would rather be home?

Woman – Yes, I think so.

³⁴ Report on visit by Diana Hyde, 1 May 1956, 'Within Our Province', BBC WAC N14 6/7 I.

D. H. – Thank you very much.³⁵

Despite her awareness that the issues surrounding perceptions of mental health were not as clean cut as she had first imagined, Hyde shied away from presenting all aspects of the problem of mental illness to her audience, seeking instead to produce an unambiguous production to educate the public and destigmatise mental illness, silencing any opposing ideas in the process.

2.2: Interactions of the BBC and Mental Health Organisations/ Professions

When examining the written records for programme suggestions it transpired that programmes which initially appeared to have been objectively conceived by the BBC were often initiated by members of BBC staff with prior connections to mental illness. Diana Hyde, producer of 'Within Our Province', admitted that her interest in the topic stemmed from her earlier work as a member of staff in a mental home.³⁶ Another example can be found in files from 1959 and 1960, when BBC employee David Gretton submitted suggestions for a programme on conditions in hospitals for the mentally defective: 'We have a young studio manager who worked as a male nurse in such a place... He is a sensitive character with a strong sense of idealism, and he is still on fire with the horror and disgrace of the conditions in which he found himself working'.³⁷

³⁵ Transcript of Interviews, Tape two, 'Within Our Province', BBC WAC N14/6/7/1. The first 'NO' written in the margins was underlined twice.

³⁶ Memo from O.P. Diana Hyde to HNIP, 25 August 1955, 'Within Our Province', BBC WAC N14/617/1.

³⁷ Memo from AHMRP David Gretton to Miss I. D. Benzie. 30 October 1959, BBC WAC R51/844/1, Health Mental Health File III, 1955–64.

Most mental illness programming produced by the BBC relied on extensive co-operation, interaction and initiation of projects by mental health professionals and organisations. When looking for expert advice and consultation, the BBC tended to rely more upon doctors than other health care professionals. Doctors were not, however, always successful at persuading the BBC to realise their proposals and an examination of Joshua Bierer's repeated attempts to secure BBC coverage of his work illustrates some areas the BBC were keen to avoid. Bierer, who worked at the Marlborough Day Hospital and was Medical Director of the Institute of Social Psychiatry, wrote to the BBC in 1956 with a proposal for a programme entitled 'Are you Normal?' Bierer prefaced his proposal with his particular view of mental illness:

It is believed that everyone deep down within himself is afraid of becoming mentally deranged. This fear is likely to continue to influence everybody's thought and action as long as those of us who have not had to be treated for any disturbance believe we are so normal and that mental patients are so abnormal...it is important to establish whether mental patients are really so abnormal that everyone would recognise them immediately by their appearance, their movements and their speech...it will help in the most important problem of educating the public, especially if the result is favourable...it is an accepted fact that we all think the other fellow is crazy because we really have doubts about our

own sanity but dare not admit it to ourselves. Few points could be found so near to everyone's heart...³⁸

Bierer suggested that normal, neurotic and psychotic participants should be found to hold discussions, and the public would be invited to adjudicate who was 'normal' and who was 'abnormal'. This basic premise may not have been as objectionable to BBC staff as the way in which he chose to phrase it: '...It is proposed, therefore, to run a programme which will be as interesting and thrilling to the masses as any other game'. Bierer later repeated himself: '...Nevertheless, apart from these important scientific and socio-medical aims, this could take the form of a thrilling game and could interest everyone'.³⁹ It seems that BBC staff, who underlined the passages in these excerpts, objected to the sublimation of the educative and destigmatising purposes of the programme, which fitted in with their sense of public duty, to entertainment. They may also have been uncomfortable with the idea of mixing the programming genres of education and entertainment. An internal memo sent in 1938, which referred to a series of intelligence tests that were to be broadcast, displayed a similar reticence: 'it is, as you know, of great importance that these programmes should not be confused by the public with the games programmes which will be broadcast at the same time on different Sundays'.⁴⁰ Moreover, BBC staff may have been concerned that Bierer was not

³⁸ Letter from J. Bierer to the BBC, 15 October 1956, BBC WAC R51/845/1, Talks Health Psychiatry 1956-57. Typed underlining in text.

³⁹ *Ibid.* Underlining in pencil, probably by BBC staff.

⁴⁰ BBC internal memo from ADT to Mr Newton, DT, and Mr Alford, Talks Ex, 19 August 1938, BBC WAC R51/223, Talks Health: Psychology Files 1 and 2, 1938-50.

representative of psychiatry as a whole and may have been dubious about giving him a platform. Certainly not all psychiatrists held Bierer's views, and senior BBC staff may not have shared his contention that most people had doubts about their own sanity. Bierer's earlier talk of 'self-emancipation for the patient' who had previously been 'a tool in the well-meaning hands of his therapists' may have sounded too controversial. In 1949, Julian Snow, the Honorary Secretary of the Institute of Social Psychiatry, wrote to Mr Grieswood at the BBC, asking if it would be possible for the chairman of the Institute to give a talk on the subject of therapeutic social clubs. An internal memo from Isa Benzie to the Assistant Controller of Talks, R. Lewin, suggests political reasons for the rejection of the suggestion: 'I smell a smell of medical politics would you agree? And I note that in spite of the Institute's being a treatment centre it is apparently not yet part of the NHS...'.⁴¹

A day after this proposal was sent, Bierer dispatched yet another letter to the BBC to see if it would be possible to arrange coverage of his work to create a more accepting attitude towards homosexuality. An internal BBC memo deemed Bierer's programme proposal as 'quite unacceptable',⁴² but Benzie was still dispatched to investigate Bierer's therapeutic social club and later reported:

T.V. in some guise had been to see him in connection with the second 'Hurt Mind' series. This visit seemed to have removed his mind entirely from old steam

⁴¹ Memo from Miss I. D. Benzie to ACT, R. Lewin, March 1949, BBC WAC R51/222, Talks Health Psychiatry 1949-55.

⁴² Memo from Chief Assistant Talks, Miss Quigley to Miss I. Benzie, 26 October 1956, BBC WAC R51/845/1.

radio...His accent I should say was really too thick to make him a desirable choice from amongst all possible psychiatrists - were other things equal, which I continue to think they are not. The late C.T. by the way was always quite clear that a point could be reached when our general world savvy closed a door.⁴³

Doctors were paid much higher fees than other professionals or patients for their involvement in programmes, while internal memos and correspondence suggests that the BBC and doctors could be dismissive of some professions. Mental nursing was not the only profession to be treated as a joke by BBC staff. Isa Benzie, reporting on the 1949 conference on Mental Health, noted: 'I have by now looked in and out at a good many conferences more or less of this sort, usually in the hope of collecting new speakers, and usually one finds the same old drearies...'.⁴⁴ PSWs Marjorie Brown and May Irvine were reviewed as 'either uninspiring or off-putting, or both. Dreary.'

Perhaps the most thorough example of an outside organisation influencing BBC programming was the involvement of the National Association of Mental Health (hereafter the NAMH) in the initiation and publicity for programming. To ensure that the interests of the charity were served, the NAMH invited BBC staff to sit on its committees. Indeed, the interactions between the BBC and the NAMH are in part illustrated by the fact that much of the material relating to mental health programming

⁴³ Memo from Miss I. D. Benzie to C.A.T. Miss Quigley and Mr Newby, 8 February 1957, BBC WAC R51/845/1.

⁴⁴ Memo from I. D. Benzie to ACT, AHTD, 26 March 1949, BBC WAC R51/219.

stored at the BBC Written Archives Centre was initially stored or created by the NAMH. The NAMH was established through an amalgamation of three of the four major health charities in 1939, in part because the activities of these charities had begun to overlap, but also because the development of government welfare services had undermined the roles of voluntary services, which needed to find a new direction.⁴⁵ As we saw in Chapter Four, changes in state provision also affected the direction and role of the MACA: however, the aims of the NAMH were very different to those of the MACA. The MACA sought to facilitate the reestablishment of former patients into social life, and saw publicity as a necessary means to raise the money for its activities. The NAMH, however, were more interested in health rather than illness and sought to promote mental hygiene, believing publicity had a much broader purpose to play, as they explained to a government committee, in answer to the question, ‘what are the main objects and aims of your organisation?’⁴⁶

To foster a wider understanding throughout the community of the importance of mental health in all relationships of everyday life, and to establish the principle that its foundations must be laid down in early childhood if healthy mental and emotional development is to be achieved...

⁴⁵ See M. Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy, and Social Policy in Britain c.1870–1959* (Oxford, 1998), pp. 175–7 and N. Crossley, ‘Transforming the Mental Health Field: The Early History of the National Association for Mental Health’, *Sociology of Health and Illness*, 20 (1998), pp. 458–88, especially pp.470–72, for more information on the formation of the NAMH.

⁴⁶ Draft Evidence to the Ministry of Health Joint Committee of the English and Scottish Health Services Councils, no date, BBC WAC S322/215/1, Mary Adams (Non BBC bodies) NAMH.

To work for and promote research into mental health and into mental disorders and defects.

To provide and to encourage the provision of courses, lectures, and conferences for the general public, and for various groups of professional workers dealing with mental health problems....

The NAMH believed that the education of the public was the best way to promote mental health through the community. It saw itself as 'standing midway between the statutory services and the lay public', acting as a bridge between the state and the public sphere.⁴⁷ Their activities included the development of new services and courses on mental health for professional groups, the organisation of mental health exhibitions, annual conferences, the publication of a range of books and pamphlets and their own journal, *Mental Health*. Nick Crossley, who has examined the NAMH's role in transforming the field of mental health, argues that the charity in its early years sought to impose their beliefs upon others using social power rather than discussion, framing their ideas as incontestable fact.⁴⁸ While mental hygiene may have drawn on a medical model, supposedly scientific and value free, it also embodied the middle-class values of its proponents, Crossley argues, as the standard of normality.⁴⁹ As the BBC in this era believed its task was to educate and improve its audience, the NAMH initially sought to promote mental health by moralising and uplifting the working class, believing that mental disorder often resulted from environmental factors. They believed that public

⁴⁷ *Ibid.*

⁴⁸ Crossley, 'Transforming the Mental Health Field', p. 464. Crossley explains this process as symbolic violence, a concept developed by Bourdieu.

⁴⁹ *Ibid.*, pp. 466-8

ignorance of available treatments created stigma and unnecessarily delayed therapy, leading to more incurable illness. In order to reach the public to achieve their mental health goals, the NAMH needed access to the general rather than the specialised media.

The NAMH also faced the same conflict of interest that the BBC sought to manage. Although keen to focus on improvements and advances in psychiatric care so that the public might be persuaded more readily to seek help, the NAMH believed that some problems still existed and that perhaps public attention should be drawn to these more negative aspects of mental health care in order to invoke change. In 1963, for example, the Public Information Committee discussed the desirability of awakening public interest in conditions in hospitals for the mentally subnormal. Despite opposition from the Minister of Health who thought that such publicity 'often boomeranged on the staff working in trying conditions', the NAMH felt that 'the time had come when the public might now be told some unpleasant truths about mental hospitals and mental disorder. This would involve a change in policy...'⁵⁰

In 1955, the NAMH had established a Public Information Department, whose functions included the provision of an information service on mental health topics for the media and the compilation of media features dealing with mental health that were circulated to its public information committee. Committee membership was split between people with a background in mental health and those involved in the media. At the initial meeting of the committee, it was explained that

⁵⁰ NAMH Public Information Committee Meeting Minutes, 18 January 1963, BBC WAC S322/215/1.

It is believed in the Association that there is in fact a great deal of public sympathy for its aims, but that its existence is not widely enough known. On the other hand, the public is continually fed with various sorts of information sometimes sensational and frightening, sometimes inaccurate, sometimes over-optimistic about the nature of mental disorders and of the means of combating them...The Association believes that the mass media of communication (i.e. film, radio, television and the press) offer excellent means for communicating our message and our knowledge to the public...⁵¹

How seriously BBC staff participated in these committees is hard to judge. Isa Benzie, commenting on two earlier NAMH committees to her BBC colleagues, was rather scathing:

(a) The public relations committee which ought to be called the education of the public committee, and a committee originally set up to attempt some study of the influence upon the state of public knowledge of films which contain psychiatric material...This committee now serves no good purpose that I can see (it is busy at present planning a symposium-book on aspects of the problems of films/children/what-have-you, which will be valueless), but I imagine Mr Manville expects to make money out of it...But I still go to at least one meeting in every two...because the spectacle is most instructive, the spectacle, that is, of a somewhat undefined racket at work.⁵²

⁵¹ 'Background Information – the Need for Better Information About Mental Health Topics', BBC WAC S322/215/1.

⁵² Memo from Miss I. D. Benzie to A.C.T. and A.H.T.D., 25 March 1949, BBC R51/219.

Although the NAMH made a significant input into BBC programming, Benzie's comments do not suggest that BBC staff held the NAMH in particularly high esteem. Her criticism that the public relations committee functioned more as an education of the public committee perhaps reflected her belief that the NAMH's efforts to influence public opinion through the media were heavy handed, aimed less at provoking debate amongst the public than imparting views. This disregard for sub-public groups was probably more marked with respect to less influential organisations such as the APSW. However, perhaps it was sub-public groups such as the NAMH who had in the first place created a 'social climate' in which mental illness could be discussed by the BBC as a topic of general public concern.

2.3: The Hurt Mind

A close examination of 'The Hurt Mind', the first television series produced by the BBC to examine mental illness, illustrates some of the trends already discussed. While the written records surrounding the production of other radio and television programmes are sometimes rather scant, the making of 'The Hurt Mind' was richly documented, both by the BBC and the NAMH, offering an interesting perspective on the role of outside organisations in the production of BBC programmes.

The initial impetus for a television programme on mental health came from several directions. In November 1955, psychiatrist Aubrey Lewis sent the BBC some pictorial representations of mental health statistics with the suggestion that they might be

helpful in planning any television series. Mary Adams, an Assistant Controller at the BBC who was also involved in the NAMH, forwarded the figures to some of her colleagues: 'Several approaches have been made to us lately – one from the chairman of the Board of Control, and another from the Minister of Health, urging us to consider mental health as a programme subject'. This suggests that the incentive to produce programming on mental illness came from sub-public groups outside the BBC staff. The C. P. Tel. wrote in the margins of the memo: 'I find these figures frightening disturbing important. "The Mind" becomes more and more an important subject for television.'⁵³ Writing back to Lewis, Adams commented on the marginality of mental health in mainstream television programming:

As you can imagine, we have often discussed the desirability of presenting the problem of mental illness in television and we have, from time to time, put over programmes on the subject...the subject often comes up for discussion not infrequently in our afternoon programme for women: 'Family affairs'. But we have never embarked on a full-scale treatment during evening programmes. Perhaps we should....⁵⁴

At the first meeting of the NAMH Public Information Committee in April 1956, members commented on the potential of the BBC. MP Kenneth Robinson felt that the

⁵³ Memo from Mrs Mary Adams to C.P. Tel, H.T. Tel., Editor, women's programmes Tel. and James McCloy, 16 November 1955, BBC WAC S322/117/2, Adams, Mary (Assistant Controller Mental Health including the 'Hurt Mind'). Tel. In this instance probably refers to members of staff attached to television rather than radio programming.

⁵⁴ Letter from Mary Adams to Aubrey Lewis, 16 November 1955, BBC WAC S322/117/2.

committee should focus on spreading knowledge of modern methods of treatment: 'it was difficult however to awaken people to the shortcomings of the mental health service without putting off possible voluntary patients. He felt that the BBC could do more than any other body in this field, but he thought there had been a certain timidity on their part in the past'.⁵⁵ The BBC also found itself under pressure from the Ministry of Health via the Standing Mental Health Advisory Committee, who wrote to ask what plans the BBC had. In an internal BBC memo, the chief assistant to the Director-General, Harman Grisewood, commented:

I imagine the subject is dealt with in a talk occasionally and, more rarely still, in a feature programme and unless we have been stimulated to do so, we are not, I suppose, thinking out anything systematic to 'educate the public in mental health matters.'⁵⁶

However, a memo sent in response to the query noted that plans were under way for a series of six programmes under the provisional title of 'Mind in Balance', and noted that Andrew Miller Jones was under consideration to produce it, and that William Sargant was advising. 'The object of the series', noted the memo, 'as in other medical programmes, will be:

1. To allay fear.
2. To encourage the sick to take advantage of available treatment in the early stages of disease.

⁵⁵ NAMH Public Information Committee, 19 April 1956, BBC WAC S322/117/2.

⁵⁶ Memo from Harman Grisewood to D.S.B., 22 May 1956, BBC WAC R19/1759/1, Mental Health.

3. To make known the latest advances of medical science and to increase the public's confidence in present-day medical science.⁵⁷

Around the same time that plans for 'The Hurt Mind' were under consideration, a series was being produced for the Scottish Home Service at the request of the Scottish Department of Health. Producer Archie Lee summarised his arguments for tackling the subject:

- a) Close on 50% of all hospital beds in the UK are occupied by patients with nervous disorders.
- b) The incidence is rising steadily.
- c) Conversely, more and more effective treatments are being devised.
- d) There is need for a largely ignorant public to be better informed of the position: this can lead to:-
 - (I) More understanding of symptoms, resulting on earlier, and more effective treatment.
 - (II) Awareness of the needs for more nurses, more equipment, and more research.
 - (III) Realisation of the scope and necessity for voluntary work.⁵⁸

Both producers cited public education of mental disorder and its therapy as major aims of the proposed programmes. They believed this would encourage people to seek earlier treatment and have more confidence in psychiatry. In addition, Lee hoped his series

⁵⁷ Memo from Leonard Miall, Head of Talks, television to A. D. Tel. B., 25 May 1956, BBC WAC R19/1759/1.

⁵⁸ Memo from Archie Lee, Features Producer Glasgow, to H.S.P, G. I, 12 January 1956, BBC WAC R19/1759/1.

would promote people to take a more active role themselves in the care of the mentally ill, by boosting nurse recruitment and encouraging people to undertake voluntary work. He used statistics to bolster his claims that the topic was an important one.

An examination of the professionals involved points to the predominance of doctors as experts. William Sargant, the main consultant for 'The Hurt Mind', was a well-known figure within the world of psychiatry. Sargant was co-author of *An Introduction to the Physical Methods of Treatment in Psychiatry*,⁵⁹ a book first published in 1944 that discussed the value of leucotomies, E.C.T., convulsion and insulin therapies and sought to bring psychiatry more within the scope of general medicine and surgery. 'There is no need to labour the practical value of the various physical methods of treatment in psychiatry', wrote Sargant and Slater in their introduction. 'Despite their relatively recent introduction, it is recognised that they produce their beneficial effects with greater speed and greater certainty than the older and more well-established psychotherapeutic methods.'⁶⁰ Perhaps Sargant's reputation as a keen advocate of the new physical therapies and his position as Registrar of the Royal Medico-Psychological Association (since 1951) made him seem a desirable choice. Sargant was also one of the more public-orientated psychiatrists. In addition to his publications aimed at a medical audience, he also wrote a popular book on religious conversion and brainwashing techniques, *The Battle for the Mind*, published in 1954 that had sold over 200,000 copies by 1967, and

⁵⁹ W. Sargant and E. Slater, *An Introduction to Physical Methods of Treatment in Psychiatry* (1944, Edinburgh, 1948).

⁶⁰ *Ibid.*, p. 1

later published an autobiography, *The Unquiet Mind*, in 1967.⁶¹ Sargant was paid 200 guineas for his advice on the content and policy of the programmes.

Other doctors were also heavily involved. GP Charles Fletcher, who later on became the presenter for the BBC series *Your Life in Their Hands*, was paid 150 guineas for carrying the second, third and fourth programme, while Dr. E. D. Barlow was paid 200 guineas for research and assistance in writing the script and appearing in one of the programmes. Christopher Mayhew, MP, who had previously addressed the NAMH, was paid 187 pounds for presenting the first programme and acting as a chairman in the last. Not everyone was happy however. Dr. David Stafford-Clark, who had been answering listeners' questions on mental health topics for the religious radio programme 'The Silver Lining', and author of his own popular book written for the general public, *Psychiatry To-day*,⁶² was 'seriously aggrieved that, after working for four years on programmes which are...on the periphery of his real work, he should now be completely by-passed when a quite considerable series of programmes have been put on which are directly related to his subject.'⁶³ Other mental health care professionals do not appear to have been consulted and expenses for nurses and patients involved in the film were far lower

⁶¹ W. Sargant, *The Unquiet Mind: The Autobiography of a Physician in Psychological Medicine* (London, 1967). Figures given for the distribution of *The Battle for the Mind* on p. 175. Sargant's popular works are discussed in Chapter One.

⁶² D. Stafford-Clark, *Psychiatry To-day* (1952, Middlesex, 1963). This book was reprinted six times between the first edition of 1952 and the edition consulted from 1963, having sold over 130,000 copies.

⁶³ Memo from the Assistant Head of Religious Broadcasting, Rev. Douglas Stewart, to H. R. B., 31 December 1956, BBC WAC R51/844/1.

than those of the doctors involved. Dr M. A. Partridge was paid 25 guineas to talk about leucotomy, but James P. was only paid three guineas to appear as a patient in a demonstration of E.C.T.⁶⁴

The first programme in the series, presented by Christopher Mayhew, depicted life in a mental hospital, using Warlingham Park as an example. The programme started with a statistic represented to make mental illness a topic of everyone's concern. 'The chances are one in twenty that you or I will spend some part of our life as a patient in a mental hospital', began Mayhew, seeking empathy from his audience.⁶⁵ Mayhew sought to tackle the stigma surrounding mental hospitals and mental illness by juxtaposing popular beliefs with what went on inside an actual mental hospital.

This is a mental hospital here – does a sight like this fill you with foreboding? I know it did me. What is really going on inside there? Hopeless misery, raving, violence, weird uncanny behaviour? I thought I'd find out...here's the dormitory here – extremely civilised and pleasant, curtains between beds even...This was my cubicle – chest of drawers and reading light, perfectly comfortable...and this was the lounge of the ward, with the morning newspapers coming round. It wasn't bad at all, comfortable chairs, television, a warm fire and surprisingly quiet...this might be almost a hostel or private hotel...⁶⁶

⁶⁴ Expenses for the Hurt Mind, BBC WAC T32/846/1, the Hurt Mind, sub-category B/C 22.1.57.

⁶⁵ Transcription of programme, 'Put Away', shown 1 January 1957, p. 1, BBC WAC S322/117/1, Adams, Mary (Assistant Controller Mental Health including the 'Hurt Mind').

⁶⁶ *Ibid.*, pp. 1-2

Mayhew tried to decrease popular fear of the mental hospital by representing it as a comfortable hotel, emphasising facilities and activities such as the shop, hairdressers, dances, films, magazines and chapel. He also sought to achieve the same ends by comparing the mental hospital as it was to a stereotypical view of the bad old asylums: 'In those days [fifty years ago] a mental hospital was a kind of prison. Treatment of insanity was widely thought to be a waste of time...'.⁶⁷ By stigmatising conditions in mental hospitals fifty years earlier, Mayhew allowed viewers a rational basis for their fears while also giving himself the ground to suggest that the situation had changed.

The programme contained interviews with actual patients, although an examination of the script does suggest that Mayhew controlled the direction of the conversation through a series of leading question, as in this extract of an interview with two female alcoholics, Betty and Sybil.

Mayhew – What did you feel when you came here, I mean, what did you expect a mental hospital would be like?

Betty or Sybil – Well, I expected locked doors for one thing, padded cells, I can't...

Mayhew – But weren't you a bit scared, I mean, you went into the canteen – did you?

Betty or Sybil – Yes, I was a bit frightened at first.

Mayhew – Mixing with the other patients mostly?

Betty or Sybil – Yes, but I found that most of them were quite friendly and...

⁶⁷ *Ibid.*, p. 1.

Mayhew – More like a hotel, this place?

Betty or Sybil – yes, it is...⁶⁸

Mayhew used a similar tactic when interviewing a male nurse, Mr Rowse. Mayhew had just argued that ‘emphasis on treatment has transformed this place from a prison to a hospital’, and was using leading questions to get Rowse to admit that nurses in the bad old days had used violence to control patients.

Rowse – Well in 1933 when I came to the hospital it was like a prison...

Mayhew – And this made the patients frustrated I suppose and violent.

Rowse – Well naturally...they did tend to get irritable.

Mayhew – And then the nurses, I suppose, had to retaliate a bit?

Rowse – Well, on the whole they were a very tolerant staff...

Mayhew – You hit out because you were frightened? Was that it?

Rowse – Often in self-defence.⁶⁹

Like Diana Hyde before him, Mayhew faced the paradox of attempting to destigmatise mental illness and persuade more people to seek early, voluntary treatment in mental hospitals while simultaneously admitting that the condition of many hospitals left much to be desired. While showing a film of Cane Hill hospital, Mayhew commentated:

Out of over two hundred health service mental hospitals, only six have been built in the last forty years. These are ugly, oppressive, wretched places. You feel you’re in a

⁶⁸ *Ibid.*, pp. 2–3.

⁶⁹ *Ibid.*, p. 10.

nineteenth-century prison or workhouse...staff shortage and overcrowding mean locked doors and gates – it's the only way hard working staff can manage. This gate locks patients into this exercise yard, or airing court as it's called. It's sunless, crowded, ugly, like a cage for wild animals.⁷⁰

The medical superintendent of the hospital used this opportunity to call for money, but also 'what's behind money. You see we need public opinion, public support',⁷¹ likening mental hospitals as the 'Cinderella' of the health services.

At this stage in the programme, Mayhew found himself having to balance the conflicting duties of BBC reporting:

Well that was a depressing film. We had to show it because it's the truth – more shame on all of us. But I know there'll be some people watching this tonight who feel responsible for some mentally ill person...or perhaps who are mentally ill themselves, who may feel put off from applying for treatment by the kind of thing we've just shown...⁷²

Mayhew then felt it necessary to reassure viewers that even in the older hospitals modern treatment was given to patients, who usually only required short stays in the more pleasant areas of the hospital. Mayhew's narration technique – his use of the pronoun 'us' – sought to make viewers feel responsible for the state of the mental health services. This may have been an attempt to encourage people to volunteer their services to their local

⁷⁰ *Ibid.*, p. 12.

⁷¹ *Ibid.*, p. 13.

⁷² *Ibid.*, p. 13.

mental hospitals, given that at the end of the programme Mayhew urged viewers to become involved in associations of friends for mental hospitals or their hospital management committee. Mayhew also used the documentary to attempt to boost nurse recruitment: 'This hospital, like most others, is badly short of female nurses. It seems a great pity – for people with imagination and compassion this is surely a fine job to do.'⁷³

Perhaps unsurprisingly, given that Sargant was the chief consultant for the film, it was confidently asserted that 'mental diseases have almost certainly got physical causes, just like physical diseases, and there's no real distinction to be made...'.⁷⁴ To make this point, a girl was shown visiting a general hospital in London to receive psychotherapeutic treatment for an anxiety state. 'Like most young and intelligent mental patients, this girl doesn't mind us filming her at all', commented Mayhew. 'She knows that she can't help her illness and it is nothing to be ashamed of, any more than any other illness.'⁷⁵ An out-patients department was also shown, and the administration of treatments such as abreaction, modified insulin and E.C.T. 'These patients will be back at home or at work later today', Mayhew announced, seeking to break the link in the public mind between mental disorder and a prolonged stay within a mental hospital.⁷⁶ No scripts survive for the subsequent programmes. The second programme dealt with different theories about the causes of mental disorder, and covered theories of the brain, child guidance, Freud, heredity and chemical changes in the brain. All the participants were doctors: this episode

⁷³ *Ibid.*, p. 3.

⁷⁴ *Ibid.*, p. 15.

⁷⁵ *Ibid.*, p. 13.

⁷⁶ *Ibid.*, p. 14.

was later described by Leonard Miall as 'terrible', although he had thought the first had been 'very good indeed'.⁷⁷ The third programme in the series dealt with psychotherapy and social therapy and depicted the different methods of treatment used for individuals and groups. Again, all participants were doctors.

In the fourth programme, physical methods of treatment were examined. 'Twenty or thirty years ago it was no good even starting to open the doors of our mental hospitals, while there were so many mentally tortured persons only waiting for an opportunity to escape and perhaps to kill themselves', Sargant argued, warming to the topic. 'Fortunately these new physical methods of treatment have been found to help the sort of patient who is too depressed and agitated to be helped by psycho-therapeutic methods alone.'⁷⁸ This programme demonstrated E.C.T. and described insulin treatment, tranquillisers, abreaction and leucotomy, the efficacy of the latter demonstrated through a conversation with a compliant leucotomised patient. The doctors were quick to dismiss criticism of these treatments: Fletcher noted that in spite of the positive review of E.C.T. given by the demonstration patient, 'there seems to be considerable fear of E.C.T., judging from letters sent in – even from patients who have had it and presumably not felt actual physical pain'. Meanwhile, Sargant dismissed the side effects of leucotomies: 'one must remember that the choice is not between what the person was before the illness and what they are after leucotomy, but between an utterly miserable and incapacitated patient

⁷⁷ Memo from Head of Talks Leonard Miall to T. O. Tel., 30 January 1957, BBC WAC/T32/845/1, The Hurt Mind - General. Outline of programme two, BBC WAC S322/117/1.

⁷⁸ Outline of programme four, BBC WAC S322/117/1.

and a normal or near normal person'.⁷⁹ The fifth programme – a studio discussion of letters sent in by viewers – has no outline or script record in the archives.

The involvement of the NAMH continued through the making of the film. In an answer to the question 'what has been your experience with different types of publicity material...?' posed by the Ministry of Health joint committee of the English and Scottish Health Services Council, the NAMH used their experiences with 'The Hurt Mind' as their first example.

The Association co-operated with the BBC in supplying background information...the producer attended meetings of the public information committee...the Association helped to compile and distribute a leaflet about the programmes to the press and voluntary organisations. The BBC referred all the letters with a casework content to the NAMH casework department...These queries were afterwards...summarised and answered by psychiatrists in a booklet 'Fifty Questions and Answers on Mental Illness' and published by the Association. Lord Feversham, as chairman of the NAMH, wrote to the Director General of the BBC asking that the Hurt Mind programmes be recorded and made available to the public on film and this request was acceded to.⁸⁰

In their annual report of 1956–57, the NAMH paid tribute to the assistance the BBC had rendered to their cause. 'One series should perhaps be singled out for special mention.

⁷⁹ *Ibid.* Underlining in original text.

⁸⁰ Draft Evidence to the Ministry of Health Joint Committee of the English and Scottish Health Services Councils, BBC WAC S322/215/1.

The BBC television programmes entitled “The Hurt Mind”. These did great service in enlisting public sympathy and the Association...had some part in the preparation and follow-up of these programmes.’⁸¹

However, the BBC was keen to emphasise their independence from this organisation, perhaps feeling that the NAMH were trying to annex control and credit over the series. When the NAMH asked if they might be given the telerecording of the series, the BBC response was initially rather hostile. ‘I personally think that we should turn this request down completely’, wrote BBC talks organiser Cyril Jackson. ‘We are making a pretty considerable contribution to the work of the Association by putting on these programmes and this should amply repay any co-operation we have had from them...’.⁸²

Psychiatrists had been heavily involved in the making of the Hurt Mind and T. P. Rees, President of the RMPA in 1956, wrote the introduction on mental illness for the BBC / NAMH pamphlet that was produced to accompany the series.

A better informed public opinion can only benefit the mentally ill everywhere...I sincerely hope that this series of programmes will awaken in the hearts and minds of the British public a due sense of responsibility to their less fortunate fellow citizens who are the victims of mental illness or of mental subnormality.⁸³

⁸¹ *NAMH Annual Report 1956-57* (London, 1957).

⁸² Memo from Talks Organiser Television Cyril Jackson to Head of Talks, Television, 19 December 1956, BBC WAC T32/845/1.

⁸³ *Mind Out of Balance: Programmes on Mental Health Broadcasting by BBC Television and by the BBC Home Service*, BBC WAC T32/846/1.

Rees chose to stress the role - indeed duty – of the average citizen in the care of the mentally ill. He also acknowledged the paradox of the project of destigmatising mental health care by recognising that the problems of mental hospitals, as well as their advances, would be shown.

Within the BBC written archives is a file of letters sent mainly by professionals in response to the *Hurt Mind* series. In a cover letter to the BBC registry, Andrew Miller Jones' secretary Daphne Meier explained that they fell into a different category from 'the bunch of viewers' letters' sent by lay people, which were deemed to be of 'no further interest and could be thrown away as far as we're concerned', wrote Meier, 'but the enclosed bunch we might want to refer to at some future date'.⁸⁴ These letters were from psychiatrists, duly authorised officers, occupational therapists, charity workers, psychiatric nurses and psychiatric social workers, people who had not been consulted by the BBC in the making of the programmes, all seeking to ensure that their professions were adequately and accurately represented within the series. 'The going...has been pretty tough', admitted Miller Jones to a friend, 'as there is schism and faction throughout the field of psychiatry and psychology. Too exhausting.'⁸⁵

⁸⁴ Letter from Daphne Meier to the BBC Registry, undated, BBC WAC T32/200, *The Hurt Mind* – Correspondence.

⁸⁵ Letter from A. Miller Jones to Tony Barnett, 4 February 1957, BBC WAC T32/200.

Some writers touched upon the inherent problems of a broadcast seeking to raise public awareness of mental hospital conditions. This was expressed most strongly by Dr. A. M. Spencer, the Medical Superintendent of Powick hospital.

I should like to express the hope that the series will give a balanced view of our mental hospitals, by this I mean that the unsatisfactory features of so many hospitals will be spotlighted as well as attempts made to show the public that mental hospitals are not as bad as they are thought to be and that they have become places of treatment like other hospitals, where all the doctors and nurses are full of kindness, the ward doors unlocked etc; etc.

...We need, I think, not so much programmes which will allay people's fears but programmes which will stir the social conscience until something is done about the overcrowding, institutionalisation, poor feeding, poor clothing and general level of poverty to which so many of our patients are condemned.⁸⁶

Other writers sought to correct errors in the programme. Several duly authorised officers wrote in after the certification procedure was reported inaccurately and successfully managed to persuade the BBC to correct this mistake in the subsequent programme. W. Percy King of the MACA also wrote to Miller Jones hoping to get his charity's work mentioned, only to find that the NAMH had got there first. 'I'm afraid we were only able to refer very briefly to after-care in our final programme', Daphne Meier responded. 'As with so many of the subjects that we touched upon in our series, it is a vital and interesting aspect of mental health', Meier wrote, enclosing the BBC/NAMH

⁸⁶ Letter from Dr. A. M. Spencer to the BBC, 19 December 1956, BBC WAC T32/200.

pamphlet.⁸⁷ Meanwhile, occupational therapist Carol Henderson offered her thoughts on the programmes:

I look upon educating the public as one of the major tasks of any of us who work with mental patients...unfortunately...I didn't manage to see number one programme – but everyone I have discussed it with...all agree it was clear, constructive and instructive. Good television and good propaganda. I saw number two myself, and I'm afraid I didn't think it was up to the same standard...⁸⁸

Henderson may have disapproved of the second programme because she disagreed with the explanation put forward to describe the causation of mental illness. She may also have felt that the competing explanations offered in the programme would have confused the audience. This might suggest that some commentators felt that the public should be given an unambiguous account rather than being offered different explanations from which to form their own opinions.

Like most of the people involved in the production of the programme, Henderson saw her task as educative and felt that the programme was helpful not because it inspired debate amongst the general public but because it was 'good propaganda'. This view was at odds with Dr Spencer's hopes that the BBC, instead of simply seeking to destigmatise mental illness, should be giving the public evidence of the shortcomings of the mental health system. Not all BBC staff believed that programming should simply seek to inculcate views either: Isa Benzie at least appears to have been interested in offering the

⁸⁷ Letter from Daphne Meier to W. P. King, 12 February 1957, BBC WAC T32/200.

⁸⁸ Letter from Carol Henderson to A. Miller Jones, 10 January 1957, BBC WAC T32/200.

public different views. In a letter to Miss McClennan of the NAMH Public Information Committee, Benzie was scathing about the use of propaganda as a means of reaching the public, defining it as 'flat statements without explanation, accurate or inaccurate', before adding 'in my experience the other two categories [the provision of information and the forming of attitudes] are infinitely more interesting, profitable, delicate and important...'.⁸⁹ Henderson, however, had another agenda in writing to the BBC and asked: 'I wondered who has been advising you on the OT side; I can only hope they have persuaded you that it is not arts and crafts, but that it is the organisation of the entire hospital into a therapeutic community, with the aim of occupying every patient for every possible working minute of the day'.⁹⁰

PSWs were also concerned that their profession had not received due recognition. Mary Lane, then chairman of the APSW wrote to Miller Jones complaining that no mention was made of the part played by PSWs in the hospital and local authority service, and that only GPs and psychiatrists were described as dealing with the patient's rehabilitation. Several letters were exchanged in which Miller Jones and his assistants protested that there had not been enough time in the series to deal adequately with all aspects of mental health care while Lane suggested that PSWs should have been consulted about the production of the programme. 'I am sure that you will realise that mental illness is far too big a subject to be covered in five short programmes', wrote Miller Jones. 'I can only say that I was advised by most eminent members of the medical

⁸⁹ Letter from I. D. Benzie to Miss McClennan, 26 June 1956, BBC WAC S322/117/2.

⁹⁰ Letter from Henderson.

profession, who were responsible for the content and emphasis of the programmes',⁹¹ he added, passing on Lane's letter and his response to be vetted by his chief medical advisor, Dr Sargant. Sargant later responded to Miller Jones: 'Dear Andrew, I have sent off your letter to Miss Lane. Actually I think you have been much too polite, but I suppose you have to be.'⁹²

The fact that psychiatric social work was barely given a mention in the programme, and that Sargant was so scathing about their protest, is perhaps not surprising given Sargant's views about their utility within psychiatry. In his only reference to PSWs in his autobiography, Sargant recalled that at the start of his career:

We also compiled 'social' histories: tactful women interrogators called PSWs were sent to compile facts about the patient's family and home circumstances, all of which had to be studied before we examined him. This, too, was often a waste of time, but what else could one do? Nowadays we may only need to prescribe four or five electric shock treatments, or a course of some new antidepressant drug, and the patient is himself again, without any need for elaborate case-history or social investigation, still less for the former eternity of talk.⁹³

Sargant's antipathy probably stemmed from his belief that mental illness should be tackled through a physical and biological approach, rather than the social approach advocated by PSWs.

⁹¹ Letter from A. Miller Jones to Mary A. Lane, copied to Dr W. Sargant, 25 February 1957, BBC WAC T32/200

⁹² Letter from Dr. W. Sargant to A. Miller Jones, 26 February 1957, BBC WAC T32/200.

⁹³ Sargant, *The Unquiet Mind*, p. 36.

The series generated a large response outside the sub-public spheres of the professions, as can be gleaned by the 25,000 letters the BBC claimed were written in response to the programme, some of which were later incorporated into a NAMH pamphlet, *50 Questions and Answers on Mental Illness*. An analysis carried out by the NAMH of 300 letters sent to the BBC revealed that two thirds were written by women, perhaps reflecting more willingness amongst women to discuss mental illness.⁹⁴ However, few of the letters seemed to have been sent by members of the public without any connection to mental illness: of the 300, 237 dealt with obtaining treatment or advice. Patients sent 102 and relatives and friends of patients wrote a further 135. According to the NAMH analysis, many writers complained that their GP was unsympathetic. Other patients who had experienced shock treatment and found it frightening had also written in large numbers, expressing their determination to never submit to it again. This point of view had been swept over in the actual programme. 'The majority of the letters have been from people in distress, either because of their own illness or the illness of friends or relatives. They are unsure either of getting the right treatment, whether they should seek another opinion or how to persuade their friends to seek treatment', the report stated.⁹⁵ It was noted that around 25 per cent of the letters asked questions that might be suitable for the planned NAMH pamphlet, but that the rest dealt with questions deemed to be out of the scope of the NAMH, such as the relation of skin conditions to mental condition.

⁹⁴ NAMH Public Information Committee Meeting Minutes, 26 April 1957, BBC WAC S322/117/3.

⁹⁵ Analysis made by Mrs Hector McNeill of letters received by the BBC in the wake of 'The Hurt Mind', BBC WAC S322/117/1. Only the first page is in the file and it appears that later pages may be missing.

In an attempt to measure the impact of the programme upon the general public, the BBC carried out an audience research report.⁹⁶ 15 per cent of the adult population of Britain – approximately five and a half million people - had seen the broadcasts, and the appreciation indices had been 80, 62, 70, 78 and 77 in order of transmission, which compared favourably against a mean appreciation index of all televised talks and discussions in the previous quarter of 64. Only the second programme, which had dealt with different theories of causation and had received negative feedback amongst professionals and BBC staff, was rated lower. The report noted that ‘the primary aim of the series, however, was to inform viewers about the nature and treatment of mental illness, and it was hoped that one result of this would be a change in people’s views and attitudes on that subject’.⁹⁷ The BBC tested both those who had seen and had not seen the series to see if a difference could be measured in attitudes ‘before’ and ‘after’ the programme, using a sample group of 800 people. The report found that amongst those who had watched the series there was generally a slight reduction in the feeling that the mentally ill were different, accompanied by an increased insight into their condition and a more sympathetic attitude towards them. Viewers of the series were also more likely to believe that psychiatry had made great progress over the past twenty years – 58 per cent as opposed to 45 per cent who had not watched the programme.⁹⁸ The researchers felt that ‘The Hurt Mind’ had been successful as ‘the changes produced [in attitude] are

⁹⁶ BBC, *An Audience Research Report - ‘The Hurt Mind’ – An Enquiry into Some of the Effects of the Series of Five television Broadcasts about Mental Illness and Its Treatment* (1957). BBC WAC T32/846/1.

⁹⁷ *Ibid.*, p. 1.

⁹⁸ *Ibid.*, p. 9.

practically all in the intended direction and are broadly based and consistent', although they noted that 'where presentation of a point was made in concrete terms or by confronting viewers with the patients themselves, changes in attitude or knowledge tended to occur. Where the exposition was mainly in the form of a direct statement, change in the intended direction tended not to occur.'⁹⁹ The programme did fail to alter some beliefs. 90 per cent of viewers and non-viewers still believed that there was a difference between mental illness and insanity (the former regarded as more curable than the latter), while viewers of the series continued to underestimate the percentage of hospital beds used by the mental health services. Despite Sargant's brisk assurances about the efficacy of leucotomy, viewers also remained unconvinced that the operation would leave the patient's personality unaltered, 46 per cent of both viewers and non-viewers believing that the personality could change, while a further 40 per cent remained uncertain.¹⁰⁰

3: Conclusion

An analysis of BBC coverage of mental health topics between 1950 and 1970 suggests that unlike the more recent television coverage examined by the Glasgow media group, the BBC was careful to avoid representing mental illness as entertainment in this era. Indeed, the BBC believed it should be educating the public to be less, not more, afraid of mental illness by informing them of the 'facts' through worthy documentaries on life

⁹⁹ *Ibid.*, p. 17.

¹⁰⁰ *Ibid.*, p. 7.

within mental hospitals. The manner in which the BBC chose to cover the topic of mental disorder no doubt reflected the belief of the corporation that its programming should fulfil a public service function. We might perhaps explain the conflict faced by the BBC between depicting the mental health services as delivering quality medical treatment, and drawing attention to the poor standards of some hospitals, by remembering that the BBC was in the process of seeking political autonomy from the government. The corporation was unsure if it should wholeheartedly be supporting government health services, or drawing public attention to their shortcomings. The recognition of some BBC staff that a conflict existed was sometimes translated into programmes. By acknowledging in the Hurt Mind series that problems did exist in the mental health services, the programmes provided viewers with different ways of perceiving the situation rather than simply attempting to create good propaganda. However, the BBC's rather paternalistic attitude and its belief that it should be enlightening an ignorant public and destigmatising mental illness, beliefs often shared by the sub-public groups it worked with, often led the corporation to portray the problems posed by mental illness in a rather one-dimensional fashion, precluding debate.

The subject of mental illness, as opposed to mental health, only began to be covered by the BBC from the 1950s. BBC staff such as Isa Benzie believed that a 'social climate' in which such programming could be broadcast did not exist until this time. This increase in media receptivity to the issue of mental illness could be attributed in part to the efforts of sub-public groups who had been seeking to make the issue news for years. Other factors such as the absorption of mental hospitals into the NHS and the growing number

of people receiving in-patient care in mental hospitals, which peaked in the mid-1950s, made the issue one of general medical and public concern. Motivated (somewhat unwillingly) to cover the topic by pressure from sub-public groups, mostly notably psychiatrists and the NAMH, BBC coverage was dominated by a medicalised, top-down approach in which the psychiatrist was the arbiter of the facts. Although former patients were initially able to discuss the process and experiences of mental distress in radio programmes, the BBC rapidly curtailed such programming. Other professionals and users, who may have sought to challenge the medical approach by proposing a paradigm of social/political causation and treatment, were marginalised. While the BBC sought to avoid any kind of coverage that could be deemed to have a political angle, they generally fell in line behind the ministry of health and the psychiatric profession to promote NHS policies. Indeed, reliance upon a medicalised approach fronted by psychiatrists could in itself be seen to have political consequences, as Ann Karpf argues:

In spite of greater diversity in the media's reporting of health and medical issues over the past decade, medical definitions and perceptions still prevail and squeeze out more contentious, oppositional viewpoints which take an environmental approach and look at the politics of health...By excluding or marginalising other perspectives – notably, a more explicitly political analysis of the origins of illness – the media play a significant part in narrowing public debate about health, illness and medicine.¹⁰¹

This chapter also illustrates the fluidity of boundaries between sub-public spheres and the general public. BBC coverage tended to be aimed at the general public; both in the

¹⁰¹ Karpf, *Doctoring the Media*, p. 2.

stages of planning and in the actual programmes, the scale of the social and medical problem posed was emphasised as programme makers sought to make mental distress a topic of everyone's concern. Indeed, a first glance at the extensive feedback generated by the 'Hurt Mind' programme might suggest that it had reached out to the general public. A closer examination, however, reveals that not only did many health care professionals contact the programme makers, but that many members of the 'general public' who wrote in response to the programme, might themselves be classified as belonging to a sub-public sphere with a personal (private) stake in the issue of mental disorder. Many seem to have experienced mental health problems personally or were writing because someone in their family or social network had experienced problems. Moreover, an examination of audience research reports suggests that BBC attempts to overwrite popular ideas or personal experiences of mental illness were not wholly successful. While these reports tended to illustrate a slight increase in sympathy for those affected by mental disorder, the psychiatrist-presenters had failed to ease the public mind about the side affects of leucotomies, while users remained fearful of E.C.T.

Although we might conclude that the media had a democratic function in enabling sub-public groups to communicate their needs to a wider public, it is important to recognise the constrictions. First, it must be noted that the power to communicate ideas and needs varied amongst different sub-publics at different times. Thus, while for a time in the early 1950s former patients were able to use the medium of radio to represent their experiences as enriching, over time the balance of reporting tended to be skewed in favour of the psychiatric profession. This was despite the fact that audiences do not

appear to have been that receptive to the pronouncements of psychiatrists, retaining significant scepticism regarding the efficacy of leucotomies for example. Furthermore, it should be acknowledged that some sub-public organisations, utilising a commercialised media, propagated negative images of mental disorder in order to further their own private interests, and thus it should be questioned whether media coverage served a public rather than private interest. Finally, it must be remembered that what Bourdieu termed 'the constraints of the journalistic field' operated to restrict what media organisations would cover, which might explain the BBC avoidance of the topic of mental distress for so long.

Conclusion

1: Sub-Public Spheres and Democratic Representation

This thesis has used Nancy Fraser's concept of sub-public spheres to examine the statements groups made to convey their opinion regarding mental illness. It has also explored whose interests groups sought to represent by these statements, in the hope of understanding how change in the representation of mental illness occurred.¹ Habermas' concept of the public sphere has been criticised by academics for excluding domestic and economic concerns as private interests, thus helping to sustain social and economic inequalities. Sub-public spheres, which concern themselves with such 'private' matters, recognising them as valid topics of debate, thus potentially broaden both the topics considered valid for public contestation and the groups of people who can participate in these debates. Arguably, the formation of sub-public groups with an interest in mental illness played a pivotal role in shifting perceptions of mental illness from a private problem to an issue of public concern, requiring debate and state action. Not all the sub-public groups examined in this thesis, however, conformed exactly to Fraser's ideal of a group that provided both a space for withdrawal and a base from which to spread ideas to a wider audience. The historiography of mental illness has tended to focus upon the

¹ N. Fraser, 'Rethinking the Public Sphere: A Contribution to the Critique of Actually Existing Democracy', in C. Calhoun (ed.) *Habermas and the Public Sphere* (Cambridge, Massachusetts, 1999), pp. 109–42. It is worth noting here that individuals might be members of more than one sub-public sphere, belonging for example both to the MPA and the MACA, thus membership and interests of the mental health groups overlapped.

profession of psychiatry and the efforts of these individuals to create a new sphere of work and influence through the promotion of a system of asylum care. There is no question that the Medico-Psychological Association and its journal, the *Journal of Mental Science*, acted as a space of regroupment and withdrawal: it is far less certain that it acted as a base for psychiatrists to launch their ideas to a wider audience. In Chapter One it was argued that psychiatry struggled on many different fronts to protect itself – from challenges by the legal profession, dissatisfied ex-patients, other doctors and even fellow psychiatrists – that when it did seek to open and direct a public debate it was more concerned to destigmatise psychiatry than mental illness.

The National Asylum Workers' Union, examined in Chapter Two, sometimes presented the interests of psychiatric nurses to wider groups of the public. However, it is important to ask in this instance which nurses were represented, as a gender imbalance in senior positions within the union appears to have compromised the democratic potential within the sphere. Pursuit of personal interests frequently outweighed efforts to advance not just conditions for patients, but also the interests of psychiatric nurses as a group. Psychiatric social workers, the subject of Chapter Three, had an effective system for promoting internal debate, through the auspices of their journal, annual meetings and local branch meetings. However, their efforts to target a wider audience seem to have been hampered by their own uncertainty about their low profile, what exactly they sought to achieve and whose interests they sought to represent.

Charities might be seen to replicate on a smaller scale the actions of a public sphere, as they in theory consist of private individuals uniting to work for a public concern separate from governmental organisation and professional interest. However, the Mental After Care Association, examined in Chapter Four, blurred these distinctions. Many charity workers involved in other sub-public spheres such as psychiatry or poor law administration sought to advance private or professional interests through the charity, be that a destigmatisation of the asylum or a reduction in the poor rates. Indeed, the research for this thesis suggests that many individuals belonged to multiple sub-public spheres, and might seek to advance the interests of one sphere in another. Moreover, although in the nineteenth century the MACA emphasised its independence from the state, through the course of the twentieth century the state and the charity cooperated in their provision of care for the mentally ill. Rather than viewing the MACA's interaction with the state as a Habermasian example of the intermeshing of the public and private, leading to the exclusion of rational critical debate amongst private persons, we could see the MACA as an organisation that empowered private people, enabling them to become active in the running of social services at a time when most people were denied access to formal political structures. Not only did the MACA cooperate with the state, it helped innovate government policy in the twentieth century by pioneering new methods of supporting the mentally ill. However, while the MACA enabled some private individuals to have an impact on the mental health services, patients and users remained excluded from active involvement in the charity's operations until the 1960s. Chapter Five examined the potential for patients to form their own sub-public spheres, focussing on the example of the *Mirror* as a forum provided for Edinburgh patients to represent their

ideas. However, the potential for patients and former patients to express their beliefs to a wider audience was partly circumvented by the difficulties many individuals experienced in re-establishing themselves within society after an episode of illness.

Historians and sociologists have argued that the pressures of the journalistic field have enabled private interests to infiltrate, prioritising entertainment over information and thus circumventing the potential of the media to fulfil its functions as a public sphere. An examination of the BBC written archives in Chapter Six, however, suggested that different factors motivated BBC programming on mental illness, at least in the period 1950 to 1970. Sub-public groups appear to have created a climate in which the BBC felt it should cover mental illness as an issue of general (public) rather than individual (private) concern, and indeed two of the sub-public groups in particular, psychiatrists and the National Association of Mental Health, helped shape BBC programming on the issue. However, even when the BBC sought to represent the interests of the mentally ill, it was unsure what message to put across, debating whether the problems arising from mental illness should be portrayed as stemming from a single cause, the prejudice of the public, or whether the audience should be informed of the more complex nature of the problems, such as the inadequate and outdated facilities available for treatment. This dilemma probably stemmed from the BBC's perception of the public, reflecting their doubts regarding the public's capacity to appreciate the complexities of the situation and arrive at a rational conclusion.

We can argue that the concept of the Habermasian public sphere fails to be truly democratic because the exclusion of private interests invalidates problems individuals experience that reinforce social inequalities. However, if the consideration of private interests is incorporated via sub-public spheres to widen democratic participation, it might be found that private interests are pursued at the expense of public interest. Four of the six groups examined were established primarily to represent the interests of mental health workers, and may have felt that their priority was to achieve professional status for their occupation. In order to advance as a profession they needed to appear altruistic, skilled, and to be working in the interests of the public and their clients.² This strategy aimed to counter ideas that their occupation was a trade which operated for profit, and usually led workers to represent mental disorder as an illness requiring skilled medical treatment and sympathetic understanding. However, if occupations did not wish to be confused with charity workers, there was a danger that stressing the vocational nature of one's occupation might create the belief that the job did not require remuneration as professional or demanding work. Professional recognition could also be hindered by the perceived gender of an occupation. Thus psychiatric social work, which was perceived largely as a female occupation, struggled to achieve the same status and remuneration as similarly skilled male-dominated professions. Conversely, psychiatric nurses drew on the professional ideal created originally by the female profession of general nursing when they sought to depict their occupation as a skilled medical profession. Mental health workers faced the dilemma of deciding whether their interests or those of their clients

² This in itself could be problematic, as the interests of the health worker's clients, the state and society might diverge, as was explored in Chapter Three.

should be prioritised when they made representations to the public. All too often, sub-publics argued that they needed to advance their own interests before they could advance the interests of the mentally ill, rather than vice versa.

Thus, while the plurality of interests represented in the occupational sub-public spheres might be welcomed as a sign of increasing representation of people's interests, it is worth asking whether this benefited the sub-public group at the heart of the issue, mental health service users. Not even patients and former patients consistently represented the interests of the mentally ill as a group. Moreover, not all sub-public groups examined within the thesis experienced the same success in gaining access to the public ear: while participation may be broadened, it is important to recognise the constraints on democracy posed when not all participants contribute on an equal footing with access to the same resources. While many different beliefs were expressed in the multiple sub-publics, only some groups had the required ability or power to transmit these ideas to a wider audience through the media or government.

The idea of the sub-public sphere was deployed in this thesis to distinguish people with a specific stake in the issue of mental disorder from the general public, those people without a personal interest in the issue. When examining the BBC records surrounding the responses to 'The Hurt Mind', these two categories became harder to distinguish. It appeared that mental distress might be a topic that affected most of the population to a variable extent, perhaps because psychiatric care impinged more upon people's lives up until the 1970s. The actual number of people believed to be affected by mental disorder

within the population may not have undergone much change, listed by the MACA as one in five in 1968 and as one in six currently by the Office for National Statistics.³ The percentage of people likely to receive care as an inpatient for a psychiatric disorder, however, has dropped from the 1968 figure of 9 per cent (and 47 per cent of all hospital beds) to just 0.6 per cent of the population today.⁴ Indeed, the high incidence of mental disorder amongst the community and the large number of hospital beds given over to the treatment of the disorder was often used in advertisements and programmes in the era under study to persuade viewers and readers that mental disorder affected everyone in some way. We might also explain this blurring of the boundaries between the sub-public and general public groups by suggesting that the earlier nineteenth-century concern with mental illness had been displaced through the course of the twentieth century with interest in the mental health of the whole community. In the late nineteenth and early twentieth centuries, madness and the mentally ill were clearly demarcated from sane society. However, by the early twentieth century, new ideas began to permeate popular

³ The MACA figures were devised for their 1968 ATV appeal, 'One in Five', described in Chapter Four. SA/MAC/D.3/1/8 ATV Appeal, '1 in 5', 7 April 1968, flyer. The statistics from the Office for National Statistics relate to the number of people believed to be affected by 'significant' mental health problems; a lower figure of one in four was given for general mental health problems. These statistics were drawn from I. Hatloy, 'Statistics 1: How Common is Mental Distress?', MIND, March 2003 <http://www.mind.org.uk/NR/exeres/A1B90E68-1EBC-4DBE-978F-33C0CC37787A.htm?NRMODE=Published&wbc_purpose=Basic&WBCMODE=PresentationUnpublished> (4 September 2003).

⁴ Again, the MACA figures were drawn from their 1968 ATV campaign, 'One in Five'. The figure of 9 per cent was worked out by combining the variable percentages for men and women. The figures for current rates of hospitalisation were drawn again from Hatloy, 'Statistics'.

culture. The distinction between the mad and sane became more blurred, as mental health groups sought to persuade people that everyone's lives were affected by mental disorder, and represented the public as a community that needed to fight together to preserve mental health.⁵

2: Representing the Public

The manner in which most mental health groups represented the public may have precluded their desire to welcome lay people as equal partners in any debate on mental illness. If the public were believed to be apathetic, ignorant and prejudiced, attracted by sensationalist reporting and only to be wooed by buns and padded cells,⁶ then it was logical that many felt a democratic debate to be out of the question. Moreover, many members of sub-public mental health groups believed their opinions to be based on incontestable scientific fact, and thus not open to debate. Thus we might recall the quote of John Charles Bucknill at the start of this thesis, in which the only type of public opinion that was valued by mental health groups was that which regurgitated opinions passed on to them by scientific experts. Sometimes members of sub-public groups

⁵ For an overview of the social developments of psychiatry in the twentieth century, see R. Porter, 'Two Cheers for Psychiatry! The Social History of Mental Disorder in Twentieth Century Britain', in G. E. Berrios and H. Freeman (eds), *150 Years of British Psychiatry Volume II: The Aftermath* (London, 1998), pp. 383–406.

⁶ This sentence recaps points made by MPA President R. W. Armstrong in 1957, which is cited in full in Chapter One: R. W. Armstrong, 'Education in Psychiatry: Presidential Address', *Journal of Mental Science*, 103 (1957), pp. 691–8.

encountered stumbling blocks when, armed with their preconceptions about the public, they tried to enlighten them. Diana Hyde, who produced a BBC radio programme about mental health care in Northern Ireland, found she had to reassess her opinion about public attitudes after she discovered that an episode of mental illness could have consequences for an individual's work, marriage career and emigration prospects. 'I must modify my attitude to the public attitude', she wrote, 'which is not necessarily the result of ignorance, but also a perfectly reasonable fear of the consequences'.⁷

Apathy could be as problematic as prejudice, and so public opinion was not always seen as a negative factor. Members of sub-public groups frequently expressed the aspiration that the public would pressurise the government to provide better facilities for treatment, better funding for research, and improved wages for workers. Psychiatrists hoped that public opinion might counter institutionalism and help them escape from the asylum. However, as this implies, it had to be the right kind of public opinion – governed by the beliefs and desires of mental health professionals. Appeals to the public were based on different arguments. Some campaigned on behalf of the mentally ill by appealing to notions of religious duty. Others sought to destigmatise mental illness by deploying a scientific, medicalised discourse. These efforts often made recourse to statistical evidence to suggest that everyone was potentially at risk from mental illness. Sometimes the mentally ill were represented as part of a broader community of unproductive people, who should be encouraged to be productive.

⁷ 0BBC WAC N14/6/7/1 Mental Illness 1955–60. Report on visit by Diana Hyde, May 1 1956, 'Within our Province'.

3: Changing Representations of Mental Illness

As the nineteenth century gave way to the twentieth, earlier distinctions between the sane and insane began to break down and attention shifted beyond the walls of the asylum into the community. Psychiatrists were among the earliest group of workers to explore the possibilities of promoting mental health in society, expressing their concerns on the dangers of drinking and education, for example. However, the MPA had surprisingly little to say about mental illness. This did not stop psychiatrists in an individual capacity from campaigning for more media coverage of mental health issues, as we saw in the examination of the BBC, or indeed from producing their own accounts. Popular psychiatry books touched on a wide range of issues, from the neglect of patients in war time,⁸ the advances made by heroic doctors pioneering physical therapies for the mentally sick⁹ to the possibility of understanding not just the process of going mad but achieving personal transcendence oneself.¹⁰ Perhaps the most common factor in these works was not the advancement of any particular representation of mental illness, but a critique of supposed public ignorance regarding both mental illness and psychiatry.¹¹

⁸ M. Lomax, *The Experiences of an Asylum Doctor: With Suggestions for Asylum and Lunacy Law Reform* (London, 1921).

⁹ W. Sargant, *The Unquiet Mind: The Autobiography of a Physician in Psychological Medicine* (London, 1967).

¹⁰ R.D. Laing, *The Divided Self: An Existential Study in Sanity and Madness* (1959, London, 1965).

¹¹ See H. Yellowlees, *To Define True Madness: Commonsense Psychiatry for Lay People* (1953, London, 1955); D. Stafford – Clarke, *Psychiatry To-day* (1952, London, 1963).

The representations advanced by psychiatric nurses initially appear to fit the story of progression from a stigmatisation of the mad to a humanisation and medicalisation of mental illness, a process linked intrinsically to the representation of attendant's work and workplaces. When the NAWU commenced in 1910 the Union represented the interests of attendants who worked in asylums, and its journal related tales of the dangerous, deviant inmates that attendants had to control and pacify. Over the course of the twentieth century, corresponding to the developments of new treatments, the Union began to represent madness as an illness requiring medicalised treatment from skilled nurses in hospitals. This image represented the interests of both workers and patients, humanising the mental patient and professionalising the nurse. However, the strength of the Union's resolution to advance the interests of patients was challenged when plans to close down the psychiatric hospitals surfaced and nurses were initially denied a large role in the new community services.

PSWs might initially be seen as one of the groups of mental health workers who abandoned the asylum and set out to work with healthier and more prestigious clients. They were, after all, situated more within the community than the asylum and early in the history of the occupation largely disregarded cases labelled as mentally deficient, preferring to work with the neurotic mothers of children who had been referred to the CGCs. However, the profession later developed psychiatric social treatment with chronic cases, advancing the idea that mental illness did not necessarily debar an individual from living a fulfilling life within the community, provided their satisfactions could be

maintained. PSWs took the problem of mental illness into the community, often working amongst networks of people rather than individuals and seeking to remove social and environmental impediments to mental ill health.

To maintain its relevance in an era of increasing government intervention, the MACA created services that were different to those provided by the state, and correspondingly created representations of patients who would benefit from these services in its work. Thus, in the late nineteenth century, when the initial optimism regarding the efficacy of asylum treatment had largely expired and medical superintendents frequently represented their patients as suffering from hereditary, degenerative conditions, the MACA tended to represent mental illness as a curable conditions which often afflicted respectable citizens in a time of understandable strain. Such patients, the MACA claimed, could be assisted back to the productive workforce with befriending, recuperation and assistance finding employment. However, the development of welfare services prompted the MACA to rethink its service provisions in the mid-twentieth century, a time when new physical treatments suggested that mental disorder, like physical illness, could be treated and cured in a medical environment. The charity began to provide more care for chronically disordered patients, promoting representations of chronically ill patients who could be assisted to have more personally fulfilling lives in a sheltered environment. The MACA's services for and representations of the mentally ill were thus affected by changing state provision. However, as this thesis has attempted to show, the process was reciprocal: the state often responded to developments made by the sub-public groups, just as the groups sometimes responded to

the state, and new directions in mental health care entailed new representations of mental illness and of the groups that worked with the mentally ill.

Within the confines of the *Mirror*, some patients at the REA were able to fashion an alternative identity for themselves than that of mental patient, as poet or literary critic or sportsman, competing on an equal footing with the medical staff. The *Mirror* also provided the clearest example of a counter-public, in that it used satire to subvert the dominant representation of insanity, mostly notably in the articles about the Secret Society of Certified Lunatics. However, former patients seeking to write for a broader audience did not always seek to represent the interests of the mentally ill, and while some expressed sympathy for the predicament of the mentally ill and urged reform, they were careful to distance themselves from their former companions. Even Clifford Beers, who spearheaded the Mental Hygiene movement, sought to distance himself from other people who had experienced mental illness.¹² Moreover, it might be questioned whether the mental health campaign, which focused on the nominally healthy, may not have disadvantaged chronically ill patients by diverting attention and resources. However, biographies written by former patients from the mid-twentieth century suggest that some were able to represent their experiences of mental illness as part of their life, a product of social constraints and damaging relationships, which led to personal revelation.¹³

12 C. Beers, *A Mind that Found Itself: An Autobiography* (London, 1908). Discussed in R. Porter, *A Social History of Madness: Stories of the Insane* (London, 1999), pp. 36–37

13 See, for example, Anonymous, *The Autobiography of David, edited by Ernest Raymond* (London, 1946); J. Vincent, *Inside the Asylum* (London, 1948); M. Barnes and J. Berke, *Two Accounts of a Journey Through Madness* (London, 1971).

The examination of the BBC records shows that the corporation only began broadcasting on issues of mental health as opposed to mental illness from the mid-twentieth century. BBC broadcasts largely represented mental illness as a curable condition that could affect anyone and which responded to the medical treatments provided by hospitals. The corporation aimed to destigmatise mental illness through this approach by representing it as analogous to physical illnesses. However, while the BBC may have hoped to serve the interests of the mentally ill through its broadcasting, patients were rarely allowed to speak without intervention and the medicalised approach largely excluded any representations of mental disorder as a condition amenable to social approaches.

These case studies have been chosen to illustrate in detail how and why certain representations of mental illness might obtain prominence at a given time. This thesis has argued that representations of mental disorder are almost accidental, telling us more about those who worked with the mentally ill – their professional aspirations, identities, economic motivations and perceptions of the public - than about the mentally ill or the public themselves. The somewhat haphazard way in which representations of mental disorder are generated and accepted as public representations means that positive representations of mental illness might co-exist alongside negative representations, or even that positive representations might give way to more detrimental images of mental illness. Progress towards the destigmatisation of mental illness has not been straightforward, and thus negative representations of mental illness continue to affect the

lives of mental health service users. Throughout the period that this thesis has been researched and written, the Royal College of Psychiatrists has been engaged in a five-year campaign to destigmatise mental illness entitled 'changing minds'.¹⁴ People affected by mental illness continue to be thought of as (potentially dangerous) mental patients rather than people, a perception that has a damaging impact on the lives of mental health service users, their families and carers.¹⁵

¹⁴ See Royal College of Psychiatrists, 'Changing Minds', Royal College of Psychiatrists, 2003 <<http://www.rcpsych.ac.uk/campaigns/cminds/>> (8 December 2003).

¹⁵ Representations of mental health service users within the community have been examined by Peter Barham, who interviewed users and discussed the negative impact such representations can have on individuals. The Glasgow media group, which focused on representations of mental illness within the media, also argue that negative representations adversely affect users: This is discussed in Chapter Six. P. Barham, *Closing the Asylum: The Mental Patient in Modern Society* (London, 1997); G. Philo (ed.), *Media and Mental Distress* (London, 1996).

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